AGENDA

BOARD OF SUPERVISORS, COUNTY OF MONO
STATE OF CALIFORNIA

Regular Meetings: First, Second, and Third Tuesday of each month. Location of meeting is specified below.
Teleconference Only - No Physical Location

Regular Meeting
February 16, 2021

TELECONFERENCE INFORMATION

As authorized by Governor Newsom's Executive Order, N-29-20, dated March 17, 2020, the meeting will be held via teleconferencing with members of the Board attending from separate remote locations. This altered format is in observance of recommendations by local officials that precautions be taken, including social distancing, to address the threat of COVID-19.

Important Notice to the Public Regarding COVID-19

Based on guidance from the California Department of Public Health and the California Governor's Officer, in order to minimize the spread of the COVID-19 virus, please note the following:

1. Joining via Zoom

There is no physical location of the meeting open to the public. You may participate in the Zoom Webinar, including listening to the meeting and providing public comment, by following the instructions below.

To join the meeting by computer:

Visit https://monocounty.zoom.us/j/96554411849

Or visit https://www.zoom.us/ click on "Join A Meeting" and use the Zoom Meeting ID 965 5441 1849.

To provide public comment (at appropriate times) during the meeting, press the **"Raise Hand"** button on your screen.

To join the meeting by telephone:

Dial (669) 900-6833, then enter Webinar ID 965 5441 1849.

To provide public comment (at appropriate times) during the meeting, press ***9** to raise your hand.

2. Viewing the Live Stream

If you are unable to join the Zoom Webinar of the Board meeting you may still view the live stream of the meeting by visiting *http://monocounty.granicus.com/MediaPlayer.php?publish_id=759e238f-a489-40a3-ac0e-a4e4ae90735d*

NOTE: In compliance with the Americans with Disabilities Act if you need special assistance to participate in this meeting, please contact Shannon Kendall, Clerk of the Board, at (760) 932-5533. Notification 48 hours prior to the meeting will enable the County to make reasonable arrangements to ensure accessibility to this meeting (See 42 USCS 12132, 28CFR 35.130).

ON THE WEB: You can view the upcoming agenda at http://monocounty.ca.gov. If you would like to receive an automatic copy of this agenda by email, please subscribe to the Board of Supervisors Agendas on our website at http://monocounty.ca.gov/bos.

UNLESS OTHERWISE SPECIFIED BY TIME, ITEMS SCHEDULED FOR EITHER THE MORNING OR AFTERNOON SESSIONS WILL BE HEARD ACCORDING TO AVAILABLE TIME AND PRESENCE OF INTERESTED PERSONS. PUBLIC MAY COMMENT ON AGENDA ITEMS AT THE TIME THE ITEM IS HEARD.

9:00 AM Call meeting to Order

Pledge of Allegiance

1. OPPORTUNITY FOR THE PUBLIC TO ADDRESS THE BOARD

Please refer to the Teleconference Information section to determine how to make public comment for this meeting.

2. RECOGNITIONS - NONE

3. COUNTY ADMINISTRATIVE OFFICE

CAO Report regarding Board Assignments
Receive brief oral report by County Administrative Officer (CAO) regarding work activities.

4. DEPARTMENT/COMMISSION REPORTS

Receive brief oral report on emerging issues and/or activities.

5. CONSENT AGENDA

(All matters on the consent agenda are to be approved on one motion unless a board member requests separate action on a specific item.)

A. Board Minutes - January 5, 2021

Departments: Clerk of the Board

Approval of the Board Minutes from the Regular Meeting on January 5, 2021.

Recommended Action: Approve the Board Minutes from the Regular Meeting on January 5, 2021.

Fiscal Impact: None.

B. Reappointment to the Mono County Child Care Council

Departments: Mono County Child Care Council

Mono County Child Care Council seeks the re-appointment of Pam Heays by the Mono County Board of Supervisors for a two-year term beginning February 28, 2021 and terminating February 27, 2023.

Recommended Action: Appoint Pam Heays to a two-year term in the category of Consumer of Child Care beginning February 28, 2021 and terminating February 27, 2023.

Fiscal Impact: None.

C. Appointment to County Service Area #1 Advisory Board

Departments: Clerk of the Board

The County Service Area #1 (CSA1) Advisory Board recommends the appointment of David Titus to its Board effective February 16, 2021, for a term expiring November 30, 2024.

Recommended Action: Appoint David Titus to the CSA1 Board effective February 16, 2021, for a term expiring November 30, 2024.

Fiscal Impact: None.

D. Authority to Hire WIC Program Manager/Registered Dietician at Step B

Departments: Public Health

Authorize the Public Health Director to fill the WIC Program Manager/Registered Dietician position at Step B (75B).

Recommended Action: Authorize the Public Health Director to hire Ms. Stephanie Riley-Stai at a B step in the position of WIC Program Manager/Registered Dietician.

Fiscal Impact: There is no impact to the County General Fund. The cost of this position is currently budgeted in fiscal year 2020-21 through the approved budget. The fiscal impact for the remainder of fiscal year 2020-21 will be approximately $62,897 consisting of $37,650 in salary and $25,247 in benefits.

E. Authority to Hire Two Community Health Outreach Specialists at Step B

Departments: Public Health

Authorize the Public Health Director to fill two (2) Community Health Outreach Specialist positions at Step B (63B).

Recommended Action: Authorize the Public Health Director to hire Ms. Maria Vega and Mr. Juan Rios into the positions of Community Health Outreach Specialist as a Step B (63B).

Fiscal Impact: There is no impact to the County General Fund. Both positions are fully grant funded through the term of the grant, with the positions coming to an end on November 17, 2022. The cost of these positions is currently budgeted in fiscal year 2020-21. The fiscal impact for the remainder of fiscal year 2020-21 will be approximately $32,596 per position, consisting of $20,350 in salary and $12,246 in benefits, or $65,192 total for both positions in fiscal year 2020-21.

F. Emergency Guardrail Replacement - Justification for Continued Emergency

Departments: Public Works - Roads

Update on the Emergency Guardrail replacement project on Eastside Lane and North River Lane and finding of continued emergency.

Recommended Action:
1. Receive update on Eastside Lane and North River Lane emergency guardrail repair/replacement project.
2. As established by Public Contract Code Chapter 2.5, "Emergency Contracting Procedures," review the emergency action taken on Jan 5, 2021 and make a finding, based on substantial evidence set forth in this staff report and at the meeting, that the emergency continues to exist as to Eastside Lane and North River Lane, and that continuation of action to replace the damaged guardrail on both roads is necessary to respond to the emergency. [4/5th Vote Required.]
3. Delegate to the Mono County Road Operations Superintendent the authority to continue to procure the necessary equipment, services, and supplies for the emergency guardrail replacement on Eastside Lane and North River Lane, without giving notice for bids to let contracts, including executing any agreements or contracts for the construction or repair of the damaged/destroyed guardrails. [4/5th Vote Required.]

Fiscal Impact: The total cost of the emergency repair/replacement of the guardrails is approximately $160,000. The emergency projects are eligible for 75% funding via the California Disaster Assistance Act (CDAA) Program administered by the Governor's Office of Emergency Services (CalOES). The LTC approved using transportation funding for the remaining 25% County match. Project costs are included in the amended budget for FY 2020-21.

G. Ordinance Amending Chapter 13.40 of the Mono County Code - Public Use of Conway Ranch

Departments: Public Works, County Counsel

Proposed ordinance amending Chapter 13.40 of the Mono County Code related to public use of portions of Conway Ranch dedicated to livestock grazing during grazing season or for other future uses.

Recommended Action: Adopt proposed ordinance.

Fiscal Impact: None.

6. CORRESPONDENCE RECEIVED

Direction may be given to staff regarding, and/or the Board may discuss, any item of correspondence listed on the agenda.

A. Notice Of Petitions for Change for Licenses 10191 And 10192 (Applications 8042 And 8043) of The City of Los Angeles, Department of Water And Power

On November 14, 2013, the State Water Resources Control Board received Petitions for Change from the City of Los Angeles, Department of Water and Power (LADWP) pursuant to California Code of Regulations, title 23, section

791, subdivision (e) requesting incorporation into its water right Licenses 10191 and 10192 the Mono Basin Settlement Agreement Regarding Continuing Implementation of Water Rights Orders 98-05 and 98-07.

B. Federal Energy Regulatory Commission (FERC) Letters re: Dams Part of the Lee Vining Creek Project, FERC Project No. 1388-CA

Federal Energy Regulatory Commission (FERC) letters regarding responses to FERC Comments on the 3rd Independent Consultant's Safety Inspection Report for Rhinedollar Dam, responses to FERC Comments on 11th Independent Consultant's Safety Inspection Report for Saddlebag Dam, and Revised Semi-Quantitative Risk Analysis (SQRA) Report for Rhinedollar Dam.

7. REGULAR AGENDA - MORNING

A. First 5 Fiscal Year 2019-20 Evaluation Report

Departments: First 5

20 minutes (10 minute presentation; 10 minute discussion)

(Molly DesBaillets, Executive Director) - Evaluation of services provided to families and children prenatal to five years old in Mono County for Fiscal Year 2019-20.

Recommended Action: None, informational only.

Fiscal Impact: None.

B. Revolving Loan Update

Departments: Finance

20 minutes

(Patricia Robertson, Mammoth Lakes Housing Executive Director) - Mammoth Lakes Housing has utilized the Mono County Revolving Loan Fund for a total of five (5) purchases of deed-restricted properties between September 26, 2017 and December 31, 2019. There have been no new loans issued since December 2019. There is one outstanding loan that received a 6- month extension for Unit H101 located on 550 Mono Street.

Recommended Action:
(1) Receive presentation and update from Mammoth Lakes Housing (“MLH”) staff on use of Mono County Revolving Loan Fund (Affordable Housing) (“RLF”) as required by Resolution Nos. 15-8, 17-86 and 20-104;
(2) Receive update on use of RLF funds to purchase affordable/deed-restricted housing and compliance with RLF program requirements; and
(3) Provide any desired direction to staff.

Fiscal Impact: Interest continues to accrue for outstanding loan which now supports affordable housing activities.

C. COVID-19 (Coronavirus) Update

1 hour

(Robert C. Lawton, CAO, Bryan Wheeler, Public Health Director) - Update on Countywide response and planning related to the COVID-19 pandemic, including reports from the Emergency Operations Center (EOC), Unified Command (UC), and the various branches of the EOC, including Community Support and Economic Recovery, Joint Information Center (JIC), and Public Health.

Recommended Action: None, informational only.

Fiscal Impact: None.

D. Mountain View Fire Update

10 minutes

(Justin Nalder, EOC Director) - Update on the Mountain View Fire in Walker, California.

Recommended Action: Receive update from Incident Command for the Mountain View Fire and involved staff regarding impacts of the fire, recovery efforts, County response, debris removal and related topics. Provide any desired direction to staff.

Fiscal Impact: No impact from this update.

E. Legislative Platform Workshop

Departments: Administration

1.5 hours

(Robert C. Lawton, CAO) - Workshop for the Board of Supervisors to review changes suggested by County departments for the 2021 Legislative Platform

Recommended Action: Make changes and recommendations for the 2021 Legislative Platform. Provide any desired direction to staff.

Fiscal Impact: None.

8. OPPORTUNITY FOR THE PUBLIC TO ADDRESS THE BOARD

Please refer to the Teleconference Information section to determine how to make public comment for this meeting.

9. CLOSED SESSION

A. Closed Session - Labor Negotiations

CONFERENCE WITH LABOR NEGOTIATORS. Government Code Section 54957.6. Agency designated representative(s): Bob Lawton, Stacey Simon,

Janet Dutcher, and Dave Wilbrecht. Employee Organization(s): Mono County Sheriff's Officers Association (aka Deputy Sheriff's Association), Local 39 - majority representative of Mono County Public Employees (MCPE) and Deputy Probation Officers Unit (DPOU), Mono County Paramedic Rescue Association (PARA), Mono County Public Safety Officers Association (PSO). Unrepresented employees: All.

B. Closed Session - Public Employee Evaluation

PUBLIC EMPLOYEE PERFORMANCE EVALUATION. Government Code section 54957. Title: County Administrative Officer.

C. Closed Session - Public Employee Evaluation

PUBLIC EMPLOYEE PERFORMANCE EVALUATION. Government Code section 54957. Title: County Counsel.

D. Closed Session - Existing Litigation

CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Paragraph (1) of subdivision (d) of Government Code section 54956.9. Name of case: Abshire et. al, v. Newsom, et al. (US Dist. Ct. for the Eastern District 2:21-cv-00198-JAM-KJN).

THE AFTERNOON SESSION WILL RECONVENE NO EARLIER THAN 1:00 P.M.

10. OPPORTUNITY FOR THE PUBLIC TO ADDRESS THE BOARD

Please refer to the Teleconference Information section to determine how to make public comment for this meeting.

11. REGULAR AGENDA - AFTERNOON

A. New Statewide Inland Trout Fishing Regulations for the 2021-2022 Fishing Season

Departments: Economic Development

15 minutes

(Jeff Simpson, Economic Development Manager) - The California State Fish and Game Commission approved new Statewide Inland Trout Fishing Regulations for the 2021-2022 fishing season. The current 2020-2021 regulations remain in effect through Feb. 28, 2021. The new regulations will go into effect on: March 1, 2021.

Recommended Action: None, informational only.

Fiscal Impact: None.

B. Discussion of MediCal Managed Care and Presentation from Inland Empire Health Plan

Departments: Social Services; Public Health; Behavioral Health

Item scheduled to start at 1:30 PM (45 minutes)

(Kathy Peterson, Mono Social Services; Meaghan McCamman, Inyo HHS) - A brief presentation on the upcoming procurement of new MediCal managed care plans through the state Department of Health Care Services will be provided, followed by a presentation from Inland Empire Health Plan.

Recommended Action: Receive presentation on the upcoming procurement of new MediCal managed care plans through the state Department of Health Care Services followed by a presentation from Inland Empire Health Plan on the possibility of partnering with Mono County to provide Medi-Cal Managed Care Services for Mono County Medi-Cal beneficiaries. Provide staff direction.

Fiscal Impact: None.

C. Housing Update

Departments: CAO

1 hour

(Robert C. Lawton, County Administrative Officer) - In 2018, a toolbox matrix consisting of strategies to address Mono County's housing challenges was established and vetted through extensive community outreach. The toolbox matrix proposed integration of goals and strategies into potential programs and actions.

In the absence of a dedicated County housing office, staff in a range of departments have stepped in to provide momentum. Their efforts have enabled the County to be proactive and responsive despite the other demands on their time, especially during the Pandemic.

The County is now recruiting for a dedicated Housing Coordinator, and a new Supervisor has been elected to the Board since the toolbox was last reviewed.

Recommended Action: Staff recommends the Board review and discuss the Housing Toolbox Prioritization set forth in 2018 for possible recommendation of staff action and amendment at a future date.

Fiscal Impact: None noted at this time.

12. BOARD MEMBER REPORTS

The Board may, if time permits, take Board Reports at any time during the meeting and not at a specific time.

ADJOURN

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Clerk of the Board

TIME REQUIRED

SUBJECT Board Minutes - January 5, 2021

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Approval of the Board Minutes from the Regular Meeting on January 5, 2021.

RECOMMENDED ACTION:

Approve the Board Minutes from the Regular Meeting on January 5, 2021.

FISCAL IMPACT:

None.

CONTACT NAME: Queenie Barnard

PHONE/EMAIL: 760-932-5534 / qbarnard@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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Minutes

History

Time	Who	Approval
2/11/2021 3:57 PM	County Counsel	Yes
2/11/2021 10:45 AM	Finance	Yes
2/12/2021 9:06 AM	County Administrative Office	Yes

DRAFT MEETING MINUTES
BOARD OF SUPERVISORS, COUNTY OF MONO
STATE OF CALIFORNIA

Regular Meetings: First, Second, and Third Tuesday of each month. Location of meeting is specified below.
Teleconference Only - No Physical Location

Regular Meeting
January 5, 2021

Backup Recording	Zoom
Minute Orders	M21-01 – M21-13
Resolutions	R21-01 – R21-08
Ordinance	ORD21-01 Not Used

9:02 AM Meeting Called to Order by Chair Corless.

Supervisors Present: Corless, Gardner, Kreitz, Peters, and Stump (all attended via teleconference).
Supervisors Absent: None.

The Mono County Board of Supervisors stream most of their meetings live on the internet and archives them afterward. To search for a meeting from June 2, 2015 forward, please go to the following link: http://www.monocounty.ca.gov/meetings.

Pledge of Allegiance led by Supervisor Duggan.

1. OPPORTUNITY FOR THE PUBLIC TO ADDRESS THE BOARD

Elaine Kabala, Eastern Sierra Council of Governments (ESCOG) Staff:

- Introduced self as new staff with the ESCOG

Gary Nelson. Mono City resident:

- Recycling services at transfer stations, request to expand services to include mixed paper

2. RECOGNITIONS

A. Swearing In of Rhonda Duggan as District Two Supervisor, Bob Gardner as District Three Supervisor, and John Peters as District Four Supervisor

Departments: Board of Supervisors

(Judge Magit) - Swearing in of Rhonda Duggan as District Two Supervisor, Bob Gardner as District Three Supervisor, and John Peters as District Four Supervisor

Action: No Board action required. Judge Magit administered the oaths of office to Supervisors Duggan, Gardner, and Peters.

B. Election of New 2021 Board Chair

Departments: Board of Supervisors

(Stacy Corless, Outgoing Board Chair) - The outgoing Board Chair will call for nominations to elect the Chair of the Board for 2021.

Action: Elect Supervisor Jennifer Kreitz as the new Chair of the Board for 2021.
Peters motion; Gardner seconded.
Vote: 5 yes, 0 no
M21-01

- Supervisor Peters nominated Supervisor Kreitz as Board Chair

C. Presentation to Outgoing Board Chair Corless

Departments: Board of Supervisors

(Board Chair) - Presentation to outgoing Board Chair Corless by newly elected Board Chair honoring Supervisor Corless' service to the Board in 2020.

Action: None.

- Newly-elected Chair Kreitz presented a plaque to outgoing-Chair Corless
- Other Board members spoke, expressing their gratitude to Supervisor Corless

D. Election of New 2021 Vice Chair

Departments: Board of Supervisors

(Board Chair) - The newly elected Board Chair will call for nomination to elect the Vice Chair of the Board for 2021.

Action: Elect Supervisor Bob Gardner as new Vice Chair of the Board for 2021.
Peters motion; Duggan seconded.
Vote: 5 yes, 0 no
M21-02

- Supervisor Peters nominated Supervisor Gardner as Vice Chair

E. Election of New 2021 Chair Pro-Tem

Departments: Board of Supervisors

(Board Chair) - The newly elected Board Chair will call for nominations to elect the Chair Pro-Tem of the Board for 2021.

Action: Elect Supervisor Rhonda Duggan as new Chair Pro-Tem of the Board for 2021.
Corless motion; Gardner seconded.

Vote: 5 yes, 0 no
M21-03

- Supervisor Corless nominated Supervisor Duggan as Chair Pro-Tem

3. COUNTY ADMINISTRATIVE OFFICE

CAO Report regarding Board Assignments
Bob Lawton, CAO:

- EOC meetings, COVID response meetings
- Mountain View Fire – thanked Justin Nalder, Mary Booher, Jennifer Baker
- Behavioral Health housing project at The Parcel
- Business roundtables with Mammoth Lakes and June Lake small businesses and lodging owners
- Continuing engagement with CalOES
- Mid-year budget development
- Meeting with CalTrans District 9 Director

4. DEPARTMENT/COMMISSION REPORTS

Stacey Simon, County Counsel:

- Introduced Kevin Moss, new Office Manager/Paralegal in County Counsel's office

Justin Nalder, Solid Waste Superintendent:

- Granted HD35 grant, Household Hazardous Waste discretionary fund: $100,000

Ingrid Braun, Mono County Sheriff:

- Retirements: Civil Deputy Pete DeGeorge, Sergeant Tim Minder and Sergeant Jeff Beard
- Promotions: Brent Gillespie and Eli Clark both promoted to Sergeant, Jason Pelichowski promoted to Investigator, Cory Custer promoted to Civil Deputy

5. CONSENT AGENDA

(All matters on the consent agenda are to be approved on one motion unless a board member requests separate action on a specific item.)

A. Board Minutes - November 10, 2020

Departments: Clerk of the Board

Approval of the Board Minutes from the Regular Meeting on November 10, 2020.

Action: Approve the Board Minutes from the Regular Meeting on November 10, 2020.
Gardner motion; Corless seconded.
Vote: 5 yes, 0 no
M21-04

B. Board Minutes - November 17, 2020

Departments: Clerk of the Board

Approval of the Board Minutes from the Regular Meeting on November 17, 2020.

Action: Approve the Board Minutes from the Regular Meeting on November 17, 2020.
Gardner motion; Corless seconded.
Vote: 5 yes, 0 no
M21-05

C. Joint Town/County Meeting Minutes - November 17, 2020

Departments: Clerk of the Board

Approval of the Joint Town/County Meeting Minutes from the Special Meeting on November 17, 2020.

Action: Approve the Joint Town/County Meeting Minutes from the Special Meeting on November 17, 2020.
Gardner motion; Corless seconded.
Vote: 5 yes, 0 no
M21-06

D. Board Minutes - November 24, 2020

Departments: Clerk of the Board

Approval of the Board Minutes from the Special Meeting on November 24, 2020.

Action: Approve the Board Minutes from the Special Meeting on November 24, 2020.
Gardner motion; Corless seconded.
Vote: 5 yes, 0 no
M21-07

E. June Lake Citizens Advisory Committee Appointment

Departments: Community Development - Planning

Reappoint David Rosky for a second, four-year term to the June Lake Citizens Advisory Committee (CAC). The CAC consists of 6 members at this time and may have up to 10 members. Three seats will remain open.

Action: Appoint David Rosky to the June Lake Citizens Advisory Committee for a four-year term, expiring December 31, 2024.
Gardner motion; Corless seconded.
Vote: 5 yes, 0 no
M21-08

F. Mono County Child Care Council Certification Statement Regarding Composition of Local Planning Council Membership

Departments: Mono County Child Care Council

The Board of Supervisors and Superintendent of Schools make the appointments of the council members to the Mono Council Child Care

Council. The Certification Statement Regarding Composition of Local Planning Council (LPC) Membership certifies that the membership criteria as established under the Education Code are met. The submission of certification is required annually by the California Department of Education.

Action: Approve the membership certification for the Mono County Child Care Council and authorize the Board of Supervisors Chair to sign the certification.
Gardner motion; Corless seconded.
Vote: 5 yes, 0 no
M21-09

G. Annual Resolution Delegating Investment Authority to the County Treasurer

Departments: Finance

Resolution Delegating Investment Authority to the County Treasurer.

Recommended Action: Adopt Resolution R21-01, Delegating Investment Authority to the County Treasurer.
Gardner motion; Corless seconded.
Vote: 5 yes, 0 no
R21-01

H. Mono County Statement of Investment Policy

Departments: Finance

Annual approval of the Mono County Statement of Investment Policy pursuant to Section 27133 of the Government Code of the State of California.

Action: Approve the Mono County Statement of Investment Policy.
Gardner motion; Corless seconded.
Vote: 5 yes, 0 no
M21-10

6. CORRESPONDENCE RECEIVED

Direction may be given to staff regarding, and/or the Board may discuss, any item of correspondence listed on the agenda.

The Board acknowledged receipt of the correspondence.

A. Los Angeles Department of Water and Power (LADWP) Notice of Intent to Adopt a Mitigated Negative Declaration Extension of Public Review Period

The City of Los Angeles Department of Water and Power (LADWP) prepared an Initial Study for the Mono Basin Water Rights Licenses Project. Based on the information contained in the Initial Study, LADWP intends to adopt a Mitigated Negative Declaration for the project under the California

Environmental Quality Act (CEQA). The public review period commenced on October 30, 2020 and originally concluded on December 15, 2020. An extension request has been granted, therefore the public review period is updated to conclude on January 6, 2021 at 5:00 pm.

B. Federal Energy Regulatory Commission (FERC) Letter re: Revised Supporting Technical Information Document (STID) for Tioga Lake Dams

A letter from Frank L. Blackett, P.E., Federal Energy Regulatory Commission Regional Engineer, to James A. Buerkle, Southern California Edison Company Director of Generation, in response to a letter from Wayne Allen submitting the revised Supporting Technical Information Document (STID) for Tioga Lake Dams, which are part of the Lee Vining Creek Project, FERC No. 1388.

7. REGULAR AGENDA - MORNING

A. Mountain View Fire Update

(Justin Nalder, EOC Director) - Update on the Mountain View Fire in Walker, California.

Action: None.

Justin Nalder, EOC Director / Solid Waste Superintendent:

- CDAA application for private property debris removal
- Department of Toxic Substances Control onsite today – hazardous waste
- Approved for small business administration declaration – allows individuals to apply for low interest loans if they choose to rebuild
- Continue to collect information through needs survey led by Social Services

Supervisor Peters:

- Community workshops update
- Donations update

B. Resolution Waiving Well and Septic System Permit Fees Associated with the Mountain View Fire (MVF)

Departments: Public Health

(Louis Molina, Environmental Health Director) - Proposed resolution to waive any permit fees for onsite wastewater treatment (OWTS) and water well construction associated with new construction or repairs on properties affected by the MVF.

Action: Adopt Resolution R21-02, waiving water well permit fees and onsite wastewater treatment system permit fees for reconstruction associated with Mountain View Fire recovery.
Peters motion; Corless seconded.
Vote: 5 yes, 0 no
R21-02

Louis Molina, Environmental Health Director:

- Presented item

C. Resolution Waiving Encroachment Permit and Grading Permit Fees for Victims of the Mountain View Fire

Departments: Public Works

(Tony Dublino, Director of Public Works) - Proposed resolution waiving encroachment permit and grading permit fees for reconstruction associated with Mountain View Fire recovery.

Action: Adopt Resolution R21-03, waiving encroachment permit and grading permit fees for reconstruction associated with Mountain View Fire recovery.
Peters motion; Gardner seconded.
Vote: 5 yes, 0 no
<u>R21-03</u>
Tony Dublino, Director of Public Works:

- Presented item

D. Eastside Lane and North River Lane Emergency Guardrail Repair/Replacement Projects

Departments: Public Works - Roads

(Kevin Julian, Road Operations Superintendent) - Authorization of Emergency Repair and Replacement of Eastside Lane and North River Lane Guardrails Damaged and/or Destroyed by the Mountain View Fire.

Action:
1. As established by Public Contract Code Chapter 2.5, "Emergency Contracting Procedures," find that based on substantial evidence set forth in this staff report and at the meeting that the emergencies posed by the damaged/destroyed Eastside Lane guardrails and the damaged/destroyed North River Lane guardrails require the County to take directly related and immediate action, including but not limited to procuring the necessary equipment, services, and supplies for those purposes, without giving notice for bids to let contracts. [4/5th Vote Required.]
2. Adopt the attached resolution that includes the emergency findings and delegates to the Mono County Road Operations Superintendent the authority to order any directly related and immediate action required by the emergencies created by the damaged/destroyed Eastside Lane guardrails and the damaged/destroyed North River Lane guardrails, and procure the necessary equipment, services, and supplies for those purposes, without giving notice for bids to let contracts, including executing any agreements or contracts for the construction or repair of the damaged/destroyed guardrails. [4/5th Vote Required.]

Peters motion; Gardner seconded.
Vote: 5 yes, 0 no
<u>R21-04</u>
Kevin Julian, Road Operations Superintendent:

- Presented item

Break: 10:26 AM
Reconvened: 10:33 AM

E. COVID-19 (Coronavirus) Update

(Robert C. Lawton, CAO, Dr. Tom Boo, Mono County Health Officer) - Update on Countywide response and planning related to the COVID-19 pandemic, including reports from the Emergency Operations Center (EOC), Unified Command (UC), and the various branches of the EOC, including Community Support and Economic Recovery, Joint Information Center (JIC), and Public Health.

Action: None.

The following individuals gave updates:

- Bryan Wheeler, Public Health Director - PPT presentation (can be found under Supporting Documents on the meeting webpage) – vaccines, testing, local positivity rates
- Supervisor Peters – CSAC Rural County Group update
- Bob Lawton, CAO – Update on joint letter from County and Town of Mammoth Lakes to Governor Newsom regarding regional grouping
- Stacey Simon, County Counsel – Midway Venture case update
- Janet Dutcher, Finance Director – CARES Act funding

Public Comment:

- Ron Day
- Alisa Rosa
- Good Citizen

8. OPPORTUNITY FOR THE PUBLIC TO ADDRESS THE BOARD

None.

Moved to Item 12.

9. CLOSED SESSION

Closed Session: 12:20 PM
Reconvened: 1:05 PM

Reentered Closed Session: 2:08 PM
Reconvened: 3:07 PM

Nothing to report out of Closed Session.

A. Closed Session - Public Employee Evaluation

PUBLIC EMPLOYEE PERFORMANCE EVALUATION. Government Code section 54957. Title: County Administrative Officer.

B. Closed Session - Exposure to Litigation

CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION. Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Government Code section 54956.9. Number of potential cases: two.

THE AFTERNOON SESSION WILL RECONVENE NO EARLIER THAN 1:00 P.M.

10. OPPORTUNITY FOR THE PUBLIC TO ADDRESS THE BOARD

None.

11. REGULAR AGENDA - AFTERNOON

A. Employment Agreement - Social Services Director

Departments: Human Resources/CAO

(David R Butters, HR Director) - Proposed resolution approving a contract with Kathryn E. Peterson as Social Services Director, and prescribing the compensation, appointment and conditions of said employment.

Action: Announce Fiscal Impact. Approve Resolution R21-05, approving a contract with Kathryn E. Peterson as Social Services Director, and prescribing the compensation, appointment and conditions of said employment. Authorize the Board Chair to execute said contract on behalf of the County.

Fiscal Impact: The cost for this position for the remainder of FY 2020-2021 (January 5th to June 30th) is approximately $98,961 of which $63,727 is salary, and $34,964 is the cost of the benefits and was included in the approved budget. The cost for an entire fiscal year would be approximately $204,683 of which $132,168 is salary and $72,515 is the cost of benefits.

Gardner motion; Duggan seconded.
Vote: 5 yes, 0 no
R21-05
Dave Butters, HR Director:

- Presented item

B. Employment Agreement - Emergency Medical Services Chief

Departments: Human Resources/CAO

(David R Butters, HR Director) - Proposed resolution approving a contract with Chris Mokracek as Emergency Medical Services Chief, and prescribing the compensation, appointment and conditions of said employment.

Action: Announce Fiscal Impact. Approve Resolution R21-06, approving a contract with Chris Mokracek as Emergency Medical Services Chief, and prescribing the compensation, appointment and conditions of said employment. Authorize the Board Chair to execute said contract on behalf of the County.

Fiscal Impact: The cost for this position for the remainder of FY 2020-2021 (January 5th to June 30th) is approximately $97,778 of which $59,740 is salary and $38,038 is the cost of the benefits and is included in the approved budget. Total cost for a full fiscal year would be $202,789 of which $123,900 is annual salary and $78,889 is the cost of the benefits.

Corless motion; Gardner seconded.
Vote: 5 yes, 0 no
R21-06
Dave Butters, HR Director:

- Presented item

C. Employment Agreement - Assistant Assessor

Departments: Human Resources/CAO

(David R Butters, HR Director) - Proposed resolution approving a contract with Tracy Morgan as Assistant Assessor, and prescribing the compensation, appointment and conditions of said employment.

Action: Announce Fiscal Impact. Approve Resolution R21-07, approving a contract with Tracy Morgan as Assistant Assessor, and prescribing the compensation, appointment and conditions of said employment. Authorize the Board Chair to execute said contract on behalf of the County.

Fiscal Impact: The cost for this position for the remainder of FY 2020-2021 (January 5th to June 30th) is approximately $89,072 of which $56,602 is salary, and $32,470 is the cost of the benefits and was included in the approved budget. The cost for an entire fiscal year would be approximately $164,441 of which $104,494 is salary and $59,945 is the cost of benefits.

Gardner motion; Corless seconded.
Vote: 5 yes, 0 no
R21-07
Dave Butters, HR Director:

- Presented item

D. Employment Agreement - Solid Waste Superintendent

Departments: Human Resources/CAO

(David R Butters, HR Director) - Proposed resolution approving a contract with Justin Nalder as Solid Waste Superintendent, and prescribing the compensation, appointment and conditions of said employment.

Action: Announce Fiscal Impact. Approve Resolution R21-08, approving a contract with Justin Nalder as Solid Waste Superintendent, and prescribing the compensation, appointment and conditions of said employment. Authorize the Board Chair to execute said contract on behalf of the County.

Fiscal Impact: The cost for this position for the remainder of FY 2020-2021 (January 5th to June 30th) is approximately $78,583 of which $44,489 is salary and $34,095 is the cost of the benefits and is included in the approved budget. Total cost for a full fiscal year would be $162,980 of which $92,268 is annual salary and $70,712 is the cost of the benefits.
Peters motion; Gardner seconded.
Vote: 5 yes, 0 no
R21-08
Dave Butters, HR Director:

- Presented item

E. 2021 Calendar of Regular Meetings of the Board of Supervisors

Departments: Clerk of the Board

(Shannon Kendall, Clerk-Recorder-Registrar) - Rule 3 of the Mono County Board Rules of Procedure specifies that an annual calendar of meetings shall be adopted by the Board at its first meeting in January. The calendar will include all known regular meetings. Any meeting may be canceled upon the order of the Chair or by a majority of Board members.

Action: Approve proposed calendar of regular meetings for 2021.
Duggan motion; Corless seconded.
Vote: 5 yes, 0 no
M21-11
Shannon Kendall, Clerk-Recorder-Registrar:

- Presented item

F. Supervisors' Appointments to Boards, Commissions, and Committees for 2021

Departments: Clerk of the Board

(Shannon Kendall, Clerk-Recorder-Registrar) - Mono County Supervisors serve on various board, commissions, and committees for one-year terms that expire on December 31st. Each January, the Board of Supervisors makes appointments for the upcoming year.

Action: Appoint Supervisors to boards, commissions, and committees for 2021 as stated.
Gardner motion; Peters seconded.
Vote: 5 yes, 0 no
M21-12
Shannon Kendall, Clerk-Recorder-Registrar:

- Reviewed appointments to board, commissions, and committees

G. Reimbursement of Elections Costs

Departments: Elections

(Shannon Kendall, Clerk-Recorder-Registrar) - On November 3, 2020, the Mono County Elections Office conducted a Statewide General Election. Pursuant to Elections Code 10002, “the city or district shall reimburse the county in full for the services performed upon presentation of

a bill to the city or district." There were eight contests (two for Mammoth Unified School District, one for all others) included in the November General Election that are eligible to be reimbursed by a Special or School District.

Action: Approve 7 invoices: $457.17 to Antelope Valley Fire; $2,285.88 to Eastern Sierra Unified School District; $2,743.06 to Mono County Office of Education; $6171.89 to Mammoth Unified School District (covers board race and Measure "G"); $457.17 to Bishop Unified School District; $457.17 to Hilton Creek Community Services District; and $2,285.88 to Town of Mammoth for costs incurred by races/measures on the ballot in the Statewide General Election which occurred on November 3, 2020.
Corless motion; Gardner seconded.
Vote: 5 yes, 0 no
M21-13
Shannon Kendall, Clerk-Recorder-Registrar:

- Presented item

Moved back to item 9.

12. BOARD MEMBER REPORTS

Supervisor Corless:

- 12/9 – RCRC Board of Directors meeting. RCRC staff put together a comprehensive wildfire prevention and response legislative package
- Next week's Installation Reception, panel discussion with Natural Resources Secretary, Wade Crowfoot, US Forest Service Region 5 Forester Randy Moore, and Sierra Nevada Conservancy Executive Officer Angela Avery to talk about wildfire issues
- 12/10 – attended final Sierra Nevada Conservancy board meeting representing the Eastern region. Alpine, Inyo, and Mono Counties switch representatives every two years. Alpine County Supervisor Ron Hames will be our new eastside representative starting 2021
- Wildlife Stewardship team meeting – group working on wildlife crossing project on Highway 395
- Thanked Eastern Sierra Land Trust for offering to serve as the nonprofit fiscal agent for private donations.
- Eastern Sierra Council of Governments meeting, Behavioral Health Advisory Board meeting, NACo Public Lands Steering Committee meeting, meeting with Inyo National Forest Supervisor Lesley Yen, attended several Yosemite Gateway Area Coordination team meetings, Eastern Sierra Sustainable Recreation partnership meeting, joint meeting with Town Council
- Many conversations and messages from residents regarding COVID – fear, anger, frustration on all sides. Urge us as a County and other agencies responding to try to maintain compassion and understanding and to continue to work together as a region.

Supervisor Duggan:

- 12/1-2/20 – CSAC New Supervisors Institute – Sessions I/II
  - As part of the CSAC Annual Convention, I participated in the first of 6 sessions focused on county policy issues, the basics of county government, and the role of county supervisor.

- 12/10/20 – CSAC Institute – Supervisor Credential Courses
    - I participated in the CSAC Institute Mastering Social Media Basics. The course was designed to guide a social media presence to effectively communicate and inform our constituents. I found it beneficial considering the ongoing changes to SM platforms and new regulations.
- 12/10/20 – OVGA (Owens Valley Groundwater Authority)
    - As earlier reported on by Former Supervisor Stump, I attended the monthly meeting where issues of Mono County continuing to contribute to the GSP were discussed.
    - I look forward to working with the OVGA as Mono County's representative and ensuring the County's interests and concerns are addressed and satisfied.
- 12/16/20 – TVGA (Tri-Valley Groundwater Authority).
    - I attended the monthly meeting where the TVGA Board discussed options for future engagement with OVGA and the process for re-acquiring their GSA status.
    - We saw a presentation from OVGA on the groundwater pumping maps for the region and status report on the progress of the Groundwater Sustainability Plan for the area.
    - The TVGA Board is planning options for community outreach in the Tri-Valley to gather citizen input and contribute information to the regional plan. More information on outreach dates to come.
- 12/21/20- Land Development Technical Advisory Committee
    - I attended the meeting as there were (3) three projects in District 2 communities under consideration.
    - This was the initial opportunity for applicants and the public to exchange ideas and concerns. Staff answers procedural questions and helps to guide projects for the best outcome for all. Projects may ultimately come to the Board for approval.
- 1/4/21- Land Development Technical Advisory Committee
    - I attended the meeting where projects were presented by staff and applicants for North County and in Crowley Lake. Our staff gave guidance to the applicants on how to proceed with the permitting process and heard questions and concerns from the public.
    - These items will be noticed and will proceed to the Planning Commission for denial or recommendation to the Board of Supervisors for approval where needed.

Supervisor Gardner:

- On Dec. 9 I participated in the June Lake Chamber of Commerce annual membership meeting. The Chamber continues to support several projects related to strengthening the June Lake business community.
- On Dec. 10 I participated in the NACO Rural Action Caucus webinar. There were several presentations on various topics, including COVID relief legislation, vaccine distribution, and building back local economies.
- On Dec. 11 I participated with Chair Corless in the ESCOG meeting. We had a very informative briefing from IMACA Director Larry Emerson about their homeless programs. We also discussed planning for presentations to each of the ESCOG entities about the Sustainable Recreation Ecosystem Management Program Resolution and received an update on activities of the Eastern Sierra sustainable Recreation Partnership.
- On Dec. 11 I also participated in the monthly meeting of the ESTA Board. ESTA's ridership is still well below last year's levels but is showing some increase each month.

- On Dec. 14 I participated in a June Lake Chamber Roundtable meeting about COVID. Thanks to the many County and other staff who attended this session.
- On Dec. 14 I attended the monthly meeting of the Mono Basin Fire Safe Council. The Council continues to work on fire prevention and other related projects.
- On Dec. 18 I participated in a meeting of the NACO Public Lands Policy Committee. We heard updates on pending legislation and were briefed on potential Biden Administration appointees.
- Also, on Dec. 18 I attended a meeting of the Regional Forest and Fire Capacity Program stakeholders. We discussed further work by this group on possible projects.
- On Dec. 23 I attended the joint Town and County special meeting about COVID restrictions.
- Yesterday I participated with Supervisor Corless in the monthly meeting of the Eastern Sierra Sustainable Recreation Partnership. Besides updates from each of the partners, we heard about several possible recreation-related grant opportunities for the region.

Supervisor Kreitz:

- On December 8th I attended the Town Council special meeting where the Council authorize additional funding for community support services in response to the COVID19 economic impacts.
- December 9th I participated in the NACo Community Workforce and Economic Development committee meeting. There was a guest speaker to provide an overview of Section 8 Vouchers. Later in the afternoon I attended the Mammoth Lake Planning and Economic Development Commission public hearing on The Parcel Master Plan including phase 1 of the planned development which is proposed to create 81 apartments, (1-, 2-, and 3-bedroom units), a childcare facility and community center. The Commission recommended approval to the Town Council. It's currently schedule to be before the Council at their January 6th meeting.
- NACo held an informative LUCC/RAC Virtual Symposium on December 10. The LUCC and RAC members talked about housing and hunger as the pandemic continues. To read the County News article highlighting the symposium, please click here.
- Friday, December 11 was both the ESTA board meeting and the California Coalition for Rural Housing board meeting. ESTA staff have not had any COVID19 outbreaks within the staff. The late-night Mammoth Lakes trolley service has been reduced due to the COVID19 curfew and Stay at Home order.
- The MLH labor negotiation ad-hoc committee met on December 11. I met with Cortney Powell, Mono County Child Care Council Coordinator on December 11 to discuss the childcare center included in phase one of The Parcel.
- The regular monthly Local Transportation Commission meeting was held on December 14. The Commission adopted a resolution of appreciation for Commissioner Stump and wished him well and expressed their gratitude for his service. The Board received a presentation from Caltrans on the District 9 Origin and Destination Study as well as a presentation on the Caltrans SHOPP program.
- On December 16th I attended the CCP General Committee meeting. The committee reviewed committees that will work on the 11 strategic objectives. Later in the day I participated in the CoC PIT Count for 2021. Due to the coronavirus pandemic HUD is allowing a COCs to not do a PIT count in 2021 and the Eastern Sierra COC agreed to not do a count this year. They will count those that are being served in units at this time through homeless outreach programs.
- On December 17th I participated in a discussion on child care at The Parcel and later met with Behavioral Health Director Robin Roberts and staff Amanda

Greenberg to discuss the County's participation in phase one of The Parcel development. That evening I attended the COVID 19 Community Conversation.

- Monday, January 4th was the regularly scheduled CCRH Legislative Committee meeting followed by the regular MLH Board meeting. The state legislature has multiple housing related bills already proposed. The MLH Board considered the 2021 staff work priorities based on the organization's Strategic Plan.
- On Wednesday, January 6th at 4PM the Town Council will consider adoption of The Parcel Master Plan.
- "You can use all the qualitative data you can get, but you still have to distrust it and use your own intelligence and judgement." – Alvin Toffler

Supervisor Peters:

- 12/18 – NACo Human Services and Education Quarterly leadership call, WIR Board meeting
- 12/21 – Met with Robin Roberts and Amanda Greenberg to discuss various housing opportunities and projects
- Serving on the CSAC and NACo Broadband Taskforces

Moved to Item 9.

ADJOURNED AT 3:08 PM

ATTEST

____

JENNIFER KREITZ
CHAIR OF THE BOARD

____

QUEENIE BARNARD
SENIOR DEPUTY CLERK OF THE BOARD

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Mono County Child Care Council

TIME REQUIRED

SUBJECT Reappointment to the Mono County Child Care Council

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Mono County Child Care Council seeks the re-appointment of Pam Heays by the Mono County Board of Supervisors for a two-year term beginning February 28, 2021 and terminating February 27, 2023.

RECOMMENDED ACTION:

Appoint Pam Heays to a two-year term in the category of Consumer of Child Care beginning February 28, 2021 and terminating February 27, 2023.

FISCAL IMPACT:

None.

CONTACT NAME: Courtney Powell, Local Planning Council Coordinator

PHONE/EMAIL: 760-934-0031 / cpowell@monocoe.org

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
Staff Report
Membership Roster

History

Time	Who	Approval
2/8/2021 2:45 PM	County Counsel	Yes
2/10/2021 9:32 AM	Finance	Yes
2/12/2021 9:05 AM	County Administrative Office	Yes

P. O. Box 130
Mammoth Lakes, CA 93546

January 25, 2021

To: Mono County Board of Supervisors

From: Courtney Powell, Mono County Child Care Planning Council (MCCCC) Coordinator

Re: Reappointment of Member to the Mono County Child Care Council – Pam Heays

Dear Board of Supervisors;

The Mono County Child Care Planning Council (MCCCC) is requesting reappointment by the Board of Supervisors of Pam Heays to serve as a member of the Child Care Council in the category of Consumer of Child Care. Originally appointed by the County Superintendent of Schools, her term expires February 28, 2021. On January 21, 20201 the Mono County Child Care Planning Council (MCCCC) voted unanimously to reappoint Pam Heays for a two-year term.

The new appointment will be for a two-year term beginning 2/28/2021ending 2/27/2023.

Please confirm your agreement to Pam Heays to serve as a member of the Council.

Thank you for considering this request.

Courtney Powell, MCCCC Coordinator
cpowell@monocoe.com
760-934-0031 ext.136

______________________________________ __________________
Mono County Board of Supervisors **Date**

2020-21 MCCCC Membership List

<table>
<tr><th colspan="2">Consumers of Child Care</th></tr>
<tr><td>Pam Heays
Town of Mammoth Lakes, Consumer of Child Care
760-965-3603 (w); 509-671-0785 (c)
P.O. Box 1609
Mammoth Lakes, CA 93546
pkobylarz@townofmammothlakes.ca.gov
Term ends: 2/28/21 MCOE</td><td>Brooke Bien
Mammoth Unified School District
760-934-6802 x513 (w); 760-914-2290 (c)
P.O. Box 3509
Mammoth Lakes, CA 93546
bbien@mammothusd.org
Term ends: 8/14/2021 MCOE</td></tr>
<tr><th colspan="2">Child Care Providers</th></tr>
<tr><td>Danielle Dublino
IMACA Lee Vining Preschool Lead Teacher
760-937-1126(w);760-647-6095(c)
P.O. Box 845
Bishop Ca, 93515
ddublino@imaca.net
Term ends: 6/17/2022 MCOE</td><td>Julie Winslow
Mammoth Kids Corner
760-934-4700 (w); 541-326-7124 (c)
P.O. Box 9048
Mammoth Lakes, CA 93546
juliemarieblack14@gmail.com
Term ends: 12/18/21 Bd of Sups</td></tr>
<tr><th colspan="2">Public Agency Representatives</th></tr>
<tr><td>Jacinda Croissant
Mono County Health Department
760-924-1842 (w); 720-220-2124 (c)
P.O. Box 3329
Mammoth Lakes, CA 93546
jcroissant@mono.ca.gov
Term ends: 10/22/2022 Bd of Sups</td><td>Molly DesBaillets (Chair)
First 5 Mono County
760-924-7626 (w)
P.O. Box 130
Mammoth Lakes, CA 93546
mdesbaillets@monocoe.org
Term ends: 10/31/22 MCOE</td></tr>
<tr><th colspan="2">Community Representative</th></tr>
<tr><td>Sofia Flores (Vice-Chair)
Mono County Behavioral Health
760-924-1740 (w)
P.O. Box 2619
Mammoth Lakes, CA 93546
sflores@mono.ca.gov
Term ends: 12/18/21 MCOE</td><td>Annaliesa Calhoun (Secretary)
First 5 Mono County
760-924-7626 (w)
P.O. Box 130
Mammoth Lakes, CA 93546
acalhoun@monocoe.org
Term ends: 3/17/22 Bd of Sups</td></tr>
<tr><th colspan="2">Discretionary Appointees</th></tr>
<tr><td>Kelly Conboy
Inyo Mono Advocates for Community Action
Community Connections for Children
760-934-3343 (w); 425-894-5078 (c)
P.O. Box 8571
Mammoth Lakes, CA 93546
kconboy@imaca.net
Term ends: 6/17/2022 Bd of Sups</td><td>Brittany Nelson
Inyo Mono Advocates for Community Action
760-873-3001 (w)
180 E. Clarke Street
Bishop, CA 93514
bnelson@imaca.net
Term ends: 5/30/2021 Bd of Sups</td></tr>
<tr><th colspan="2">LPC Coordinator</th></tr>
<tr><td colspan="2">Courtney Powell
Mono County Office of Education
760- 934-0031 (w); 661-860-5000 (c)
451 Sierra Park Rd., P.O. Box 130, Mammoth Lakes, Ca 93546
cpowell@monocoe.org</td></tr>
</table>

Updated: 11/12/2020

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Clerk of the Board

TIME REQUIRED

SUBJECT Appointment to County Service Area #1 Advisory Board

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

The County Service Area #1 (CSA1) Advisory Board recommends the appointment of David Titus to its Board effective February 16, 2021, for a term expiring November 30, 2024.

RECOMMENDED ACTION:

Appoint David Titus to the CSA1 Board effective February 16, 2021, for a term expiring November 30, 2024.

FISCAL IMPACT:

None.

CONTACT NAME: Queenie Barnard

PHONE/EMAIL: 760-932-5534 / qbarnard@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
Minute Order
Board Application

History

Time	Who	Approval
2/8/2021 2:11 PM	County Counsel	Yes
2/10/2021 9:33 AM	Finance	Yes
2/12/2021 9:05 AM	County Administrative Office	Yes

COUNTY SERVICE AREA #1
Television Service
CROWLEY LAKE - LONG VALLEY
Post Office Box 3861
Mammoth Lakes, CA 93546

MINUTE ORDER 2021-02

At the January 26, 2021 regular Board meeting of Mono County Service Area No. 1, motion was made by John Connolly to recommend to the Board of Supervisors the appointment of David Titus to the Board of Mono County Service Area No. 1 for a four-year term expiring 11/30/2024, filling the vacancy created when the term of Carlene Millan expired 11/30/20. Rick Laborde seconded the motion and the Board voted as follows:

John Connolly – Yes
Rick Laborde - Yes
Denise Perpall – Yes

The motion was passed unanimously.

Attest:

Marianne O'Connor
Secretary of the Board

Dear CSA1 Board,

I'm interested in becoming a CSA1 board member. I live in Crowley Lake, CA at 61 Lager Lane within the district boundaries and am a registered voter in Mono County. Thanks for your consideration in accepting me on the board for the current term.

Sincerely,

Dave

Dave Titus
760-914-3762

DAVE TITUS ILLUSTRATIONS
61 LAGER LANE, CROWLEY LAKE, CA 93546
(760)914-3762
ME@DAVETITUS.COM
WWW.DAVETITUS.COM

MONO COUNTY
APPLICATION FOR APPOINTMENT
TO BOARDS/COMMISSIONS/COMMITTEES

DATE	2/4/21
NAME	Dave Titus
POSITION APPLIED FOR:	
	CSA1 Board Member

RESIDENCE ADDRESS	61 LAGER LANE CROWLEY LAKE, CA 93546
PHONE	760-914-3762
BUSINESS / MAILING ADDRESS	Same as above
PHONE	Same
OCCUPATION	Graphic Artist

How did you learn of the opening? Word of mouth

Please state briefly any experience of which you feel will be helpful when you serve in this appointment: I was a board member (4 years) Mono County Office of Education. Instrumental in raising money for and building the Crowley ball field. Started/founded the Crowly Lake Trail Run.

Other information may be submitted by resume if desired.

Summary of background and skills: [illegible] years Mono County Little League boardmember + Past President. Leave no trace trainer (LNT) Coach and Teacher recreational youth sports.

Professional experience: 27 years Self-employed freelance Illustrator Graphic Designer

Education: BS Graphic Design (SJSU)

Professional and/or community organizations: 3 Year High School baseball coach, WASC committee member,

Personal interests and hobbies: Mountaineering, photography, Horse riding, hiking.

Have you ever been convicted of a felony, which would disqualify you from appointment? If you are appointed and cannot be bonded as required, your appointment will be revoked. NO

If you desire a personal interview or wish to address the Board, you may contact the Board of Supervisor's Office directly at (760) 932-5533.

Please return application to:

Clerk of the Board
County of Mono
P. O. Box 715
Bridgeport, CA 93517

[signature]

Signature

2-4-21

Date

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Public Health

TIME REQUIRED

SUBJECT Authority to Hire WIC Program Manager/Registered Dietician at Step B

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Authorize the Public Health Director to fill the WIC Program Manager/Registered Dietician position at Step B (75B).

RECOMMENDED ACTION:

Authorize the Public Health Director to hire Ms. Stephanie Riley-Stai at a B step in the position of WIC Program Manager/Registered Dietician.

FISCAL IMPACT:

There is no impact to the County General Fund. The cost of this position is currently budgeted in fiscal year 2020-21 through the approved budget. The fiscal impact for the remainder of fiscal year 2020-21 will be approximately $62,897 consisting of $37,650 in salary and $25,247 in benefits.

CONTACT NAME: Bryan Wheeler

PHONE/EMAIL: 760-924-1835 / bwheeler@mono.ca.gov

SEND COPIES TO:

Bryan Wheeler, Stephanie Butters, Dave Butters

MINUTE ORDER REQUESTED:

☑ YES ☐ NO

ATTACHMENTS:

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Staff Report

History

Time	Who	Approval
2/8/2021 2:46 PM	County Counsel	Yes
2/10/2021 9:42 AM	Finance	Yes
2/12/2021 9:06 AM	County Administrative Office	Yes

MONO COUNTY HEALTH DEPARTMENT
Public Health

P.O. BOX 476, BRIDGEPORT, CA 93517 PHONE (760) 932-5580 • FAX (760) 932-5284
P.O. BOX 3329, MAMMOTH LAKES, CA 93546 PHONE (760) 924-1830 • FAX (760) 924-1831

Date: February 16, 2021

To: Honorable Board of Supervisors

From: Bryan Wheeler, Public Health Director

Subject: Authority to Hire at Step B

Recommendation:

Authorize the Public Health Director to fill the WIC Program Manager/Registered Dietician position at Step B (75B).

Discussion:

The WIC Program Manager/Registered Dietician was a vacant position due to the resignation of the prior incumbent. After interviews, Stephanie Riley-Stai was hired as the successful candidate on January 4th 2021. Due to her qualifications, we are requesting to promote her to a Step B retroactive to her hire date.

Stephanie Riley-Stai possesses excellent qualifications for the position of WIC Program Manager/Registered Dietician. She has over five years of experience working with and providing nutritional assessments to neonatal, pediatric, and obstetrics/postpartum patients. Additionally, she has experience providing bilingual and culturally appropriate nutrition and breastfeeding education, counseling, and explanation of evidence-based practices to patients at varying developmental and educational levels. Lastly, Stephanie has experience managing programmatic responsibilities, collaborating on quality improvement projects, and developing program policies and procedures. Typically, a new employee is placed at Step A of a given salary range. In accordance with the Mono County Personnel System (MCPE), Board of Supervisors approval is required when an employee is hired above Step A. Given Ms. Riley-Stai's experience and qualifications, the department is requesting authorization to offer her employment at Step B of the salary range (Range 75) for this position.

Fiscal Impact:

There is no impact to the County General Fund. The cost of this position is currently budgeted in fiscal year 2020-21 through the approved budget. The fiscal impact for the remainder of fiscal year 2020-21 will be approximately $62,897 consisting of $37,650 in

salary and $25,247 in benefits.

For questions regarding this item, please call Bryan Wheeler at (760) 924-1835.

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Public Health

TIME REQUIRED

SUBJECT Authority to Hire Two Community Health Outreach Specialists at Step B

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Authorize the Public Health Director to fill two (2) Community Health Outreach Specialist positions at Step B (63B).

RECOMMENDED ACTION:

Authorize the Public Health Director to hire Ms. Maria Vega and Mr. Juan Rios into the positions of Community Health Outreach Specialist as a Step B (63B).

FISCAL IMPACT:

There is no impact to the County General Fund. Both positions are fully grant funded through the term of the grant, with the positions coming to an end on November 17, 2022. The cost of these positions is currently budgeted in fiscal year 2020-21. The fiscal impact for the remainder of fiscal year 2020-21 will be approximately $32,596 per position, consisting of $20,350 in salary and $12,246 in benefits, or $65,192 total for both positions in fiscal year 2020-21.

CONTACT NAME: Bryan Wheeler

PHONE/EMAIL: 760-924-1835 / bwheeler@mono.ca.gov

SEND COPIES TO:

Bryan Wheeler, Stephanie Butters, Dave Butters

MINUTE ORDER REQUESTED:

☑ YES ☐ NO

ATTACHMENTS:

Click to download
Staff Report

History

Time	Who	Approval
2/8/2021 2:43 PM	County Counsel	Yes
2/10/2021 9:40 AM	Finance	Yes
2/12/2021 9:06 AM	County Administrative Office	Yes

MONO COUNTY HEALTH DEPARTMENT
Public Health

P.O. BOX 476, BRIDGEPORT, CA 93517 PHONE (760) 932-5580 • FAX (760) 932-5284
P.O. BOX 3329, MAMMOTH LAKES, CA 93546 PHONE (760) 924-1830 • FAX (760) 924-1831

Date: February 16, 2021
To: Honorable Board of Supervisors
From: Bryan Wheeler, Public Health Director
Subject: Authority to Hire at Step B

Recommendation:

Authorize the Public Health Director to fill two (2) Community Health Outreach Specialist positions at Step B (63B).

Discussion:

The two (2) vacancies for Community Health Outreach Specialist are grant-funded, limited term positions ending with the grant termination date of November 17, 2022. Both are new positions that were recently introduced as a result of targeted funding from the California Department of Public Health provided to local Health Departments to hire additional staff to support a robust COVID-19 response during the pandemic (COVID-19 Enhancing Laboratory Capacity/Enhancing Detection Funding Grant Award). Maria Vega and Juan Rios have been selected as successful candidates to fill these positions.

Ms. Vega comes to the table with strong prior experience. She has worked closely with the Health Department to assist with COVID-19 testing and health education since July 2020. Her familiarity with COVID-19 programing and operations will allow her to hit the ground running. She is fluent in Spanish and well positioned to assist with outreach to the Latinx community.

Mr. Rios possesses excellent qualifications for his new role. He has a bachelor's degree in a healthcare field, which well exceeds the minimum prerequisite for the role. He is also fluent in Spanish and already an active participant in Latinx community engagement conversations, making his connections and insights very valuable for future Health Department health equity work.

In accordance with the Mono County Personnel System, Board of Supervisors approval is required when an employee is hired above Step A. Given Ms. Vega's past experience, and Mr. Rios' strong educational credentials, the Health Department is requesting authorization to offer both of them employment at Step B (63B).

Fiscal Impact:

There is no impact to the County General Fund. Both positions are fully grant funded through the term of the grant, with the positions coming to an end on November 17,

2022. The cost of these positions is currently budgeted in fiscal year 2020-21. The fiscal impact for the remainder of fiscal year 2020-21 will be approximately $32,596 per position, consisting of $20,350 in salary and $12,246 in benefits, or $65,192 total for both positions in fiscal year 2020-21.

For questions regarding this item, please call Bryan Wheeler at (760) 924-1835.

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Public Works - Roads

TIME REQUIRED		**PERSONS APPEARING BEFORE THE BOARD**
SUBJECT	Emergency Guardrail Replacement - Justification for Continued Emergency	

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Update on the Emergency Guardrail replacement project on Eastside Lane and North River Lane and finding of continued emergency.

RECOMMENDED ACTION:

1. Receive update on Eastside Lane and North River Lane emergency guardrail repair/replacement project.

2. As established by Public Contract Code Chapter 2.5, “Emergency Contracting Procedures,” review the emergency action taken on Jan 5, 2021 and make a finding, based on substantial evidence set forth in this staff report and at the meeting, that the emergency continues to exist as to Eastside Lane and North River Lane, and that continuation of action to replace the damaged guardrail on both roads is necessary to respond to the emergency. [4/5th Vote Required.]

3. Delegate to the Mono County Road Operations Superintendent the authority to continue to procure the necessary equipment, services, and supplies for the emergency guardrail replacement on Eastside Lane and North River Lane, without giving notice for bids to let contracts, including executing any agreements or contracts for the construction or repair of the damaged/destroyed guardrails. [4/5th Vote Required.]

FISCAL IMPACT:

The total cost of the emergency repair/replacement of the guardrails is approximately $160,000. The emergency projects are eligible for 75% funding via the California Disaster Assistance Act (CDAA) Program administered by the Governor’s Office of Emergency Services (CalOES). The LTC approved using transportation funding for the remaining 25% County match. Project costs are included in the amended budget for FY 2020-21.

CONTACT NAME: Kevin Julian

PHONE/EMAIL: 7609325449 / kjulian@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☑ YES ☐ NO

ATTACHMENTS:

Click to download
Staff Report

History

Time	Who	Approval
2/11/2021 3:54 PM	County Counsel	Yes
2/11/2021 10:49 AM	Finance	Yes
2/12/2021 9:07 AM	County Administrative Office	Yes

MONO COUNTY
DEPARTMENT OF PUBLIC WORKS

POST OFFICE BOX 457 • 74 NORTH SCHOOL STREET • BRIDGEPORT, CALIFORNIA 93517
760.932.5440 • Fax 760.932.5441 • monopw@mono.ca.gov • www.monocounty.ca.gov

Date: February 16, 2021

To: Honorable Chair and Members of the Board of Supervisors

From: Kevin Julian, Road Operations Superintendent

Re: Emergency Guardrail Replacement – Justification for Continued Emergency

Recommended Action:

1. Receive update on Eastside Lane and North River Lane emergency guardrail repair/replacement project.
2. As established by Public Contract Code Chapter 2.5, “Emergency Contracting Procedures,” review the emergency action taken on Jan 5, 2021 and make a finding, based on substantial evidence set forth in this staff report and at the meeting, that the emergency continues to exist as to Eastside Lane and North River Lane, and that continuation of action to replace the damaged guardrail on both roads is necessary to respond to the emergency. [4/5th Vote Required.]
3. Delegate to the Mono County Road Operations Superintendent the authority to continue to procure the necessary equipment, services, and supplies for the emergency guardrail replacement on Eastside Lane and North River Lane, without giving notice for bids to let contracts, including executing any agreements or contracts for the construction or repair of the damaged/destroyed guardrails. [4/5th Vote Required.]

Fiscal Impact:

Based on the initial estimates obtained by the Public Works Department – Roads Division, the total cost of the emergency repair/replacement of the Eastside Lane and North River Lane guardrails is approximately $160,000.00. The emergency projects are eligible for 75% funding via the California Disaster Assistance Act (CDAA) Program administered by the Governor’s Office of Emergency Services (CalOES). Staff proposes that the 25% County match for the emergency guardrail repairs/replacements be paid with available transportation funding.

Strategic Plan Alignment: ***Infrastructure, Public Safety***

Current project status:

- Temporary protective measures (k-rails) were removed on 2/8/21 in conjunction with the Coral Construction mobilization to the job site
- Southbound lane guardrail at Eastside Bridge replacement complete
- Northbound lane guardrail at Eastside Bridge replacement complete

- North River Lane guardrail replacement scheduled 2/12/21
- Southbound Lane guardrail north of Eastside Bridge scheduled 2/12-2/13

Justification for Continued Emergency – Eastside Lane and North River Lane:

Full replacement of the guardrail is required to ensure traffic safety along Eastside Lane and North River Lane. Once the construction phase is complete, the continued emergency declaration needs to remain in force until project closeout.

If you have any questions regarding this item, please contact me at 760.932.5449. I may also be contacted by email at kjulian@mono.ca.gov.

Respectfully submitted,

Kevin Julian
Road Operations Superintendent

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Public Works, County Counsel

TIME REQUIRED

SUBJECT Ordinance Amending Chapter 13.40 of the Mono County Code - Public Use of Conway Ranch

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Proposed ordinance amending Chapter 13.40 of the Mono County Code related to public use of portions of Conway Ranch dedicated to livestock grazing during grazing season or for other future uses.

RECOMMENDED ACTION:

Adopt proposed ordinance.

FISCAL IMPACT:

None.

CONTACT NAME: Stacey Simon

PHONE/EMAIL: / ssimon@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
Staff Report
Ordinance

History

Time	Who	Approval
2/8/2021 2:44 PM	County Counsel	Yes
2/10/2021 9:35 AM	Finance	Yes
2/12/2021 9:05 AM	County Administrative Office	Yes

County Counsel
Stacey Simon

Assistant County Counsels
Christian E. Milovich
Anne L. Frievalt

OFFICE OF THE
COUNTY COUNSEL
Mono County

South County Offices
P.O. BOX 2415
MAMMOTH LAKES, CALIFORNIA 93546

Telephone
760-924-1700

Facsimile
760-924-1701

Paralegal/Office Manager
Kevin Moss

To: Board of Supervisors

From: Stacey Simon, County Counsel and Justin Nalder, Conway Ranch Manager

Date: February 16, 2021

Re: Ordinance amending Mono County Code Chapter 13.40 related to public access on Conway Ranch

Recommended Action
Adopt proposed ordinance amending Mono County Code Chapter 13.40 related to public use of areas on Conway Ranch dedicated to livestock grazing during grazing season or other future uses.

Strategic Plan Focus Areas Met
☒ Economic Base ☐ Infrastructure ☒ Public Safety
☒ Environmental Sustainability ☐ Mono Best Place to Work

Fiscal Impact
None.

Discussion
This ordinance was introduced at the Board's February 9, 2021, regular meeting and is on the consent agenda today for adoption.

Background
Mono County Code Chapter 13.40 governs public use of Conway and Mattly Ranches ("Ranch") which are public properties owned by the County. That chapter includes a specific prohibition on public access to the area of the Ranch which had been used for aquaculture activities during the past decade.

As the Board knows, aquaculture activities have ceased, at least temporarily, in recent years and other activities have been approved and/or proposed for the Ranch. Also on today's agenda, the Board considered a grazing lease with Hunewill Land and Livestock Co., Inc. for the use of a portion of the Ranch for livestock grazing, consistent with historic use of the property (see staff report accompanying that item). Other proposals not yet acted on include use of a portion of the Ranch for small-scale agriculture and/or its possible use as a cry dance site by the Mono Lake Kutzadika'a Tribe.

As a result of these evolving uses of the Ranch, it is necessary to update Chapter 13.40 to add flexibility to the provisions limiting public access to accommodate grazing and other potential future uses. The proposed ordinance would make that amendment.

Please feel free to contact me, or Justin Nalder, if you have any questions prior to the meeting.

ORDINANCE NO. ORD21-__

AN ORDINANCE OF THE MONO COUNTY BOARD OF SUPERVISORS AMENDING CHAPTER 13.40 OF THE MONO COUNTY CODE RELATED TO PUBLIC USE OF PORTIONS OF CONWAY RANCH DEDICATED TO LIVESTOCK GRAZING DURING GRAZING SEASON OR OTHER FUTURE USES

WHEREAS, Mono County Code Chapter 13.40 governs public use of Conway and Mattly Ranches (the "Ranch") in Mono County; and

WHEREAS, Chapter 13.40 describes a portion of the Ranch which has been used for fish rearing and prohibits public entry into that area without the express written consent of County; and

WHEREAS, fish rearing activities have not been active on the Ranch for the past several years, however, the County intends to continue historic grazing activities on the Ranch during the 2021 grazing season (May 1 through September 15) and thereafter, in order to maintain vegetative health and historic uses of the Ranch, and minimize fire danger; and

WHEREAS, public access to grazing areas during the grazing season should be restricted to protect the public and livestock from adverse interaction;

NOW, THEREFORE, THE BOARD OF SUPERVISORS OF THE COUNTY OF MONO ORDAINS that:

SECTION ONE: Subdivision H is hereby added to section 13.40.010 ("Definitions") and shall read as follows:

> "H. Leased grazing area" means that portion of Conway Ranch devoted primarily to livestock grazing by the County or any lessee or licensee of the County as shown in the applicable lease or license between the County and the grazer. The Leased grazing area shall be completely enclosed by fencing installed by the County or its lessee or licensee.

SECTION TWO: Subdivision A.1 of Section 13.40.020 ("Prohibitions") is hereby amended to read as follows:

> "1. Entering or occupying the leased grazing area during the grazing season (May 1 through September 15), any licensed fish-rearing and fishing area, or any other area leased or licensed by County to a third party which requires that public access be limited, provided that adequate signage, notice and/or fencing is installed to demarcate the area.

SECTION THREE: This ordinance shall become effective 30 days from the date of its adoption and final passage, which appears immediately below. The Clerk of the Board of Supervisors shall post this ordinance and also publish it in the manner prescribed by Government Code Section 25124 no later than 15 days after the date of its adoption and final passage. If the Clerk fails to publish this ordinance within said 15-day period, then the ordinance shall not take effect until 30 days after the date of publication.

PASSED, APPROVED and **ADOPTED** this _________ day of ____________, 2021, by the following vote, to wit:

AYES:

NOES:

ABSENT:

ABSTAIN:

____
Jennifer Kreitz, Chair
Mono County Board of Supervisors

ATTEST:

____
Clerk of the Board

APPROVED AS TO FORM:

____
County Counsel

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

TIME REQUIRED

SUBJECT Notice Of Petitions for Change for Licenses 10191 And 10192 (Applications 8042 And 8043) of The City of Los Angeles, Department of Water And Power

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

On November 14, 2013, the State Water Resources Control Board received Petitions for Change from the City of Los Angeles, Department of Water and Power (LADWP) pursuant to California Code of Regulations, title 23, section 791, subdivision (e) requesting incorporation into its water right Licenses 10191 and 10192 the Mono Basin Settlement Agreement Regarding Continuing Implementation of Water Rights Orders 98-05 and 98-07.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME: Queenie Barnard

PHONE/EMAIL: 760-932-5534 / qbarnard@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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Notice

History

Time	Who	Approval
2/11/2021 3:54 PM	County Counsel	Yes
2/11/2021 10:46 AM	Finance	Yes
2/12/2021 9:05 AM	County Administrative Office	Yes

NOTICE OF PETITIONS FOR CHANGE FOR LICENSES 10191 AND 10192 (APPLICATIONS 8042 AND 8043) OF THE CITY OF LOS ANGELES, DEPARTMENT OF WATER AND POWER

COUNTY: MONO

STREAM SYSTEMS: RUSH CREEK, LEE VINING CREEK, PARKER CREEK, AND WALKER CREEK

On November 14, 2013, the State Water Resources Control Board (State Water Board) received Petitions for Change (Petitions) from the City of Los Angeles, Department of Water and Power (LADWP) pursuant to California Code of Regulations, title 23, section 791, subdivision (e) requesting incorporation into its water right Licenses 10191 and 10192 the Mono Basin Settlement Agreement Regarding Continuing Implementation of Water Rights Orders 98-05 and 98-07 (Settlement Agreement).

Background:

In September 1994, the State Water Board adopted Water Right Decision 1631 (D-1631) modifying LADWP's water right Licenses 10191 and 10192 for diversions from streams tributary to Mono Lake in order to protect public trust resources in and around Mono Lake. D-1631, and subsequent Orders WR 98-05 and WR 98-07 amending D-1631, established minimum base flows and Stream Restoration Flow (SRF) requirements on four tributary streams to Mono Lake, minimum lake level requirements, restoration requirements, and associated monitoring and study requirements. Order 98-05 required a State Water Board-approved stream monitoring team (SMT) to evaluate and provide recommendations on the SRFs and that LADWP implement the recommendations "unless it determines that the recommendation is not feasible." The SMT evaluated the magnitude, duration, and frequency of flows necessary for the restoration of the Mono Basin ecosystem, the need for an outlet from Grant Dam to achieve such flows, and related matters.

In April 2010, the SMT presented its recommendations in *Mono Basin Stream Restoration and Monitoring Program: Synthesis of Instream Flow Recommendation to the State Water Resources Control Board and the Los Angeles Department of Water and Power, Final Report* (Synthesis Report). LADWP determined that certain recommendations in the Synthesis Report were not feasible, and as an alternative to disputing that determination under Order WR 98-05, which would have triggered resolution of the disputes by the Deputy Director of the Division of Water Rights, LADWP, Mono Lake Committee, California Trout, and California Department of Fish and Wildlife (Settlement Parties) requested permission to undertake settlement

negotiations. By letter dated November 1, 2010, the State Water Board authorized such negotiations, and by subsequent letters extended the deadline for completion of the negotiations until September 30, 2013.

As part of the Settlement Agreement and proposed amendments to LADWP's License 10191 and 10192, LADWP circulated for public comment on October 30, 2020 an "Initial Study and Mitigated Negative Declaration for Mono Basin Water Rights Licenses Project" (IS-MND). The IS-MND provides LADWP's environmental analysis of the license amendments that have been requested as a result of the Settlement Agreement. The IS-MND analyzes the impacts of building the chosen outlet design as well as operating the outlet under the new Stream Ecosystem Flows (SEF) requirements. In addition, the IS-MND analyzes the potential impacts of authorizing LADWP to export an additional one-time 12,000 acre-feet of water that can only be exercised under certain circumstances. This additional export was intended to offset the costs of building the Grant Lake Reservoir Outlet.

Proposed Changes:

The changes proposed in the petitions submitted by LADWP are to incorporate the provisions of the Settlement Agreement as terms and conditions in Licenses 10191 and 10192. The purposes of the Settlement Agreement are: (i) resolution of disputes between the Settlement Parties related to the Synthesis Report; (ii) provision and adaptive management of flows sufficient to complete stream restoration and fish protection required by D-1631, Orders 98-05 and 98-07, and relevant case law, including modification of Grant Lake Reservoir to release such flows; (iii) re-focusing the stream monitoring program on adaptive management and related improvements in the limnology and waterfowl monitoring programs; and (iv) reduction in LADWP's costs associated with modification of Grant Lake Reservoir and ongoing monitoring programs.

Drafts of the amended licenses are available on the State Water Board's website for review of all changes being proposed.

Summary of Water Right License 10191 (Application 8042)

Sources:
(1) Lee Vining Creek, (2) Walker Creek, (3) Parker Creek, and (4) Rush Creek

Points of Diversion:
(1) NE¼ of NW¼ of Section 20, T1N, R26E;
(2) NW¼ of NW¼ of Section 4, T1S, R26E;
(3) SW¼ of NW¼ of Section 9, T1S, R26E;
(4) NW¼ of NW¼ of Section 15, T1S, R26E, all within MDB&M

Points of Rediversion:
Grant Lake Reservoir - NW¼ of NW¼ of Section 15, T1S, R26E; Long Valley Reservoir - SE¼ of NW¼ of Section 19, T4S, R30E; Tinemaha Reservoir - NE¼ of NW¼ of Section 26, T10S, R34E;
Los Angeles Aqueduct Intake - NE¼ of SW¼ of Section 24, T11S, R34E;
Haiwee Reservoir - SW¼ of NE¼ of Section 2, T21S, R37E, all within MDB&M

Amount:
16,000 acre-feet per year in combination with License 10192.

Water diversion criteria applicable until the water level of Mono Lake reaches 6,391 feet:

a. Licensee shall not export any water from the Mono Basin any time that the water level in Mono Lake is below 6,377 feet above mean sea level, or any time that the water level of Mono Lake is projected to fall below 6,377 feet at any time during the runoff year of April 1 through March 31.
b. If the water level of Mono Lake is expected to remain at or above 6,377 feet throughout the runoff year of April 1 through March 31 of the succeeding year based on Licensee's final May 1 runoff projections and any subsequent runoff projections, then Licensee may divert up to 4,500 AF of water per year under the terms of this amended license.
c. If the water level of Mono Lake is at or above 6,380 feet and below 6,391 feet, then Licensee may divert up to 16,000 AF of water per year under the terms of this amended license.

Water diversion criteria applicable after the water level of Mono Lake reaches 6,391 feet:

a. Once the water level of Mono Lake has reached an elevation of 6,391 feet, no diversions shall be allowed any time that the water level falls below 6,388 feet.
b. Once the water level of 6,391 feet has been reached and the lake level has fallen below 6,391 feet, diversions by Licensee shall be limited to 10,000 AF per year provided that the water level is at or above 6,388 feet and less than 6,391 feet.

c. When the water level of Mono Lake is at or above 6,391 feet on April 1, Licensee may divert all available water in excess of the amount needed to maintain the SEFs, up to the amounts otherwise authorized under this amended license.

Season:
January 1 through December 31

Purpose of Use:
Municipal

Place of Use:
Within the service area of the City of Los Angeles, Department of Water and Power, as shown on map filed with the State Water Board

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Summary of Water Right License 10192 (Application 8043)

Sources:
(1) Lee Vining Creek, (2) Walker Creek, (3) Parker Creek, and (4) Rush Creek

Points of Diversion:
(1) NE ¼ of NW¼ of Section 20, T1N, R26E;
(2) NW¼ of NW¼ of Section 4, T1S, R26E;
(3) SW¼ of NW¼ of Section 9, T1S, R26E;
(4) NW¼ of NW¼ of Section 15, T1S, R26E, all within MDB&M

Points of Rediversion:
Grant Lake Reservoir - NW¼ of NW¼ of Section 15, T1S, R26E;
Long Valley Reservoir - SE¼ of NW¼ of Section 19, T4S, R30E;
Upper Gorge Power Plant - SE¼ of NE¼ of Section 5, T5S, R31E;
Middle Gorge Power Plant - SE¼ of SE¼ of Section 16, T5S, R31E, all within MDB&M

Amount:
16,000 acre-feet per year in combination with License 10191. Water diversion criteria similar to License 10191.

Season:
January 1 through December 31

Purpose of Use:
Power

Places of Use:
Upper Gorge Power Plant - SE¼ of NE¼ of Section 5, T5S, R31E;
Middle Gorge Power Plant - SE¼ of SE¼ of Section 16, T5S, T31E;
Control Gorge Power Plant - NW¼ of SE¼ of Section 10, T6S, R31E, all within MDB&M.

Project documents, including this notice, petitions, draft licenses (with proposed changes), IS-MND, project map along with procedures for protesting and protest forms are available at: https://www.waterboards.ca.gov/waterrights/water_issues/programs/applications/petitions/2021.html. Protests must be received by the Division of Water Rights by **4:30 p.m. on March 12, 2021**.

A copy of the protest must also be sent to the Petitioner to the following contact:

Mr. Adam Perez
City of Los Angeles
Department of Water and Power
300 Mandich Street
Bishop, CA 93514

If you have any questions regarding this project, please contact Steve Marquez by e-mail at: steve.marquez@waterboards.ca.gov.

DATE OF NOTICE: **February 10, 2021**

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

TIME REQUIRED

SUBJECT Federal Energy Regulatory Commission (FERC) Letters re: Dams Part of the Lee Vining Creek Project, FERC Project No. 1388-CA

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Federal Energy Regulatory Commission (FERC) letters regarding responses to FERC Comments on the 3rd Independent Consultant's Safety Inspection Report for Rhinedollar Dam, responses to FERC Comments on 11th Independent Consultant's Safety Inspection Report for Saddlebag Dam, and Revised Semi-Quantitative Risk Analysis (SQRA) Report for Rhinedollar Dam.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME: Queenie Barnard

PHONE/EMAIL: 760-932-5534 / qbarnard@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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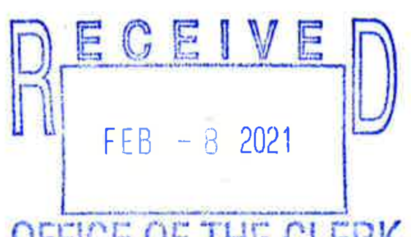
Letters

History

Time	Who	Approval
2/11/2021 3:53 PM	County Counsel	Yes
2/11/2021 10:46 AM	Finance	Yes
2/12/2021 9:07 AM	County Administrative Office	Yes



FEDERAL ENERGY REGULATORY COMMISSION
Office of Energy Projects
Division of Dam Safety and Inspections – San Francisco Regional Office
100 First Street, Suite 2300
San Francisco, CA 94105-3084
(415) 369-3300 Office – (415) 369-3322 Facsimile

January 14, 2021

In reply refer to:
Project No. 1388-CA

Mr. James A. Buerkle
Director
Generation
Southern California Edison Company
1515 Walnut Grove Ave
Rosemead, CA 91770-3710

Re: Responses to FERC Comments on the 3rd Independent Consultant's Safety Inspection Report for Rhinedollar Dam (Lee Vining Creek FERC Project No. 1388-CA)

Dear Mr. Buerkle:

This is in response to a letter dated November 4, 2020 from Mr. Wayne Allen that submitted the Responses to FERC Comments on the 3rd Independent Consultant's Safety Inspection Report (CSIR) for Rhinedollar Dam, which are part of the Lee Vining Creek Project, FERC Project No. 1388. We have reviewed the submittal and have the following comments.

Supporting Technical Information Document (STID):

1. Please submit revisions to the STID for updates that have been completed.

Updated Plan and Schedule for Part12D recommendations:

2. Please note that SCE was overdue on addressing several Part 12D recommendations based on SCE's plan and schedule that was submitted on February 5, 2019. SCE is reminded that while we encourage verbal and/or email communication prior to the due date of the submittal, if there is an indication that the date may not be met, it must be understood that all requests for extension of

time must be submitted in writing to this office prior to the date the item in question is due. The request should also be submitted in ample time for the Commission to accept or reject the request prior to the original due date. If the required submittal is not received by the agreed upon due date, it becomes an issue of non-compliance. As indicated in our February 12, 2020 Annual Letter, the request should typically be submitted 30 days in advance of the submittal due date.

3. Recommendation 4: Please submit the completed report on the stochastic flood modeling studies that provides estimated probability of a flood that is large enough to overtop the dam
4. Recommendation 6, 7, 8: SCE's plan and schedule for these recommendations to be completed by 10/30/2021 is acceptable.
5. Recommendation 13: Please submit a brief report that provides the information that the repairs are not required for voids at the downstream end of the spillway.
6. Recommendation 14: Please submit a brief report with photos that indicates the timber sills have been removed and patch repaired with concrete.
7. Recommendation 20: This recommendation was noted to be completed. Please submit a brief report that shows the comparison of the ground motions between 84th percentile and 10,000-year return period.

Within 45 days of the date of this letter, please address our comments or provide a plan and schedule to address our comments. We appreciate your cooperation in this aspect of the Commission's dam safety program. If you have any questions, please contact Mr. Rakesh Saigal at (415) 369-3317.

Sincerely,

Frank L. Blackett

Frank L. Blackett, P.E.
Regional Engineer

RECEIVED
FEB - 8 2021
OFFICE OF THE CLERK

FEDERAL ENERGY REGULATORY COMMISSION
Office of Energy Projects
Division of Dam Safety and Inspections – San Francisco Regional Office
100 First Street, Suite 2300
San Francisco, CA 94105-3084
(415) 369-3300 Office – (415) 369-3322 Facsimile

January 14, 2021

In reply refer to:
Project No. 1388-CA

Mr. James A. Buerkle
Director
Generation
Southern California Edison Company
1515 Walnut Grove Ave
Rosemead, CA 91770-3710

Re: Responses to FERC Comments on 11th Independent Consultant's Safety Inspection Report for Saddlebag Dam (FERC Project No. 1388-CA)

Dear Mr. Buerkle:

This is in response to a letter dated November 4, 2020 from Mr. Wayne Allen that submitted the Responses to FERC Comments on the 11th Independent Consultant's Safety Inspection Report for Saddlebag Dam, which are part of the Lee Vining Creek Project, FERC Project No. 1388. We have reviewed the submittal and have the following comments.

Supporting Technical Information Document (STID):

1. Please submit revisions to the STID that have been completed.

Plan and Schedule for Part12D recommendations:

2. Recommendation 25: This recommendation was listed as being completed. Please submit a brief report that shows the comparison of the ground motions between 84th percentile and 10,000-year return period.

Within 45 days of the date of this letter, please address our comments or provide a plan and schedule to address our comments. We appreciate your cooperation in this aspect of the Commission's dam safety program. If you have any questions, please contact Mr. Rakesh Saigal at (415) 369-3317.

Sincerely,

Frank L. Blackett, P.E.
Regional Engineer

FEDERAL ENERGY REGULATORY COMMISSION
Office of Energy Projects
Division of Dam Safety and Inspections – San Francisco Regional Office
100 First Street, Suite 2300
San Francisco, CA 94105-3084
(415) 369-3300 Office – (415) 369-3322 Facsimile

January 26, 2021

In reply refer to:
Project No. 1388-CA

Mr. James A. Buerkle
Director of Generation
Southern California Edison Company (SCE)
1515 Walnut Grove Ave
Rosemead, CA 91770-3710

Re: Revised Semi-Quantitative Risk Analysis (SQRA) Report – Rhinedollar Dam

Dear Mr. Buerkle:

This is in response to a letter dated February 21, 2019 from Mr. Wayne Allen that submitted a revised SQRA Report for Rhinedollar Dam, which is part of the Lee Vining Creek Project, FERC No. 1388, to address comments that were provided in a November 21, 2018 Commission letter. We have reviewed your submittal and have no comments.

We appreciate your continued efforts in this aspect of the Commission's dam safety program. If you have any questions, please contact Mr. Chris Wang at (415) 369-3366.

Sincerely,

Frank L. Blackett, P.E.
Regional Engineer

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: First 5

TIME REQUIRED 20 minutes (10 minute presentation; 10 minute discussion)

SUBJECT First 5 Fiscal Year 2019-20 Evaluation Report

PERSONS APPEARING BEFORE THE BOARD Molly DesBaillets, Executive Director

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Evaluation of services provided to families and children prenatal to five years old in Mono County for Fiscal Year 2019-20.

RECOMMENDED ACTION:

None, informational only.

FISCAL IMPACT:

None.

CONTACT NAME: Molly DesBaillets

PHONE/EMAIL: 760-924-7626 / mdesbaillets@monocoe.org

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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Staff Report
Evaluation Report
Presentation

History

Time	Who	Approval
2/10/2021 9:55 AM	County Counsel	Yes
2/10/2021 9:37 AM	Finance	Yes
2/12/2021 9:07 AM	County Administrative Office	Yes

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Mammoth Lakes Housing

Molly DesBaillets, MA
Executive Director

Date: February 16, 2021

To: Honorable Board of Supervisors

From: Molly DesBaillets, Executive Director First 5 Mono County

Subject: FY 2019-20 Evaluation Report

Subject

Evaluation of services provided to families and children prenatal to five years old in Mono County for Fiscal Year 2019-20

Recommendation

Receive a report of activities and evaluation results from First 5 Mono County and provide comments about services to families prenatal to five.

Fiscal Impact

None

Discussion

The California Children and Families Act (also known as Proposition 10 or "First 5") was enacted in 1998, increasing taxes on tobacco products to provide funding for services to promote early childhood development from prenatal to age 5. The Mono County Board of Supervisors created the Mono County Children and Families Commission, First 5 Mono, in 1999 to:

- Evaluate the current and projected needs of young children and their families.
- Develop a strategic plan describing how to address community needs.
- Determine how to expend local First 5 resources.
- Evaluate the effectiveness of funded programs and activities.

First 5 Mono County currently receives a baseline of $350,000 a year from tobacco tax funds including annual allocations and small population county funding augmentations. Around $105,000 a year comes from Mono County Social Services and Behavioral Health for high-needs home visiting and Peapod Playgroups. First 5 Mono also collaborates with Mono County to: 1) provide funding through CDBG for child care in Bridgeport, and, 2) Increase home visiting services to use the Parents as Teachers evidence-based model.

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FY 2019-20
EVALUATION REPORT

Our goal is to enhance the network of support services for families with children ages 0 to 5 years.

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OVERVIEW

The California Children and Families Act (also known as Proposition 10 or “First 5”) was enacted in 1998, increasing taxes on tobacco products to fund services that promote early childhood development from prenatal to age 5. The Mono County Children and Families Commission, First 5 Mono, was created in 1999 by the Mono County Board of Supervisors to:

- Evaluate the current and projected needs of children birth to five years old.
- Develop a strategic plan describing how to address community needs.
- Determine how to expend local First 5 resources.
- Evaluate the effectiveness of funded programs and activities.

First 5 Mono currently receives an annual baseline revenue from First 5 California of $350,000 which includes tobacco tax allocations and Small Population County Funding Augmentations (SPCFA). Additional Commission funds come from partner agencies like First 5 California, California Department of Education, and Mono County. To meeting funding requirements and guide Commission work, First 5 Mono adopted the 2019-2024 Strategic Plan which describes how Proposition 10 funds will promote a comprehensive and integrated system of early childhood development services.

The 2019-20 Evaluation Report helps fulfill the intended function of First 5 Mono, meet state and local requirements, and evaluate funded programs for the purposes of guiding quality improvement and fund allocation. The report includes data and analysis on the 18 indicators in the 2019-2024 Strategic Plan, logic models, findings, and conclusions. Guiding the format of the 2019-20 Evaluation Report are: Small Population County Funding Agreement requirements, example content from First 5 California, and First 5 California supported feedback from Child Trends on the 18-19 Evaluation Report.

Demographics

The US Census estimates for Mono County[1] are as follows:

	Population	0-5 Population
2018	14,250	691, 5%
2019	14,444	693, 5%

Childhood poverty declined in Mono County between 2016 and 2018. The 2019 Childcare Portfolio for Mono County reports 7% of the 0-5 population was living in poverty, a decrease from 13% in 2016 (Appendix IX, Page 50). With the devastating economic impacts of COVID-19, the number of children living in poverty in Mono County shifted suddenly and dramatically after March

[1] https://www.census.gov/quickfacts/monocountycalifornia

2020. Our local economy, in Mammoth Lakes most predominantly, has a tourism-based economy. After hotels and restaurants closed, there was an estimated 85% unemployment rate in Mammoth Lakes. Families served through Home Visiting and Peapod Playgroups shared needs for rent support, utility payments, and diapers after job loss or reductions in hours after COVID-19 mandates shifted our world. First 5 met these needs through creation of an Emergency Fund which funded $10,000 in rent support through Mammoth Lakes Housing, collaboration with IMACA to distribute PPE from First 5 California to childcare providers, and providing grocery cards and utility payments to families in need enrolled in home visiting.

Alongside nationwide and local movements to build systemic equity, some First 5 Mono Staff and a Commissioner chose to participate in a United Way 21 Day Equity Challenge to seek better understanding of personal, implicit, and systemic biases and to learn to apply cultural humility to Commission work while promoting equity for children and families. To that end, this report includes some shifts from prior years to seek to more clearly illuminate issues of equity through our work.

Investment Areas, Programs, & Indicators

The tables below show the investment areas, programs and the percent of the 0-5 population served, and associated outcomes and their result for FY 2019-20. Numbers for each program are unduplicated, across programs numbers include duplicates.

Table 1: Investment Areas, Programs and Indicators

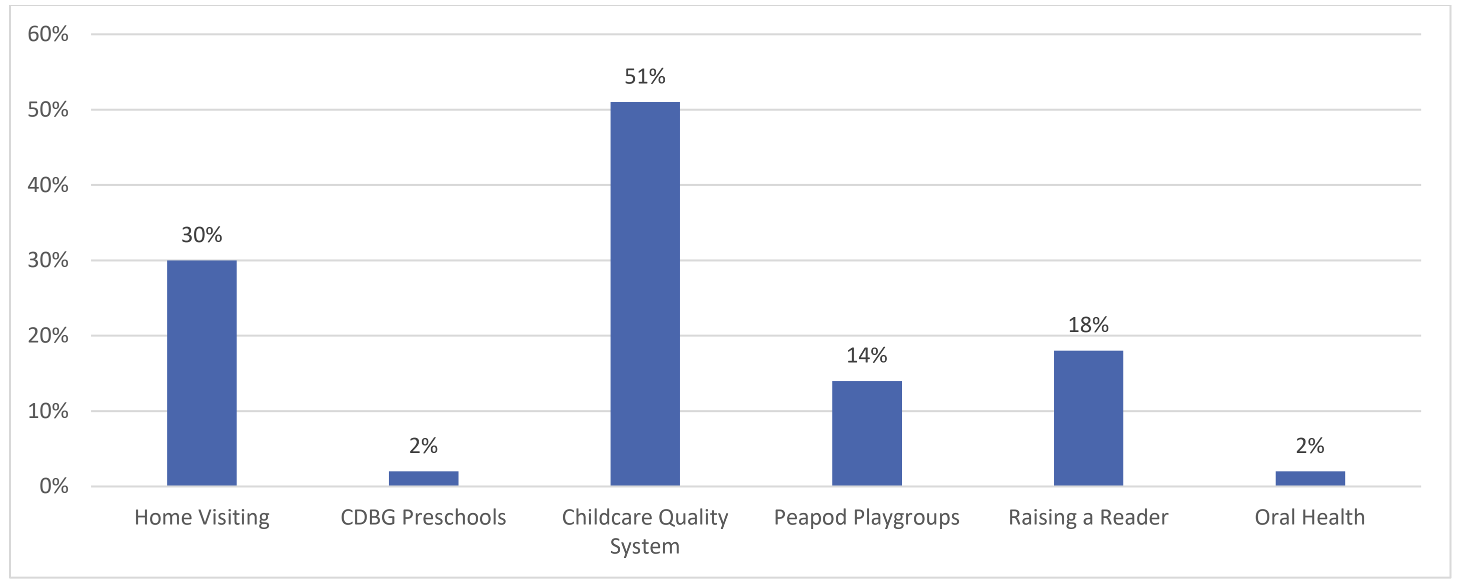
Indicator numbers refer to pages 45-48. *reporting rate below 60%

Investment Area	Programs and % served	Indicators		
		Achieved	Static	Need improvement
Improved Family Functioning	Home Visiting: Welcome Baby and Healthy Families 30%	9 School readiness rate 4 Developmental Screening rates 14 Parents get developmental and parenting education*	2 & 3, Higher participation rates: 0-1 no; 0-5, yes	15 Higher breastfeeding rates* 16 Expected BMI*
Improved Child Development	School Readiness: CDBG Preschool 2% Raising a Reader 18%	8 Preschool attendance by K entry* 9 School readiness rate 10 Families attended Round Up 11 Literacy programs accessed 13 Kindergarteners assessed for readiness		12 Preschool slot availability
	Family Behavioral Health: Peapod Playgroups 14%	1 Parents satisfied		14 High participation rates
	Childcare Quality 51% (omitting estimate 25% duplication)	4 Developmental screening rate	5 Children in high quality care (slight decrease from last year, but still a significant increase from 2 years ago)	6 Provider permit attainment rate 7 Childcare availability

Investment Area	Programs and % served	Indicators		
		Achieved	Static	Need improvement
Child Health	Oral Health 2%	18 Low number of Children at K entry with untreated dental problems*	17 Annual dental screening rate*	
	Child Safety	Child safety information and materials shared with parents.		

*Reporting rate below 60%

Table 2: Percent of the 0-5 Population Served by First 5 Funded Program

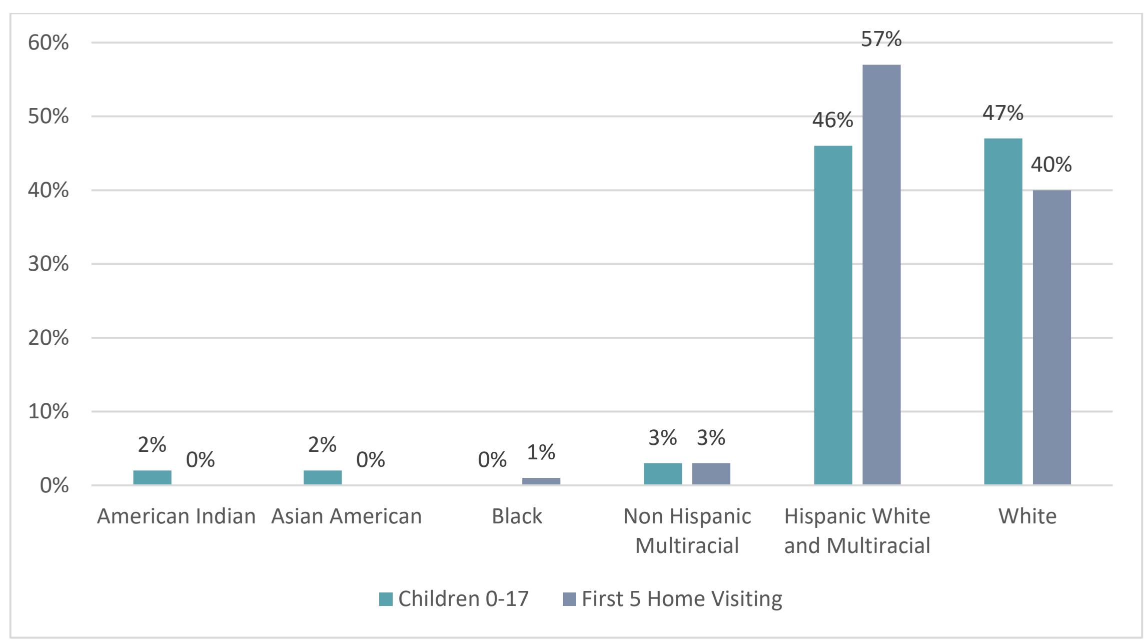


Demographics

The most robust demographic data comes from Welcome Baby and Healthy Families, the First 5 Mono home visiting program. Other programs don't include an enrollment process that gathers ethnicity or area of residence, or, if the data is collected like for Raising a Reader, a data sharing agreement with First 5 Mono is not in place. Although this is the most robust data for participants, we do not have data for 100% of participants, and the database limits data compilation for these reasons the number of children in each data set (the n) varies.

To better understand if First 5 Mono programs serve proportional numbers of children by race and ethnicity, the following considers data from home visiting and the 0-17 population—see table 3 below. Compared to the percentage of children in the County, in FY 19-20 home visiting served more Hispanic children, but less American Indian, Asian American, and White children. The same percent of Non-Hispanic Multiracial children were served.

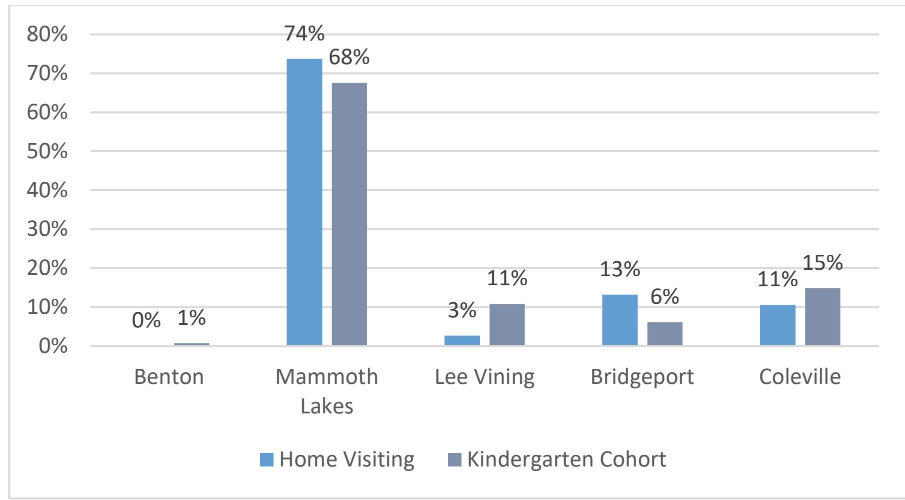
Table 3: Race Ethnicity Comparison: First 5 Mono Home Visiting (n=113) and the 0-17 population



Source: kidsdata.org for children 0-17 race/ethnicity and home visiting data

To understand better if First 5 Mono programs are serving a proportional number of children in the birth to five population in each community as the school systems served kindergartners, Table 3 compares them. Compared to the distribution of kindergarten students across the County's communities, home visiting served a higher percentage of families in Mammoth Lakes and Bridgeport, and lower percentages in Benton, Lee Vining, and Coleville.

Table 3: Area of Residence Comparison: New Families in Home Visiting (n=76) and the Kindergarten Cohort (n=120)



Key Findings

- Home Visiting
  - Participating families have improved parental knowledge, understanding, and engagement in promoting their children's development and physical and mental health.
  - Qualifying children[2] received developmental screenings (n=60), 59, 98%
  - A higher proportion of Hispanic families were served than the 0-17 population.
  - Services shifted to virtual with COVID 19 health department orders.
  - Participants received direct support of $200 for two months if impacted by COVID 19.
- Oral Health
  - Children at kindergarten entry have a significantly lower percentage of carries than in the past, (n=120) 10%.
- Peapod Playgroups
  - Participating families are receiving child-development and parenting education. Services shifted to virtual with COVID 19 health department orders. Facebook Live participation was higher than Zoom.
- School Readiness
  - Funding for the Summer Bridge Program ended in spring of 2020 based on low participation and lack of desired results as reported in previous evaluation reports.
- Emergency Funds
  - In response to the COVID pandemic, the Commission created an Emergency Fund in 2020. Funds were used to support rental assistance through Mammoth Lakes Housing ($10,000) and the Mammoth Lakes IMACA preschool which suddenly lost Head Start Funding ($10,000).
- First 5 California Personal Protective Equipment (PPE)
  - In response to the COVID pandemic, First 5 California partnered with Inyo Mono Advocates for Community Action (IMACA) to provide PPE to childcare providers to support reopening and remaining open. 212 boxes of 40 gloves, 6 boxes of 50 masks, and 12 gallons of disinfectant were distributed.

Due to the data, findings, and conclusions herein, First 5 Mono County will continue to fund existing programs in FY 2020-21 while implementing measures to improve quality. First 5 Mono will seek to leverage supports around investment areas by working with community partners to support the well-being of children birth to five and their families. This evaluation examines program efficacy, participation, and partner agency activities for the purposes of allocating funding to the most impactful initiatives for Mono County.

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[2] older than 4 months, not already receiving special needs services, and with at least 3 visits in the program year

PROGRAMS AND EVALUATION

IMPROVED FAMILY FUNCTIONING

HOME VISITING

Home Visiting is included in the First 5 Mono Strategic Plan due to national recognition and strong data that Home Visiting is a strong strategy to improve outcomes for children and families. Home Visiting is an effective tool to: improve family functioning, decrease child abuse, and improve school readiness and literacy[3]. In 2019-20 the investment in Home Visiting increased to $324,789. With a new contribution from Mono County, the program was able to become evidence-based. The new program, renamed **Welcome Baby and Healthy Families** uses the Parents as Teachers evidence-based model. Families are offered between 12 and 24 visits a year, depending on need, until their child is enrolled in preschool, Transitional Kindergarten, or Kindergarten.

First 5 Mono conducts the Home Visiting program with funding support from:

- Mono County: $150,000
- First 5 California Small Population County Funding Augmentation (SPCFA): $135,609
- Mono County Department of Social Services
  - Child Abuse Prevention, Intervention, and Treatment (CAPIT): $32,271
  - CalWORKS Home Visiting Program (CWHVP): $6,830

Program objectives include:

- Facilitate parents' role as their child's first and most important teacher
- Provide information on typical child development
- Stimulate child development by providing age-appropriate activities
- Increase and support breastfeeding and literacy activities
- Link families to community services and support access to services
- Conduct developmental screenings and refer families to early intervention programs

---

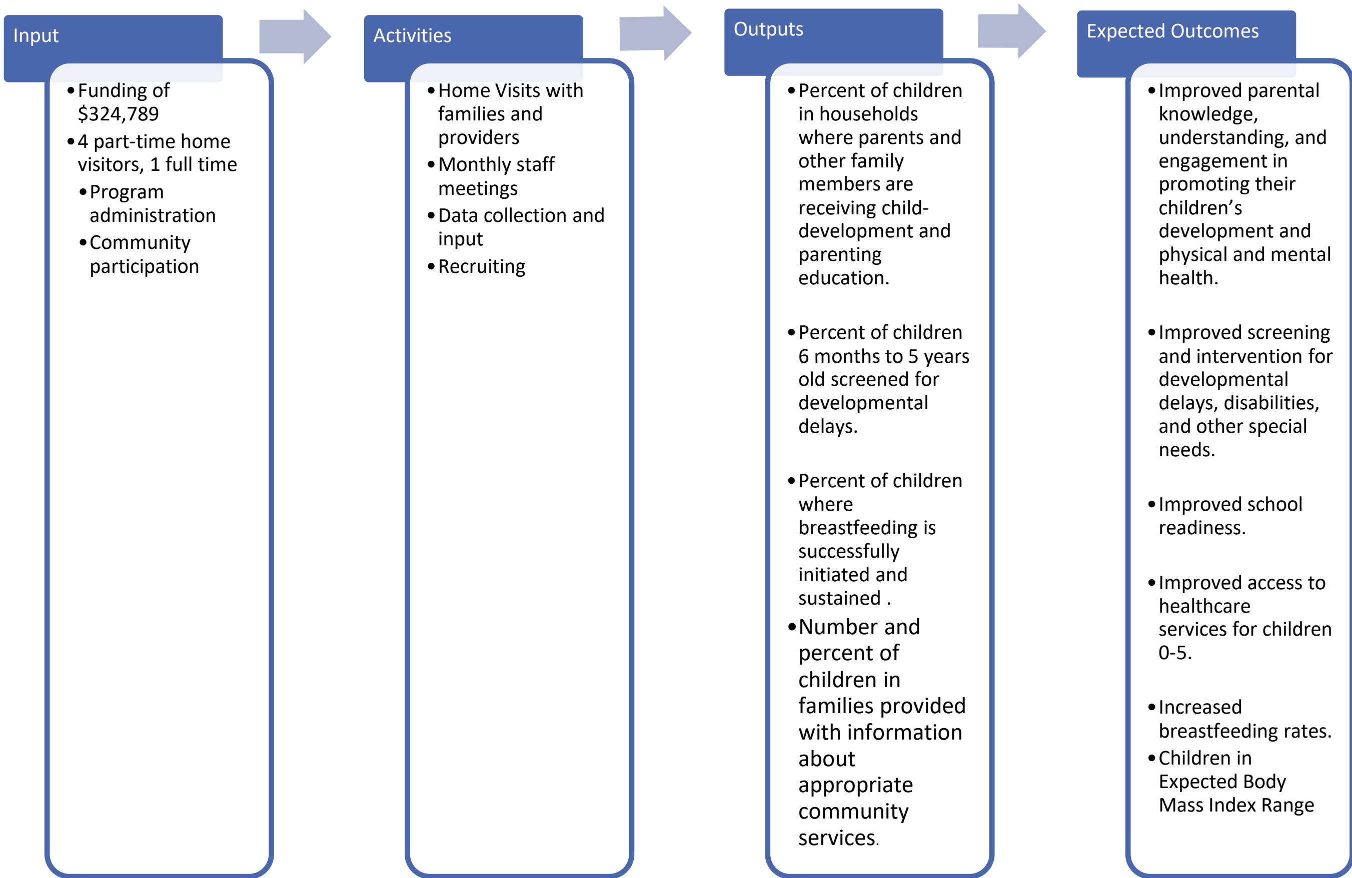
[3] Promising Practice Local Model: Modified Parents as Teachers Evidence-based framework: Pfannenstiel, J. C., & Zigler, E. (2007). Prekindergarten experiences, school readiness and early elementary achievement. Unpublished report prepared for Parents as Teachers National Center.

Snow, C.E., Burns, M., and Griffin, P. (Eds.). (1998). Preventing reading difficulties in young children. Washington, DC: National Academy Press.

Parents as Teachers has a long history of independent research demonstrating effectiveness. For more details, refer to the Parents as Teachers evaluation brochure or Web site, www.parentsasteachers.org.

- Provide culturally competent services in Spanish and English
- Facilitate optimal family functioning
- Decrease child abuse and neglect

Logic Model



Evaluation Findings and Conclusions

Home Visiting Quick look:

Indicator numbers refer to pages 45-47 and analysis below

Percent of indicators	Indicator Achievement	Indicator
67%		4 Screening rates improved 9 School readiness improved 14 Parents get developmental and parenting education*
		2 & 3 Higher participation rates Infants: no Children: yes
33%		15 Higher breastfeeding rates* 16 Expected BMI*

*Under 60% reporting rate

2. & 3. Is the number of parents participating high or increasing for the following age ranges: prenatal to 1 and prenatal to 5? No, and Yes

- Data Source: parents' participation in home visiting:
  - Prenatal -1 year old: 35%
  - Prenatal - 5 years old: 30%
- Finding: A lower percentage of infants were served this year than last. Conversely, a higher percentage of children prenatal-5 were served this year than last.
- Conclusion: In the last year a higher percent of children prenatal-5 were served and a lower percent of children 0-1 were served. Recruiting through Labor and Delivery changed significantly in March of 2020 when, due to COVID precautions, Home Visitors could only talk on the phone to new mothers to recruit rather than going into the hospital, supporting breastfeeding, and giving a new parent kit. As a result, the number of referrals through L&D—the main source of infant referrals—decreased on FY 19-20.

4. Does Home Visiting improve screening and intervention for developmental delays, disabilities, and other special needs? For children enrolled in Home Visiting, yes

- Data Source: Ages and Stages Questionnaire (ASQ) screening data

Table 1: Home Visiting Ages and Stages Questionnaire Developmental Screenings

	Number of children	Percent of qualifying children* n=60
Screenings Completed	59	98%
With one or more identified concern(s)	14	24% of those screened
Who received Early Intervention Services as a result of a screening	1	2% of those screened

*children without special needs services, who are over 4 months old, and had 3 or more visits, qualify for a screening.

- Finding: 98% of qualifying children (without an identified delay, older than 4 months, and with at least 3 visits) received a screening. Of those screened, 24% had a concern identified, and 2% of children screened received early intervention services because of a screening. The gap between the 24% of children with an identified concern and 2% of children with a screening who received services is attributed to the following:
    1. Concerns were addressed by providing activities to families that lead to growth to the extent that there was no longer a concern;
    2. The parents refused a referral;
    3. After assessment by early intervention specialists, the concern did not meet the threshold to qualify for early intervention services.
    4. The services do not exist in our area
    5. The child was put on a waitlist for services
- Conclusion: The program is achieving this outcome. Looking at population-based screening rates however, there was a slight decline from last year.

9. Does Home Visiting improve school readiness? Yes

- Data Source: Kindergartners Assessed as School Ready and Kindergarten School Readiness by Activity Participation (both below)

Table 1: Kindergartners Assessed as School Ready by District 2017-2019

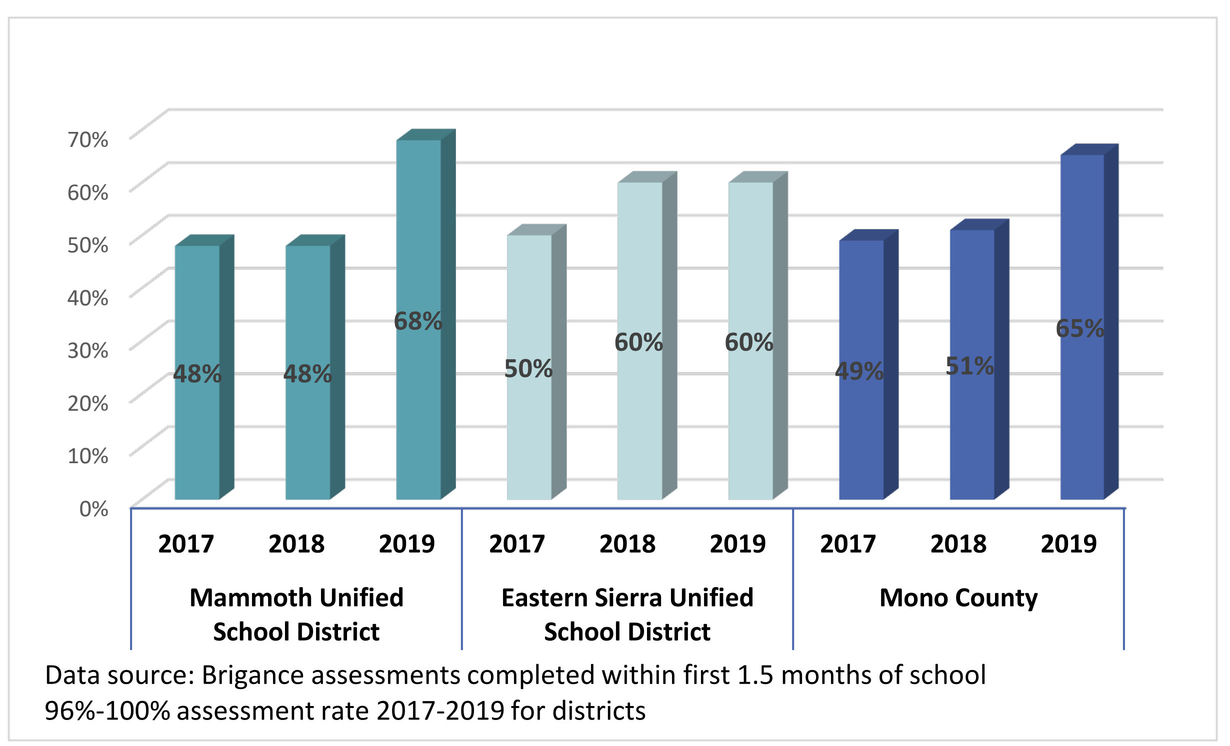


Table 2: 2019 Percent of Kindergartners Assessed as School Ready by Program Participation Compared to School Readiness Rate

Playgroups n-12
CA State Preschools n=18
Other PreK Care/Preschools n=16
Summer Bridge n=23
Raising A Reader n=25
Story Time n-14
Home Visiting n-14
Early Intervention n=1
No participation n=8
Footsteps to Brilliance n=3

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

69%
61%
81%
38%
71%
79%
92%
100%
60%
67%

Baseline: 65% Countywide School Readiness

Activity participation data source: parent surveys completed at kindergarten entry
School readiness data source: Brigance screening at kindergarten entry
n=60, 50% of the K class
* duplicates inlcuded, children reported as participating in multiple programs are counted in each activity

- Findings: Compared to an overall increased school readiness rate of 65%, 92% of children who participated in Home Visiting were assessed as school ready. School readiness has been around 50% for the last 5 years, this is an exciting year to report a significant increase to a rate of 65%. Based on the data in the previous figures, children participating in First 5 funded programs are more likely to be school ready at kindergarten entry.
- Considerations: The use of the Brigance tool for assessment in Mono is being reevaluated due to discussions across the State about Racial Equity, Diversity, and Inclusion in Early Childhood which highlight the importance of assessing social-emotional readiness in assessments as it may better highlight culturally diverse students' strengths. As the Brigance tool, used through 2019 to determine readiness in Mono County, does not include a social emotional component, the Commission will consider recommendations for a new tool for School Readiness Assessments in 2020-21.
- Conclusion: Children who participate in Home Visiting are:
    - 32% more likely to be school ready than those who did not participate in early learning programs
    - 27% more school ready than the cohort as a whole

  First 5 Mono does not have data on the kindergarteners' demographic characteristics, e.g., how many come from families with low income, low educational attainment, or other stressors. If the proportion of children experiencing stressors served through Home Visiting (43%) was higher than those of the kindergarten cohort as a whole, it would point to even more significant readiness gains for children enrolled in Home Visiting. At the February 2019 Strategic Planning Retreat, the Commission asked staff to seek additional funding for home visiting to expand to an evidence-based program which includes school readiness as a demonstrated outcome. To that end, Commissioner Gardner and Executive Director DesBaillets worked through the County budget process to successfully support inclusion of a $150,000 annual contribution from the County general fund to raise the standard of home visiting in Mono County.

14. Are parents participating in Home Visiting receiving child development and parenting education? Yes

- Data Source: Home Visiting exit surveys and resource referrals

Table 3: Exit Survey for children older than 1 year n=2

Scale of 1 (Strongly disagree) to 5 (strongly agree)	Before program average	After Program Average	Change
I know how to meet my child's social and emotional needs	4	5	1
I understand my child's development and how it influences my parenting responses.	4	5	1
I regularly support my child's development through play, reading, and shared time together.	4.5	5	0.5
I stablish routines and set reasonable limits and rules for my child.	5	5	0
I use positive discipline with my child.	4	5	1
I make my home safe for my child.	5	5	0
I am able to set and achieve goals.	4	5	1
I am able to deal with the stresses of parenting and life in general.	3.5	5	1.5
I feel supported as a parent.	3.5	5	1.5
Total			7.5

Table 4: Exit Surveys

	Strongly Agree FY 19-20 N=4	Strongly Agreed FY 18-19 N=26
I feel comfortable talking with my parent educator.	95%	94%
I would recommend this program to a friend.	*95%*	94%
My parent educator gives me handouts that help me continue learning	*95%*	94%
about parenting and child development.	*95%*	94%
My parent educator is genuinely interested in me and my child.	*95%*	94%
My parent educator encourages me to read books to my child.	*95%*	*88%*
This program increases my understanding of child's development.	*95%*	*69%*
My parent educator helps me find useful resources in my community.	*100%*	*75%*
Activities in the visits strengthen my relationship with my child.	*95%*	*69%*
I feel less stressed because of this program.	*95%*	*50%*

Table 5: Resource Referrals

	FY 2017-18		FY 2018-19		**FY 2019-20**	
Community Resource	Referred	Accessed	Referred	Accessed	**Referred**	**Accessed**
Adult Education	17	2	5	1	**2**	**0**
Early Intervention	10	5	16	4	**8**	**1**
Early Education Care and Education Setting	21	9	16	5	**19**	**3**
Financial Resources	13	1	4	0	**35**	**5**
Nutrition Resources (WIC, IMACA, DSS, Lactation)	6	2	8	1	**22**	**2**
Parenting or Social Support, Community Participation	102	33	104	21	**58**	**11**
Language/Literacy Activities	19	4	8	1	**6**	**0**
Medical Services	12	6	14	7	**14**	**0**
Mental Health Services	9	4	12	5	**10**	**0**
Housing and utilities					**14**	**1**
Other (injury prevention, crisis intervention, transportation, employment and legal resources)	18	2	16	2	**20**	**2**
Total	227	71	104	47	**208**	**25**
% Referrals Accessed	31%		45%		**12%**	

- Findings: Survey data yielded agreement of 95% or higher in measures pertaining to child development and parenting and an increase in activities related to child development after program participation. Referral data demonstrates parent engagement in accessing resources related to health and development and referrals to support families.

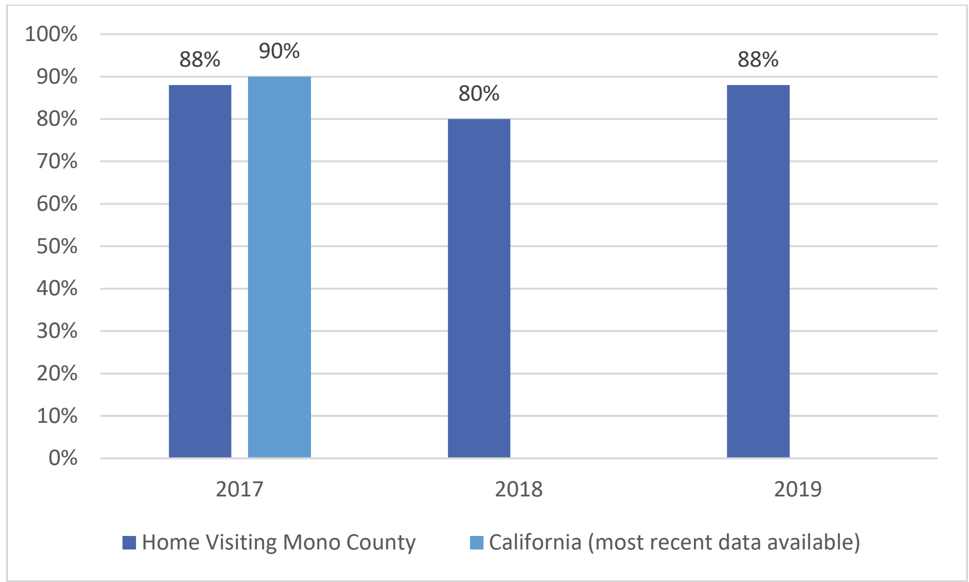
  Referral data reflect some COVID 19 related hardships: new referrals to housing and utilities and increased numbers for financial and nutrition resources. Although the percent of reported access to referrals accessed dropped significantly, the following impacted that data:
  - Evidence-based model implementation: as staff was focused on the many program changes, attention to some data became a challenge.
  - COVID 19: office staff did not have access to hard copy folders to verify and enter data at the end of the fiscal year.
- Conclusion: The program is achieving this outcome

15. Do children whose mothers participate in Home Visiting have increased breastfeeding rates? No

The rate of breastfeeding for infants whose mothers were enrolled in home visiting is high, although a bit lower than California as a whole. With the shift to an evidence-based program, breastfeeding data was only collected on 24 children (50% of children birth to one served). In future years, more training will be conducted with Home Visitors to support health evaluation data entry to better understand County breastfeeding rates for children enrolled in Home Visiting.

- Data Source: 2017-2020 Home Visiting Records

Table 6: Children ever Breastfed: Infants enrolled in First 5 Mono Home Visiting Compared to California 2017-18 to 2019-20[4]



- Finding: Mothers enrolled in Welcome Baby and Healthy Families who completed the health survey (50% of infants served) had static percentages of breastfeeding between 2017 and 2019.
- Conclusion: The program is not achieving this outcome and needs to improve data collection to ascertain the efficacy of the program at supporting breastfeeding.

[4] California data: https://www.cdc.gov/breastfeeding/data/reportcard.htm

16. Is the percent of children 0-5 with the expected BMI high or increasing? No

Data from Mammoth Hospital; Finding: 76%, a decrease from 81%; Conclusion: Continue to educate parents on healthy nutrition and seek to expand community opportunities for parents to expand learning.

Conclusion

The Commission will continue to fund Welcome Baby and Healthy Families as program-specific evaluation results indicate achievement of the desired outcomes. Thanks to funding allocated by the Mono County Board of Supervisors and funded by the taxpayers of Mono County, in 2019-20 home visiting expanded to become an evidence-based model. This was a significant shift from the previously funded locally-developed model. The expansion was quite a feat and led to growth for the First 5 Home Visitors and higher-quality services for clients.

IMPROVED CHILD DEVELOPMENT

SCHOOL READINESS

A child's education begins very early. Since school-based educational systems do not begin until 3-5 years of age, First 5 and community partners offer programs to help prepare children for school in the early years. School readiness programs include all Mono County public elementary schools, childcare and preschool centers, special needs programs, and the Mono County Library System. The FY 2019-20 investment in school readiness was $49,241 with funding support from First 5 SPCFA ($21,846). For all incoming kindergartners planning to attend a public school, First 5 Mono funds transition to school support with Kindergarten Round Up (which First 5 also implements in partnership with the schools). Early literacy investments include: Raising A Reader and Story Time (conducted and partially funded by Mono County Libraries) and Readers' Theatre and First Book (conducted and funded by First 5 Mono).

The objectives and a brief description for the programs funded in this category are as follows:

Transition to School Programs

Kindergarten Round Up: informational meeting held at all public elementary schools in the County

Objectives:

- Introduce families and children to the school, teachers, principal, and each other
- Provide information on entering school and kindergarten readiness
- Facilitate children and families' smooth transition into the education system
- Enroll children in kindergarten
- Sign children up for Summer Bridge

Incoming Kindergarten Assessments: school readiness assessments conducted by teachers in the first month of school

Objectives:

- Assess students' school readiness
- Identify children's skill development needs

Early Literacy Programs

Raising A Reader: book bags distributed by libraries and early learning programs

Objectives:

- Increase literacy for young children
- Encourage use of the library system
- Increase parental and care-provider literacy activities

Readers' Theatre: a literacy program provided to licensed childcares

Objectives:

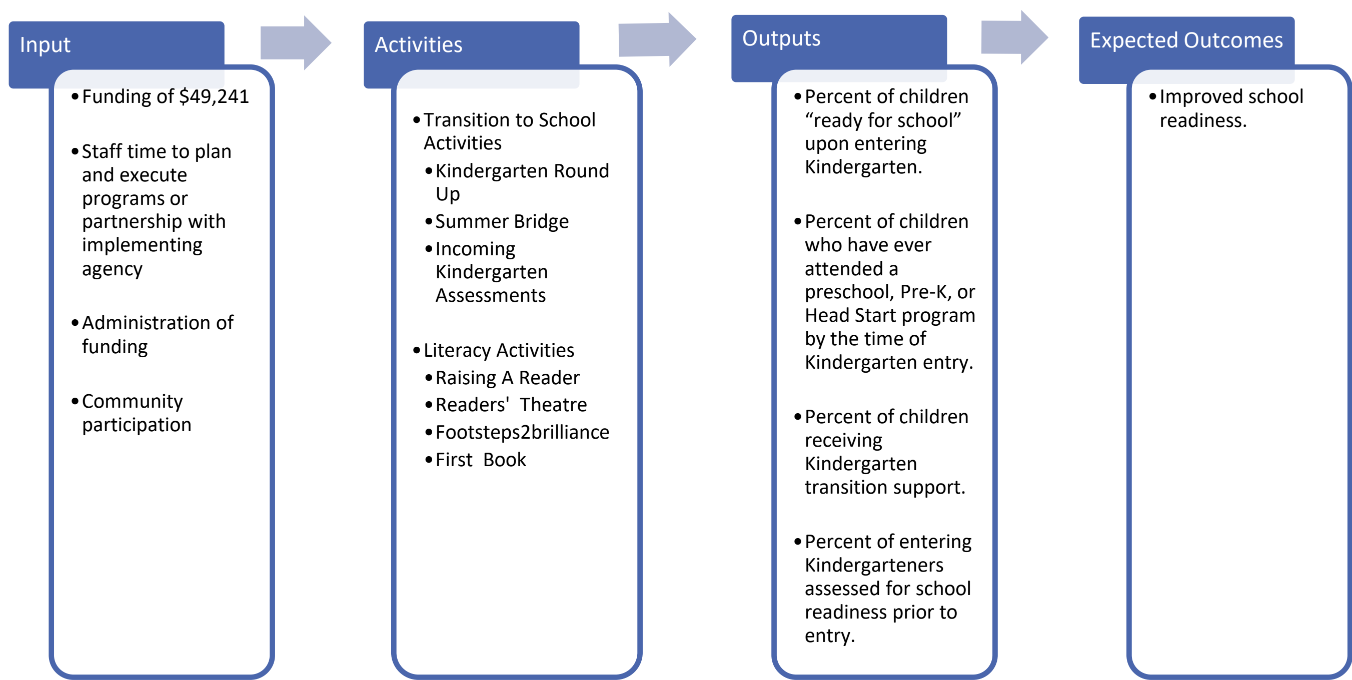
- Increase literacy for young children
- Increase care-provider literacy activities

First Book: free children's books

Objectives:

- Increase parent-child literacy activities
- Facilitate positive parent-child interaction

Logic Model



Evaluation Findings and Conclusions

School Readiness Quick look:

Indicator numbers refer to pages 45-47 and analysis below

Percent of Indicators	Indicator Achievement	Indicator
83%	⬆	8 Preschool attendance by K entry* 9 School readiness rate 10 Families attended Round Up 11 Literacy programs accessed 13 Kindergarteners assessed for readiness
17%	⬇	12 Preschool slot availability

* Under 60% reporting rate

8. Is the percent of children who have ever attended a preschool, Pre-K, or Head Start program by the time of Kindergarten entry increasing? Yes

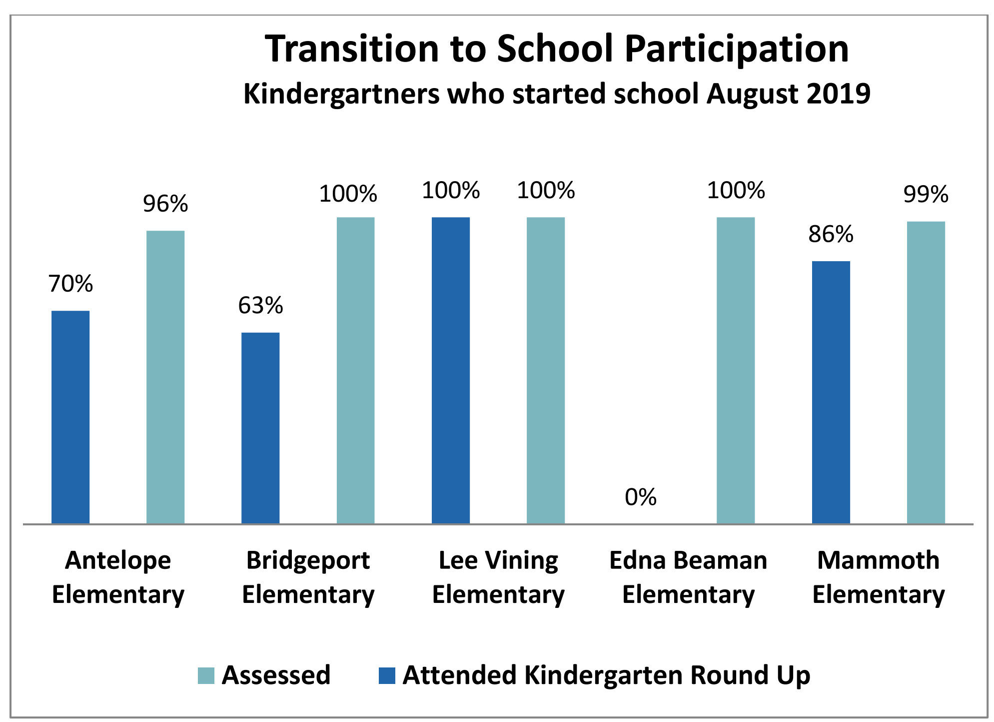
- Data Source: Incoming Kindergarten Parent Survey
- Finding: yes, 87% compared to 76% last year
- Conclusion: Efforts to maximize enrollment and increase the number of available slots coupled with the district-mandated Transitional Kindergarten program had a positive impact on the rate of preschool attendance.

9. Is the percent of children "ready for school" upon entering kindergarten increasing? Yes

- Data Source: Brigance Assessments (Figure 1, page 11)
- Finding: Readiness increased to 65% from 51% last year
- Conclusion: While school readiness has been a major investment for 19 years, only in the last 3 years was a standardized universal assessment used to measure school readiness. The Percent of Kindergartners Assessed as School Ready by Program Participation (Figure 2, page 11) demonstrates that funded programs support school readiness across the county. After many years of a rate of around 50%, the increase in FY 2019-20 is quite exciting! First 5 Mono will seek to sustain and continue to increase the rate of school readiness in Mono County.

10. Is the percent of children whose parents attended Kindergarten and TK Round-Up increasing or remaining high? Yes

- Data Source:
  - Table 7: Participation in Transition to School Activities



- Finding: Kindergarten Round Up participation increased to 82%, and has steadily increased from 54% in 2017-18.
- Conclusion: The program is achieving its goal.

11. Is the percent of children birth to 5 accessing funded literacy activates high or increasing? Yes

- Data Source: Participation in Raising a Reader and Home Visiting, includes duplicates.
- Findings: 48%, up from baseline of 47%
- Conclusion: First 5 does not have access to the Raising a Reader participant names so cannot provide unduplicated numbers. The number remained largely static since last year around 47%

12. Is there a high or increasing percent of preschool slots for age-eligible children? No

- Data Source: Number of slots licensed for a preschool age-specific classroom
- Finding: 43%, down from 51% last year. Note: last year's figure was revised due to an update in what slots are counted, now only age-specific classrooms.
- Conclusion: The decrease from 51% to 43% represents the closing of a site in 2019-20. Although there are preschool slots for only 43% of age-eligible children, some slots still remain unfilled. Reasons for underutilization are:
    - Slots are located in towns without enough age qualifying children to fill them
    - Children's families fall above income requirements (e.g., State Preschool, Head Start, or CDBG)
    - Lack of transportation
    - Lack of sufficient hours to be feasible for the family, many programs are only around 4 hours a day.
    - Federal employment requirements for parents (e.g., Mountain Warfare Training Facility Child Development Center).

13. Is the percent of entering Kindergartners assessed for school readiness at entry increasing or remaining high? Yes

- Data Source: Kindergarten readiness assessments (Figure 2 page 11)
- Findings: yes, 98% of kindergartners
- Conclusion: The new protocol to assess kindergartners at kindergarten entry (instead of prior to kindergarten) had a positive impact on the percentage of students assessed for the past two years.

As the majority of the program-specific evaluation results indicate achievement of the desired outcomes, the Commission will continue to fund the same School Readiness activities in 2012-21 as in 2019-20. The Commission ended Summer Bridge program funding earlier than planned—at the end of 2019-20 due to COVID. The decision to no longer fund Summer Bridge was based on low participation and lack of desired outcomes for over 5 years. Data in the evaluation report will continue to inform improvement and future investments.

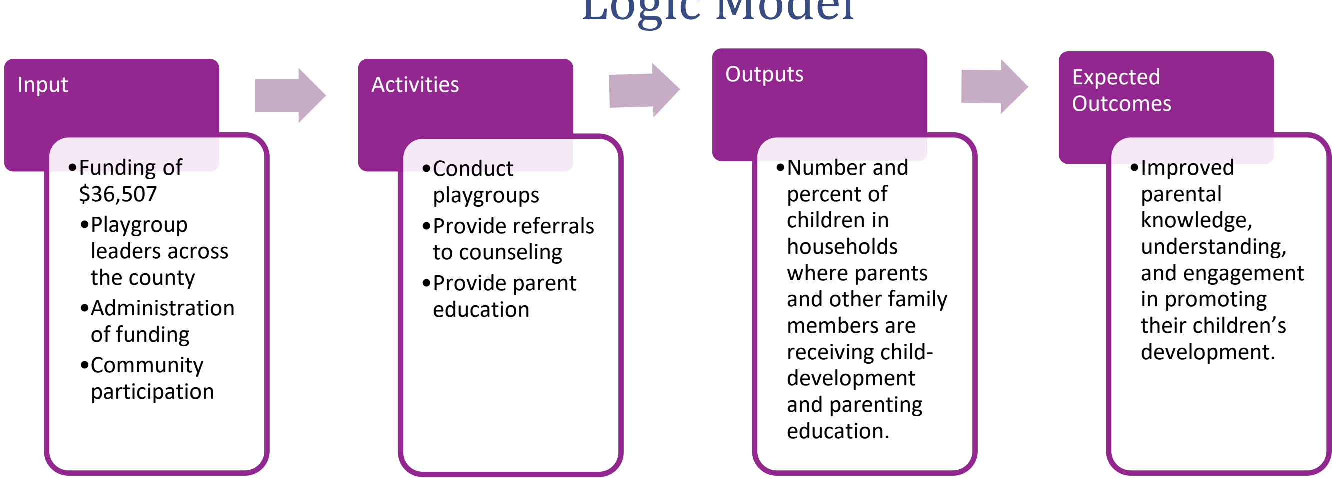
Family Behavioral Health

In such a rural and geographically isolated county, it is easy for families to feel alone. Opportunities for children and their parents are fewer than in more populated areas. To meet the social needs of parents and their children, a weekly playgroup program was developed. Funding is primarily from Mono County Behavioral Health for $36,507. Playgroups and parent education are conducted by First 5 Mono.

The objectives and a brief description for the program funded in this category is as follows:
Peapod Playgroups: For parents, caregivers, and children birth to 5 years old. Playgroups meet for 10-week sessions. Sessions were held in the following communities: Walker, Bridgeport, Mammoth Lakes, Crowley Lake, and Chalfant.
Objectives:

- Decrease isolation by providing parents and children an opportunity to socialize
- Destigmatize seeking behavioral health services
- Link families to community services
- Encourage school readiness and early literacy.

Logic Model



Evaluation Findings and Conclusions

Peapod Playgroups Quick Look:

Indicator numbers refer to pages 45-47 and analysis below

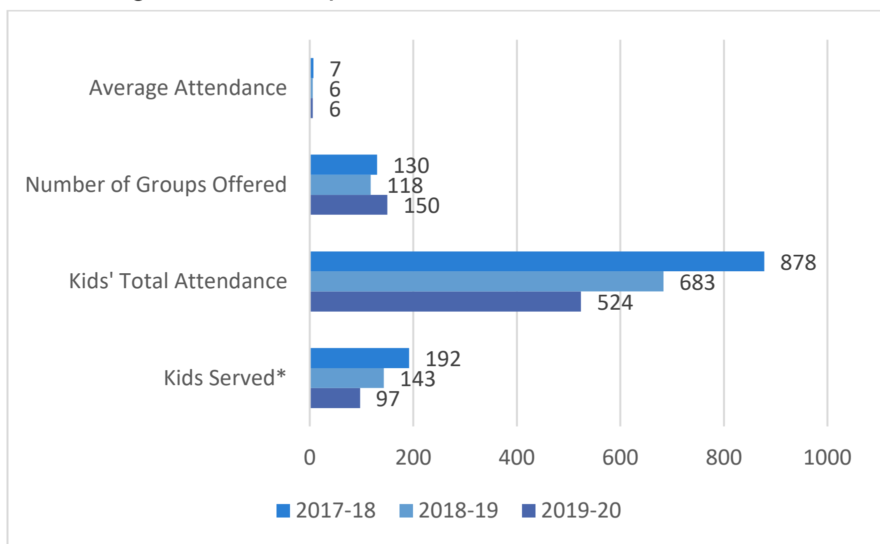
Percent of indicator	Indicator Achievement	Indicator
50%	↑	1 Parents satisfied
50%	↓	14 High participation rates

1. Does Peapod survey data yield 100% satisfaction or an average of 4-5 on a scale of 1-5 that the playgroup met participant expectations. Yes

- Data Source: Peapod surveys
  - Figure 1: Participant Survey Results (appendix III Table 3, page 38)
- Finding: Yes
- Conclusion: Due to client satisfaction with the program, the program will continue to offer services as it has in the past.

14. Is the percent of children in households where parents and other family members are receiving child-development and parenting education high or increasing? No

- Data Source: Number of children participating in playgroups.
  - Figure 1: Participation 2017-18 to 2019-20



*Kids participating via Facebook live not counted

- Finding: Down to 14% from 21% of children birth to 5 in the County last year.
- Conclusion*:* Due to participation in Peapod, children lived in households receiving child-development and parenting education. More groups were offered than in the past, and children participating on Facebook Live were not counted. Changes in staffing for the playgroups has contributed to the decline in participation over the last several years, all efforts will be made to support existing staff in rebuilding participation. COVID 19 significantly impacted the number of children who participated since in-person groups were not allowed after mid-March. Although there was a decrease in the percent of children who participated this year, the program is still achieving its intended outcome.

Families have more information about parenting and child development because Peapod Playgroups, the First 5 Mono Family Behavioral Health investment. The Commission will continue to invest in and seek funding partnership for this initiative. Outreach efforts through COVID 19 have shifted online. In following with local and state health guidelines, groups shifted to a virtual platform in March of 2020. Groups were held first virtually on Zoom, than, as participation declined, on Facebook Live which received wider participation (albeit not interactive). Despite the pandemic, Peapod Playgroups still enjoy significant participation.

Childcare Quality

First 5 Mono includes Childcare Quality in the strategic plan as many children spend a significant amount of their early years with their childcare provider. The initiative is fiscally supported by First 5 California, the California Department of Education, and a Federal Community Development Block Grant through Mono County. Educating child care providers on how to best meet the needs of children helps ensure children will spend their formative years in optimal learning environments.

The Childcare Quality investment for FY 2019-20 was $536,836 that came from the following funding streams:

- Improve and Maximize Programs so All Children Thrive (IMPACT), conducted by First 5 Mono for Mono and Alpine Counties funded by First 5 Mono & First 5 California: $102,290
- Region 6 Training and Technical Assistance Hub, funded by First 5 California: $178,350
- California Department of Education (CDE) California State Preschool Program Block Grant (CSPP BG): $18,013
- Certification and Coordination Grant (CDE): $2,625
- Quality Rating and Improvement System (QRIS) Block Grant: $9,119
- Equitable Learning Opportunities (CDE): $23,134
- Childcare services provided by Eastern Sierra Unified School District funded by the Community Development Block Grant (CDBG) through Mono County: $203,305.

The objectives and a brief description for the programs funded in this category are as follows:

IMPACT: Training, coaching, rating, stipends, and support for childcare providers for the provision of high-quality care for children and their families.

Objectives:

- Provide site-specific professional development to child care providers.
- Support providers' implementation of developmental screenings and parent engagement activities
- Build public awareness and support for quality early care
- Build a Childcare Quality System that leverages funding and maximizes support for care providers

QRIS and CSPP QRIS Block Grants: Support for state preschool sites and sites serving infants and toddlers.

Objectives:

- Provide site-specific professional development to child care providers
- Support provider understanding of quality care and education

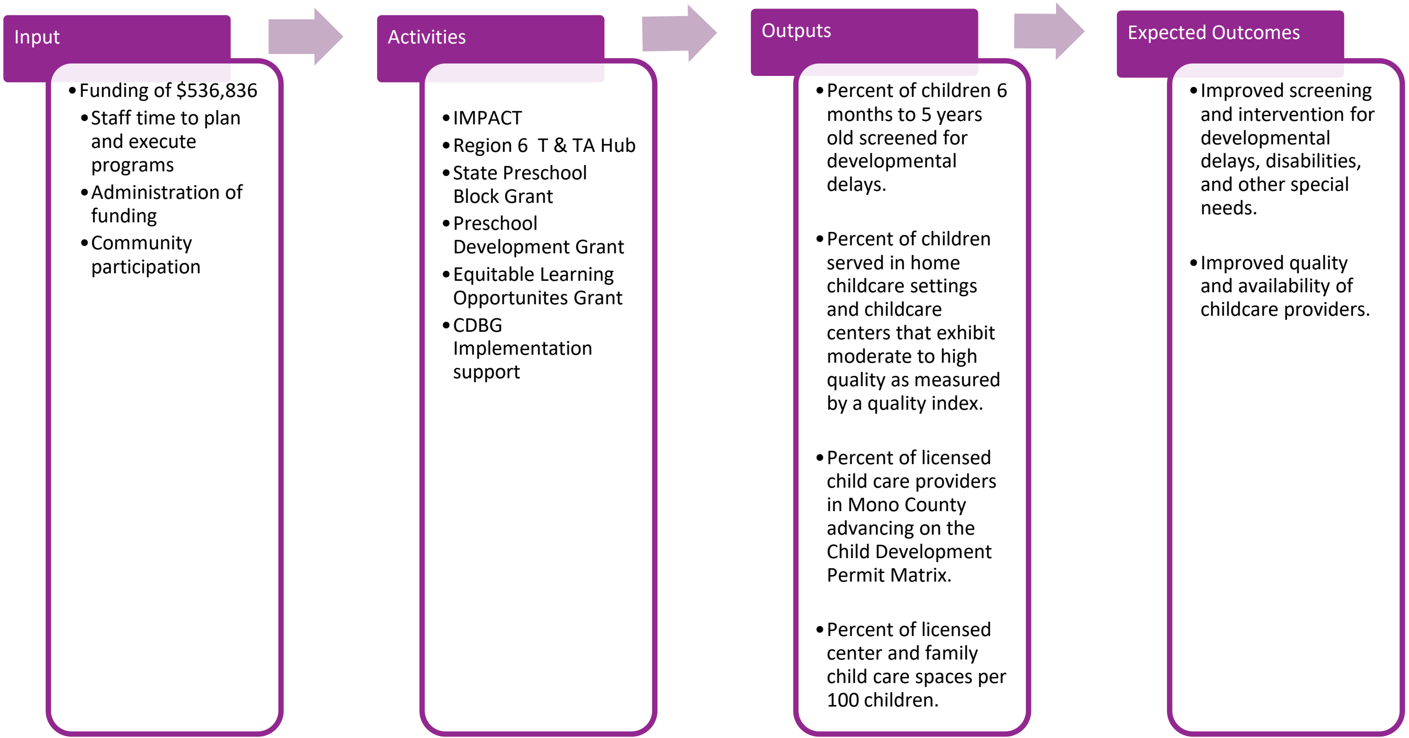
Training and Technical Assistance Hub: Support regional efficiencies in Childcare Quality work

Objectives:

- Provide assessors for Spanish speaking sites
- Contract with Viva for coordination for the Hub
- Contract with i-Pinwheel database to track sites' participation
- Contract with American Institute of Research for the Early Learning Needs Assessment Tool (ELNAT) database to analyze child data to determine needs

CDBG Childcare: Provide high-quality care to preschool age children in Bridgeport and Benton.

Logic Model



Evaluation Findings and Conclusions

Childcare Quality Quick Look:

Indicator numbers refer to pages 45-47 and analysis below

Percent of indicators	Indicator Achievement	Indicator
50%	⬆ (green up arrow)	4 Developmental screening rate
	⬌ (yellow double arrow)	5 Children in high quality care, slight decrease from last year, but still a significant increase from 2 years ago.
50%	⬇ (red down arrow)	6 Provider permit attainment rate 7 Childcare availability

4. Is the percent of children 6 months to 5 years old screened for developmental delays increasing? Yes for the Childcare Quality System

- Data Source: Childcare Quality System Completed ASQs
  - Table 1: Developmental Screening, ASQ, from Childcare Quality System Sites

Fiscal Year	*Number of Screenings*	*Percent of enrolled children screened*	*Number of children screened with an identified concern*	*Percent of children screened with an identified concern*
2017-18	130	60%	22	23%
2018-19	180	85%	33	18%
2019-20 n=197	173	88%	5	3%

- Finding: Yes, 88% of children enrolled at participating sites were screened for a developmental delay, up from 85% the previous year.
- Conclusion: More children were screened for developmental delays through their childcare provider this year.

5. Is the percent of children served in home childcare and childcare centers that exhibit moderate to high quality as measured by a quality index increasing? 6. No, but still a significant increase over the last several years.

- Data Sources: Site ratings and Childcare Quality System participation data
- Finding: 127 children in Mono County attended a site with a high quality rating, 91% of children enrolled in programs participating in the Childcare Quality System and 24% of all children in the County. Gains from last year were maintained, the decrease was due to two family childcare sites not wishing to maintain their rating.
- Conclusion: Although fewer sites were rated as having high quality this year, those that were rated achieved the highest ratings, 4 & 5 out of 5. Lee Vining Preschool was rated at a 5--highest quality, the first site in Mono County to achieve the highest rating! 7 sites were rated as 4—exceeding quality. Although less sites were rated in FY 19-20, all rated sites were rated as high quality and the number of sites rated as high quality has significantly increased over the last several years from 8% in 2016-17 to 25% in 2019-20.

6. Is the percent of licensed childcare providers in Mono County advancing on the Child Development Permit Matrix high or increasing? No

- Data Source: Childcare Quality System participation
- Finding: 0, down from 2 in 2017-18
- Conclusion: Although child development permits are an element of a high quality program, the incentive to improve quality is not enough to support providers in overcoming the barriers to attain a child development permit. Barriers include low pay regardless of permit achievement, no licensing requirement to have a permit, and the difficulty of gathering supporting documents and properly completing the permit application. Progress was made towards permit attainment through the AB 212 program administered by the Mono County Office of Education and gains are expected for FY 2020-21.

7. Is the percent of licensed center and family childcare spaces per 100 children high or increasing? Almost the same, slight decrease

- Data Source: IMACA Resource and Referral slot numbers and the Childcare Portfolio
- Findings: In September of 2019 there were slots for 46% of children birth to 5 in the County
- Conclusion: Although the number of slots available to children in Mono County decreased dramatically from 56% in 2008, the percent of available slots has increased over the years and is now 46%, a an increase over the last three years, albeit a loss of one percent from last year. First 5 Mono continues to actively participate in the Mono County Child Care Council to support initiatives seeking to increase the number of child care slots in Mono County. First 5 collaborates with the Mono County Office of Education, which has taken the lead on a coordinated effort to create more slots in Mammoth Lakes. First 5 also continues to apply for CDBG funds and partner with the County and Eastern Sierra Unfired School District to help fund the Bridgeport Elementary Preschool.

The Commission will continue to invest in Childcare Quality because of successes in leveraging First 5 California and California Department of Education funds, rating sites, supporting developmental screenings, and partnering with local providers to maintain and increase quality. Over the last several years, First 5 Mono has built significant capacity in this investment area. After completion of training and successful testing, First 5 Mono staff is able to provide teacher-specific coaching based on classroom observations, conduct observations, and rate sites. Childcare Quality System work is supported by the Mono County Office of Education's Local Planning Council (the Mono County Child Care Council) and Inyo Mono Advocates for Community Action's local Resource and Referral and Alternative Payment programs, as well as collaboration with Cerro Coso's Child Development Department and partners in Alpine and Inyo Counties.

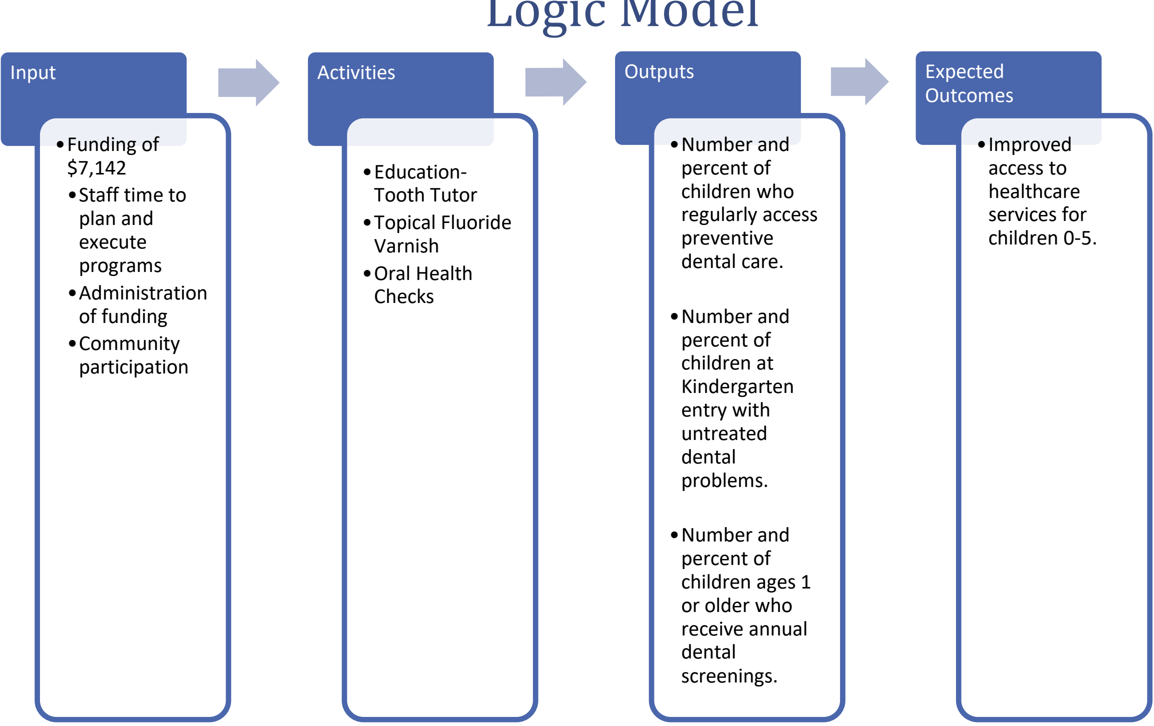
IMPROVED CHILD HEALTH

ORAL HEALTH

The 2009 First 5 Mono Strategic Plan identified a significant community need in the area of oral health. Pediatricians saw visible tooth decay spurred development of a topical fluoride varnish application program. Pediatricians in the County continue to report needs for sustained efforts in oral health due to high numbers of children with poor oral health. The Oral Health Program consists of education, oral health checks, and topical fluoride varnish application for children in childcare settings across the County. The program was funded and operated by First 5 Mono at a cost of $7,142 for FY 2019-20. The program provides free toothbrushes, toothpaste, and floss to families to help maintain oral health.

Objective: Provide application of topical fluoride varnish twice a year to all Mono County children age 1-5 not already receiving services from a dentist, and educate children and parents about oral health.

Logic Model



Evaluation Findings and Conclusions

Oral Health Quick Look:

Indicator numbers refer to pages 45-47 and analysis below

Percent of indicators	Indicators Achievement	Indicators
50%	⬇ (green)	18 Children at K entry with untreated dental problems*
50%	⬇ (red)	17 Annual dental screening rate*

*Lower than 60% reporting rate

17. Is the percent of children ages 1 or older who receive annual dental screenings high or increasing? No

- Data Source: Sierra Park Dental Data, 2017-20
- Finding: 42% of children age 1-5 years old had an annual exam at Mammoth Hospital—, a drop from 51% the previous year. There was a corresponding drop in the reporting rate as the number of patients at Sierra Park Dental has declined by 134 individuals since 2017.
- Conclusion: First 5 will continue oral health education efforts to support higher percentages of children receiving an annual screening. A data challenge is that only one dental provider is included—Mammoth Hospital.

18. Is there a low percent of children at Kindergarten entry with untreated dental problems? Yes

- Data Source: Kindergarten Oral Health Checks
- Finding: 10% of the oral health checks turned in at kindergarten enrollment indicated the child had untreated caries (cavities), a significant decrease from the last 5 years which have been around 30%. Note the low reporting rate though, 42%.
- Conclusion: The percent of untreated caries at kindergarten significantly decreased to 10%.

Fewer children are being seen at Mammoth Hospital Dental Clinic--45%. The actual rate of annual screening reported herein of 42% is certainly higher as some children access care through a private provider and data is only from Mammoth Hospital. The Commission will continue to invest in this initiative and seek to sustain the 19-20 improvements in oral health for children 0-5. First 5 will continue to provide topical fluoride varnish and oral health checks for children between one and 5-

years-old served in Childcare sites participating in the Childcare Quality System as well as promote oral health through home visiting, playgroups, and school readiness.

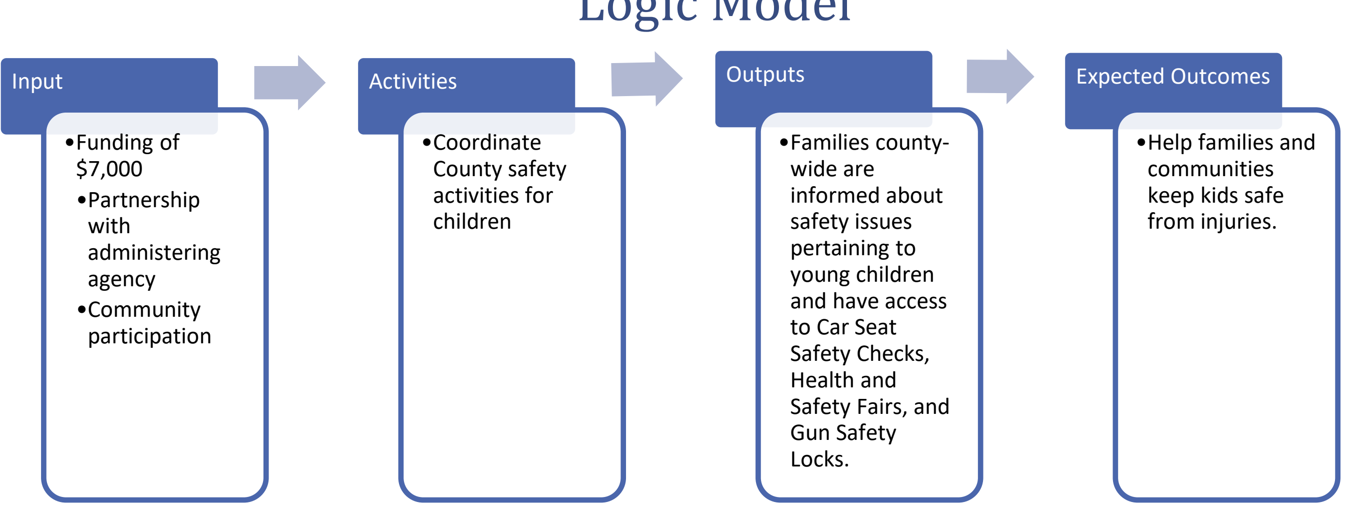
The 0-5 population's oral health needs decreased in 19-20 based on the rate of untreated carries at kindergarten entry-- 10%. The decrease may be linked to First 5 and partner agency oral health investments, but may also be attributable to the low reporting rate. Analysis in future years will help identify if the decrease from the multi-year average of 32% to 10% is indeed a trend. Once funded by First 5 California, First 5 Mono continues to allocate discretionary funds for the oral health initiative. Leveraging the First 5 Mono investments are supplies from the Mono County Health Department, and the pediatric office's application of topical fluoride varnish.

CHILD SAFETY

Prior to the formation of *Safe Kids California, Mono Partners*, no agency in the County specifically focused on child safety. While some agencies conducted safety activities, services were not coordinated. Initially spearheaded by Mammoth Hospital, multiple community agencies met to pursue the formation of a Safe Kids Coalition. Based on higher than average injury data for Mono & Inyo Counties, and after learning the benefits of such collaborations, the Commission decided to fund the coordination of *Safe Kids California, Mono Partners* as no other participating agencies had the necessary funding to conduct coordinating activities. With combined funding from SPCFA ($7,000) and the Mono County Office of Education, the Mono County Office of Education coordinates Safe Kids California, Mono Partners.

Objective: Bring safety services & resources to families

Logic Model



Evaluation Findings and Conclusions

Child Safety Quick Look:

Not included in Strategic Plan Indicators

Percent of indicators	Indicator Achievement	Indicators
100%	⬆	Child safety information and materials shared with parents.

Are families countywide informed about safety issues pertaining to young children and able to access Car Seat Safety Checks, Health and Safety Fairs, and Gun Safety Locks? Yes

- Data Source: Coordinator report
- Finding: services were greatly reduced due to COVID 19
- Conclusion: As a result of investments, car seat checks, safety material distribution, and bike helmet distribution continued throughout the year at Mammoth Lakes Police Department, State Farm, and through First 5 Home Visiting.

Families had access to child safety equipment and car seat checks as a result of the Safe Kids investment, thus the Commission will continue to invest in this initiative. As part of the continuous quality improvement of the Safe Kids California, Mono Partners work, outreach efforts will continue to ensure as many families as possible participate in future Health & Safety Fairs.

APPENDICIES

Appendix I, Home Visiting

Table 1: Referral Source

	Number	Percent
Mammoth Hospital Labor & Delivery	17	22%
Self	16	21%
Doctor, Pediatrician, or Hospital Staff	12	16%
Other, Family/Friends	6	8%
Childcare Quality System	5	6%
Peapod	4	5%
First 5 Home Visitors	3	4%
Early Start/ screening agency	3	18%
School	2	
Tribal Organization	1	
IMACA	1	
Childbirth Education Class	1	
Not recorded	6	
19-20 Total	**77**	
18-19 Total	104	
17-18 Total	70	

Table 2: Visits Provided

Visit Type	*FY 2017-18*	*FY 18-19*	***FY 19-20***
Prenatal Home Visits	63	65	**32**
Birth-5 Home Visits	561	527	**584**
Total Visits	624	592	**616**

Table 3: Families Served

	FY 17-18	FY 18-19	**FY 19-20**
New Babies Enrolled	58	89	**48**
*Births to Mono County Residents**	134	135	**137**
Percent of Mono County Babies Enrolled	43%	66%	**35%**
Total Families Served	125	136	**207**

*Source: California Department of Finance January 2020, projections
FY calculations use the calendar year projections of the year the FY begins (e.g., 2018 for FY 2018-19)

Table 4: Child's Race & Ethnicity, N=113 children newly enrolled in the program year for whom data is available.

- Child Race/Ethnicity (n=113)
  - Non-Hispanic 47 (43%)
    - White: 43
    - Black or African American: 1
    - Multi-race: 3
  - Hispanic 66 (57%)
    - Multi-race: 58
    - White: 8

Non-Hispanic	**47, 43%**	Black or African American	1
		White	42
		Multi-race	3
Hispanic	**66, 57%**	Multi-race	53
		White	13

Table 5: Stressors

Families with multiple stressors: 47, 43% (of 113 families who received a visit in the program year)

Families with multiple stressors, previously called families with high needs, are determined using the national home visiting standard. If a family has *more than one of the following* stressors, they are considered as having multiple stressors and can access home visits twice a month, rather than monthly.

low income or education	foster parents	death in the immediate family
child or parent with a disability	incarcerated parent	child abuse or neglect
homeless or unstable housing	very low birth weight	active military family
young parent	domestic violence	
substance abuse	recent immigrant	

Stressors	*Number of families*
Low income	62
High School Diploma or Equivalency not attained	22
Child with a Disability	10
Parent with a Disability	9
Young Parent (parenting under age of 21)	7
Housing Instability	8
Recent immigrant or refugee	2
Parent incarcerated during child's lifetime	2
Very low birthweight and preterm birth	3
Intimate Partner Violence	1

Figure 1: Home Visiting Families' Town of Residence Compared to the Kindergarten Cohort

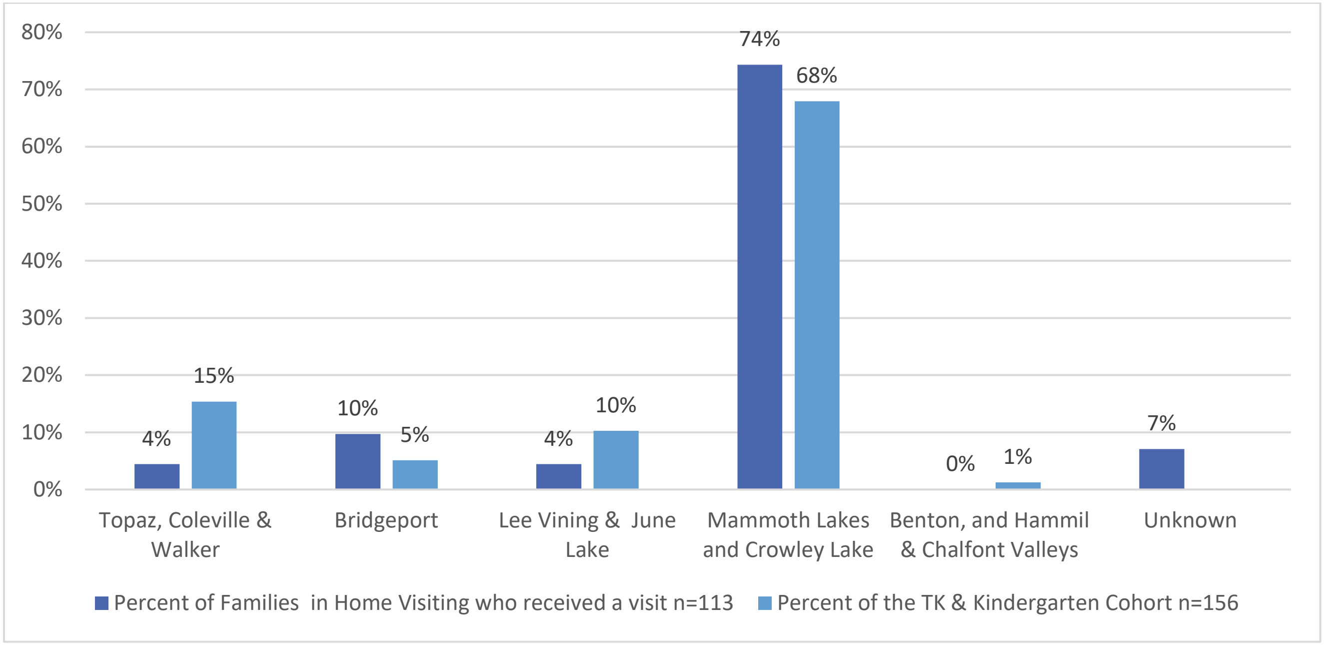


Table 6: Parenting Reflection exit Survey for families with children over 1

N=4 *Scale of 1 (Strongly disagree) to 5 (strongly agree)*	Before program average	After Program Average	Change
I know how to meet my child's social and emotional needs	3.75	4.5	0.75
I understand my child's development and how it influences my parenting responses.	3.5	4.25	0.75
I regularly support my child's development through play, reading, and shared time together.	4.5	4.75	0.25
I stablish routines and set reasonable limits and rules for my child.	4.5	4.75	0.25
I use positive discipline with my child.	4.25	4.25	0
I make my home safe for my child.	4.75	4.75	0
I am able to set and achieve goals.	3.75	4.5	0.75
I am able to deal with the stresses of parenting and life in general.	3.25	4	0.75
I feel supported as a parent.	3.5	4.5	1
Total			4.5

Table 7: Satisfaction exit survey

	Strongly Agree FY 19-20 N=10	Strongly Agree FY 18-19 N=26
I feel comfortable talking with my parent educator.	98%	94%
I would recommend this program to a friend.	98%	94%
My parent educator gives me handouts that help me continue learning	98%	94%
about parenting and child development.	98%	94%
My parent educator is genuinely interested in me and my child.	98%	94%
My parent educator encourages me to read books to my child.	98%	*88%*
This program increases my understanding of child's development.	*94%*	*69%*
My parent educator helps me find useful resources in my community.	*100%*	*75%*
Activities in the visits strengthen my relationship with my child.	*98%*	*69%*
I feel less stressed because of this program.	*88%*	*50%*

Survey comments:

What about the program has been most helpful to you and your family?

- Todo nos dan muccha informacion y nos explican paso a paso las cosas para mejorar toda la familia. (Everything gives us a lot of information and explains things step by step to improve the whole family.)
- Mejorar las metas que tango para mis hijos (Improve the goals that I have for my children)
- The thing that really helped my son and myself was being able to practice new stuff, for example using scissors was one thing my son loved and I didn't know he was ready for that.
- Debbie was great! She was always very flexible with scheduling. I liked that she listened and was patient with my concerns. She always had good and productive suggestions.
- Everything, any other knowledge is helpful.
- The early help with breastfeeding was great.
- Reinforcement of milestones and helpful ways to achieve them.
- As a new mom, I didn't know what to expect. Debbie was very helpful and I always looked forward to our meetings. She provided a lot of useful information + made me feel comfortable.
- The breastfeeding support that I received helped me so much and I felt like I could count on Debbie to check in and follow up with me.
- I love that the parent educator came to our house it makes a lot easier with the little ones, and she was great giving alternative options on what to try to solve my problems.

What could be improved about the program?

- Que fueran mas las visitas a casa, en lugar dde 1 vez por mes. That there be more visits, instead of once a month.)
- Creo que nada todo es excelente (I think nothing, all is excellent)
- In my experience I feel like everything that was taught to my son was great and helpful. I don't have any suggestion to improvements. Just keep being an awesome program!!
- No Complains, This program is great!
- More visits
- Nothing
- Group sessions every few months
- I wish she came more frequently

What changes have you made in your family or personal life as a result of Parents as teachers?

- Todo nos motivan y nos dicen come hablar con los hijos. (Everything motivates us and tells us how to talk with our children.)

Additional Comments:

- Gracias por todo su apoyo. (Thank you for all your support.
- Debbie was incredible! She was patient, understanding, kind, and empathetic. She was a key person in helping facilate my breastfeeding journey. I am forever grateful for this program and her support. Thank you!
- Excelente programa y excelente trabajador social mil Gracias Elvira.(Excellent program and excellent social worker Elvira)
- Thank you Elvira for making time for us, being available after my work hours. I (we) loved all the new activities and games and simply rearranging and accommodating my schedule. I feel like we both learned a lot of new things. Wish we could stay with you guys!! Thank you.
- Everything was fantastic, and this program is an asset to our community.

Appendix II Early Literacy

Figure 1: Raising A Reader, Participation by Age 2017-18 to 2019-20

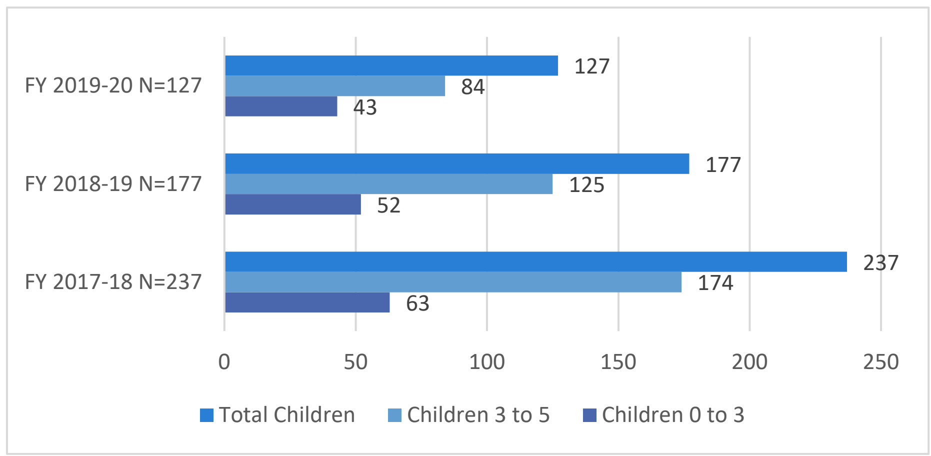


Table 1: First Book Distribution

Program	***Number of Books***
Home Visiting & Peapod	600
Health & Safety Fairs	168
Total	**768**

Appendix III Peapod Playgroups

Table 1: Families Served by Location 2017-18 to 2019-20, includes duplicates between locations

Playgroup Location	*FY 17-18*	*FY 18-19*	***FY 19-20***
Benton/Chalfant	2	3	**4**
Bridgeport	12	21	**12**
Crowley Lake	45	38	**10**
Lee Vining/ June Lake	0	3	**0**
Mammoth English	55	38 (bilingual)	**42 (bilingual)**
Mammoth Spanish	4		
Walker	4	15	**8**
Total	122	118	**76**

Table 2: Surveys, n=13

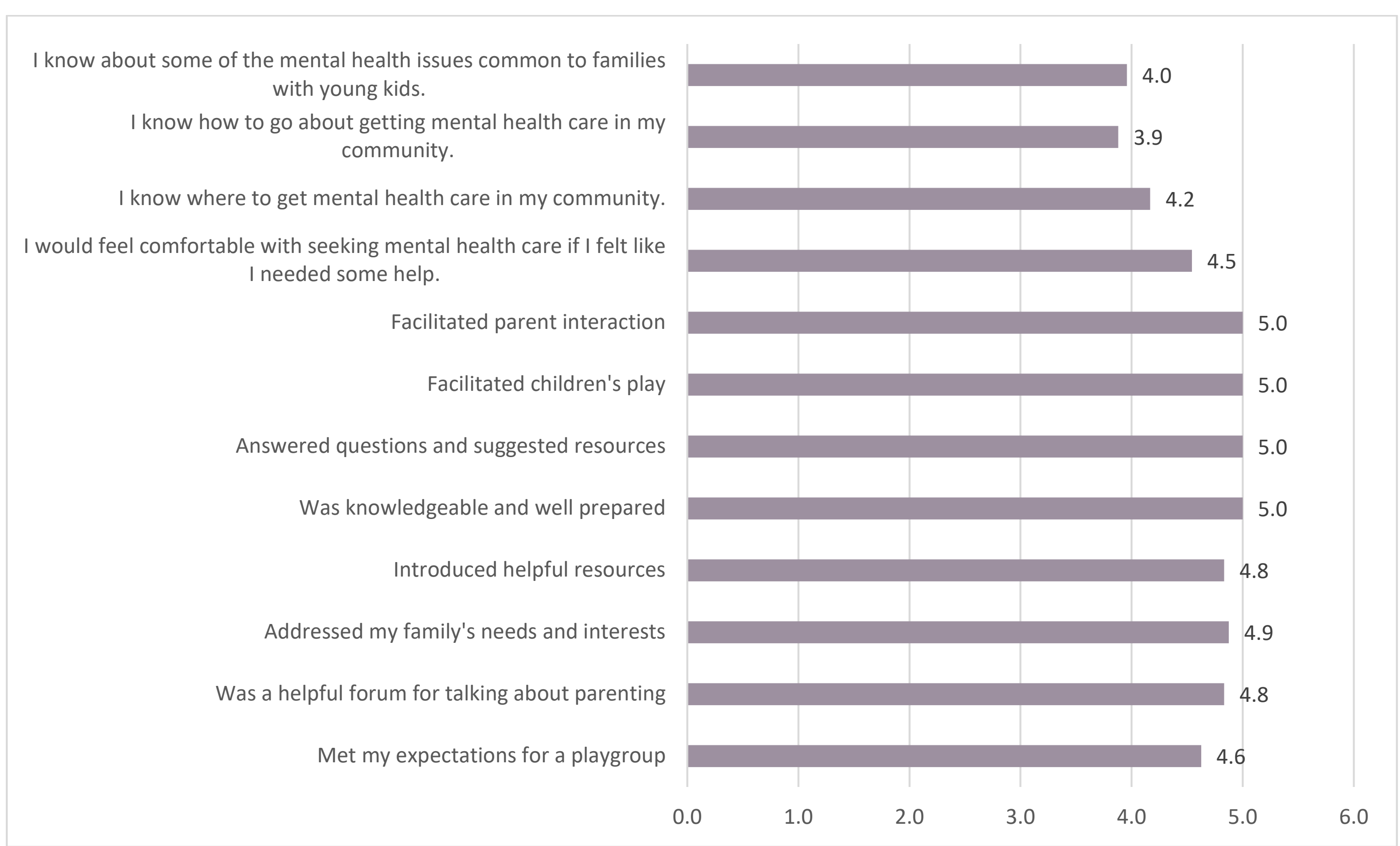


Table 3: Survey Demographics (numbers differ between categories as not all surveys answered all questions) n=13:

Race/ethnicity	White: 12 Hispanic: 1
Language	English 13 Spanish 1 (also checked English)
Age	16-25: 1 26-40: 9 41-59: 2 60+: 1
Sex	Female: 12 Male: 1

Parent Survey Comments:

- Playing and sharing
- Songs, Kids, Learning to play together, practice sharing, talking w/ parents, Spanish and parachute.
- Parent interactions, singing songs
- Social interactions for kids.
- Great interaction for kids with other kids. Great selection of play toys and learning activities.
- Great songs and parent time too.
- Parent and children interaction.
- Regular place to go with routine.
- Great Toys
- Free play, songs, safety
- Attendance, toys, free play
- Socialization for my daughter

Parent Suggestions:

- Peapods are great. We love coming to them.
- Keep going, year around
- Music
- None, we love Peapod
- More of the same. More baby signs.
- Maybe longer playgroups - 1 hour goes fast
- Musical tools for songs to spark interest.
- More outreach, bring in more children

Appendix IV, Childcare Quality

- Interactions between teachers and children
- How teachers meet and support the developmental needs of children
- The health and safety of the classroom
- Staff qualifications and training
- Group size, number of children per teacher

Rating	Description
1	COMMITTED TO QUALITY – participating in quality improvement efforts
2	RAISING QUALITY – meeting some quality standards
3	ACHIEVING QUALITY – meeting multiple quality standards
4	EXCEEDING QUALITY – meeting quality standards in all areas
5	HIGHEST QUALITY – exceeding quality standards in all areas

2019-20 Mono Alpine Rated Childcare & Education Sites
participating sites opting to be rated

Rating	Sites
Highest Quality 5	• Lee Vining IMACA Head Start/ State Preschool
Exceeding Quality 4	• Coleville IMACA State Preschool • Edna Beaman Elementary Preschool • Kindred Spirits • Mammoth IMACA Head Start/ State Preschool • Mammoth Lakes Lutheran Preschool • Mammoth Kids Corner • Mountain Warfare training Center Child Development Center • Alpine Early Learning Center (Alpine County)
TBD Ratings were not completed due to COVID 19 restrictions	• MCOE Inclusive Preschool • Maria Garcia Family Childcare

Appendix V Child Health

Table 1: Oral Health Services Provided

	Oral Health Education	*Fluoride Varnish*
FY 2019-20 Total	**12**	**9**
FY 2018-19 Total	114	114
FY 2017-18 Total	102	155

Table 2: Safe Kids Activities

County-Wide Birth to 5 Health & Safety Fairs were cancelled due to COVID 19
Car seat checks at Mammoth Lakes Police Department and Helmet distribution at State Farm continued.

Appendix VI Results and Indicators

Quick Look: 3 Year Trend (indicator numbers refer to pages 45-47)

% of indicators	Trend	Indicator
72%	Up	• 1 Peapod satisfaction • 3 Children in home visiting • 4 Children screened for developmental delay • 5 Children in high quality childcare • 7 Childcare spaces • 8 Incoming kindergartners who attended preschool* • 9 Children ready for school • 10 Families who attended kindergarten round up • 11 Literacy program participation • 13 Kindergartners assessed at entry • 14 Breastfeeding successful*
	Down	• 18 Kindergartners with untreated dental problems *
	No change	• 14 Parenting education participation*
28%	Down	• 2 Infants in Home Visiting • 6 Childcare provider permit attainment • 12 Preschool slots • 16 Expected BMI* • 17 Annual dental screening*

*Less than 60% reporting rate

Result I: *Mono County children 0-5 are educated to their greatest potential.*

Indicator	Investment area	2017-18	2018-19	2019-20
1. Peapod survey data yields 100% satisfaction or an average of 4-5 on a scale of 1-5 that the playgroup met participant expectations	Family Behavioral Health	New Indicators	Yes	Yes
2. Number and percent of children prenatal to age 1 whose parents accessed Home Visiting	Home Visiting		66%	48, 35%
3. Number and percent of children prenatal to age 5 whose parents accessed Home Visiting.			22%	207, 30%
4. Number and percent of children 6 months to 5 years old screened for developmental delays.	Home Visiting & Childcare Quality	29%	35%	232, 33%
5. Number and percent of children served in home childcare settings and childcare centers that exhibit moderate to high quality as measured by a quality index.	Childcare Quality	13%	28%	127, 25%
6. Number and percent of licensed child care providers in Mono County advancing on the Child Development Permit Matrix.		4%	0	0
7. Number and percent of licensed center and family child care spaces per 100 children.		37%	47%	322, 46%

Sources:

1. Peapod Program Parent Surveys
2. Home Visiting Participation 48/ 137 Department of Finance 2019 Birth projection from January 2020
3. Home Visiting Participation 207/ 693 US Census population estimate children 0-5 in Mono County
4. Children in commission-run programs who received a developmental screening—Home Visiting (59) & children in child care programs participating in quality programs (173) 232/ 693 US Census population estimate children 0-5 in Mono County (67% reporting rate as 466 of the 693 birth-5 population is enrolled in home visiting, playgroups, or with a provider who participates in the Childcare Quality System, includes duplication). Screened is defined as a completed evidence and research-based formal screening tool like the Ages and Stages Questionnaire. While overall population screening rates declined, Home Visiting and Childcare Quality both increased rates of screening.
5. Children served at sites with a rating of 3 or higher 127/ 693 US Census population estimate children 0-5 in Mono County (100% reporting rate)
6. Childcare Quality System data 0 of 32 participating providers (88% reporting rate, the percent of sites participating in the Childcare Quality System)
7. Number of licensed child care spaces available to Mono County children birth-5 on the IMACA Resource and Referral list, 322 /693 US Census population estimate children 0-5 in Mono County (100% reporting rate)

Result I continued: *Mono County children 0-5 are educated to their greatest potential.*

Indicator	Investment area	2017-18	2018-19	2019-20
8. Number and percent of children who have ever attended a preschool, Pre-K, or Head Start program by the time of Kindergarten entry.	School Readiness	66%	76%	52, 87%*
9. Number and percent of children "ready for school" upon entering Kindergarten.		49%	51%	77, 65%
10. Number and percent of children whose parents attended Kindergarten and TK Round Up.		54%	73%	98, 82%
11. Number and percent of children birth to 5 accessing funded literacy activities.		New Indicators	47%	334, 48%
12. Number and percentage of age-eligible children for whom a preschool slot is available.			51%**	119, 43%
13. Number and percent of entering Kindergartners assessed for school readiness at entry.		100%	98%	117, 98%
14. Number and percent of children in households where parents and other family members are receiving child-development and parenting education.	Home Visiting & Family Behavioral Health	44%	40%	304, 44%*

* Under 60% reporting rate

**updated from last year to reflect the number of preschool specific slots rather than all possible slots for preschool aged children.

Sources:

8. Incoming Kindergarten Parent Surveys indicating enrollment in preschool or pre-K--52/60 surveys. The reporting rate is 50%, 60/120 kindergarten students.
9. In-kindergarten Brigance screens of students assessed as within the typical range and above the gifted cutoff 77/117 assessed. 98% reporting rate 117 /120 kindergarten students. Previous year's reporting rates: 2017, 100%; 2018, 98%.
10. Children participating in Kindergarten and TK Round Up 87/120 number of children on the first day of kindergarten, school district data.
11. Number of children enrolled in Raising a Reader (127) and or Home Visiting (207), includes duplicates 334/ 693 US Census population estimate children 0-5 in Mono County.
12. The number of available preschool slots in the County based on the number of slots licensed to age-specific 3-4 year old classrooms 119/ 280-- Five-year Kinder and TK average (2014-2018) multiplied by 2 to get a projected number of 3 & 4 year olds. The decrease from 18/19-19/20 represents the closing of Edna Beaman Elementary Preschool.
13. Number of Brigance screens completed by the school district 117/ 120 kindergarten students.
14. Children in commission-run programs with child-development education components (Home Visiting 207 and Peapod 97) 304/ 693 US Census population estimate children 0-5 in Mono County. 44% reporting rate, as data is limited to commission run programs to ensure an unduplicated count.

Result II: *All Mono County children 0-5 are healthy.*

Indicator	Investment Area	2017-18	2018-19	2019-20
15. Number and percent of children where breastfeeding is successfully initiated and sustained.	Home Visiting	Not available	86%	78, 89%*
16. Number and percent of children 0 to 5 years of age who are in the expected range of weight for their height and age, or BMI.		Not available	81%	277, 76%*
17. Number and percent of children ages 1 or older who receive annual dental screenings.	Oral Health	59%	51%	294, 42%*
18. Number and percent of children at Kindergarten entry with untreated dental problems.		30%	33%	9, 10%*

*Under 60% reporting rate. To move to population-based data for a higher reporting rate, research suggests would mean a shift to considering only prenatal indicators.

Sources:

15. Sierra Park Pediatrics number of Mono County children still breastfed at visits to pediatrics up to 1 month of age. Children seen up to 1 month 78/ 90 patients. 57% reporting rate, 78/137 births in 2019 Department of Finance projection January 2020. 2017-18 data not able to be collected due to a change in record keeping at Mammoth Hospital.

16. Sierra Park Pediatrics number of Mono County 2-5 year olds seen in 2018-19 within the expected range of weight and height 277 of 366 patients. 53% reporting rate, 366 patients/693 US Census population estimate children 0-5 in Mono County. 2017-18 data not able to be collected due to a change in record keeping at the hospital.

17. Number of children 1 year to 5.99 years old seen annually for a screening in the Mammoth Hospital Dental Clinic 294/693 US Census population estimate children 0-5 in Mono County. 45% reporting rate, clients seen at Mammoth Hospital Dental Clinic 318/ 693 Census estimated children 0-5. Note: the number of patients in the age range declined by 134 clients (from 452 to 318) between FY 2017-18 and FY 2019-20.

18. Oral Health Assessments turned into the school indicating untreated dental problems 9/108 completed oral health assessments. 87% reporting rate from the SCOHR school reporting system oral health assessments 108/ /124.

Appendix VII Fiscal Overview

Revenue	Amount
Prop. 10 Tax Revenue	$76,204
Small County Augmentation	$250,748
Prop 56 apportionment	$22,885
Mono County Home Visiting	$150,000
CalWORKS HVI	$6,830
SMIF (Surplus Money Investment Fund)	$343
Mono County Social Services CAPIT (High Needs Home Visiting)	$32,257
IMPACT	$83,799
Region 6 T&TA Hub	$178,351
CDBG Administration	$7,951
CDBG	$195,384
CDE State Preschool Block Grant	$17,039
Equitable Learning Opportunities	$23,217
Mono County Behavioral Health Peapod Program	$35,807
Miscellaneous	$26,016
Interest on Mono County First 5 Trust Fund	$12,257
Total Revenue	**$1,119,088**

Expense	Amount	% of Expenditures	% of Discretionary Funds	5-year Strategic Plan % of Discretionary Funds
Home Visiting	$324,789	30%	37%	33%
Childcare Quality	$536,836	49%	1%	3%
Emergency Fund	$25,850	2%	7%	-
Operations/Support/Evaluation	$68,312	6%	19%	39%
Oral Health	$7,412	1%	2%	1%
Peapod	$36,507	3%	0%	0
Safe Kids Coalition	$7,000	1%	2%	2%
School Readiness	$49,241	5%	14%	22%
Systems Building	$29,172	3%	8%	-
Total Expenses	$1,085,119			
Total Revenue	$1,119,088			
Net Revenue	$33,969			

Fund Balance	**Amount**
Fund Balance Beginning	$557,717
Fund Balance End	$591,686
Net Change in Fund Balance	$33,969

Mono County

Family & Child Data

The 2019 California Child Care Portfolio, the 12th edition of a biennial report, presents a unique portrait of child care supply, demand, and cost statewide and county by county, as well as data regarding employment, poverty, and family budgets. The child care data in this report was gathered with the assistance of local child care resource and referral programs (R&Rs). R&Rs work daily to help parents find child care that best suits their family and economic needs. They also work to build and support the delivery of high-quality child care services in diverse settings throughout the state. To access the full report summary and county pages, go to our website at www.rrnetwork.org.

PEOPLE[1]	COUNTY			STATE		
	2016	2018	CHANGE	2016	2018	CHANGE
Total number of residents	13,785	13,887	1%	39,354,432	39,864,538	1%
Number of children 0-12	2,069	2,001	-3%	6,631,621	6,578,476	-1%
Under 2 years	287	274	-5%	982,688	941,215	-4%
2 years	149	133	-11%	498,782	489,567	-2%
3 years	126	152	21%	503,064	503,509	0.1%
4 years	138	150	9%	503,461	503,657	0.04%
5 years	144	133	-8%	518,282	506,494	-2%
6-10 years	861	807	-6%	2,596,934	2,576,958	-1%
11-12 years	364	352	-3%	1,028,410	1,057,076	3%

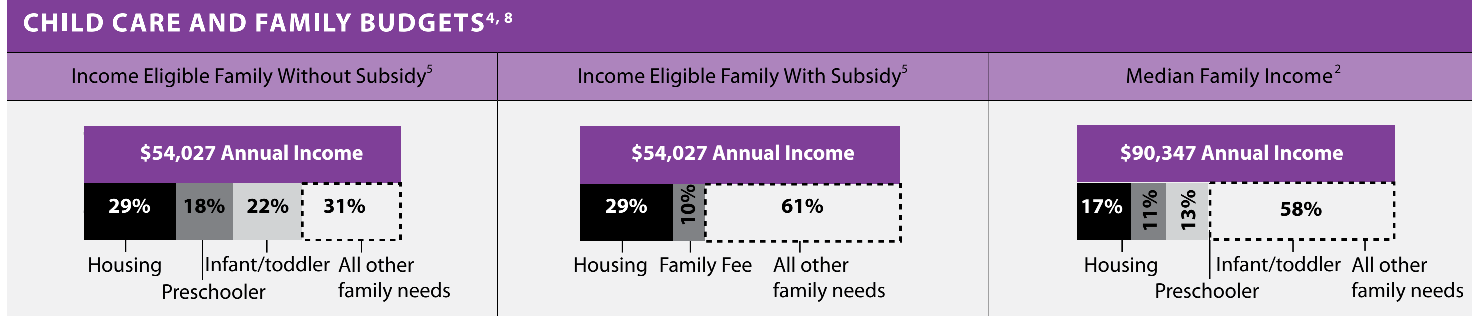
LABOR FORCE[2*]	COUNTY			STATE		
	2016	2018	CHANGE	2016	2018	CHANGE
Two-parent families, both parents in labor force	474	430	-9%	1,667,628	1,673,759	0.4%
Single-parent families, parent in labor force	280	176	-37%	966,506	957,871	-1%

*Due to the availability of data in the U.S. Census Bureau's ACS, these numbers do not include unmarried two-parent families or families with same-sex parents

POVERTY[2]	COUNTY			STATE		
	2016	2018	CHANGE	2016	2018	CHANGE
Number of people living in poverty	684	1,378	101%	5,525,524	4,969,326	-10%
Children 0-5 living in poverty	95	114	20%	608,247	499,726	-18%
Children in subsidized care[3]	112	121	8%	315,100	337,264	7%

FAMILIES IN POVERTY IN 2018[2]	
COUNTY	STATE
7%	14%

CHILD CARE AND FAMILY BUDGETS[4, 8]



Mono County

Child Care Data

AGE/TYPE

CHILD CARE SUPPLY[6]	LICENSED CHILD CARE CENTERS			LICENSED FAMILY CHILD CARE HOMES		
	2017	2019	CHANGE	2017	2019	CHANGE
Total number of spaces	234	234	0%	114	100	-12%
Under 2 years	36	36	0%			
2-5 years	198	198	0%			
6 years and older	0	0	0%			
Total number of sites	9	9	0%	12	11	-8%

CHILD CARE REQUESTS[7]	
Under 2 years	27%
2-5 years	50%
6 years and older	23%

25% Child care programs participating in the Child Care Food Program

56% Child care centers with one or more federal/ state/local contracts

SCHEDULE AND COST

CHILD CARE SUPPLY	LICENSED CHILD CARE CENTERS	LICENSED FAMILY CHILD CARE HOMES
Full-time and part-time spaces	100%	92%
Only full-time slots	0%	8%
Only part-time slots	0%	0%
Sites offering evening, weekend or overnight care	22%	55%
Annual full-time infant care[8]	$13,231	$12,028
Annual full-time preschool care[8]	$9,733	$11,138

CHILD CARE REQUESTS	
AGES	FULL-TIME
Under 2 years	100%
2 years	0%
3 years	100%
4 years	100%
5 years	0%

REQUESTS FOR CARE DURING NONTRADITIONAL HOURS	
Evening / weekend / overnight care	8%

MAJOR REASONS FAMILIES SEEK CHILD CARE[9]

95%	Employment	9%	Parent seeking employment	5%	Parent in school or training

LANGUAGE

CENTERS WITH AT LEAST ONE STAFF SPEAKING THE FOLLOWING LANGUAGES[9]
English 100%, Spanish 33%
FAMILY CHILD CARE PROVIDERS SPEAKING THE FOLLOWING LANGUAGES[9]
Spanish 64%, English 55%

LANGUAGE SPOKEN AT HOME	
English only	75%
Spanish	22%
Asian/Pacific Island language	2%
Another language	2%

1. CA Department of Finance Population Projections 2018
2. American Community Survey 2018 1-year estimates. Poverty is defined using the federal poverty guidelines.
3. CA Department of Education CDD 801-A October 2018, CA Department of Social Services CW115, October 2018
4. U.S. Housing and Urban Development rent for 2-bedroom 50th percentile
5. 70% of 2018 State Median Income for a family of three
6. Resource and referral (R&R) databases 2019
7. R&R child care referrals April/May/June 2019
8. 2018 Regional Market Rate Survey, Network estimate
9. Percentages may exceed 100% when multiple options are chosen

For more information about child care in MONO COUNTY:

IMACA Community Connections for Children
800-317-4700
www.imaca.net

FY 2019-20 EVALUATION REPORT PRESENTATION

Our goal is to enhance the network of support services for families with children ages 0 to 5 years.

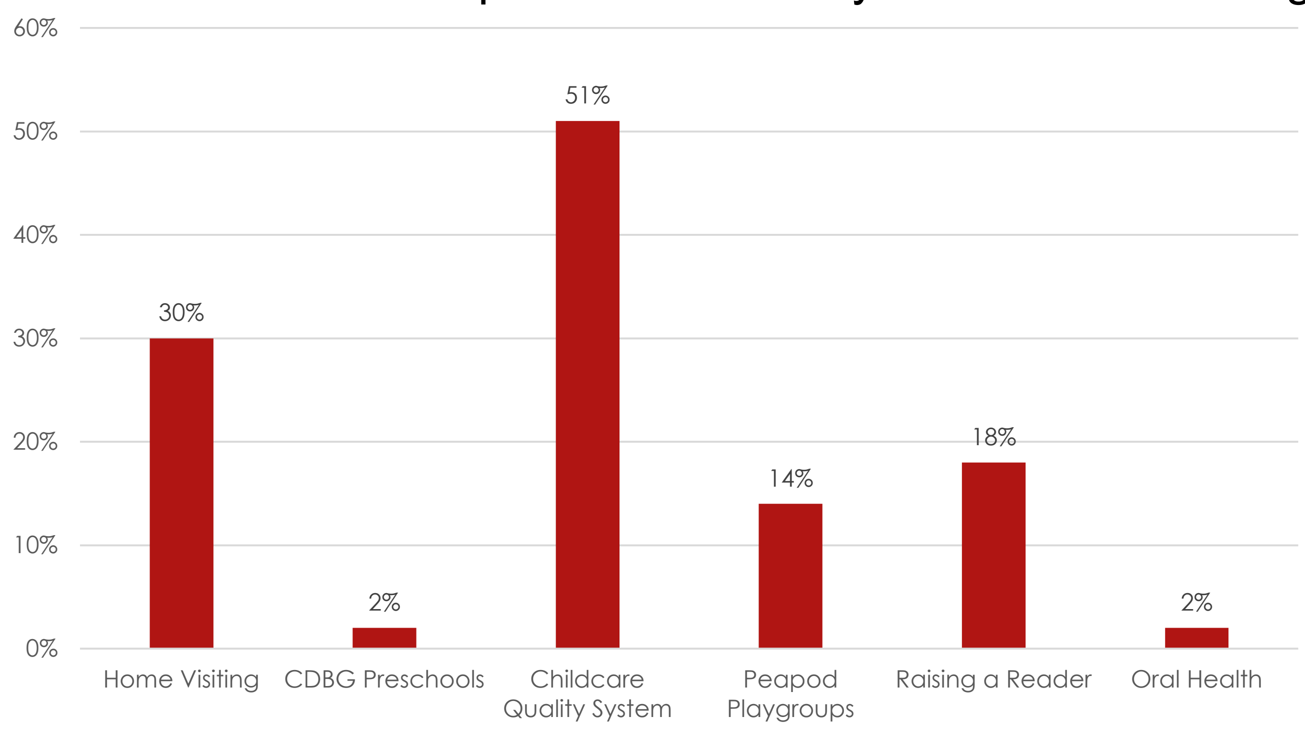
Overview

The California Children and Families Act (also known as Proposition 10 or "First 5") was enacted in 1998, increasing taxes on tobacco products to provide funding for services to promote early childhood development from prenatal to age 5. Mono County currently receives approximately $350,000 from annual allocations and the Small Population County Funding Augmentation.

The Mono County Children and Families Commission, First 5 Mono, was created in 1999 by the Mono County Board of Supervisors to:

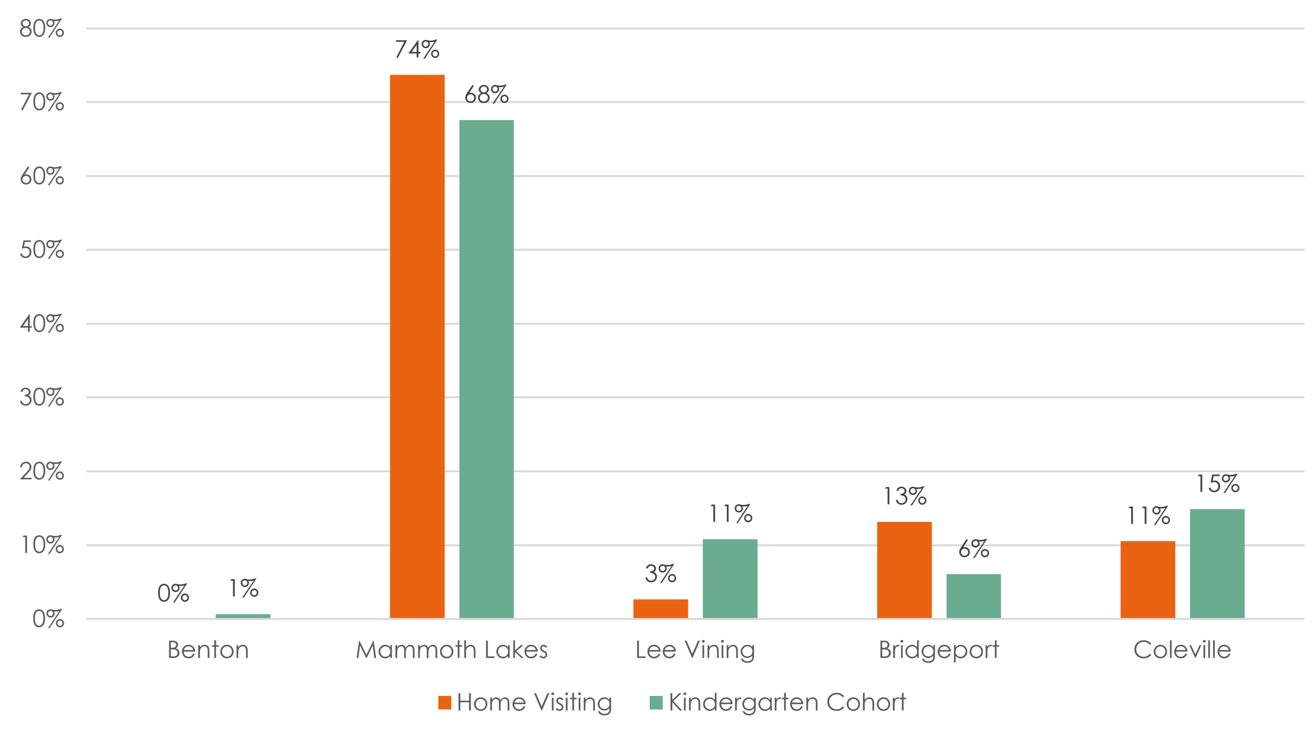
- Evaluate the current and projected needs of children birth to five years old
- Develop a strategic plan describing how to address community needs.
- Determine how to expend local First 5 resources.
- Evaluate the effectiveness of funded programs and activities.

How many kids were served?



Where do the families served live?

Area of Residence Comparison: New Families in Home Visiting (n=76) and the Kindergarten Cohort (n=120)



Emergency Fund & COVID Response

- The Commission formed an Emergency Fund policy and allocated resources to: Mammoth Lakes Housing for rent support for the families of children 0-5 and Inyo Mono Advocates for Community Action (IMACA) to pay for their facility in Mammoth Lakes due to the sudden loss of Head Start Funding.
- Partnered with IMACA to receive Personal Protective Equipment from First 5 California and distribute it to Childcare Providers and families with young children free of charge.
- Partnered with Childcare Providers, Mono County Public Health, Mono County Office of Education, and IMACA to develop Childcare COVID guidance.
- Supported utility payments or grocery cards for families in Welcome Baby and Healthy Families (Home Visiting)experiencing the impacts of COVID.

Systems Building

- Ensured consideration of the birth to 5 population at the regular meetings of: the Mono County Childcare and Child Abuse Prevention Councils.
- Sought partners to develop a plan and funding source for a new childcare site in Mammoth Lakes.
- Explored options to expand the Mono County CDBG Childcare Program.
- Completed CDBG application through Mono County for the Bridgeport Preschool.
- Partnered with the First 5 Association as an Executive Committee member and leadership of the North East Region.
- Participated in advocacy by signing letters supported by the First 5 Association.
- Served on the MCOE Cabinet after the COVID pandemic began.

Programs and Evaluation

IMPROVED FAMILY FUNCTIONING

- Home Visiting

IMPROVED CHILD DEVELOPMENT

- School Readiness
- Family Behavioral Health
- Childcare Quality

IMPROVED CHILD HEALTH

- Oral Health
- Child Safety

Improved Family Functioning

Home Visiting

The 2018-19 investment in Welcome Baby and Healthy Families was $324,789

Program objectives include:

- Facilitate parents' role as their child's first and most important teacher
- Provide information on typical child development
- Stimulate child development by providing age-appropriate activities
- Increase and support breastfeeding and literacy activities
- Link families to community services and support access to services
- Conduct developmental screenings and refer families to early intervention programs
- Provide culturally competent services in Spanish and English
- Facilitate optimal family functioning
- Decrease child abuse and neglect

Home Visiting: Key Takeaways

Improved Family Functioning

- Program quality increased by offering evidence-based visits thanks to increased funding from Mono County.
- More families were served and more visits provided than last year.
- More families with multiple stressors were served than last year.
- A higher proportion of Hispanic families were served than the 0-17 population in the County.

School Readiness: Transition to School and Early Literacy

Improved Child Development

The FY 2019-20 investment in School Readiness was $49,241

Transition to School Programs

Kindergarten Round Up: informational meeting held at all public elementary schools in the County

Objectives:

- Introduce families and children to the school, teachers, principal, and each other
- Provide information on entering school and kindergarten readiness
- Facilitate children and families' smooth transition into the education system
- Enroll children in kindergarten
- Sign children up for Summer Bridge

Incoming Kindergarten Assessments: school readiness assessments conducted by teachers in the first month of school

Objectives:

- Assess students' school readiness
- Identify children's skill development needs

Early Literacy Programs

Raising A Reader: book bags distributed by libraries and early learning programs

Objectives:

- Increase literacy for young children
- Encourage use of the library system
- Increase parental and care-provider literacy activities

First Book: free children's books

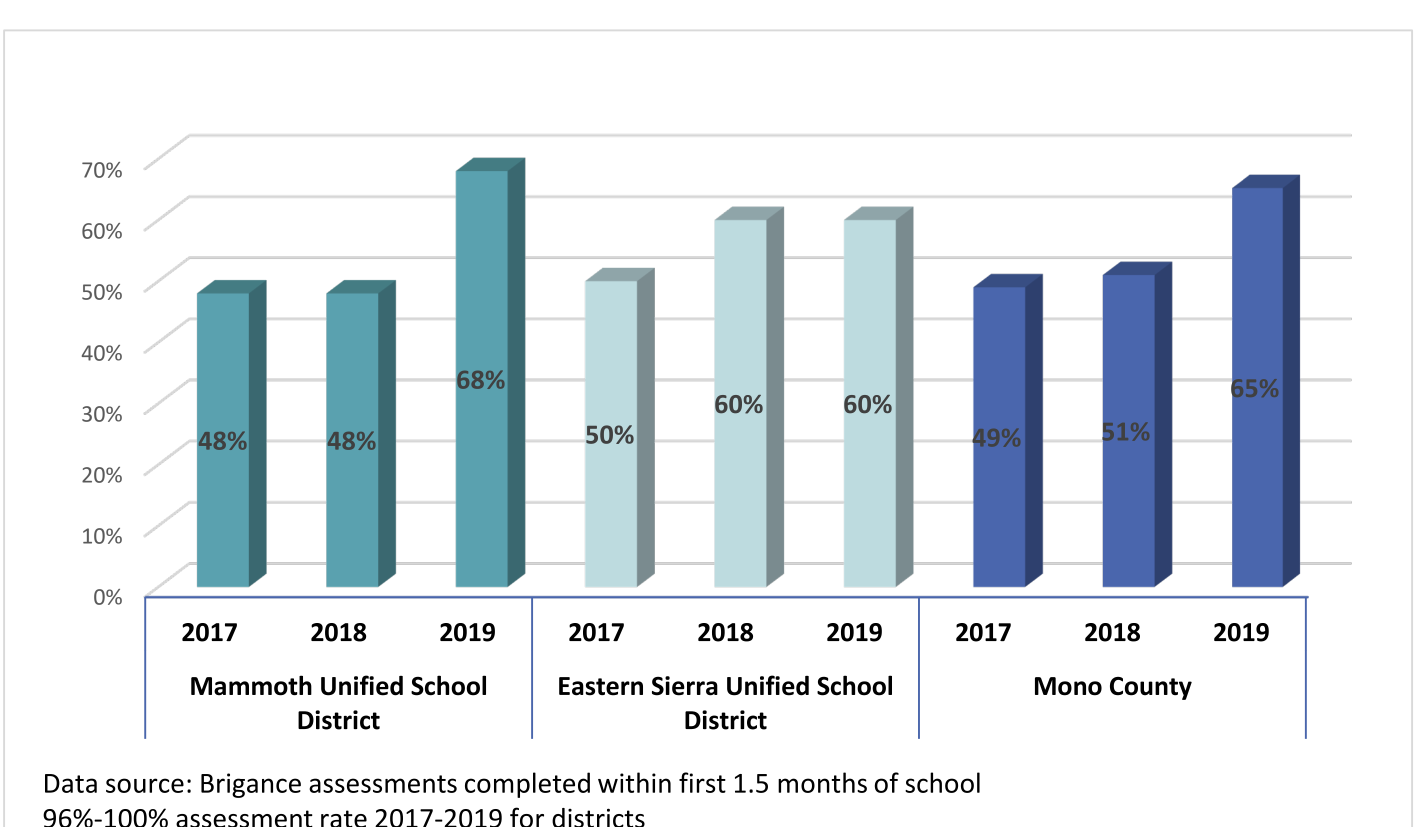
Objectives:

- Increase parent-child literacy activities

Facilitate positive parent-child interaction

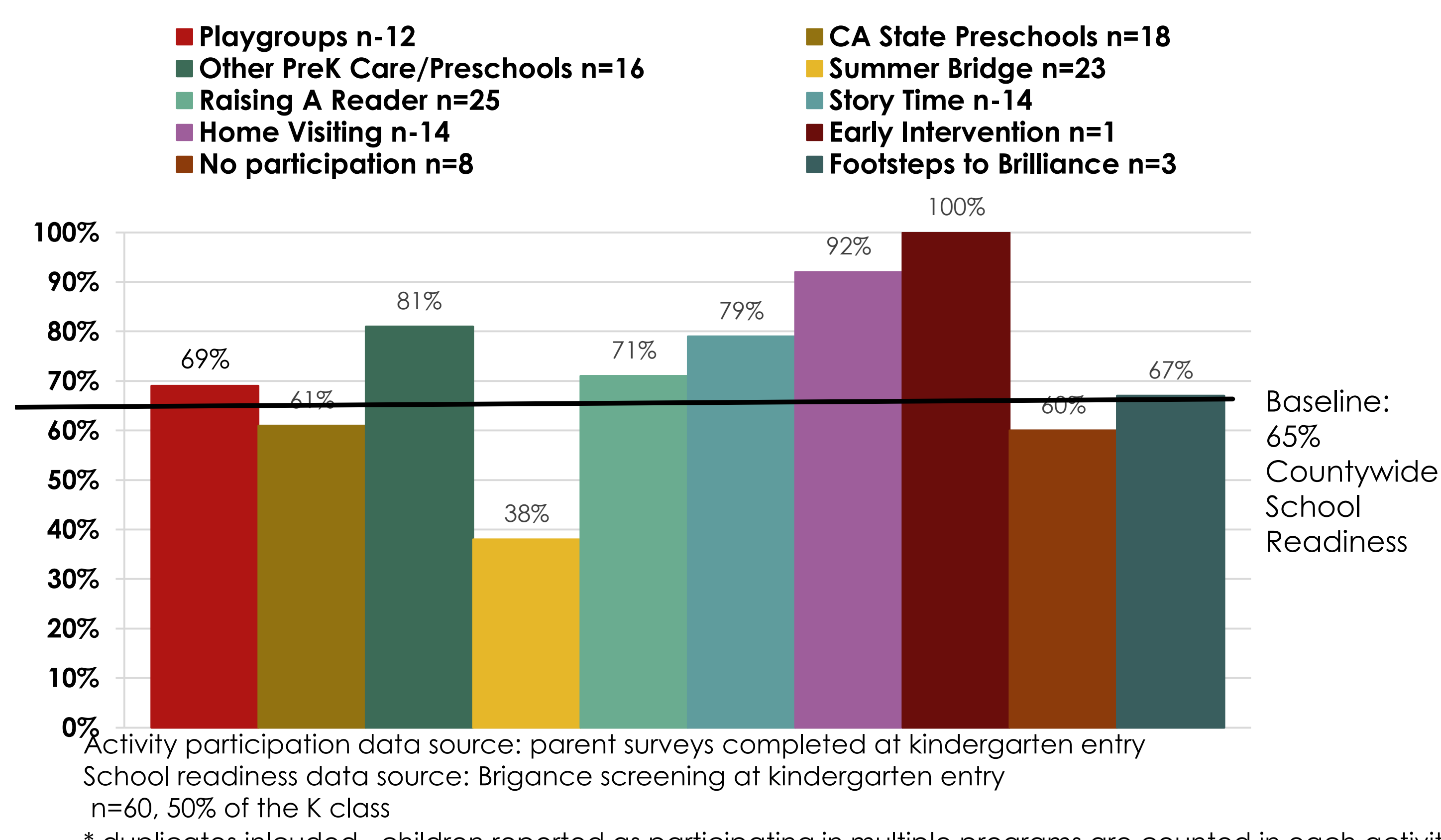
Kindergartners Assessed as School Ready by District 2017-2019

School Readiness, Improved Child Development



Percent of Kindergartners Assessed as School Ready by Program participation 2019

School Readiness, Improved Child Development



Activity participation data source: parent surveys completed at kindergarten entry
School readiness data source: Brigance screening at kindergarten entry
n=60, 50% of the K class
* duplicates inlcuded, children reported as participating in multiple programs are counted in each activity

School Readiness: Key Takeaways

Improved Child Development

- After many years of around 50% readiness, the rate increased to 65%.
- Children who participate in First 5 funded programs are more school ready.
- More families participated in transition to school activities than last year

Family Behavioral Health

The FY 19-20 investment in Family Behavioral Health was $36,507.

Peapod Playgroups: For parents, caregivers, and children birth to 5 years old. Playgroups meet for 10-week sessions. Sessions were held in the following communities: Walker, Bridgeport, Mammoth Lakes, Crowley Lake, Lee Vining, June Lake and Chalfant/Benton.

Objectives:

- Decrease isolation by providing parents and children an opportunity to socialize
- Destigmatize seeking behavioral health services
- Link families to community services
- Encourage school readiness and early literacy.

Peapod Paly groups: Key Takeaways

Improved Child Development

- The families who participate continue to enjoy Peapod Playgroups
- Although more playgroups were offered, less families were served in-person than last year. Online participation was not counted since we don't have the data to know who participants were. Typically, Facebook groups enjoy about 40 views, Zoom groups generally have only a couple participants.

Childcare Quality

The Childcare Quality investment for FY 2019-20 was $536,836.

The objectives and a brief description for the programs funded in this category are as follows:

- **IMPACT:** Training, coaching, rating, stipends, and support for childcare providers for the provision of high-quality care.

Objectives:

- Provide site-specific professional development to child care providers.
- Support providers' implementation of developmental screenings and parent engagement activities
- Build public awareness and support for quality early care
- Build a Childcare Quality System that leverages funding and maximizes support for care providers

- **QRIS and CSPP QRIS Block Grants:** Support for state preschool sites and sites serving infants and toddlers.

Objectives:

- Provide site-specific professional development to child care providers
- Support provider understanding of quality care and education

- **Training and Technical Assistance Hub:** Support regional efficiencies in Childcare Quality work

Objectives:

- Provide assessors for Spanish speaking sites
- Contract with Viva for coordination for the Hub
- Contract with i-Pinwheel database to track sites' participation
- Contract with American Institute of Research for the Early Learning Needs Assessment Tool (ELNAT) database to analyze child data to determine need.

- **CDBG Childcare:** Provide high-quality care to preschool age children in Bridgeport.

Childcare Quality: Rating Definition

Rating is based on the following set of California State standards known to promote high-quality early learning for kids.

- Interactions between teachers and children
- How teachers meet and support the developmental needs of children
- The health and safety of the classroom
- Staff qualifications and training
- Group size, number of children per teacher

1	COMMITTED TO QUALITY – participating in quality improvement efforts
2	RAISING QUALITY – meeting some quality standards
3	ACHIEVING QUALITY – meeting multiple quality standards
4	EXCEEDING QUALITY – meeting quality standards in all areas
5	HIGHEST QUALITY – exceeding quality standards in all areas

Childcare Quality: Ratings

Participating sites opting to be rated

Mono County Childcare Quality Ratings 2019-20	
Highest Quality 5	• Lee Vining IMACA Head Start/ State Preschool
Exceeding Quality 4	• Coleville IMACA State Preschool • Edna Beaman Elementary Preschool • Kindred Spirits • Mammoth IMACA Head Start/ State Preschool • Mammoth Lakes Lutheran Preschool • Mammoth Kids Corner • Mountain Warfare training Center Child Development Center • Alpine Early Learning Center (Alpine County)
TBD Ratings were not completed due to COVID 19 restrictions	• MCOE Inclusive Preschool • Maria Garcia Family Childcare

Childcare Quality: Key Takeaways

- This program has grown in the last several years to be able to rate sites, offer coaching, and provide home visits.
- At 87%, Mono has one of the highest rates of participation in the State.
- In the last several years sites have increased their ability to screen children for developmental delays and refer to special needs programs if needed.
- Lee Vining Preschool became the first site in Mono with the highest rating, 5.

Child Health: Oral Health & Safety

Oral Health was funded and operated by First 5 Mono at a cost of $7,412 for FY 2019-20. The program provides free toothbrushes, toothpaste, and floss to families to help maintain oral health.

Objective: Provide application of topical fluoride varnish twice a year to all Mono County children age 1-5 not already receiving services from a dentist, and educate children and parents about oral health.

Child Safety: With combined funding from Small County Funding Augmentations, $7,000, and the Mono County Office of Education, the Mono County Office of Education coordinates Safe Kids California, Mono Partners.

Objective: Bring safety services & resources to families

Child Health Key Takeaways

- Safe Kids partners provided car seat checks, bike helmets, home safety kits, and other resources to families.
- Health and Safety Fairs were cancelled due to COVID
- Children were able to get topical Fluoride Varnish through their preschool or childcare provider.

Outcome Indicators
3 Year Trend

% of indicators	Trend	Indicator
72%	Up	1 Peapod satisfaction 3 Children in home visiting 4 Children screened for developmental delay 5 Children in high quality childcare 7 Childcare spaces 8 Incoming kindergartners who attended preschool* 9 Children ready for school 10 Families who attended kindergarten round up 11 Literacy program participation 13 Kindergartners assessed at entry 14 Breastfeeding successful*
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Systems Building	$29,172	3%	8%	-

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Finance

TIME REQUIRED 20 minutes

SUBJECT Revolving Loan Update

PERSONS APPEARING BEFORE THE BOARD Patricia Robertson, Mammoth Lakes Housing Executive Director

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Mammoth Lakes Housing has utilized the Mono County Revolving Loan Fund for a total of five (5) purchases of deed-restricted properties between September 26, 2017 and December 31, 2019. There have been no new loans issued since December 2019. There is one outstanding loan that received a 6- month extension for Unit H101 located on 550 Mono Street.

RECOMMENDED ACTION:

(1) Receive presentation and update from Mammoth Lakes Housing ("MLH") staff on use of Mono County Revolving Loan Fund (Affordable Housing) ("RLF") as required by Resolution Nos. 15-8, 17-86 and 20-104;
(2) Receive update on use of RLF funds to purchase affordable/deed-restricted housing and compliance with RLF program requirements; and
(3) Provide any desired direction to staff.

FISCAL IMPACT:

Interest continues to accrue for outstanding loan which now supports affordable housing activities.

CONTACT NAME: Megan Mahaffey

PHONE/EMAIL: 760-924-1836 / mmahaffey@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
Staff Report RLF
Property pictures
Financial Information

History

Time	Who	Approval
2/10/2021 9:56 AM	County Counsel	Yes
2/11/2021 10:46 AM	Finance	Yes
2/12/2021 9:05 AM	County Administrative Office	Yes

DEPARTMENT OF FINANCE
AUDITOR-CONTROLLER
COUNTY OF MONO

Kim Bunn
Assistant Finance Director
Auditor-Controller

Janet Dutcher, CPA, CGFM, MPA
Director of Finance

Gerald Frank
Assistant Finance Director
Treasurer-Tax Collector

TO: Mono County Board of Supervisors

FROM: Janet Dutcher, Finance Director
Megan Mahaffey, Accountant
Patricia Robertson, Mammoth Lakes Housing Executive Director

DATE: February 16, 2021

RE: Mono County Revolving Loan Fund (Affordable Housing) Presentation and Update

---

Recommended Actions

(1) Receive presentation and update from Mammoth Lakes Housing ("MLH") staff on use of Mono County Revolving Loan Fund (Affordable Housing) ("RLF") as required by Resolution Nos. 15-8, 17-86 and 20-104;

(2) Receive update on use of RLF funds to purchase affordable/deed-restricted housing and compliance with RLF program requirements; and

(3) Provide any desired direction to staff.

Fiscal Impact

None at this time.

Strategic Plan

The RLF program moves Mono County towards the Mono County Strategic Plan by enhancing quality of life for county residents by addressing the housing crisis through policy, assistance and development programs.

Background

MLH has utilized the RLF for a total of five (5) purchases of deed-restricted properties between September 26, 2017 and December 31, 2019. There is one outstanding loan that received a 6- month extension for Unit H101 located on 550 Mono Street.

Discussion

The Revolving Loan fund continues to be a good partnership in preserving affordable homeownership opportunities. The most recent activity was the two loans issued at the end of 2019. Both of the loans were used to purchase 3-bedroom, 2-bath units at Meridian Court, which is a complex in the Town of Mammoth Lakes that does not allow for long-term rentals. Both units have a one-car garage and one surface parking space. The first purchase closed on November 22, 2019, located at 550 Mono Street Unit B202. This unit received new carpet and paint, and other minor repairs. The unit closed escrow and the loan was paid back with interest on October 26, 2020. The unit was sold to an income-eligible household earning below 80% of the Area Median Income ($63,900 for a household of four). The second loan was used for a purchase that

closed escrow on December 18, 2019, on a home located at 550 Mono Street Unit H101. This unit was occupied by long-term tenants who were unable to secure alternative housing during the holiday season. A short-term lease was entered with the tenants through May 2020. The tenants vacated the unit in June and repairs have been underway including new a window, new carpet, new keys, as well as repairs to luminant, drywall, doors and blinds. The unit will be sold to an income-eligible household earning below 120% of the Area Median Income ($97,450 for a household of four).

Upon transfer to the new owners, resale restriction agreements will be executed and recorded. These agreements preserve the affordability and below-market-rate value of the home for 60 years from the date of execution. This is an asset to the community and region that helps to ensure there are quality homes affordable to members of the community and workforce.

If you have any questions regarding this agenda item or staff report, please contact Megan Mahaffey at (760) 924-1836 or mmahaffey@mono.ca.gov.

Attachment:

1. Photos of Meridian Court Units
2. Financial Information

Deed Restriction Stewardship in partnership with Mono County through the RLF

Mono County made 2 RLF Loans in 2020 to preserve 2 affordable homes in the Town of Mammoth Lakes

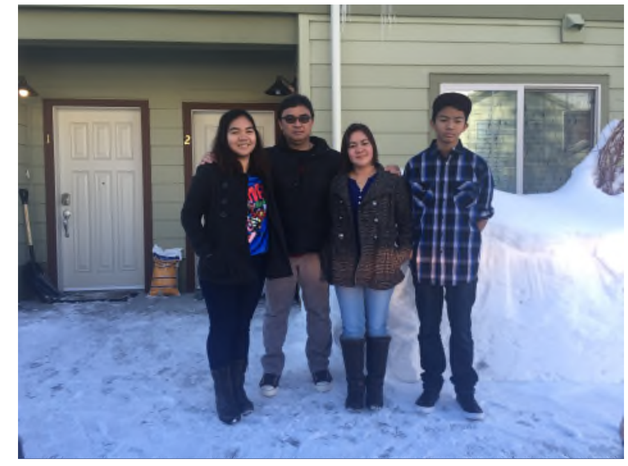
UNIT #1
3 bedroom
2 bath
1 garage
Restricted to 80% AMI
$64,700 for family of 4
550 Mono Street
Unit B202

- New paint and carpet
- New dishwasher
- SOLD October 2020
- Household working in medical field

550 Mono Street
Unit H101
Unit #2

- New window
- New carpet
- New paint
- New keys
- Minor repairs: laminate, drywall, doors, blinds, etc.
- Available for households earning below 120% AMI
- $97,450 for a family of four
- 6-month loan extension through June 2021

Thank you for your partnership in persevering affordable homeownership opportunities!



Mono County RLF

SCHEDULE OF CASH TRANSACTIONS

Beginning Balance	*date*	*Transaction Amount*	*Ending balance*	*Activity detail*
$ 300,000	9/26/2017	$ (20,000)	$ 280,000	Loan issued for home
$ 280,000	9/30/2017	$ 222	$ 280,222	Interest
$ 280,222	11/14/2017	$ (220,000)	$ 60,222	Loan issued for home
$ 60,222	12/11/2017	$ 20,000	$ 80,222	Loan repaid after 76 days
$ 80,222	12/26/2017	$ 220,000	$ 300,222	Loan repaid after 42 days
$ 300,222	12/31/2017	$ 517	$ 300,739	Interest
$ 300,739	2/28/2018	$ (191,220)	$ 109,519	Loan issued for home
$ 109,519	3/31/2018	$ 811	$ 110,330	Interest
$ 110,330	6/1/2018	$ 191,200	$ 301,530	Loan repaid after 94 days
$ 301,530	6/30/2018	$ 719	$ 302,249	Interest
$ 302,249	6/30/2018	$ (2,249)	$ 300,000	transfer interest to GF
$ 300,000	11/21/2019	$ (196,000)	$ 104,000	Loan issued for home
$ 300,000	12/17/2019	$ (104,000)	$ (0)	Loan issued for home
$ -	10/26/2020	$ 196,000	$ 196,000	Loan repaid after 340 days
$ 196,000	1/1/2021		$ 196,000	Current Balance

SCHEDULE OF LOAN TRANSACTIONS

Property Address	*Loans Issued*	*Ending balance*	*Days outstanding*
61 Callahan Way, Unit 12, Door E2	$ 20,000	$ -	76 days
550 Mono Street, Unit A202	220,000	-	42 days
550 Mono Street, Unit C101	191,220	-	93 days
550 Mono Street, Unit B202	196,000		340 days
550 Mono Street, Unit H101	104,000	104,000	380 days as of January 1 2021
	$ 731,220	$ 104,000	

RLF Quick facts

Creation:	11/17/15 R15-81	
Modified:	12/ 5/17 R17-86	
Interest to date		$ 6,414
Average days for repayment:		176
Loans issued to date:		5

REGULAR AGENDA REQUEST

Print

MEETING DATE	February 16, 2021		
TIME REQUIRED	1 hour	**PERSONS APPEARING BEFORE THE BOARD**	Robert C. Lawton, CAO, Bryan Wheeler, Public Health Director
SUBJECT	COVID-19 (Coronavirus) Update		

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Update on Countywide response and planning related to the COVID-19 pandemic, including reports from the Emergency Operations Center (EOC), Unified Command (UC), and the various branches of the EOC, including Community Support and Economic Recovery, Joint Information Center (JIC), and Public Health.

RECOMMENDED ACTION:

None, informational only.

FISCAL IMPACT:

None.

CONTACT NAME: Robert C. Lawton

PHONE/EMAIL: 760-932-5415 / rlawton@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
No Attachments Available

History

Time	Who	Approval
2/11/2021 3:56 PM	County Counsel	Yes
2/11/2021 10:45 AM	Finance	Yes
2/12/2021 9:07 AM	County Administrative Office	Yes

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

TIME REQUIRED 10 minutes

SUBJECT Mountain View Fire Update

PERSONS APPEARING BEFORE THE BOARD Justin Nalder, EOC Director

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Update on the Mountain View Fire in Walker, California.

RECOMMENDED ACTION:

Receive update from Incident Command for the Mountain View Fire and involved staff regarding impacts of the fire, recovery efforts, County response, debris removal and related topics. Provide any desired direction to staff.

FISCAL IMPACT:

No impact from this update.

CONTACT NAME: Justin Nalder

PHONE/EMAIL: 760-932-5453 / jnalder@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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History

Time	Who	Approval
2/11/2021 3:54 PM	County Counsel	Yes
2/11/2021 10:45 AM	Finance	Yes
2/12/2021 9:05 AM	County Administrative Office	Yes

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Administration

TIME REQUIRED 1.5 hours

SUBJECT Legislative Platform Workshop

PERSONS APPEARING BEFORE THE BOARD Robert C. Lawton, CAO

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Workshop for the Board of Supervisors to review changes suggested by County departments for the 2021 Legislative Platform

RECOMMENDED ACTION:

Make changes and recommendations for the 2021 Legislative Platform. Provide any desired direction to staff.

FISCAL IMPACT:

None.

CONTACT NAME: Rebecca Buccowich

PHONE/EMAIL: 760-932-5408 / rbuccowich@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
2021 Legislative Platform (conformed)
2021 Legislative Platform (redline)

History

Time	Who	Approval
2/12/2021 8:02 AM	County Counsel	Yes
2/12/2021 8:56 AM	Finance	Yes
2/12/2021 9:04 AM	County Administrative Office	Yes

Mono County

2021 State and Federal Legislative Platform

Reviewed and adopted by the Mono County Board of Supervisors
March 2, 2021

Mono County Board of Supervisors

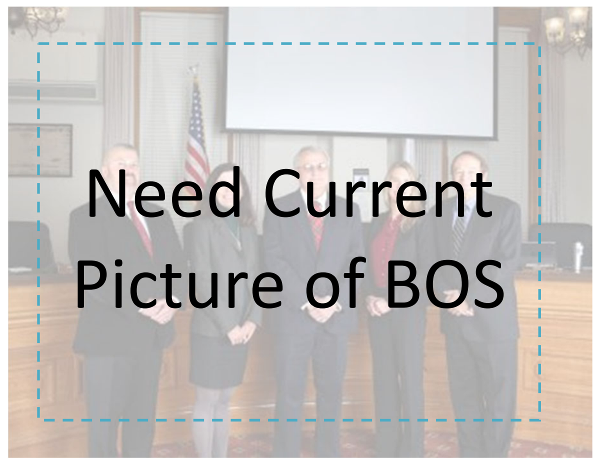
Jennifer Kreitz.................................... District 1

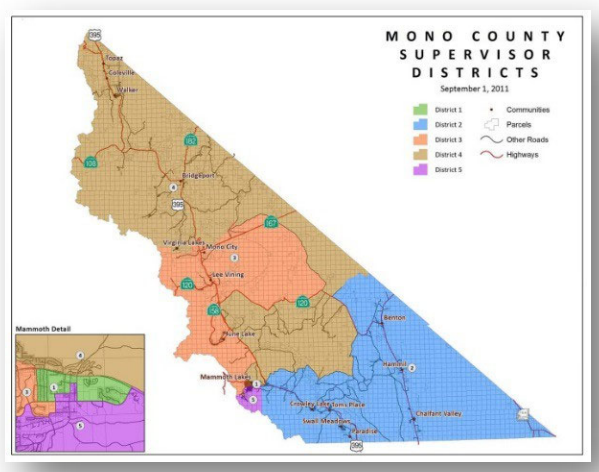
Rhonda Duggan.................................. District 2

Bob Gardner .... District 3

John Peters .... District 4

Stacy Corless...................................... District 5





Robert C. Lawton
County Administrative Officer
PO Box 696
Bridgeport, CA 93517
Tel: (760) 932-5415
Email: rlawton@mono.ca.gov

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Introduction

Mono County, California, is a rural county situated between the crest of the Sierra Nevada and the California/Nevada border. Accessed by US Highway 395 which weaves its way north-south and is a state-designated Scenic Byway from its southern boundary all the way to Topaz Lake in the north, Mono County is 108 miles in length, and has an average width of only 38 miles. With dramatic mountain boundaries that rise in elevation to over 13,000 feet, the county's diverse landscape includes forests of Jeffrey and Lodgepole pine, juniper and aspen groves, hundreds of lakes, alpine meadows, streams and rivers, and sage-covered high desert. The county has a land area of 3,030 square miles, or just over 2 million acres, 94% of which is publicly owned. Much of the land is contained in the Inyo and Humboldt-Toiyabe National Forests, as well as the John Muir and Ansel Adams Wilderness areas. As a result, Mono County offers vast scenic and recreational resources, and has unsurpassed access to wilderness and outdoor recreation and adventure.

Mono County Tourism / Mono Lake Tufas

The county is home to, and named after, Mono Lake, which is a large high-desert saline lake with intriguing limestone tufa formations and is a vital habitat for millions of migratory and nesting birds. Mono Lake is just one of the reasons that Mono County draws landscape photographers year-round.

Another highlight is the historic gold rush town of Bodie, which during its heyday in the late 1800s, was home to as many as 10,000 people, and is now maintained as a State Historic Park with about 200 buildings still standing as they were left, preserved in a state of "arrested decay" for visitors to enjoy. Other natural wonders that attract people to Mono County include Devils Postpile National Monument, one of the world's finest examples of columnar basalt and the headwaters of the Owens and Middle Fork San Joaquin Rivers; two of the state's most important watersheds. Yosemite National Park's eastern entrance at Tioga Pass is only 12 miles from Lee Vining and Mono Lake.

Mono County Tourism / Bodie State Historic Park

Mono County has several small towns and charming villages, each with its own scenic beauty, year-round recreational opportunities, natural and historical attractions, and unique characteristics. The County seat is proudly located in Bridgeport, where the original 1881 courthouse is the second oldest in the state to be in continuous use. The only incorporated town in the county is Mammoth Lakes, which is located at the base of world-renowned Mammoth Mountain Ski Area, with a summit of 11,053 feet, over 3500 skiable acres, 28 lifts, and an average of 400 inches of snowfall annually. For example, January 2017 recorded historic amounts of snow, with 20.5 feet accumulating in Mammoth during that month alone. Approximately 8,100 people reside in the Mammoth Lakes area year-round, and during the peak winter season, the population swells to over 35,000 when visitors from around the state, country, and world come to ski, snowboard, and take part in many other winter activities. The sister resort, June Mountain, just 20 miles north of Mammoth, offers uncrowded, wide-open slopes and a more peaceful, family-friendly alternative to busier ski areas.

Mono County Tourism / Bridgeport Courthouse

Summer, however, is when Mono County really shines. The region offers countless miles of alpine hiking, superb trout fishing at dozens of well-stocked lakes, streams and rivers, kayaking, cycling, horseback riding, golfing, and endless warm-weather adventures. Photographers flock to the county in September and October when it is almost impossible to take a bad photo of the fall color that lights up the Eastern Sierra landscape. *Sunset Magazine* named Mono County one of the "Top 5 places to Hike" in autumn and *TravelAndLeisure.com* listed Mono County as one of "America's Best Fall Color Drives.

Mono County Tourism / Silver Lake

A wide variety of lodging, restaurants, and shops are available throughout the county, and commercial air service to Mammoth Yosemite Airport, just a 10-minute drive from the Town of Mammoth Lakes, is accessible non-stop and year-round from Los Angeles, and seasonally from many other airports. Air services are offered through United Airlines and JSX.

Guidelines for Implementation of this Platform

It is the intention of the Board of Supervisors that this Legislative Platform streamline and support the County's ability to comment on matters impacting the County and its citizens. Accordingly, any individual Board Member or Department Head, in consultation with the CAO and the Board Chair (unless consultation with the Chair would result in a violation of the Brown Act), may draft and submit a letter on behalf of the entire Board of Supervisors in support of or in opposition to an issue or matter addressed in this Legislative Platform, provided that the letter is consistent with the position expressed in this Platform. Following its delivery or mailing, the letter shall be placed on the next available Board of Supervisors' agenda as correspondence so that other Board Members, and the public, are aware of its contents.

When a request for a letter in support of or in opposition to an issue or matter comes to the attention of a Department Head, the Department Head shall first consult this Legislative Platform for consistency with policy direction as described above. If there is no clear policy direction in this Platform, but the subject of the letter is consistent with the goals and workplan of the county department, the Department Head shall draft the proposed letter and present it to the CAO for approval. The CAO may additionally consult with the Board Chair in his or her discretion. If the proposed letter is approved by the CAO, the Department Head may send the letter and, if the subject matter is of interest to the entire Board, place it on the next available Board of Supervisors' agenda under correspondence. If the proposed letter is not approved by the CAO, the Department Head may agendize it for consideration and possible approval by the full Board.

The Mono County Board of Supervisors supports the general guidelines set forth below. County staff will apply these guidelines in evaluating State and Federal legislation, as well as executive and regulatory actions. It is the Board's objective to implement these guidelines.

To support the County's service to the community, the County should:

- Support legislative and budget efforts that protect and/or enhance local government revenues, maximize the County's access to state and federal funding sources, including pandemic support and relief programs, and/or increase local funding flexibility;

- Oppose any effort to balance the State budget through the taking of local government resources;

- Support legislation that protects the County's quality of life and diverse natural resources, while preserving the essence and historic values of the County;

- Support legislation that provides tax and funding formulas for the equitable distribution of state and federal monies while opposing attempts to decrease, restrict, or eliminate County revenue sources;

- Support legislation and budget action which provides additional and continued funding for local road infrastructure, including complete street features;

- Oppose legislative and administrative actions which would create federal unfunded mandates and/or preempt local decision-making authority;

- Support legislation that realigns governmental services in such a manner as to improve the delivery of services and make government more accountable to the people;

- Support the promotion of tourism, recreation, sustainable fisheries, filming, and a diversified local economy in the Eastern Sierra to achieve strong economic growth and prosperity;

- Continue to support legislation that honors our veterans for their service to our country;

- Support efforts that further the strategic directions outlined in the County's Strategic Plan;

- Engage on any proposals to repeal or additionally alter the Affordable Care Act (ACA), which provides Mono County citizens the ability to obtain affordable health care;

- Support efforts to combat climate change;

- Support legislation that seeks to address the insufficient quantity and quality of homes affordable to our residents; and

- Support legislation that addresses the burgeoning substance use disorder crisis and increases access to Medication Assisted Treatment.

- Support measures that increase resources for disaster response initiatives requiring county involvement.

- Support legislation that waives the local share of cost of all emergency response and disaster recovery activities.

- Support funding for counties to provide for higher demands on critical recovery services.

- Support local, regional, state, and federal initiatives and legislation that advance efforts to dismantle systemic racism and reduce inequity.

State Priorities

1) Protect County revenue sources

   Many County programs are at risk due to the instability of State funding. The Board of Supervisors supports efforts to sustain funding, enabling the continuation of critical programs for Mono County's constituents.

2) Encourage regulation relief/reform

   Mono County applauds California's efforts to protect the environment. The Board supports efforts to achieve responsible regulation relief in the following areas:

   a) **Provide regulatory relief for solid waste operations**

      i) Continue to provide regulatory relief to rural jurisdictions from statewide solid waste and recycling mandates when recycling infrastructure does not yet exist and causes significant transportation costs and emissions.
      ii) Provide funding for the siting and development of recycling infrastructure, and/or develop policies within state agencies and businesses such as Caltrans, Los Angeles Department of Water and Power and Southern California Edison for the local re-use of materials (glass cullet, wood chips) when generated in rural areas.

   b) **Support CARB compliance legislation**

      Support legislation regarding California Air Resources Board (CARB) compliance to assist rural counties with the costs associated with State mandated compliance.

   c) **Encourage communication between air districts especially as it relates to smoke management.**

   d) **Support environmental processing legislation**

      Support legislation that streamlines environmental processing, including the application of certain urban exemptions under the California Environmental Quality Act (CEQA) to rural communities.

   e) **Support regulation of short-term rental online platforms**

      Online short-term rental platforms are unregulated, leaving accountability and compliance issues to local jurisdictions. Mono County urges the legislature to support regulation of short-term rentals to ensure an even playing field with traditional commercial lodging, require accountability, provide for tax collection, and support compliance at the state and local levels.

f) **Ensure adequate oversight of state requirements for commercial cannabis activities, respect local CEQA processes for cannabis permits and encourage development of hemp regulations**

Mono County is concerned about the state's allocation of resources for monitoring and inspection of commercial cannabis permits to ensure compliance with state requirements, particularly in rural areas like Mono County. Where oversight is delegated to local agencies, such as the Agricultural Commissioner, adequate funding should also be provided. Where oversight is retained by the state, state agency staff should have adequate on-the-ground presence to ensure accountability and compliance without increasing the burden on local jurisdiction staff. Further, the state should respect the CEQA process conducted by local jurisdictions serving as lead agencies, even if the state's responsible agency role is not triggered, or assume lead agency status and conduct separate CEQA evaluations for the approval of state licenses. As with cannabis, state industrial hemp regulations are critical for local governments to craft local regulations that create a comprehensive set of rules to protect public health and safety while providing for the industry. Without state regulations, local jurisdictions are acting in a vacuum that may increase challenges due to uncoordinated or inconsistent requirements and approval processes. The state should continue working toward federally approved industrial hemp regulations.

g) **Continue to provide and increase funding for local jurisdictions to meet affordable housing goals**

In an effort to address affordable housing needs throughout the state, new housing laws are passed every year. Some carry new mandates that place a regulatory burden on local jurisdictions, and some simply require funding to implement. We encourage the State to continue providing new funding streams, such as SB 2 and the Regional Early Action Planning (REAP) grants program, as well as technical assistance programs, to assist local jurisdictions with meeting new mandates and working toward statewide and local housing goals.

3) Natural Resources, Public Lands and Agriculture

a) **Support sustainable funding for State parks**

Continue to support measures to sustain our State parks, roads that access these parks, and recreation programs for the continued enjoyment of visitors and residents. Closure or underfunding of these parks would result in a significant negative economic impact on our County as tourism and recreation are our most important economic drivers.

b) **Protect our communities from wildfire and promote forest health**

Support a balanced approach to fuels management that increases funding and capacity for community protection and, also, considers air quality and other health related issues within the Great Basin Unified Air Pollution Control District.

c) **Support legislation regarding programs and policies that promote the creation of both state and local disaster prevention, response, and recovery planning policy.**

d) **Support continued and enhanced state funding for non-native, invasive plant management programs**

After years of no state funding allocation, weed management area groups throughout the state will have funding opportunities in the coming budget year. These programs are critical to the protection of our local and statewide environment, and have proven positive effects on natural fire regimes, species diversity, watershed health, and many other concerns. State funding for these programs should be maintained and enhanced if possible.

e) **Ensure full funding of California Department of Fish and Wildlife Hatchery and Inland Fisheries Program (AB 7 - 2006)**

In 2006, AB 7 dedicated by law one third of all sport fishing license fees to be used for adequate stocking of Department of Fish and Wildlife Hatcheries. Beyond the funding dedication, AB 7 dictated the size of fish to be stocked. Recent California Department of Fish and Wildlife (CDFW) actions, as well as state budget actions, have reduced the size of the stocking fish and not fully directed the fee funding to this program. Mono County supports the original intent including all funding being directed to the state hatchery program, fish size, and reproducing diploid fish countywide as described in the original legislation.

f) **Support budget appropriations to modernize and maintain the state hatchery system.**

g) **Support a balanced approach to regulating fishing**

Support a fishing season in the Eastern Sierra that provides economic opportunity while maintaining the balance of environmental health and sustainable fisheries and requires California Department of Fish and Wildlife (CDFW) to notify local government of proposed fishing regulation changes.

h) **Support sustainable fishing**

Support the funding of efforts to enhance the fish population in Mono County including sustainable fishing, ongoing fish stocking, education for proper catch and release practices, protection of spawning waterways, and support of the California Department of Fish and Wildlife (CDFW) stocking of diploid trout in allowable waters.

i) **Support bio-energy action plan development**

Encourage the various state agencies involved to continue evolving this field of work to produce and permit cleaner, more affordable technology based on sustainable and healthy forestry principles in a manner that benefits rural Sierra economies. Mono County has

encouraged state agencies, such as the Sierra Nevada Conservancy (SNC) and California Energy Commission (CEC) to provide funding for project scoping and planning.

j) **Support legislation that promotes, protects, or facilitates the sustainability of our local agriculture**

Mono County agriculture is an important local economic driver. It provides jobs and contributes to the open-space landscape that draws visitors. Reinstate Williamson Act subventions and continue to develop alternative funding measures, such as the Strategic Growth Council's Sustainable Agricultural Lands Conservation Program.

k) **Support development of domestic recycling markets and streamline process for recycling infrastructure development.**

Domestic recycling markets are needed to address the changes in international trade policies which have disrupted California's solid waste and recycling industry by restricting foreign imports of recyclable materials and requiring reduced contamination levels in recycling streams. In order to meet California's ambitious recycling mandates, investment in and development of domestic markets has become necessary.

l) **Support legislation that allows for alternative organic programs for rural areas and exempts them from the SB 1383 requirements until such time that an economically feasible infrastructure is in place**

Rural jurisdictions are disproportionately burdened under mandates of SB 1383/Short Lived Climate Pollutants. With no developed infrastructure, no economy of scale and great hauling distances to existing infrastructure, this remains a major challenge for rural areas.

m) **Support legislation and funding that eases the burden of implementing the Sustainable Groundwater Management Act, including creating necessary infrastructure in rural, sparsely populated areas**

The Sustainable Groundwater Management Act provides for local agencies to develop groundwater sustainability plans and, pursuant to those plans, sustainably manage groundwater resources. The funding mechanism for these activities provided in the law is for local agencies to impose fees on water users. Areas in Mono County that have been subject to the Act in the past are sparsely populated and primarily in agricultural production. Accordingly, very few individuals (less than a dozen) would have to bear the significant burden of funding compliance with the Act, should it apply again in the future, which would endanger the viability of Mono County's agricultural operations.

n) **Continued engagement in Bi-State Sage Grouse conservation efforts**

Mono County appreciates the State's increased role in sage-grouse conservation efforts and addressing the threat posed by the Los Angeles Department of Water and Power's

(LADWP's) management of water in Long Valley, a key habitat area for the South Mono Population Management Unit. The California Department of Fish and Wildlife is a significant player in this conservation effort. Ultimately, continuation of the collaborative multi-party partnership, including the cooperative engagement of LADWP, would be the ideal outcome to ensure the health and viability of sage grouse populations. If the bird us ultimately listed, the result would be an additional regulatory burden with devastating impacts to Mono County's agricultural and recreational activity-based economy.

o) **Climate and drought resiliency**

Support measures that provide funding and resources to develop drought and climate resilient water supplies in California, such as water recycling and reuse, leak and loss prevention/remediation and other solutions to enhance the State's water resources in order to reduce reliance on increasingly unpredictable precipitation amounts.

4) Public Safety and Criminal Justice

a) **Advocate to prevent adverse local impacts from cannabis and hemp legislation**

Advocate for local control, taxation and funding for addressing the environmental, land use, and public safety impacts of the cultivation of cannabis and hemp.

b) **Ensure State realignment & cost-shifts**

Continue to ensure successful implementation of the broad array of programs transferred to county jurisdiction under the 2011 Public Safety Realignment, including appropriate distribution of AB 109 funding. Support state policy changes that will allow for greater administrative and program flexibility for county programs associated with this shift of responsibility.

c) **Support of rural fire districts**

The population of Mono County is highly rural and dependent upon voluntary associations that provide basic emergency services. These volunteer fire districts provide services to residents and tourists, and they are often the first responders to accidents. Support relief for rural fire districts.

d) **Advocate for Community Paramedicine**

Advocate for the State Emergency Medical Services Agency (EMSA) to expand the current number of EMS Programs participating in the Community Paramedicine Demonstration Project.

e) **Advocate for legislation to extend the age for juvenile services from 18 through the age of 20**

Neuroscience supports that brain development continues until the age of 23.

f) **Support legislation that provides financial support to probation**

Provide financial support to probation to include more evidence-based services and incentives for both adults and youth.

5) Transportation and Infrastructure

a) **Support action for transportation funding**

Support the multiple transportation funding sources that provide for improved transportation systems and multimodal networks, including SB 1 as enacted and delivery of projects that rehabilitate and improve local roads and related infrastructure.

b) **Support State highway access**

Mono County supports budget policy and legislation to fund rehabilitation of the Bodie Road (Highway 270) that provides access to Bodie State Park and to facilitate early Sierra Pass openings (including Highways 120 and 108).

c) **Support complete streets and walkable community principles**

Mono County is a strong supporter and advocate of the complete streets and walkable community principles in the 2040 California Transportation Plan. This focus is a transportation paradigm and culture shift that will impact projects from initiation to completion and maintenance. Recently, local jurisdictions have been increasingly tasked with the funding and maintenance of complete street features on state facilities such as state highways. These maintenance responsibilities lie with the state, and a corresponding shift in the functioning and funding of Caltrans is needed to ensure success of complete street designs.

d) **Support broadband deployment and communications systems improvements**

Leverage existing work efforts focused on broadband infrastructure investments and deployment projects to further increase access to Gigabit broadband throughout the County. Advocate and work to improve communication systems including:

i) Plain Old Telephone Systems (POTS) system reliability;
ii) Reliable 911 service, the NextGen 911 transformation (including the leveraging of broadband for improving 911), 211 service, and public notification and warning services;

iii) Cellular-based communication systems and networks including those designed for commercial and public safety use (such as FirstNet);
iv) Policies, programs, and funding opportunities for other public safety communication platforms, including but not limited to Land Mobile Radio;
v) Appropriate and effective definitions of 'broadband' which recognize the importance of technology and dependence on the internet for public safety and economic development;
vi) Legislation and associated programs that provide funding for broadband infrastructure projects and adoption/education efforts.

e) **Investor-Owned Utility Wildfire Mitigation and Public Safety Power Shutoff (PSPS) policy**

In coordination with local allied agencies and community organizations, advocate for policies and practices which ensure public safety while recognizing and addressing the unique challenges of PSPS events in a tourism-driven rural environment. Encourage utilities' investment in infrastructure hardening, grid modernization, and situational awareness tools.

6) Administrative and Fiscal Services

a) **Support Clerk/Recorder Services and Elections Administration improvements**

Support resources for improving county record keeping services and election administration, and monitor legislation that may impact the following:

i) Recording fees and process, and recorded documents;
ii) Vital statistic fees and process;
iii) Public records;
iv) Unfunded mandates;
v) Vote-by-mail, voter registration, election management systems, elections process, and election equipment;
vi) Funding for records preservation (such as Board of Supervisors historic records);
vii) Funding for modernization of elections equipment;

b) **Support Vote-by-mail legislation**

Support legislation to authorize vote-by-mail ballot elections for rural counties.

c) **Support leveraging SB2 Recording fees to return to Mono County for housing.**

d) **Support the full funding of all Payment In Lieu of Taxes (PILT)**

Support legislation and budget efforts that provide for payment of past due balances and continue to maximize the PILT revenue to counties and maintain full funding of PILT without restrictions beyond the current authorization.

e) **Oppose legislation that would limit and/or impose significant procedural or substantive barriers to counties' ability to contract for services.**

7) Health and Human Services

a) **Support accurate, adequate, flexible, and stable funding and regulatory interpretation to best meet Federal/State Health and Human Services program requirements**

These include Child Welfare Services, Mental Health Services, Substance Use Disorder Services, Human Services, Adult Protective Services, In-Home Supportive Services, California Children Services, and Health Reform. In addition, support new innovation by maximizing flexibility in program design, increase Federal/State funding leveraging opportunities, and streamline State program requirements and regulations including those serving specialized needs due to COVID-19.

b) **Support client access permitting online engagement and electronic interviews to reduce cost, increase participation and reduce duplicative eligibility processes.**

c)

d) **Support funding opportunities for environmental health regulation**

Support funding opportunities including fees for State mandates related to environmental health regulation of food establishments, sewage disposal facilities, water systems, well construction, swimming pools, and recreational health facilities, occupied housing, underground storage tank facilities, solid waste facilities, land use development, rabies and vector control, and the management of hazardous waste/materials.

e) **Support legislation that provides funding for the Local Primacy Agency (LPA) program that ensures safe drinking water to residents**

The LPA program provides local oversight of small public water systems (SPWS) in Mono County. This program is implemented by the Environmental Health Division of the Public Health Department. Currently, program costs are offset by annual permit fees collected from the SPWS and by Public Health Realignment. The revenues do not cover the costs of this program.

f) **Support funding opportunities for Mono County's CUPA Program**

The California Unified Program Agency (CUPA) is implemented by the Environmental Health Division of the Public Health Department. Funding for this program is provided through environmental health fees and Public Health Realignment. In the past, the CUPA was provide grant funding through Cal EPA to offset costs incurred in implementing the program. This grant funding was subsequently discontinued last year. Negotiations are ongoing to reinstitute this funding program.

g) **Support legislation for public health programs**

Support legislation and programing, and advocate for upstream approaches to health and preventative public health programs including Maternal, Child, and Adolescent Health (MCAH), Oral Health, Tobacco Education, Women, Infants and Children (WIC), Emergency Preparedness, Communicable Disease, HIV/STDs, and Immunizations.

h) **Support revenue opportunities and increased flexibility with State allocations for local public health departments**

With rising costs of business, the Mono County Health Department's expenditures are now greater than its revenues. With a decline of Public Health Realignment funds since 2007, these dollars no longer cover the cost of fulfilling mandates, backfilling State grants, and addressing local health priorities. Opportunities include increasing revenues through State allocations and advocating for a broader, less restrictive scope of work which can be tailored to a community's unique health needs.

i) **Support public health fiscal sustainability in rural counties in the form of relaxed programmatic FTE requirements and indirect cost rate caps**

Health programs are continually evolving and new opportunities to improve community wellness are on the rise. Rural counties face unique recruitment and retention challenges and much of the prospective funding comes with strict FTE requirements and/or caps on what can be reimbursed in indirect costs. Funding allocations usually do not provide enough resources to hire new staff and the majority of existing staff manage or support multiple public health programs. Additionally, funding allocations do not cover the true cost of the program, especially overhead costs, leading to difficult decisions about implementing programs that have been recognized as a need in our rural communities.

j) **Support legislation for health providers**

Support legislation and advocate for increasing the number of dental and medical providers in rural counties, especially those who accept Medi-Cal and Denti-Cal insurance.

k) **Advocate for a level of funding that enables counties to properly administer the Medi-Cal program on the state's behalf.**

l) **Support improvements to Medi-Cal**

Support the streamlining of Medi-Cal administration and improve access to health coverage for uninsured families.

m) **Support legislation that would increase the number of volunteer Emergency Medical Technicians**

Current licensing requirements are onerous and deter volunteer first responders from seeking EMT licenses.

n) **Provide a State funding stream for county spending on Public Administrator/Public Guardian/Public Conservator (PA/PG/PC) programs**

County Public Administrator, Public Guardian and Public Conservator (PA|PG|PC) programs provide critical safety net services to the most vulnerable adult Californians. The PG/PC provides protective services to individuals with diminished capacity to make decisions due to cognitive impairments and severe mental illness. The PA function handles the disposition of deceased estates. Working collaboratively with local medical, mental health, social services, and justice providers, PA|PG|PC programs petition the Courts to be appointed the legal decision maker with regard to healthcare, psychiatric care, and/or financial management for clients who are unable to make decisions for themselves. County PA|PG|PCs are the only major county safety net programs that receive no direct State or Federal funding.

o) **Support legislation that increases services and supports Child Welfare**

i) Federal Family First Prevention Services Act of 2018: Support full state funding of required program changes to enact the newly mandated child welfare system reforms related to this Act.
ii) Support legislation that increases services and resources for caregivers of children and former foster youth who are victims of or at risk of abuse, neglect, or exploitation..

p) **Support legislative, administrative and budgetary efforts that seek to maintain active and healthy independence for seniors and the disabled**

including affordable housing, funding and other support for those who are homeless or at imminent risk of homelessness.

q) **Support legislation to increase skilled nursing facilities that are willing to accept dually diagnosed seniors with comorbid medical and mental health conditions.**

r) **Older Adults and Persons with Disabilities**

i) Support legislation that promotes the financial sustainability of the In- Home Supportive Services Program through programmatic changes and appropriate cost sharing mechanisms between the State and counties.
ii) Support the continuation of federal and state funding for IHSS and oppose any efforts to shift additional IHSS costs to counties.

iii) Support funding for the full range of aging programs that provide services to older adults including services provided by Area Agencies on Aging (AAAs), senior nutrition programs, caregiver supports, resource centers, ombudsman programs, and home and community-based supports.
iv) Support legislation that would establish a comprehensive and coordinated system and provide options for long term care activities that will secure and maintain maximum independence and dignity in a home environment, remove individual and social barriers to economic and personal independence, provide a continuum of care for vulnerable seniors, and provide a comprehensive response to elder abuse/neglect and exploitation.
v) Support legislation to increase skilled nursing facilities that are willing to accept dually diagnosed seniors with comorbid medical and mental health conditions.

s) **Support efforts to develop permanent supportive housing and affordable housing**

i) Support State laws that support affordable housing and broaden the opportunities and reduce barriers for local government, and non-profit housing entities and instrumentalities of government to increase homeownership and the creation of rental housing. This includes repealing of California State Constitution Article XXXIV. In addition, support increased financing, subsidy options, and tax incentives to support development of new, affordable housing units in rural communities such as Mono County.
ii) Support efforts to streamline funding, construction processes and land use regulations, which expedite the development of low and moderate income housing units and allow local governments to adequately plan to meet the housing needs of all economic segments of the community.
iii) Support measures that enable seniors and the adult disabled population to obtain affordable housing and live independently.
iv) Support additional funding for the Older Californians Act and other programs that assist older adults and caregivers.

t) **Support the enhancement of childcare and development**

Support measures that enhance the overall quality, affordability, capacity, accessibility, and safety of childcare and development programs. Specifically, support legislation and budget action that would:

i) Ensure continuity of childcare for children and families.
ii) Preserve, protect and increase funding for subsidized and other government-funded childcare.

u) **Support measures that seek to prevent Adverse Childhood Experiences (ACEs), address the impacts of trauma, and build resilience.**

i) Support legislation and budget efforts that support children, youth, and families, including restoring and expanding quality childcare and preschool opportunities, homeless youth, promoting safety for all children, and mental and developmental health prevention and early intervention activities.

v) **Support legislation to combat human trafficking**

Support legislation that will develop or enhance programs and services to combat the negative impact that human trafficking and commercial sexual exploitation of children has on victims and support efforts to provide additional tools, resources, and funding to help counties address this growing problem.

w) **Support full funding to ensure that state mandates are cost-neutral to the County and pursue revisions to streamline the process for local government.**

x) **State Realignment & Cost-Shifts**

Oppose proposals to restructure, realign, or otherwise shift the cost of programs to local government, without commensurate compensation.

y) **Support legislation, funding opportunities, and multidisciplinary efforts to provide harm reduction and substance use disorder services in Mono County.**

z) **Support Peer Support Certification (SB 803)**

Unlike 48 states, the Centers for Medicare and Medicaid Services and the Department of Veterans' Affairs (DVA), California fails to value or maximize the benefits of providers with lived experience in the state's Medicaid program, Medi-Cal, because California does not certify peer support specialists nor recognize these professionals as Medi-Cal billable providers. In addition, unlike most states and the DVA, California does not include peer support services as a Medi-Cal mental health benefit. Demand for peer services is growing, but there is no statewide scope of practice, training standards, supervision standards, or certification in California. SB 803 (Beall) establishes a statewide certification program for peer support specialists and provides the structure needed to maximize the federal match for peer services under Medi-Cal. The program defines the range of responsibilities and practice guidelines for peer support specialists, specifies required training and continuing education requirements, determines clinical supervision requirements, and establishes a code of ethics and processes for revocation of certification. (Cosponsored by CBHDA with Los Angeles County, The Steinberg Institute, and the California Association of Mental Health Peer Run Organizations (CAMHPRO))

aa) **Support legislation effort that would encourage Integrated School Behavioral Health Services**

The Integrated School-Based Behavioral Health Services Partnership Program (Partnership Program) encourages local educational agencies (LEAs) and county behavioral health agencies to collaborate on providing on-campus services for students at the earliest onset of a behavioral health condition. In the schools participating in the Partnership Programs, county behavioral health agency trained professionals will serve any student appropriately referred by school personnel, including Medi-Cal beneficiaries, privately-insured and uninsured students and provide brief initial intervention services intended to prevent a behavioral health condition from worsening. The county behavioral health professionals will ensure privately-insured students access a private plan provider, if available. If the private plan cannot provide an appropriate provider within state mandated timely access timeframes, the county behavioral health agency will initiate services as appropriate and consistent with professionally recognized standards of practice. The Partnership Program will include annual reporting requirements to help the state evaluate the impact of these intervention services on the health and well-being of students.

bb) **Strengthen the Mental Health Services Act (MHSA)**

Support legislation proposals to review the MHSA, recognizing the importance and significant contribution this critical funding source has made to persons with mental illness. The MHSA review provides the opportunity to reflect on 15 years of MHSA implementation and find areas for improvement while preserving core MHSA services, including the crisis continuum, prevention/early intervention, and full-service partnerships. Improvements should seek to eliminate restrictive mandatory funding distributions for each component of the MHSA and ensure MHSA funds can be used for individuals with primary substance use disorder diagnoses, as well as support the protection of MHSA's current ratios and funding for small, rural counties. A review should also identify a process for the development of statewide performance and outcome measures to be reported annually to the state, the legislature and the public.

cc) **Enhance Board and Care rates to prevent further loss of critical housing for SMI clients and build out housing options**

There is a critical lack of housing in California, particularly for its most vulnerable low-income adults most at-risk of homelessness: older adults, persons with disabilities, and persons with serious mental illness (SMI). With the rapidly growing aging population and continually rising housing costs, the homeless population is expected to grow, and a larger number of the homeless population are expected to be disabled and elderly. Even more alarming, California has lost hundreds of board and care homes in recent years that are specifically set up to serve these very populations. Los Angeles County has lost about 1200 beds since January 2016. The reimbursement rates provided by SSI/SSP are inadequate at $35/ day and counties do not have the capacity to patch facilities at the demand needed.

CBHDA proposes enhancing board and care rates through $500 million one-time General Fund (GF), reforming punitive regulations/ enforcement of facilities by CDSS, and exploring federal waiver opportunities to fund board and cares. (Co- sponsored by CBHDA with the Steinberg Institute)

i) **Status:** Board and Care funding is a component of the $750 million Flexible Funding Pool Proposed in the Governor's January budget, however, CBHDA will request a state lawmaker sponsor the full $500 million budget request via the legislature for consideration as part of the budget.

dd) **Pursue Funding for Pretrial Mental Health Diversion (AB 1810)**

There is an overrepresentation of individuals with SMI in the criminal justice system. All too often, individuals with SMI in crisis are inappropriately routed by law enforcement into jails and ultimately prison, instead of receiving treatment in the community. Once incarcerated, individuals living with a mental illness tend to stay longer in jail and upon release are at a higher risk of returning to incarceration than those without a mental illness. A significant number of individuals experiencing homelessness with behavioral health conditions can cycle in and out of the criminal justice system. California passed in 2018 AB 1810 which establishes pre-trial MH diversion in CA for individuals with SMI and who could be experiencing homelessness. Funding AB 1810 with $250 million one- time GF would help alleviate strains on justice systems and break the cycle of individuals experiencing homelessness with SMI from cycling in and out of the justice system. (Co-sponsored by CBHDA with the Steinberg Institute)

8) Economic Development

a) **Support new and current business development**

Support legislation and programs that support economic development efforts that augment and promote business retention and expansion, as well as create an environment conducive to new business attraction.

b) **Support of commercial filming**

Support bills and initiatives to attract and retain film production in the state as increased filming statewide will result in commercial opportunities for commercial filming projects in Mono County.

c) **Support sustainable tourism and recreation economy**

Support legislation that strengthens the tourism and recreation economy, including continued support of the State Office of Outdoor Recreation, formed in 2016.

Federal Priorities

1) Support Funding/Program Preservation

   Support legislative, regulatory, and budget efforts that protect and/or enhance local government revenues, maximize the County's access to federal funding sources, and/or increase local funding flexibility. Oppose legislative and administrative actions that would create federal unfunded mandates and/or preempt local decision-making authority. Strongly encourage Congress and the President to commit to negotiate successfully so as to avoid any future Federal Government shutdowns.

   a) **Support Sustainable Funding for Secure Rural Schools**

      Support legislation that creates a sustainable revenue stream for Secure Rural Schools, such as the Forest Management for Rural Sustainability Act.

   b) **Support the full funding of all Payment in Lieu of Taxes (PILT)**

      Support legislation and budget efforts that continue to maximize the PILT revenue to counties and continue full funding of PILT without restrictions beyond the current authorization.

   c) **Support full federal funding for the United States Department of Agriculture (USDA) Rural Development (RD) Programs**

      Support funding for community development programs and affordable housing such as the Section 502 Direct Loan Program and the necessary program staff to implement these programs.

   d) **Support full and expanded federal funding for Housing and Economic Development programs**

      Support the highest possible funding level for key federal housing and economic development programs, including the Community Development Block Grant (CDBG), the HOME Investment Partnership Program, and the creation of a minimum four percent Low Income Housing Tax Credit floor.

   e) **Support continued rural broadband deployment and communications improvements through local, State, and Federal policy advocacy, infrastructure projects, and grant programs**

      Having appropriate policy at the local, State, and Federal levels is imperative to ensure adequate communications connectivity, which is a critical part of public safety and economic development. Because Mono County has dedicated resources to improve access to high-quality broadband in our communities and as a result of the completion of the Digital 395 project, roughly 90% of our households have access to Gigabit internet.

Unfortunately, several Mono County communities and residents still face barriers to connectivity as there is inadequate infrastructure to support basic Plain Old Telephone Service (POTS) telephone service, including cellular phone service, let-alone high-speed Internet. In order to improve the landscape, the County should advocate for:

i) Policies, regulations, and enforcement around providers delivering basic POTS services to all locations desiring this service;
ii) Appropriate and effective definitions of 'broadband' which recognize the importance of technology and dependence on the internet for public safety and economic development;
iii) Legislation and associated programs that provide funding for broadband infrastructure projects and adoption/education efforts; Programs and efforts that move to improve the accuracy of metrics used to represent the current state of broadband in Mono County.

f) **Support legislation that promotes, protects, or facilitates the sustainability of our local agriculture**

Mono County agriculture is an important local economic driver, provides jobs, puts food on the table and contributes to the open-space landscape that draws visitors.

g) **Support Economic Development resources**

i) Support legislation and federal programs that provide access to small business capital for local business development through the Small Business Administration, Small Business Development Corporation and other government loan and financial programs.
ii) Support legislation and federal programs that promote locally-based business retention and expansion, as well as create an environment conducive to new business attraction.
iii) Support initiatives to attract commercial filming opportunities to the region: in particular, budgetary allocations that increase capacity for processing special use permits on the Inyo and Humboldt Toiyabe National Forests.
iv) Support bills, initiatives, and programs that strengthen the tourism and recreation economy, with a focus on sustainable practices.

h) **Disaster Response**

Support measures that increase resources for disaster response initiatives requiring county involvement.

2) Natural Resources, Public Lands, and Agriculture

Support legislation that promotes agriculture and that protects the County's quality of life, its diverse natural resources, and preserves the essence and history of the County, along with legislation that provides adequate funding for stewardship of our public lands.

a) **Support sustainable funding for federal public lands**

Support measures to sustain our federal lands. Closure or underfunding of these lands managed by the US Forest Service, Bureau of Land Management and National Park Service would result in a significant negative impact to our county as tourism and recreation are our economic drivers.

b) **Support outdoor recreation economy and public lands**

Support the enacted 2016 Outdoor Recreation and Jobs Act and the effort to measure the outdoor recreation economy's contribution to the US Gross Domestic Product. Once the federal government fully understands the economic benefits of outdoor recreation, land management agencies and local governments will have necessary data to measure the impact of the recreation economy and the key role that sustainable recreation needs to play in the management decisions of public lands agencies.

c) **Support special designations**

Support special use designations for public lands such as National Scenic Areas, Wild & Scenic Rivers, Wilderness, National Monuments, National Conservation Areas, when demonstrated conservation values and public support warrant such designations.

d) **Oppose public lands disposal**

Oppose the large-scale sale, transfer or "disposal" of public lands except for strategic, widely supported transfers or exchanges for management and boundary adjustments with demonstrated public benefit, for example community expansion in support of affordable housing.

e) **Support wildfire funding and fuels reduction**

Support immediate enactment of legislation to change the method of funding wildfire suppression on National Forests by providing access to funding outside of the statutory discretionary limits for emergency purposes and for investment in additional resources for forest management/fuels reduction to mitigate wildfire risk to communities and increase forest health.

f) **Support public land infrastructure**

Support increased funding for public land management agencies to address deferred maintenance of infrastructure in forests, national parks and reserves that rural counties depend on for tourism and recreation-based economies.

g) **Support regulatory relief for Mill City Cabin Tract funding**

Support administrative and legislative solutions for funding and/or regulatory relief for the cleanup of contaminated soils at the Mill City recreation residence tract on the Inyo National Forest in Mammoth Lakes.

h) **Support land management directives**

Support Mono County's tourism and recreation economy by ensuring funding, programs, and management directives for federal land agencies (including the Land & Water Conservation Fund) that facilitate the planning, building, and maintenance of infrastructure for sustainable recreation, travel, and commercial film permitting on public lands.

i) **Support sustainable fishing**

Support federal initiatives and / or funding of efforts towards enhancement of Mono County's fish population, including sustainable fishing, ongoing fish stocking, education for proper catch and release practices, protection of spawning waterways, and support of the stocking of diploid trout in allowable waters.

j) **Support the control of invasive species**

Support control and mitigation for the spread of invasive species to protect, conserve, and restore public and private lands.

k) **Support biomass project development**

Support legislation that encourages the US Forest Service (USFS) and Bureau of Land Management (BLM) to continue actively promoting and assisting with biomass project development.

l) **Support alternative energy**

i) Support local efforts to develop renewable, distributed energy sources including but not limited to environmentally and appropriately scaled biomass, solar, and wind, while ensuring projects and their supporting infrastructure (i.e., transmission lines, pipes lines, towers, service roads) does not degrade the County's quality of life, natural or visual resources, water or essence and history.
ii) Continue to support geothermal power production that is environmentally sustainable and doesn't negatively affect local domestic water supplies.

m) **Support Devils Postpile National Monument legislative requests**

Support legislation to authorize a boundary adjustment request, and to designate a portion of the Middle Fork San Joaquin River as Wild & Scenic, as described in Devils Postpile National Monuments 2015 Management Plan.

n) **Support endangered species conservation**

Support a balanced approach to the implementation of endangered species regulation with impacts to the rural economy and communities of Mono County. Mono County is fortunate to have a rich natural heritage that should be conserved, and it supports the need to protect and recover imperiled species. These conservation measures should be specifically tailored to the threats and circumstances in the Eastern Sierra and Mono County, and must be weighed and balanced against impacts to the fragile tourism and recreation-based rural economy and local communities. Every effort must be made to protect private property rights and avoid detrimental impacts to county residents.

o)

p) **Support sage grouse conservation**

Mono County appreciates the strong support of the multi-party, collaborative Bi-State conservation effort, including several federal agencies such as the U.S. Fish and Wildlife Service, Bureau of Land Management, U.S. Forest Service (Inyo National Forest and Humboldt- Toiyabe National Forest), and U.S. Geological Survey. The coalition includes technical and scientific support, legislative and policy support, and funding to ensure conservation commitments are met and honored by federal agencies Ultimately, continuation of the collaborative partnership requires the federal agencies to remain stalwart in their commitments with the flexibility to address new issues, such as the management of water by the Los Angeles Department of Water and Power (LADWP) in Long Valley, and adequate budgets to support a positive conservation outcome. If the bird is listed, the result could be an additional regulatory burden with devasting impacts to Mono County's agricultural and recreational activity-based economy.

q) **Support legislation to avoid landfilling of waste originating on Federal Land**

Develop policies and programs that successfully re-use, recycle and transform resources that originate on USFS, BLM, and DOD lands. Support policies that reduce the impacts of Federally generated waste on local jurisdictions' waste management systems, and/or support policies that enhance local systems to effectively manage Federally-generated waste.

3) Public Safety and Criminal Justice

a) **Support full funding of Byrne Justice Assistance Grants**

Support the preservation of funding levels for existing safety programs such as the Byrne Justice Grant (Byrne/JAG) Program and oppose efforts to reduce or divert funding away from these programs.

b) **Support continued funding of FEMA's Assistance to Firefighters Grant (AFG) program**

Support continued funding to enhance the safety of the public and firefighters with respect to fire-related hazards by providing direct financial assistance to eligible fire departments, nonaffiliated Emergency Medical Services organizations, and State Fire Training Academies. This funding is for critically needed resources to equip and train emergency personnel to recognized standards, enhance operations efficiencies, foster interoperability, and support community resilience.

c) **Support legislation that resolves the conflict federal statutes have with legalization of recreational cannabis use in California**

Ideally, this includes removing cannabis as a schedule 1 drug and providing cannabis businesses with access to business banking services by changing federal banking access laws. Barring a legislative solution by Congress, the County supports reinstatement of the concepts stated in the past Justice Department memorandums allowing for commercial cannabis activities to operate free and clear of federal enforcement interference so long as the County has a robust regulatory framework in place.

d) **Urge common-sense gun safety legislation.**

e) **Support sustainable Federal Aviation Administration (FAA) funding for airport safety related projects on public and private property on or near our airports.**

4) Transportation and Infrastructure

a) **Ensure that federal transportation formulas support rural road infrastructure**

Mono County relies on the network of state highways and locally maintained roads to link residents to essential services. Transportation funding formulas should provide funding protections or guarantees for California's rural transportation system and reflect that rural counties lack viable means to fund larger projects that provide statewide benefit. We must advocate for formulas that distribute federal funds to support local transportation priorities.

b) **Support efforts to protect the Highway Trust Fund**

Support efforts protecting the Highway Trust Fund and programs that provide funding for local roads, bridges, and transit initiatives including pedestrian and bicycle systems, and other multi-modal transportation programs.

c) **Provide funding that maintains and enhances regional access across Federal Lands and National Parks**

Mono County supports budget policy and legislation that maintains, enhances, and extends the operational season of roads crossing federal lands and National Parks that provide access to communities, federal lands, national parks and monuments.

d) **Support Yosemite Area Regional Transportation and Eastern Sierra Transit Authority funding**

Support efforts to seek sustainable funding for regional public transportation to Yosemite National Park, other National Parks in our region, and other public lands destinations throughout the Eastern Sierra.

e) **Support the resurgence of the Scenic Byway program**

Mono County completed a Scenic Byway Corridor Plan through a federal grant, then shelved the plan because the Scenic Byway program was not funded. The program has been re-established, and continuity of funding is needed for jurisdictions to dust off inactive plans, program their implementation into the workflow again, and being making an impact.

5) Health and Human Services

a) **COVID 19**

Support and advocate for any legislative or budgetary action, including stimulus money, related to the response, recovery and/ or economic impacts of COVID-19 both during the emergency and the long-term effects of the pandemic.

b) **Disaster Response**

Support measures that increase resources for disaster response initiatives requiring county involvement.

c) **Support Cost-Neutral Federal Mandates**

Support full funding to ensure that federal mandates are cost-neutral to the County and pursue revisions to streamline the process for local government.

d) **Oppose legislation to repeal the Affordable Care Act (ACA**)

Work to preserve and expand the number of citizens currently receiving health insurance. Oppose efforts to reduce benefits and block grants or other actions that would shift the current federal/state cost and responsibility to the states and counties.

e) **Ensure that Affordable Care Act (ACA) funding is maintained for local governments**

Support the Prevention and Public Health Fund of the ACA, the nation's first dedicated mandatory funding stream for public health and prevention activities, which supports Mono County health care services to underserved residents.

f) **Medi-Cal Funding**

Support all efforts to adequately fund the federal Medicaid program. Similarly, oppose all efforts to block grant, cap or otherwise reduce federal and state funding to support this critical safety net program.

g) **Administration of the Medi-Cal program**

Fully fund county costs for County administration of the Medi-Cal program.

h) **Managed Care Medi-Cal**

Advocate for a Medi-Cal Managed Care model that generates high healthcare quality scores, increases primary care capacity, improves coordination of care, and conducts outreach to enroll uninsured populations.

i)

j) **Oppose other eligibility changes, including but not limited to elimination of retroactive benefits or grace periods for eligibility pending verifications.**

k) **Oppose turning Medicaid over to States**

Oppose efforts to turn Medicaid (Medi-Cal in California) over to the states with less federal funding.

l) **Support full funding of programs that provide health insurance to children.**

m) **Support funding of Veterans benefits**

Support provision and funding for current benefits and health care programs for Veterans.

n) **Support Women's Rights to Health**

Health care is key to women's well-being and economic stability. Support provisions that make sure new health care law works for women.

o) **Support Child Welfare**

i) **Federal Family First Prevention Services Act of 2018**
Advocate for full federal and state funding of the Federal Family First Prevention Services Act of 2018 (P.L. 115-123) enacted to reform the federal foster care system.

ii) Support efforts to reform child welfare financing, including expanding the types of prevention activities eligible for the IV-E foster care financial match.

iii) Support a provision allowing for "skyping" with non-minor youth in the extended foster care program when the youth is attending college or living in another state or out of country as an alternative to monthly, in-person visits.

iv) Support increased federal funding for services and income support needed by parents seeking to reunify with their children in foster care.

v) Support increased federal financial support for programs that assist foster youth in the transition to self-sufficiency, including post- emancipation assistance such as secondary education, job training, and access to health care.

vi) Support retaining the entitlement nature of the Title IV-E Foster Care and Adoption Assistance programs and eliminate outdated rules that base the child's eligibility for funds on parental income and circumstances.

vii) Support increased federal funding to respond to the service needs of youth who are victims of commercial sexual exploitation.

p) **Support legislation to combat human trafficking**

Support legislation that will develop or enhance programs and services to combat the negative impact that human trafficking and commercial sexual exploitation of children has on victims and support efforts to provide additional tools, resources, and funding to help counties address this growing problem.

q) **Support the enhancement of childcare and development**

Support measures that enhance the overall quality, affordability, capacity, accessibility, and safety of childcare and development programs. Specifically, support legislation and budget action that would:

i) Ensure continuity of childcare for children and families.

ii) Preserve, protect and increase funding for subsidized and other government-funded childcare.

r) **Oppose Immigration Reform**

Oppose immigration reform efforts that would eliminate a pathway to full and equal citizenship, that would restrict the rights of immigrants or break up families, or that would focus on a mass deportation of undocumented immigrants.

s) **Temporary Assistance for Needy Families (TANF) Reauthorization**

i) Support increased federal support for TANF/CalWORKS subsidized employment programs.
ii) Support more flexible work participation requirement measures to give credit for client engagement and for work activities not meeting the current thresholds.
iii) Support the ability of states to provide and receive federal support for vocational education and career technical training for longer than 12 months.

t) **Supplemental Nutrition Assistance Program (SNAP)**

i) Support a thorough review and updates to the U.S. Department of Agriculture's (USDA) Thrifty Food Plan (TFP) to more accurately account for the cost of food, dietary needs, purchasing patterns and regional differences in food costs, housing and medical care, which affect the purchasing power of Supplemental Nutrition Assistance Program (SNAP) benefits.
ii) Support increased nutritional supplementation efforts at the state and federal levels, including increased aid, longer terms of aid, and increased access for those in need.
iii) Support extending Able Bodied Adults Without Dependents work requirement waivers for as many counties and sub-county regions as possible.
iv) Support further collaboration with the federal government and national partners to increase outreach and enrollment for SNAP/CalFresh, especially in underserved populations such as students, former foster youth, non-English-speaking populations and seniors.
v) Support provisions to further streamline and simplify federal requirements for SNAP/CalFresh recipients to enhance enrollment and retention.
vi) Support additional flexibility for states to align SNAP/CalFresh eligibility and processes with state TANF/CalWORKS programs.
vii) Support efforts to improve timeliness of data provided by the Food and Nutrition Services (FNS) to states for use in administering SNAP/CalFresh.

u) **Support Adult and Disability Services**

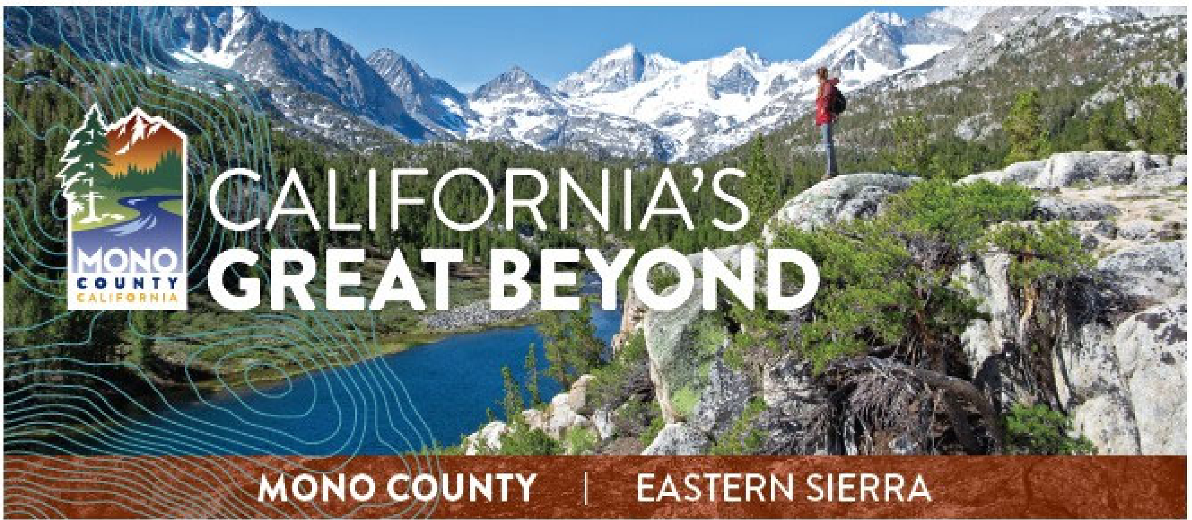
Support legislation that would provide adequate funding such as state-only funded programs, programs authorized under the Older Americans Act, a return to full funding for Social Services Block Grant (SSBG) programs and increases to the SSBG allocation to keep up with inflation and population growth.

v) **Support Homelessness Legislation**

Support federal homelessness legislation funding an array of services to individuals and families at risk of or who are experiencing homelessness.

w) **Support State and Federal funding and regulatory changes or guidance that supports landlords and tenants, and prevents homelessness resulting from COVID-19 related financial impacts.**

County Attractions



TOP ATTRACTIONS

YOSEMITE NATIONAL PARK Drive California's highest pass to Yosemite's east entrance—just 12 miles from Lee Vining—for ten-story waterfalls, iconic granite domes, rock climbing, hiking, and more (pass closed in winter). *www.NPS.gov/yose • 209-372-0200 • Bus service: www.Yarts.com*

MONO LAKE This ancient inland sea with its unique limestone formations and alkaline waters is home to hundreds of bird species! Learn more at: *Mono Basin Scenic Area Visitor Center 760-647-3044 • Mono Lake Committee www.MonoLake.org • 760-647-6595*

DEVILS POSTPILE NATIONAL MONUMENT Located near Mammoth Lakes, Devils Postpile is one of the world's finest example of columnar basalt formations. *www.NPS.gov/depo • 760-924-5500*

BODIE STATE HISTORIC PARK With about 200 buildings still standing—thanks to ongoing preservation efforts—keep an eye out for spirits roaming the once-wild streets of this genuine gold-mining ghost town. *www.Parks.CA.gov • 760-647-6445 www.BodieFoundation.org*

WHAT LIES **BEYOND?**

When the things right in front of us turn invisible and the everyday loses its magic, you know it's time to go beyond.

Beyond the traffic, the deadlines and the incessant chatter of so-called civilization.

A journey to Mono County will take you to a California you didn't even imagine existed. A land of lava and ice, sparkling clear waters, miles of hiking trails and dozens of secret fishing holes.

Discover rock formations from another world at Mono Lake and Gold Rush history at Bodie ghost town. You'll also find genuine local hospitality, like a welcome from another era.

It takes a bit of traveling to get here, but that's the way we like it. Because once you're out here, you'll start to see again.

Welcome to **Mono County: California's Great Beyond.**

TOWNS & COMMUNITIES

BENTON HOT SPRINGS Soak in hot tubs fed by natural hot springs at the Historic Benton Inn. Once a bustling Wells Fargo stagecoach station, Old Benton offers a self-guided tour of numerous original buildings, historic sites and the cemetery.

BRIDGEPORT Gateway to Bodie ghost town and home of the county seat, Bridgeport's iconic courthouse has been in use since 1880. The California state-record brown trout, at **26 lbs 8 oz**, was caught in Bridgeport's Twin Lakes.

CONVICT LAKE / McGEE CREEK Dramatically situated under towering Mt. Morrison, Convict Lake is loved by anglers, hikers, and...wedding parties! Catch wildflowers or fall colors at McGee Creek Canyon—hiking or on horseback.

CROWLEY LAKE Fishing season opener's home base, this expansive lake offers world-class trout fishing.

JUNE LAKE Tucked away at the base of 10,909-ft. Carson Peak, June Lake is a scenic mountain hideaway. Famous for trout fishing and brilliant fall colors, the June Lake Loop is a snowy retreat in winter. June Mountain Ski Area offers free lift tickets every day, all winter long for kids age 12 and under.

LEE VINING Overlooking dramatic Mono Lake, Lee Vining is the gateway town to Yosemite National Park—just 12 breath-taking miles up Tioga Pass Road/SR 120.

MAMMOTH LAKES Mammoth Mountain Ski Area consistently ranks as one of the top winter sports destinations in North America. In the town of Mammoth Lakes, you'll find quaint shops, gourmet restaurants and accommodations from cozy cabins to four-star luxury hotels.

ROCK CREEK / TOM'S PLACE With beautiful Little Lakes Valley hiking trail, fall colors and winter "Adventure Dining" at Rock Creek Lodge—complete with snowmobile taxi—Rock Creek Canyon is magical all four seasons.

TOPAZ At the northern tip of the county, Topaz Lake boasts a nine month fishing season, a big cash derby and a Nevada casino.

WALKER AND COLEVILLE Ranch towns in the northern part of Mono County, Walker and Coleville host California's only ATV/UTV Jamboree every September!

VISITOR AMENITIES

LODGING With more than 140 hotels, motels, bed & breakfast inns, cabins and campgrounds, Mono County has a diverse lodging base—from deluxe spa hotels to rustic cottages and scenic RV parks.

DINING There are more than 100 restaurants, cafés, pubs and bakeries to choose from throughout Mono County, with options ranging from traditional comfort food to delicious ethnic cuisine and fine dining.

SHOPPING If you're looking for Macy's, you won't find it in Mono County! However, with over 125 stores to browse through, you'll find intriguing shops, art galleries, Native American crafts, fishing and sports gear, and unique souvenirs in every community.

MUSEUMS The Mono County Museum in Bridgeport, Mono Basin History Museum and Upside-Down House, Hayden Cabin in Mammoth Lakes and Benton Historical Society all bring the region's rich history to life with unique exhibits.

VISITOR INFORMATION Mammoth Lakes Welcome Center, Mono Basin Scenic Area Visitor Center and Mono Lake Committee Information Center in Lee Vining, as well as the Bridgeport Ranger Station provide maps, guide books, permits, and visitor info.

TOP MONO COUNTY ACTIVITIES

SUMMER

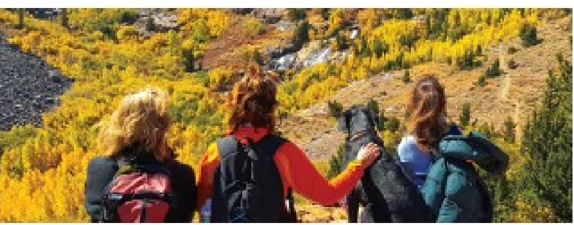
- Hiking, Backpacking & Rock Climbing
- Fishing & Camping
- Mountain Biking & Road Cycling
- Kayaking & Canoeing
- Horseback Riding
- ATVs & Off-Highway Vehicles

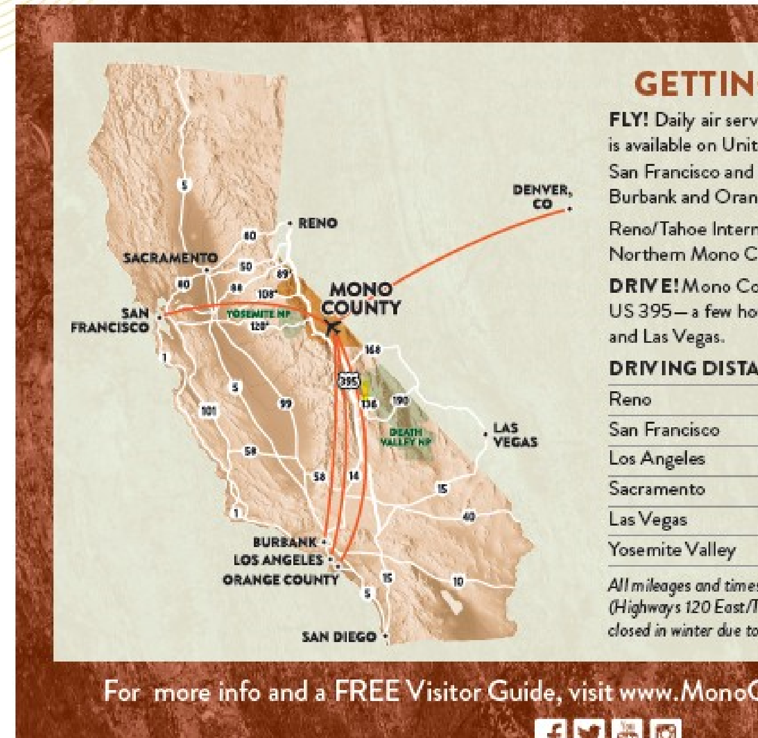
WINTER

- Skiing & Snowboarding
- Cross Country Skiing
- Snowshoeing & Ice Skating
- Snowmobiling
- Dog-Sledding
- Sledding & Tubing

2020 EVENTS HIGHLIGHTS

Event	Location	Date
Fishing Season Opener	Mono County	Apr 25
Mammoth Lakes Film Festival	Mammoth Lakes	May 20-24
Mono Basin Bird Chautauqua	Lee Vining	Jun 19-21
How Big Is Big Fishing Derby	Walker / Coleville	Jul 1-31
Old-Fashioned 4th of July	Bridgeport	Jul 2-5
Mammoth Festival of Beers & Bluesapalooza	Mammoth Lakes	Aug 1-2
Friends of Bodie Day	Bodie	Aug 7-8
Founders' Day Celebrations	Bridgeport	Sep 4-7
Eastern Sierra ATV/UTV Jamboree	Walker / Coleville	Sep 8-12
Ambush at the Lake Fishing Derby	Convict Lake	Oct 1 – Nov 15
Leaves in the Loop	June Lake	Oct 16-18
Benton Hot Springs Victorian Christmas Dinner	Old Benton	Dec 12





GETTING TO MONO COUNTY

FLY! Daily air service to Mammoth Yosemite Airport (MMH) is available on United Airlines from Los Angeles year-round and San Francisco and Denver in the winter. JSX flies to MMH from Burbank and Orange County, winter only.

Reno/Tahoe International Airport is just 1.5 hours drive from Northern Mono County.

DRIVE! Mono County is situated along beautiful Scenic Byway US 395—a few hours' drive from Los Angeles, San Francisco and Las Vegas.

DRIVING DISTANCES AND TIMES

From	Time	Distance
Reno	2.5 hours	140 miles / 225 km
San Francisco	5.5 hours	250 miles / 402 km
Los Angeles	5.5 hours	330 miles / 531 km
Sacramento	4 hours	220 miles / 354 km
Las Vegas	5.5 hours	340 miles / 547 km
Yosemite Valley	2 hours	75 miles / 121 km

*All mileages and times are from Lee Vining, CA. *East-west mountain passes (Highways 120 East/Tioga Pass, 108/Sonora Pass and 89/Monitor Pass are closed in winter due to snow and usually open before Memorial Day.*

For more info and a FREE Visitor Guide, visit www.MonoCounty.org | **800-845-7922**

Elected State Representatives:

Assembly Member Frank Bigelow 5th Assembly District State Capitol, Suite #4153 Sacramento, CA 94249 Capitol Office Phone: (916) 319-2005 District Office Phone: (559) 673-0501 Website: https://ad05.asmrc.org	Senator Andreas Borgeas 8th Senate District State Capitol, Room 3082 Sacramento, CA 95814-4900 Capitol Office Phone: (916) 651-4008 District Office Phone: (559) 243-8580 Fax: (916) 651-4908 Website: http://borgeas.cssrc.us/
Governor Gavin Newsom State Capitol, Suite 1173 Sacramento, CA 95814 Phone: (916) 445-2841 Fax: (916) 558-3160 Website: http://gov.ca.gov/	

Elected Federal Representatives:

Senator Alex Padilla United States Senate Russell Senate Office Building, Suite B03 Washington, D.C. 20510 Phone: (202) 224-3553 Fax: (202) 224-2200 Website: http://padilla.senate.gov/	Senator Dianne Feinstein United States Senate 331 Hart Senate Office Building Washington, D.C. 20510 Phone: (202) 224-3841 Fax: (202) 228-3954 TTY/TDD: (202) 224-2501 Website: http://feinstein.senate.gov/
Representative Jay Obernolte 8th Congressional District 1029 Longworth House Office Building Washington, DC 20515 Phone: (202) 225-5861 Website: http://obernolte.house.gov/	

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Mono County

2021 State and Federal Legislative Platform

Reviewed and adopted by the Mono County Board of Supervisors
March 2, 2021

Mono County Board of Supervisors

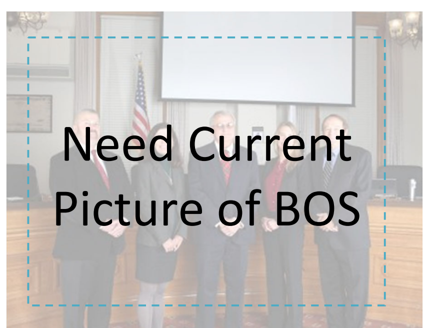
Jennifer Kreitz..................................... District 1

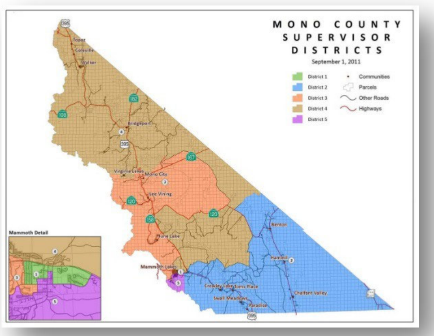
Rhonda Duggan................................... District 2

Bob Gardner .... District 3

John Peters .... District 4

Stacy Corless....................................... District 5





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Introduction

Mono County, California, is a rural county situated between the crest of the Sierra Nevada and the California/Nevada border. Accessed by US Highway 395 which weaves its way north-south and is a state-designated Scenic Byway from its southern boundary all the way to Topaz Lake in the north, Mono County is 108 miles in length, and has an average width of only 38 miles. With dramatic mountain boundaries that rise in elevation to over 13,000 feet, the county's diverse landscape includes forests of Jeffrey and Lodgepole pine, juniper and aspen groves, hundreds of lakes, alpine meadows, streams and rivers, and sage-covered high desert. The county has a land area of 3,030 square miles, or just over 2 million acres, 94% of which is publicly owned. Much of the land is contained in the Inyo and Humboldt-Toiyabe National Forests, as well as the John Muir and Ansel Adams Wilderness areas. As a result, Mono County offers vast scenic and recreational resources, and has unsurpassed access to wilderness and outdoor recreation and adventure.

Mono County Tourism / Mono Lake Tufas

The county is home to, and named after, Mono Lake, which is a large high-desert saline lake with intriguing limestone tufa formations and is a vital habitat for millions of migratory and nesting birds. Mono Lake is just one of the reasons that Mono County draws landscape photographers year-round.

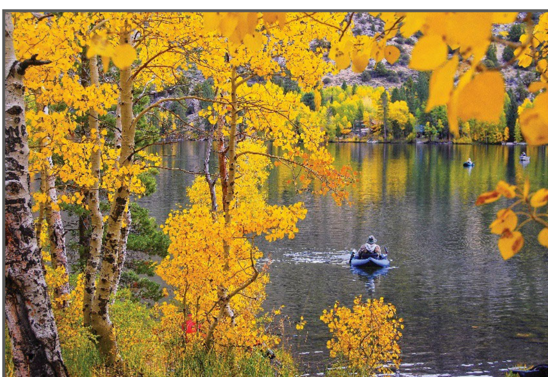
Another highlight is the historic gold rush town of Bodie, which during its heyday in the late 1800s, was home to as many as 10,000 people, and is now maintained as a State Historic Park with about 200 buildings still standing as they were left, preserved in a state of "arrested decay" for visitors to enjoy. Other natural wonders that attract people to Mono County include Devils Postpile National Monument, one of the world's finest examples of columnar basalt and the headwaters of the Owens and Middle Fork San Joaquin Rivers; two of the state's most important watersheds. Yosemite National Park's eastern entrance at Tioga Pass is only 12 miles from Lee Vining and Mono Lake.

Mono County Tourism / Bodie State Historic Park

Mono County has several small towns and charming villages, each with its own scenic beauty, year-round recreational opportunities, natural and historical attractions, and unique characteristics. The County seat is proudly located in Bridgeport, where the original 1881 courthouse is the second oldest in the state to be in continuous use. The only incorporated town in the county is Mammoth Lakes, which is located at the base of world-renowned Mammoth Mountain Ski Area, with a summit of 11,053 feet, over 3500 skiable acres, 28 lifts, and an average of 400 inches of snowfall annually. For example, January 2017 recorded historic amounts of snow, with 20.5 feet accumulating in Mammoth during that month alone. Approximately 8,100 people reside in the Mammoth Lakes area year-round, and during the peak winter season, the population swells to over 35,000 when visitors from around the state, country, and world come to ski, snowboard, and take part in many other winter activities. The sister resort, June Mountain, just 20 miles north of Mammoth, offers uncrowded, wide-open slopes and a more peaceful, family-friendly alternative to busier ski areas.

Mono County Tourism / Bridgeport Courthouse

Summer, however, is when Mono County really shines. The region offers countless miles of alpine hiking, superb trout fishing at dozens of well-stocked lakes, streams and rivers, kayaking, cycling, horseback riding, golfing, and endless warm-weather adventures. Photographers flock to the county in September and October when it is almost impossible to take a bad photo of the fall color that lights up the Eastern Sierra landscape. *Sunset Magazine* named Mono County one of the "Top 5 places to Hike" in autumn and *TravelAndLeisure.com* listed Mono County as one of "America's Best Fall Color Drives.



Mono County Tourism / Silver Lake

A wide variety of lodging, restaurants, and shops are available throughout the county, and commercial air service to Mammoth Yosemite Airport, just a 10-minute drive from the Town of Mammoth Lakes, is accessible non-stop and year-round from Los Angeles, and seasonally from many other airports. Air services are offered through United Airlines and JSX.

~~State and Federal General~~ Guidelines for Implementation of this Platform

Commented [RL1]: Change per Stacey Simon

It is the intention of the Board of Supervisors that this Legislative Platform streamline and support the County's ability to comment on matters impacting the County and its citizens. Accordingly, any individual Board Member or Department Head, in consultation with the CAO and the Board Chair (unless consultation with the Chair would result in a violation of the Brown Act), may draft and submit a letter on behalf of the entire Board of Supervisors in support of or in opposition to an issue or matter addressed in this Legislative Platform, provided that the letter is consistent with the position expressed in this Platform. Following its delivery or mailing, the letter shall be placed on the next available Board of Supervisors' agenda as correspondence so that other Board Members, and the public, are aware of its contents.

When a request for a letter in support of or in opposition to an issue or matter comes to the attention of a Department Head, the Department Head shall first consult this Legislative Platform for consistency with policy direction as described above. If there is no clear policy direction in this Platform, but the subject of the letter is consistent with the goals and workplan of the county department, the Department Head shall draft the proposed letter and present it to the CAO for approval. The CAO may additionally consult with the Board Chair in his or her discretion. If the proposed letter is approved by the CAO, the Department Head may send the letter and, if the subject matter is of interest to the entire Board, place it on the next available Board of Supervisors' agenda under correspondence. If the proposed letter is not approved by the CAO, the Department Head may agendize it for consideration and possible approval by the full Board.

Commented [RL2]: Addition per Stacey Simon

The Mono County Board of Supervisors supports the general guidelines set forth below. County staff will apply these guidelines in evaluating State and Federal legislation, as well as executive and regulatory actions. It is the Board's objective to implement these guidelines.

To support the County's service to the community, the County should:

- Support legislative and budget efforts that protect and/or enhance local government revenues, maximize the County's access to state and federal funding sources, including pandemic support and relief programs, and/or increase local funding flexibility;

Commented [RL3]: Recommended by Alicia Vennos

- Oppose any effort to balance the State budget through the taking of local government resources;
- Support legislation that protects the County's quality of life and diverse natural resources, while preserving the essence and historic values of the County;
- Support legislation that provides tax and funding formulas for the equitable distribution of state and federal monies while opposing attempts to decrease, restrict, or eliminate County revenue sources;
- Support legislation and budget action which provides additional and continued funding for local road infrastructure, including complete street features;

- Oppose legislative and administrative actions which would create federal unfunded mandates and/or preempt local decision-making authority;
- Support legislation that realigns governmental services in such a manner as to improve the delivery of services and make government more accountable to the people;
- Support the promotion of tourism, recreation, sustainable fisheries, filming, and a diversified local economy in the Eastern Sierra to achieve strong economic growth and prosperity;
- Continue to support legislation that honors our veterans for their service to our country;
- Support efforts that further the strategic directions outlined in the County's Strategic Plan;
- Engage on any proposals to repeal or additionally alter the Affordable Care Act (ACA), which provides Mono County citizens the ability to obtain affordable health care;
- Support efforts to combat climate change;
- Support legislation that seeks to address the insufficient quantity and quality of homes affordable to our residents; and
- Support legislation that addresses the burgeoning substance use disorder crisis and increases access to Medication Assisted Treatment.
- Support measures that increase resources for disaster response initiatives requiring county involvement.
- Support legislation that waives the local share of cost of all emergency response and disaster recovery activities.
- Support funding for counties to provide for higher demands on critical recovery services.
- Support local, regional, state, and federal initiatives and legislation that advance efforts to dismantle systemic racism and reduce inequity.

Commented [RL4]: Recommended by Kathy Peterson

Commented [RL5]: Recommended by Sheriff Braun

State Priorities

1) Protect County revenue sources

   Many County programs are at risk due to the instability of State funding. The Board of Supervisors supports efforts to sustain funding, enabling the continuation of critical programs for Mono County's constituents.

2) Encourage regulation relief/reform

   Mono County applauds California's efforts to protect the environment. The Board supports efforts to achieve responsible regulation relief in the following areas:

   a) **Provide regulatory relief for solid waste operations**

      i) Continue to provide regulatory relief to rural jurisdictions from statewide solid waste and recycling mandates when recycling infrastructure does not yet exist and causes significant transportation costs and emissions.
      ii) Provide funding for the siting and development of recycling infrastructure, and/or develop policies within state agencies and businesses such as Caltrans, Los Angeles Department of Water and Power and Southern California Edison for the local re-use of materials (glass cullet, wood chips) when generated in rural areas.

   b) **Support CARB compliance legislation**

      Support legislation regarding California Air Resources Board (CARB) compliance to assist rural counties with the costs associated with State mandated compliance.

   c) **Encourage communication between air districts especially as it relates to smoke management.**

   d) **Support environmental processing legislation**

      Support legislation that streamlines environmental processing, including the application of certain urban exemptions under the California Environmental Quality Act (CEQA) to rural communities.

   e) **Support regulation of short-term rental online platforms**

      Online short-term rental platforms are unregulated, leaving accountability and compliance issues to local jurisdictions. Mono County urges the legislature to support regulation of short-term rentals to ensure an even playing field with traditional commercial lodging, require accountability, provide for tax collection, and support compliance at the state and local levels.

f) **Ensure adequate oversight of state requirements for commercial cannabis activities, respect local CEQA processes for cannabis permits and encourage development of hemp regulations**

Mono County is concerned about the state's allocation of resources for monitoring and inspection of commercial cannabis permits to ensure compliance with state requirements, particularly in rural areas like Mono County. Where oversight is delegated to local agencies, such as the Agricultural Commissioner, adequate funding should also be provided. Where oversight is retained by the state, state agency staff should have adequate on-the-ground presence to ensure accountability and compliance without increasing the burden on local jurisdiction staff. Further, the state should respect the CEQA process conducted by local jurisdictions serving as lead agencies, even if the state's responsible agency role is not triggered, or assume lead agency status and conduct separate CEQA evaluations for the approval of state licenses. ~~In addition, the state has issued emergency regulations for hemp cultivation but has not yet proposed a regulatory plan for final regulations or federal government review.~~ As with cannabis, state industrial hemp regulations are critical for local governments to craft local regulations that create a comprehensive set of rules to ~~that~~ protect public health and safety while providing for the industry. Without ~~those~~ state regulations, local jurisdictions are acting in a vacuum that may increase challenges due to uncoordinated or inconsistent requirements and approval processes. The state should continue working toward federally approved industrial hemp regulations.

Commented [RL6]: Amendments to this Item recommended by Wendy Sugimura

g) **Continue to provide and increase funding for local jurisdictions to meet affordable housing goals**

In an effort to address affordable housing needs throughout the state, new housing laws are passed every year. Some carry new mandates that place a regulatory burden on local jurisdictions, and some simply require funding to implement. We encourage the State to continue providing new funding streams, such as SB 2 and the Regional Early Action Planning (REAP) grants program, as well as technical assistance programs, to assist local jurisdictions with meeting new mandates and working toward statewide and local housing goals.

3) Natural Resources, Public Lands and Agriculture

a) **Support sustainable funding for State parks**

Continue to support measures to sustain our State parks, roads that access these parks, and recreation programs for the continued enjoyment of visitors and residents. Closure or underfunding of these parks would result in a significant negative economic impact on our County as tourism and recreation are our most important economic drivers.

b) **Protect our communities from wildfire and promote forest health**

Support a balanced approach to fuels management that increases funding and capacity for community protection and, also, considers air quality and other health related issues within the Great Basin Unified Air Pollution Control District.

c) **Support legislation regarding programs and policies that promote the creation of both state and local disaster prevention, response, and recovery planning policy.**

d) **Support continued and enhanced state funding for non-native, invasive plant management programs**

After years of no state funding allocation, weed management area groups throughout the state will have funding opportunities in the coming budget year. These programs are critical to the protection of our local and statewide environment, and have proven positive effects on natural fire regimes, species diversity, watershed health, and many other concerns. State funding for these programs should be maintained and enhanced if possible.

e) **Ensure full funding of California Department of Fish and Wildlife Hatchery and Inland Fisheries Program (AB 7 - 2006)**

In 2006, AB 7 dedicated by law one third of all sport fishing license fees to be used for adequate stocking of Department of Fish and Wildlife Hatcheries. Beyond the funding dedication, AB 7 dictated the size of fish to be stocked. Recent California Department of Fish and Wildlife (CDFW) actions, as well as state budget actions, have reduced the size of the stocking fish and not fully directed the fee funding to this program. Mono County supports the original intent including all funding being directed to the state hatchery program, fish size, and reproducing diploid fish countywide as described in the original legislation.

f) **Support budget appropriations to modernize and maintain the state hatchery system.**

g) **Support a balanced approach to regulating fishing**

Support a fishing season in the Eastern Sierra that provides economic opportunity while maintaining the balance of environmental health and sustainable fisheries and requires California Department of Fish and Wildlife (CDFW) to notify local government of proposed fishing regulation changes.

h) **Support sustainable fishing**

Support the funding of efforts to enhance the fish population in Mono County including sustainable fishing, ongoing fish stocking, education for proper catch and release practices, protection of spawning waterways, and support of the California Department of Fish and Wildlife (CDFW) stocking of diploid trout in allowable waters.

i) **Support bio-energy action plan development**

Commented [RL7]: Amendments to this Item recommended by Alicia Vennos

Commented [RL8]: Amendment recommended by Alicia Vennos

Encourage the various state agencies involved to continue evolving this field of work to produce and permit cleaner, more affordable technology based on sustainable and healthy forestry principles in a manner that benefits rural Sierra economies. Mono County has encouraged state agencies, such as the Sierra Nevada Conservancy (SNC) and California Energy Commission (CEC) to provide funding for project scoping and planning.

j) **Support legislation that promotes, protects, or facilitates the sustainability of our local agriculture**

Mono County agriculture is an important local economic driver. It provides jobs and contributes to the open-space landscape that draws visitors. Reinstate Williamson Act subventions and continue to develop alternative funding measures, such as the Strategic Growth Council's Sustainable Agricultural Lands Conservation Program.

k) **Support development of domestic recycling markets and streamline process for recycling infrastructure development.**

Domestic recycling markets are needed to address the changes in international trade policies which have disrupted California's solid waste and recycling industry by restricting foreign imports of recyclable materials and requiring reduced contamination levels in recycling streams. In order to meet California's ambitious recycling mandates, investment in and development of domestic markets has become necessary.

l) **Support legislation that allows for alternative organic programs for rural areas and exempts them from the SB 1383 requirements until such time that an economically feasible infrastructure is in place**

Rural jurisdictions are disproportionately burdened under mandates of SB 1383/Short Lived Climate Pollutants. With no developed infrastructure, no economy of scale and great hauling distances to existing infrastructure, this remains a major challenge for rural areas.

m) **Support legislation and funding that eases the burden of implementing the Sustainable Groundwater Management Act, including creating necessary infrastructure in rural, sparsely populated areas**

The Sustainable Groundwater Management Act provides for local agencies to develop groundwater sustainability plans and, pursuant to those plans, sustainably manage groundwater resources. The funding mechanism for these activities provided in the law is for local agencies to impose fees on water users. Areas ~~subject to the Act~~ in Mono County that have been subject to the Act in the past are sparsely populated and primarily in agricultural production. Accordingly, very few individuals (less than a dozen) would have to bear the significant burden of funding compliance with the Act, should it apply again in the future, which would endanger the viability of ~~. This raises real concerns regarding the future of~~ Mono County's agricultural operations.

Commented [RL9]: Amendments to this Item recommended by Alicia Vennos

n) **Continued engagement in Bi-State Sage Grouse conservation efforts**

Mono County appreciates the State's increased role in sage-grouse conservation efforts and addressing the threat posed by the Los Angeles Department of Water and Power's (LADWP's) management of water in Long Valley, a key habitat area for the South Mono Population Management Unit. The California Department of Fish and Wildlife is a significant player in this conservation effort. Ultimately, continuation of the collaborative multi-party partnership, ~~strengthened by~~ including the cooperative engagement ~~by~~ of LADWP, would be the ideal outcome to ensure the health and viability of sage grouse populations ~~warrant a new decision not to list the species under the federal Endangered Species Act~~. If the bird us ultimately listed, the result ~~could~~ would be an additional regulatory burden with devastating impacts to ~~our~~ Mono County's agricultural and recreational activity-based economy.

Commented [RL10]: Amendments to this Item recommended by Wendy Sugimura

o) **Climate and drought resiliency**

Support measures that provide funding and resources to develop drought and climate resilient water supplies in California, such as water recycling and reuse, leak and loss prevention/remediation and other solutions to enhance the State's water resources in order to reduce reliance on increasingly unpredictable precipitation amounts.

Commented [RL11]: Insertion of this Item recommended by Stacey Simon

4) Public Safety and Criminal Justice

a) **Advocate to prevent adverse local impacts from cannabis and hemp legislation**

Advocate for local control, taxation and funding for addressing the environmental, land use, and public safety impacts of the cultivation of cannabis and hemp.

b) **Ensure State realignment & cost-shifts**

Continue to ensure successful implementation of the broad array of programs transferred to county jurisdiction under the 2011 Public Safety Realignment, including appropriate distribution of AB 109 funding. Support state policy changes that will allow for greater administrative and program flexibility for county programs associated with this shift of responsibility.

c) **Support of rural fire districts**

The population of Mono County is highly rural and dependent upon voluntary associations that provide basic emergency services. These volunteer fire districts provide services to residents and tourists, and they are often the first responders to accidents. Support relief for rural fire districts.

d) **Advocate for Community Paramedicine**

Advocate for the State Emergency Medical Services Agency (EMSA) to expand the current number of EMS Programs participating in the Community Paramedicine Demonstration Project.

e) **Advocate for legislation to extend the age for juvenile services from 18 through the age of 20**

Neuroscience supports that brain development continues until the age of 23.

f) **Support legislation that provides financial support to probation**

Provide financial support to probation to include more evidence-based services and incentives for both adults and youth.

5) Transportation and Infrastructure

a) **Support action for transportation funding**

Support the multiple transportation funding sources that provide for improved transportation systems and multimodal networks, including SB 1 as enacted and delivery of projects that rehabilitate and improve local roads and related infrastructure.

b) **Support State highway access**

Mono County supports budget policy and legislation to fund rehabilitation of the Bodie Road (Highway 270) that provides access to Bodie State Park and to facilitate early Sierra Pass openings (including Highways 120 and 108).

c) **Support complete streets and walkable community principles**

Mono County is a strong supporter and advocate of the complete streets and walkable community principles in the 2040 California Transportation Plan. This focus is a transportation paradigm and culture shift that will impact projects from initiation to completion and maintenance. Recently, local jurisdictions have been increasingly tasked with the funding and maintenance of complete street features on state facilities such as state highways. These maintenance responsibilities lie with the state, and a corresponding shift in the functioning and funding of Caltrans is needed to ensure success of complete street designs.

Commented [RL12]: Amendments to this Item recommended by Wendy Sugimura

d) **Support broadband deployment and communications systems improvements**

Leverage existing work efforts focused on broadband infrastructure investments and deployment projects to further increase access to Gigabit broadband throughout the County. Advocate and work to improve communication systems including:

Commented [RL13]: Spelling correction recommended by Nate Greenberg

i) Plain Old Telephone Systems (POTS) system reliability;

ii) Reliable 911 service, the NextGen 911 transformation (including the leveraging of broadband for improving 911), 211 service, and public notification and warning services;
iii) Cellular-based communication systems and networks including those designed for commercial and public safety use (such as FirstNet);
iv) Policies, programs, and funding opportunities for other public safety communication platforms, including but not limited to Land Mobile Radio;
v) Appropriate and effective definitions of 'broadband' which recognize the importance of technology and dependence on the internet for public safety and economic development;
vi) Legislation and associated programs that provide funding for broadband infrastructure projects and adoption/education efforts.

e) **Investor-Owned Utility Wildfire Mitigation and Public Safety Power Shutoff (PSPS) policy**

In coordination with local allied agencies and community organizations, advocate for policies and practices which ensure public safety while recognizing and addressing the unique challenges of PSPS events in a tourism-driven rural environment. Encourage utilities' investment in infrastructure hardening, grid modernization, and situational awareness tools.

6) Administrative and Fiscal Services

a) **Support Clerk/Recorder Services and Elections Administration improvements**

Support resources for improving county record keeping services and election administration, and monitor legislation that may impact the following:

i) Recording fees and process, and recorded documents;
ii) Vital statistic fees and process;
iii) Public records;
iv) Unfunded mandates;
v) Vote-by-mail, voter registration, election management systems, elections process, and election equipment;
vi) Funding for records preservation (such as Board of Supervisors historic records);
vii) Funding for modernization of elections equipment;

b) **Support Vote-by-mail legislation**

Support legislation to authorize vote-by-mail ballot elections for rural counties.

c) **Support leveraging SB2 Recording fees to return to Mono County for housing.**

d) **Support the full funding of all Payment In Lieu of Taxes (PILT)**

Support legislation and budget efforts that provide for payment of past due balances and continue to maximize the PILT revenue to counties and maintain full funding of PILT without restrictions beyond the current authorization.

e) **Oppose legislation that would limit and/or impose significant procedural or substantive barriers to counties' ability to contract for services.**

7) Health and Human Services

a) **Support accurate, adequate, flexible, and stable funding and regulatory interpretation to best meet Federal/State Health and Human Services program requirements**

These include Child Welfare Services, Mental Health Services, Substance Use Disorder Services, Human Services, Adult Protective Services, In-Home Supportive Services, California Children Services, and Health Reform. In addition, support new innovation by maximizing flexibility in program design, increase Federal/State funding leveraging opportunities, and streamline State program requirements and regulations including those serving specialized needs due to COVID-19.

b) **Support client access permitting online engagement and electronic interviews to reduce cost, increase participation and reduce duplicative eligibility processes.**

~~b)~~c) ~~**Ensure State and Federal Healthcare Reform has equitable funding formulas for rural counties**~~

~~Affordable Care Act (ACA) implementation began in 2014, and it is vital that local government funding streams reflect equitable distribution formulas to service our rural constituents. Securing adequate funding to sustain health care reform measures is important to Mono County. Key issues include Medi-Cal expansion and funding for these mandates and continuation of 1991 realignment allocation/amounts.~~

~~c) **Support legislation that provides funding to support the Local Primacy Agency (LPA) program that ensures safe drinking water to Mono County residents.**~~

d) **Support funding opportunities for environmental health regulation**

Support funding opportunities including fees for State mandates related to environmental health regulation of food establishments, sewage disposal facilities, water systems, well construction, swimming pools, and recreational health facilities, occupied housing, underground storage tank facilities, solid waste facilities, land use development, rabies and vector control, and the management of hazardous waste/materials.

e) **Support legislation that provides funding for the Local Primacy Agency (LPA) program that ensures safe drinking water to residents**

Commented [RL14]: Addition of these Items recommended by Kathy Peterson

Commented [RL15]: Deletion of this Item recommended by Kathy Peterson as redundant with other items below.

Commented [RL16]: Amendment to this Item recommended by Louis Molina. See also Item "D"

The LPA program provides local oversight of small public water systems (SPWS) in Mono County. This program is implemented by the Environmental Health Division of the Public Health Department. Currently, program costs are offset by annual permit fees collected from the SPWS and by Public Health Realignment. The revenues do not cover the costs of this program. ~~AB 402, introduced last legislative cycle but continued to this year, proposes a new method of financial support of LPA programs statewide whereby an LPA would be able to bill the state for costs associated with implementing their LPA program. AB 402 is expected to be voted upon by the State legislature this legislative cycle.~~

Commented [RL17]: Amendment to this Item recommended by Louis Molina; legislation not signed by Governor Newsom.

f) **Support funding opportunities for Mono County's CUPA Program**

The California Unified Program Agency (CUPA) is implemented by the Environmental Health Division of the Public Health Department. Funding for this program is provided through environmental health fees and Public Health Realignment. In the past, the CUPA was provide grant funding through Cal EPA to offset costs incurred in implementing the program. This grant funding was subsequently discontinued last year. Negotiations are ongoing to reinstitute this funding program.

g) **Support legislation for public health programs**

Support legislation and programing, and advocate for upstream approaches to health and preventative public health programs including Maternal, Child, and Adolescent Health (MCAH), Oral Health, Tobacco Education, Women, Infants and Children (WIC), Emergency Preparedness, Communicable Disease, HIV/STDs, and Immunizations.

h) **Support revenue opportunities and increased flexibility with State allocations for local public health departments**

With rising costs of business, the Mono County Health Department's expenditures are now greater than its revenues. With a decline of Public Health Realignment funds since 2007, these dollars no longer cover the cost of fulfilling mandates, backfilling State grants, and addressing local health priorities. Opportunities include increasing revenues through State allocations and advocating for a broader, less restrictive scope of work which can be tailored to a community's unique health needs.

i) **Support public health fiscal sustainability in rural counties in the form of relaxed programmatic FTE requirements and indirect cost rate caps**

Health programs are continually evolving and new opportunities to improve community wellness are on the rise. Rural counties face unique recruitment and retention challenges and much of the prospective funding comes with strict FTE requirements and/or caps on what can be reimbursed in indirect costs. Funding allocations usually do not provide enough resources to hire new staff and the majority of existing staff manage or support multiple public health programs. Additionally, funding allocations do not cover the true cost

of the program, especially overhead costs, leading to difficult decisions about implementing programs that have been recognized as a need in our rural communities.

j) **Support legislation for health providers**

Support legislation and advocate for increasing the number of dental and medical providers in rural counties, especially those who accept Medi-Cal and Denti-Cal insurance.

k) **Advocate for a level of funding that enables counties to properly administer the Medi-Cal program on the state's behalf.**

l) **Support improvements to Medi-Cal**

Support the streamlining of ~~the~~ Medi-Cal administration and improve access to health coverage for uninsured families.

Commented [R18]: Amendment to this Item recommended by Kathy Peterson

m) **Support legislation that would increase the number of volunteer Emergency Medical Technicians**

Current licensing requirements are onerous and deter volunteer first responders from seeking EMT licenses.

n) **Provide a State funding stream for county spending on Public Administrator/Public Guardian/Public Conservator (PA/PG/PC) programs**

County Public Administrator, Public Guardian and Public Conservator (PA|PG|PC) programs provide critical safety net services to the most vulnerable adult Californians. The PG/PC provides protective services to individuals with diminished capacity to make decisions due to cognitive impairments and severe mental illness. The PA function handles the disposition of deceased estates. Working collaboratively with local medical, mental health, social services, and justice providers, PA|PG|PC programs petition the Courts to be appointed the legal decision maker with regard to healthcare, psychiatric care, and/or financial management for clients who are unable to make decisions for themselves. County PA|PG|PCs are the only major county safety net programs that receive no direct State or Federal funding. ~~Significant legislative changes to PA|PG|PC services, such as the Omnibus Conservator Act of 2006, and amendments to California Penal Code 1370 regarding criminal defendants who are found to be incompetent to stand trial and deemed unrestorable, have profoundly impacted programs through significant increases in referrals and case complexity. County PA|PG|PC programs on average are short staffed by 20% or more according to a 2018 study by CAPAPGPC and this impacts their ability to provide high quality services, find housing for conservatees, and stabilize treatment. Last year, the coalition requested augmenting spending on PA|PG|PC programs by $68 million GF annually or by 35% statewide which would significantly improve the lives of impaired Californians. (Co-sponsored by CBHDA with the California State Association of Counties,~~

California Association of Public Administrators, Public Guardians and Public Conservators, and Service Employees International Union – California)

Commented [R19]: Amendment to this Item recommended by Kathy Peterson

o) **Support legislation that increases services and supports Child Welfare**

i) Federal Family First Prevention Services Act of 2018: Support full state funding of required program changes to enact the newly mandated child welfare system reforms related to this Act.

Commented [RL20]: Addition of this Item recommended by Kathy Peterson

i) Support legislation that increases services and resources for caregivers of children and former foster youth who are victims of or at risk of abuse, neglect, or exploitation.

ii) Support legislation that increases and supports appropriate short and long-term placements, services, and resource options for children and former foster youth who are victims of or at risk of abuse, neglect, or exploitation.

Commented [RL21]: Deletion of this Item recommended by Kathy Peterson

p) **Support county implementation of the Continuum of Care Reform**

Support adequate funding for county implementation of the Continuum of Care Reform including the recruitment, retention, and support of resource families so that they may provide stable, loving homes for children in the foster care system.

Commented [RL22]: Deletion of this Item recommended by Kathy Peterson

q) **Support legislative, administrative and budgetary efforts that seek to maintain active and healthy independence for seniors and the disabled**

including affordable housing, funding and other support for those who are homeless or at imminent risk of homelessness.

Commented [RL23]: Addition of this Item recommended by Kathy Peterson

r) **Support legislation to increase skilled nursing facilities that are willing to accept dually diagnosed seniors with comorbid medical and mental health conditions.**

Commented [RL24]: Addition of this Item recommended by Kathy Peterson

r)s) **Older Adults and Persons with DisabilitiesSupport legislation that increases Adult and Disability Services**

i) Support legislation that promotes the financial sustainability of the In- Home Supportive Services Program through programmatic changes and appropriate cost sharing mechanisms between the State and counties.

i) Support efforts to increase resources and services available to adults who are unable to live independently or victims of or at-risk of abuse or neglect and the individuals who provide them with care. Support legislative and budgetary efforts to reduce fragmentation within the long- term care delivery system and adequately fund a system of care for seniors in California. A coordinated support system would better utilize state resources and provide a greater benefit to those receiving services.

ii) Support the continuation of federal and state funding for IHSS and oppose any efforts to shift additional IHSS costs to counties.

iii) Support funding for the full range of aging programs that provide services to older adults including services provided by Area Agencies on Aging (AAAs), senior nutrition programs, caregiver supports, resource centers, ombudsman programs, and home and community-based supports.
iv) Support legislation that would establish a comprehensive and coordinated system and provide options for long term care activities that will secure and maintain maximum independence and dignity in a home environment, remove individual and social barriers to economic and personal independence, provide a continuum of care for vulnerable seniors, and provide a comprehensive response to elder abuse/neglect and exploitation.
~~ii)~~v) Support legislation to increase skilled nursing facilities that are willing to accept dually diagnosed seniors with comorbid medical and mental health conditions.

Commented [RL25]: Amendments to this Item recommended by Kathy Peterson

~~s)~~t) **Support efforts to develop permanent supportive housing and affordable housing**

i) Support State laws that support affordable housing and broaden the opportunities and reduce barriers for local government, and non-profit housing entities and instrumentalities of government to increase homeownership and the creation of rental housing. This includes repealing of California State Constitution Article XXXIV. In addition, support increased financing, subsidy options, and tax incentives to support development of new, affordable housing units in rural communities such as Mono County.
ii) Support efforts to streamline funding, construction processes and land use regulations, which expedite the development of low and moderate income housing units and allow local governments to adequately plan to meet the housing needs of all economic segments of the community.
iii) Support measures that enable seniors and the adult disabled population to obtain affordable housing and live independently.
iv) Support additional funding for the Older Californians Act and other programs that assist older adults and caregivers.

~~t)~~u) **Support the enhancement of childcare and development**

Support measures that enhance the overall quality, affordability, capacity, accessibility, and safety of childcare and development programs. Specifically, support legislation and budget action that would:

i) Ensure continuity of childcare for children and families.
ii) Preserve, protect and increase funding for subsidized and other government-funded childcare.

v) **Support measures that seek to prevent Adverse Childhood Experiences (ACEs), address the impacts of trauma, and build resilience.**

~~iii)~~i) Support legislation and budget efforts that support children, youth, and families, including restoring and expanding quality childcare and preschool opportunities, homeless youth, promoting safety for all children, and mental and developmental health prevention and early intervention activities.

Commented [RL26]: Addition of this item recommended by Kathy Peterson

~~u)~~w) **Support legislation to combat human trafficking**

Support legislation that will develop or enhance programs and services to combat the negative impact that human trafficking and commercial sexual exploitation of children has on victims and support efforts to provide additional tools, resources, and funding to help counties address this growing problem.

~~v)~~x) **Support full funding to ensure that state mandates are cost-neutral to the County and pursue revisions to streamline the process for local government.**

~~w)~~y) **State Realignment & Cost-Shifts**

Oppose proposals to restructure, realign, or otherwise shift the cost of programs to local government, without commensurate compensation.

~~x)~~z) **Support legislation, funding opportunities, and multidisciplinary efforts to provide harm reduction and substance use disorder services in Mono County.**

~~y)~~aa) **Support Peer Support Certification (SB 803)**

Unlike 48 states, the Centers for Medicare and Medicaid Services and the Department of Veterans' Affairs (DVA), California fails to value or maximize the benefits of providers with lived experience in the state's Medicaid program, Medi-Cal, because California does not certify peer support specialists nor recognize these professionals as Medi-Cal billable providers. In addition, unlike most states and the DVA, California does not include peer support services as a Medi-Cal mental health benefit. Demand for peer services is growing, but there is no statewide scope of practice, training standards, supervision standards, or certification in California. SB 803 (Beall) establishes a statewide certification program for peer support specialists and provides the structure needed to maximize the federal match for peer services under Medi-Cal. The program defines the range of responsibilities and practice guidelines for peer support specialists, specifies required training and continuing education requirements, determines clinical supervision requirements, and establishes a code of ethics and processes for revocation of certification. (Cosponsored by CBHDA with Los Angeles County, The Steinberg Institute, and the California Association of Mental Health Peer Run Organizations (CAMHPRO))

~~z)~~bb) **Support legislation effort that would encourage Integrated School Behavioral Health Services**

The Integrated School-Based Behavioral Health Services Partnership Program (Partnership Program) encourages local educational agencies (LEAs) and county behavioral health agencies to collaborate on providing on-campus services for students at the earliest onset of a behavioral health condition. In the schools participating in the Partnership Programs, county behavioral health agency trained professionals will serve any student appropriately referred by school personnel, including Medi-Cal beneficiaries, privately-insured and uninsured students and provide brief initial intervention services intended to prevent a behavioral health condition from worsening. The county behavioral health professionals will ensure privately-insured students access a private plan provider, if available. If the private plan cannot provide an appropriate provider within state mandated timely access timeframes, the county behavioral health agency will initiate services as appropriate and consistent with professionally recognized standards of practice. The Partnership Program will include annual reporting requirements to help the state evaluate the impact of these intervention services on the health and well-being of students.

~~aa)~~cc) **Strengthen the Mental Health Services Act (MHSA)**

Support legislation proposals to review the MHSA, recognizing the importance and significant contribution this critical funding source has made to persons with mental illness. The MHSA review provides the opportunity to reflect on 15 years of MHSA implementation and find areas for improvement while preserving core MHSA services, including the crisis continuum, prevention/early intervention, and full-service partnerships. Improvements should seek to eliminate restrictive mandatory funding distributions for each component of the MHSA and ensure MHSA funds can be used for individuals with primary substance use disorder diagnoses, as well as support the protection of MHSA's current ratios and funding for small, rural counties. A review should also identify a process for the development of statewide performance and outcome measures to be reported annually to the state, the legislature and the public.

~~bb)~~dd) **Enhance Board and Care rates to prevent further loss of critical housing for SMI clients and build out housing options**

There is a critical lack of housing in California, particularly for its most vulnerable low-income adults most at-risk of homelessness: older adults, persons with disabilities, and persons with serious mental illness (SMI). With the rapidly growing aging population and continually rising housing costs, the homeless population is expected to grow, and a larger number of the homeless population are expected to be disabled and elderly. Even more alarming, California has lost hundreds of board and care homes in recent years that are specifically set up to serve these very populations. Los Angeles County has lost about 1200 beds since January 2016. The reimbursement rates provided by SSI/SSP are inadequate at $35/ day and counties do not have the capacity to patch facilities at the demand needed. CBHDA proposes enhancing board and care rates through $500 million one-time General Fund (GF), reforming punitive regulations/ enforcement of facilities by CDSS, and exploring

federal waiver opportunities to fund board and cares. (Co- sponsored by CBHDA with the Steinberg Institute)

i) **Status:** Board and Care funding is a component of the $750 million Flexible Funding Pool Proposed in the Governor's January budget, however, CBHDA will request a state lawmaker sponsor the full $500 million budget request via the legislature for consideration as part of the budget.

~~cc)~~ee) **Pursue Funding for Pretrial Mental Health Diversion (AB 1810)**

There is an overrepresentation of individuals with SMI in the criminal justice system. All too often, individuals with SMI in crisis are inappropriately routed by law enforcement into jails and ultimately prison, instead of receiving treatment in the community. Once incarcerated, individuals living with a mental illness tend to stay longer in jail and upon release are at a higher risk of returning to incarceration than those without a mental illness. A significant number of individuals experiencing homelessness with behavioral health conditions can cycle in and out of the criminal justice system. California passed in 2018 AB 1810 which establishes pre-trial MH diversion in CA for individuals with SMI and who could be experiencing homelessness. Funding AB 1810 with $250 million one- time GF would help alleviate strains on justice systems and break the cycle of individuals experiencing homelessness with SMI from cycling in and out of the justice system. (Co-sponsored by CBHDA with the Steinberg Institute)

8) Economic Development

a) **Support new and current business development**

Support legislation and programs that support economic development efforts that augment and promote business retention and expansion, as well as create an environment conducive to new business attraction.

b) **Support of commercial filming**

Support bills and initiatives to attract and retain film production in the state as increased filming statewide will result in commercial opportunities for commercial filming projects in Mono County.

c) **Support sustainable tourism and recreation economy**

Support legislation that strengthens the tourism and recreation economy, including ~~the formation of a~~ continued support of the State Office of Outdoor Recreation, formed in 2016.

Commented [RL27]: Amendment to this Item recommended by Alicia Vennos

Federal Priorities

1) Support Funding/Program Preservation

   Support legislative, regulatory, and budget efforts that protect and/or enhance local government revenues, maximize the County's access to federal funding sources, and/or increase local funding flexibility. Oppose legislative and administrative actions that would create federal unfunded mandates and/or preempt local decision-making authority. Strongly encourage Congress and the President to commit to negotiate successfully so as to avoid any future Federal Government shutdowns.

   a) **Support Sustainable Funding for Secure Rural Schools**

      Support legislation that creates a sustainable revenue stream for Secure Rural Schools, such as the Forest Management for Rural Sustainability Act.

   b) **Support the full funding of all Payment in Lieu of Taxes (PILT)**

      Support legislation and budget efforts that continue to maximize the PILT revenue to counties and continue full funding of PILT without restrictions beyond the current authorization.

   c) **Support full federal funding for the United States Department of Agriculture (USDA) Rural Development (RD) Programs**

      Support funding for community development programs and affordable housing such as the Section 502 Direct Loan Program and the necessary program staff to implement these programs.

   d) **Support full and expanded federal funding for Housing and Economic Development programs**

      Support the highest possible funding level for key federal housing and economic development programs, including the Community Development Block Grant (CDBG), the HOME Investment Partnership Program, and the creation of a minimum four percent Low Income Housing Tax Credit floor.

   e) **Support continued rural broadband deployment and communications improvements through local, State, and Federal policy advocacy, infrastructure projects, and grant programs**

      Having appropriate policy at the local, State, and Federal levels is imperative to ensure adequate communications connectivity, which is a critical part of public safety and economic development. Because Mono County has dedicated resources to improve access to high-quality broadband in our communities and as a result of the completion of the Digital 395 project, roughly 90% of our households have access to Gigabit internet.

Unfortunately, several Mono County communities and residents still face barriers to connectivity as there is inadequate infrastructure to support basic Plain Old Telephone Service (POTS) telephone service, including cellular phone service, let-alone high-speed Internet. In order to improve the landscape, the County should advocate for:

i) Policies, regulations, and enforcement around providers delivering basic POTS services to all locations desiring this service;
ii) Appropriate and effective definitions of 'broadband' which recognize the importance of technology and dependence on the internet for public safety and economic development;
iii) Legislation and associated programs that provide funding for broadband infrastructure projects and adoption/education efforts; Programs and efforts that move to improve the accuracy of metrics used to represent the current state of broadband in Mono County.

f) **Support legislation that promotes, protects, or facilitates the sustainability of our local agriculture**

Mono County agriculture is an important local economic driver, provides jobs, puts food on the table and contributes to the open-space landscape that draws visitors.

g) **Support Economic Development resources**

i) Support legislation and federal programs that provide access to small business capital for local business development through the Small Business Administration, Small Business Development Corporation and other government loan and financial programs.
ii) Support legislation and federal programs that promote locally-based business retention and expansion, as well as create an environment conducive to new business attraction.
iii) Support initiatives to attract commercial filming opportunities to the region: in particular, budgetary allocations that increase capacity for processing special use permits on the Inyo and Humboldt Toiyabe National Forests.
iv) Support bills, initiatives, and programs that strengthen the tourism and recreation economy, with a focus on sustainable practices.

h) **Disaster Response**

Support measures that increase resources for disaster response initiatives requiring county involvement.

Commented [RL28]: Addition of this Item recommended by Kathy Peterson

2) Natural Resources, Public Lands, and Agriculture

Support legislation that promotes agriculture and that protects the County's quality of life, its diverse natural resources, and preserves the essence and history of the County, along with legislation that provides adequate funding for stewardship of our public lands.

a) **Support sustainable funding for federal public lands**

Support measures to sustain our federal lands. Closure or underfunding of these lands managed by the US Forest Service, Bureau of Land Management and National Park Service would result in a significant negative impact to our county as tourism and recreation are our economic drivers.

b) **Support outdoor recreation economy and public lands**

Support the enacted 2016 Outdoor Recreation and Jobs Act and the effort to measure the outdoor recreation economy's contribution to the US Gross Domestic Product. Once the federal government fully understands the economic benefits of outdoor recreation, land management agencies and local governments will have necessary data to measure the impact of the recreation economy and the key role that sustainable recreation needs to play in the management decisions of public lands agencies.

c) **Support special designations**

Support special use designations for public lands such as National Scenic Areas, Wild & Scenic Rivers, Wilderness, National Monuments, National Conservation Areas, when demonstrated conservation values and public support warrant such designations.

d) **Oppose public lands disposal**

Oppose the large-scale sale, transfer or "disposal" of public lands except for strategic, widely supported transfers or exchanges for management and boundary adjustments with demonstrated public benefit, for example community expansion in support of affordable housing.

e) **Support wildfire funding and fuels reduction**

Support immediate enactment of legislation to change the method of funding wildfire suppression on National Forests by providing access to funding outside of the statutory discretionary limits for emergency purposes and for investment in additional resources for forest management/fuels reduction to mitigate wildfire risk to communities and increase forest health.

f) **Support public land infrastructure**

Support increased funding for public land management agencies to address deferred maintenance of infrastructure in forests, national parks and reserves that rural counties depend on for tourism and recreation-based economies.

g) **Support regulatory relief for Mill City Cabin Tract funding**

Support administrative and legislative solutions for funding and/or regulatory relief for the cleanup of contaminated soils at the Mill City recreation residence tract on the Inyo National Forest in Mammoth Lakes.

h) **Support land management directives**

Support Mono County's tourism and recreation economy by ensuring funding, programs, and management directives for federal land agencies (including the Land & Water Conservation Fund) that facilitate the planning, building, and maintenance of infrastructure for sustainable recreation, travel, and commercial film permitting on public lands.

i) **Support sustainable fishing**

Support ~~the~~ federal initiatives and / or funding of efforts ~~to enhance the fish population in Mono County~~ towards enhancement of Mono County's fish population, including sustainable fishing, ongoing fish stocking, education for proper catch and release practices, protection of spawning waterways, and support of the ~~California Department of Fish and Wildlife~~ stocking of diploid trout in allowable waters.

Commented [RL29]: Amendments to this Item recommended by Alicia Vennos

j) **Support the control of invasive species**

Support control and mitigation for the spread of invasive species to protect, conserve, and restore public and private lands.

k) **Support biomass project development**

Support legislation that encourages the US Forest Service (USFS) and Bureau of Land Management (BLM) to continue actively promoting and assisting with biomass project development.

l) **Support alternative energy**

i) Support local efforts to develop renewable, distributed energy sources including but not limited to environmentally and appropriately scaled biomass, solar, and wind, while ensuring projects and their supporting infrastructure (i.e., transmission lines, pipes lines, towers, service roads) does not degrade the County's quality of life, natural or visual resources, water or essence and history.
ii) Continue to support geothermal power production that is environmentally sustainable and doesn't negatively affect local domestic water supplies.

m) **Support Devils Postpile National Monument legislative requests**

Support legislation to authorize a boundary adjustment request, and to designate a portion of the Middle Fork San Joaquin River as Wild & Scenic, as described in Devils Postpile National Monuments 2015 Management Plan.

n) **Support endangered species conservation**

Support a balanced approach to the implementation of endangered species regulation with impacts to the rural economy and communities of Mono County. Mono County is fortunate to have a rich natural heritage that should be conserved, and it supports the need to protect and recover imperiled species. These conservation measures should be specifically tailored to the threats and circumstances in the Eastern Sierra and Mono County, and must be weighed and balanced against impacts to the fragile tourism and recreation-based rural economy and local communities. Every effort must be made to protect private property rights and avoid detrimental impacts to county residents.

o) ~~**Support Red Fox conservation**~~

~~In particular, the current proposed listing of the Sierra Nevada Red Fox should be carefully evaluated to ensure conditions specific to the Eastern Sierra/Mono County have been taken into account.~~

Commented [RL30]: Deletion of this Item recommended by Wendy Sugimura

p) **Support sage grouse conservation**

Mono County appreciates the strong support of the multi-party, collaborative Bi-State conservation effort, including several federal agencies such as the U.S. Fish and Wildlife Service, Bureau of Land Management, U.S. Forest Service (Inyo National Forest and Humboldt- Toiyabe National Forest), and U.S. ~~Geologic~~ Geological Survey. The coalition includes technical and scientific support, legislative and policy support, and funding to ensure conservation commitments ~~made during the 2015 listing withdrawal~~ are met and honored by federal agencies Ultimately, continuation of the collaborative partnership requires the federal agencies to remain stalwart in their commitments with the flexibility to address new issues, such as the ~~threat posed~~ management of water by the Los Angeles Department of Water and ~~Power's (LADWP's) dewatering of~~ Power (LADWP) in Long Valley, and adequate budgets to support a positive conservation outcome ~~such that a new decision can be made not to list the species under the federal Endangered Species Act~~. If the bird is listed, the result could be an additional regulatory burden with devasting impacts to ~~our~~ Mono County's agricultural and recreational activity-based economy.

Commented [RL31]: Amendments to this Item proposed by Wendy Sugimura

q) **Support legislation to avoid landfilling of waste originating on Federal Land**

Develop policies and programs that successfully re-use, recycle and transform resources that originate on USFS, BLM, and DOD lands. Support policies that reduce the impacts of Federally generated waste on local jurisdictions' waste management systems, and/or support policies that enhance local systems to effectively manage Federally-generated waste.

3) Public Safety and Criminal Justice

a) **Support full funding of Byrne Justice Assistance Grants**

Support the preservation of funding levels for existing safety programs such as the Byrne Justice Grant (Byrne/JAG) Program and oppose efforts to reduce or divert funding away from these programs.

b) **Support continued funding of FEMA's Assistance to Firefighters Grant (AFG) program**

Support continued funding to enhance the safety of the public and firefighters with respect to fire-related hazards by providing direct financial assistance to eligible fire departments, nonaffiliated Emergency Medical Services organizations, and State Fire Training Academies. This funding is for critically needed resources to equip and train emergency personnel to recognized standards, enhance operations efficiencies, foster interoperability, and support community resilience.

c) **Support legislation that resolves the conflict federal statutes have with legalization of recreational cannabis use in California**

Ideally, this includes removing cannabis as a schedule 1 drug and providing cannabis businesses with access to business banking services by changing federal banking access laws. Barring a legislative solution by Congress, the County supports reinstatement of the concepts stated in the past Justice Department memorandums allowing for commercial cannabis activities to operate free and clear of federal enforcement interference so long as the County has a robust regulatory framework in place.

d) **Urge common-sense gun safety legislation.**

e) **Support sustainable Federal Aviation Administration (FAA) funding for airport safety related projects on public and private property on or near our airports.**

4) Transportation and Infrastructure

a) **Ensure that federal transportation formulas support rural road infrastructure**

Mono County relies on the network of state highways and locally maintained roads to link residents to essential services. Transportation funding formulas should provide funding protections or guarantees for California's rural transportation system and reflect that rural counties lack viable means to fund larger projects that provide statewide benefit. We must advocate for formulas that distribute federal funds to support local transportation priorities.

b) **Support efforts to protect the Highway Trust Fund**

Support efforts protecting the Highway Trust Fund and programs that provide funding for local roads, bridges, and transit initiatives including pedestrian and bicycle systems, and other multi-modal transportation programs.

c) **Provide funding that maintains and enhances regional access across Federal Lands and National Parks**

Mono County supports budget policy and legislation that maintains, enhances, and extends the operational season of roads crossing federal lands and National Parks that provide access to communities, federal lands, national parks and monuments.

~~d) **Support federal highway access** Mono County supports budget policy and legislation that funds infrastructure such as roads on federal land with access to popular destinations including national parks and monuments.~~

~~e)~~d) **Support Yosemite Area Regional Transportation and Eastern Sierra Transit Authority funding**

Support efforts to seek sustainable funding for regional public transportation to Yosemite National Park, other National Parks in our region, and other public lands destinations throughout the Eastern Sierra.

~~f)~~e) **Support the resurgence of the Scenic Byway program**

Mono County completed a Scenic Byway Corridor Plan through a federal grant, then shelved the plan because the Scenic Byway program was not funded. The program has been re-established, and continuity of funding is needed for jurisdictions to dust off inactive plans, program their implementation into the workflow again, and being making an impact.

5) Health and Human Services

a) **COVID 19**

Support and advocate for any legislative or budgetary action, including stimulus money, related to the response, recovery and/ or economic impacts of COVID-19 both during the emergency and the long-term effects of the pandemic.

Commented [RL32]: Addition of this Item recommended by Kathy Peterson

b) **Disaster Response**

Support measures that increase resources for disaster response initiatives requiring county involvement.

Commented [RL33]: Addition of this Item recommended by Kathy Peterson

c) **Support Cost-Neutral Federal Mandates**

Support full funding to ensure that federal mandates are cost-neutral to the County and pursue revisions to streamline the process for local government.

d) **Oppose legislation to repeal the Affordable Care Act (ACA)**

Work to preserve and expand the number of citizens currently receiving health insurance. Oppose efforts to reduce benefits and block grants or other actions that would shift the current federal/state cost and responsibility to the states and counties.

e) **Ensure that Affordable Care Act (ACA) funding is maintained for local governments**

Support the Prevention and Public Health Fund of the ACA, the nation's first dedicated mandatory funding stream for public health and prevention activities, which supports Mono County health care services to underserved residents.

f) **Medi-Cal Funding**

Support all efforts to adequately fund the federal Medicaid program. Similarly, oppose all efforts to block grant, cap or otherwise reduce federal and state funding to support this critical safety net program.

g) **Administration of the Medi-Cal program**

Fully fund county costs for County administration of the Medi-Cal program.

h) **Managed Care Medi-Cal**

Advocate for a Medi-Cal Managed Care model that generates high healthcare quality scores, increases primary care capacity, improves coordination of care, and conducts outreach to enroll uninsured populations.

i) ~~**Oppose funding reductions for Medicaid**~~

~~Oppose efforts to reduce or block grant federal funding for Medicaid administration or benefits, including efforts to place a per- capita cap on funding or limiting the ability of states to leverage funds through assessments on providers.~~

~~j) **Oppose federal efforts mandating states to require work as a condition for receiving Medicaid benefits.**~~

~~k)~~j) **Oppose other eligibility changes, including but not limited to elimination of retroactive benefits or grace periods for eligibility pending verifications.**

~~l)~~k) **Oppose turning Medicaid over to States**

Oppose efforts to turn Medicaid (Medi-Cal in California) over to the states with less federal funding.

~~m)~~l) **Support full funding of programs that provide health insurance to children.**

~~n)~~m) **Support funding of Veterans benefits**

Support provision and funding for current benefits and health care programs for Veterans.

~~o)~~n) **Support Women's Rights to Health**

Health care is key to women's well-being and economic stability. Support provisions that make sure new health care law works for women.

~~p)~~o) **Support Child Welfare**

i) **Federal Family First Prevention Services Act of 2018**
Advocate for full federal and state funding of the Federal Family First Prevention Services Act of 2018 (P.L. 115-123) enacted to reform the federal foster care system.

~~i) Support amendments to the Family First Prevention Services Act to better align the FFPSA with California's Continuum of Care Reform initiatives and prevention services provided in the state.~~

ii) Support efforts to reform child welfare financing, including expanding the types of prevention activities eligible for the IV-E foster care financial match.

iii) Support a provision allowing for "skyping" with non-minor youth in the extended foster care program when the youth is attending college or living in another state or out of country as an alternative to monthly, in-person visits.

iv) Support increased federal funding for services and income support needed by parents seeking to reunify with their children in foster care.

v) Support increased federal financial support for programs that assist foster youth in the transition to self-sufficiency, including post- emancipation assistance such as secondary education, job training, and access to health care.

vi) Support retaining the entitlement nature of the Title IV-E Foster Care and Adoption Assistance programs and eliminate outdated rules that base the child's eligibility for funds on parental income and circumstances.

~~vii) Support legislation that would provide tax credits to companies that hire current or former foster youth.~~

~~viii)~~vii) Support increased federal funding to respond to the service needs of youth who are victims of commercial sexual exploitation.

~~q)~~p) **Support legislation to combat human trafficking**

Support legislation that will develop or enhance programs and services to combat the negative impact that human trafficking and commercial sexual exploitation of children has on victims and support efforts to provide additional tools, resources, and funding to help counties address this growing problem.

~~r)~~q) **Support the enhancement of childcare and development**

Support measures that enhance the overall quality, affordability, capacity, accessibility, and safety of childcare and development programs. Specifically, support legislation and budget action that would:

i) Ensure continuity of childcare for children and families.
ii) Preserve, protect and increase funding for subsidized and other government-funded childcare.

s)r) **Oppose Immigration Reform**

Oppose immigration reform efforts that would eliminate a pathway to full and equal citizenship, that would restrict the rights of immigrants or break up families, or that would focus on a mass deportation of undocumented immigrants.

t) **Oppose Legal Immigrant Benefit Changes**

i) Oppose the Administration's regulatory efforts to include non-cash benefits in the definition of 'public charge'.
ii) Oppose federal efforts to further restrict legal immigrants' access to federal benefits.

Commented [RL34]: Deletion of this Item recommended by Kathy Peterson

u)s) **Temporary Assistance for Needy Families (TANF) Reauthorization**

i) Support increased federal support for TANF/CalWORKS subsidized employment programs.
ii) Support more flexible work participation requirement measures to give credit for client engagement and for work activities not meeting the current thresholds.
iii) Support the ability of states to provide and receive federal support for vocational education and career technical training for longer than 12 months.

iv) Support new federal measures demonstrating success in meeting outcomes rather than processes that would align with the CalWORKs Outcomes and Accountability Review (CalOAR) process underway in the state.
v) Support federal efforts aligning with the goals and vision of the CalWORKs 2.0 Strategic Initiative to better meet the needs of individual families and support families in a more holistic way.

Commented [RL35]: Deletion of these Items recommended by Kathy Peterson

v)t) **Supplemental Nutrition Assistance Program (SNAP)**

i) Oppose proposed rules to limit eligibility, reduce benefits and/or limit state and county flexibility in administering the Supplemental Nutrition Assistance Program (SNAP/CalFresh).
ii) Oppose efforts to block grant or otherwise limit the federal contribution to SNAP/CalFresh.
iii) Oppose federal mandates to require states to increase SNAP/CalFresh work requirements.

Commented [RL36]: Deletion of these Items recommended by Kathy Peterson

i) Support a thorough review and updates to the U.S. Department of Agriculture's (USDA) Thrifty Food Plan (TFP) to more accurately account for the cost of food, dietary needs, purchasing patterns and regional differences in food costs, housing and medical care,

which affect the purchasing power of Supplemental Nutrition Assistance Program (SNAP) benefits.

ii) Support increased nutritional supplementation efforts at the state and federal levels, including increased aid, longer terms of aid, and increased access for those in need.

~~iv)~~iii) Support extending Able Bodied Adults Without Dependents work requirement waivers for as many counties and sub-county regions as possible.

~~v)~~iv) Support further collaboration with the federal government and national partners to increase outreach and enrollment for SNAP/CalFresh, especially in underserved populations such as students, former foster youth, non-English-speaking populations and seniors.

~~vi)~~v) Support provisions to further streamline and simplify federal requirements for SNAP/CalFresh recipients to enhance enrollment and retention.

~~vii)~~vi) Support additional flexibility for states to align SNAP/CalFresh eligibility and processes with state TANF/CalWORKS programs.

~~viii)~~vii) Support efforts to improve timeliness of data provided by the Food and Nutrition Services (FNS) to states for use in administering SNAP/CalFresh.

~~w)~~u) **~~Support the Older Americans Act (OAA)~~**

~~Support the Older Americans Act (OAA) and increased federal funding for the OAA programs. The Act established a national network of Area Agencies on Aging (AAA) which oversee a variety of social services for seniors, including nutrition, elder abuse prevention, legal services and advocacy, and caregiver resources. The OAA is not adequately funded and does not reflect the need for senior services or the population growth of people over age 60. With the limited state funding to support California's AAA programs, it is critical that the federal funding expand to support senior services.~~

Commented [RL37]: Deletion of this Item as duplicative recommended by Kathy Peterson

~~x)~~v) **Support Adult and Disability Services**

Support legislation that would provide adequate funding such as state-only funded programs, programs authorized under the Older Americans Act, a return to full funding for Social Services Block Grant (SSBG) programs and increases to the SSBG allocation to keep up with inflation and population growth.

~~i) Support full appropriations of $100 million authorized under the Elder Justice Act to support state and county adult protective services programs.~~

~~ii) Oppose the termination of the Social Services Block Grant, which in California is used primarily to augment county and state funded in-home supportive services for elderly and disabled persons, and to coordinate services to children with disabilities.~~

~~iii) Support the Older Americans Act OAA reauthorization and increased federal funding for the OAA programs.~~

Commented [RL38]: Amendments to this Item recommended by Kathy Peterson

~~y)~~w) **Support Homelessness Legislation**

Support federal homelessness legislation funding an array of services to individuals and families at risk of or who are experiencing homelessness.

~~z)~~x) **Support State and Federal funding and regulatory changes or guidance that supports landlords and tenants, and prevents homelessness resulting from COVID-19 related financial impacts.**

Commented [RL39]: Addition of this Item recommended by Kathy Peterson

County Attractions

TOP ATTRACTIONS

YOSEMITE NATIONAL PARK Drive California's highest pass to Yosemite's east entrance—just 12 miles from Lee Vining—for ten-story waterfalls, iconic granite domes, rock climbing, hiking, and more (pass closed in winter). *www.NPS.gov/yose • 209-372-0200 • Bus service: www.Yarts.com*

MONO LAKE This ancient inland sea with its unique limestone formations and alkaline waters is home to hundreds of bird species! Learn more at: *Mono Basin Scenic Area Visitor Center 760-647-3044 • Mono Lake Committee www.MonoLake.org • 760-647-6595*

DEVILS POSTPILE NATIONAL MONUMENT Located near Mammoth Lakes, Devils Postpile is one of the world's finest example of columnar basalt formations. *www.NPS.gov/depo • 760-924-5500*

BODIE STATE HISTORIC PARK With about 200 buildings still standing—thanks to ongoing preservation efforts—keep an eye out for spirits roaming the once-wild streets of this genuine gold-mining ghost town. *www.Parks.CA.gov • 760-647-6445 www.BodieFoundation.org*

WHAT LIES BEYOND?

When the things right in front of us turn invisible and the everyday loses its magic, you know it's time to go beyond.

Beyond the traffic, the deadlines and the incessant chatter of so-called civilization.

A journey to Mono County will take you to a California you didn't even imagine existed. A land of lava and ice, sparkling clear waters, miles of hiking trails and dozens of secret fishing holes.

Discover rock formations from another world at Mono Lake and Gold Rush history at Bodie ghost town. You'll also find genuine local hospitality, like a welcome from another era.

It takes a bit of traveling to get here, but that's the way we like it. Because once you're out here, you'll start to see again.

Welcome to Mono County: California's Great Beyond.

TOWNS & COMMUNITIES

BENTON HOT SPRINGS Soak in hot tubs fed by natural hot springs at the Historic Benton Inn. Once a bustling Wells Fargo stagecoach station, Old Benton offers a self-guided tour of numerous original buildings, historic sites and the cemetery.

BRIDGEPORT Gateway to Bodie ghost town and home of the county seat, Bridgeport's iconic courthouse has been in use since 1880. The California state-record brown trout, at **26 lbs 8 oz**, was caught in Bridgeport's Twin Lakes.

CONVICT LAKE / McGEE CREEK Dramatically situated under towering Mt. Morrison, Convict Lake is loved by anglers, hikers, and...wedding parties! Catch wildflowers or fall colors at McGee Creek Canyon—hiking or on horseback.

CROWLEY LAKE Fishing season opener's home base, this expansive lake offers world-class trout fishing.

JUNE LAKE Tucked away at the base of 10,909-ft. Carson Peak, June Lake is a scenic mountain hideaway. Famous for trout fishing and brilliant fall colors, the June Lake Loop is a snowy retreat in winter. June Mountain Ski Area offers free lift tickets every day, all winter long for kids age 12 and under.

LEE VINING Overlooking dramatic Mono Lake, Lee Vining is the gateway town to Yosemite National Park—just 12 breath-taking miles up Tioga Pass Road/SR 120.

MAMMOTH LAKES Mammoth Mountain Ski Area consistently ranks as one of the top winter sports destinations in North America. In the town of Mammoth Lakes, you'll find quaint shops, gourmet restaurants and accommodations from cozy cabins to four-star luxury hotels.

ROCK CREEK / TOM'S PLACE With beautiful Little Lakes Valley hiking trail, fall colors and winter "Adventure Dining" at Rock Creek Lodge—complete with snowmobile taxi—Rock Creek Canyon is magical all four seasons.

TOPAZ At the northern tip of the county, Topaz Lake boasts a nine month fishing season, a big cash derby and a Nevada casino.

WALKER AND COLEVILLE Ranch towns in the northern part of Mono County, Walker and Coleville host California's only ATV/UTV Jamboree every September!

VISITOR AMENITIES

LODGING With more than 140 hotels, motels, bed & breakfast inns, cabins and campgrounds, Mono County has a diverse lodging base—from deluxe spa hotels to rustic cottages and scenic RV parks.

DINING There are more than 100 restaurants, cafés, pubs and bakeries to choose from throughout Mono County, with options ranging from traditional comfort food to delicious ethnic cuisine and fine dining.

SHOPPING If you're looking for Macy's, you won't find it in Mono County! However, with over 125 stores to browse through, you'll find intriguing shops, art galleries, Native American crafts, fishing and sports gear, and unique souvenirs in every community.

MUSEUMS The Mono County Museum in Bridgeport, Mono Basin History Museum and Upside-Down House, Hayden Cabin in Mammoth Lakes and Benton Historical Society all bring the region's rich history to life with unique exhibits.

VISITOR INFORMATION Mammoth Lakes Welcome Center, Mono Basin Scenic Area Visitor Center and Mono Lake Committee Information Center in Lee Vining, as well as the Bridgeport Ranger Station provide maps, guide books, permits, and visitor info.

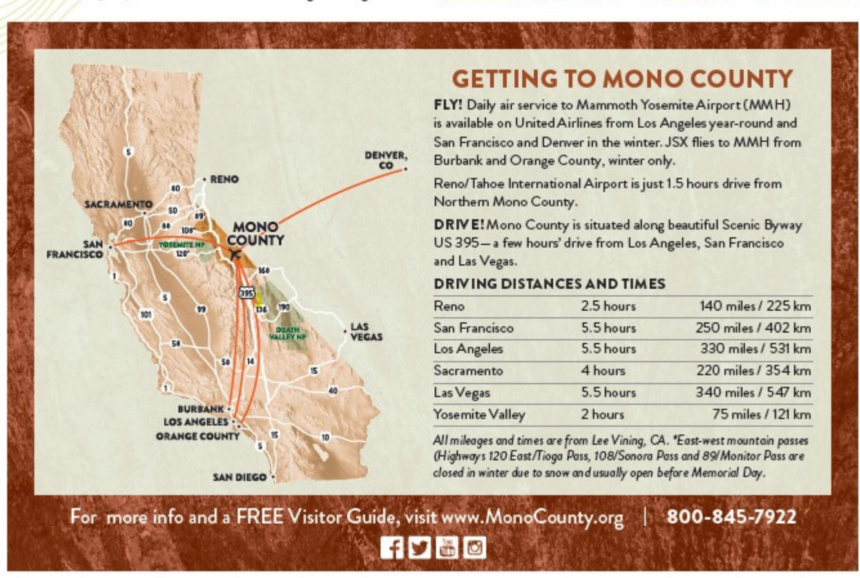
TOP MONO COUNTY ACTIVITIES

SUMMER
- Hiking, Backpacking & Rock Climbing
- Fishing & Camping
- Mountain Biking & Road Cycling
- Kayaking & Canoeing
- Horseback Riding
- ATVs & Off-Highway Vehicles

WINTER
- Skiing & Snowboarding
- Cross Country Skiing
- Snowshoeing & Ice Skating
- Snowmobiling
- Dog-Sledding
- Sledding & Tubing

2020 EVENTS HIGHLIGHTS

Event	Location	Date
Fishing Season Opener	Mono County	Apr 25
Mammoth Lakes Film Festival	Mammoth Lakes	May 20-24
Mono Basin Bird Chautauqua	Lee Vining	Jun 19-21
How Big Is Big Fishing Derby	Walker / Coleville	Jul 1-31
Old-Fashioned 4th of July	Bridgeport	Jul 2-5
Mammoth Festival of Beers & Bluesapalooza	Mammoth Lakes	Aug 1-2
Friends of Bodie Day	Bodie	Aug 7-8
Founders' Day Celebrations	Bridgeport	Sep 4-7
Eastern Sierra ATV/UTV Jamboree	Walker / Coleville	Sep 8-12
Ambush at the Lake Fishing Derby	Convict Lake	Oct 1 – Nov 15
Leaves in the Loop	June Lake	Oct 16-18
Benton Hot Springs Victorian Christmas Dinner	Old Benton	Dec 12



GETTING TO MONO COUNTY

FLY! Daily air service to Mammoth Yosemite Airport (MMH) is available on United Airlines from Los Angeles year-round and San Francisco and Denver in the winter. JSX flies to MMH from Burbank and Orange County, winter only.

Reno/Tahoe International Airport is just 1.5 hours drive from Northern Mono County.

DRIVE! Mono County is situated along beautiful Scenic Byway US 395—a few hours' drive from Los Angeles, San Francisco and Las Vegas.

DRIVING DISTANCES AND TIMES

Destination	Time	Distance
Reno	2.5 hours	140 miles / 225 km
San Francisco	5.5 hours	250 miles / 402 km
Los Angeles	5.5 hours	330 miles / 531 km
Sacramento	4 hours	220 miles / 354 km
Las Vegas	5.5 hours	340 miles / 547 km
Yosemite Valley	2 hours	75 miles / 121 km

*All mileages and times are from Lee Vining, CA. *East-west mountain passes (Highways 120 East/Tioga Pass, 108/Sonora Pass and 89/Monitor Pass are closed in winter due to snow and usually open before Memorial Day.*

For more info and a FREE Visitor Guide, visit www.MonoCounty.org | **800-845-7922**

Elected State Representatives:

Assembly Member Frank Bigelow 5th Assembly District State Capitol, Suite #4153 Sacramento, CA 94249 Capitol Office Phone: (916) 319-2005 District Office Phone: (559) 673-0501 Website: https://ad05.asmrc.org	Senator Andreas Borgeas 8th Senate District State Capitol, Room 3082 Sacramento, CA 95814-4900 Capitol Office Phone: (916) 651-4008 District Office Phone: (559) 243-8580 Fax: (916) 651-4908 Website: http://borgeas.cssrc.us/
Governor Gavin Newsom State Capitol, Suite 1173 Sacramento, CA 95814 Phone: (916) 445-2841 Fax: (916) 558-3160 Website: http://gov.ca.gov/	

Elected Federal Representatives:

Senator Alex Padilla United States Senate Russell Senate Office Building, Suite B03 Washington, D.C. 20510 Phone: (202) 224-3553 Fax: (202) 224-2200 Website: http://padilla.senate.gov/	Senator Dianne Feinstein United States Senate 331 Hart Senate Office Building Washington, D.C. 20510 Phone: (202) 224-3841 Fax: (202) 228-3954 TTY/TDD: (202) 224-2501 Website: http://feinstein.senate.gov/
Representative Jay Obernolte 8th Congressional District 1029 Longworth House Office Building Washington, DC 20515 Phone: (202) 225-5861 Website: http://obernolte.house.gov/	

County of Mono
Post Office Box 696
Bridgeport, California 93517
(760) 932-5410
www.mono.county.ca.gov

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

TIME REQUIRED

SUBJECT Closed Session - Labor Negotiations

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

CONFERENCE WITH LABOR NEGOTIATORS. Government Code Section 54957.6. Agency designated representative(s): Bob Lawton, Stacey Simon, Janet Dutcher, and Dave Wilbrecht. Employee Organization(s): Mono County Sheriff's Officers Association (aka Deputy Sheriff's Association), Local 39 - majority representative of Mono County Public Employees (MCPE) and Deputy Probation Officers Unit (DPOU), Mono County Paramedic Rescue Association (PARA), Mono County Public Safety Officers Association (PSO). Unrepresented employees: All.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME:

PHONE/EMAIL: /

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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No Attachments Available

History

Time	Who	Approval

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

TIME REQUIRED

SUBJECT Closed Session - Public Employee Evaluation

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

PUBLIC EMPLOYEE PERFORMANCE EVALUATION. Government Code section 54957. Title: County Administrative Officer.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME:

PHONE/EMAIL: /

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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History

Time	Who	Approval

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

TIME REQUIRED

SUBJECT Closed Session - Public Employee Evaluation

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

PUBLIC EMPLOYEE PERFORMANCE EVALUATION. Government Code section 54957. Title: County Counsel.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME:

PHONE/EMAIL: /

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MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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History

Time	Who	Approval
2/10/2021 9:54 AM	County Counsel	Yes
2/9/2021 9:58 AM	Finance	Yes
2/12/2021 9:06 AM	County Administrative Office	Yes

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

TIME REQUIRED

SUBJECT Closed Session - Existing Litigation

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Paragraph (1) of subdivision (d) of Government Code section 54956.9. Name of case: Abshire et. al, v. Newsom, et al. (US Dist. Ct. for the Eastern District 2:21-cv-00198-JAM-KJN).

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME:

PHONE/EMAIL: /

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

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History

Time	Who	Approval

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Economic Development

TIME REQUIRED 15 minutes

SUBJECT New Statewide Inland Trout Fishing Regulations for the 2021-2022 Fishing Season

PERSONS APPEARING BEFORE THE BOARD Jeff Simpson, Economic Development Manager

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

The California State Fish and Game Commission approved new Statewide Inland Trout Fishing Regulations for the 2021-2022 fishing season. The current 2020-2021 regulations remain in effect through Feb. 28, 2021. The new regulations will go into effect on: March 1, 2021.

RECOMMENDED ACTION:

None, informational only.

FISCAL IMPACT:

None.

CONTACT NAME: Jeff Simpson

PHONE/EMAIL: 760-924-4634 / jsimpson@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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Staff Report
CDFW Regulation Change Flyer

History

Time	Who	Approval
2/10/2021 9:55 AM	County Counsel	Yes
2/10/2021 9:35 AM	Finance	Yes
2/12/2021 9:05 AM	County Administrative Office	Yes

MONO COUNTY
ECONOMIC DEVELOPMENT and SPECIAL PROJECTS

P.O. BOX 603, MAMMOTH LAKES, CALIFORNIA 93546
(760) 924-4634 • (760) 924-1697 (Fax)

Alicia Vennos
Economic Development Manager
Avennos@mono.ca.gov
760-924-1743

Jeff Simpson
Economic Development Manager
Jsimpson@mono.ca.gov
760-924-4634

STAFF REPORT

SUBJECT: New Statewide Inland Trout Fishing Regulations for the 2021-2022 Fishing Season.

RECOMMENDATION: Informational only. Give any desired direction to staff.

BACKGROUND: The California State Fish and Game Commission approved new Statewide Inland Trout Fishing Regulations for the 2021-2022 fishing season. The current 2020-2021 regulations remain in effect through Feb. 28, 2021. The new regulations will go into effect on: March 1, 2021.

The California Department of Fish and Wildlife held numerous outreach meetings and public comment periods including in person meetings in Bridgeport and Bishop in 2019. Staff and members of the Mono County Fish and Wildlife Commission attended these meetings.

DISCUSSION: **Below are some significant changes for Inyo and Mono Counties.**

- All Lakes and Reservoirs in Inyo and Mono counties will open to year-round trout fishing with a 5/10 bag/possession limit on **March 1, 2021.**
    - **EXCEPT**
    - *(those listed in the alphabetical list of special regulations by water name).
    - ***Specifically, Crowley Lake and 19 other "Resort Lakes" will NOT open on March 1, 2021.**
    - *(These lakes retain the traditional "Fishmas" opening and closing dates. The last Saturday in April through November 15). (Bridgeport Reservoir and tributaries; Convict Lake; Crowley Lake; George Lake; Grant Lake; Gull Lake; Horseshoe Lake; June Lake; Lundy Lake; Mamie Lake; Mary Lake; Rock Creek Lake; Sabrina Lake; Silver Lake; South Lake; Twin Lakes (Mammoth); Twin Lakes, Lower and Upper (Bridgeport); Virginia Lake, Lower and Upper).
- All Rivers and Streams in Inyo and Mono counties will open to **catch and release trout fishing** (only artificial lures with barbless hooks, 0 fish limit) **on March 1, 2021.**
    - **EXCEPT**
    - *(those listed in the alphabetical list of special regulations by water name). **They are currently closed through Feb. 28, 2021.**
- All Rivers and Streams in Inyo and Mono counties open to trout fishing with a 5/10 bag/possession limit on the **last Saturday in April 2021 through November 15, 2021.**

- *(except those listed in the alphabetical list of special regulations by water name).
- There are 60 waters, or sections of a water, or geographic area listed in the alphabetical list of special regulations by water name, section, area within Inyo and Mono counties.

See the new CDFW 2021-2022 fishing regulations on their website at:
https://wildlife.ca.gov/Fishing/Inland/Trout-Plan/Regulation-Simplification
Table of proposed changes to waters with special fishing regulations (section 7.50) (PDF)
Smart phone regulations maps: https://apps.wildlife.ca.gov/sportfishingregs/

FISCAL IMPACT: None.

ATTENTION ANGLERS

The California State Fish and Game Commission has approved NEW Statewide Inland Trout Fishing Regulations for the 2021-2022 fishing season.

The current 2020-2021 regulations remain in effect through Feb. 28, 2021.

The new regulations will go into effect on:

MARCH 1, 2021.

Below are some significant changes for INYO and MONO county.

- All Lakes and Reservoirs in Inyo and Mono counties will open to year-round trout fishing with a 5/10 bag/possession limit on **March 1, 2021.**

EXCEPT

*(those listed in the alphabetical list of special regulations by water name).

***Specifically, Crowley Lake and 19 other "Resort Lakes" will NOT open on March 1, 2021.**

*(These lakes retain the traditional "Fishmas" opening and closing dates. The last Saturday in April through November 15).

(Bridgeport Reservoir and tributaries; Convict Lake; Crowley Lake; George Lake; Grant Lake; Gull Lake; Horseshoe Lake; June Lake; Lundy Lake; Mamie Lake; Mary Lake; Rock Creek Lake; Sabrina Lake; Silver Lake; South Lake; Twin Lakes (Mammoth); Twin Lakes, Lower and Upper (Bridgeport); Virginia Lake, Lower and Upper).

- All Rivers and Streams in Inyo and Mono counties will open to **catch and release trout fishing** (only artificial lures with barbless hooks, 0 fish limit) **on March 1, 2021.**

EXCEPT

*(those listed in the alphabetical list of special regulations by water name).

They are currently closed through Feb. 28, 2021.

- All Rivers and Streams in Inyo and Mono counties open to trout fishing with a 5/10 bag/possession limit on the **last Saturday in April 2021 through November 15, 2021.**

*(except those listed in the alphabetical list of special regulations by water name).

- There are 60 waters, or sections of a water, or geographic area listed in the alphabetical list of special regulations by water name, section, area within Inyo and Mono counties.

See the new CDFW 2021-2022 fishing regulations on our website at:
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Table of proposed changes to waters with special fishing regulations (section 7.50) (PDF)

Smart phone regulations maps: https://apps.wildlife.ca.gov/sportfishingregs/

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: Social Services; Public Health; Behavioral Health

TIME REQUIRED Item scheduled to start at 1:30 PM (45 minutes)

SUBJECT Discussion of MediCal Managed Care and Presentation from Inland Empire Health Plan

PERSONS APPEARING BEFORE THE BOARD Kathy Peterson, Mono Social Services; Meaghan McCamman, Inyo HHS

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

A brief presentation on the upcoming procurement of new MediCal managed care plans through the state Department of Health Care Services will be provided, followed by a presentation from Inland Empire Health Plan.

RECOMMENDED ACTION:

Receive presentation on the upcoming procurement of new MediCal managed care plans through the state Department of Health Care Services followed by a presentation from Inland Empire Health Plan on the possibility of partnering with Mono County to provide Medi-Cal Managed Care Services for Mono County Medi-Cal beneficiaries. Provide staff direction.

FISCAL IMPACT:

None.

CONTACT NAME: Kathryn Peterson

PHONE/EMAIL: 7609376518 / kpeterson@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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staff report
Attachment A
Attachment B
Attachment C
Attachment D
Attachment E

History

Time	Who	Approval
2/11/2021 3:55 PM	County Counsel	Yes
2/11/2021 2:13 PM	Finance	Yes
2/12/2021 9:07 AM	County Administrative Office	Yes

Office of the ... DEPARTMENT OF SOCIAL SERVICES

COUNTY OF MONO

P. O. Box 2969 • Mammoth Lakes • California 93546

KATHRYN PETERSON, MPH
Director

BRIDGEPORT OFFICE
(760) 932-5600
FAX (760) 932-5287

MAMMOTH LAKES OFFICE
(760) 924-1770
FAX (760) 924-5431

To: Mono County Board of Supervisors

From: Kathy Peterson, Social Services Director

Date: February 11, 2021

Re: Discussion of MediCal Managed Care and presentation from Inland Empire Health Plan

Recommended Action:
Receive presentation on the upcoming procurement of new MediCal managed care plans through the state Department of Health Care Services followed by a presentation from Inland Empire Health Plan on the possibility of partnering with Mono County to provide Medi-Cal Managed Care Services for Mono County Medi-Cal beneficiaries. Provide staff direction.

Fiscal Impact:
Discussion only.

Discussion:
Beginning in late 2013, California's Medi-Cal program expanded managed care into 28 primarily rural counties, including Inyo and Mono counties. The 2013 expansion of managed care completed the transformation of California's Medi-Cal program from fee-for-service delivery (state management and payment of claims for services submitted by providers) to managed care (state contracting with public and private health plans that arrange and pay for services.)

The state has implemented a variety of managed care models over the years, including County Organized Health Systems (COHS), in which one public plan serves an entire county, the Two-Plan Model, which provides beneficiaries a choice between a private and public plan, a Geographic Managed Care Model, which offers a wide variety of plan options, and, in Inyo County and in other very remote rural areas, the Regional model, served by two commercial health plans. Mono County's commercial health plans are Anthem Blue Cross and California Health and Wellness (owned by Health Net).

After several years and lessons learned, the state Department of Health Care Services is preparing a mass procurement of private/commercial Medi-Cal managed care plans. Many small rural counties served by the Regional Model are looking at this procurement as an opportunity to move to a different managed care model –specifically COHS or a Two-Plan model, both of which include a locally-governed, public health plan. While many Northern California counties are looking to join Partnership Health Plan, and those on the West side of the Sierra Nevada are in conversations with the Health Plan of San Joaquin, Inyo County Health and Human Services staff (and now Mono County) has begun exploratory conversations with the Inland Empire Health Plan, which serves San Bernardino and Riverside Counties.

A brief presentation on the upcoming procurement of new MediCal managed care plans through the state Department of Health Care Services will be provided, followed by a brief presentation from Inland Empire Health Plan. Following this, staff would like Board direction regarding next steps.

The attached documents include a presentation by Inland Empire Health Plan; additional background on Medi-Cal managed care and the 2013 expansion to the rural counties; and a State Auditor report about oversight of the Regional Model counties.

Overview of IEHP

IEHP® A Public Entity Inland Empire Health Plan

Jarrod McNaughton, MBA, FACHE | Chief Executive Officer

February 2021

History of IEHP

A Local Initiative serving residents of Riverside and San Bernardino counties.*

A Public Entity, formed as a Joint Powers Agency (JPA), created by Riverside and San Bernardino counties. IEHP became operational on September 1, 1996 and was organized as a Public Agency, Non-Profit HMO.

A mixed model HMO as follows:

- Contracts with Independent Physician Associations (IPA)
- Direct physician contracting

A two-plan model:

- One local initiative (IEHP) and One commercial plan (Molina)

*Partial Counties

History of IEHP

As a Public Agency IEHP must:

- **Act Responsibly**

  Accountable to both Riverside and San Bernardino County Board of Supervisors

- **Hold Board Meetings in Public Places**

  Monthly meetings are held at IEHP Headquarters in Rancho Cucamonga

- **Be Accountable to the Public Subject to:**

  State Brown Act — Conflict of Interest

  Public Records Act — Competitive Bidding for Contracts, etc.

- **Have a not-for-profit, Public Benefit Mission that is Primary, NOT Profit**

IEHP Governing Board

Comprised of Seven Board Members

Four Elected County Supervisors	Three Appointed Members of the Public
Karen Spiegel, Chair Riverside County Supervisor	Dr. Dan Anderson Riverside County Public Member
Curt Hagman, Vice-Chair San Bernardino County Supervisor	Eileen Zorn San Bernardino County Public Member
Jeff Hewitt Riverside County Supervisor	Andrew Williams Joint County Public Member
Dawn Rowe San Bernardino County Supervisor	

MISSION

We heal and inspire the human spirit.

VISION

We will not rest until our communities enjoy optimal care and vibrant health.

VALUES

We do the right thing by:

- Placing our Members at the center of our universe.
- Unleashing our creativity and courage to improve health & well-being.
- Bringing focus and accountability to our work.
- Never wavering in our commitment to our Members, Providers, Partners, and each other.

Medi-Cal

What is Medi-Cal?

Medi-Cal is a no-cost or low-cost health coverage program. It provides health, dental and vision* coverage to qualified California residents.

Who can apply for Medi-Cal and join IEHP?

People who live in our service area (most of Riverside and San Bernardino counties)

Adults with or without children, children, seniors, and people with a disability

People who meet income guidelines and other program requirements.

IEHP Dual Choice Cal MediConnect
(Medicare-Medicaid Plan)

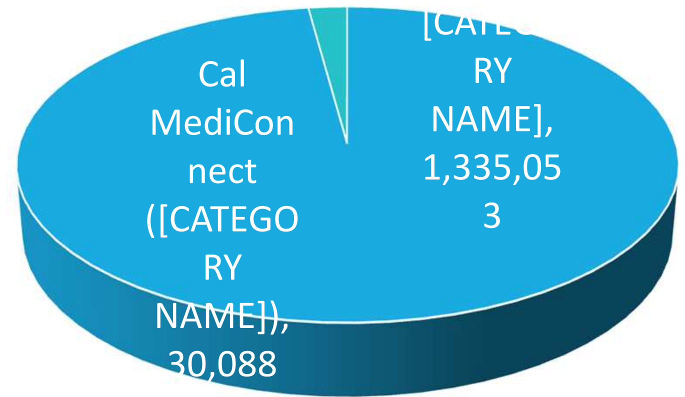
What is IEHP DualChoice?

A Cal MediConnect Plan is organized to improve care by integrating Medicare and Medi-Cal Benefits, long-term care, behavioral health and home and community-based services.

Who is eligible for IEHP DualChoice?

People with both Medicare (Part A and Part B), Medi-Cal, are not apart of the "excluded population" (i.e., under age 21, reside in rural zip code, etc.) and who live in our service area (most of Riverside and San Bernardino counties).

IEHP Membership



<u>Active membership by county:</u>

Riverside County = 689,643

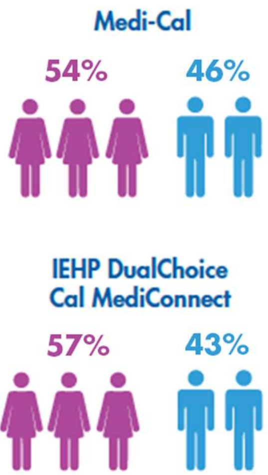
San Bernardino County = 673,756

As of January 2021

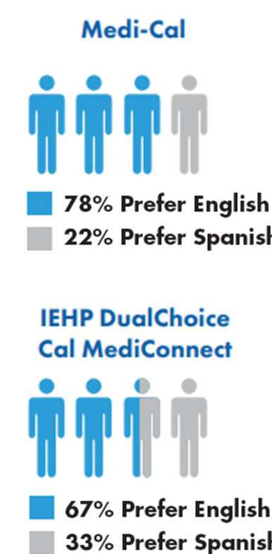
Region	Medi-Cal	CMC
High Desert	13%	13%
San Bernardino Proper	27%	30%
Low Desert	11%	15%
Temecula/Corona/Hemet	19%	19%
Riverside Proper	19%	15%
West San Bernardino	11%	8%

IEHP Membership Profile

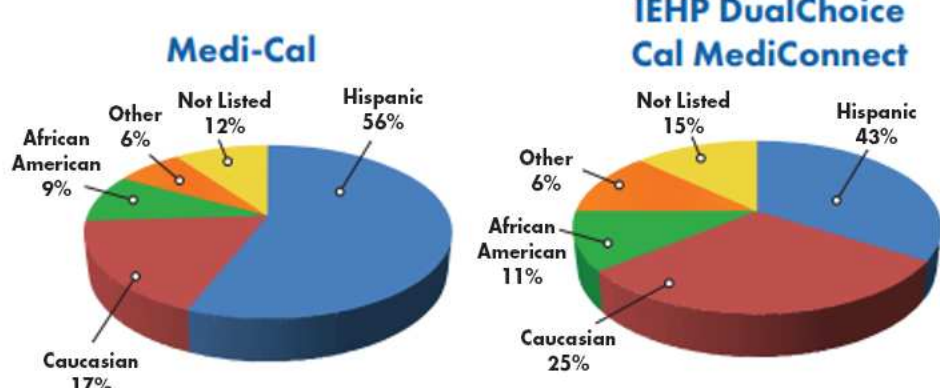
Gender



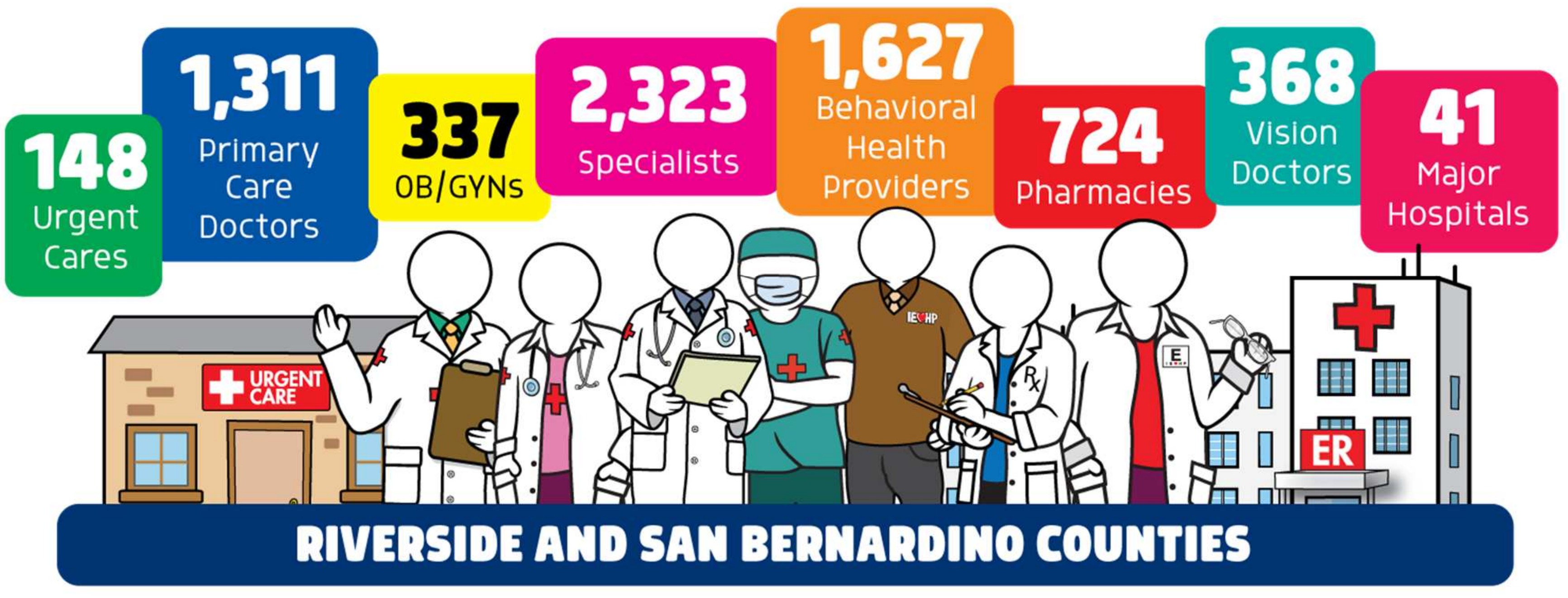
Language



Ethnicity



IEHP Provider Network



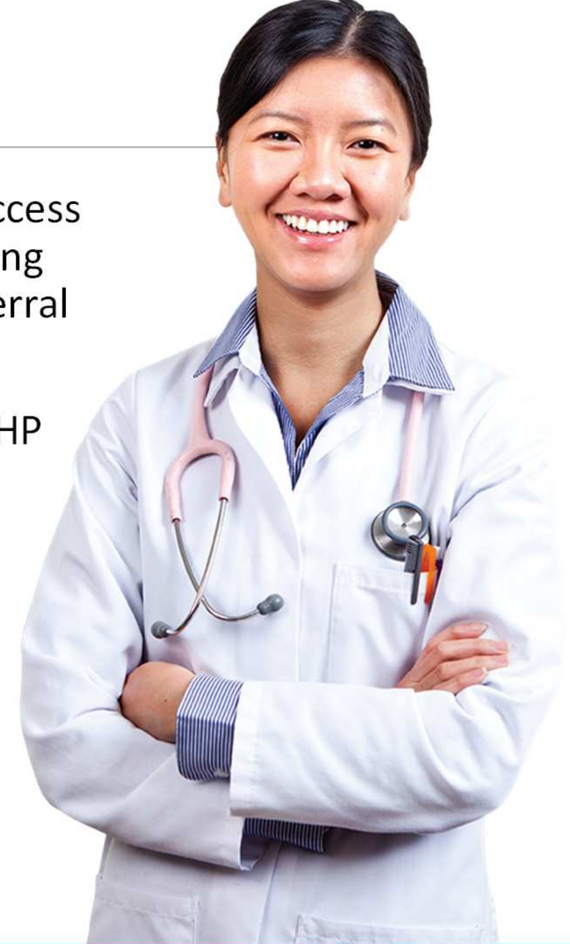
Provider Satisfaction

The 2021 Provider Satisfaction Survey focused on key drivers, including: Access to care managers, helpfulness of the health plan call center staff in obtaining referrals for patients, and the timeliness of obtaining pre-certification, referral or authorization information.

Of the Providers who responded, **98.7%** shared that they'd recommend IEHP to other physicians' practices. IEHP ranked within the **99th percentile** for:

- Provider Relations
- Health plan call center staff
- Pharmacy
- Utilization and quality management
- Coordination of care

IEHP also ranked in **98th percentile** in the financial category.



IEHP Receives Innovation Award

Inland Empire Health Plan (IEHP) was awarded the prestigious California Department of Healthcare Services (DHCS) Innovation Award for 2020.

The award was based on IEHP's groundbreaking work using location intelligence to reach high-risk members and providers in geographic areas affected by power outages, wildfires, and other natural disasters.

IEHP has received this award more than any other health plan in the state.

Please remove this slide if presenting before January 31, 2021.

IEHP Named 2020 Inland Empire Top Workplace

- Awarded by the Inland Empire Newsgroup, IEHP was recognized for scoring in the 91st percentile in the Energage survey, distributed in August 2020.
- The survey was administered six months after our transition to work from home and had a 93% participation rate.
- Survey results highlighted our engaged and mission-oriented team members, and their strong commitment to company values.
- An article announcing this achievement was published in the Press Enterprise on January 31.

Team Member Quote: *"I am able to work in my profession doing what I love, serving others and making a difference in their lives under the direction of responsible, honest and caring managers."* - IEHP Behavioral Health and Care Management team member in the survey.

2021
Key Programs

IEHP Global Quality Pay for Performance (P4P) Program

Program was designed to reward Primary Care Physicians (PCPs) for high performance and year-over-year improvements in key quality performance measures.

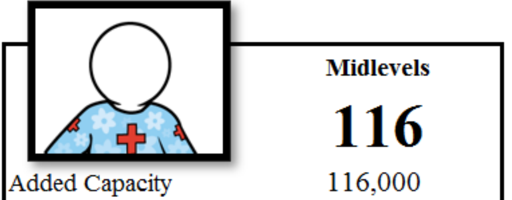
There are a total of 26 measures including: Access, Clinical Quality, Behavioral Health Integration, Patient Experience and Encounter Data.

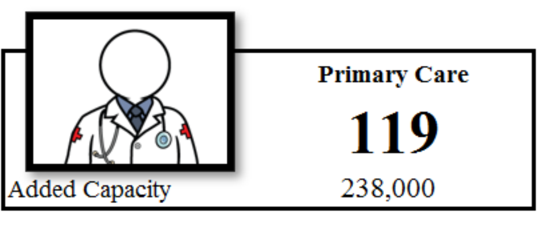
Providers are eligible to receive financial rewards for performance excellence and performance improvement.

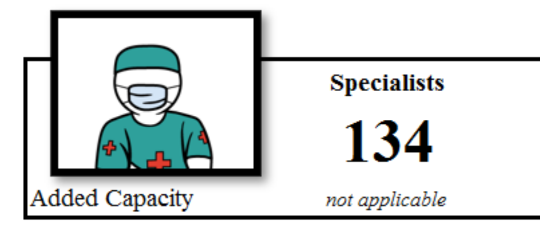
Network Expansion Fund (NEF)

IEHP Network Expansion Fund (NEF) was launched September 2014. Since inception we have invested $46M. This has translated to the hiring of 369 new Providers in the Inland Empire:

HIRED PHYSICIANS and IMPACT TO MEMBERSHIP CAPACITY







	Midlevels	Primary Care	Specialists
Hired	116	119	134
Added Capacity	116,000	238,000	*not applicable*

Total Membership Capacity Added Due to NEF

354,000

*As of January 27, 2021

Healthcare Scholarship Fund (HSF)

The HSF :

- Addresses the widespread shortage of physicians and other critically needed healthcare practitioners in the Inland Empire region.
- Develops a pipeline and growing workforce of healthcare professionals to care for the Medi-Cal population in the Inland Empire upon completion of their education.
- All scholarships have been distributed for 2020.

Scholarship allocation for 2020:

Total HSF Annual Budget	$8,000,000.00
Total Awarded to Schools	$8,000,000.00
Remaining Annual Budget	**$0.00**

School	Offered Scholarships	Awarded Scholarships	% Awarded
Loma Linda (Physician)	18	$3,150,000.00	51.9%
Loma Linda (Psychiatric Nurse Practitioner)	10	$1,000,000.00	
University of CA Riverside	15	$2,625,000.00	32.8%
CA University for Science & Medicine (CUSM)	7	$1,225,000.00	15.3%
Totals	**50**	**$8,000,000.00**	**100%**

Supportive Housing Program

- $10M towards supportive housing for IEHP Members across Riverside and San Bernardino counties.
- Two Programs:
  1. 3H Program – Focuses on the most vulnerable IEHP Members:
     Homeless
     High-utilizer of health services
     High-cost
  2. Custodial Program – Homeless IEHP Members living in Long Term Care facilities.
- Goal: House 350 Members in two years
  200 3H Program Members
  150 Custodial Program Members
- **As of January 27, 2021 – 212 Members housed**

*As of January 27, 2021

Community Health: CRCs

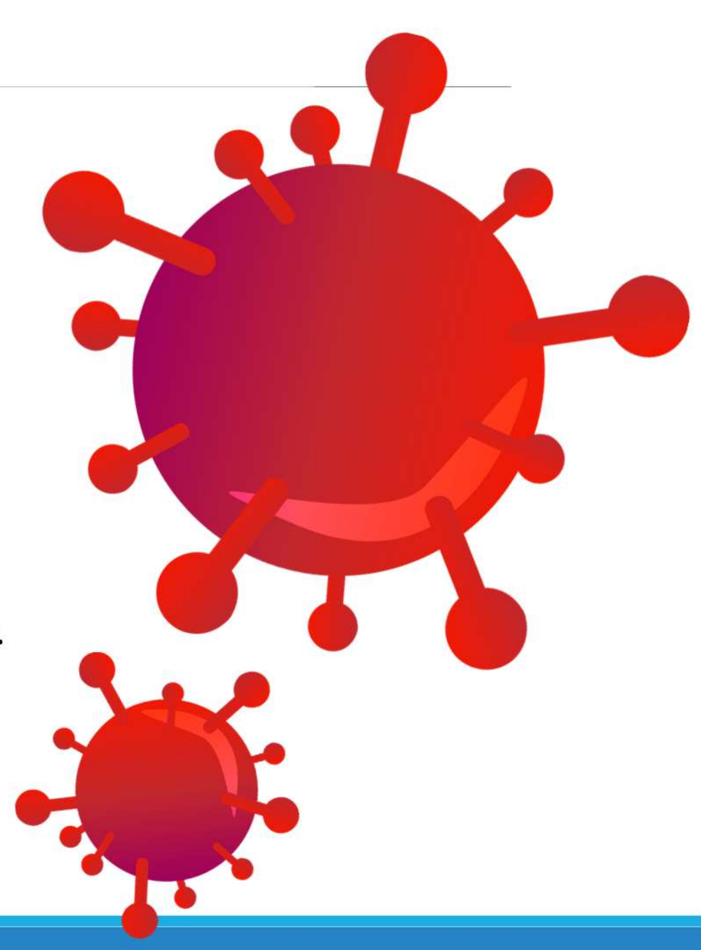
IEHP’s Community Resource Centers (CRCs), located in Riverside, San Bernardino and Victorville, are for both IEHP Members and the general community.

These CRCS provide free health and wellness classes, share information on affordable health coverage, help IEHP Members understand how to use their IEHP benefits, connect Inland Empire residents with important programs and more.

The Victorville CRC offers expanded services such as onsite pharmacy technicians to help Members with their medications and a food demonstration kitchen and pantry. The Victorville CRC was recently designated a California HUD EnVision Center.

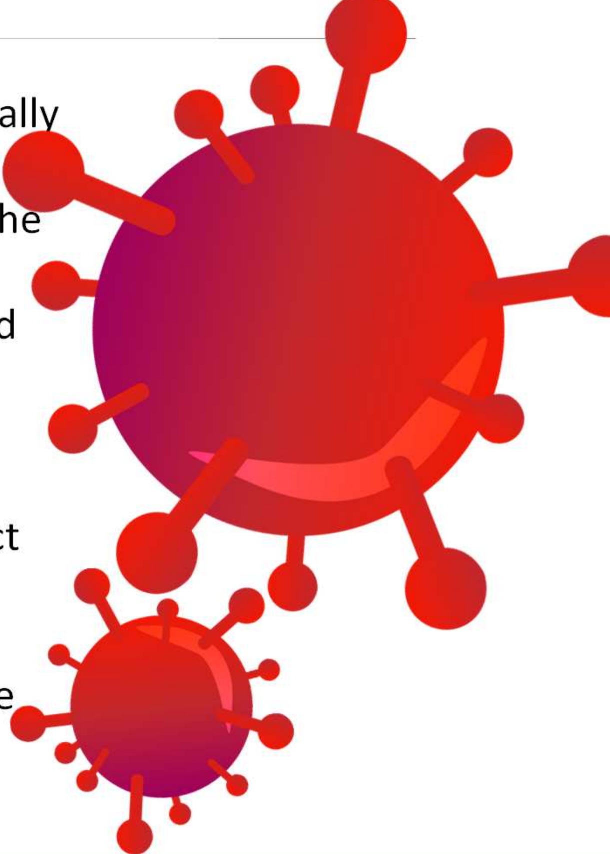
COVID-19 Efforts: Providers

- **Supported Skilled Nursing Facilities**, providing increased rates to care for COVID-19 patients.
- **Partnered with local Medical Associations and Societies** to ensure local physicians have necessary supplies to continue seeing patients.
- Developed the first-of-its-kind **Physician Specialist Compensation Program.**
- Developed and implemented the innovative **Hospital Cash Flow Emergency Amendment.**
- **Continued expedient claims processing** to ensure timely cash flow.
- Provided **meals and snacks to local hospital partner staff**.



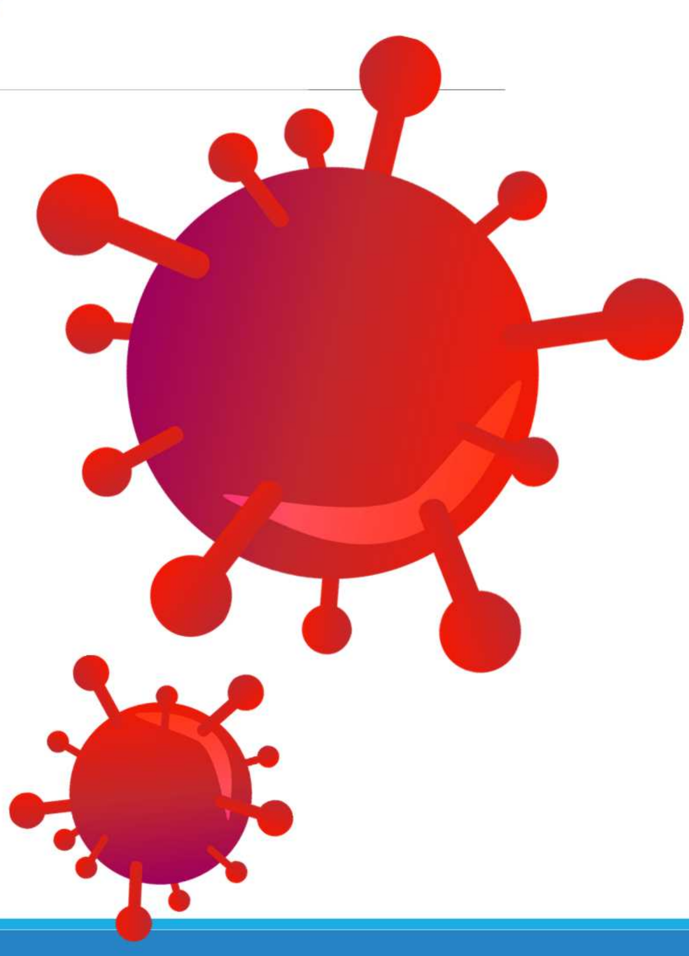
COVID-19 Efforts: Members

- Waived prior authorization requirements for diagnostic tests and medically necessary acute covered services, consistent with CDC guidance.
- Developed and maintain current **telehealth flexibilities** allowed under the pandemic emergency declaration.
- Developed and maintain **pharmacy flexibilities**, lifting 90-day supply and early refill pharmacy restrictions.
- Conducted **live outbound wellness calls** to more than 29,000 members who are seniors and have chronic conditions.
- Developed and coordinated a **social isolation texting program** to contact more than 94,000 members who are seniors and have disabilities.
- Partnered with FQHCs to provide grants to **support COVID-19 testing.**
- Drafted a regional letter with community partners to the COVID-19 State Taskforce that helped bring Rapid Response testing to the area.



COVID-19 Efforts: Community

- Collaborated with local agencies to **establish the COVID-19 Medline**, offering 24/7 medical advice to uninsured Inland Empire residents.
- Collaborated with local agencies to coordinate and support three weeks of **grocery and supply deliveries to local senior living centers**.
- Collaborated with local food banks to **combat food insecurity** by providing staff, host space and more than $50k in sponsorships.
- Donated and sourced 2.4M **PPE Units** across the Inland Empire.
- Assisted both counties with **vaccine clinics** by providing both clinical and non-clinical Team Member volunteers.



Thank you.

Questions?

THE HENRY J. KAISER FAMILY FOUNDATION
THE KAISER COMMISSION ON
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Filling the need for trusted information on national health issues…

March 2016 | Issue Brief

Medi-Cal Managed Care: An Overview and Key Issues

Margaret Tater, Julia Paradise, and Rachel Garfield

Executive Summary

California's Medicaid program, Medi-Cal, is the largest state Medicaid program in the nation, insuring almost one-third of California's more than 38 million residents. In the early 1970s, California was the first state to enter into risk contracts with managed care plans to serve some Medicaid beneficiaries, rather than pay for services on a fee-for-service (FFS) basis. Over the decades since that time, Medi-Cal has been progressively moving more beneficiaries into managed care. More than three-quarters of all Medi-Cal beneficiaries, including low-income children, adults, seniors, and people with disabilities, are now enrolled in managed care plans. Besides being the earliest Medicaid managed care program and, by far, the largest in the nation, at nearly 10 million enrollees, the Medi-Cal managed care program has a unique structure, an outgrowth of underlying historical differences in the health care systems and traditions in different counties of the state. As other state Medicaid programs increase their use of risk-based managed care, and policymakers, plans and providers, and advocates seek to understand and learn from developments in this area to guide future change, a review of Medi-Cal's managed care evolution is both timely and illustrative. It also serves to illuminate some potential implications of the proposed rule on Medicaid managed care issued by the federal Centers for Medicare & Medicaid Services (CMS) and expected to be finalized in the Spring of 2016, which represents a major overhaul of current regulatory requirements and standards.

A number of observations stand out from this review:

- ***County-based structure.*** California's managed care program is unique, involving six different managed care models, shaped by the historical and continuing role of counties in financing and delivering primary care, public hospital services, mental health services, and certain long-term services and supports to poor and medically indigent residents. More than two-thirds of all Medi-Cal managed care enrollees are enrolled in public safety-net plans; the others are served by a mix of commercial and private non-profit health plans.
- ***Phased managed care expansion***. In the early days of the state's managed care program, in a limited number of counties, managed care enrollment was mandated for nearly all Medi-Cal beneficiaries, including seniors and people with disabilities. Over time, California has expanded mandatory managed care to additional counties and to broader segments of the beneficiary population, including seniors and people with disabilities statewide, under the state's "Bridge to Reform" section 1115 waiver (2011); children who were transitioned from CHIP to Medi-Cal (2013); low-income adults covered previously through the state Low Income Health Program and those newly eligible for Medi-Cal under the ACA (2014); and, under the state's

seven-county Financial Alignment Demonstration and on a voluntary basis, beneficiaries dually eligible for Medicare and Medicaid (2014).

- ***Access to care.*** Problem with access to care in Medi-Cal FFS carry over into managed care, challenging Medi-Cal health plans to establish adequate provider networks and improve care. Gaps in access to certain specialists, including psychiatrists and other behavioral health providers, and long-term care services, are the most significant gaps. Providers have cited Medi-Cal's low payment rates as a barrier to their participation in the program and sued the state on the basis that the fees violate federal Medicaid payment standards. Language and cultural gaps in access to care and gaps in rural access are additional issues.
- ***Benefit carve-outs.*** Medi-Cal managed care plans provide for most primary and acute care services. However, certain services are "carved out" from managed care contracts. In particular, while mental health services for mild or moderate mental illness are included in plan contracts, specialty mental health services and substance use disorder treatment continue to be delivered through county mental health departments and local and county alcohol and drug programs. In most counties, nursing home care and certain home and community-based services (HCBS) are also carved out of managed care.
- ***Managed long-term services and supports***. In 2014, under its Coordinated Care Initiative in seven counties, California required all Medi-Cal beneficiaries, including dually eligible enrollees who were previously exempt from managed care, to enroll in a managed care plan to receive their Medi-Cal benefits, including nursing home and certain HCBS.
- ***Transitions for people with complex needs.*** California's experience shows that robust transition planning is necessary to minimize disruptions in care for beneficiaries with complex needs who are required to move from FFS to managed care. Beneficiary and provider engagement, timely transfers of data, continuity of care protections, beneficiary information and navigation assistance, and coordination with carve-out services emerge as essential elements of sound transitions.
- ***Increasing focus on metrics, performance, and accountability.*** California has taken significant steps to improve the data reported by Medi-Cal managed care plans, which are needed for rate-setting, managed care monitoring, efforts to move to value-based purchasing. The state also established a managed care performance dashboard that makes plan-level quality and other data available to the public, increasing the program's transparency and plan accountability.
- ***Major current issues.*** Two recent developments – CMS' proposed modernization of the Medicaid managed care regulations and the approval of "Medi-Cal 2020," the renewal of California's section 1115 waiver – can be expected to bear on the Medi-Cal managed care program, by increasing plan- and state-level requirements and state oversight responsibilities, and by setting the stage for potential changes in the role and operation of managed care plans in a transforming health care delivery and payment system.

Introduction

California's Medicaid program, Medi-Cal, is the largest state Medicaid program in the nation. Insuring almost one-third of California's more than 38 million residents,[1] Medi-Cal is a key source of health coverage in the state and the main source of coverage for low-income children, adults, and people with disabilities. It also provides wrap-around coverage for many elderly Medicare beneficiaries in the state.

For several decades, Medi-Cal has been transitioning away from a fee-for-service (FFS) payment and delivery system to one that relies on risk-based managed care. Under the FFS system, beneficiaries could see any provider who accepted Medi-Cal, and providers were reimbursed for each individual service or visit. Under managed care, the state contracts with health plans to deliver Medi-Cal benefits to enrollees in exchange for a monthly premium, or "capitation" payment for each enrollee. The plans are accountable for and at financial risk for providing the services in the contract.

California was the first state to pilot managed care in Medicaid, beginning in the early 1970s, and the Medi-Cal managed care program has a unique structure that grew out of the different health care delivery and financing systems in different counties of the state. Over time, California has transitioned progressively more Medi-Cal beneficiaries into managed care, and its program is, by far, the largest Medicaid managed care program in the nation, with nearly 10 million children, adults, seniors, and people with disabilities – or more than three-quarters of all Medi-Cal beneficiaries – enrolled in plans.

In its early managed care pilot programs, California awarded contracts to health plans to serve Medi-Cal beneficiaries in a specified county or service area. Over time, the Department of Health Care Services (DHCS), California's Medicaid agency, expanded the reach of its managed care program to include additional counties. Later, as part of the "California Bridge to Reform Demonstration," a Section 1115 waiver approved by CMS in November 2010,[2] the state extended mandatory managed care to seniors and people with disabilities enrolled in Medi-Cal. California opted to expand Medi-Cal eligibility under the Affordable Care Act (ACA), greatly increasing the number of Medi-Cal beneficiaries overall and in managed care plans. As of July 2015, 77% of Medi-Cal beneficiaries were enrolled in Medi-Cal managed care plans,[3] and in October 2015, over 10 million beneficiaries were enrolled in Medi-Cal managed care plans.[4] In addition, DHCS has collaborated with the Centers for Medicare and Medicaid Services (CMS) to launch a demonstration program in seven large counties under which beneficiaries who are dually eligible for Medicare and Medicaid may enroll in capitated managed care plans that provide the full range of services covered by both programs, including managed long-term services and supports (MLTSS).

As other states increase their reliance on risk-based managed care to serve their Medicaid beneficiaries, this review of California's transition to a largely managed care-based Medicaid program is both timely and informative for Medicaid's many stakeholders. It also serves to highlight some potential implications for Medi-of CMS' proposed rule on Medicaid managed care, a major overhaul of the current regulations that is expected to be finalized in the Spring of 2016.

Structure of Medi-Cal Managed Care Program

County-Based Managed Care Models

A distinguishing feature of Medi-Cal's managed care program is that different managed care models operate in different counties (Figure 1), shaped strongly by the historical role of the counties in the financing and delivery of primary care, public hospital services, mental health services, and certain long-term services and supports to poor and medically indigent residents. In the 1980's, the first Medi-Cal managed care programs began as **County Organized Health System (COHS)** plans, including the Health Plan of San Mateo and Santa Barbara Regional Health Authority, operating under Section 1915(b) waivers. COHS plans were created by counties, with mandatory enrollment for virtually all Medi-Cal beneficiaries in the county service area (including seniors and persons with disabilities) and with almost all Medi-Cal services covered. In the early 1990's, Medi-Cal expanded its managed care program by adding more COHS plans (e.g., Partnership Health Plan serving Solano and Napa Counties, CalOptima serving Orange County, and Central California Alliance for Health serving Santa Cruz and Monterey Counties).

Medi-Cal Managed Care Models
County Organized Health System (COHS). A health plan created and administered by a County Board of Supervisors. Within a COHS county, all managed care enrollees are in the same plan. (22 counties)
Two-Plan Model. This model is comprised of a publicly-run entity (a "Local Initiative") and a commercial plan. (14 counties)
Geographic Managed Care (GMC). In this model, DHCS contracts with a mix of commercial and non-profit plans that compete to serve Medi-Cal beneficiaries. (2 counties)
Regional Expansion Model. DHCS contracts with two commercial plans in each county. (18 counties)
Imperial Model. This model only operates in Imperial County where DHCS contracts with two commercial plans.
San Benito (Voluntary) Model. This model only operates in San Benito County where DHCS contracts with one commercial plan.

The state also created the **Two-Plan Model,** which was designed to shift large segments of the Medi-Cal population into managed care while preserving the role of traditional safety-net providers,[5] and the **Geographic Managed Care Model (GMC)** in Sacramento and San Diego Counties. The Two-Plan Model offers enrollees a choice between one commercial plan and one "Local Initiative" public plan. Like COHS plans, Local Initiative plans are public entities and are expected to work collaboratively with county public hospitals and safety-net providers to support the safety-net delivery system. In general, Two-Plan Model counties tend to be ones with large Medi-Cal populations and public hospital systems critical to the safety-net; they include nine of California's 12 public hospital health system counties[6].

Local Initiative plans enjoy strong local support and have generally secured a 65%-85% Medi-Cal market share, with commercial plans in their service areas playing a smaller role. Notably, although there is only one Local Initiative plan in each county, some of them subcontract with one or more commercial plans, effectively providing Medi-Cal enrollees in these counties with more than two plan options. For example, L.A. Care, the Local Initiative plan in Los Angeles County, subcontracts with Anthem Blue Cross, Care1st, and Kaiser Permanente, in addition to providing health plan services directly to enrollees.[7]

The GMC Model relies on a mix of commercial and non-profit health plans but does not include Local Initiative plans. Enrollees in GMC counties have more than two plan options.[8] Like in COHS, enrollment in both the Two-Plan and GMC Models is mandatory for low-income adults and children, but, unlike in COHS, enrollment in the Two-Plan and GMC Models was initially voluntary for seniors and persons with disabilities, becoming mandatory in 2012.

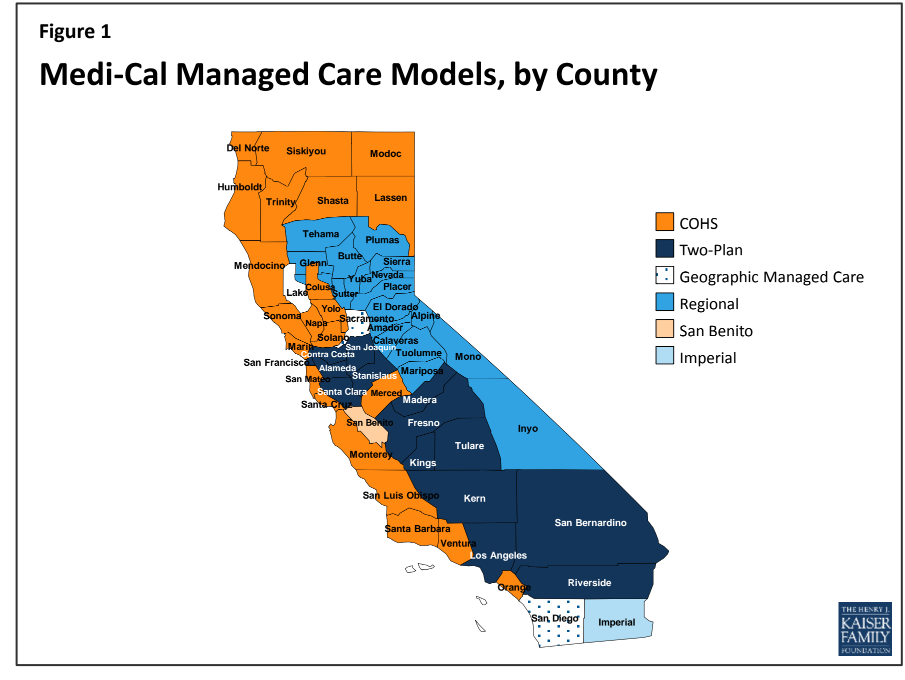


Figure 1
Medi-Cal Managed Care Models, by County

Finally, the **Regional Expansion, Imperial**, and **San Benito (Voluntary) Models** were created when Medi-Cal began expanding managed care to rural areas in late 2013. Both the Regional Expansion and Imperial Models involve contracts with two commercial plans. When children in the Healthy Families Program – California's Children's Health Insurance Program (CHIP) – who were enrolled in Kaiser Permanente's Healthy Families plan transitioned to Medi-Cal coverage in 2013, the state contracted with Kaiser Permanente in three Regional Expansion Model counties to ensure continuity of care for these children.[9] The San Benito Model allows Medi-Cal enrollees in San Benito County to choose between FFS and the one contracted commercial plan.

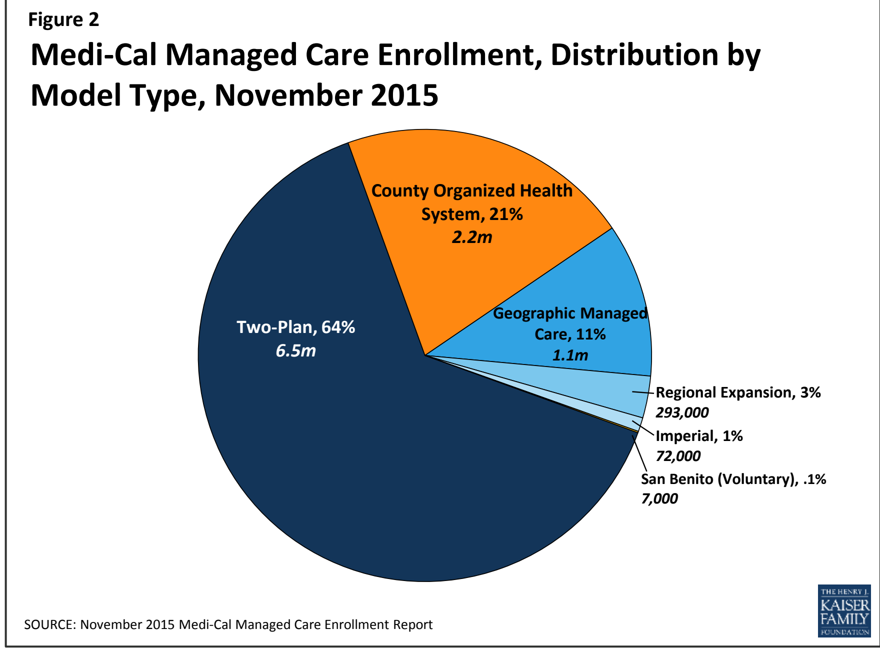
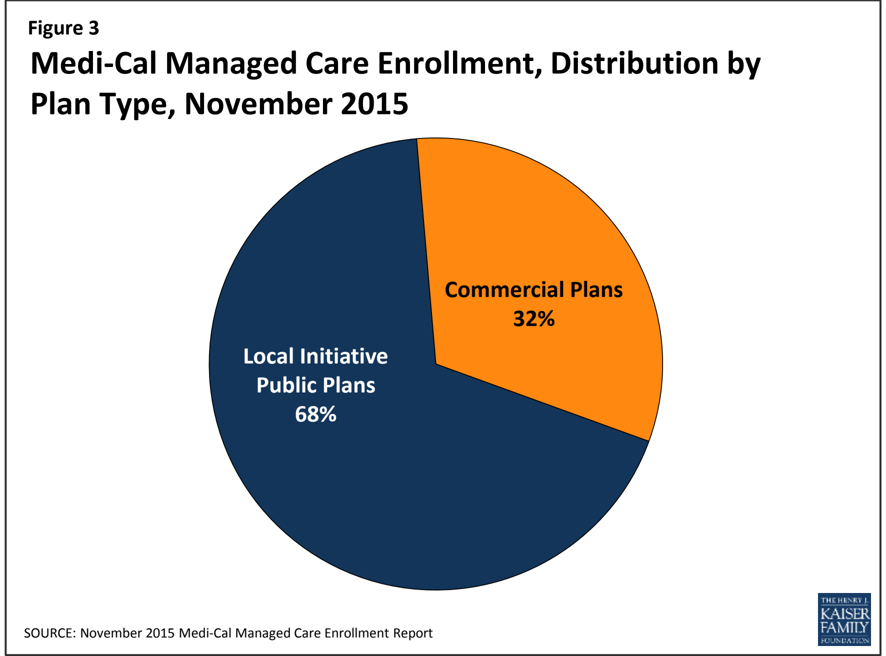


Figure 2
Medi-Cal Managed Care Enrollment, Distribution by Model Type, November 2015
SOURCE: November 2015 Medi-Cal Managed Care Enrollment Report

In all then, six different managed care models operate across California's 58 counties today.[10] Reflecting population distribution across the state, the largest share of Medi-Cal beneficiaries – nearly two-thirds as of October 2015 (64%) – were enrolled in the Two-Plan Model. Another 21% were enrolled in the COHS Model, and 11% were enrolled in the GMC Model (Figure 2). A large majority of Medi-Cal managed care enrollees (68%) were served through local public plans (COHS plans and Local Initiative plans under the Two-Plan Model), while about one-third were served through commercial plans (Figure 3).

Key Programmatic Dimensions of Medi-Cal Managed Care



- ### Managed Care Plan Enrollment

  People can apply for Medi-Cal in several ways: by mail, in person, by phone through their County Social Services Office, or, since the launch of the ACA coverage expansions in 2014, online via the Covered California website (www.coveredca.com). Once their eligibility is determined, individuals are enrolled in Medi-Cal and issued a Benefits Identification Card. They then choose from two or more health plan options, or are auto-assigned to a plan if they do not select a plan. In COHS counties, a single plan administers Medi-Cal and all enrollees are mandatorily enrolled in that plan. In San Benito County, only one health plan is available and beneficiaries may enroll in that plan or choose to stay in Medi-Cal FFS.

- ### Primary Care Provider Selection

  Upon enrollment in a health plan, beneficiaries choose a primary care physician (PCP) who is in the health plan's network or, if they do not choose a PCP, the health plan will assign them one. Notably, California established special provisions regarding PCP selection for ACA Medicaid expansion adults in the 12 counties with public hospital health systems[11] that previously served these adults through Low Income Health Programs[12] (discussed below) and county indigent programs. As in other counties, Medicaid expansion adults in these counties either select or are automatically assigned by their health plan to a PCP. However, to maintain support for the county public hospital health systems, for the period January 1, 2014 through December 31, 2016, plans must auto-assign at least 75% of newly eligible adults who do not select a PCP to a PCP in the county hospital health system until the system meets its enrollment target or notifies the plan that it is at capacity. The required percentage drops to 50% beginning January 1, 2017.[13] [14]

- ### Benefits and Carve-Outs

  Medi-Cal covers comprehensive primary and acute care, behavioral health care, and long-term services and supports (LTSS) for beneficiaries. While most primary and acute care benefits for managed care enrollees are provided by the managed care plans, the following services are generally "carved out" and provided on a FFS basis:

  - Dental care;
  - Specialty mental health services, such as targeted case management, partial hospitalization, and outpatient and inpatient mental health services (delivered through county mental health departments, which are responsible for intake, triage, and treatment of people who meet specific eligibility criteria for serious mental illness);

- Substance use disorder treatment services (delivered by local and county alcohol and drug programs);
- In-Home Supportive Services, which include personal assistance and other services that enable seniors and persons with disabilities to live safely in their homes (administered by counties, except in the seven MLTSS counties, where these services are provided by the health plan);
- Home and community-based waiver services (HCBS), such as case management, continuing care nursing, day care, and respite services, for beneficiaries who would otherwise meet the functional eligibility criteria for institutional care (except in the seven MLTSS counties, where services authorized under the Multipurpose Senior Services HCBS waiver are covered by the health plan); and
- Skilled nursing facility services beyond 91 days (except in COHS counties and the seven MLTSS counties, where these services are provided by the health plan).

• Provider Network Adequacy and Other Access Standards

Except for most COHS plans, Medi-Cal managed care plans are licensed by the California Department of Managed Health Care (DMHC) and are subject to statutory and regulatory consumer protections, including network adequacy requirements.[15] In addition, all DHCS contracts with health plans specify network adequacy standards. The COHS plans (except for the Health Plan of San Mateo) are exempt from statutory licensure requirements but are subject to the network adequacy requirements contained in their Medi-Cal contracts. (Appendix Table 1 describes network adequacy standards in Medi-Cal managed care. Appendix Table 2 describes standards for timely appointments in Medi-Cal managed care.)

Recent Medi-Cal Managed Care Expansions

To prepare for the implementation of the ACA coverage expansions in 2014, California applied for its "Bridge to Reform" Section 1115 demonstration waiver, which CMS approved in November 2010.[16] This section 1115 demonstration waiver allowed the state to implement the Low Income Health Program, an expansion of county-based coverage programs for low-income adults, who would later become eligible for new ACA coverage options.). The waiver also allowed the state to pursue fundamental program changes intended to improve health outcomes and ensure the long-term financial sustainability of the Medi-Cal program. Mandatory enrollment of seniors and persons with disabilities (SPDs) in managed care was among these changes. Waiver amendments in subsequent years further expanded managed care to additional populations and geographic areas. Ultimately, over the period 2011-2014, California transitioned or enrolled almost 5 million Medi-Cal beneficiaries into managed care under authority provided by the Bridge to Reform waiver, including beneficiaries in rural counties; seniors and persons with disabilities; children previously covered by Healthy Families, the state's Children's Health Insurance Program (CHIP); individuals previously enrolled in the Low-Income Health Program; and adults newly eligible for Medi-Cal under the ACA.

• Seniors and Persons with Disabilities (SPDs)

Prior to 2011, California mandated managed care enrollment for seniors and persons with disabilities (SPDs) only in COHS counties. In all other managed care models, enrollment of seniors and persons with disabilities was voluntary. However, in 2011, after the Bridge to Reform waiver was approved, the state began to transition these beneficiaries, excluding those dually eligible for Medicare and Medicaid, into managed care in 16 additional counties that had managed care for other Medi-Cal populations at the time, and where managed care for seniors and persons with disabilities had previously been voluntary. During the 12 months beginning June 2011, nearly 240,000 SPDs were enrolled into managed care plans in these

counties, where they were offered a choice of at least two plans. As California began to expand mandatory managed care to rural counties in 2013, SPDs in these counties were also enrolled in plans.[17] As of September 2014, 647,968 seniors and persons with disabilities (non-dually eligible) were enrolled in Medi-Cal managed care, making up 7.7% of all Medi-Cal managed care enrollment statewide.[18]

- **CHILDREN ENROLLED IN THE HEALTHY FAMILIES PROGRAM**

  Starting in 2013, children enrolled in the Healthy Families Program were moved into Medi-Cal. This change was intended to simplify eligibility and coverage for children and families; improve children's coverage through retroactive eligibility, increased access to vaccines, and expanded mental health benefits; and eliminate premiums for lower-income children in the Healthy Families Program.[19] The shift was also expected to produce budget savings for the state, as average rates paid to Medi-Cal plans were generally lower than those paid under the Healthy Families Program for a largely equivalent benefit package (after adjustments for carve–outs).[20] DHCS identified approximately 750,000 children eligible to be transitioned to Medi-Cal; the transition was implemented in four phases to minimize service disruptions and ensure continued access to care.[21]

- **ADULTS IN LOW INCOME HEALTH PROGRAM AND NEWLY ELIGIBLE ADULTS UNDER THE ACA**

  Through the Low Income Health Program (LIHP), county and local entities strengthened their primary and specialty care delivery systems, implemented primary care medical homes, and enrolled over 630,000 uninsured adults ages 19-64 with incomes up to 200% of the federal poverty level in coverage. On January 1, 2014, all but 24,000 LIHP enrollees (whose incomes qualified them instead for subsidies for Marketplace plans) became eligible for Medi-Cal under the ACA Medicaid expansion and were enrolled in managed care plans.

RECENTLY ADDED SERVICES IN MANAGED CARE

Since 2011, California has expanded the benefits covered under managed care contracts through amendments to its Bridge to Reform waiver. The services added include adult day health services, mental health services and, in seven demonstration counties, certain long-term services and supports, as further described below.

- **COMMUNITY-BASED ADULT SERVICES (CBAS) BENEFIT**

  Prior to 2011, Adult Day Health Care (ADHC), a community-based day care program that provided health, therapeutic, and social services for persons at risk of nursing home placement, was offered as an optional Medicaid State Plan service on a FFS basis. To achieve budget savings, Governor Brown's January 2011 budget plan proposed to eliminate the ADHC benefit, and in March 2011, the state legislature voted to eliminate the ADHC benefit, subject to CMS approval (which was delayed until April 2012).[22] In August 2011, DCHS began transitioning ADHC participants from FFS to managed care plans, which were to coordinate their medical and social support needs. Later, under a settlement with the ADHC providers, the Community-Based Adult Services (CBAS) benefit — utilizing the same ADHC providers — was created to replace ADHC as a managed care benefit only. In effect, the former ADHC benefit was carved into managed care as the new CBAS benefit. Accessible only to managed care enrollees, Community-Based Adult Services became the first community-based LTSS managed care plan benefit. Currently, CBAS providers serve 31,000 managed care enrollees statewide.

- **Managed Long-Term Services and Supports (MLTSS)**

  In January 2012, Governor Jerry Brown proposed his Coordinated Care Initiative (CCI), aimed at improving health outcomes and beneficiary satisfaction for low-income seniors and persons with disabilities, while achieving substantial savings from rebalancing the delivery of long-term services and supports toward home and community-based care.[23] The CCI proposal was enacted by the state legislature in 2012 to be implemented in seven counties in 2014.[24] One component of the CCI was a mandatory managed long-term services and supports (MLTSS) program. The second component, a demonstration program for persons dually eligible for Medicare and Medicaid, is described later.

  In the seven CCI counties, Medi-Cal beneficiaries, including dually eligible enrollees who were exempt from managed care before 2014, are required to enroll in a managed care plan to receive their Medi-Cal benefits, including the following long-term services and supports: consumer-directed In-Home Supportive Services, Community-Based Adult Services, the Multipurpose Services and Supports Program (the state's HCBS waiver services for frail elders), and long-term (over 91 days) skilled nursing facility services. Other HCBS waiver services (such as those under the state's Assisted Living waiver and the waiver for persons with intellectual and developmental disabilities) remain carved out. MLTSS coverage began on April 1, 2014. As of October 2015, over 300,000 dually eligible beneficiaries were enrolled in the MLTSS program in the seven counties.

- **Mental Health Services and Autism Care**

  In 2014, mental health services for mild or moderate mental illness were added to managed care contracts (specialty mental health services continue to be carved out and provided through the counties). Also, in 2015, behavioral health therapy for beneficiaries with autism or autism spectrum disorder was added as a Medi-Cal-covered benefit and will be covered by managed care plans in 2016.

Other Managed Care Initiatives

Dual Eligible Demonstration

As mentioned earlier, the seven-county CCI also provided for a three-year Financial Alignment Demonstration ("Dual Demonstration"), as authorized by the ACA to promote coordinated health care delivery for individuals dually eligible for Medicare and Medicaid. Under the demonstration, called "Cal MediConnect," dually eligible enrollees can elect to receive all of their Medicare and Medicaid services, including medical, behavioral health, and institutional and home and community-based long-term services and supports, through a single managed care plan. Plan participation in the Dual Demonstration is limited to Medi-Cal plans already serving the area. Participating plans contract with other entities to provide some services, such as behavioral health and In-Home Supportive Services, although the goal is that dually eligible beneficiaries receive all their care in a single, organized delivery system. A Memorandum of Understanding (MOU) between the state and CMS authorizing the Dual Demonstration outlines its principles and operational plan.[25]

The Dual Demonstration puts many new demands on Medi-Cal health plans, including the requirement to cover Medicare Part A, B, and D benefits as well as Medi-Cal long-term services and supports. To accomplish this, plans must organize providers who have not previously contracted with managed care plans or who have not previously provided services to Medicare beneficiaries. Under the Dual Demonstration, plans are also subject to specific and detailed DHCS and CMS contract requirements to maintain continuity of care, perform

health risk assessments, and use person-centered, interdisciplinary care management teams. Enrollment in the Dual Demonstration is voluntary; as of December 1, 2015, 115,743 dually eligible enrollees – about one-quarter of the eligible population – were enrolled in it.[26]

Managed Care Data Initiatives and Dashboard

In late 2012, DHCS initiated the statewide Encounter Data Improvement Project (EDIP). The goal of the EDIP is to improve the timeliness, accuracy, and completeness of encounter data reported by managed care plans, to improve rate-setting and managed care monitoring, and to prepare for value-based purchasing. As part of the project, DHCS develops performance metrics and works with managed care plans to address their data collection and reporting deficiencies. This collaborative effort on data and metrics is critical in connection with performance reporting and will be foundational to value-based purchasing in the future.

To increase transparency regarding the quality of managed care plans, DHCS has created a Managed Care Performance Dashboard that provides plan-reported data on a variety of measures to help DHCS and other stakeholders examine and understand managed care activity and performance at the state level, by managed care model, and at the individual plan level. The dashboard contains metrics related to enrollment, enrollee health care utilization, appeals and grievances, and quality of care. The dashboard stratifies the plan-reported data by beneficiary population.[27]

Key Challenges and Lessons

Access to Care

Provider payment rates and participation. Managed care plans are required to maintain adequate provider networks and capacity to ensure access to care for their members. Historically, Medi-Cal FFS payment rates have been among the lowest Medicaid fees in the nation.[28] Research has shown a positive relationship between fee levels and physician participation in Medicaid.[29] [30] [31] In managed care, although provider payment rates are a contractual matter between plans and providers, the role of persistent low rates in depressing provider participation and beneficiary access continues to be a major issue. California providers have sued the state on the basis that Medi-Cal rates violate the "equal access" provision of federal Medicaid law.[32] [33] This provision requires that payment rates be "consistent with economy and efficiency… and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[34] On November 2, 2015, CMS issued a final rule implementing the equal access provision, which requires states to conduct access reviews on a regular basis and to consider the findings from those reviews in setting provider rates. However, CMS limited application of the latter requirement to FFS rate-setting, stating that standards for capitation payment rates are set in the June 1, 2015 proposed rule on Medicaid managed care.[35]

Data from a 2012 survey of Medi-Cal enrollees show that the vast majority of beneficiaries found it easy to find a provider who accepted Medi-Cal, but almost 1 in 5 enrollees had difficulty. Fewer than half of Medi-Cal enrollees said it was easy to find a specialist or mental health provider who accepted Medi-Cal; enrollees in fair or poor health were particularly likely to report difficulty finding specialists.[36] A separate analysis, based on national survey data, found that Medi-Cal adults were significantly more likely than adults with Medicaid in

other states not to have a doctor visit (37% vs. 30%) or a specialist visit (48% vs. 36%) and to delay care because of difficulty getting an appointment.[37] Along with medical groups and other physicians, federally qualified health centers (FQHCs) and community clinics play an important role in providing primary care for Medi-Cal beneficiaries, but arranging specialist referrals for patients in these settings is an ongoing challenge.

A recent federal report shows that 54% of office-based physicians in California were accepting new Medicaid patients in 2013, compared to nearly 69% of office-based physicians nationally who were doing so.[38] A 2013 California survey of physicians, including facility-based physicians, found a higher rate overall -- 62% accepting new Medi-Cal patients, compared to 75% for Medicare and 79% for privately insured patients.[39] The rate was 70% among pediatricians, but just over 50% among other primary physicians. Facility-based specialists were mostly likely to accept new Medi-Cal patients, and only 36% of psychiatrists did so. In June 2015, the California State Auditor issued a report identifying major gaps in state oversight of Medi-Cal plan provider networks to ensure their adequacy, a high volume of unanswered calls to the office of the Medi-Cal managed care ombudsman, and inconsistent monitoring of Medi-Cal plans to ensure they meet Medi-Cal beneficiaries' medical needs.[40]

Linguistic and cultural gaps in access. Another challenge in Medi-Cal is the lack of linguistic and cultural concordance between the current provider workforce and the low-income population in California. A 2013 analysis by the state showed that 40% of Californians eligible for Medi-Cal reported a language other than English as their primary language and that 13 languages met the state's definition of a "Threshold Language" spoken at a high proportional rate within a geographic area.[41] A separate study documented that nearly 40% of all Californians and approximately 50% of Medi-Cal beneficiaries are Latino, but that only 5% of licensed physicians in California are Latino and only 6% of California physicians speak Spanish.[42]

Rural areas. While access to care is generally sufficient in most urban areas, securing access to care in rural areas is more challenging for publicly and privately insured patients alike. FQHCs, rural health centers (RHCs), and other health clinics form the backbone of the ambulatory care delivery system serving low-income populations in rural counties, and these safety net provider play an increasingly critical role in Medi-Cal managed care networks in rural as well as other areas of the state.[43]

Transitions to Managed Care

California's shift of seniors and people with disabilities from FFS to managed care yielded important lessons about the importance of appropriate planning to foster smooth transitions and avoid disruptions in care, especially for people with complex health care needs.

Stakeholder engagement. Robust stakeholder engagement is needed to support smooth managed care transitions.[44] In implementing the Healthy Families and Low Income Health Program transitions and the Dual Demonstration, DHCS increased its engagement with beneficiaries, advocates, providers, and plans. For example, in the Dual Demonstration, the state held extensive webinars, workshops, and stakeholder meetings, which state officials said resulted in better and more effective outreach.[45] DHCS also established a dedicated webpage to report on all meetings, updates, and notices.

Data issues. In the SPD transition, inaccurate enrollee contact information, privacy rules that prevented plans and providers from accessing beneficiary medical records, and other data problems made timely implementation of care coordination challenging for Medi-Cal plans. The state was able to improve its data-sharing processes in the Dual Demonstration to give plans more time to contact incoming enrollees and prepare for their needs. Still, contacting beneficiaries to complete health assessments to support care management remains a challenge for plans, particularly in the case of individuals newly eligible for Medi-Cal and people without stable addresses.

Continuity-of-care protections. SPDS were permitted to request continued access to an out-of-network provider for 12 months following their plan enrollment.[46] However, lack of plan, provider, and beneficiary understanding of this provision led to unnecessary disruptions in established patient-provider relationships. In subsequent managed care transitions, DHCS and plans increased their engagement with enrollees and providers to improve understanding of the continuity-of-care protection. DHCS also incorporated specific continuity-of-care requirements in its managed care contracts.

Enrollment processes. In the lead-up to the Dual Demonstration, advocates and plans urged greater transparency in the enrollment process and beneficiary protections, including the right to opt out of or disenroll from the Demonstration. In response, the state published the enrollment schedule and the mailing dates for notices to beneficiaries, to help advocates and insurance assisters prepare and stage beneficiary outreach and education efforts. The state also published issues that arose in the beneficiary notice/enrollment process and the steps the state took to address them. Advocates and plans also worked with DHCS to improve the managed care enrollment process for beneficiaries with LTSS needs and dually eligible beneficiaries.

Coordination with carve-out services. Coordination between plan and carve-out services is an ongoing challenge. This came up in the SPD transition, particularly in the context of mental health care, as prescription drugs were provided by plans, while specialty mental health services were carved out and provided by county mental health departments.[47] In the MLTSS transition, plan coordination with waiver services that remained carved-out was also difficult. Differences between waiver service care managers and health plans in their assessments of beneficiary needs and care goals can create access barriers for beneficiaries.

Improving Quality

Performance measurement and monitoring. Managed care contracting enables states to measure and require accountability for quality. Through its contracts, California requires Medi-Cal managed care plans to periodically submit various quality-related reports, including Consumer Assessments of Healthcare Providers and Systems (CAHPS) survey findings, Healthcare Effectiveness and Data Information Set (HEDIS) scores, reports on member complaints, grievances, and resolutions, and other statistical reports.

Transparency. DCHS collection and monitoring of quality data and the public availability of data on plan performance in the Managed Care Performance Dashboard strengthen the foundation for state oversight of managed care, transparency of plan quality, and value-based purchasing strategies. DHCS works with Medi-Cal plans to improve its quality measures and refine its enforcement mechanisms. This work includes developing corrective action plans to improve plans' quality reporting and outcomes and reporting formats that capture data accurately and completely. DHCS also conducts an annual quality forum to publicly recognize plans for

their progress and achievements in quality performance. Poor-performing plans may be subject to enforcement actions or corrective action plans, or may lose out under the state's auto-assignment algorithm.

Special reports for Dual Demonstration plans. All plans participating in the Dual Demonstration must submit additional reports to CMS that include data on quality metrics for both Medi-Cal and Medicare services. DHCS and CMS review these reports and work with the plans to ensure that data are reported consistently to support evaluation purposes. DHCS recently published the first quarterly Health Risk Assessment Dashboard, which compares the plans' compliance with the requirement to complete Health Risk Assessments for Dual Demonstration members.[48]

Major Current Issues

Medicaid Managed Care Rule

CMS' proposed rule on Medicaid managed care would modernize and fundamentally redraw the current regulatory framework for managed care. It would strengthen beneficiary protections and network adequacy requirements, establish requirements to increase the fiscal integrity of capitation rates, address health care delivery and payment reform in managed care, increase state and plan accountability for access and quality, and strengthen oversight of Medicaid managed care programs.[49] If these provisions are preserved in the final rule, expected in the Spring of 2016, they could have significant bearing on provider networks and beneficiary access to care, provider payment, and other issues in the Medi-Cal managed care program.

In a letter to CMS submitted during the public comment period on the rule, the California Hospital Association expressed support for the overall direction of the rule and many of its specifics, but also identified some major concerns. Chief among them is the concern that the rule's proposed limitations on states' ability to direct plan expenditures and plan payments to specific providers would interfere with current supplemental payments targeted to certain hospitals– typically, safety-net and public hospitals that serve large numbers of Medicaid beneficiaries.[50] The letter to CMS also commented on many other provisions of the proposed rule, recommending stronger standards in some areas and increased flexibility in others, and stressing the need for adequate state resources to audit and enforce the regulatory standards.

Section 1115 Waiver Renewal

California's Bridge to Reform demonstration waiver expired on October 31, 2015. DHCS applied for a five-year extension of the waiver under the name "Medi-Cal 2020" and, on December 30, 2015, the terms of that waiver were announced. Among the key components of the waiver is the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) fund, a pool of up to almost $7.5 billion in combined federal and state spending over the five-year waiver period for delivery system reform in California's public hospital systems. The PRIME pool builds off the Delivery System Reform Incentive Program (DSRIP) included in California's original waiver. DHCS will use it to fund public provider system projects to change care delivery and strengthen the ability of these systems to be paid under risk-based alternative payment models (APMs) that hold providers accountable for quality and the cost of care. The waiver documents state that CMS and the state will measure the success of PRIME, in part, by assessing the progress in moving to APMs for designated entities through Medi-Cal

managed care.[51] It remains to be seen exactly how the DSRIP and PRIME pools will interact with the Medi-Cal managed care program and what the implications will be for plans and their Medi-Cal members.

Medi-Cal 2020's "Whole Person Care Pilots," intended to provide more integrated care for vulnerable, high-utilizing beneficiaries, also involve Medi-Cal plans. In these county-based pilots, Medi-Cal managed care plans, safety-net providers, and other community-based service providers and affordable housing providers, are expected to develop innovative partnerships to address social determinants of health as well as integrate physical and behavioral health care and improve beneficiary health and well-being.

Looking Ahead

In the short time from 2011 to 2015, California expanded managed care to 28 rural counties, transitioned or enrolled almost 5 million beneficiaries into managed care, carved adult day health and mental health services into managed care, and, in seven counties, launched a managed long-term services and supports program and a Dual Demonstration. Currently, Medi-Cal managed care plans operate in all 58 counties in California and cover over three-quarters of all Medi-Cal enrollees. To absorb the influx of new members, including many with complex care needs, Medi-Cal plans have been challenged to expand their provider networks and reinforce their operations rapidly to handle increased demand for services, increased demand on call centers, and utilization management, care management, quality improvement, and claims processing on a larger scale. In addition, the state has been challenged to provide adequate notice and education to enrollees transitioning to managed care and to ensure that health plans receive data on a timely basis.

Other states considering managed care expansions – especially, expansions to Medicaid populations with more complex care needs – can learn from California's experience. Managed care is unlikely to solve longstanding access problems attributable to systemic provider shortages and/or low Medicaid payment rates and limited provider participation. As states expand their managed care programs to more Medicaid beneficiaries, including those with high needs, ensuring that plan networks are adequate to serve their enrollees could be more challenging for both plans and states. Robust transition planning is essential to minimize disruptions in care when states mandate that new groups of FFS beneficiaries enroll in managed care plans. Engaging beneficiaries, providers, consumer advocates, and other stakeholders in this planning process and its implementation is necessary to ensure that beneficiaries know how to navigate their plans to obtain needed services and assistance and are fully informed about their rights and options. Data-sharing systems and procedures to support managed care transitions, and information systems and data analytics capacity to support ongoing monitoring, oversight, and performance improvement are integral to both plan and state accountability for Medicaid managed care programs.

California, like many other states, is increasingly oriented toward achieving better performance from its managed care contractors. Key areas of focus include further delivery system transformation to improve care while reducing costs; enhanced care integration; expansion of managed long-term services and supports; transparency regarding health outcomes of managed care enrollees; and improving population health. To meet these challenges, managed care plans will need to develop new ways to engage beneficiaries, partner with community-based social services and supportive housing organizations, and structure provider payment models to promote health care quality and outcomes – all in the context of limited federal and state funding.

Finally, if, as managed care evolves in new ways, its potential to provide more coordinated and integrated care is to be optimized and gaps in access are to be minimized, close state monitoring of managed care plans and rigorous enforcement of federal and state managed care requirements will continue to be essential.

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Appendix Table 1: Network Adequacy Standards in Medi-Cal Managed Care		
Knox-Keene Act Standards[a]	Medi-Cal Two-Plan and GMC Contract Standards[b]	COHS Contract Standards[b]
General Requirements		
Comprehensive range of primary, specialty, institutional, and ancillary services readily available at reasonable times to all enrollees.	Maintain network adequate to serve 60% of all eligible beneficiaries within the service area and provide full scope benefits. Ensure appropriate provider network, including PCPs, specialists, and other personnel and an adequate number of inpatient facilities within the service area.	Submit a complete provider network adequate to provide covered services to eligible beneficiaries within the service area. Increase capacity of the network to accommodate growth.
Time and Distance Standards		
Primary care and hospital services must be available within 30 minutes or 15 miles of enrollee's residence or workplace. Laboratory, pharmacy, and similar services available at locations within a reasonable distance from PCP.	Maintain a network of PCPs located within 30 minutes or 10 miles of a member's residence unless MCO has an approved alternative standard.	Maintain a network of PCPs located within 30 minutes or 10 miles of a member's residence unless MCO has an approved alternative standard.
Provider-to-Enrollee Ratios and Other Access Standards		
• PCPs: 1: 2,000 • Total physicians: 1: 1,200 • Complete network of PCPs and specialists with admitting staff privileges at least one contracting hospital equipped to provide range of basic health care services • Emergency 24/7 • Access to medically required specialists	• PCPs: 1: 2,000 • Total physicians: 1: 1,200 • Non-physicians not to exceed provider/patient caseload of 1: 1,000 • Emergency services 24/7 • Adequate number and type of specialists	• PCPs: 1: 2,000 • Total physicians: 1: 1,200 • Non-physicians not to exceed provider/patient caseload of 1: 1,000 • Emergency services 24/7 • Adequate number and type of specialists

[a] Title 28, California Code of Regulations, §1300.51.H and §1300.67.2.
[b] COHS Boilerplate Contract and Two Plan Boilerplate Contract, available at http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

Appendix Table 2: Timeliness Standards for Appointments in Medi-Cal Managed Care	
Type of Appointment	Standard for Timeliness
Urgent care, no prior authorization	48 hours*
Urgent care, prior authorization	96 hours
Non-urgent primary care	10 business days of request
Specialist care	15 business days of request
Non-urgent ancillary services for diagnosis or treatment of injury, illness, or other health condition	15 business days of request
First prenatal visit	10 business days
Urgent dental care	72 hours
Non-urgent dental care	36 business days
Preventive dental care	40 business days

* The COHS contract has a more stringent urgent care provision that requires that a member needing urgent care be seen within 24 hours.

Endnotes

[1] Cite to new SHFO CPS data once posted.

[2] Most of the state's Medi-Cal managed care programs were included in the California "Bridge to Reform" Section 1115 waiver amendment effective for the 2010 – 2015 time period. The waiver amendment also expanded the managed care programs to include seniors and persons with disabilities, expanded managed care to additional counties, and added benefits. California Bridge to Reform Section 1115 Demonstration Fact Sheet, Updated August 2015. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-bridge-to-health-reform-fs.pdf

[3] See http://kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/

[4] Medi-Cal Managed Care Enrollment Report, October 2015, available at http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptOct2015.pdf

[5] *Medi-Cal Managed Care*, Medi-Cal Facts No. 8, March 2000, Medi-Cal Policy Institute, a project of the California Health Care Foundation. Accessed at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20M/PDF%20mmc2.pdf

[6] California's 12 public hospital health system counties are: Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura. *All Plan Letter 13-022*, California Department of Health Care Services, July 25, 2014, available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-022.pdf. These 12 counties are served under the Two Plan Model, except for Monterey, San Mateo, and Ventura counties, which are served by COHS plans. .

[7] L.A. Care Health Plan website, Plan Partners page. Accessed at http://www.lacare.org/health-plans/medi-cal/plan-partners

[8] As of August 2015, there are four plan choices in Sacramento County and five in San Diego County. Medi-Cal Managed Care Enrollment Report, August 2015. Accessed at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

[9] Medi-Cal Update, Part 1 – Program and Eligibility, October 2013. Accessed at http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/part1201310.asp

[10] California Department of Health Care Services, *Medi-Cal Managed Care Program Fact Sheet – Managed Care Models,* November 2014. Accessed at http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf; Medi-Cal Managed Care Enrollment Report, August 2015. Accessed at http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

[11] California's 12 public hospital health system counties are: Alameda, Contra Costa, Kern, Los Angeles, Monterey, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, and Ventura. See *All Plan Letter 13-022*, op. cit.

[12] California's "Bridge to Reform" section 1115 waiver, approved in November 2010, created the Low Income Health Program (LIHP), which allowed counties to receive federal Medicaid reimbursement for providing health services through the LIHP to residents who would become newly eligible for coverage under the ACA Medicaid expansion in 2014.

[13] *All Plan Letter 13-022*, op. cit.

[14] MCOs can avoid oversight action associated with not meeting the 75% auto-assignment standard if they demonstrate that they have attempted to meet it but are constrained by regulatory geographic access standards.

[15] Knox-Keene Health Care Service Plan Act of 1975, §1367.03, and Title 28, California Code of Regulations §1300.51 and §1300.67.2.

[16] Bridge to Reform Waiver Resources, California Department of Health Care Services, available at http://www.dhcs.ca.gov/provgovpart/Pages/1115-Bridge-to-Reform.aspx

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Department of Health Care Services

It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care

August 2019

REPORT 2018-122

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Elaine M. Howle *State Auditor*

August 6, 2019
2018-122

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, the California State Auditor performed an audit of the oversight by the Department of Health Care Services (DHCS) of the *Regional Model*, a form of administering managed care to beneficiaries of the California Medical Assistance Program (Medi-Cal) in 18 counties.

This report concludes that DHCS has not ensured that some Medi-Cal beneficiaries in the Regional Model received an acceptable level of care, which we define as adequate access to care combined with adequate quality of care. Specifically, DHCS did not enforce state requirements that limit the distances health plans may direct their Medi-Cal beneficiaries to travel to receive health care. By approving health plans' requests for exceptions to the requirements without validating the reasonableness of those requests, DHCS allowed the health plans to require some of the Regional Model beneficiaries to travel excessive distances to receive care. DHCS' actions also reduced the health plans' incentives to expand their provider networks to include providers within reasonable distances of their beneficiaries. The Regional Model beneficiaries also generally received a lower quality of care than beneficiaries in other areas of the State, although that quality has recently improved as a result of DHCS' enforcement of the health plans' quality-of-care requirements.

When transitioning the Regional Model counties in 2013 from a fee-for-service delivery system to managed care, DHCS did not adequately assist the counties in identifying the options available to them, despite some counties expressing interest in joining a county organized health system (COHS). The COHS Model, used in 22 other counties in the State, may provide beneficiaries in the Regional Model counties with better access to care than they receive through their current health plans. Establishing a COHS would likely provide the beneficiaries with access to a greater proportion of the Medi-Cal providers in their geographic areas, thereby reducing the distances that the beneficiaries would need to travel to receive care. Because DHCS plans to establish new managed care contracts with the health plans currently serving the Regional Model counties after its current contracts expire in 2023, it is an ideal time for DHCS to evaluate whether the COHS Model would be better suited to provide reasonable access to care and to assist counties with making such a transition if they desire to do so.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
California State Auditor

Selected Abbreviations Used in This Report

CAP	corrective action plan
CMS	Centers for Medicare & Medicaid Services
COHS	county organized health system
DHCS	Department of Health Care Services
HEDIS	Healthcare Effectiveness Data and Information Set
Managed Health Care	Department of Managed Health Care
Regional Model	New managed care model into which DHCS grouped 18 rural expansion counties in 2012
rural expansion counties	The 28 counties that state law required DHCS to transition to managed care in 2012

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Summary

Results in Brief

In 2012 state law required the Department of Health Care Services (DHCS) to transition the recipients of California Medical Assistance Program (Medi-Cal) services (beneficiaries) in 28 fee-for-service counties in rural areas (rural expansion counties) to managed care. In contrast to the fee-for-service delivery system in which a beneficiary seeks medical care from a Medi-Cal provider and that provider then bills the Medi-Cal program for the individual service, in the managed care delivery system, DHCS contracts with and pays monthly rates to health plans to coordinate and administer services to beneficiaries enrolled in these plans. Eight of the 28 counties chose to join a nonprofit health plan called Partnership Health Plan of California (Partnership) that operated under county oversight, while DHCS worked with two other counties to establish their own unique models for providing health care. DHCS grouped the remaining 18 counties into a new managed care model that it called the *Regional Model*. DHCS then contracted with two commercial health plans—Anthem Blue Cross Partnership Plan (Anthem) and California Health & Wellness (Health & Wellness)—to deliver managed care services to the beneficiaries covered under the Regional Model. The Joint Legislative Audit Committee requested that we determine whether the Regional Model beneficiaries have received an acceptable level of care and to evaluate how that care compares to the care beneficiaries in other models have received. *Acceptable level of care* is not a standard term DHCS uses, so for the purposes of this audit, we have defined the term to mean adequate access to care combined with adequate quality of care. Under this definition, beneficiaries in the Regional Model have not received an acceptable level of care.

Most significantly, even though Partnership operates in comparable rural counties, the two Regional Model health plans have provided beneficiaries with worse access to care than Partnership has provided its beneficiaries. In fact, our analysis showed that the Regional Model health plans have required some beneficiaries to travel hundreds of miles to reach certain health care providers, including obstetricians, oncologists, neurologists, and pulmonologists. In many instances, these distances far exceeded the distances that Partnership required its beneficiaries to travel for similar care. For example, according to DHCS' January 2019 provider location data, Partnership required rural beneficiaries to travel up to 60 miles for an appointment with a cardiologist compared to 239 miles for Anthem and 115 miles for Health & Wellness.

Audit Highlights . . .

Our audit of DHCS' oversight of managed care in the Regional Model counties revealed the following:

» *The Regional Model health plans have not provided all Medi-Cal beneficiaries with adequate access to care.*

- *DHCS did not enforce state requirements that limit the distances health plans may direct their Medi-Cal beneficiaries to travel to receive health care—some beneficiaries were required to travel hundreds of miles to receive care.*
- *DHCS failed to hold Regional Model Health plans accountable for improving beneficiaries' access to care.*

» *Regional Model beneficiaries have generally received a lower quality of care than beneficiaries in other areas of the State.*

» *DHCS did not adequately educate the Regional Model counties about the options available to them regarding their transition to managed care.*

- *It did not assist Regional Model counties that wanted to create or join a COHS, which may have provided its beneficiaries with better access to care.*

Regional Model beneficiaries had to travel such long distances in part because most of the providers that contracted with the Regional Model health plans contracted with only one of the two health plans. Consequently, a beneficiary of one plan might have to travel significantly farther for care than a beneficiary of the other plan from the same location who was seeking the same care. For example, according to DHCS' January 2019 provider location data, a resident of Olancha in Inyo County who was seeking oncologist care would need to travel 60 miles to Ridgecrest if he were an Anthem beneficiary; however, if he were a Health & Wellness beneficiary, he would need to travel more than 150 miles to Burbank for the same care because Health & Wellness did not have a contract with the closer provider. When health plans require beneficiaries to travel this far to receive care, those beneficiaries may be unable or unwilling to do so.

In many cases, the distances that the Regional Model health plans required far exceeded the limits state law imposes, which range from 10 to 60 miles depending on the type of service. Nonetheless, DHCS did not effectively intervene when health plans did not meet these access requirements as it did when it found that health plans were not meeting quality standards. Instead, after the current distance and travel time requirements first became effective in 2018, DHCS ultimately approved all the requested exceptions to the access requirements even though it had not evaluated whether the health plans had exhausted all other reasonable options to identify providers that would meet those requirements. As a result, all the health plans—including those in the Regional Model counties—remained in compliance with state law because of those approvals even though the distances that the plans required beneficiaries to travel did not comply. If DHCS had placed health plans on corrective action plans (CAPs) pertaining to access to care instead of approving their exception requests, it might have motivated them to improve their provider networks. By establishing CAPs, DHCS could also have required the health plans to pay for out-of-network care for beneficiaries that did not have adequate access to care. However, by approving the health plans' requests for exceptions to travel-distance requirements, DHCS reduced their incentives to improve their networks and undermined the intent of the law, which is to provide beneficiaries access to care within prescribed distance limits.

In addition, the Regional Model health plans have consistently provided a lower quality of care than many other plans in the State. Specifically, from 2015 through 2018, DHCS determined that the health plans in all 28 rural expansion counties performed below a number of national minimum performance levels. Further, when the Department of Managed Health Care—which state law authorized to perform audits on behalf of DHCS—audited the

rural expansion counties' health plans from 2014 through 2016, it identified more serious deficiencies in the 18 Regional Model plans than in the health plans of the other 10 rural expansion counties. However, because DHCS has taken steps to address these types of issues, such as imposing CAPs, the quality of care in the Regional Model counties has steadily improved in recent years.

DHCS provided the counties with only limited guidance and information to assist them in their transition to managed care. As the agency responsible for overseeing the effective delivery of health care to Medi-Cal beneficiaries throughout the State, DHCS should have proactively educated the rural expansion counties on the available managed care model options before they transitioned to managed care and thus better ensured that the counties would select models that would best serve their beneficiaries' needs. According to DHCS, the limited-guidance approach had worked well when it transitioned other counties to managed care before 2012. However, this approach was not as effective for the rural expansion counties because many of them lacked the knowledge and resources to determine the model that would best serve their beneficiaries.

We believe that DHCS could improve the future access to managed care services of the Regional Model beneficiaries by assisting counties in transitioning from the Regional Model to a county organized health system (COHS). Partnership—the health plan that currently serves eight of the 28 rural expansion counties and has generally provided adequate access within those counties—is a COHS that non-rural expansion counties established before the rural expansion. In contrast to the Regional Model, a COHS uses a single health plan to deliver services to all of its beneficiaries. Consequently, these beneficiaries can receive care from the same network of providers unlike in the Regional Model in which the two health plans frequently contract with different providers. Further, a COHS operates under the direct influence of county officials who make up a portion of its board of commissioners. The counties are therefore better able to direct the COHS to use its resources to address the specific needs of their beneficiaries. Although many variables affect health plans' abilities to establish provider networks that deliver acceptable access to care, a COHS might enable better access to care in the Regional Model counties.

Transitioning the Regional Model counties to a COHS will be possible after DHCS' contract with Anthem expires in 2023. However, transitioning from the Regional Model to a multicounty COHS would require the counties to complete a number of necessary start-up activities, including establishing a special commission, hiring administrative staff, and gaining federal approval. Because the Regional Model counties tend to have

fewer resources than other counties, they will likely need DHCS' assistance in performing these activities. If Regional Model counties wish to be in a COHS, DHCS would need to immediately begin efforts to allow for a smooth transition for these counties' beneficiaries. By providing the counties with assistance in creating a COHS, DHCS could ensure that Regional Model beneficiaries are better able to receive the health care services that they need.

Summary of Recommendations

To obtain assurance that health plans throughout the State have exhausted all of their reasonable options to meet the access requirements before seeking exceptions, DHCS should immediately begin doing the following:

- Develop written guidance that specifies the conditions under which staff should approve, deny, or contact health plans for clarification regarding their requests for exceptions.
- Determine a specific minimum number of providers that health plans must attempt to contract with before requesting an exception.
- Require health plans to report on their attempts to contract with providers when submitting their requests, including providing evidence of their efforts, such as the contact information for each provider with which they have attempted to contract.
- Establish a process for periodically verifying the health plans' efforts, such as contacting a sample of the listed providers and determining whether the plans attempted to contract with them.
- Require health plans to authorize out-of-network care if they do not demonstrate they have exhausted all of their reasonable options to meet the access requirements.

To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020:

- Determine the specific causes of Anthem's and Health & Wellness's inabilities to provide reasonable access to care in the Regional Model counties.
- Evaluate whether the structural characteristics of a COHS Model would be better suited to providing reasonable access to care in these counties and notify the counties of its conclusions. If some

or all of the counties desire to transition to a COHS, DHCS should assist them in making that change after their current contracts expire.

- Evaluate whether it has the financial resources to provide assistance to counties interested in establishing a COHS or other managed care model after the current Regional Model contracts expire. If DHCS does not have the required financial resources, it should seek an appropriate amount of funding from the Legislature.

- Provide counties with reasonable opportunities to decide whether to change their managed care models after the expiration of their current contracts. DHCS should provide counties that choose to do so sufficient time to establish their new models before the expiration of their current agreements to ensure continuity of service.

Agency Comments

Although DHCS agreed with most of our recommendations, it disagreed with several recommendations, stating that it will not implement them.

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Introduction

Background

Under the oversight of the Centers for Medicare & Medicaid Services (CMS), the federal Medicaid program authorizes grants to states for medical assistance to low-income individuals and families who meet federal and state eligibility requirements. In 1966 California began participating in the federal Medicaid program through its California Medical Assistance Program (Medi-Cal). The Department of Health Care Services (DHCS) is the designated state agency responsible for administering Medi-Cal. In December 2013, before the implementation of the Affordable Care Act in 2014, the Medi-Cal program had 8.6 million enrolled beneficiaries. As of November 2018, the Medi-Cal program provided services to 13 million enrolled beneficiaries—nearly one-third of California's residents. During fiscal year 2018–19, the Governor's budget funded DHCS with more than $102 billion, of which more than $21 billion came from the State's General Fund.

Since the 1970s, the State has gradually transitioned Medi-Cal beneficiaries by county from fee-for-service delivery systems to managed care systems. When the State first established the Medi-Cal program, it relied solely on the fee-for-service system, under which beneficiaries choose the health care professionals from whom they receive care, and those professionals then bill DHCS directly for the approved services that they provide to the beneficiaries. Before 2012 DHCS transitioned 30 counties to managed care systems because of its belief that members enrolled in managed care can receive care coordination and case management services that are not available through the fee-for-service system. In 2012 state law required DHCS to transition the remaining 28 fee-for-service Medi-Cal counties, which DHCS refers to as the *rural expansion counties* because many are largely rural, to managed care.[1] Other states have also provided services to beneficiaries through managed care in a similar manner. Specifically, the four states that we reviewed—Arizona, Florida, Washington, and Oregon—all have enrolled the majority of their Medicaid beneficiaries in managed care and have continuously worked on expanding managed care over the last decade.

[1] The timeline for implementing the 2013 transition of the rural expansion counties to managed care was prompted in part by the State's decision to end its Healthy Families program, a program that provided and promoted access to affordable health care services for families. The State wanted to continue providing managed care services to the individuals who had participated in that program.

Under managed care, DHCS contracts with managed care health plans and pays monthly capitation payments—a specified amount per person covered—to each plan to administer beneficiaries' services and pay health care professionals. In turn, the health plans establish provider networks by contracting with medical professionals and groups, known as *providers*, who supply health care to the beneficiaries. Establishing such a network allows health plans to monitor the quality of the providers that serve their beneficiaries, such as through conducting site reviews and monitoring providers' data. The health plans' provider networks include providers located within the counties where the plans' beneficiaries live; in nearby counties; and—at times—in adjacent states, such as Oregon and Nevada. As we discuss in more detail below, some of the State's managed care health plans are privately owned while counties oversee the others.

DHCS Established the Regional Model in 2013

As part of the State's transition process from fee-for-service to managed care, DHCS has approved six models of managed care that it uses to contract with health plans to deliver services. Table 1 summarizes the models and the types of health plans that operate within each model, and Figure 1 identifies each county's model. When transitioning counties to managed care, DHCS has allowed them to pursue various options, including establishing their own health plans, joining existing health plans that other counties had established, or contracting with a commercial health plan. The county-operated health plan options include a county organized health system (COHS), which provides health care through a single nonprofit health plan under county oversight, and a local initiative, which is a health plan with county oversight that provides services to beneficiaries in Two-Plan Model counties. For counties that did not join or create county-overseen health plans—either because they chose not to or were unsuccessful in doing so—DHCS contracted with commercial health plans. According to DHCS, this approach has worked well because it ensured that DHCS could establish managed care regardless of a county's willingness to create or join a COHS or local initiative but also allowed counties to do so if they had the ability and desire. The four other states we previously mentioned also contract with both commercial and nonprofit health plans to provide services to beneficiaries.

DHCS transitioned the rural expansion counties from fee-for-service to managed care in 2013. Figure 1 shows that of the 28 rural expansion counties, eight joined a COHS administered by Partnership Health Plan of California (Partnership), and DHCS worked with two to form their own unique models. Because none of the remaining 18 counties joined or created county-overseen

health plans, DHCS grouped them to create the Regional Model, which is the focus of this audit. In 2013 DHCS contracted with two commercial health plans, Anthem Blue Cross Partnership Plan (Anthem) and California Health & Wellness (Health & Wellness), to serve the Regional Model counties. When selecting health plans, DHCS intended to contract with additional health plans that met its selection criteria, but Anthem and Health & Wellness were the only plans that qualified. DHCS initially contracted with these health plans for five years, from 2013 to 2018, but it has since extended both contracts. We discuss DHCS' contracts with the two plans in more detail in Chapter 2.

Table 1
DHCS Has Six Models of Managed Care That Involve Different Types of Health Plans

MANAGED CARE MODEL	DESCRIPTION	NUMBER OF COUNTIES
Regional	Beneficiaries may select one of two commercial health plans.	18
COHS	Beneficiaries receive services from a single, nonprofit health plan with county oversight.	22
San Benito	Beneficiaries select either to receive managed care delivered by a commercial health plan or to receive fee-for-service through Medi-Cal.	1
Imperial	Beneficiaries may select one of two commercial health plans; one of the health plans has county oversight.	1
Two-Plan	Beneficiaries may select between one commercial health plan and one local initiative, which is a health plan with county oversight.	14
Geographic Managed Care	Beneficiaries may select from three or more commercial health plans.	2

Source: Analysis of data from DHCS' Medi-Cal managed care website, a DHCS presentation on Medi-Cal managed care, DHCS reports, Calviva Health's website, and an Imperial County Board of Supervisors resolution.

Two Agencies Share Responsibility for Overseeing Health Plans That Participate in Medi-Cal

DHCS and the Department of Managed Health Care (Managed Health Care) are responsible for overseeing most health plans that contract with providers to deliver Medi-Cal care to beneficiaries. As part of its role to administer Medi-Cal, DHCS manages the health plans' contracts and oversees their compliance with the terms of those contracts. In its role in protecting health care rights of consumers, Managed Health Care licenses health plans that are subject to the Knox-Keene Act—a state law that regulates most commercial health plans—and monitors their service delivery. Both departments evaluate whether the health plans are performing adequately by auditing their service delivery processes in areas such as access to care and quality of care.

Figure 1
All 58 of California's Counties Now Receive Medi-Cal Through Managed Care Models

Source: Analysis of data from DHCS' Medi-Cal managed care website, a DHCS presentation on Medi-Cal managed care, and DHCS' reports.

DHCS and Managed Health Care determine whether the health plans have provided adequate access to care and quality of care by assessing whether the plans meet the requirements established by law and the health plans' contracts. For access to care, these requirements address providers' availability to schedule appointments for beneficiaries within specific numbers of days, the distance beneficiaries must travel to obtain specified care, and the travel time needed for beneficiaries to arrive at the providers' locations. For quality of care, the requirements include providers' delivery of specific services, such as preventive services and some post-appointment follow-up services; the outcomes of some providers' service delivery; and the health plans' performance of certain administrative activities, such as authorizing service requests and addressing grievance claims. For the purposes of this audit, we focused our evaluation of the Regional Model health plans' performance on the specific indicators that the text box lists.

This Audit's Criteria for Evaluating Health Plan Performance

- **Access to Care:** Whether the health plans have met travel distance requirements.
- **Quality of Care:** How frequently the health plans' performances on national performance quality measures fell below acceptable levels.
- **Quality of Care:** Whether DHCS or Managed Health Care determined through their audits that the health plans were not meeting contractual quality-of-service delivery requirements.

Source: Analysis of state law and health plans' contracts.

State Law Establishes Limits on the Distances Health Plans Can Require Beneficiaries to Travel to Receive Care

Effective January 2018, state law established access requirements, which are predefined limitations on the times and distances Medi-Cal plans may require their beneficiaries to travel to obtain care. The Legislature passed the law in response to regulations that CMS issued in 2016 requiring states contracting with managed care plans to develop and enforce by 2018 time and distance standards for primary, specialty, hospital, and pharmacy services.[2] As the State's administrator of Medi-Cal, DHCS assumed responsibility for developing these requirements, which it did in 2016 and 2017, also establishing an evaluation process to ensure that those standards were reasonable. As part of that process, DHCS considered industry standards and solicited feedback from health plans and other stakeholders. Additionally, it analyzed data on the quantity of providers, the location of providers, and beneficiaries' use of services to identify the extent of beneficiaries' needs and the availability of providers to administer care.

When developing the access requirements, DHCS also considered the unique challenges of providing access in rural areas, such as the geographic dispersion of providers and beneficiaries; as

[2] State law requires health plans to evaluate whether they can meet travel distance standards for 36 different types of providers as well as pharmacies, hospitals, and mental health outpatient services for each area they serve.

a result, it established more lenient access standards for health plans operating in those locations. For primary care services, such as cancer screenings and vaccinations, DHCS established a universal requirement for all counties that aligns with a preexisting requirement in its contracts with managed care plans: within 10 miles or 30 minutes travel time from a beneficiary's residence to the provider's location. For specialty care, such as psychiatry and dermatology, DHCS created requirements based on four defined categories of counties' population densities: dense, medium, small, or rural. In dense counties like Sacramento and San Francisco, health plans must ensure beneficiaries can access specialty care within 15 miles or 30 minutes. In rural counties, such as Alpine or Inyo, health plans must ensure that their beneficiaries are able to access care within 60 miles or 90 minutes.

DHCS uses an annual network certification process to determine whether health plans are complying with the access requirements, as state law requires. It verifies the health plans' compliance in each zip code they serve by requiring them to indicate the locations of all of their providers. Using these data, DHCS calculates the time and distance required to travel to the plans' nearest providers from each zip code. In principle, for a health plan to pass the annual network certification, it would need to contract with a sufficient number of providers to ensure that beneficiaries in every zip code it serves can access care without having to travel farther than the distances specified by the access requirements.

State law also authorizes DHCS to exempt health plans from meeting the access requirements and to establish alternative requirements for them. Specifically, DHCS may allow alternative access standards upon the request of a health plan if the plan has exhausted all other reasonable options to secure local providers that meet the applicable requirement. When DHCS allows alternative access standards, it establishes the health plan's alternative standard as the distance between the location in question and the health plan's closest available provider.

DHCS Requires Health Plans to Meet Specific Performance Levels

Federal regulations also require the State to annually measure and report the quality of care that Medi-Cal managed care health plans provide using a set of standardized performance measures. To comply with this requirement, DHCS uses a selection of performance measures primarily from the Healthcare Effectiveness Data and Information Set (HEDIS), which the National Committee for Quality Assurance developed. HEDIS is a nationally accepted set of measures for assessing health plans' performance, and DHCS uses HEDIS to evaluate health plans' delivery of preventive

services, provision of care for chronic conditions, and appropriate treatment and utilization of services. For example, DHCS evaluates plans against HEDIS measures such as the percentage of eligible beneficiaries who receive breast cancer screenings and the percentage of beneficiaries with persistent asthma who are prescribed appropriate medication.

DHCS' contracts with health plans require the plans to score at or above minimum performance levels for a selection of HEDIS measures. DHCS establishes these minimum performance levels based on the national performance of the Medicaid program. Specifically, DHCS expects plans to perform in the top 75 percent of Medicaid plans nationally.[3] Health plans report their performance for each of their reporting units, which correspond to counties or groups of counties that the plans serve. For example, the Regional Model has two reporting units, which together represent the model's 18 counties. The number of measures for which DHCS holds plans accountable may vary from year to year because it periodically adds or removes HEDIS measures to align with its areas of focus, such as maternal and child health, for quality improvement. When DHCS requires health plans to report on newly added measures, it does not require the health plans to meet the minimum performance levels until the second year in which those measures are in place.

Counties Are Important Stakeholders in the Medi-Cal System

County health agencies are key to Medi-Cal because they may participate as advocates for beneficiaries, as providers who serve beneficiaries, and as administrators of health plans. In addition, state law requires county health agencies to initially determine which applicants are eligible for Medi-Cal and to assist the applicants in the application process as needed. As advocates, county health agencies may assist beneficiaries who have questions or are experiencing difficulty receiving services. For example, some counties help beneficiaries schedule appointments with providers and arrange transportation for them to attend appointments. Additionally, counties serve as primary providers for some beneficiaries in rural areas of the State through county-operated clinics. Finally, several counties are involved in administering health plans through a COHS or through a local initiative in Two-Plan Model counties.

[3] DHCS plans to modify its performance measurement process in 2020. DHCS will expect health plans to perform in the top 50 percent of Medicaid plans nationally to meet minimum performance levels, and it will select performance measures from lists published by CMS.

As a result of the many functions county health agencies perform in the Medi-Cal system, they often have specific expertise about the local conditions within their communities and may have experience working with local providers. Consequently, they are well-positioned to negotiate and collaborate with health plans and with DHCS to improve the level of care beneficiaries receive.

Chapter 1

DHCS HAS ALLOWED HEALTH PLANS TO REQUIRE SOME OF THEIR MEDI-CAL BENEFICIARIES TO TRAVEL HUNDREDS OF MILES TO RECEIVE CARE

Chapter Summary

The Regional Model health plans have not provided all beneficiaries with adequate access to care. As a result, some beneficiaries in Regional Model counties may have had to travel hundreds of miles to receive medical care from in-network providers of one health plan, even though the same care was available from closer providers who contracted with the other health plan. During the period we reviewed, DHCS failed to hold health plans accountable when they did not provide beneficiaries with access to care that met state requirements. Instead, it reduced the plans' incentives to improve their provider networks by excusing them from meeting these requirements, even though it had not ensured that they had exhausted all of their reasonable options to secure local providers as state law requires. Our analysis indicates that some beneficiaries' access to care would improve dramatically if DHCS were to require health plans to allow beneficiaries to obtain care from out-of-network providers that are closer to them when the plans are unable to provide adequate access themselves.

Additionally, the HEDIS scores for health plans in the rural expansion counties indicate that beneficiaries in these counties have generally received a lower quality of care than beneficiaries in other areas of the State. According to the HEDIS scores, the quality of care that Anthem and Health & Wellness provided in the Regional Model counties was comparable to the care that Partnership—a COHS that serves eight rural expansion counties—provided in its counties. However, Managed Health Care's audits of the rural expansion counties suggest that Anthem and Health & Wellness experienced greater difficulty meeting contractual requirements pertaining to quality of care than Partnership did. In addition, DHCS has limited the counties' abilities to respond to those problems and assist their beneficiaries in receiving adequate services because it has not taken adequate steps to share with the counties the deficiencies it and Managed Health Care have identified.

Some Beneficiaries in Regional Model Counties Have Had Poor Access to Care

The Regional Model health plans have required some beneficiaries to travel excessive distances to obtain medical care from providers. In most cases, managed care beneficiaries may receive medical care

only from the contracted providers within their plan's network. In this way, health plans choose the providers that beneficiaries may visit to obtain medical care. Within the Regional Model counties, the distances that beneficiaries have had to travel to access the closest contracted providers have varied widely, from less than 10 miles to 365 miles. Table 2 identifies the distances some beneficiaries within these counties have had to travel to receive specific health care.

Table 2
The Regional Model Health Plans Have Required Some Beneficiaries to Travel Unreasonable Distances to Access Care

	MAXIMUM DISTANCE REQUIRED TO ACCESS CARE (IN MILES)		
	REGIONAL MODEL		COHS
PROVIDER TYPE	ANTHEM	HEALTH & WELLNESS	PARTNERSHIP
Specialty Care			
Cardiology/Interventional Cardiology	239	115	60
Dermatology	272	365	60
Endocrinology	313	225	60
ENT/Otolaryngology	343	200	60
Gastroenterology	83	150	60
General Surgery	123	115	60
Hematology	99	200	165
HIV/AIDS Specialists/Infectious Diseases	324	140	60
Mental Health (Nonpsychiatry) Outpatient Services*	83	60	60
Nephrology	124	230	60
Neurology	300	215	60
OB/GYN Specialty Care*	164	60	60
Oncology	299	170	120
Ophthalmology	81	60	120
Orthopedic Surgery	164	150	60
Physical Medicine and Rehabilitation	327	220	120
Psychiatry	327	170	60
Pulmonology	327	180	60
Primary Care			
OB/GYN Primary Care	NA†	230	10
Primary Care Physician	10	85	45
Other Provider Types			
Hospital	81	120	45
Pharmacy	45	90	10

Source: Analysis of the most recent alternative access standards that DHCS had approved as of January 2019.

NA = Not applicable.

* We include OB/GYN Specialty Care and Mental Health (Nonpsychiatry) Outpatient Services with other specialists because they have the same time and distance standards.

† Anthem was exempt from this requirement because it does not designate its OB/GYN providers as primary care physicians.

Although it may be difficult for health plans to provide beneficiaries with close access to care when those beneficiaries reside in remote regions of the State, we would expect this difficulty to equally affect all the health plans that serve rural counties. However, as Table 2 also shows, Partnership provided its beneficiaries in rural counties with access to most care within 60 miles. Moreover, the longest distances beneficiaries had to travel to receive care in Partnership's counties were generally much shorter than those that Regional Model beneficiaries were required to travel for the same care. For example, Table 2 shows that Partnership required rural beneficiaries to travel up to 60 miles for an appointment with a cardiologist compared to 239 miles for Anthem and 115 miles for Health & Wellness. The additional distances that Anthem and Health & Wellness have required their beneficiaries to travel may have deterred some beneficiaries from seeking care.

We also identified inconsistencies between the distances that Anthem and Health & Wellness required their beneficiaries from the same locations to travel for the same care. When we reviewed provider location data that the two health plans submitted to DHCS, we identified more than 100 instances in which either of the plans required its beneficiaries to travel at least 100 miles farther than the other plan for the same care. In the five most extreme cases, the difference between the two plans ranged from 255 to 305 miles. For example, DHCS' data indicate that a beneficiary of Health & Wellness residing in June Lake, in Mono County, who needed to take her child to a pediatric dermatologist would have been required to travel up to 365 miles while if the same beneficiary were with Anthem, she would only have been required to travel up to 60 miles.

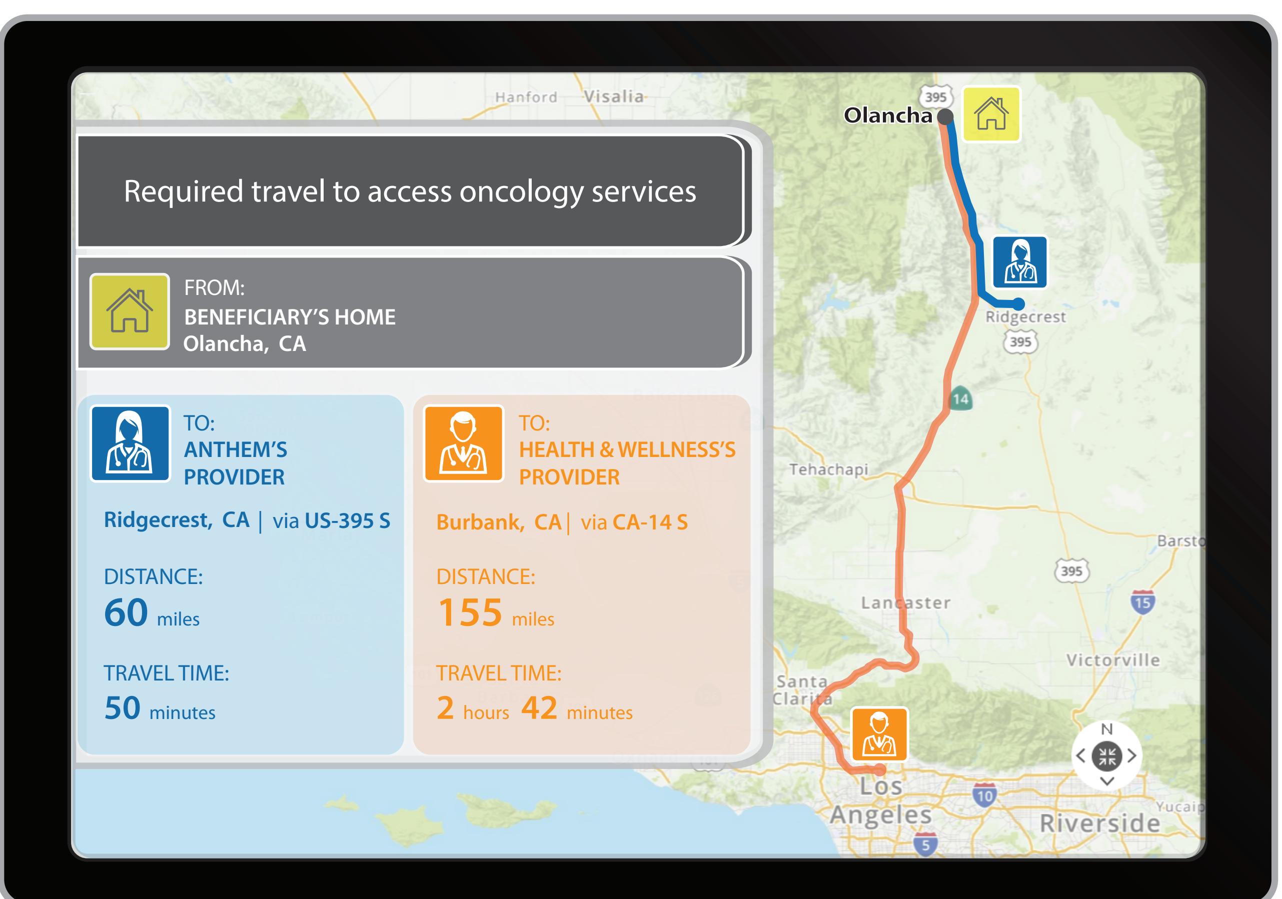
We identified inconsistencies between the distances that Anthem and Health & Wellness required their beneficiaries from the same locations to travel for the same care.

On some occasions, Anthem and Health & Wellness each required its beneficiaries to travel significantly farther than the other plan required of its beneficiaries. As Figure 2 shows, a beneficiary of Health & Wellness residing in Olancha, in Inyo County, who needed to see an oncologist would have to travel more than 150 miles to Burbank to receive cancer treatment. However, if this same beneficiary were with Anthem, he would have to travel only 60 miles for the same care. Similarly, a beneficiary of Anthem residing in Tecopa, also in Inyo County, who needed to see a pulmonologist, would have had to travel 327 miles, which is more than 175 miles farther to receive asthma treatment than if she were with Health & Wellness.

The differences in the distance requirements between the two health plans are also noticeable in more densely populated areas of the Regional Model counties. For example, according to the January 2019 data, a beneficiary of Health & Wellness who needed to take his child to visit a pediatric cardiologist and who resided in the Lake Tahoe community of Kings Beach in Placer County—

which is more densely populated than many other rural expansion counties—would have to travel up to 70 miles farther than an Anthem beneficiary from the same location who sought that same service. As we discuss in more detail below, these instances suggest that the difference in distances is not always the result of a general lack of providers but rather a lack of providers who have contracted with a specific Regional Model health plan. In other words, some beneficiaries may live reasonably close to providers who offer the needed care; however, those providers are not in-network for their plans. Although beneficiaries have the right to switch health plans, doing so may disrupt the continuity of the care they receive because they may not be able to continue seeing their primary care physicians and other providers from whom they have already received care.

Figure 2
The Two Regional Model Health Plans May Require Beneficiaries in the Same Location to Travel Significantly Different Distances to Receive the Same Services



Source: Analysis of the alternative access standards that DHCS had approved as of January 2019, Anthem's Medi-Cal provider directory, and Google Maps.

Traveling significant distances to reach providers may limit beneficiaries' ability to receive care. A beneficiary who has to travel hundreds of miles to receive medical care might be forced to miss an entire day of work and lose wages—a loss that might be critical considering that beneficiaries who qualify for Medi‑Cal while employed have limited incomes. Further, some beneficiaries might be unable to tolerate the physical hardship of traveling such substantial distances for health care. When health issues require multiple visits, it likely will exacerbate such concerns: for example, the U.S. Department of Health and Human Services suggests weekly appointments for pregnant women nearing their delivery dates.[4] If beneficiaries are unwilling or unable to seek care because of the distances required to do so, it undermines the fundamental purpose of the Medi‑Cal program, which is to improve the overall health and well‑being of all residents by providing access to affordable, integrated, and high‑quality health care.

If beneficiaries are unwilling or unable to seek care because of the distances required to do so, it undermines the fundamental purpose of the Medi‑Cal program.

DHCS Has Failed to Hold Regional Model Health Plans Accountable for Improving Beneficiaries' Access to Care

As we discuss in the Introduction, DHCS uses a network certification process to assess whether health plans are complying with state access requirements. DHCS published the initial results of its first annual network certification in June 2018 and finalized the results in January 2019. These results, which remain in effect until July 2019, indicate that DHCS granted alternative access standards to the State's health plans in nearly 10,000 instances in which they requested them. More than 1,000 of these 10,000 instances involved the Regional Model health plans. On our website, we present an interactive map of the extended distances DHCS approved through alternative access standards by county and provider type. Given that DHCS made a considerable effort in 2016 and 2017 to ensure that the access requirements that state law established were reasonable and that this effort included analyzing the availability of providers who could meet those requirements, we question why it has chosen not to enforce them. By approving alternative access standards, DHCS is not holding health plans accountable to meet the access requirements prescribed in state law. Instead, alternative access standards allow health plans to deviate from the prescribed requirements by extending the time and distance that they may require beneficiaries to travel for care.

[4] Although state law requires health plans to provide transportation services to their beneficiaries in some instances, the beneficiaries would still incur significant travel time for extensive distances.

We are particularly concerned with DHCS' decision not to enforce these state requirements given the weaknesses we identified in its process for evaluating requests for alternative access standards. In particular, although DHCS denies requests for alternative access standards if they are incomplete or inaccurate, it has not adequately evaluated whether health plans have, in fact, exhausted all other reasonable options to identify providers that would meet the access requirements before approving their requests for alternative access standards, as state law requires. DHCS stated that it must approve requests for alternative access standards, no matter what the potential hardship those alternative standards may present to beneficiaries, as long as the health plans meet legal requirements, specifically that the plan exhausts all other reasonable options to contract with providers that would meet the access requirements. DHCS requires health plans to provide written explanations of their contracting efforts that it uses to evaluate whether they have complied with this requirement. However, DHCS does not analyze the validity of these explanations; thus, its approach does not meet the apparent intent of the law.

Even though DHCS has required health plans to provide written explanations, it has not required them to provide supporting documentation to corroborate those explanations. Moreover, DHCS has not verified with any providers mentioned in those explanations whether the plans attempted to add them to their networks. Additionally, DHCS has not established a minimum number of providers that the health plans should attempt to contract with in a designated location before it considers an exemption request. We question how DHCS could conclude that a health plan had exhausted all reasonable efforts to seek providers that met an access requirement without establishing such a minimum threshold and substantiating at least some of the health plan's efforts.

DHCS has not consistently enforced its requirements for the explanations health plans must include when requesting alternative access standards.

Moreover, DHCS has not consistently enforced its requirements for the explanations health plans must include when requesting alternative access standards. DHCS' instructions for making such requests state that health plans must detail their efforts to meet the access requirements in order for it to consider their requests. However, when we reviewed a selection of 30 approved requests for alternative access standards, we found six requests in which health plans prepared their explanations using the same boilerplate text for multiple requests. For example, Health & Wellness stated all of the following as its justification in each request for a pediatric specialist we reviewed: "There are no pediatric subspecialists located to meet the standard, the available pediatric specialists do not accept Medi-Cal patients, or the available pediatric specialists have declined to contract with the Plan primarily due to capacity constraints." In none of these cases did the plan identify the specific condition that applied to the request. Similarly, Anthem

stated in some requests that no providers were in the area, yet we identified providers in the area that met the prescribed requirements. We determined that DHCS did follow up in some instances by requesting additional documentation when the health plan provided vague or inaccurate explanations, such as when it submitted a request with inaccurate provider information. DHCS acknowledged that its staff did not consistently identify when further clarification was necessary. This inconsistency can likely be attributed to DHCS' lack of formal guidance specifying the conditions under which a request should be approved or denied.

By approving alternative access standards without proper justification, DHCS has reduced incentives for health plans to improve their beneficiaries' access to care.

By approving alternative access standards without proper justification, DHCS has reduced incentives for health plans to improve their beneficiaries' access to care. When a health plan fails to comply with the access requirements specified in state law, DHCS has the authority to require that it complete a corrective action plan (CAP) to improve its provider network, which DHCS calls a *network certification CAP*. Network certification CAPs require health plans to make the necessary improvements to comply with the access requirements, such as contracting with providers that meet the travel distance requirements. DHCS initially placed health plans on network certification CAPs in 2018 but closed them after approving alternative access standard requests for those health plans that were still unable to meet access requirements. However, it approved those requests even when the health plans did not demonstrate that they had exhausted all reasonable options to obtain closer providers. As a result, DHCS' approval of such alternative access standards involving excessive distances was unreasonable. By enforcing network certification CAPs rather than approving unsupported requests for alternative access standards, DHCS could have ensured that health plans remained obligated to improve their networks.

Further, DHCS could have used network certification CAPs to provide some beneficiaries access to closer providers. Through such CAPs, DHCS may require health plans to temporarily allow beneficiaries to obtain medical care from out-of-network providers, provided that those out-of-network providers do not have a history of quality issues and are willing to accept reasonable rates as determined by the health plans. Although there is no assurance that out-of-network providers will agree to offer such care, a network certification CAP requiring plans to authorize out-of-network care to meet time and distance requirements would provide beneficiaries with greater opportunities to access care. As we previously describe, we identified multiple instances under the Regional Model in which either health plan's nearest in-network provider was significantly farther than the other health plan's provider. In such cases, the ability to seek care from out-of-network providers could significantly improve some beneficiaries' access to care.

DHCS expressed concern to us that providers might demand unreasonably high rates from health plans if they were aware that DHCS would not approve certain requests, which could burden the health plans financially and could result in increased rates that DHCS would have to pay the health plans. However, we disagree with this reasoning. DHCS could enforce the state requirements on the distances health plans may require beneficiaries to travel but allow exceptions if there are no closer providers or if health plans can demonstrate that the rates providers have requested are unreasonably high. Although DHCS requests that the health plans provide rate information when requesting alternative access standards, in practice it has not required them to do so. None of the health plans provided this information for the 30 requests that we reviewed. When health plans are unable to demonstrate that nearby, available providers are demanding unreasonably high rates, neither they nor DHCS can justify the reasonableness of their requests for alternative access standards that require beneficiaries to travel excessive distances.

Although DHCS requests that the health plans provide rate information when requesting alternative access standards, it has not required them to do so.

When we asked DHCS for its perspective regarding the weaknesses we identified in its process for evaluating and approving requests for alternative access standards during its 2018 network certification, DHCS indicated that it intends to continually adjust its procedures for evaluating health plans' requests based on the lessons it learns through each annual certification. However, DHCS did not inform us of the specific outcomes it desires to achieve through its adjustments. Instead, it informed us that as part of the 2019 network certification that it expects to complete in January 2020, it has already made changes to its process and anticipates implementing additional changes as part of its next network certification in 2020.

Although DHCS' recent efforts may address some elements of its process, these efforts do not resolve certain concerns we identified pertaining to access to care. For instance, DHCS informed us that it plans to reject health plans' requests that do not include supporting documentation to demonstrate that they attempted to contract with closer providers. However, we believe that this approach is insufficient because, according to DHCS, it would only be requiring health plans to demonstrate attempts to contract with a single provider. Consequently, that effort would not fulfill the intent of state law—requiring health plans to *exhaust all reasonable options* to obtain providers that meet access requirements—because health plans would likely have multiple providers available to them that they could attempt to contract with. Additionally, DHCS indicated that it plans to deny requests that it deems unreasonable, yet it has not developed formal guidance for its staff to use in making that determination. Without establishing such guidance for its staff and ensuring that health plans attempt to contract with multiple providers, DHCS will likely continue to approve requests that

unjustifiably excuse health plans from their obligation to meet access requirements and allow them to require beneficiaries to travel unreasonable distances to obtain care.

The Structure DHCS Selected for the Regional Model May Have Contributed to Some Beneficiaries' Inadequate Access to Care

DHCS was unable to offer a definitive explanation as to why Anthem and Health & Wellness could not provide their beneficiaries with better access to care. Managers at DHCS responsible for overseeing the approval of health plans' alternative access standard requests identified three potential causes of the excessive distances some beneficiaries may be required to travel: a lack of available providers, providers that contract with only one health plan rather than multiple plans, and providers that are unwilling to accept the payment rates that the health plans offered. Our analysis showed that a significant number of providers in the Regional Model have not contracted with either Anthem or Health & Wellness. However, we could not determine whether doing so would have improved beneficiaries' access to care because the data we evaluated did not identify the noncontracting providers' potential Medi-Cal specialties or all of the locations where they provide care. Nevertheless, our findings support the explanation that many providers contracting with only one of the two Regional Model health plans likely contributed to poor access. Additional analysis is necessary to determine whether a lack of providers in specific geographic areas of the Regional Model or their unwillingness to accept offered payment rates has contributed to the access issues.

When we analyzed licensing data from the Medical Board of California and the Osteopathic Medical Board of California—two entities responsible for licensing doctors in the State who participate in Medi-Cal—and provider network data from the health plans, we found that Anthem and Health & Wellness contracted with more than 3,900 providers located in the Regional Model counties. However, more than 1,900 additional providers in the Regional Model counties had not contracted with either health plan to provide services within these counties. It is unclear whether the two health plans contracting with these providers would improve beneficiaries' access to care. For example, some of these 1,900 providers may be located near beneficiaries who do not experience challenges with limited access.

DHCS would benefit from knowing the locations within the Regional Model counties that require additional providers and the types of providers required in those areas.

We believe that DHCS would benefit from knowing the locations within the Regional Model counties that require additional providers and the types of providers required in those areas. If it had such knowledge, DHCS could determine the extent to which a lack of providers is causing some beneficiaries' poor access to care, and it could also develop the appropriate strategies to

Some beneficiaries in the Regional Model would have significantly better access to care if they were able to seek it from the provider networks of both health plans.

alleviate those provider shortages. DHCS indicated that it would be willing to assist in an analysis of this nature, but that other state departments—such as the Office of Statewide Health Planning and Development—would be better suited to address workforce shortages among providers. Nonetheless, given DHCS' critical role in overseeing the State's provision of Medi-Cal services, we believe that it is well positioned to oversee such an analysis.

Our findings related to providers who contract with only one of the two plans are more straightforward. According to the data that the two health plans reported to DHCS in December 2018, fewer than 29 percent of the providers that contracted with either Anthem or Health & Wellness contracted with both health plans concurrently. Our analysis shows that some beneficiaries in the Regional Model would have significantly better access to care if they were able to seek it from the provider networks of both health plans. To evaluate how beneficiaries' access to care would change if they had access to both networks, we reviewed DHCS' data related to the health plans' adherence to the time and distance requirements specified in state law. During its first annual network certification, DHCS identified more than 700 instances in which one or both Regional Model plans failed to meet these access requirements.[5] However, if the Regional Model's beneficiaries had access to both health plans' provider networks, we estimate that this number would decrease to about 125, the number of instances in which both plans failed to meet the same access requirements in the same locations.

This difference reinforces our conclusion that DHCS could improve beneficiaries' access to care if it required plans to authorize out-of-network care when they do not demonstrate that they have exhausted all of their reasonable options to contract with providers that meet the state requirements and when DHCS determines that significantly closer providers of the needed care are available. The difference also underscores the supposition that the providers' tendency to contract with only one of the two Regional Model health plans has contributed to some beneficiaries' poor access to care. The geographic distribution of providers in rural areas already makes it difficult for health plans to provide adequate access to care; when providers do not contract with multiple plans, it can further compound this difficulty.

[5] We excluded OB/GYN primary care from this analysis because DHCS informed us that it exempted Anthem from the access requirement for OB/GYN primary care. As a result, DHCS does not have sufficient data for us to conclude how often both Regional Model plans are meeting the access requirement for OB/GYN primary care.

Given that Partnership operates in comparably remote areas of the State, its ability to provide significantly better access to care than the Regional Model plans suggests that beneficiaries in rural counties may receive better access to care when those counties operate under a single health plan rather than multiple plans. As part of DHCS' annual network certification, Partnership requested alternative access standards for 11 of the 39 types of providers that DHCS measures. In comparison, Health & Wellness and Anthem requested alternative access standards for 35 and 37 of the 39 provider types, respectively. Unlike the Regional Model, the structure of a COHS—such as Partnership—allows only one health plan in each county, meaning beneficiaries in COHS Model counties all have access to the same providers. We believe that this feature of the COHS Model may have contributed to Partnership's ability to provide better access to care in some rural areas of the State. We discuss the benefits of the COHS Model in greater detail in Chapter 2.

Increasing beneficiaries' access to providers currently outside of their networks could require some beneficiaries to schedule appointments farther in advance. However, the reduction in the distances the beneficiaries would have to travel might well outweigh this additional effort. As we mention in the Introduction, state law requires most health plans to ensure that their providers offer appointments within a specific number of days of the request for services. According to DHCS, if more Medi-Cal providers were to provide care to beneficiaries in both health plans, it might strain some providers' capacities and reduce their ability to meet this requirement. However, state law permits providers to extend the waiting time for appointments if they determine that waiting longer would not negatively affect the health of the beneficiaries involved. This exception could permit beneficiaries to make individual choices that are both safe and potentially more convenient. We believe that in certain circumstances beneficiaries might be willing to schedule appointments farther in advance if doing so would shorten how far they would have to travel. For example, the parent of a child with a heart condition requiring routine cardiology appointments might be willing to schedule those appointments farther in advance to avoid having to drive an additional 70 miles each direction.

Increasing beneficiaries' access to providers currently outside of their networks could require some beneficiaries to schedule appointments farther in advance.

Given Partnership's ability to provide its beneficiaries with better access to care and the apparent tendency of providers to contract with either but not both of the Regional Model health plans, we question whether having two separate health plans best serves the Regional Model counties. Conducting an assessment to identify the locations within the Regional Model that need additional providers and the types of providers necessary could offer DHCS

valuable perspective on whether access issues in the Regional Model are the result of provider shortages, the structure of the model, or both.

In 2016 DHCS commissioned an access assessment that may assist it in identifying and resolving shortages of providers in the Regional Model.

In 2016 DHCS commissioned an access assessment that may assist it in identifying and resolving shortages of providers in the Regional Model. DHCS commissioned the assessment in response to federal requirements issued in 2015. According to documentation provided by DHCS, the completed assessment will include maps comparing the number of providers for each specialty and each health plan with the number of beneficiaries. The assessment will also identify the percentage of available providers for each specialty that each health plan is contracting with, the average distance between beneficiaries and each health plan's closest primary care physicians and hospitals, and recommendations for addressing systemic deficiencies it identifies. DHCS plans to finalize the assessment in October 2019. This assessment should enhance DHCS' knowledge of the locations throughout the State, including those in the Regional Model counties, that are lacking certain types of providers.

Regional Model Health Plans Have Not Provided an Acceptable Quality of Care to Beneficiaries

Although most health plans in the State have not met some of their contractual requirements related to quality of care, the health plans that serve the 28 rural expansion counties have consistently delivered a lower quality of care to beneficiaries than the health plans delivering services to beneficiaries in other areas of the State. Further, Managed Health Care's audits of the rural expansion counties suggest that the Regional Model health plans have had more difficulty than Partnership in meeting their contractual requirements related to quality of care.

Our review of HEDIS data from 2015 through 2018 found that the Regional Model health plans failed to meet a significant number of minimum performance levels. As the Introduction explains, DHCS requires health plans to meet minimum performance levels for key HEDIS measures related to the quality of care that they provide to beneficiaries. However, both Anthem and Health & Wellness scored below minimum performance levels for at least 24 percent of these HEDIS measures for each of the four years for which the data were available. For instance, neither of the two plans conducted an adequate number of breast cancer screenings in 2018. As Table 3 shows, the two Regional Model plans scored extremely poorly in 2016: Anthem and Health & Wellness failed to meet an average of 12 and 14, respectively, of the 22 minimum performance levels. To supplement these figures on the number of HEDIS measures below the minimum performance level, we present an interactive

map on our website that shows by county, plan, and measure the percent of HEDIS scores below the minimum performance levels during the past four years.

Table 3
The Regional Model Health Plans and Partnership Have Provided a Similar Quality of Care in the Rural Expansion Counties

		AVERAGE NUMBER OF HEDIS MEASURES BELOW MINIMUM PERFORMANCE LEVEL		
		REGIONAL MODEL†		COHS
YEAR	NUMBER OF MEASURES*	ANTHEM	HEALTH & WELLNESS	PARTNERSHIP‡
2015	22	9.5	10.5	10.5
2016	22	12	14	11
2017	18	6.5	7.5	8
2018	21	5	6	6

Source: Analysis of HEDIS data.

Note: Anthem, Health & Wellness, and Partnership report on their performance using reporting units made up of groups of counties. We averaged their scores in each of their rural expansion county reporting units to determine their overall performance in the rural expansion counties.

* Excludes measures for which DHCS has not specified a minimum performance level.

† Excludes Kaiser Permanente, which operates in a limited manner in three of the 18 Regional Model counties.

‡ Excludes Lake County, which is part of the rural expansion. Partnership reports Lake County's data as part of a group of counties that includes three counties that were not in the rural expansion.

The HEDIS data indicate that although the quality of care the Regional Model health plans provided was comparable to the quality of care in the other rural expansion counties, it was lower than the quality of care in the rest of the State. As Table 3 shows, the performance of Anthem and Health & Wellness within the 18 Regional Model counties was similar to Partnership's performance in its rural expansion counties. However, Table 4 shows that the rural expansion health plans' average performance was well below the average performance of the plans serving the counties in the rest of the State. Improvements in the HEDIS scores of the Regional Model plans since 2016 have reduced the gap between the Regional Model counties and other areas of the State. According to the quality and monitoring chief, the improvements in these health plans' HEDIS scores indicate that their quality of care has improved as a result of a CAP—which it refers to as a *quality CAP*—that it imposed when they fell below standards.

Table 4
Beneficiaries in the Rural Expansion Counties Have Received a Lower Quality of Care Than Other Beneficiaries in the State

		AVERAGE NUMBER OF HEDIS MEASURES BELOW MINIMUM PERFORMANCE LEVEL	
YEAR	NUMBER OF MEASURES*	RURAL EXPANSION†	REMAINDER OF THE STATE‡
2015	22	10.2	4.1
2016	22	12.3	6.7
2017	18	7.3	4.7
2018	21	5.7	2.3

Source: Analysis of HEDIS data.

* Excludes measures for which DHCS has not specified a minimum performance level.

† Excludes Kaiser Permanente, which operates in a limited manner in three of the 18 Regional Model counties. Also excludes Imperial and San Benito counties, which Anthem and Health & Wellness serve outside the Regional Model.

‡ Includes Lake County, which is part of the rural expansion. Partnership reports Lake County's data as part of a group of counties that includes three counties that were not in the rural expansion.

Other measures suggest that the Regional Model plans have struggled more than Partnership in meeting their contractual requirements for quality of care. As we discuss in the Introduction, both DHCS and Managed Health Care perform routine audits to verify whether health plans are complying with legal and contractual requirements that affect quality of care. However, these audits generally cover each plan's performance throughout the State, without indicating the particular model or county with which the departments have identified deficiencies. Consequently, the audits do not address conditions that are specific to the Regional Model plans. Nonetheless, under the terms of an interagency agreement between DHCS and Managed Health Care for 2014 through 2016, Managed Health Care conducted an audit of each of the three health plans—Anthem, Health & Wellness, and Partnership—that focused on their legal and contractual compliance within the 28 rural expansion counties. These audits suggest that the Regional Model health plans had greater difficulty meeting their contractual requirements than Partnership did.

Managed Health Care identified contractual and legal violations that all three health plans committed in the rural expansion counties, but it identified potentially more serious deficiencies in its reviews of Anthem and Health & Wellness than of Partnership. For example, Managed Health Care determined that both Anthem and Health & Wellness failed to properly document and address potentially significant grievances and other quality issues pertaining to inadequate care, including a cardiac arrest caused by a medication error and a provider's failure to detect a serious infection. The health plans' failure to properly address these

reported quality issues may have exposed beneficiaries to harm. In contrast, Managed Health Care's findings related to Partnership did not indicate significant risks to beneficiaries' health. For example, Managed Health Care found that Partnership resolved grievances promptly but did not always list the dates it received the grievances when responding to beneficiaries.

DHCS has taken steps to ensure that the health plans have resolved the deficiencies that Managed Health Care's audits identified. As part of its interagency agreement, DHCS used quality CAPs to address these violations. In our April 2019 audit report, *Department of Health Care Services: Although Its Oversight of Managed Care Health Plans Is Generally Sufficient, It Needs to Ensure That Their Administrative Expenses Are Reasonable and Necessary*, Report 2018-115, we determined that DHCS' process to oversee health plans' quality of care—including quality CAPs—was generally sufficient.

DHCS Has Not Effectively Communicated to Counties When It Identified Quality of Care Deficiencies

Although DHCS has generally complied with state and federal reporting requirements, it could do more to inform county officials when it identifies significant quality of care issues with the Regional Model health plans. Federal and state laws require DHCS to publicly report different elements of its monitoring efforts, and DHCS complies with these requirements by publishing its HEDIS results and medical audit reports on its website. However, it has not adequately educated counties about all the types of monitoring that it performs, such as the medical audits we previously discuss and the corresponding CAPs, which DHCS calls *medical audit CAPs*. Through its medical audits, DHCS evaluates health plans' performance and compliance with contractual requirements in six categories: utilization management, case management and coordination of care, access and availability of care, member rights, quality management, and administrative and organizational capacity. If stakeholders are not aware of DHCS' monitoring efforts, they are unlikely to seek out the results of those efforts. Moreover, when it completes its audit reports, DHCS does not notify counties or distribute the reports to them, thereby placing the responsibility on the counties to review its website regularly to become aware of new medical audit findings.

DHCS has not adequately educated counties about all the types of monitoring that it performs, such as its medical audits.

Further, DHCS does not promptly update its website with its medical audit reports, which delays stakeholders' ability to review those results. For example, DHCS issued its most recent audit of Anthem in August 2018; however, it still had not made the results publicly available as of July 2019. DHCS explained that it waits

until the health plans complete the medical audit CAPs pertaining to their audits before it publishes the audit results on its website. Although state law allows this delay, counties could better assist their beneficiaries if DHCS informed them of performance issues more promptly. We believe that DHCS should publish medical audit results as they become available and then post the completed medical audit CAPs later. DHCS said it would consider making this change.

By providing counties with information about the significant quality of care issues that it identifies, DHCS could better enable them to help beneficiaries receive the care to which they are entitled.

By providing counties with information about the significant quality of care issues that it identifies, DHCS could better enable them to help beneficiaries receive the care to which they are entitled. County representatives indicated that they were aware of beneficiaries' difficulties with receiving appropriate care, and that in some cases, beneficiaries have reached out to them directly to report issues. Information about problems that DHCS has identified with health plans' performance would likely assist counties in their efforts to help these beneficiaries, particularly when DHCS has identified violations of beneficiaries' rights. For example, DHCS concluded in a 2017 audit that Health & Wellness had wrongfully denied a beneficiary an evaluation to determine whether he was eligible for an organ transplant, even though a physician recommended an evaluation and the health plan's contract with DHCS entitled its beneficiaries to such evaluations. If DHCS consistently informed counties of such problems, the counties would be better positioned to assist other beneficiaries who are facing similar issues.

To obtain the counties' perspectives on DHCS' outreach efforts, we spoke with representatives of county health agencies in a number of rural expansion counties. Representatives of seven of these counties were unfamiliar with the full scope of DHCS' monitoring efforts, and representatives of five stated that they did not even know that DHCS conducted medical audits. In general, most of these individuals who we spoke with stated that they would like DHCS to be more proactive in notifying them when it identifies serious deficiencies in their county's health plans.

The representatives' comments suggest that counties would benefit if DHCS issued a periodic form of communication, such as a newsletter. In fact, one county representative described DHCS' website as overwhelming, and another said that it is difficult to find the reports about health plans' performance levels on that website. Another county official explained that her staff lack the time to review the website regularly to determine whether DHCS has published new reports. When we asked DHCS for perspective, it explained that counties and other stakeholders can request to be added to an email distribution list (mailing list) it uses to update stakeholders on managed care topics. It also stated that it has

two advisory groups in which counties may participate, and each of these groups has an email address to which stakeholders can submit questions or concerns. However, DHCS acknowledged that it does not discuss its medical audits and other monitoring efforts in these groups unless a member requests that it do so, nor does it send such information to stakeholders on its mailing list. By improving its process for publishing its monitoring results, which it is willing to do, DHCS could better ensure that county stakeholders have the knowledge necessary to assist beneficiaries in receiving the care that they need.

Recommendations

To ensure that beneficiaries in Regional Model counties have adequate access to care, DHCS should identify by August 2020 the locations requiring additional providers and the types of providers required. It should also develop strategies for recruiting and retaining providers in those locations. If it requires additional funding to complete this assessment or to implement actions to address its findings, DHCS should determine the amounts it needs and request that funding from the Legislature.

To obtain assurance that health plans throughout the State exhaust all of their reasonable options to meet the access requirements before requesting alternative access standards, DHCS should immediately begin doing the following:

- Develop written guidance that specifies the conditions under which staff should approve, deny, or contact health plans for clarification regarding their alternative access standard requests.

- Determine a specific minimum number of providers that health plans must attempt to contract with before requesting an alternative access standard.

- Require health plans to report on their attempts to contract with providers when submitting their alternative access standard requests, including providing evidence of their efforts, such as the contact information for each provider with which they have attempted to contract.

- Establish a process for periodically verifying the health plans' efforts, such as contacting a sample of the listed providers and determining whether the plans attempted to contract with them.

- Require health plans to authorize out-of-network care if they do not demonstrate they have exhausted all of their reasonable options to meet the access requirements, unless the health

plans can demonstrate that closer providers are demanding unreasonably high rates or have documented deficiencies in quality of care.

To ensure that it promptly and sufficiently notifies counties and other stakeholders about health plans' quality of care deficiencies, DHCS should immediately do the following:

- Post its medical audit reports to its website within one month after it issues the reports to the health plans.
- Include information about its recently published medical audit reports and other monitoring efforts in its communication with counties and other stakeholders on its mailing list.
- Ensure that relevant county officials are included on its mailing list.

Chapter 2

DHCS HAS NOT ENSURED THAT ALL MEDI-CAL BENEFICIARIES IN RURAL EXPANSION COUNTIES RECEIVE SERVICES THROUGH A MODEL THAT BEST MEETS THEIR NEEDS

Chapter Summary

Over the course of the past seven years, DHCS has not adequately engaged with the Regional Model counties regarding their managed care model and contracted health plans. Specifically, before the 2013 transition, DHCS did not actively educate the rural expansion counties about the options available to them. Further, even when these counties sought to create or join a COHS, it did not assist them. DHCS' lack of engagement with the counties continued well after the transition occurred. For example, it did not seek feedback from the Regional Model counties regarding their satisfaction with Health & Wellness's performance before it extended its contract with the health plan.

However, DHCS could now take steps to begin acting on counties' preferences and feedback. Since the completion of the rural expansion in 2013, a number of counties have expressed the desire to leave the Regional Model and instead create or join a COHS. DHCS' current agreements with the Regional Model health plans make such a change difficult until 2023, but at that time, transitioning Regional Model counties to a COHS will be a viable option. Because creating a COHS would require the counties and DHCS to complete several time-consuming activities, such as establishing a provider network, starting the process now would better enable the counties and DHCS to complete these activities before the current health plan contracts expire and ensure continuity of care for the counties' beneficiaries. By assisting the counties in making such a change, DHCS could better ensure that beneficiaries receive adequate access to care.

DHCS Did Not Adequately Educate and Assist Rural Expansion Counties During Their Transition to Managed Care

As the agency responsible for overseeing the effective delivery of health care to Medi-Cal beneficiaries throughout the State, DHCS should have ensured that before the rural expansion counties transitioned to managed care, it proactively educated them on the available managed care options so that they could select a model that would best serve their needs. Instead, the counties selected their own models without receiving sufficient guidance

from DHCS. Several county representatives we interviewed stated that they were unclear about their managed care options at the time of the rural expansion transition. In addition, even when counties determined that they wanted to join or create a COHS, DHCS did not assist them in exploring that option.

DHCS Did Not Adequately Inform and Educate Rural Expansion Counties on Their Managed Care Options

DHCS did not actively collaborate with the rural expansion counties before their transition to managed care to inform them of their options, to identify any potential concerns they should consider, or to confirm that they understood the transition process. According to the special projects manager of the DHCS director's office (special projects manager), who formerly served as the managed care chief, DHCS representatives had several conversations with county representatives and providers, such as hospitals, that approached it with questions about managed care. For example, some counties asked DHCS about joining Partnership, and DHCS informed them of the steps they would need to take, including seeking federal approval. Nevertheless, because DHCS relied on the counties to select their own models, we expected it to have provided them with adequate information to ensure that they made informed decisions. That type of involvement likely would have helped ensure the overall success of the transition.

Because counties are able to create COHS Models and local initiatives in a Two-Plan Model, we expected DHCS to have considered them relevant stakeholders and to have sought their feedback.

State law required DHCS to solicit feedback from relevant managed care stakeholders such as beneficiaries, providers, and health plans regarding their perspectives on the models that would be most suitable for the 28 rural expansion counties. During the rural expansion, DHCS held open meetings to solicit feedback from stakeholders, but it did not conduct outreach that specifically targeted the counties. Because counties are able to create COHS Models and local initiatives in a Two-Plan Model, we expected DHCS to have considered them relevant stakeholders and to have sought their feedback. However, DHCS' meetings did not address topics of specific relevance to counties, such as the steps a county would need to take to create a COHS Model. According to the special projects manager, DHCS believes it addressed its responsibility to inform stakeholders, including counties, about the rural expansion transition by facilitating these meetings and by being willing to address concerns stakeholders brought to its attention.

However, we question the effectiveness of this approach given that many counties told us they were unclear about their managed care options at the time of the transition. Representatives from several Regional Model counties stated that their counties had

not fully understood the options that were available to them, the type of assistance DHCS was willing to provide them, or the steps they needed to take to establish or join a managed care model. Consequently, those counties did not take specific action to join or create another model and instead deferred to DHCS, which placed them in the Regional Model.

Several counties had not fully understood the options that were available to them, the type of assistance DHCS was willing to provide them, or the steps they needed to take to establish or join a managed care model.

Neither DHCS' chief deputy director—who was not involved in communications with the counties during the time of the rural expansion—nor its special projects manager could recall whether DHCS actively approached and educated the rural expansion counties beyond the transition meetings that it held for interested stakeholders. However, the special projects manager acknowledged that DHCS did not prepare informational material for stakeholders to explain the available managed care options, the steps the counties would need to take to act on those options, or the resources DHCS could offer to assist with the transition. Further, neither the chief deputy director nor the special projects manager recalled whether DHCS advised the counties on how to evaluate their demographics to determine whether particular models might be more effective in serving their beneficiaries. They also could not recall whether DHCS allocated staff resources, such as an assigned group of staff members, to monitor the progress of the counties during the transition and to serve as a resource for them. We expected DHCS to have taken some or all of these actions to ensure that the counties were well informed to select their own managed care models.

DHCS Did Not Assist Rural Expansion Counties That Wanted to Create or Join a COHS

Despite the questionable effectiveness of DHCS' approach to inform counties of their managed care model options, many of the rural expansion counties attempted to create or join a COHS or local initiative, as we discuss in the Introduction. However, four of the Regional Model counties were unsuccessful in their attempts. Three of these four counties informed us that they attempted to join Partnership by discussing with Partnership representatives the viability of having that health plan serve their Medi-Cal beneficiaries. One county indicated that it also passed a county board resolution affirming its support of Partnership's expansion into the county. Representatives of the three counties explained that Partnership ultimately rejected the counties' proposals because it had reached its capacity of additional counties it could accept. The other county attempted to join another COHS, the Central California Alliance for Health (Central Alliance). According to a

county representative, Central Alliance indicated that it would not be able to accept the county because it would have been financially prohibitive for it to do so.

Most of the eight rural expansion counties that successfully joined Partnership in 2013 received assistance from an external resource, which better prepared them to join a COHS.

Most of the eight rural expansion counties that successfully joined Partnership in 2013 received assistance from an external resource, which better prepared them to join a COHS. Several of these counties participated in stakeholder meetings facilitated by Health Alliance of Northern California (Health Alliance), a network of nonprofit community health clinics and health centers. The meetings informed these counties about their managed care model options, including the locations of the current COHS they could seek to join. Health Alliance recruited Partnership to attend the meetings. A Health Alliance representative informed us that Health Alliance also coordinated with the counties to obtain declarations from their boards of supervisors that demonstrated their desire to receive Medi-Cal services through Partnership. At least two counties then contacted their respective state legislators, who encouraged DHCS to allow the counties to join Partnership. DHCS subsequently approved these counties' requests to join Partnership.

DHCS did not provide the type of assistance that Health Alliance provided because it did not believe that doing so was part of its role. According to the chief deputy director, DHCS expected counties that were interested in joining a COHS to reach out directly to that COHS to determine whether it was interested in providing services in the county. Further, the special projects manager explained that the COHS would have needed to consider whether it was able to establish or expand its provider network into the counties. In other words, because DHCS believed that the counties and health plans should have taken the initiative to work together, it did not attempt to facilitate or encourage any communication among them. However, we expected DHCS—like Health Alliance—to have provided assistance to the counties to ensure that they were well positioned to work with the health plans to provide the best service to their beneficiaries.

In addition, if DHCS had made information about the transition available to counties sooner, more counties might have been able to select the health plans they determined would best serve their beneficiaries. A representative from one of the Regional Model counties told us that her county became interested in joining Partnership too late in the managed care transition process, after Partnership already reached its capacity. By that time, the county was not able to create its own COHS or establish a multicounty COHS with other counties. According to DHCS' records, it held its first stakeholder meeting to inform Regional Model counties of the transition to managed care in July 2012—only seven months before it awarded the contracts to Anthem and

Health & Wellness in February 2013. We question the sufficiency of this seven-month period to allow counties to explore the option of joining a health plan or creating an alternate managed care model, especially without informational assistance from DHCS.

Because DHCS is the entity responsible for administering the Medi-Cal program, we believe that it was in the best position to provide assistance to counties that wanted to create a COHS. We expected DHCS to have informed the counties about the specific actions required to create a COHS and to provide assistance to those counties that did not have the resources to perform such actions. For example, two Regional Model counties told us they did not explore the option of creating a COHS at the time of the transition because they believed they did not have the necessary financial resources or knowledge. Had DHCS been proactive in offering assistance, the counties might now have managed care models that are more effective at providing services to their beneficiaries.

The chief deputy director explained that providing such assistance to counties would not have been possible in 2013 because DHCS did not have sufficient financial resources at that time. She also stated that if DHCS were to take on the responsibility of providing financial assistance to counties that want to be in a different managed care model, it would need additional funding from the State. We discuss this possibility in more detail below.

DHCS Extended Its Contracts With the Regional Model Health Plans Without Seeking Input From the Counties

State law allows DHCS to enter into contracts with one or more health plans to provide managed health care services to Medi-Cal beneficiaries in the rural expansion counties. In addition, DHCS has the exclusive authority to establish rates, terms, and conditions of managed care plan contracts and subsequent amendments, although these elements are subject to federal approval. Although state law required DHCS to request stakeholder feedback as part of the rural expansion counties' transition to managed care in 2013, it does not require DHCS to request feedback from stakeholders, including counties, before extending its contracts with the Regional Model health plans. However, we believe that before taking such an action, DHCS should request the counties' feedback. Otherwise, it may miss opportunities to gain important insight from the counties on whether the health plans have been effectively serving beneficiaries.

DHCS has the exclusive authority to establish rates, terms, and conditions of managed care plan contracts and subsequent amendments, although these elements are subject to federal approval.

In 2013 DHCS established five-year contracts with Anthem and Health & Wellness to provide services in the Regional Model counties through October 2018. In November 2018, DHCS

extended its contract with Health & Wellness through a provision that allowed it the option to extend the terms in one-year increments up to four additional years. DHCS initially exercised the option to extend the contract through June 2019 and extended it again through June 2020 without seeking feedback from counties about their satisfaction with the health plan's performance. According to the managed care chief, DHCS extended the contract because of this provision and because it did not identify any concerns with Health & Wellness that warranted terminating that contract.

Although DHCS does not have a formal internal review process for determining whether to extend a contract, it stated that it considers health plans' performance when deciding whether to extend their contracts and would not do so if it identified significant issues.

Although DHCS does not have a formal internal review process for determining whether to extend a contract, it stated that it considers health plans' performance when deciding whether to extend their contracts and would not do so if it identified significant issues. DHCS asserted that it continually monitors health plans' performance through various methods, including but not limited to its medical audits and its review of HEDIS measures. DHCS also stated that it did not request stakeholder feedback before extending the contract, citing the absence of such a requirement and the fact that DHCS had received feedback from stakeholders when it first solicited proposals for the rural expansion counties in 2012. However, we question the timeliness and relevance of that feedback, given that it occurred before DHCS had even entered into a contract with Health & Wellness. We expected that each time DHCS extended Health & Wellness' contract, it would request feedback from stakeholders, including counties, to gain insight regarding the health plan's performance and the counties' desire to continue in the Regional Model.

DHCS also extended Anthem's contract without seeking feedback from stakeholders although it did so under other unique circumstances for which feedback would not have been relevant. In 2014 just one year after executing the original contract, DHCS agreed to a settlement with Anthem that extended its contracts for five additional years in all of the counties in which Anthem provided Medi-Cal services, including the Regional Model counties. According to DHCS, the settlement was the result of several lawsuits Anthem filed against DHCS regarding rates that DHCS paid it to provide Medi-Cal services. Because of the settlement, the Regional Model counties are obligated to remain in that model and have Anthem serve as one of their health plans through October 2023.

Nevertheless, it appears that DHCS did not inform counties of this extension until long after it was executed. DHCS' current management were unclear about the extent of any discussions that their predecessors had with counties before extending the contract. However, according to representatives of several Regional Model

counties, DHCS did not inform them of the extension at the time it occurred. Some of these representatives informed us that they had multiple meetings with DHCS' executive staff in 2017 and early 2018 to discuss the managed care model options that were available to them after DHCS' contracts with Anthem and Health & Wellness expired. According to some of these counties, DHCS informed them during those meetings that it had extended Anthem's contract through 2023 and that it would not be able to remove them from that contract because it would incur significant financial penalties.

DHCS announced on its website that it will initiate a new request for proposals (RFP) that it anticipates releasing in 2020 for commercial managed care health plans throughout the State that include the Regional Model counties. It plans to place all of its commercial managed care health plan contracts up for bid in 2020, including Anthem's and Health & Wellness's Regional Model contracts. According to the chief deputy director, if the Regional Model counties want to join or create a COHS, they will need to begin working on the transition while DHCS' contracts with Anthem and Health & Wellness are still in place, and they will need to inform DHCS before it issues the RFP. DHCS also identified January 2024 as the potential implementation date for the Regional Model contracts. However, that implementation date is subject to change, based on the health plans' ability to provide services. According to DHCS, the four-year period for implementation is based on the amount of time needed for it to evaluate and score proposals and to ensure that the selected health plans complete all required plan readiness activities. Although DHCS indicated it is not requesting feedback from stakeholders on this RFP because the stakeholders in those affected counties already have experience with managed care, it is willing to accept any public comments it receives after it issues the request.

DHCS announced on its website that it will initiate a new RFP that it anticipates releasing in 2020 for commercial managed care health plans throughout the State that include the Regional Model counties.

The COHS Model Is a Viable Option for the Regional Model Counties That Could Ensure That Its Beneficiaries Receive Better Access to Care

As we discuss in Chapter 1, the majority of the providers that contract with the Regional Model health plans contract with only one of the health plans but not both. Because the COHS Model consists of a single health plan that a county directly oversees, its structure might facilitate better access to care for Regional Model beneficiaries because they could access all of its contracted providers. With the assistance of DHCS, many Regional Model counties could establish a multicounty COHS that likely would more effectively serve their beneficiaries. However, any formal change could likely not occur until the contracts with the two existing Regional Model health plans expire.

The COHS Model May Provide Better Access to Care for the Beneficiaries in the Regional Model Counties

As we discuss in Chapter 1, the Regional Model's use of two health plans that must each establish adequate provider networks has negatively affected beneficiaries' access to care. The majority of providers in the Regional Model contract with either of the Regional Model health plans but not both, meaning that some beneficiaries may have to travel hundreds of miles to receive care from in-network providers. In contrast, one of the defining characteristics of the COHS Model is that it consists of a single health plan that provides services to its beneficiaries. By implementing a COHS in the Regional Model counties, all of the beneficiaries in those counties would have access to all of the providers in that model. DHCS indicated that it is not aware of any evaluation that has concluded that a particular managed care model is more effective at providing access to care than another model. However, the poor access conditions we identified in the Regional Model counties led us to conclude that DHCS could benefit from performing such an evaluation to determine whether a COHS would improve access to care for those beneficiaries.

A COHS can dedicate a greater portion of its financial resources to recruiting Medi-Cal providers to rural locations in which it operates that do not currently have such providers.

A COHS also can dedicate a greater portion of its financial resources to recruiting Medi-Cal providers to rural locations in which it operates that do not currently have enough such providers. A COHS is a nonprofit organization with a governing board that is largely composed of officials of the counties they serve. Because of its nonprofit status, a COHS does not dedicate a portion of the capitation payments it receives to corporate shareholders in the same way that Anthem and Health & Wellness do. Consequently, a COHS could have more flexibility than a commercial health plan to commit its resources to improving provider availability.

Additionally, because a COHS's board is composed largely of officials of the counties that it serves, these county officials have influence in directing the organization to dedicate its resources to their counties' greatest needs, including recruiting providers. According to Partnership, its board directed the organization to prioritize recruiting for providers to fill service gaps in its counties. Partnership asserts it has since committed significant resources to recruiting new providers for those counties and retaining existing providers.

Establishing a COHS Is a Viable Option for the Regional Model Counties

Since the completion of the rural expansion transition in 2013, at least seven counties have expressed to DHCS their interest in either switching to a COHS Model or in learning more about doing so.

We spoke with representatives of these and other counties in the Regional Model about their experiences with the rural expansion transition, their current service delivery, and their perspectives on their future involvement with managed care. Several counties identified potential benefits of the COHS Model that they do not have in the Regional Model. For example, representatives from some counties believe that the direct county oversight of a COHS can lead to the health plan's implementation of programs that address the counties' specific needs. When we spoke to Partnership, it explained that it has implemented programs to assist with the opioid epidemic in response to concerns from its counties.

DHCS' settlement with Anthem and its contract with Health & Wellness would likely preclude the counties from considering other models until those contracts expire in 2023 and 2020, respectively. Thereafter, the Regional Model counties could consider creating or joining a COHS. Federal regulations generally require that states mandating that Medicaid beneficiaries must enroll in a managed care health plan must give those beneficiaries a choice of at least two plans. However, federal regulations allow an exception for COHS Models if the COHS offers its beneficiaries a choice of at least two primary care providers.

To create a COHS that would serve multiple counties in the Regional Model, those counties would need to establish the COHS's administrative structure and provider network. For example, the counties would need to create a special commission to negotiate the contract and arrange for the provision of health care services. The counties would also need to hire personnel, procure computer systems, and establish contracts with providers, which all have associated costs. Because DHCS cannot issue health plan capitation payments until a COHS begins serving Medi-Cal beneficiaries, the COHS would not have those resources available to fund its start-up costs. Given that some of the Regional Model counties may not have sufficient staff or financial resources to fund the start-up costs of a COHS, it would seem reasonable for DHCS to provide assistance to the counties to help create the entity and hire core personnel. Further, for this same reason, it may be more cost-effective for the Regional Model counties to create a multicounty COHS for the region rather than one or more of them creating a county-specific COHS.

To create a COHS that would serve multiple counties in the Regional Model, those counties would need to establish the COHS's administrative structure and provider network.

Although DHCS has yet to provide any such assistance to counties that currently desire to create a COHS, the chief deputy director stated that DHCS would need additional funding before it could provide assistance to counties. Similarly, DHCS indicated it does not provide financial resources to new health plans for start-up costs and would need to seek funding from the Legislature to do so.

However, without DHCS' assistance, small and rural counties may not be able to develop the infrastructure required to change their managed care models.

Because DHCS' current staff do not have experience with establishing a COHS, we interviewed a representative of the State's most recently established COHS, Gold Coast Health Plan (Gold Coast), about the process Ventura County used to establish it in 2011. According to the representative, the formation of Gold Coast required Ventura County to hire staff to administer the health plan. Gold Coast then contracted with external vendors to perform some of its administrative functions, such as operating its claims and encounter data computer systems. Gold Coast obtained a portion of its start-up funding from one of its vendors. Gold Coast estimated that creating and staffing the COHS cost about $15 million.

In addition, before the Regional Model counties could begin operating a new COHS, both federal regulations and state law require DHCS to evaluate whether the COHS is adequately prepared to provide services to beneficiaries. That evaluation would entail reviewing the health plan's provider network and its procedures to monitor and improve quality of care.

The Cost to Deliver Managed Care Depends on the Specific Needs of the Beneficiary Population Being Served

DHCS pays monthly capitation payments to health plans to cover services that DHCS has contractually required the health plans to provide to beneficiaries.

To evaluate whether the costs of delivering Medi-Cal services using a COHS in the Regional Model counties would differ from the current costs of delivering those services, we reviewed DHCS' capitation payments and other associated costs for Partnership counties and for the Regional Model counties. DHCS pays monthly capitation payments to health plans to cover services that DHCS has contractually required the health plans to provide to beneficiaries. DHCS groups eligible beneficiaries into 10 aid categories, each of which consists of individuals who have similar health risk traits. It then pays different capitation payments depending on the aid category. For example, DHCS would pay a different capitation payment for a beneficiary in the *breast and cervical cancer* aid category than for a beneficiary in the *family and adult* aid category. DHCS provides certain services to beneficiaries even though it does not require some health plans to include these services in their contracts. DHCS pays providers directly for these services, which we refer to as *noncapitated services*.

As Table 5 shows, DHCS spent more per beneficiary per month from fiscal years 2013–14 through 2016–17 to deliver services to Partnership's beneficiaries than to the Regional Model beneficiaries.

However, DHCS indicated that the overall average per-member per-month cost of providing services to Partnership beneficiaries is not a reasonable representation of how much it would cost DHCS to provide services to beneficiaries in the Regional Model counties through a COHS. The research and analytic studies chief (research chief) explained that the differences in the overall average per-member per-month cost for capitation payments between the Regional Model and Partnership was primarily driven by the variation in enrollment patterns between the model types during this period. The research chief stated that Partnership's higher overall average per-member per-month cost is attributable to its counties having enrolled a greater proportion of beneficiaries in high aid categories than the Regional Model counties enrolled. For example, DHCS determined that in fiscal year 2013–14, about 13 percent of Partnership's capitation payments were for beneficiaries in one of its disabled aid categories, while only 1 percent of the Regional Model counties' payments were for such beneficiaries.

Table 5
DHCS Spent More per Member per Month for Partnership's Beneficiaries Than for the Regional Model's Beneficiaries

		MANAGED CARE MODEL TYPE	
FISCAL YEAR	PAYMENT TYPE	COHS (PARTNERSHIP)	REGIONAL MODEL
2013–14	Capitated	$409	$266
	Noncapitated*	231	88
	Totals	**$640**	**$354**
2014–15	Capitated	$428	$364
	Noncapitated*	195	113
	Totals	**$623**	**$477**
2015–16	Capitated	$365	$315
	Noncapitated*	201	129
	Totals	**$566**	**$444**
2016–17	Capitated	$318	$308
	Noncapitated*	210	141
	Totals	**$528**	**$449**

Source: Analysis of DHCS' Medi-Cal expenditures from fiscal years 2013–14 through 2016–17.

Note: According to DHCS, neither capitation payments nor noncapitated services costs include certain supplemental payments, Medicare premiums, pharmacy rebates, or settlements.

* Noncapitated services are those that DHCS does not require health plans to provide to beneficiaries in their benefits packages. Instead, DHCS pays providers directly for the services when billed by the providers.

According to the research chief, another factor contributing to the difference between Partnership's costs and Regional Model health plans' costs is their beneficiaries' utilization of noncapitated services. For example, DHCS paid about $27 more per member per month in fiscal year 2016–17 for Partnership's beneficiaries to receive in-home supportive services, which are noncapitated, than it did for the Regional Model beneficiaries. The research chief informed us that like capitation payments, costs relating to noncapitated services depend on the number of beneficiaries in a health plan who qualify to receive the services and the degree of assistance that each beneficiary needs. If a health plan has more beneficiaries that require noncapitated services, DHCS will pay a higher overall average per-member per-month cost for those beneficiaries. Consequently, the costs that DHCS incurs for health plans to deliver care to their beneficiaries is based on the specific needs of those beneficiaries whom the health plans serve.

Recommendations

To ensure that all counties are aware of the managed care model options available to them and of the steps necessary to implement those models, DHCS should provide by December 2019 information to all counties that clearly defines each managed care model and the steps and legal requirements needed to establish each model.

To ensure that it makes informed decisions regarding the extension or renewal of its contracts with managed care health plans, DHCS should immediately begin the practice of requesting annual feedback from the counties that the health plans serve and of using that feedback in its decision-making process.

To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020:

- Determine the specific causes of Anthem's and Health & Wellness's inabilities to provide reasonable access to care in the Regional Model counties.

- Evaluate whether the structural characteristics of a COHS Model would be better suited to providing reasonable access to care in the Regional Model counties and notify the counties whether a COHS would improve beneficiaries' access to care. If some or all of these counties desire to transition to a COHS, DHCS should assist them in making that change after their current contracts expire.

- Evaluate whether it has the financial resources to provide assistance to counties interested in establishing a COHS or other managed care model after the current Regional Model contracts expire. If DHCS does not have the required financial resources, it should seek an appropriate amount of funding from the Legislature.

- Provide these counties with reasonable opportunities to decide whether to change their managed care models after the expiration of the Regional Model health plan contracts. DHCS should provide counties that choose to do so sufficient time to establish their new models. DHCS should also include language in its 2020 RFP to allow Regional Model counties that can demonstrate their ability to implement a COHS Model in their county by 2023 to opt out of the RFP process.

We conducted this audit under the authority vested in the California State Auditor by Government Code 8543 et seq. and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,

Elaine M. Howle

ELAINE M. HOWLE, CPA
California State Auditor

Date: August 6, 2019

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Appendix

SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor to examine DHCS' oversight of the rural expansion and of managed care in the Regional Model counties. Specifically, the Audit Committee directed us to identify the process DHCS used to create the Regional Model, determine whether the level of care health plans have provided the Regional Model's beneficiaries has been acceptable, and identify factors that may prevent the Regional Model counties from establishing a COHS. The table below lists the objectives that the Audit Committee approved and the methods we used to address them.

Audit Objectives and the Methods Used to Address Them

	AUDIT OBJECTIVE	METHOD
1	Review and evaluate the laws, rules, and regulations significant to the audit objectives.	Reviewed relevant federal and state laws, rules, and regulations related to DHCS' oversight of managed care, health plans' acceptable delivery of managed care, and the establishment of a COHS.
2	Identify the process by which DHCS identified and grouped the 18 counties in question into the Regional Model and evaluate the reasonableness of the process.	• Interviewed DHCS staff to identify the process it used to transition the 28 rural expansion counties, including the 18 Regional Model counties, to managed care. • Interviewed representatives of the rural expansion counties, including the Regional Model counties, to determine how their counties learned they would be transitioning from fee-for-service to managed care, what types of interactions they had with DHCS, and whether DHCS addressed any concerns or health plan preferences they had. • Evaluated any efforts DHCS made to communicate with counties regarding the managed care transition process. • Reviewed and evaluated the process DHCS used to group the 18 counties into the Regional Model and whether that process was reasonable.
3	For the past three years, assess the rates of claims being paid by the Regional Model commercial plans and how they compare to Medi-Cal managed care plans offered through the COHS Model.	• Evaluated available fiscal years 2015–16 through 2017–18 financial records for Anthem, Health & Wellness, and Partnership to determine the amounts they spent to provide services to their beneficiaries. • Interviewed DHCS staff to determine how it sets capitation rates. • Evaluated the differences between the benefit packages for the Regional Model and the COHS Model and the effect that the benefit packages had on the amounts DHCS paid those models' health plans per beneficiary. • Evaluated Medi-Cal cost data from fiscal years 2013–14 through 2016–17 for all 18 Regional Model counties and eight Partnership counties to determine how much DHCS spent to deliver services to the beneficiaries of those counties.
4	Determine how DHCS selected the Regional Model commercial plans, review the terms of any relevant agreements, and assess the degree to which DHCS considered stakeholder input or other relevant factors.	• Interviewed DHCS staff to determine the process it used to select the Regional Model health plans. • Evaluated whether DHCS followed the applicable laws when it selected the Regional Model health plans. We determined that DHCS followed relevant laws when it selected Anthem and Health & Wellness to provide services in the Regional Model counties. • Evaluated DHCS' method for requesting feedback from stakeholders before it selected the health plans, as well as the extent to which DHCS addressed that feedback during its selection process.

continued on next page . . .

<table>
<tr><th></th><th>AUDIT OBJECTIVE</th><th>METHOD</th></tr>
<tr><td>5</td><td>For the counties served under the Regional Model, determine the following:
a. Whether the level of care in those counties is disproportionately low as compared to other parts of California. To the extent possible, determine whether and how the level of care has changed since the implementation of the Regional Model.</td><td>• Analyzed DHCS' statewide alternative access standard data to determine whether Anthem and Health & Wellness provided beneficiaries in the Regional Model with access to care that was comparable to other parts of the State.
• Analyzed statewide HEDIS data from 2015, the earliest year data was available, through 2018 to determine how the quality of care Anthem and Health & Wellness provided beneficiaries in the Regional Model changed since its implementation and whether that care was comparable to other parts of the State.
• Reviewed DHCS' and Managed Health Care's audit reports to determine whether the care that Anthem and Health & Wellness provided was similar to the care provided by other plans operating in rural expansion counties.
• Analyzed DHCS' provider directory data to calculate the number of providers with which Anthem, Health & Wellness, and Partnership contracted.</td></tr>
<tr><td></td><td>b. Whether the level of care received is acceptable as it relates to industry standards and state and federal requirements.</td><td>• Interviewed staff at DHCS and Managed Health Care to identify criteria defining an acceptable level of care.
• Reviewed DHCS' and Managed Health Care's audit reports of Anthem and Health & Wellness to determine whether the health plans met state, federal, and contractual requirements.
• Analyzed HEDIS data from 2015 through 2018 to determine whether Anthem and Health & Wellness met the minimum performance levels that DHCS required.
• Analyzed DHCS' alternative access standard data to determine whether Anthem and Health & Wellness provided beneficiaries in the Regional Model with access to care that met state requirements. We were unable to identify the number of beneficiaries whose access to care exceeded the state requirements because DHCS could not provide us with records that identified the number of beneficiaries assigned to each health plan by zip code.</td></tr>
<tr><td></td><td>c. Whether DHCS has taken steps to ensure that the plans adhere to the provisions of their contracts and whether DHCS has provided that information to the counties.</td><td>• Reviewed DHCS' policies and procedures related to medical audits and corrective action plans.
• Determined the extent to which DHCS made its monitoring results available to counties and potential stakeholders.
• Evaluated DHCS' efforts to notify counties and potential stakeholders of its monitoring and of the results of that monitoring.
• Interviewed a selection of Regional Model and Partnership county representatives to obtain their perspectives on DHCS' efforts to notify them of its monitoring results.</td></tr>
<tr><td></td><td>d. Whether opportunities exist to improve the current level of care Medi-Cal beneficiaries receive under the Regional Model.</td><td>• Interviewed DHCS staff to determine whether DHCS has identified opportunities to improve the Regional Model's level of care.
• Evaluated DHCS' policies and procedures related to alternative access standards and network certification CAPs to identify opportunities to reduce access barriers.
• Evaluated the extent of DHCS' authority to require health plans to take corrective actions.
• Compared provider data from the Medical Board of California and the Osteopathic Medical Board of California to DHCS' provider directory data to determine whether Anthem and Health & Wellness have contracted with all of the available providers located in the Regional Model counties.
• Evaluated the characteristics of DHCS' managed care models to determine whether any were better suited than others to serve the Regional Model counties.</td></tr>
<tr><td>6</td><td>Determine whether DHCS, when negotiating and extending its contract with the Regional Model commercial plans, made efforts to consider and mitigate any concerns communicated to DHCS by affected counties. Assess whether the process was sufficiently transparent.</td><td>Interviewed DHCS staff and a selection of Regional Model county staff to determine whether DHCS requested feedback from the counties before it extended Anthem's and Health & Wellness's contracts.</td></tr>
</table>

	AUDIT OBJECTIVE	METHOD
7	Evaluate what compels the Regional Model counties to remain in the existing commercial plan model as opposed to creating or joining a COHS.	• Evaluated DHCS' contracts with Anthem and Health & Wellness to determine whether they require the counties to remain in the Regional Model. • Interviewed DHCS staff and other personnel at selected Regional Model and Partnership counties, Partnership, and Gold Coast to identify the processes for joining or establishing a COHS, the cost of establishing a COHS, and the entities responsible for funding the establishment of a COHS. • Evaluated federal and state laws to determine whether they impose any limitations on DHCS' contracting with an additional COHS.
8	Review and assess any other issues that are significant to the audit.	• Interviewed DHCS staff to determine its process for approving or denying alternative access standards. • Evaluated DHCS' policies and procedures for reviewing alternative access standard requests. • Evaluated a selection of 30 alternative access standard requests to determine whether DHCS adhered to its policies and procedures when it approved them.

Source: Analysis of the Audit Committee's audit request number 2018-122, state law, and information and documentation identified in the column titled Method.

Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of the computer-processed information that we use to support our findings, conclusions, and recommendations. In performing this audit, we relied on DHCS' provider directory, alternative access standard data, and HEDIS performance data to evaluate the access to care and quality of care that the Medi-Cal managed care health plans provided to their beneficiaries. Additionally, we relied on license and eligibility data from the Medical Board of California and the Osteopathic Medical Board of California in order to identify licensed medical providers who are eligible to contract with Medi-Cal. To evaluate these data, we performed electronic testing of the data, reviewed existing information about the data, interviewed agency officials knowledgeable about the data, and performed data set verification procedures. We found that the DHCS provider directory, alternative access standards, and HEDIS performance data were sufficiently reliable for the purposes of our audit.

However, during our review, we identified limitations with the Medical Board of California and Osteopathic Medical Board of California license data. Specifically, we found that the license data limited the number of practice locations for each provider and that not all providers submitted this information. As a result, we found the license data were of undetermined reliability for identifying the practice location of all providers. Although this determination may

affect the precision of some of the numbers we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

Ms. Elaine M. Howle*
California State Auditor
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) hereby provides response to the draft findings of the California State Auditor's (CSA) report entitled, *Department of Health Care Services: It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care.* The CSA conducted this audit and issued 13 recommendations.

DHCS agrees with nine of the recommendations, disagrees with three of the recommendations, and believes it is already in compliance with the remaining recommendation. DHCS has prepared corrective action plans to implement the nine recommendations it agrees with. DHCS appreciates the work performed by the CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Nicole Jacot, External Audit Coordination Manager, at (916) 713-8812.

Sincerely,

Jennifer Kent
Director

Enclosure

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* California State Auditor's comments begin on page 59.

Department of Health Care Services' Response to the California State Auditor's Draft Report, *Department of Health Care Services: It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care* Report Number: 2018-122 (19-06)

Finding 1: The Department of Health Care Services (DHCS) has allowed health plans to require their Medi-Cal beneficiaries to travel hundreds of miles to receive care.

Recommendation 1

To ensure that beneficiaries in Regional Model counties have adequate access to care, DHCS should identify by August 2020 the locations requiring additional providers and the types of providers required. It should also develop strategies for recruiting and retaining providers in those locations. If it requires additional funding to complete this assessment or to implement actions to address its findings, DHCS should determine the amounts it needs and request that funding from the Legislature.

Current Status: Will Not Implement

Estimated Implementation Date: N/A

Implementation Plan:

As previously stated in the responses to the audit conducted by the California State Auditor titled: "Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services," DHCS does agree increasing the number of physicians who practice in California is beneficial for all health care delivery systems; however, such statewide assessment is not something that DHCS is the subject matter expert in given that Medi-Cal is responsible for about 30% of the health care coverage. (1) DHCS suggests that this would be better suited for the Office of Statewide Health Planning and Development (OSHPD) and the California Workforce Investment Board and DHCS would support OSHPD in addressing this important matter. However, we do note that within DHCS' purview, DHCS has been actively involved in implementing a physician and dental provider loan repayment program using Proposition 56 funds as authorized and approved in the Budget Act of 2018. These loan repayments were targeted specifically at newly-practicing providers that agree to see a specific percentage of Medi-Cal patients in their practice (at least 30 percent) and maintain that commitment for at least five years. The loans were open to both pediatric and adult providers and additional criteria will include providers that are practicing in high-need specialty areas such as child psychiatry or practicing in a medically underserved area. On July 2, 2019, DHCS announced that it paid $58.6 million in student loans for 247 physicians through the loan repayment program. These efforts are specifically targeted at increasing participation in Medi-Cal within the state's existing workforce.

Recommendation 2

To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Develop written guidance that specifies the conditions under which staff should approve, deny, or contact health plans for clarification regarding their alternative access requests.

Current Status: Not Fully Implemented

Estimated Implementation Date: July 2020

Implementation Plan:
DHCS currently has written guidance that is used to process alternative access requests. DHCS ensures that the alternative access requests are being process correctly through a secondary review process that includes multiple levels of management. DHCS will continue to expand on the existing guidance, including information on process changes that will be put into place for the July 1, 2020, annual network certification process. ②

Recommendation 3
To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Determine a specific minimum number of providers that health plans must attempt to contract with prior to requesting an alternative access standard.

Current Status: Not Fully Implemented

Estimated Implementation Date: July 2020

Implementation Plan:
DHCS is in the process of modifying the alternative access request process for the July 1, 2020, annual network certification. The health plans will be required to search the same databases that DHCS uses when reviewing alternative access requests. If a provider is identified that is in closer proximity to what has been requested, the health plan will be required to submit contracting efforts to DHCS. DHCS would note that the amended process will be more stringent than what the CSA is suggesting. Previously, DHCS had a process that required the health plans to attempt to contract with a minimum number of providers and report that information to DHCS. DHCS was unable to process the requests in a timely fashion due to health plan errors. The enhancements that DHCS has made to date and is in the process of operationalizing for the July 1, 2020, annual network certification are both stricter and more efficient that what has been done in the past. ③

Recommendation 4
To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Require health plans to report on their attempts to contract with providers when submitting their alternative access standard requests, including providing evidence of their efforts, such as the contact information for each provider with which they have attempted to contract.

Current Status: Not Fully Implemented

Estimated Implementation Date: July 2020

Implementation Plan:
DHCS is in the process of modifying the alternative access request process for the July 1, 2020, annual network certification. The health plans will be required to search the same databases that DHCS uses when reviewing alternative access requests. If a provider is identified that is in closer proximity to what has been requested, the health plan will be required to submit contracting efforts to DHCS that would demonstrate why a health plan was unable to enter into such contracts.

Recommendation 5
To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Establish a process for periodically verifying the health plans' efforts, such as contacting a sample of the listed providers and determining whether the plans attempted to contract with them.

Current Status: Not Fully Implemented

Estimated Implementation Date: September 2019

Implementation Plan:
DHCS has already established a process to select a random sample of alternative access approvals and verify health plan contacting efforts. This process is currently underway for the approvals issued for the annual network certification process that was completed on July 1, 2019. DHCS aims to complete the sampling and analysis by September 2019.

Recommendation 6
To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Require health plans to authorize out-of-network care if they do not demonstrate they have exhausted all of their reasonable options to meet the access requirements, unless the health plans can demonstrate that closer providers are demanding unreasonably high rates or have documented deficiencies in quality of care.

(4) **Current Status:** Will Not Implement/Already In Compliance

Estimated Implementation Date: N/A

Implementation Plan:
This is a current requirement in the health plan contract. The health plan contract requires that health plans allow beneficiaries to obtain medically necessary covered services from out-of-network providers if the services cannot be provided in-network. A

link to the current health plan boilerplate contract is listed below, but this requirement can be found in Exhibit A, Attachment 9 - Out of Network Providers. If DHCS denies an alternative access request, the health plan will be held to the contractual requirements prescribed in their contract and state and federal law. DHCS will deny alternative access requests when the department determines that there are potentially willing providers and a health plan has not sufficiently demonstrated that it made efforts to contract and providers were not willing to contract for reasonable rates. ④

https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

Recommendation 7

To ensure that it promptly and sufficiently notifies counties and other stakeholders about health plans' quality of care deficiencies, DHCS should immediately do the following: (a) Post its medical audit reports to its website within one month after it issues the audit to the health plan. (b) Include information about its recently published medical audit reports and other monitoring efforts in its communication with counties and other stakeholders on its mailing list. (c) Ensure that relevant county officials are included on its mailing lists.

Current Status: Not Fully Implemented

Estimated Implementation Date: September 2019

Implementation Plan:

DHCS is currently in compliance with its state law requirements to post annual medical audits and their corrective action plans to its website once they have both been completed. DHCS does post its audit reports to its website once they have been completed and meet various requirements for public posting, such as accessibility. DHCS will include additional information on its monitoring efforts in its communications with stakeholders through its mailing lists. ⑤

Finding 2: DHCS has not ensured that all Medi-Cal beneficiaries in the rural expansion counties receive services through a model that best meets their needs.

Recommendation 8

To ensure that all counties are aware of the managed care model options available to them and of the steps necessary to implement those models, DHCS should provide by December 2019 information to all counties that clearly defines each managed care model and the steps and legal requirements needed to establish each model.

Current Status: Not Fully Implemented

Estimated Implementation Date: December 2019

Implementation Plan:
DHCS already provides via the DHCS website, the various Plan Model types and a (6) description of each model. However, DHCS agrees to post additional information on the DHCS website for counties to access, that provides information on the steps and legal requirements to establish each model. In addition, DHCS has been willing to meet with counties when requested to discuss issues about managed care and answer questions regarding the models.

Link to current DHCS website for Plan Model Type Information:
https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf

Recommendation 9
To ensure that it makes informed decisions regarding the extension or renewal of its contracts with managed care health plans, DHCS should immediately begin the practice of requesting annual feedback from the counties that the health plans serve and of using that feedback in its decision-making process.

Current Status: Not Fully Implemented

Estimated Implementation Date: July 2020

Implementation Plan:
DHCS agrees to implement a practice of requesting annual feedback from the counties that the health plans serve and use that feedback in its decision-making process when extending or re-procuring health plan contracts.

Recommendation 10
To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020: Determine the specific causes of Anthem's and Health and Wellness's inabilities to provide reasonable access to care in the Regional Model counties.

Current Status: Not Fully Implemented

Estimated Implementation Date: June 2020

Implementation Plan:
DHCS will conduct an analysis of access in the Regional Model using available data, existing workforce shortages information, alternative access standard requests, the independent Access Assessment required under the Special Terms and Conditions of the 1115 Waiver that is being conducted by the DHCS External Quality Review Organization, and other relevant information pertinent to the analysis as its being designed.

Recommendation 11
To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020: Evaluate whether the structural characteristics of a County Organized Health System (COHS) model would be better suited to providing reasonable access to care in the Regional Model counties and notify the counties whether a COHS would improve beneficiaries' access to care. If some or all of these counties desire to transition to a COHS, DHCS should assist them in making that change after their current contracts expire.

Current Status: Not Fully Implemented

Estimated Implementation Date: Unknown

Implementation Plan:
Will implement as needed. As noted in recommendation ten, DHCS will conduct an analysis of access in the Regional Model. Once this analysis has been competed, DHCS will use the results to determine next steps. Additionally, DHCS has and will remain open to meeting with counties and plans to discuss what is necessary to transition to a different model. ⑦

Recommendation 12
To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020: Evaluate whether it has the financial resources to provide assistance to counties interested in establishing COHSs or other managed care models after the current Regional Model contracts expire. If DHCS does not have the required financial resources, it should seek an appropriate amount of funding from the Legislature.

Current Status: Will Not Implement

Estimated Implementation Date: N/A

Implementation Plan:
DHCS will not implement as DHCS does not have the financial resources to provide direct financial assistance to counties to establish a Health Care Plan. The county interested in establishing a COHS would be responsible for seeking the necessary funding (from any source, whether county, state, or other) and overallcounty support to establish the COHS plan. ⑧

Recommendation 13
To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020: Provide counties with reasonable opportunities to decide whether to change their managed care models after the expiration of the Regional Model health plan contracts. DHCS should provide counties who choose to do so sufficient time to establish their new models. DHCS should also include language in the 2020 request for proposals (RFP) to allow Regional Model

counties that can demonstrate their ability to implement a COHS model in their county by 2023 to opt out of the RFP process.

⑨ **Current Status:** Will Not Implement

Estimated Implementation Date: N/A

Implementation Plan:
The RFP release and the dates of implementation will not preclude counties from seeking a COHS model in those counties that are a part of the RFP. ⑨ We would expect counties and plans interested in switching to a COHS model in any of the RFP counties to make DHCS aware during the RFP process, which should provide them a reasonable amount of time to choose to opt out of the RFP process and take the necessary steps to implement a COHS model.

COMMENTS

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on DHCS' response to our audit. The numbers below correspond to the numbers we have placed in the margin of DHCS' response.

① We stand by our recommendation. As we state on page 24, given DHCS' critical role in overseeing the State's provision of Medi-Cal services, we believe that it is well positioned to perform the assessment of locations requiring additional providers and strategies for recruiting those providers we describe. If DHCS believes that it would benefit from collaborating with other state agencies, we would encourage it to do so while still maintaining overall responsibility for performing this assessment.

② Contrary to its assertion, the written guidance DHCS currently uses to process alternative access requests, which we evaluated during the audit, is inadequate. As we state on page 21, DHCS lacks formal guidance specifying the conditions under which its staff should approve or deny a request. Consequently, DHCS cannot ensure that its staff approve only those requests in which health plans have demonstrated that they exhausted all reasonable options to obtain closer providers so that beneficiaries are not required to travel excessive distances to receive care.

③ DHCS' statement is incorrect. As we state on page 20, DHCS has not established a minimum number of providers that health plans should attempt to contract with in a designated location before it considers an alternative access standard request. By not requiring health plans to demonstrate that they have attempted to contract with a minimum number of providers before approving their alternative access standard requests, DHCS cannot ensure that the health plans have exhausted all reasonable efforts to seek providers that are closer to beneficiaries.

④ We disagree with DHCS' statement that it is already in compliance with our recommendation. We acknowledge that the current contracts for Anthem and Health & Wellness contain a requirement that the health plans must allow beneficiaries to obtain medically necessary covered services from out-of-network providers if they cannot provide the services in-network. However, we did not observe DHCS sufficiently enforcing this requirement during our audit. As we report on page 21, DHCS initially placed health plans

on network certification CAPs in 2018 to enforce the requirement but closed those CAPs after approving alternative access standard requests for those health plans that were still unable to meet access requirements. However, DHCS approved those requests even when health plans did not demonstrate that they had exhausted all reasonable options to obtain closer providers. We look forward to reviewing DHCS' 60-day response to the audit recommendations to learn about the steps that it will implement to enforce this contract requirement when it determines that health plans have not made sufficient efforts to contract with providers.

(5) DHCS misses the point of our recommendation, which is to ensure that it promptly and sufficiently notifies counties and other stakeholders about health plans' quality of care deficiencies. Although state law allows DHCS to delay the publication of health plan audits until the health plans complete the medical audit CAPs, which we acknowledge on page 30, we believe counties could better assist their beneficiaries if DHCS informed them of performance issues more promptly. Therefore, to provide this important information in a more timely manner to counties, we recommended DHCS post its medical audit reports to its website within one month after it issues the audit to the health plan, which state law allows.

(6) We look forward to reviewing DHCS' 60-day response to learn about the progress it has made to post additional information regarding the steps and legal requirements to create each model. However, DHCS also needs to send this information directly to counties—especially rural counties that lack resources and ability to seek such information—to ensure that they are informed of their managed care options. Simply posting or updating information on DHCS' website does not necessarily ensure that counties become aware of such information; we cite examples on page 30 of counties that find DHCS' website overwhelming or that experience difficulties finding information on DHCS' website about health plans.

(7) DHCS' approach to implement this recommendation does not sufficiently address the issues we identified with access to care. As we state starting on page 39 of the report, there are structural aspects of the COHS Model that may provide better access to care for beneficiaries in the Regional Model counties than those beneficiaries currently receive. However, the analysis that DHCS refers to, which is described in its implementation plan for recommendation 10, does not include an evaluation of whether the COHS Model would be better suited to provide reasonable access to care in the Regional Model counties. Until DHCS performs the evaluation we recommend and proactively assists counties

that desire to transition to a COHS, those counties with limited resources may not be able to establish the health care systems that could best serve their beneficiaries.

⑧

We disagree with DHCS' perspective. Because the Regional Model includes many counties that may desire to transition to a single multicounty COHS, we believe that it would be more effective for DHCS to submit a consolidated funding request to the Legislature rather than for each county to submit its own individual request. As we state on page 7, DHCS is the state agency responsible for administering Medi-Cal. By submitting a single request, DHCS would help expedite authorization of such funding and would also help ensure that all of the counties are treated equitably, despite differences in their size and resources. As we characterize on page 42, small and rural counties may not be able to develop the infrastructure required to change their managed care models without DHCS' assistance.

⑨

We disagree with DHCS' determination that it does not need to implement our recommendation. Although DHCS acknowledges that the release of the RFP and the dates of implementation will not preclude affected counties from seeking a COHS Model, it did not specify that it would include that provision in the RFP. By implementing our recommendation to include language in the 2020 RFP to allow counties to opt out of the Regional Model if they can demonstrate their ability to implement a COHS Model, DHCS would demonstrate its commitment to helping small and rural counties improve the access to care for their beneficiaries.

CALIFORNIA HEALTHCARE FOUNDATION

On the Frontier:
Medi-Cal Brings Managed Care to California's Rural Counties

MARCH 2015

About the Author

Lee D. Kemper is founder and principal of Kemper Consulting Group, which provides health and human services program and policy consulting services. Mr. Kemper has held senior positions with California counties and the State of California, and in the non-profit sector. For additional information, see www.kempercg.com.

About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

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Introduction

Beginning late in 2013, California's Medi-Cal program expanded managed care into 28 primarily rural counties that include some of the state's most geographically remote areas. Many of these counties have very limited health care provider capacity, particularly for specialty care, behavioral health services, and services and supports to seniors and persons with disabilities. All but two of the counties have a population below 200,000, and 18 of the most sparsely populated are designated as "frontier" counties or have "frontier" areas.[1]

As of July 2014, more than 400,000 Medi-Cal beneficiaries had joined Medi-Cal managed care health plans under this rural expansion.[2] This report offers a "first look" at implementation of the expansion and identifies key issues and opportunities to help guide policy and program development going forward. In particular, the report looks at:

- The unique characteristics of the health care environments in the rural expansion counties
- Managed care plan standards and how the relevant state agencies — the California Department of Health Care Services (DHCS) and the California Department of Managed Health Care (DMHC) — are and will be evaluating the performance of Medi-Cal managed care in rural areas
- What early data indicate are key issues that require state attention going forward

This report is based on interviews with a wide range of key informants, including senior DHCS and DMHC officials overseeing the program, and leading representatives of hospitals, doctors, clinics, counties, health plans, and consumers. (See Appendix A.) Interviews were conducted between November 2013 and June 2014. In addition, various publicly available documents, and information on the health plan programs obtained through Public Records Act requests to DHCS and DMHC, were reviewed.

Background on Medi-Cal Managed Care

Over 30 years ago, the State of California began transforming the Medi-Cal program from fee-for-service (FFS) delivery (state management and payment of claims for services submitted by providers) to managed care (state contracting with public and private health plans that arrange and pay for services). The state has implemented a variety of managed care models over the years, including County Organized Health Systems (COHS), in which one public plan serves an entire county, and beginning in the early 1990s, the Two-Plan Model, which in 14 counties provides beneficiaries with a choice between a private and a public plan. California also implemented Geographic Managed Care (GMC), which offers beneficiaries a variety of plan options, in two counties. With the state's managed care expansion into rural counties, California has adopted an approach that relies upon both a COHS model and a Regional Model, which offers two commercial plan options.

From the managed care program's inception, each COHS served most Medi-Cal beneficiaries in a county, including seniors and persons with disabilities, while the Two-Plan Model and GMC programs started with mandatory enrollment only of low-income women and children. In 2011, the state began requiring seniors and persons with disabilities in Two-Plan counties to enroll in a managed care plan, with certain exceptions.[3]

Responsibilities of Health Plans and the State

Health plans providing coverage in the Medi-Cal managed care program receive monthly per-person payments (capitation) from the state, which contracts with the plans to organize provider networks, including negotiation of rates, incentives, and other payment arrangements, and to assume responsibility for assuring that care delivery meets state statutory and contractual standards related to access, availability, and quality.

Under California law, all managed care plans (not including COHS plans) must be licensed as health care service plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene).[4] In addition, each plan participating in Medi-Cal must meet specific Medi-Cal contractual and regulatory standards affecting how services are

arranged and paid for by the plan. Except for formal Knox-Keene licensure, the standards applied to COHS plans are the same as those for all other types of Medi-Cal managed care plans. The Knox-Keene standards apply to a managed care plan whether it provides services in an urban or suburban jurisdiction or in a new rural expansion county. Similarly, the regulatory and contractual standards DHCS has set for health plans operating in rural expansion counties are the same as those for health plans operating in urban and suburban counties.

Rural counties differ significantly in number and type of health care providers as compared to urban and suburban counties. In recognition of these differences, this report focuses on the early evidence of health plan performance in meeting certain DHCS standards in the rural expansion counties. These include standards pertaining to access and availability of health care services, including provider network composition and maximum travel time and distance from primary care providers, hospitals, and specialists.

Glossary of Terms: Medi-Cal Managed Care

County Organized Health System (COHS). An independent public agency that contracts with the state to be the sole administrator of Medi-Cal benefits for an entire county; all Medi-Cal beneficiaries in the county, excluding certain carved-out populations, are mandatorily enrolled in the single COHS plan.

Frontier Area. A Medical Service Study Area (MSSA) that has low population density, as designated by the California Office of Statewide Health Planning and Development. A "rural" MSSA has a population density of less than 250 persons per square mile and no census-defined area with a population exceeding 50,000. A rural MSSA is further designated as "frontier" if it has a population density of less than 11 persons per square mile.

Geographic Managed Care (GMC). A model of Medi-Cal managed care in which the state contracts with, and offers to Medi-Cal beneficiaries, multiple commercial health plan options within a single county.

Local Initiative (LI). A Knox-Keene-licensed, county-sponsored managed care plan that serves an entire county (or multiple counties) as the public plan in a Two-Plan Model. The LI is established by county ordinance but is legally independent from county government.

Medi-Cal Managed Care Delivery Models. Service delivery and contracting models for managed care in Medi-Cal, which include County Organized Health Systems, Geographic Managed Care and Two-Plan Model programs, and the Regional Model, a slightly modified version of the Two-Plan approach, created for the rural expansion.

Medical Service Study Area (MSSA). Sub-city and sub-county geographical units used to organize and display population, demographic, and physician data.

Medically Underserved Area (MUA) and Medically Underserved Population (MUP). Medically underserved areas and populations that are federally designated based on criteria established by the federal Health Resources and Services Administration. The four criteria are the ratio of primary care physicians per 1,000 population, infant mortality rate, percentage of the population below the poverty level, and percentage of the population age 65 and over.

Regional Model. A model of Medi-Cal managed care developed for the rural expansion in which the state contracts with two commercial plans to administer Medi-Cal benefits in a county or counties, with Medi-Cal beneficiaries having a choice between the two plans. (In San Benito County, beneficiaries choose either a commercial plan or FFS.)

Two-Plan Model. A model of Medi-Cal managed care in which the state contracts with two plans, one a public Local Initiative and the other a commercial health plan, to administer Medi-Cal benefits in a specific county or counties, with Medi-Cal beneficiaries having a choice between the two plans.

Bringing Medi-Cal Managed Care to Rural Counties

Goals of Rural Managed Care Expansion

In public statements and in interviews for this report, DHCS summed up the benefit of managed care for rural counties as the opportunity to strengthen the organization of health care in those communities by assisting Medi-Cal beneficiaries to "get the care they need at the right time by the right provider." Within this overall purpose, DHCS's basic goals for the rural expansion effort, as described in a presentation to stakeholders in 2012, are to deliver:

- Quality care in an environment that manages costs
- Care that is medically necessary and appropriate for the beneficiary's condition
- Care by the most appropriate provider and in the least-restrictive setting

Additional benefits of managed care for rural populations identified by DHCS in that presentation include:

- A medical home that coordinates care, emphasizes prevention and wellness, and provides case management
- Supplemental support through nurse advice phone lines
- Transportation assistance
- Assistance getting appointments with specialists
- Health education
- Grievance systems
- Greater accountability through reporting of Healthcare Effectiveness Data and Information Set (HEDIS) and other data[5]

In interviews, DHCS also identified the following dynamics that particularly affect rural areas and associated expectations for health plans:

- **Rural provider options can be limited.** As a consequence, health plans will need to demonstrate access across a region by addressing geographic barriers to care.
- **Access and transportation barriers can be more significant in rural areas.** Therefore, health plans have a stronger obligation to ensure that rural beneficiaries can reach providers who offer the plans' covered benefits.
- **Hospital dynamics are different.** There may be only one hospital in a rural region, which therefore can have more control in pricing and thus create cost pressures for the health plan.
- **Providers invited to join health plan networks are accustomed to FFS payment.** Health plan efforts to switch to capitation payment arrangements may require longer-term development.

Structure of Rural Managed Care

The FY 2012-13 California State Budget, as set forth in Assembly Bill 1467, authorized DHCS to implement Medi-Cal managed care in the rural expansion counties.[6] After a competitive Request for Application process, DHCS selected four health plans to serve Medi-Cal beneficiaries in 28 expansion counties. Of these, a Regional Model, composed of two commercial health plans, operates in 19 counties; eight counties are served by a COHS; and in one county, beneficiaries have a choice of a private health plan or Medi-Cal FFS. (See Table 1 on page 6 and map on page 7.)

AB 1467 requires enrollment in a Medi-Cal managed care plan for the following Medi-Cal beneficiaries in the 28 expansion counties: low-income families with children associated with CalWORKS; pregnant women; seniors and persons with disabilities; and low-income adults newly eligible for Medi-Cal under the Affordable Care Act (ACA). Certain Medi-Cal enrollees or services are excluded, or "carved out," such as children whose condition makes them eligible for California Children's Services, beneficiaries for whom Medicare is their primary source of coverage ("dual eligibles"), and people eligible for HIV/AIDS Home and Community Based Waiver services. As a COHS, Partnership HealthPlan of California (Partnership) assumed responsibility at implementation for all the required Medi-Cal populations in the counties it serves. The health plans operating in the Regional Model started with low-income families, pregnant women, and single adults; seniors and persons with

Table 1. Health Plans in Rural Managed Care Expansion Counties

PLANS	COUNTIES	EFFECTIVE DATE
Partnership HealthPlan	Del Norte, Humboldt, Lake,* Lassen, Modoc, Shasta, Siskiyou, and Trinity	September 1, 2013
Anthem Blue Cross **California Health & Wellness**	Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba	November 1, 2013
California Health & Wellness **Molina Health Systems**	Imperial	November 1, 2013
Anthem Blue Cross **Fee-for-Service Medi-Cal**†	San Benito	November 1, 2013

*Partnership HealthPlan began operating in Lake County on September 1, 2013, under a previously approved expansion.

†Maintained by DHCS to provide a second choice for beneficiaries in San Benito county.

Sources: "Medi-Cal Managed Care Program Fact Sheet — Managed Care Models," www.dhcs.ca.gov; Medi-Cal Managed Care Models map, www.dhcs.ca.gov; DHCS Interested Parties Letter, February 28, 2013.

disabilities began joining these plans in a second-phase expansion that started December 1, 2014.

Characteristics of Rural Expansion Counties and Their Health Care Systems

Until quite recently, health care delivery in rural California, whether privately or publicly funded, has relied on the FFS delivery model. Under this FFS system, to participate in Medi-Cal a hospital, community health center, private physician, or other provider executed a Medi-Cal provider agreement. DHCS directly administered the treatment authorization process and contracted with a fiscal intermediary to process and pay medical claims. In contrast, under a managed care arrangement DHCS steps back from direct benefit administration while health plans assume responsibility for the organization and delivery of care, including network development, treatment authorization, and claims payment.

While data are limited, the evidence of past efforts to bring managed care to rural areas in California indicates that these areas have not offered a hospitable environment for it. In a 2002 study, California's Legislative Analyst looked at reasons for withdrawal of managed care plans from the state's rural areas from 1997 through 2002.[7] According to the Legislative Analyst, the plans withdrew due to a combination of factors:

- Rural residents were more expensive to cover because the populations as a whole were older, had lower incomes, were more likely to be unemployed, and had poorer health than those in urban areas.
- Plans had difficulty distributing risks and costs of health care across a small population of covered enrollees because there were insufficient numbers of healthy enrollees to offset higher-cost enrollees.
- Plans faced shortages of health care providers, including primary care physicians (PCP), who were needed to fill plan networks.
- Plans had difficulties building comprehensive provider networks due to geographic distances and a limited number of specialists in certain areas.
- Plans had concerns about low payer reimbursement rates and their ability to fund the costs of care.

According to informants for this report, most of the dynamics identified by the Legislative Analyst in 2002 still exist. However, the context has changed. First, the Medi-Cal populations to be enrolled in rural managed care are now potentially large enough to offset historic health plan concerns about distributing risks and costs. Second, most of the participating health plans have had more than a decade of experience delivering managed care in the Medi-Cal program since the 2002 study. Nonetheless, the underlying dynamics of limited provider availability, particularly for specialty care, and the demographic composition of these rural areas remain the same.

Figure 1. The 28 Medi-Cal Managed Care Rural Expansion Counties and Their Health Plans

Demographics of the Rural Expansion Counties

The economies of most of the 28 rural expansion counties are based on agriculture, recreation, or tourism. Nearly all were hit hard by the economic recession that began in 2007, and the lingering effects are still felt in most. Many of the Legislative Analyst's 2002 findings on the challenges facing rural counties remain true today, as evidenced by poverty, unemployment, and public program participation data. (See Table 2 on page 8.)

A recent report by The Robert Wood Johnson Foundation (RWJF), *County Health Rankings 2014: California,* offers a portrait of health disparities across California's 58 counties by looking at certain health outcomes (length of life, health/mental health status, birth outcomes) and health factors (health behaviors, clinical care, social and economic factors, physical environment). The RWJF report shows that 19 of the 28 rural expansion counties (68%) rank in the bottom half of all California counties for at least one of these two measures and 15 counties (54%) rank in the bottom quarter for at least one of the measures. (See Appendix B.)

Further, for residents of the 28 rural expansion counties, medical underservice is a regular challenge. Geographic

Table 2. Selected Demographics of the 28 Rural Managed Care Expansion Counties

	POPULATION	POVERTY RATE	UNEMPLOYMENT RATE	CALFRESH ENROLLMENT	MEDI-CAL ENROLLMENT	MUA/ MUP	RURAL MSSA	FRONTIER MSSA
California	**38,340,074**	**15%**	**8%**	**4,288,454**	**7,594,872**	n/a	n/a	n/a
Alpine	1,079	14%	11%	180	193			x
Amador	36,151	11%	8%	3,400	4,606	x	x	
Butte	222,316	21%	9%	30,349	62,008	x	x	x
Calaveras	44,650	10%	9%	5,077	6,701		x	
Colusa	21,660	15%	20%	1,788	4,710		x	x
Del Norte	28,131	22%	10%	5,143	8,219	x	x	
El Dorado	182,404	8%	7%	12,323	19,110	x	x	
Glenn	28,353	20%	11%	3,666	7,202	x	x	x
Humboldt	134,648	20%	7%	18,180	27,304	x	x	x
Imperial	180,672	23%	22%	36,840	68,088	x	x	x
Inyo	18,590	11%	7%	2,179	3,641	x	x	x
Lake	64,699	24%	10%	10,814	18,109	x	x	
Lassen	32,581	15%	10%	3,230	6,146	x	x	x
Mariposa	18,467	15%	8%	2,050	2,888	x	x	x
Modoc	9,197	20%	11%	997	2,084	x		x
Mono	14,143	10%	7%	915	1,381		x	
Nevada	97,225	12%	6%	7,792	11,668	x	x	
Placer	366,115	8%	6%	18,252	31,026		x	x
Plumas	19,140	14%	12%	1,951	3,112	x	x	x
San Benito	57,517	13%	11%	6,303	10,336	x	x	
Shasta	179,412	18%	10%	24,156	41,918	x	x	x
Sierra	3,089	17%	12%	302	487	x		x
Siskiyou	45,231	20%	12%	7,003	10,671	x	x	x
Sutter	95,733	17%	15%	12,740	23,430	x	x	
Tehama	63,717	20%	10%	10,860	18,073	x	x	x
Trinity	13,389	18%	12%	1,771	2,826	x	x	x
Tuolumne	53,604	13%	8%	5,536	8,283	x	x	x
Yuba	73,682	21%	13%	13,089	20,868	x	x	

Notes: **CalFRESH** is California's version of the federal Supplemental Nutrition Assistance Program (SNAP) that provides food assistance for low-income families. **MUA/MUP** stand for Medically Underserved Area and Medically Underserved Population, which are defined by the number of primary care physicians per population, plus other factors. **Rural MSSA** (Medical Service Study Area) refers to an area with less than 250 persons per square mile and no population center exceeding 50,000. **Frontier MSSA** refers to a Rural MSSA with less than 11 residents per square mile.

Sources: California Department of Finance, "Population Estimates for Cities, Counties, and the State — January 1, 2013 and 2014"; US Bureau of the Census, American Community Survey, "5-Year Estimate (2008-2012) for Poverty Rate"; California Economic Development Department, *Monthly Labor Force Data for Counties for 2013, Report 400C;* California Department of Social Services, *Food Stamp Program Participation and Benefit Issuance Reports (DFA256),* April 2014; California Department of Health Care Services, "Number of Medi-Cal Beneficiaries by County: July 2011," July 2012; California Office of Statewide Health Planning and Development, "Medically Underserved Areas and Populations" (map), October 2010 and "California Medical Service Study Areas, Urban, Rural and Frontier Defined Areas," September 2010.

isolation and transportation difficulties are common barriers to obtaining medical care, particularly specialty care. Of the 28 counties, 23 include designated Medically Underserved Areas (MUA) or Medically Underserved Populations (MUP). (See Table 2.)

Health Care Providers in the Rural Expansion Counties

The starting point for developing Medi-Cal managed care in the 28 rural expansion counties has been each county's existing health care infrastructure. Most of the expansion counties have basic infrastructure, but several lack essential health system building blocks. For example, there are 17 hospitals in the eight new counties served by Partnership HealthPlan of California, and 29 hospitals in the 20 counties served by Anthem Blue Cross (Anthem) and California Health & Wellness (CHW). Three counties, however, have no hospital. (See Appendix D for a complete list of hospitals in the 28 counties.)

Community health centers (CHC) and rural health clinics (RHC) form the backbone of the ambulatory care delivery system in these rural California counties. (See Table 3.) CHCs, including Federally-Qualified Health Centers (FQHCs), FQHC look-alikes, and community health clinics, free health clinics, and Indian health clinics, are nonprofit or public, community-directed health care providers serving low-income and medically underserved communities. Almost one-quarter of the 995 CHCs in California are located in rural communities and many serve the 28 expansion counties.

Table 3. Community Health Centers and Rural Health Clinics in Rural California, 2013-2014

HEALTH CENTER TYPE	NUMBER
Community Health Centers (CHC) in Rural/Frontier MSSAs	**249**
➤ Federally Qualified Health Centers (FQHC)	189
➤ FQHC Look-Alikes	14
➤ Community/Free Clinics	29
➤ Indian/Tribal Health Center Licensed Sites	17
95-210 Rural Health Clinics (RHC)	**285**
TOTAL*	**510**

*Total reflects that 24 clinics are simultaneously designated as CHCs and 95-210 RHCs.

Sources: California Primary Care Association, email communications, April 2014 and February 2015, citing OSHPD 2013 data; Centers for Medicare and Medicaid Services, CASPER Report 0006D, Name and Address Listing for Rural Health Clinics – California (August 2014).

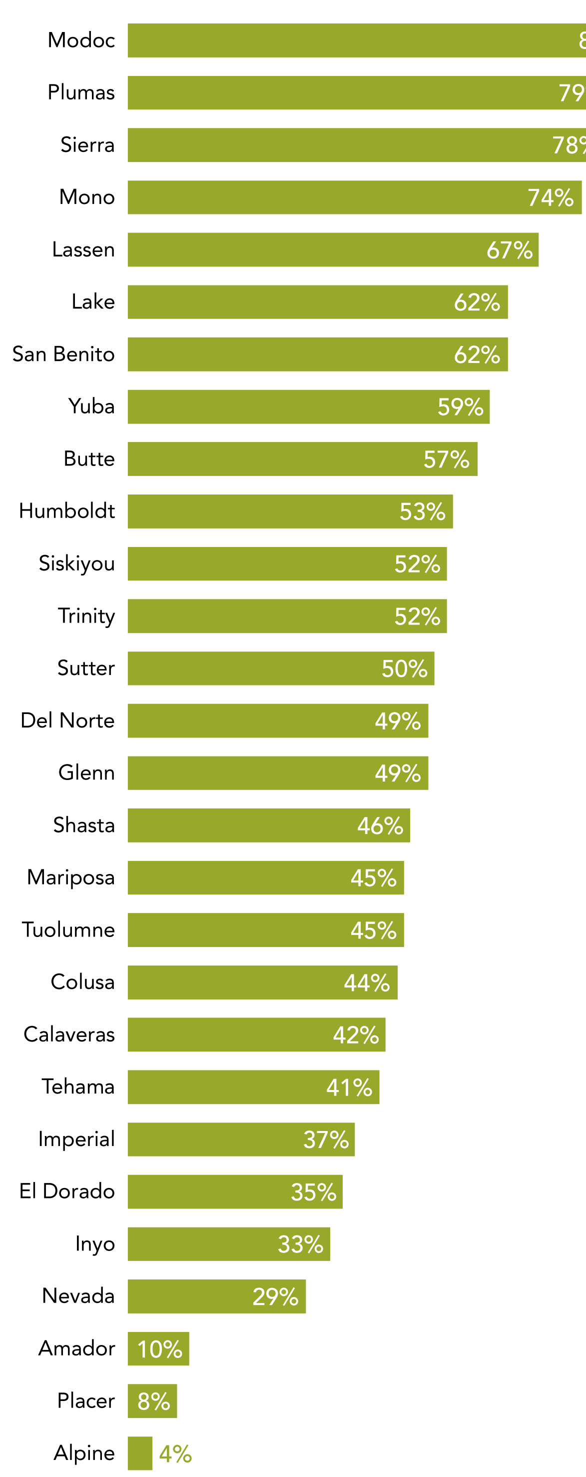
RHCs are clinics specifically dedicated to increasing primary cares services for Medicare and Medicaid patients in underserved rural areas. RHCs may be nonprofit or for-profit. As of summer 2014, there were 285 RHCs in California, the large majority of them either private practices or hospital-based programs. Of those, 120 were in the 28 expansion counties.

While both CHCs and RHCs in California are reimbursed via the Prospective Payment System (PPS) — a fixed, per-visit payment — there are differences between the two types of entities. For example, CHCs are required to provide a full range of primary and preventive care services. They must serve all ages and all residents of their service area regardless of insurance status or ability to pay, and have a sliding scale of charges. RHCs do not have minimum service requirements and generally do not see uninsured patients.

A 2011 DHCS study of Medi-Cal beneficiary health care access underscores the important role FQHC and RHC providers play in serving Medi-Cal beneficiaries in the 28 expansion counties. According to this study, in nearly half of these counties more than 50% of beneficiaries with medical claims had 70% or more of their visits at an FQHC or RHC. In three-quarters of the counties, more than 40% of Medi-Cal beneficiaries received 70% or more of their visits at an FQHC or RHC. (See Figure 2 on page 10.)

Finally, California Medical Board records show approximately 3,900 licensed physicians in the 28 expansion counties in 2011-12, although this figure does not necessarily reflect active physicians. This level of physician licensure has remained flat since 2007-08. (See Appendix C.)

Figure 2. Medi-Cal Beneficiaries* Receiving 70% or More of All Medical Services at FQHCs/RHCs, 28 Rural Expansion Counties, 2009



*Among those with claims.

Source: Department of Health Care Services, *Measuring Access to Medi-Cal Covered Healthcare Services: Physicians, Physician Groups, Clinics, and Hospital Emergency Departments*, September 2011.

Implementation of the Rural Expansion

Key informants for this report were interviewed in the late fall of 2013 and winter of 2014. Among questions asked were those soliciting their views about the implementation process for the new managed care program. These views provide a useful framework for understanding some of the difficulties associated with implementation and key issues needing attention as the rural expansion proceeds.

Initial Implementation Difficulties

DHCS set an ambitious timeline for the rural expansion. The initial "go-live" date for the expansion was June 1, 2013, less than one year after statutory authorization. Provider and county informants agreed that this timeline was unrealistic, given the procurement process required for the selection of health plans, associated planning and development, and the number of counties involved. DHCS released the Request for Applications for prospective plans in early November 2012, with the selected plans to be announced by the end of February 2013.[8] Ultimately, the start date for the expansion was pushed back to September or November of 2013, depending on the county, to address various implementation issues.

In support of this process, DHCS held stakeholder meetings and community forums in five counties — Imperial, Mariposa, Sacramento, San Benito, and Shasta — between July and December 2012 and conducted several webinars in summer 2012 and spring 2013. Following the announcement of health plan contracts, the plans themselves organized dozens of community meetings during late 2013 and into 2014. Despite these activities, provider and county informants said that DHCS's tight timeframe for selecting health plans and implementing the program resulted in a rushed process with limited opportunities in many expansion counties for active stakeholder involvement to address local issues and concerns.

Informants across the spectrum were also critical of the process used to inform Medi-Cal beneficiaries about the impending shift to managed care. DHCS reported that written notices were sent to each beneficiary at 90 days, 60 days, and 30 days prior to the beneficiary's date of enrollment into managed care, and that the notices were prepared with stakeholder input. DHCS also reported

that phone calls were made to beneficiaries who had not selected a plan after the 30-day notice. However, some informants interviewed for this report asserted that this DHCS beneficiary education process was inadequate. First, informants reported that some of the information beneficiaries received from Health Care Options, contracted by DHCS to assist beneficiaries with plan selection, was incomplete or out-of-date, which created confusion for beneficiaries. Second, informants reported that DHCS notices to beneficiaries about the change to managed care were difficult for some beneficiaries to understand, and some notices went to the wrong people, which created additional beneficiary confusion.

Better Transition in Certain Counties

Informants reported that in certain counties the managed care rollout was less disruptive and better oriented to local needs. According to these interviewees, in Imperial County and in the seven northern counties where Partnership was selected as the sole health plan, local stakeholders had more opportunity to engage with the process and thereby to facilitate implementation and improve outcomes.

In the seven northern counties, these transition efforts grew from the work of a local health alliance of Shasta County providers and other stakeholders that began meeting after the passage of the ACA in 2010. The group came to the conclusion that managed care was inevitable with implementation of the ACA. As a consequence, the alliance initiated discussions with Partnership about bringing Medi-Cal managed care to the county. These initial contacts did not yield an agreement to proceed, but when DHCS proposed expansion of Medi-Cal managed care to rural counties, Shasta County stakeholders, including provider groups, reopened their discussions with Partnership.

After more than a year of collaborative work, Partnership, already approved for expansion into Lake County, determined that it would need seven contiguous counties to support an overall expansion of Medi-Cal managed care into this rural region. The collaborative ultimately obtained the support of the Boards of Supervisors of seven counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, and Siskiyou) for Partnership to be their sole Medi-Cal managed care provider. DHCS initially held to its intent of having two health plans in each county but eventually accepted Partnership as the sole plan after hearing from the county Boards of Supervisors, key legislators, local health care providers, and other stakeholders. Stakeholders in the seven counties now credit the trust built over several years of collaborative "pre-work" for the success of the managed care rollout there.

In Imperial County, a previously established health leadership group chaired by a local physician had been meeting to look at changes on the horizon, including meaningful use of electronic health records, health care reform under the ACA, and accountable care organizations. When DHCS announced its intention to implement the rural expansion, the local leadership group reached out to and incorporated a health care stakeholder group that included several dozen local physicians. This expanded group developed and recommended a Two-Plan Model to include an LI plan (a public, countywide plan) and a private plan, and the county Board of Supervisors endorsed the concept. A steering committee devised and implemented a process for selecting the LI plan, and several plans were considered. While the county ultimately concluded that development of an LI plan was not feasible in the near term and recommended that DHCS approve a single commercial plan, CHW, to serve the county, the local planning effort resulted in a managed care plan with broad-based support in the county. DHCS approved CHW and later added Molina Health Systems (Molina) as a second commercial plan to provide beneficiary choice.

Health Plan Standards for the Rural Expansion

All of the health plans participating in the rural managed care expansion have executed contracts with DHCS, and all of them are subject to DHCS regulatory oversight. In addition, Anthem, CHW, and Molina are licensed under the Knox-Keene Health Care Act and therefore are also subject to regulatory oversight by DMHC. As a COHS, Partnership is not a Knox-Keene plan and so is subject to DHCS but not DMHC regulation.

Nothing in Knox-Keene, in the enabling statutes for the expansion, or in the DHCS contract identifies unique circumstances or conditions associated with rural health care delivery that must be addressed as a part of health plan responsibilities for the rural managed care expansion. Rather, existing access and availability requirements concerning Medi-Cal managed care that were defined for more populated areas have been carried over and applied to the rural expansion counties. The remainder of

this section examines the early evidence on plans' adherence to DHCS and DMHC standards for provider access and availability of services, which are outlined in Table 4. Hereafter, the report highlights some of the difficulties that plans have experienced in meeting these access and availability standards in certain counties.

Table 4. Provider Access and Availability Requirements for Medi-Cal Managed Care Plans

General Requirements	➤ Each plan member has a primary care physician (PCP) who is available and physically present for sufficient time to ensure access. ➤ Members have access to specialists for all medically necessary services. ➤ Health care plan has a procedure to monitor waiting times in providers' offices and for telephone calls. ➤ Members are offered appointments for covered health care services within a time period appropriate for their condition..
Minimum Number of Providers	➤ PCPs — ratio of 1:2,000* ➤ All physician providers — ratio of 1:1,200* ➤ Specialty care providers — ratio not specified; number subject to approval by DHCS and DMHC based on plan proposals to meet specialty care needs
Time/Distance Standards	➤ PCPs — 10 miles/30 minutes† ➤ Specialty care providers — discretionary standard determined by DHCS/DMHC

Appointment Waiting Times	➤ Emergency care —available in the service area 24 hours/day
	➤ Urgent care:
	  ➤ No prior authorization required — available within 48 hours
	  ➤ Prior authorization required — available within 96 hours
	➤ PCP (non-urgent) — available within 10 business days
	➤ Ancillary services (non-urgent) — available within 15 business days
	➤ Specialty care — available within 15 business days

Specialty Care	➤ Members have access to specialty services in accordance with Title 28 CCR Section 1300.67.2: "Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees."
	➤ Plan has procedures for:
	  ➤ Member to receive a standing referral to a specialist if member needs continuing specialty care
	  ➤ Member with a condition or disease that requires specialized medical care over a prolonged period of time to receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease

Other Requirements	➤ Appointment timeframes may be shortened or extended, as clinically appropriate, by a qualified health care professional and must be documented in the member's medical records. ➤ Plan shall arrange for a member to receive timely care as necessary for a health condition if timely appointments within the time and distance standards required are not available. ➤ Plan shall refer members to, or assist members in locating, available and accessible contracted providers in neighboring service areas for obtaining health care services in a timely manner appropriate for the member's needs. ➤ If services are not available in network, the plan must adequately and timely cover these services out of network for member.

*The ratio is one provider per general population figure within the plan area.

†Medi-Cal managed care plans are subject by contract to a stricter time and distance standard than required by Knox-Keene, which requires PCPs to be available within 15 miles/30 minutes of where enrollees work or reside. DMHC enforces the Medi-Cal standard for the Medi-Cal plans under its jurisdiction.

Source: Medi-Cal Managed Care COHS and Two-Plan contracts, Exhibit A, Attachments 6 (www.dhcs.ca.gov) and 9 (www.dhcs.ca.gov).

Assessment of Health Plan Readiness at Go-Live

For the rural expansion counties served by Partnership, the go-live date for the program was September 1, 2013. For counties served by other health plans, the rollout date was delayed until November 1, 2013. By these implementation dates, the health plans were required to have organized provider networks in place that included contracts with a sufficient number of key providers, including hospital, primary care, specialty care, and ancillary services.

Network approval involved both DHCS and DMHC, and both agencies approved the networks submitted by the plans as meeting required standards. DMHC's focus was review of the networks for licensure purposes and review of alternative standards of accessibility, as applicable. DHCS reviewed the networks to determine contract regulatory compliance and comparability to FFS access.[9]

Key informants were asked about the readiness of the provider networks and the overall system at the time of implementation. Informants from health plans stated that the provider networks were ready at the go-live date. Molina, which was not designated by DHCS as the second plan in Imperial County until late in the fall of 2013, reported that the network was "ready enough" to begin initial service delivery at the go-live date, with improvements expected over the first months of operation. Health plan informants stated they generally expected to see improvements in all of the networks over time as the plans reached out to providers who initially had declined to participate. DHCS informants shared this view. As discussed immediately below, however, provider and county informants were not as positive about network readiness.

Initial Shortcomings Identified by Providers and Counties

Provider and county informants were somewhat more critical than the health plans and DHCS about the readiness of provider networks at the time of implementation. These informants suggested that provider networks "were a work in progress," particularly with regard to specialty care. On this key point, health plan informants acknowledged that access to specialty care providers, depending on the provider type and county, was a continuing challenge because of the limited number of these providers in rural counties.

In particular, provider and county informants reported the following concerns about initial network readiness:

- Provider networks were not fully worked out; many contracts were still in development.
- In various instances, patient assignments to contracting PCPs were being made by the plans without regard to actual availability of those local providers for all the patients assigned.
- Delays in health plan contracting with county-operated clinics created service delays and the need for clinics to submit repeated authorization requests for patients who had long been in their care.
- Specialty care presented manifold problems: many specialty care providers chose to limit the number of new Medi-Cal patients, travel times to contracted specialty providers presented a new barrier for some patients, and health plans referred patients out-of-county for certain specialty care consults, often requiring a wait of several months.
- Because of a lack of contracted specialists, one health plan encouraged PCPs to "find the specialist" they wanted their patient to see; the plan would then attempt to execute a contract with that provider.
- Because of new health plan requirements and plan changes to drug formularies, PCPs spent a lot of additional time getting prior authorizations for specialty care and prescription drugs, and there were new challenges in obtaining coverage for non-formulary medications.
- Hospitals had difficulties with prior authorization processes, including hospital transfer authorizations, and with the process for billing for services provided under treatment authorization requests previously approved by Medi-Cal.
- Mental health provider networks were not ready, and the role of plans versus county mental health programs was unclear.

Many of the issues identified by these informants could be expected with a transition to a new health care delivery system — the movement from FFS Medi-Cal to managed care operated by four different health plans across 28 counties presented a massive planning and

logistical challenge. In the present case, though, provider and county informants felt that many of these problems could have been mitigated by better DHCS planning and communication, by additional work with local stakeholders, and by a longer lead time before implementation.

Specific Contracting Challenges Identified in Some Regional Model Counties

Some provider informants reported that certain providers in the 18 counties served by Anthem and CHW, particularly hospitals and specialty providers, experienced difficulties with the execution of provider contracts. Some of these difficulties reportedly stemmed from the lack of time plans had to engage providers while others were the result of differing expectations about payment rates.

Provider and county informants reported that some specialty providers already participating in Anthem did not understand that they were now included in the Medi-Cal network by virtue of an "all-products" provision in their existing Anthem contracts, which required them to provide care to enrollees in any of Anthem's products. Typically, providers can terminate their entire relationship with a health plan if they do not want to accept a new business arrangement via an all-products clause, but they cannot reject only a specific new product or program. A number of these Anthem providers reportedly responded to this contractual difficulty by accepting the new contract terms but then limiting the number of Medi-Cal referrals they accepted.

Provider informants also reported that payment rates, particularly for specialty care, were a continuing concern in the Regional Model counties. Even where health plans in those counties offered rates higher than traditional FFS rates, some participating providers limited the number of Medi-Cal plan patients they accepted. As one informant stated, "A specialist can *say* they will participate. That doesn't mean full access to that specialist." That is, specialists may contract with a plan but then limit the number of referrals they will accept under the plan, whether because of rates or other reasons.

Health Plan Networks Approved by the State

To understand the overall composition of health plan networks approved by DHCS and DMHC in the fall of 2013, research for this report included a review of selected health plan network submissions approved by DHCS and DMHC, along with information posted by the health plans on their websites. These submissions to DHCS and DMHC provided information on each health plan's contracted primary care, hospital, and specialty care providers. All of the health plans provide this information to DHCS as a contractual requirement. Also, Knox-Keene-licensed plans file certain of these reports with DMHC by March of each year as part of their annual timely access reporting.

The health plan–reported data provided by DMHC for this review had certain limitations. In particular, the data did not follow a single format. For example, data from DMHC on Anthem was aggregated and did not clearly delineate Medi-Cal business versus other lines of business or clearly present the data by county for the 19 counties in which it was doing Medi-Cal business. For the other health plans, DMHC data was disaggregated and provided a clearer picture of the networks at the county level.

The health plan submissions to DHCS followed a more consistent format. Accordingly, the analysis that follows relies primarily on the DHCS data and on information collected from the health plans' websites regarding provider availability. This information is supplemented by data the plans provided to DMHC, where available and applicable.

Primary Care and Hospital Care Access

As shown in Table 5, above, DHCS's contracts with Medi-Cal managed care plans establish specific time and distance standards that the plans must meet for access to PCPs and hospital care. Overall, health plan reporting to DHCS and DMHC in the fall of 2013 showed mixed results by the plans in meeting the PCP access standard of at least one provider within 10 miles and 30 minutes driving time in the rural expansion counties. In summary:

- Partnership reported that it could meet the 10-mile and 30-minute PCP standards for the majority of Medi-Cal beneficiaries served in its eight expansion counties, except for beneficiaries in certain Zip Codes in Del Norte, Humboldt, Modoc, Shasta, Siskiyou, and Trinity Counties, and nearly all beneficiaries in Lassen County.
- Anthem reported that it could only meet the 10-mile PCP standard for roughly half of the beneficiaries in the 19 rural counties it served. Anthem could not meet this standard for most beneficiaries in the

counties of Colusa, El Dorado, Inyo, Mono, Nevada, Plumas, Sierra, and Tehama. However, Anthem reported that most beneficiaries could access a PCP within 11 to 20 miles, excluding those in Inyo, Mono, Nevada, Plumas, and Sierra Counties, for whom travel distances would be considerably greater. Anthem reported that it could meet the 30-minute standard for most beneficiaries, except those in Mono, Nevada, Plumas, and Sierra Counties.

- CHW reported that it could meet the 10-mile PCP standard for most beneficiaries in the 19 counties it served, except for small portions of each county and for 40% or more of beneficiaries in the counties of Amador, Inyo, Mono, and Plumas. CHW reported that it could meet the 30-minute standard for most beneficiaries, except for parts of Inyo and Mono Counties.
- Molina reported no problems meeting the 10-mile and 30-minute PCP standards in Imperial County, except for small populations in the northern areas of the county.

With respect to the hospital-access standard of 15 miles and 30 minutes, health plans could meet the requirement for the most part but reported some problem areas, including:

- CHW identified alternative hospital-access standards for parts of most counties, ranging from 60/60 (miles/minutes) to 150/150, depending on the county. For Mono, Nevada, Sutter, and Tehama Counties, CHW identified countywide alternative standards.
- Partnership identified no problems with the hospital care access standard for Del Norte and Lake Counties, but identified problems meeting the standard for certain Zip Codes in its other six expansion counties.
- In the DHCS records concerning Molina, there was no documentation of an alternative standard for hospital care, but the network data Molina provided showed small populations in the northern part of Imperial County for which Molina's network hospital did not meet the 30-minute standard.
- Information on Anthem's hospital coverage provided by DHCS and DMHC for this review did not allow for evaluation of whether Anthem's hospital network meets the access standard, but Anthem did identify hospital contracts in place across the range of its 19 expansion counties.

Specialty Care Access

There are no uniform state-mandated time and distance standards for specialty care services. Instead, the DHCS contract states generally that, "Contractor shall maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care." The contract references existing law and regulations, which define adequacy as "adequate numbers of specialists and subspecialists to provide access to preventive and managed health care services to . . . members."[10] In addition, health plans are required to "maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and . . . [to] make it available to enrollees, at a minimum, by phone, written material, and Internet Web site."[11]

In light of the broad definition of what constitutes adequacy of specialty care access, the determination of adequacy in any specific county and specialty is generally left to the health plans, with the state regulator, either DHCS or DMHC, accepting or rejecting a plan's proposed standard. DHCS reported that the basic metric it used to determine specialty care adequacy for each new health plan's network was the level of availability that previously existed under FFS Medi-Cal. To make this determination, both DHCS and DMHC reviewed plan networks for the expansion counties. Plans were required to submit geographic access mapping and to demonstrate their ability to contract with out-of-network providers for any of 16 core specialties not in their network. If these conditions were met, the network was approved as adequate.

Specialty Care Provider Access in Summer 2014

To get a snapshot of specialty care access under the rural expansion about 10 months into the program, research for this report included review of selected specialty provider availability as posted on the websites of the participating health plans. For illustrative purposes, the review focused on 6 of the 16 "core specialties" identified by DHCS: cardiology, gastroenterology, neurology, orthopedic surgery, otolaryngology (ENT), and urology. (For detailed data regarding these six specialties under each plan in the 28 expansion counties, see Appendix E.) Because distances to health care providers in rural areas can be long, particularly for specialty care, a standard of

50 miles was used to determine relative availability of these six specialties in the Regional Model counties and in Imperial County, while a different standard was used for counties served by Partnership, as described below.

Health plan networks for specialties beyond these six may be more or less robust, depending on the county and health plan involved. For example, notwithstanding a comparably robust level of participation in these six specialties, CHW identified alternative time and distance standards for other specialties and for parts of most of the counties it serves.

Regional Model Counties

In the Regional Model two-plan counties, the data show that the number of contracting providers offered by CHW in the six high-need specialties is substantially more robust than that offered by Anthem. For the selected specialties, a CHW-contracted specialty provider is not available within 50 miles of the county border only 6% (7/108) of the time. In contrast, an Anthem-contracted specialty provider is not available within that distance nearly 60% (62/108) of the time. (See Appendix E.)

In its filing with DHCS, Anthem reported on strategies to compensate for its specialty care provider shortfalls. In addition to its provider contracts, Anthem stated that it operates an Access to Care Unit designed to assist beneficiaries locate not only in-network specialty care but also out-of-network care when in-network care is not reasonably available. According to Anthem, this unit is tasked with locating appropriate out-of-network specialty providers as needed, negotiating reimbursement terms, assisting in scheduling an appointment for the beneficiary, and coordinating transportation if necessary to ensure that beneficiaries have access to needed specialty services. Anthem stated that it developed this unit because providers are often unwilling to contract for a small volume of patients and prefer to accept referrals on a case-by-case basis in anticipation of higher rates.

While Anthem's Access to Care Unit may be effective in promoting access to specialty care, the absence of contracting providers for specialty services formally listed on the Anthem website leaves Medi-Cal beneficiaries, and the PCPs caring for them, with limited information about the specialty care options available through the plan. Further, it is not clear how DMHC or DHCS monitors this type of arrangement to assure network specialist adequacy.

Reported Specialist Provider Availability Is Not the Same as Actual Availability

The data posted on the health plan websites for the six high-need specialties — the source for the analysis above and in Appendix E — were comparable, but not identical, to the data the health plans reported to DHCS in the fall of 2013 in preparation for implementation. In some instances, the availability of providers in these specialties appeared greater in the later website data than in the fall 2013 submissions to DHCS. In other instances, it was less than described in those submissions.

However, while the posted networks show contracted providers, they do not reflect the willingness of those providers to take new patients. The willingness of providers to participate became even more important when the two Regional Model health plans serving 19 counties expanded to cover roughly 24,000 seniors and persons with disabilities as of December 1, 2014.

The provider finder function on the Anthem, CHW, and Molina websites can show whether a provider is "taking new patients." However, the reliability of this information depends on whether the provider keeps this information current with the health plan and whether the health plan updates its website with sufficient frequency. A spot check made for this report found that the number of contracted network providers listed on the plan websites as taking new patients was frequently less than the overall number of contracted providers. Moreover, the listing of a specialist as taking new patients did not guarantee that the provider was actually still doing so.

The health plans are required by statute to "maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and shall make it available to enrollees, at a minimum, by phone, written material, and Internet Web site." Timely and regular website updates will be important for plans to meet legal requirements and to accurately inform beneficiaries and their providers about the true state of their care options, including specialty care.

Partnership Counties

The Partnership website does not allow a user to judge the distance of a provider from a beneficiary's home, so it is not possible to determine how many providers are within 50 miles of each county. As a result, the assessment for Partnership counties is of reported specialty care availability *within* each county. For the eight expansion counties served by Partnership, the data show that access to the six specialties is most widely available in Humboldt, Mendocino, and Shasta Counties, with more limited access in the other counties. (See Appendix E.)

Depending on the beneficiary's county of residence, obtaining needed specialty care often involves significant driving distance and time. For the six specialties in the eight counties served by Partnership, specialty providers were not available anywhere in the county nearly 60% (28/48) of the time.

To address specialty care needs in counties with limited access, Partnership reported that it recently initiated a number of local efforts to promote greater access. These include an Innovations Grant program to provide funding for local provider network development and support for provider recruitment in counties with the most significant shortages of primary care and specialty care providers.[12]

Imperial County

Availability for the six high-need specialty providers in Imperial County reported by CHW and Molina shows comparability between the two plans. (See Appendix E.) For only one of the six specialties (ENT) did Molina not offer a provider within 50 miles of the county; the nearest was 70 miles away. CHW offered at least one provider within 50 miles in each specialty category.

Other Matters Affecting Access to Care

In addition to the number and distribution of providers, several other aspects of managed care take on particular importance in rural areas. These include standards concerning transportation, telehealth, and grievances and appeals. As with provider networks, the DHCS standards for these matters are the same for plans operating in the rural expansion counties as for those serving urban and suburban counties.

Transportation

Access to transportation services is critical for rural residents, where distances to sites of care are great, public transport is scarce, and transportation options for low-income beneficiaries are limited. In interviews in late 2013, senior DHCS officials indicated an understanding that access and transportation barriers can be more significant in rural areas, and suggested that health plans therefore have a stronger obligation to ensure that beneficiaries can reach providers who offer the covered benefits. However, nothing in Medi-Cal statutes or regulations or in the DHCS contract with health plans establishes a "stronger obligation" on health plans to provide transportation support for rural Medi-Cal beneficiaries.

For adults, Medi-Cal regulations define covered medical transportation as ambulance, litter van, and wheelchair van services, which are to be provided "when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care."[13] The regulations also state that any nonemergency medical transportation necessary to obtain covered services requires a physician's, dentist's, or podiatrist's prescription, plus prior authorization, except when it involves transfer of the patient from an inpatient hospital to a skilled nursing facility. Both nonemergency medical transportation and nonmedical transportation are covered benefits under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children enrolled in Medi-Cal.

The DHCS Medi-Cal managed care contract requires health plans to describe coverage of both medical and nonmedical transportation services in their member services guide, specifically:

- A description of both medical and nonmedical transportation services
- Procedures for obtaining any transportation services offered by the plan or available through the Medi-Cal program
- The conditions under which nonmedical transportation is available[14]

Research on plan coverage for nonemergency medical transportation offered by the participating health plans

was conducted through a review of member guides and other information provided on the health plan websites in late summer 2014. Overall, while discussion of coverage for nonemergency medical transportation services varied by health plan, none of the plans' policies indicated that transportation support is provided to assist beneficiaries to get to regular medical or specialty care appointments, even those that require long travel distances or times. Legal services informants reported confusion among beneficiaries about the availability and extent of transportation coverage, particularly in the Regional Model counties.

In describing the availability of nonemergency transportation, the plans generally gave vague and sometimes contradictory information. For example, Anthem's member services guide stated that it will approve nonemergency transportation when it is "medically necessary" and a provider asks for the service, but elsewhere stated, "We will approve a ride for you as long as the request is for a medical service. We do not cover public transport, such as airplane, car, or taxi rides, unless it involves transport to a kidney transplant center that is outside the service area."[15] In its filing with DHCS, Anthem also noted that it "will coordinate transportation if necessary to ensure members are able to access needed primary care and other medically necessary services." However, evidence of plan coverage for this transportation support was not apparent from available public documents.

CHW's website stated that nonemergency medical transportation must be approved by both the plan and the patient's PCP, and lists criteria "to get medically necessary health care services" and "when it is not medically advisable for you to use a public or private vehicle." Elsewhere, the site said, "Information on nonemergency transportation will be posted soon."[16]

Partnership's website included a one-page document that described emergency transport, nonemergency transport, and a supplemental transport benefit. Nonemergency transport required prior approval, while the supplemental benefit would be provided when the beneficiary does not meet the criteria for Medi-Cal-covered transportation and the beneficiary is "considered high risk" due to a medical condition that makes transportation "critical to the well-being of the member and/or fetus."[17]

Molina's website stated that doctor-prescribed nonemergency medical transportation is covered when a medical condition "does not allow" regular means of transportation. Molina also covers nonmedical transportation if a beneficiary is recovering from a "serious injury or medical procedure" that prevents them from driving to a medical appointment and no other transportation is available.[18]

None of the referenced health plan terms and conditions indicated that transportation support is provided to assist beneficiaries to get to regular medical or specialty appointments, or how to address barriers to access resulting from long travel distances or times and a lack of transportation options. Further, none offered beneficiaries clear information about procedures for requesting transportation assistance. In follow-up discussion, DHCS confirmed that there are no transportation requirements on the health plans serving the expansion counties beyond those specified in the global reference to the state regulations, as quoted above.

DHCS reported in December 2014 that it had recently surveyed the health plans to assess the status of transportation access, particularly in rural counties, and found that all of the plans polled either have a nonemergency medical transportation network in place or are developing contracts for such a network. Additionally, all plans polled have processes in place to evaluate their beneficiaries' needs for transportation services. However, DHCS did not provide plan-specific information on this topic.[19]

In sum, based on the information publicly available, it appears that coverage for nonemergency medical transportation is potentially available from each health plan based on medical necessity or other plan criteria, but beneficiary access to this information and awareness of the coverage appear to be limited.

Telehealth

An area of promise for the delivery of specialty care in rural and remote areas is telehealth services, which involve the delivery of care, including diagnosis, consultation, and treatment, through telecommunications technologies. The DHCS managed care contract with the health plans authorizes delivery of telehealth services but does not require it, and to date the health plans serving the expansion counties have incorporated telehealth services only to a very limited extent.

Of the contracting plans, Anthem has presented the most defined telehealth strategy. According to Anthem's compliance report to DMHC, the plan's telehealth program has 62 primary care presentation sites across California where the patient can connect to a remote specialist via telecommunication. Of these 62 presentation sites, 21 are in provider offices in the rural counties of Butte, Colusa, Glenn, Imperial, Nevada, Plumas, Sierra, Tehama, and Yuba.

Partnership has a small number of telehealth services available, including dermatology, ophthalmology, and optometry services, and is working with providers to add more specialty care telehealth services.[20] For example, Partnership recently initiated development of three telemedicine sites in Humboldt, Lassen, and Shasta Counties focused on care for hepatitis-C and on endocrinology.

The other health plans have not yet introduced telehealth services, and plan materials submitted to DHCS were vague about their intent to do so. CHW reported that it is exploring options regarding telehealth in the expansion counties it serves. Molina stated that telehealth initiatives had not been needed with its prior book of Medi-Cal business. However, with Molina's entry into Imperial County and the beginning of the Cal

New Behavioral Health Coverage

New Mental Health Responsibilities. Beginning January 1, 2014, all Medi-Cal managed care plans were given new responsibility for providing mental health services to Medi-Cal enrollees with "mild to moderate" mental health conditions. County Mental Health Plans (MHP) continue to be responsible for Medi-Cal beneficiaries with serious mental illness.

Provider and county informants expressed concern about the separation of responsibility between health plans and counties for delivery of mental health services and the coordination required to make this work. "What has not been fully recognized is the movement of people across the continuum of mental illness and the fact that patients can't be pigeonholed into one diagnosis of mild, moderate, or severe," said one provider informant.

The roles and responsibilities of mental health providers at the county level are defined in a memorandum of understanding (MOU) between each participating health plan and each county in which it operates. Beyond these MOUs, health plans and counties will need to build business and clinical relationships around the provision of care in order to address the unique care needs of persons with mental illness.

In many of the 28 expansion counties, community health centers provide mental health services to Medi-Cal beneficiaries either independently or under contract with the county. With health plans now required to deliver the expanded Medi-Cal mental health benefit, they will need to coordinate closely with these community health centers in the delivery of services, particularly where the county infrastructure to address severely mentally ill Medi-Cal beneficiaries is most limited. A variety of issues will need to be addressed regarding the continuing mental health service role for community health centers, including payment structures and how health centers fit within the MOUs between health plans and counties.

New Medi-Cal Substance Use Disorder Benefit. An expansion of Medi-Cal coverage for Substance Use Disorders (SUD) was approved as a part of the FY 2013-14 State Budget and will affect the managed care health plans in the rural expansion. Beginning January 1, 2014, all Medi-Cal beneficiaries are entitled to screening, brief intervention, and referral to treatment (SBIRT) for addiction; intensive outpatient treatment; residential treatment; and inpatient detoxification. Among these services, Medi-Cal managed care plans have responsibility only for SBIRT and will refer beneficiaries to county SUD programs for additional services.

In most of the 28 expansion counties, there is very limited SUD treatment capacity, particularly for residential treatment. In general, rural counties do not have many Drug Medi-Cal Treatment Program providers and have experienced a low state investment in SUD treatment services. For example, of approximately $131 million allocated in FY 2011-12 under the Drug Medi-Cal Treatment Program, the 28 rural counties received roughly $7 million, or 5.3%.[21]

DHCS is developing a federal Medicaid Rehabilitation Waiver for the delivery of SUD services. To the extent this waiver supports rural provider expansion efforts, including opportunities to regionalize service delivery across several counties, there may be an opportunity to expand the existing small investment in this type of care in the 28 counties.

MediConnect program (California/federal partnership to provide coordinated care to Medi-Cal/Medicare dual eligibles) in several of its service areas, the plan "will look for opportunities" to utilize telehealth.

Appeals and Grievances

Medi-Cal beneficiaries' ability to file grievances and appeals concerning benefit coverage or other matters is essential to assuring effective review and oversight of plan decisions. The DHCS contract requires health plans to establish procedures for beneficiaries to file a grievance or appeal with the plan, either in writing, in person, or by phone. This includes appealing decisions regarding the beneficiary's coverage, benefits, relationship to the health plan, or other matters of dissatisfaction. Explanations of these procedures are to be included in the plan's membership guide provided to the beneficiary.

Further, the contract and DMHC regulations describe the rights of beneficiaries concerning appeals of plan decisions about medical services. In the Regional Model counties, where the plans are Knox-Keene licensed and thus regulated by DMHC, beneficiary rights include (1) requesting an Independent Medical Review (IMR) from DMHC, which involves a clinician decisionmaker, and (2) requesting a State Fair Hearing from DHCS if dissatisfied with the IMR decision. The State Fair Hearing process generally takes considerably longer than an IMR, according to legal aid informants, and does not include a clinician decisionmaker. Beneficiaries enrolled in Partnership, which is a COHS not licensed under Knox-Keene or regulated by DMHC, may only request a State Fair Hearing from DHCS. Thus, depending on their location, Medi-Cal beneficiaries across the rural expansion counties may have different appeal protections.

DHCS has reported that it will assess grievance and appeal data as a part of its consideration of health plan performance. Legal services representatives reported that the grievances and appeals filed with the state represent only a small fraction of the numerous issues beneficiaries and their representatives address locally. This is due in large part to the need of beneficiaries and their representatives to resolve immediate health-related issues that cannot wait for a protracted appeal process. In light of this dynamic, additional information about the beneficiary experience in the rural managed care expansion would provide greater context for aggregated reporting on beneficiary grievances and appeals. To this end, DHCS has said that it conducted a baseline member satisfaction survey among Medi-Cal beneficiaries in rural counties prior to implementing the managed care expansion, and will repeat that survey 18 months later, in spring 2015.[22]

Rural Expansion Going Forward

State Monitoring of the Expansion

With the delegation of responsibility to health plans for delivery of health care services to Medi-Cal beneficiaries in the 28 rural expansion counties, the role of the state has evolved from a direct payer of care to one of contracting with health plans, monitoring their performance and holding them accountable, and providing leadership to address issues facing rural health care access. As one provider informant for this report said, "If the state wants to get out of the business of health care and contract with health plans, the state needs to monitor the delivery of care. The state's role is to assure that the health plans have adequate networks." According to DHCS, that is the state's intention, and the state's joint agency oversight will incorporate a variety of qualitative and quantitative methods. (See sidebar on page 21.)

Under the terms of the state's Medicaid waiver, DHCS has been reporting to the federal government on the status of the rural expansion since implementation in late 2013. This reporting has focused on: enrollment; beneficiaries assigned to a PCP and those who change a PCP; beneficiaries who change a plan due to access to care or continuity of care concerns; additions and deletions from the provider network; continuity of care requests and outcomes; health plan call summaries; grievance reporting; and calls to the Office of the Ombudsman. In preparing this report, a request was made to DHCS for copies of the information submitted to the federal government, but this request was denied.

DHCS made its first public report on the status of the rural managed care expansion in December 2014 at a meeting of the department's Stakeholder Advisory Committee. The report was a summary discussion of experience to date and presented only enrollment data. Results of the comprehensive interagency monitoring of the rural expansion (see sidebar on page 21) were not yet available for a formal report on plan performance.

DHCS and DMHC Health Plan Assessment and Monitoring

DHCS Medical Audits. Performed by the Audits and Investigations Division, Medical Review Branch; conducted annually beginning in 2015; address utilization management, care coordination, access to care, members rights / quality management, administrative capacity

DMHC Routine Medical Surveys. Performed by DMHC; conducted at least every three years; address quality management, member complaints, access and availability, referrals and authorizations, overall plan performance

DHCS and DMHC Interagency Agreements. Coordinated joint agency review of rural expansion (as well as other transitions); includes financial audit, network adequacy, and medical survey

DHCS and DMHC Audit and Survey Coordination. Coordinated audit schedule with teams from both agencies onsite concurrently; findings consolidated in the Corrective Action Plan process (see below)

Non-routine Audits and Surveys. Other reviews as needed

Corrective Action Plans. Administered by DHCS for DHCS Medical Audits, Interagency Agreement surveys, and other unscheduled audits or surveys

Other monitoring indicators for rural expansion:

Transition Data. Grievance reports, continuity-of-care reports, provider network additions and deletions, PCP assignment and changes, consumer satisfaction, fraud and abuse

Ongoing Data. All-member grievance reports, detailed provider network reports, continuity-of-care reports, grievance logs, geo access reports, out-of-network reports, network adequacy reports

Source: "Network Assessments and Monitoring," Sarah C. Brooks and Nathan Nau (DHCS) and Nancy Pheng Street (DMHC), presentation to DHCS Stakeholder Advisory Group, September 11, 2014.

Staff from both agencies repeated their commitment to conducting coordinated reviews of plan performance and beneficiary experience, including the post-expansion beneficiary survey.[23]

More than a year into the rural managed care expansion, summary reporting on the new program is helpful, but it offers little description of the range of experiences across the 28 rural expansion counties. Further, in the absence of more detailed reporting, continuing issues of restricted health care access experienced in many rural counties are at risk of being overlooked at the state level. Most key informants interviewed for this report expressed a desire for a more collaborative, transparent, ongoing process with DHCS to discuss and consider findings associated with the managed care expansion as they occur, and to focus on actual beneficiary and provider experiences.

State Opportunities for Ongoing Leadership

Going forward with the rural Medi-Cal managed care program, DHCS has the opportunity to demonstrate leadership in two areas: monitoring and enforcement of health plan performance, and affirmative efforts to address the underlying challenges with rural Medi-Cal provider access.

With respect to monitoring and enforcement, DHCS and its partner agency DMHC should utilize available information to report regularly and specifically about the rural managed care program in each of the 28 expansion counties. DHCS and DMHC should consider including the following matters:

- Specific information about the composition and other aspects of the provider networks that DHCS and DMHC have approved for the health plans serving the 28 expansion counties
- Specialty care access standards accepted for each plan
- Alternative network standards that DHCS and DMHC have approved for the health plans and the justification for approving them
- Specific steps by DHCS and DMHC to monitor network standards and address deficiencies with each participating plan

- Within the context of nonemergency and non-medical transportation provided by health plans, clear documentation of plan services and criteria, and of processes for beneficiary use of these services
- Reporting of grievance and appeal filings with DHCS and DMHC at a county and plan level
- DHCS efforts to document the beneficiary and provider experience under the new program, including any DHCS plans to obtain rural health stakeholder feedback through county site visits and surveys of consumer and provider satisfaction
- Steps by DHCS to promote growth of specialty care provider capacity across the 28 expansion counties, including the use of telehealth services

With respect to the underlying challenges of rural Medi-Cal provider access, DHCS can demonstrate renewed leadership for rural health in partnership with the health plans now carrying out state responsibilities and with providers, beneficiaries, counties, and other community stakeholders. This state leadership could produce long-term strategic goals for improved provider access and availability and necessary community supports for Medi-Cal beneficiaries in the 28 rural expansion counties, and define specific state policy, program, and financing approaches to achieve those goals. In its December 2014 presentation on the rural expansion, DHCS identified the state's next Medicaid waiver as a vehicle through which to consider rural workforce issues. DHCS has the opportunity to use this Medicaid waiver to lay out a strategic plan for rural health that focuses on the health care services and supports needed by all Medi-Cal beneficiaries.

Finally, the Legislature itself, particularly the Committee on Budget, which authored AB 1467, should give renewed attention to the rural managed care expansion in order to learn more about how this important programmatic change is working and to fulfill its essential oversight role. The timing for renewed legislative attention to the rural expansion could not be more important. Beginning December 1, 2014, roughly 24,000 seniors and persons with disabilities in the Regional Model two-plan counties began joining these health plans. (In the expansion counties served by Partnership, this population joined managed care at the outset.) These new entrants to managed care have higher-level needs, particularly for specialty care, than the first group of plan enrollees. DHCS, DMHC, and the health plans should be asked to report on network readiness for these populations and on their experience so far.

Moving from an FFS system to a more highly organized managed health care system, through Medi-Cal health plans, marks an important step toward improving rural health care delivery for Medi-Cal beneficiaries. But it is only a first step. Moving ahead, DHCS, DMHC, and the Legislature should focus on the key questions and issues that have been raised by rural health stakeholders, many of which are identified in this report, and develop the next level of improvement in rural health care delivery. Rural Californians and the rural health system need this affirmative state leadership.

Appendix A. List of Key Informants

ORGANIZATION	INFORMANT	TITLE
Providers		
Adventist Health	Gail Nickerson	Director, Rural Health Services
California Hospital Association	Peggy Wheeler Sherree Kruckenberg	Vice President, Rural Health & Governance Vice President, Behavioral Health
California Medical Association	Richard Thorp, MD	President
California Primary Care Association	Carmela Castallano-Garcia	President/CEO
Central Valley Health Network	Cathy Frey	CEO
Health Alliance of Northern California	Doreen Bradshaw	Executive Director
Hospital Council of Northern and Central California	Suzanne Ness	Regional Vice President
Shasta Community Health Center	Dean Germano	CEO
Western Sierra Medical Clinic	Scott McFarland	CEO
Health Plans		
Anthem Blue Cross	Steve Melody	President, California Medicaid Health Plan
California Health and Wellness Plan Centene Corporation	Greg Buchert, MD Wade Rakes	President/CEO Director of Business Development
Molina Medical	James Novello	COO
Partnership HealthPlan of California	Jack Horn	Executive Director/CEO
Consumers		
Health Access of California	Anthony Wright Beth Capell	Executive Director Lobbyist/Policy Advocate
Legal Services of Northern California	Liza Thantranon	Staff Attorney
Counties		
California Institute for Mental Health	Sandra Naylor Goodwin	President/CEO
CMSP Governing Board	Alison Kellen	Program Manager
Imperial County Public Health Department	Robin Hodgkin	Director
Plumas County Public Health Department	Mimi Hall	Director
Sutter County Human Services Department	Tom Sherry	Director
Tehama County Health Services Agency	Valerie Lucero	Executive Director
State Regulators		
California Department of Health Care Services	Toby Douglas Mary Cantwell Jane Ogle	Director Chief Deputy Director Chief Deputy Director
California Department of Health Care Services, Medi-Cal Managed Care Division	Javier Portela Sarah Brooks Karen Thalhammer	Plan Management Branch Chief Program Monitoring and Medical Management Branch Chief Policy and Contracts Branch Chief
California Department of Managed Health Care	Shelley Rouillard Katie Coyne Gary Baldwin	Director Deputy Director, Office of Plan Licensing Deputy Director, Plan and Provider Relations

Appendix B. State Ranking of Health Outcomes and Health Factors in the 28 Medi-Cal Rural Expansion Counties

COUNTY	HEALTH OUTCOMES* RANK OF 58 COUNTIES	HEALTH FACTORS† RANK OF 58 COUNTIES
Placer	2	2
El Dorado	7	9
Nevada	8	7
San Benito	10	28
Colusa	13	37
Mono	19	19
Tuolumne	21	21
Mariposa	24	25
Glenn	25	34
Imperial	27	55
Sutter	29	36
Calaveras	32	23
Amador	33	20
Plumas	34	32
Lassen	36	39
Humboldt	38	26
Sierra	39	27
Butte	45	33
Shasta	48	41
Trinity	49	46
Tehama	50	47
Inyo	51	22
Yuba	52	56
Modoc	53	29
Siskiyou	55	42
Del Norte	56	43
Lake	57	52
Alpine	NR	NR

*Health outcomes include length of life, health/mental health status, and birth outcomes.

†Health factors include health behaviors, clinical care, social and economic factors, and physical environment.

Source: "California Rankings Data," Robert Wood Johnson Foundation, www.countyhealthrankings.org; for ranking methodology, see www.countyhealthrankings.org/ranking-methods/ranking-system.

Appendix C. California Medical Board Physician Licenses in the 28 Medi-Cal Rural Expansion Counties

COUNTY	2007-08	2009-10	2011-12
Alpine	1	2	2
Amador	66	65	62
Butte	476	461	482
Calaveras	54	49	52
Colusa	9	10	9
Del Norte	48	44	40
El Dorado	303	288	293
Glenn	12	11	9
Humboldt	290	291	284
Imperial	127	129	136
Inyo	47	42	41
Lake	80	77	73
Lassen	37	37	37
Mariposa	16	11	13
Modoc	5	5	6
Mono	36	30	29
Nevada	258	303	246
Placer	966	947	1,104
Plumas	37	30	27
San Benito	43	43	40
Shasta	467	439	426
Sierra	0	0	0
Siskiyou	84	80	81
Sutter	201	196	192
Tehama	50	48	49
Trinity	14	9	8
Tuolumne	126	125	117
Yuba	53	41	43
Total	**3,906**	**3,813**	**3,901**

Source: "Physician and Surgeon License by County," California Medical Board, www.mbc.ca.gov.

Appendix D. Hospitals in the 28 Medi-Cal Rural Expansion Counties

COUNTY	HOSPITALS
Alpine	none
Amador	Sutter Amador Hospital
Butte	Adventist Health/Feather River Hospital Enloe Medical Center Orchard Hospital Oroville Hospital
Calaveras	Mark Twain St. Joseph's Hospital
Colusa	Colusa Regional Medical Center
Del Norte	Sutter Coast Hospital
El Dorado	Barton Memorial Hospital Marshall Medical Center
Glenn	Glenn Medical Center
Humboldt	Jerold Phelps Community Hospital Mad River Community Hospital Redwood Memorial Hospital St. Joseph Hospital
Imperial	El Centro Regional Medical Center Pioneers Memorial Health Care District
Inyo	Northern Inyo Hospital Southern Inyo Hospital
Lake	St. Helena Hospital Sutter Lakeside
Lassen	Banner Lassen Medical Center
Mariposa	John C. Fremont Healthcare District
Modoc	Modoc Medical Center Surprise Valley Health Care District

COUNTY	HOSPITALS
Mono	Mammoth Hospital
Nevada	Sierra Nevada Memorial Hospital Tahoe Forest Hospital District
Placer	Kaiser Permanente Roseville Medical Center Sutter Auburn Faith Hospital Sutter Roseville Medical Center
Plumas	Eastern Plumas Health Care Plumas District Hospital Seneca Healthcare District
San Benito	Hazel Hawkins Memorial Hospital
Shasta	Mayers Memorial Hospital District Mercy Medical Center Redding Shasta Regional Medical Center Vibra Hospital of Northern California
Sierra	none
Siskiyou	Fairchild Medical Center Mercy Medical Center Mount Shasta
Sutter	none
Tehama	St. Elizabeth Community Hospital
Trinity	Trinity Hospital
Tuolumne	Sonora Regional Medical Center/ Adventist Health
Yuba	Rideout Memorial Hospital

Sources: "List of Hospitals in California, USA," OSHPD, gis.oshpd.ca.gov; Hospital Council of Northern and Central California, email communication, May 30, 2014.

Appendix E. Availability of Providers in Six Core Specialties

The following three tables provide data obtained from the websites of the managed care health plans participating in the 28 rural expansion counties. They show the number of individual Board Certified providers for six core specialties for each of the counties served by the plans.

E1. California Health & Wellness Plan (CHW) and Anthem Blue Cross (AN) (providers within 50 miles of the county)

	Cardiology		Gastro-enterology		Neurology		Orthopedic Surgery		Otolaryngology (ENT)		Urology	
County*	CHW	AN	CHW	AN	CHW	AN	CHW	AN	CHW	AN	CHW	AN
Alpine	6	0	1	0	1	0	>10	0	1	0	1	0
Amador	>10	>10	2	0	5	1	>10	1	4	0	5	0
Butte	>10	8	>10	8	9	5	>10	>10	7	6	8	3
Calaveras	8	0	3	0	5	0	>10	0	4	0	5	0
Colusa	>10	1	5	0	6	0	10	0	5	0	4	0
El Dorado	>10	>10	7	1	4	4	>10	8	5	1	3	0
Glenn	>10	0	7	0	5	0	>10	0	7	0	7	1
Inyo	1	5	1	0	0	0	0	1	0	0	0	0
Mariposa	2	0	4	0	3	0	6	0	2	0	3	0
Mono	0	0	0	0	1	0	4	1	0	0	1	0
Nevada	>10	>10	7	5	8	1	>10	>10	6	1	3	2
Placer	>10	8	6	7	8	8	>10	6	6	6	4	3
Plumas	4	0	3	1	1	1	7	2	3	0	2	0
Sierra	5	0	7	0	1	0	>10	0	3	0	3	0
Sutter	>10	>10	>10	3	8	1	>10	9	3	3	4	2
Tehama	>10	0	7	0	6	0	>10	0	8	1	6	0
Tuolumne	3	0	2	1	3	0	7	1	2	0	3	2
Yuba	>10	1	>10	1	>10	0	>10	0	9	0	8	0

E2. California Health & Wellness Plan (CHW) and Molina (MOL) (providers within 50 miles of the county)

	Cardiology		Gastro-enterology		Neurology		Orthopedic Surgery		Otolaryngology (ENT)		Urology	
County	CHW	MOL	CHW	MOL	CHW	MOL	CHW	MOL	CHW	MOL	CHW	MOL
Imperial	4	8	5	7	1	4	2	1	5	0	3	2

*No review was conducted for San Benito County.

Note: If a specialty is listed as "0," beneficiaries in that county must travel more than 50 miles for these specialty care services.

Sources: "Find a Provider," California Health & Wellness, accessed August 22, 2014, www.cahealthwellness.com; "Provider Directory," Anthem Blue Cross, accessed August 23, 2014, www.anthem.com; California Health & Wellness and Anthem Blue Cross provider network filings to DHCS; "Find a Provider," Molina Healthcare, accessed August 26, 2014, eportal.molinahealthcare.com.

Appendix E. Availability of Providers in Six Core Specialties, *continued*

E3. Partnership HealthPlan (providers within the county)

COUNTY	CARDIOLOGY	GASTROEN-TEROLOGY	NEUROLOGY	ORTHOPEDIC SURGERY	OTOLARYNGOLOGY (ENT)	UROLOGY
Del Norte	0	0	0	1	0	0
Humboldt	3	2	5	4	2	3
Lake	6	0	1	1	2	0
Lassen	0	0	0	0	0	0
Modoc	0	0	0	0	0	0
Shasta	>10	2	2	>10	5	3
Siskiyou	1	0	0	6	0	0
Trinity	1	0	0	0	0	0

Note: If a specialty is listed as "0", beneficiaries in the county must travel to another county for these specialty care services.

Source: Medi-Cal Specialist Directory, Partnership HealthPlan of California, www.partnershiphp.org.

Endnotes

1. As defined by the California Office of Statewide Health Planning & Development, a "frontier" Metropolitan Statistical Service Area (MSSA) is one with less than 11 people per square mile.
2. "Medi-Cal Managed Care Enrollment Report — July 2014," California Department of Health Care Services, www.dhcs.ca.gov.
3. Carrie Graham, *In Transition: Seniors and Persons with Disabilities Reflect on Their Move to Medi-Cal Managed Care*, California HealthCare Foundation, April 2014, www.chcf.org.
4. California Health and Safety Code §1340 et seq.
5. California Department of Health Care Services, *28-County PowerPoint,* November 19, 2012.
6. Committee on Budget, Chapter 23, Statutes of 2012.
7. *HMOs and Rural California,* Office of the Legislative Analyst, August 8, 2002.
8. Medi-Cal Managed Care Regional Expansion Request for Applications (Number 28RFA2012/2013), California Department of Health Care Services.
9. Sarah Brooks, "Timely Access and Network Adequacy: Rural Expansion Counties" (presentation to the California Department of Health Care Services Stakeholder Advisory Committee, December 3, 2014), www.dhcs.ca.gov.
10. Title 22 CCR § 53853(a).
11. California Welfare and Institutions Code § 14182(c)(2).
12. Northern Region Outreach/Program Activities, Partnership HealthPlan, via email from Amy Turnipseed, Director of Policy and Program Development, October 15, 2014.
13. Title 22 CCR § 51323.
14. Two-Plan California Department of Health Care Services Contract (DHCS MMCD TwoPlanBoilerPlate-Web.6-1-11), p. 102.
15. *Medi-Cal Health Plan,* Anthem Blue Cross, July 2013, www22.anthem.com.
16. "Benefit Information," California Health & Wellness, www.cahealthwellness.com; "Transportation Services," California Health & Wellness, www.cahealthwellness.com.
17. "Transportation Coverage," Partnership HealthPlan of California, www.partnershiphp.org.
18. "Transportation," Molina Healthcare, www.molinahealthcare.com.
19. Personal communication from California Department of Health Care Services to author, December 9, 2014.
20. Partnership Rural Expansion GeoAccess Report to California Department of Health Care Services, p. 4.
21. "2012-13 Percent Allocations Based on 2011-12 Substance Abuse Subaccount Allocations," California Department of Health Care Services, September 7, 2012.
22. "Rural Expansion Survey Questions," accessed February 2, 2015, www.dhcs.ca.gov.
23. "Rural Expansion Survey Questions."

A Close Look at Medi-Cal Managed Care:
Quality, Access, and the Provider's Experience Under the Regional Model

OCTOBER 2019

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

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Executive Summary

Medi-Cal enrollees in 18 rural counties in California receive care under Medi-Cal's Regional model of managed care, in which enrollees have the option of choosing between one of two commercial managed care plans (MCPs). The Department of Health Care Services (DHCS) intends to re-procure all of the commercial Medi-Cal MCPs statewide beginning in 2020, with implementation for the Regional model scheduled for January 2024.[1] This procurement provides an opportunity to review and evaluate the ways in which managed care is implemented in California, to incentivize improvements in MCP performance leading up to the procurement, and to develop and implement specific improvements under new contracts with MCPs following the procurement.

This report examines the performance of the two Regional model MCPs. It compares access to care, quality of care, and both patients' and providers' satisfaction with MCPs in Regional model counties with (1) a "rural comparison" group consisting of 14 other rural counties in California and (2) the "PHC north" group, which includes seven of these rural comparison group counties that joined Partnership HealthPlan of California (PHC) as part of the Medi-Cal rural expansion in 2013. The data analyzed for this report include the following: qualitative data collected through structured interviews with providers, county officials, and MCP representatives; quantitative data from surveys and measures of access and quality; and data from a recent report by the California State Auditor, which conducted an audit of the oversight by DHCS of Regional model MCPs.[2]

Results

Rural Californians struggle with health care challenges unique to their setting. The state's rural areas tend to have fewer health care providers relative to more urban areas, and many patients need to travel long distances in order to obtain certain types of specialty care. Within the state's rural areas, however, important differences exist. Compared with rural comparison counties, Medi-Cal enrollees residing in Regional model counties have received somewhat poorer quality of care, have greater difficulty accessing specialty care, and are less satisfied with their health care. The rate of improvement in health care quality and access to primary care has been somewhat better for Medi-Cal enrollees in Regional model counties than for enrollees in the rural comparison group (findings from the comparison of the Regional model with PHC north are presented in the full paper).

Key findings of the analysis include the following:

- **Medi-Cal enrollees' access to primary care in Regional model counties is comparable to that in other rural regions.** On a survey of Medi-Cal MCP members, those enrolled in the two Regional model MCPs were, on average, more likely to report that they get care quickly and have a usual source of care than those enrolled in MCPs in the rural comparison group. However, Regional model MCP members were somewhat more likely to report that they had difficulty accessing primary care.

- **Access to specialty care is difficult for Medi-Cal enrollees in Regional model counties.** Many providers in these counties indicated that limited specialty care networks hindered their ability to deliver effective patient care and reported that the commercial MCPs had not invested in attracting and retaining specialty care providers. These providers also indicated that patients had difficulty accessing some benefits, such as the transportation or mild-to-moderate mental health benefits. Analysis of survey data suggests that Medi-Cal enrollees in Regional model counties are somewhat more likely to report difficulty accessing specialty care than residents of other rural areas of the state. Moreover, some enrollees in Regional model counties need to travel very long distances to access care when compared with enrollees in other rural areas.[3] State administrative data on network adequacy are of limited value in assessing whether patients are able to access the care they need.

- **The quality of care provided to Medi-Cal enrollees in Regional model MCPs was worse, on average, than for Medi-Cal enrollees of MCPs in other rural counties.** Although the differences were relatively small in percentage terms, the two Regional model MCPs scored, on average, well below the statewide average, whereas the MCPs in the rural comparison group scored, on average, above the statewide average. Quality scores have, however, been improving more rapidly in Regional model counties relative to rural comparison group counties.

- **Overall Medi-Cal enrollee satisfaction with MCP performance was lower in Regional model counties relative to other rural regions of the state.** On the measure of "Rating of All Health Care," Medi-Cal MCPs in Regional model counties scored worse than Medi-Cal MCPs in the rural comparison group counties.

- **Many providers and county officials in Regional model counties are concerned with the performance of the two Regional model MCPs.** Many providers expressed frustrations with the responsiveness of the MCPs in addressing patient and provider needs. They noted increased demands for staff resources needed to secure pre-authorizations and handle billing and other managed care administrative tasks. They also reported that the MCPs frequently denied claims and were slow to pay approved claims, which put a financial strain on providers.

- **Representatives of the two MCPs serving the Regional model counties said they were taking steps to address the concerns that had been raised by stakeholders.** Representatives from Anthem Blue Cross (Anthem) and California Health & Wellness (CHW) indicated they had sought to increase staff resources dedicated to Regional model counties, respond to provider concerns, reduce the number of procedures requiring pre-authorization, expand the specialty care network, and increase access to telehealth and other electronic means of accessing care.

Considerations for Improvement

This assessment of quality and access to care in Medi-Cal's Regional model of managed care shows mixed results. Compared with MCPs in other rural regions of the state, MCPs serving Medi-Cal enrollees in the 18 Regional model counties performed better on some measures of access and quality (e.g., primary care access) and worse on others (e.g., specialty care access). What is clear, however, is that provider dissatisfaction is greater in Regional model counties. This should not be ignored: Research suggests that provider satisfaction is an important component of effective patient care and that, conversely, burnout or provider dissatisfaction can lead to poorer patient outcomes.[4]

To ensure that Medi-Cal enrollees in the 18 Regional model counties receive access to timely, high-quality care, state policymakers and program officials should conduct additional research on the nature and extent of provider dissatisfaction and undertake careful monitoring of patient satisfaction, care quality, and health outcomes in Regional model counties. In addition, this assessment identified several opportunities for improvement that could be implemented by the MCPs or by DHCS. These include the following:

- Developing a regional health care provider recruitment strategy
- Increasing use of telehealth and other electronic mechanisms for accessing care
- Improving communication among MCPs, providers, and counties to address challenges associated with having MCPs headquartered outside of the region
- Involving DHCS or another neutral third party in discussions between MCPs and providers regarding unresolved contracting issues
- Developing and enforcing more meaningful network adequacy standards
- Requiring MCPs and their delegates to deploy a valid, reliable, and standardized provider satisfaction survey annually

Finally, some providers in Regional model counties have expressed an interest in changing managed care delivery models, with most indicating a desire to participate in a public MCP, either a County Organized Health System (COHS) or a Local Initiative (LI) as part of a Two-Plan model. Several important obstacles to COHS expansion may limit the ability of counties to change Medi-Cal managed care models, including a federally imposed cap on the number of COHSs and a cap on the percentage of Medi-Cal enrollees who can participate in a COHS. Forming a regional LI or drawing one into the 18-county region might face fewer regulatory obstacles but would still involve significant effort. Regardless of which path is taken, policymakers, program officials, and local stakeholders should take steps in the near term to improve provider satisfaction, hold MCPs accountable for meeting access and quality requirements, and expand the health care workforce in rural counties.

Introduction

In 2013, the state Department of Health Care Services (DHCS) continued the Medi-Cal program shift from traditional fee-for-service to managed care, transitioning a group of largely rural Northern California counties into managed care delivery models. Some of these Northern California counties joined Partnership HealthPlan of California (PHC), an existing County Organized Health System (COHS). Eighteen of the remaining counties were part of a new "Regional model" of managed care delivery created by DHCS. DHCS contracted with Anthem Blue Cross (Anthem) and California Health & Wellness (CHW) to serve these Regional model counties.

This study analyzed the experience of patients and providers in Regional model counties during the period following the transition to managed care and compared those experiences with the outcomes in comparable counties. Specifically, this report examined available data on managed care plan (MCP) quality, access to care, and patient experience as well as qualitative information from interviews with providers, MCPs, and others in order to develop an assessment of the Regional model. Its intent is to identify opportunities for improvement and to inform the procurement process for commercial MCPs that DHCS will begin in 2020 with the scheduled release of its Request for Proposals.[5] This procurement is an opportunity to reshape and strengthen the program to accelerate improvements in access to care, quality, consumer experience, and health outcomes.

Issues in Rural Health Care

Rural patients face unique health challenges. Rates for the five leading causes of death nationally — heart disease, cancer, chronic respiratory disease, unintentional injury, and stroke — are higher in rural areas. Additionally, while mortality rates are decreasing nationwide, they are falling at a slower rate in rural regions. Rural residents face higher rates of cancer from modifiable risks, including human papillomavirus, tobacco, and a lack of preventive cervical cancer and colorectal screenings. Opioid overdose deaths are also 45% higher nationwide in rural regions, yet urban centers have more treatment facilities.[6]

Delivering health care in these rural settings poses unique challenges. Patients must travel long distances to receive care, and access to specialty care can be especially limited. Having to travel long distances can mean taking time off from work and needing to pay for child or elder care, creating delays in or avoidance of treatment. This lack of access sometimes means that residents of rural areas present with diseases in advanced stages. Longer travel times can also lead to longer waits for emergency medical services, putting the lives of patients in danger when they need immediate treatment.[7] In California, 25% of rural hospitals closed during the two decades prior to 2018.[8]

Physician shortages also contribute to access-to-care difficulties in rural areas. Primary care physicians in rural regions often face heavy patient loads, and access to mental health providers and other specialists can be limited.[9] Prior studies have found large differences in the number of providers in rural versus urban areas; one study found that rural areas had only 40 primary care physicians per 100,000 people, compared

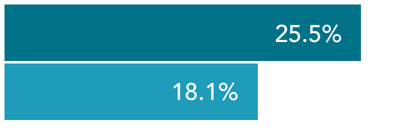
with urban areas, which had 53 physicians per 100,000 people. This discrepancy is even larger for specialists, with only 30 per 100,000 people in rural areas versus 263 per 100,000 in urban areas.[10]

An examination of data from the California Health Interview Survey (CHIS) indicates that rural Medi-Cal patients face more barriers to care than Medi-Cal patients statewide, particularly when attempting to access specialty care. Rural patients are more likely to face issues getting doctor's appointments, having their insurance accepted by specialists, and finding specialty care, as shown in Figure 1.

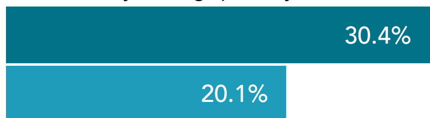
Figure 1. Difficulty Accessing Care

Sometimes/never able to get a doctor's appointment within two days in the past 12 months

Insurance not accepted by medical specialist in the past year



Had difficulty finding specialty care



*Includes the following counties: Butte, Shasta, Humboldt, Del Norte, Siskiyou, Lassen, Trinity, Modoc, Plumas, Sierra, Mendocino, Tehama, Glenn, Colusa, Sutter, Yuba, Nevada, Tuolumne, Calaveras, Amador, Inyo, Mariposa, Mono, Alpine, Placer, El Dorado, Tulare, Merced, Madera, San Luis Obispo, San Benito, and Imperial.

Source: Blue Sky Consulting Group analysis of 2017 CHIS data.

These difficulties in access mean that actions on the part of MCPs such as supporting specialty care networks, making telehealth services available, or facilitating transportation to available facilities can be especially important to bridge gaps in care.

Medi-Cal Managed Care Models

Among the states, California pioneered the use of managed care for Medicaid, launching some of the first pilots to test this delivery system in the 1970s. Beginning in the 1980s with the creation of the COHS model, the state has progressively transitioned all 58 counties and most Medi-Cal populations into managed care.

The Regional model was implemented as part of Medi-Cal's expansion into the remaining, rural areas of the state in 2013. Under the Regional model, Medi-Cal enrollees can choose to enroll in one of two commercial MCPs. Enrollment in the 18 Regional model counties is mandatory for most Medi-Cal enrollees.[11]

Methodology

This study involved two principal components. First, the study team conducted structured interviews with a range of providers, MCP representatives, county officials, and policy experts. These interviews were aimed at identifying specific strengths and weaknesses in the Regional model approach, and at surfacing suggestions for potential recommendations or improvements. Next, available data regarding patient satisfaction, health care quality, and access to care were analyzed, and the Regional model results were compared with those in other, similar counties. In addition, the study analyzed network adequacy data from DHCS and data from the California State Auditor on travel distance to the nearest provider.

Structured Interviews

The study team conducted more than two dozen structured interviews during the course of the evaluation, including interviews with the following[12]:

- Providers, including clinics and hospitals
- MCPs and independent physician associations (IPAs)
- County officials, advocates, consultants, and others

During the interviews, participants were asked to describe their interactions with the two Regional model MCPs, identify specific strengths and weaknesses of the Regional model, and provide specific examples where MCP performance could be improved. Where participants had information about Regional model and alternative models of delivering managed care, they were asked to comment on the differences.

Data Analysis

As a supplement to the structured interviews, the study team collected and analyzed available data on patient satisfaction and experience, access to care, and measures of MCP performance, including the following:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- CHIS
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Selected DHCS Medi-Cal Managed Care Performance Dashboard measures
- Network adequacy reports — Alternative Access Standards

Comparison Groups

Because of the unique challenges of delivering health care in rural areas, two comparison groups of counties that matched the characteristics of the Regional model counties as closely as possible were developed. Specifically, Regional model counties were compared with (1) a "rural comparison" group consisting of 14 other rural counties in California and (2) the "PHC north" group, which includes seven of these rural comparison group counties that joined PHC as part of the Medi-Cal rural expansion in 2013. The rural comparison group includes some counties where Medi-Cal managed care has been in place longer and is the more important comparison group in terms of setting state policy expectations and goals. The PHC north group is more directly comparable to the Regional model counties in terms of geography and experience with managed care, consisting of relatively remote counties that made the transition to managed care when the Regional model was established.[13] Table 1 lists the Regional model counties and counties from both comparison groups.

Table 1. Regional Model and Comparison Group Counties

REGIONAL	PHC NORTH	RURAL COMPARISON
Alpine	Del Norte	Del Norte
Amador	Humboldt	Humboldt
Butte	Lassen	Imperial
Calaveras	Modoc	Lassen
Colusa	Shasta	Madera
El Dorado	Siskiyou	Mendocino
Glenn	Trinity	Merced
Inyo		Modoc
Mariposa		San Benito
Mono		San Luis Obispo
Nevada		Shasta
Placer		Siskiyou
Plumas		Trinity
Sierra		Tulare
Sutter		
Tehama		
Tuolumne		
Yuba		

Note: In smaller counties, MCPs report results aggregated by region. For example, PHC reports data for both HEDIS and CAHPS in four regions: northeast, northwest, southeast, and southwest. Although Lake and Napa counties met the criteria to be included in the rural comparison group, the data for these counties are aggregated with other non-rural counties in the PHC southwest region. Therefore, data for these counties were not available for analysis, and these two counties were excluded from the rural comparison group.

Source: Blue Sky Consulting Group, 2019.

Analytic Approach

In order to assess the performance of the Regional model, specific comparison metrics were identified; results from Regional model counties were compared with those from comparison group counties. In addition, data from CHIS were analyzed using a regression analysis in which key outcome measures from the survey were assessed while controlling for factors such as patient demographic characteristics.[14]

Findings: Stakeholder Interviews

Structured interviews with stakeholders revealed that many Regional model providers and county health officials were deeply concerned about the performance of the two Regional model MCPs. In contrast, providers in the PHC north group were largely satisfied with the way their MCP has been performing. In addition to the contrast in providers' reactions, interviews also revealed that the two Regional model MCPs acknowledged difficulties associated with the initial transition to managed care and have made efforts since that time to improve both MCP performance and communication with Regional model counties and providers.

Burdensome Processes, Procedures, and Bureaucracy

Many providers expressed frustrations with the processes, procedures, and bureaucracy associated with their interactions with the two MCPs. Interviewees indicated that the MCPs lacked a consistent, formal presence in their communities, especially during the initial transition period from fee-for-service to managed care. Some reported that there was frequent staff turnover among the MCPs' regional staff, which made it difficult to identify the appropriate person to contact. Others reported that the initial contracting process with the MCPs (and Anthem in particular) was long and burdensome, with at least one clinic reporting that it still does not have a contract in place. Several interviewees indicated that the initial rollout of managed care in Regional model counties was not handled well by the MCPs. These interviewees reported that they received little orientation or education about managed care from the MCPs and that communication was poor.

Interviewees also expressed concern that the MCPs did not engage with or understand the region. For example, some interviewees noted that the two MCPs are headquartered and managed outside of the region and may therefore lack community input at the leadership level. This, they noted, was in contrast to PHC, which has local representation on its governing board and a chief medical officer who is a provider in the community.

Providers also noted poor communication and information sharing around their panels of patients; some indicated that patients had been assigned to their clinics who had not previously been seen at the facility or by its providers, and who were difficult to reach due to inaccurate contact information. Providers also noted that communication, education, and support around efforts to increase HEDIS scores were sporadic and inconsistent, which made the task of improving these scores difficult.

In addition to the concerns about a limited presence in the community, many interviewees expressed concern about what they described as tedious pre-authorization processes required for many procedures and frequent denials of their requests for authorization. A related concern involved slow adjudication of claims for reimbursement. Several interviewees noted that the transition to managed care required adding new staff members to handle the increased administrative requirements of seeking pre-authorization or approval. Interviewees indicated that this process was often opaque, and that obtaining what they believed was simple information, such as whether a particular medication was covered, required making a phone call and waiting on hold for an extended period. Another specific example that was mentioned involved the recently implemented transportation benefit, which covers the cost of transportation for Medi-Cal enrollees who lack

alternative means of transport. When this benefit was initially made available, several interviewees indicated that the procedures for accessing the benefit were burdensome and overly complicated or confusing such that the benefit was very difficult to access and therefore not widely used by enrollees.

One source of potential communication difficulty between providers and MCPs relates to the role of IPAs. These organizations effectively operate in between the providers and the MCPs to aid in managing care. Under this model, the IPA receives a capitated payment for each covered member and is responsible for paying for care for those members through contracts with participating providers. The IPA structure can offer a more locally based connection to providers, and therefore may be more nimble in responding to local concerns than a larger MCP would be. However, the IPA also represents an additional layer of bureaucracy or administration between the providers and the MCPs.

In the Regional model counties, California Health & Wellness generally has not used IPAs, while most care covered by Anthem is provided via the River City IPA. While interviewees generally did not explicitly indicate that problems with River City or the IPA model were root causes of their concerns or frustrations, it is nevertheless possible that this additional layer of complexity (and the difference between Anthem and CHW) was a source of confusion or contributed to difficulties in communication or in identifying the appropriate person to address a problem.

Limited Specialty Care Networks

The second important area where interviewees expressed concerns related to limited specialty care networks. Many interviewees reported that existing referral networks were disrupted by the transition to managed care. This transition (and what interviewees considered to be inadequate efforts to build networks) resulted in poor access to specialty care. Many interviewees highlighted examples where patients had to travel long distances or endure long waits in order to access specialty care. For example, one interviewee reported that there were no rheumatologists accepting patients in his region. Other interviewees reported that access to common specialties such as urology, neurology, gastroenterology, and podiatry was very limited or nonexistent in the region.

Differences in Philosophical Approaches to Providing Services

One final issue that emerged in several interviews relates to differing ideas about how Medi-Cal should be provided. Specifically, several interviewees noted that the two commercial MCPs are seeking to earn a profit through their administration of Medi-Cal benefits. These interviewees identified at least two perceived issues or deficiencies that result from this arrangement. First, some interviewees perceived the profit motive as being responsible for burdensome preapproval processes, denials of claims and authorization requests, and delays in receiving reimbursement from the MCPs. Second, several interviewees noted that PHC (a COHS that does not seek to earn a profit) had made significant community investments, such as in affordable housing or grants for clinic construction. Interviewees equated these investments to the lack of need for profits, in effect suggesting that commercial MCPs have resources that could be invested in the community rather than going to shareholders.[15] Together with concerns about MCP leadership being based outside of the region (in contrast to PHC, where the MCP is locally based and providers and counties have representation on the governing board), these more philosophical objections provide important context for evaluating the other practical concerns raised by interviewees.

Other Perspectives Regarding Regional Model MCPs

In order to put the concerns of Regional model providers and counties in perspective, interviews were conducted with providers in rural counties that had direct experience with PHC, including some who also have experience with one or both Regional model MCPs. In addition, interviews were conducted with representatives of both Anthem Blue Cross and California Health & Wellness as well as other experts familiar with Medi-Cal managed care in rural Northern California. These interviews suggest a somewhat more complex and nuanced situation that defies easy characterization.

Experience with Partnership HealthPlan Has Been Positive

All of the providers interviewed that had experience with PHC as a payer, including those with direct experience of both Regional model MCPs and PHC, described the experience in positive terms. Interviewees indicated that PHC provided important training and shared important information during the transition to managed care. Some interviewees indicated that the specialty care network improved following the transition to managed care when compared with the fee-for-service provider network (reportedly as a result of higher rates paid by PHC to specialists). Interviewees also indicated that PHC had logical and reasonable requirements for pre-authorizations that were not viewed by providers as overly burdensome. Moreover, interviewees reported that exceptions to rules, such as the requirement to try a generic medication as a first-line treatment, were granted if a compelling reason could be provided. Interviewees also indicated that it was easy to contact the appropriate person at PHC regarding any issues that needed to be addressed and that communication around the rollout of new benefits, such as the transportation benefit, was timely and effective. Many interviewees stated that PHC is a "true partner" in their shared efforts to deliver care to their patients. In sum, the comments received about PHC were in stark contrast to many of the comments made about Anthem and CHW.

The positive reputation that PHC has earned appears to have paid dividends. When problems arise, providers interviewed were usually willing to give PHC the benefit of the doubt. These same issues, when they have emerged in Regional model counties, have frequently resulted in conflicts or criticisms. For example, providers in both PHC and Regional model areas described an issue in which patients were assigned to a clinic but could not be reached due to inaccurate contact information. In the case of one PHC provider, this was viewed as an inevitable outcome and one that provided an unanticipated benefit in the form of assistance with the clinic's cash flow. That is, while capitation payments received for patients not seen at the clinic eventually had to be returned, their initial receipt helped the clinic to manage its intra-fiscal-year cash flow. In contrast, the Regional model provider that described this same situation viewed the assignment of these "unseen patients" as an avoidable MCP error, and one that caused increased administrative burden as the clinic fruitlessly attempted to contact them. Furthermore, while providers viewed the assignment of these unseen new patients as MCP mismanagement, MCP interviewees reported that this was simply part of their mandate to assign all patients to a primary care provider in their area.

A similar circumstance surrounded the transportation benefit, with providers in both PHC and Regional model areas describing difficulty in accessing the benefit. However, the PHC provider mostly viewed this difficulty as stemming from a lack of reliable transportation providers, while the Regional model providers viewed these issues as due to MCP bureaucracy or intransigence.

This goodwill that PHC has earned may help to explain at least some of the differences in attitudes among providers in the PHC and Regional model areas. Interviewees indicated that at least some of the issues identified with respect to the Regional model MCPs have been addressed, while the lack of goodwill that early problems generated may have lingered.

Some Concerns Have Been Addressed

Over time, both Regional model MCPs have reportedly responded to concerns raised by counties and providers. MCPs reported both an increased effort to make staff available and the addition of dedicated staff to support providers and counties in the region. Both MCPs also reported that they had made efforts to expand the available specialty care network, and that they were prepared to contract with "all willing providers." In addition, both MCPs reported making investments in telehealth or other electronic means of expanding access to care as well as efforts to reduce the number of zip codes with Alternative Access Standards. In response to concerns about burdensome pre-authorization requirements, Anthem reported that, in conjunction with River City IPA, the number of procedures and services requiring pre-authorization had been significantly reduced (reportedly by 80%).

Interviewees from the MCPs also suggested that at least some of the concerns about the Regional model do not relate specifically to MCP performance, but instead to the transition from a long-established fee-for-service model to the more tightly controlled managed care model. This transition inevitably resulted in significant changes to the way care was delivered and paid for, and required changes to the ways some providers treated specific patients or conditions. Interviewees reported that these types of changes were precisely the reason DHCS has promoted the switch to managed care (i.e., to promote value-based payment methods, increase evidence-based practice, and better align provider incentives).

At least some interviewees acknowledged that some of these efforts on the part of the MCPs have been successful. While most interviewees continued to be concerned about specialty care access, some reported that the situation had improved relative to the initial period following the implementation of managed care. Others reported that the initial difficulties associated with accessing the transportation benefit had been addressed, and at least some of the initial contracting difficulties have reportedly been resolved (although at least some providers reportedly still do not have contracts in place).

Despite MCP Improvement Efforts, Stakeholders Remain Concerned

Analysis of interviews with PHC and Regional model providers, MCPs, and others suggests a complex and nuanced picture. Circumstances in Regional model counties appear to have improved at least somewhat since the initial rollout of managed care, and both MCPs reported a willingness and desire to work with counties and providers to continue to make improvements. The MCPs have added staff to support Regional model counties; the number of procedures requiring pre-authorization has decreased at least in some cases; and efforts to address contracting issues, expand the provider network, and expand access to specialty care are ongoing. Nevertheless, many Regional model providers remain deeply concerned with the performance of the two MCPs. The initially troubled relationship between MCPs and providers, combined with the generally glowing reviews of PHC offered by providers in neighboring communities, has led some in the Regional model counties to believe that only a switch to a COHS model (and, ideally, joining PHC) will address their concerns.

Findings: Access, Quality, and Consumer Experience

An extensive data analysis comparing the results in Regional model counties with those in comparable rural counties was conducted as a companion to the structured interviews. This data analysis indicates that patient experience and quality-of-care measures are similar, particularly when comparing Regional model and PHC north counties. On the broadest measures of patient satisfaction and health care quality from HEDIS, the rural comparison group showed somewhat better results when compared with either the Regional model or PHC north. Specific results are discussed below.

Consumer Experience Was a Mixed Bag, but Mostly Worse for Enrollees of Regional Model MCPs

Patient satisfaction was measured through two separate data sources, a patient satisfaction survey and an analysis of grievance data filed with DHCS.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a patient satisfaction survey conducted every three years. The most recent survey covers 2016 and was published in January 2018.[16] The CAHPS survey is administered to patients in all Medi-Cal MCPs and covers patient satisfaction with both their MCP and providers. Results are summarized by MCP, allowing for a comparison across managed care models when results are aggregated by MCP.

Table 2 presents a comparison of Regional model MCPs, PHC north, and the rural comparison group. The values reflect the average score of all MCPs in each region, presented as the statewide percentile score. For example, 20th percentile means that 80% of MCPs performed better.

Table 2. Consumer Experience with MCPs, by Region

	CAHPS PERCENTILE RANKING		
	REGIONAL	PHC NORTH	RURAL COMPARISON
All Health Care	20th	10th	37th
Personal Doctor	26th	18th	53rd
Specialist Seen Most Often	21st	51st	46th
Getting Needed Care	32nd	42nd	59th
Getting Care Quickly	75th	73rd	64th
How Well Doctors Communicate	49th	86th	48th
Customer Service	45th	99th	66th

Notes: CAHPS results are presented as a single value for each health plan. For smaller (generally rural) counties, results are presented for groups of counties. For example, both Anthem and CHW present the results for Regional model counties grouped into two regions. PHC presents results for counties grouped into four regions. Results presented here are the simple average, with one observation per plan/reporting unit. Results for adult and child measures were averaged to simplify presentation of the available data. Results for all measures are reported in Appendix D. Results exclude Kaiser Permanente.

Source: Blue Sky Consulting Group analysis of 2016 CAHPS data.

These results show a mixed picture. Regional model MCPs scored, on average, worse than PHC north on four of seven measures and worse than rural comparison MCPs on five of seven measures. On the broadest measure, "Rating of All Health Care," Both the Regional model and PHC north counties earned scores well below that of the rural comparison group. Specifically, the result from the rural comparison group placed that region in the 37th percentile when compared with all MCPs statewide (i.e., 63% of MCPs scored better). In contrast, the Regional model earned a result in the 20th percentile and PHC north's score was in the 10th percentile. Similarly, the rural comparison group outperformed both the Regional model and the PHC north group on the measures "Rating of Personal Doctor" and "Getting Needed Care." In contrast, both the Regional model and PHC north counties outperformed the rural comparison group on the measure "Getting Care Quickly." On the measures "Rating of Specialist Seen Most Often" and "Customer Service," both the PHC north and rural comparison groups outperformed the Regional model.

Other Indicators of Patient Satisfaction

In addition to the CAHPS survey, two additional measures from the DHCS Medi-Cal Managed Care Performance Dashboard were examined that can help to illuminate the satisfaction of patients in Regional model counties. These measures included medical exemption requests and grievances filed.

Table 3. Selected DHCS Dashboard Data, by Region

	REGIONAL	PHC NORTH	RURAL COMPARISON
Medical exemption requests per 10,000 members	1.38	0.04	0.29
Grievances per 1,000 member months	53.6	69.3	46.6

Source: Blue Sky Consulting Group analysis of data from the DHCS Medi-Cal Managed Care Performance Dashboard, 2018.

Medical exemption requests are made by members who seek to remain in fee-for-service Medi-Cal rather than receive care from an MCP. As shown in Table 3, such requests were very rare among PHC north Medi-Cal enrollees. Somewhat more enrollees in the rural comparison group filed such requests in 2018, but by far the largest rate of medical exemption requests came from Regional model county Medi-Cal enrollees. Although this rate (1.38 requests per 10,000 members) substantially exceeded the rate for either comparison group, the rate in Regional model counties was only slightly higher than the average rate of 1.08 requests per 10,000 members across all MCPs statewide (not shown).

The data on grievances presents a somewhat different picture. While PHC north had the lowest rate of exemption requests among the three comparison groups, the rate of grievances filed against MCPs was highest for PHC north members. Grievances for Regional model MCPs were lower than for PHC north and only slightly higher than for the rural comparison group. Both the Regional model and rural comparison groups had grievance rates that were lower than the MCP average statewide, which was 56.8 grievances per 1,000 member months (not shown).

Regional Model MCP Enrollees Fare Worse on Some Measures, but Differences Are Not Statistically Significant

The California Health Interview Survey (CHIS) is a large-scale annual survey of Californians. Respondents are asked detailed questions about health conditions, health insurance, and various economic and demographic characteristics, among other topic areas. Because CHIS is a large-scale survey with detailed questions about these respondent characteristics, it is possible to identify and separately analyze the Medi-Cal population and identify the type of managed care delivery model they are enrolled in.[17]

CHIS includes several important questions that can be used to evaluate potential differences among Medi-Cal managed care delivery models. Table 4 presents the results of the CHIS data comparison.

Table 4. CHIS Variables - Regional Model Comparison

	REGIONAL	PHC NORTH	RURAL COMPARISON
Did not have usual source of care	12%	10%	16%
Usual source of care: ER, some other place, no usual place	20%	15%	22%
Had difficulty finding primary care	17%	16%	10%
Had difficulty finding specialty care	35%	40%	32%
Insurance not accepted by medical specialist in past year	37%	35%	27%
Sometimes/never able to get doctor's appointment within two days	38%	31%	47%

Note: Results are pooled across the years 2014–2017 in order to obtain a statistically stable result.

Source: Blue Sky Consulting Group analysis of CHIS data, 2014–2017.

This analysis does not point to clear differences among the three comparison groups. The first two measures provide an indication of whether rural county Medi-Cal enrollees have a usual place to go when sick or needing care. On both of these measures, Regional model enrollees are very slightly less likely to lack a usual source of care (12%) or to use the ER as their usual source of care (20%) when compared with Medi-Cal enrollees in the rural comparison group (16% and 22%, respectively). Members in the PHC north group were the least likely to lack a usual source of care (10%) or use the emergency room as their usual source of care (15%). Although rural comparison county enrollees were the most likely to report that they used the emergency room as their usual source of care, these same enrollees were the least likely to report that they "had difficulty finding primary care," with only 10% reporting such difficulty as compared with 17% of Regional model enrollees and 16% of PHC north enrollees.

Results were similarly mixed for the two access-to-specialty-care measures. About a third of enrollees in all three groups reported difficulty finding specialty care. A larger share of enrollees in Regional model counties reported that their insurance was not accepted by a medical specialist in the past year (37%) when compared with respondents in the rural comparison group (27%).

In addition to the analysis of CHIS descriptive statistics, each of these CHIS measures was tested using a regression analysis. Regression allows researchers to control for demographic and other variations across populations which may account for any observed differences. Any differences in outcomes due to the managed care model can then be identified. Regression analysis results did not find any reliable, statistically significant differences in outcomes due to the MCP.[18]

Overall, the analysis of CHIS data suggests that Medi-Cal enrollees in Regional model counties have experiences that are substantially similar to those in comparable rural counties. Residents of rural areas are more likely to report difficulty in accessing care when compared with Medi-Cal enrollees statewide.

Quality of Care Was Also Comparable Across Groups

The Healthcare Effectiveness Data and Information Set (HEDIS) represents perhaps the most widely used data source for evaluating and comparing MCP performance. According to the Centers for Medicare & Medicaid Services (CMS), HEDIS measures can be used by MCPs "to identify opportunities for improvement, monitor the success of quality improvement initiatives, track improvement, and provide a set of measurement standards that allow comparison with other [managed care] plans."[19] The state of California uses HEDIS to measure the effectiveness of Medi-Cal MCPs, and publishes the results annually in the *Medi-Cal Managed Care External Quality Review Technical Report*.[20]

HEDIS includes measures relating to immunization status, cancer screening, heart disease and diabetes management, emergency department utilization, and hospital readmissions. Data are available for more than two dozen separate HEDIS measures for each of California's Medi-Cal MCPs. In order to facilitate analysis of available data, Medi-Cal MCP HEDIS measures were summarized into four categories for the purposes of this report[21]:

- **All-measures average.** This measure includes the simple average for all available measures.[22]
- **Child and adolescent access to primary care.** This summary measure includes the average of the following individual measures: Childhood Immunization Status—Combination 3, Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years, Children and Adolescents' Access to Primary Care Practitioners—7–11 Years, Children and Adolescents' Access to Primary Care Practitioners—12–19 Years, Immunizations for Adolescents—Combination 2, and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.
- **Chronic disease management.** This summary measure includes the average of the following individual measures: Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Annual Monitoring for Patients on Persistent Medications—Diuretics, Asthma Medication Ratio—Total, Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg), Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, Comprehensive Diabetes Care—HbA1c Control (<8.0%), Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, Comprehensive Diabetes Care—Medical Attention for Nephropathy, and Controlling High Blood Pressure.
- **All-cause readmissions.** This measure is reported in its original form.

Table 5. Summary of HEDIS Measures, by Region, 2015–18

	ALL-MEASURES AVERAGE	CHILD AND ADOLESCENT ACCESS TO PRIMARY CARE	CHRONIC DISEASE MANAGEMENT	ALL-CAUSE READMISSIONS
Regional	66%	75%	67%	15%
PHC north	66%	73%	67%	13%
Rural comparison	71%	78%	70%	14%

Source: Blue Sky Consulting Group analysis of HEDIS data from Department of Health Care Services, *Medi-Cal Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2016–June 30, 2017 and July 1, 2017–June 30, 2018), www.dhcs.ca.gov. Results reflect the unweighted MCP average score. Results exclude Kaiser Permanente.

Table 5 presents the results of a comparison of HEDIS scores for Regional model and comparison group counties. As shown in Table 5, Regional model MCPs demonstrate performance that is substantially similar to that of the PHC north group; performance of the rural comparison group was somewhat better across all measures.

An examination of average HEDIS scores over time (Table 6) also finds that performance in Regional model counties was very similar to that of the PHC north group; however, the rural comparison group counties demonstrated somewhat higher HEDIS scores across each of the years examined.

Scores improved slightly for all three comparison groups between 2015 and 2018, although the increase was largest in Regional model counties. The average HEDIS score in Regional model counties improved from 64% in 2015 to 68% in 2018. Other counties in the rural comparison group saw a smaller improvement, from 70% in 2015 to 71% in 2018. Finally, average HEDIS scores improved in the PHC north group from 65% in 2015 to 67% in 2018.

Overall, an examination of HEDIS scores shows that the results are substantially similar in Regional model counties as compared with other comparable parts of the state, particularly in the most recent, 2018 period.[23] The comparison group of rural counties did outperform both the Regional model counties and the PHC north group, both of which implemented managed care relatively recently.

Table 6. Average HEDIS Score, by Region, 2015–18

	2015	2016	2017	2018
Regional	64%	67%	67%	68%
PHC north	65%	67%	66%	67%
Rural comparison	70%	71%	70%	71%

Notes: Results reflect the unweighted MCP average score. Results exclude Kaiser Permanente.

Source: Blue Sky Consulting Group analysis of HEDIS data from Department of Health Care Services, *Medi-Cal Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2016–June 30, 2017 and July 1, 2017–June 30, 2018), www.dhcs.ca.gov.

Some Regional Model Enrollees Need to Travel Long Distances to the Nearest In-Network Provider

DHCS requires (pursuant to federal requirements set forth by CMS) Medi-Cal MCPs to meet specific access standards. The standards measure both the distance and the time required to travel to specific types of providers, including adult and pediatric primary and specialty care, hospitals, outpatient mental health, obstetrics/gynecology, and pharmacies.

According to the most recent *Compliance Assurance Report* from DHCS, all MCPs, including those in Regional model and comparison group counties, are "in full compliance with the Annual Network Certification requirements set forth in 42 C.F.R. section 438.207 or [are] passing with conditions."[24] In cases where MCPs are not able to meet a specific standard, however, they can request an Alternative Access

Standard, which allows for longer travel times in cases where MCPs indicate that the original standard cannot be met. Table 7 presents the most recent data on the percentage of zip codes affected by an Alternative Access Standard in Regional model, PHC north, and rural comparison counties.

Table 7. Percentage of Regions with Alternative Access Standards, by Area of Specialty

	REGIONAL	PHC NORTH	RURAL COMPARISON
Pediatric	28%	27%	53%
Adult	27%	27%	24%
Hospital	14%	30%	31%
Mental health (non-psychiatry) outpatient services	1%	0%	0%
Ob/gyn	1%	0%	0%
Pharmacy	11%	0%	2%
Ob/gyn PCP	69%	0%	7%

Source: Blue Sky Consulting Group analysis of data from Department of Health Care Services, *2019 Approved Alternative Access Standards Report*, as of January 30, 2019, www.dhcs.ca.gov (PDF).

As shown in Table 7, Regional model counties required Alternative Access Standards for more service categories when compared with either the PHC north or rural comparison groups, although the percentage of zip codes requiring an Alternative Access Standard was very similar in several cases. All three regions required an Alternative Access Standard for at least some zip codes for pediatric, adult, and hospital care. However, in the Regional model, more zip codes had an Alternative Access Standard for pharmacy and obstetrics/gynecology primary care provider (ob/gyn PCP) in relation to both comparison groups.

Although there were more service categories in the Regional model with an Alternative Access Standard, there were some categories where the frequency of Alternative Access Standard zip codes was lower. For example, nearly twice as many zip codes in the rural comparison group (53%) were affected by an Alternative Access Standard for pediatric care compared with the Regional model (28%) or the PHC north group (27%). For hospital care, just 14% of Regional model zip codes were affected by an Alternative Access Standard, about half the level in the rural comparison or PHC north groups.

The California State Auditor also examined access to care using the network adequacy data, concluding that "Regional Model health plans have required some beneficiaries to travel excessive distances to obtain medical care from providers."[25] The State Auditor also found that, while both Regional model MCPs cover the same counties, enrollees may face very different travel distances depending on which plan they are enrolled in. For example, the State Auditor reported that some Anthem enrollees needed to travel as far as 239 miles to see a cardiologist, while the maximum distance for CHW enrollees was 115 miles. Conversely, some CHW enrollees needed to travel as far as 85 miles to see a primary care provider, while the maximum distance for Anthem enrollees was just 10 miles.[26]

There can be many reasons for an Alternative Access Standard, including geographic obstacles to care (i.e., rural areas are difficult to serve). Nevertheless, while the need for an Alternative Access Standard does not in itself demonstrate diminished access to care, a larger fraction of Alternative Access Standard zip codes in a particular region does suggest poorer access to care.

Data Analysis Conclusions

Patients in rural areas can face important challenges in accessing health care (Figure 1). In comparing differences among rural areas, the analysis presented in this report suggests wide variation, depending on the region and measure used. The following are the important findings from this data analysis:

- On the broadest measures of patient satisfaction from the CAHPS survey and health care quality as measured by HEDIS, results were poorer in the Regional model and PHC north counties when measured against the results in a comparison group of rural counties.

- While HEDIS scores were generally lower in Regional model counties when compared with the rural comparison group, scores increased more rapidly in Regional model counties over the 2015–2018 period.
- Using administrative data to examine patient satisfaction showed that Regional model Medi-Cal enrollees had more medical exemption requests than those in either comparison group, but fewer grievances than those in the PHC north group (grievance rates were similar for Regional model and rural comparison group counties).
- Access to care remains an important challenge for rural Medi-Cal enrollees across the state. However, available data on access to care presents a mixed picture when comparing performance across rural groups. For example, analysis of one survey measure, "Getting Care Quickly," showed that both Regional model and PHC north MCPs received scores near the 75th percentile statewide (meaning they outperformed three-quarters of the MCPs); rural comparison group MCPs earned an average score at the 64th percentile. An examination of CHIS access-to-care data found that Regional model enrollees reported somewhat more difficulty finding specialty care relative to enrollees in the rural comparison group, but were less likely to report not having a usual source of care.

In general, data analysis suggests that Regional model MCP performance could be improved, at least in some areas, when compared with other, comparable rural counties. Available data are limited, however, and may not be the most appropriate tool for measuring important provider concerns such as difficulty accessing benefits, lack of adequate specialty networks, limited presence in the community, or difficulty obtaining reimbursement. These concerns remain an important aspect of health care delivery in rural California, and challenges in delivering care remain in rural areas throughout the state.

Discussion

Available data show that — at least according to some measures — opportunities exist to improve patient satisfaction, access to care, and other outcomes in Regional model counties when compared with other rural counties in California, although important differences in individual measures exist. Moreover, providers in Regional model counties were more likely to report serious frustrations with and concerns about the two Regional model MCPs, Anthem Blue Cross and California Health & Wellness. Higher levels of provider dissatisfaction, if not addressed, may lead to poorer patient outcomes in the future.[27] In addition, provider concerns have led some in Regional model counties to seek an alternative Medi-Cal managed care delivery model. Specifically, several interviewees indicated a desire to join with Partnership HealthPlan, form a regional COHS, or develop another alternative to the current Regional model arrangement with two commercial MCPs. The depth and extent of these provider concerns, therefore, suggest that changes or improvements to the current system should be considered.

Further Research

Although important provider concerns were identified, this identification was based on structured interviews with a selected group of providers. In order to more systematically identify the breadth of these provider concerns, establish whether they are different from provider concerns in other comparable counties, and determine whether they have persisted over time, further research would be required. The most suitable vehicle for this research would be a survey of providers in both Regional model and comparison group counties. Such an analysis of provider satisfaction can supplement a continued monitoring of patient satisfaction and outcome data, and determine if poor provider satisfaction (if confirmed) is translating into poorer outcomes for patients.

In addition, while this study has sought to incorporate all available, relevant data sources, the analysis presented nevertheless is subject to important limitations. Most important, very limited data on access to

specialty care exist. HEDIS largely addresses quality measures subject to primary care intervention and, to a more limited extent, hospitalization. In general, however, these data do not address access to specialty care. DHCS network adequacy standards are intended to ensure that an adequate network is available; however, the available data do not directly allow for an analysis of whether such a network is in fact available to most enrollees. The survey data sources (CHIS and CAHPS) do more specifically address access to care, but these data are not a complete substitute for clinical or administrative data measuring access to care directly.

Considerations for Improvement

Given the numerous and vociferous provider and county concerns, combined with the fact that no model change is likely before the current contract expires in 2023,[28] state policymakers and program officials should consider a variety of approaches to improving the current model's performance. Changing the Regional model to another managed care model (e.g., COHS or Two-Plan model with a Local Initiative) could also be considered; considerations associated with this approach are discussed in Appendix C.

During the course of the interviews, the following suggestions for improvement emerged. The two MCPs could devote resources to these improvements, and DHCS could use its regulatory power to enable and enforce them.

Develop a regional recruitment strategy for improving access to care. Numerous interviewees highlighted the difficulties associated with accessing care due to provider shortages, most importantly for specialty care. While the MCPs are responsible for ensuring adequate networks, there is no explicit requirement for MCPs to recruit new providers to the region, and neither of the two Regional model MCPs makes significant investments in provider recruitment (although PHC does make such investments). Because all MCPs in the region (including commercial and Medicare MCPs) would potentially benefit from recruiting additional providers, it makes sense for multiple MCPs to share the costs associated with recruiting and retaining providers. A regional pool or fund dedicated to provider recruitment could help to lower the cost (for any individual MCP), while simultaneously increasing the total available resources for this purpose. These resources could be supplemented with state resources, potentially from Proposition 56. In addition, developing a more general mechanism for the two MCPs to address issues of mutual concern could be beneficial in terms of improving performance and responding to provider concerns. Leadership from state officials is likely to be needed to help MCPs develop a shared regional strategy and overcome strong incentives to differentiate themselves from competitors.

Increase use of telehealth and other electronic mechanisms for accessing care. Because of the large distances that many patients must travel and the relative lack of providers in the region, tools such as telehealth have the potential to make an important difference in access to care. MCPs are already making investments in telehealth and other similar tools to increase access to care. However, additional investments in telehealth (including the development of mechanisms that allow individual clinics to finance and receive reimbursement for services) have the potential to dramatically improve access to care.

Improve communication between MCPs, providers, and counties. One of the most important concerns raised by providers was the difficulty associated with communicating with large commercial Medi-Cal MCPs headquartered outside of the region. Both commercial MCPs do have dedicated staff assigned to interfacing with providers and counties, and the MCPs report that the level of investment in such staffing has increased since the initial implementation of managed care in the region. Nevertheless, effective communication remains an important goal, and increased investment in MCP staffing for purposes of ensuring effective two-way communication, providing provider education about MCP features or changes, and other matters remains an important goal. Scheduling more regular contact or meetings between MCPs and providers could help to improve communication. In addition,

providers and counties might see an improvement in the responsiveness of the MCPs if they identify common concerns that span multiple clinics or counties and present these issues to MCPs as a group rather than on an ad hoc or individual basis.

Involve a neutral third party or DHCS in discussions regarding unresolved contracting issues. Although many of the contracting issues that characterized the initial rollout of managed care have been addressed, interviews identified a handful of cases in which individual clinics or hospitals do not have contracts with one of the MCPs. These negotiations appear to have reached a stalemate, suggesting that involvement of a neutral facilitator, mediator, or other third party might be a fruitful step toward resolving these outstanding issues.

Develop and enforce more meaningful network adequacy standards. Network adequacy standards could be designed to require MCPs to monitor and incentivize service delivery to Medi-Cal enrollees by providers in the network rather than a "head count" of providers as currently measured. This could necessitate higher rates or additional incentives paid to providers to increase the share of their practice serving Medi-Cal enrollees.

Require MCPs and their delegates to deploy a valid, reliable, and standardized provider satisfaction survey annually. DHCS could incorporate this survey into its Medi-Cal Managed Care Quality Strategy. The survey goals would be developed with the input of MCPs, providers, advocates, and other stakeholders. DHCS could incorporate the results from an annual survey into its Quality Improvement Reports and included them on the Medi-Cal Managed Care Performance Dashboard.

The rural expansion of Medi-Cal, particularly in the 18 counties that are part of the Regional model, brought with it a dislocation of established provider networks and business arrangements, which has resulted in important concerns on the part of many local providers and county officials. An investigation of available data suggests that the state's rural areas do face numerous challenges in delivering care to patients, although many of these difficulties extend beyond the Regional model counties. Opportunities for improvement exist, however, such as developing cooperative mechanisms for recruiting providers and addressing issues of mutual concern to rural MCPs. In developing its procedures for the Medi-Cal procurement, DHCS should pursue an array of approaches to accelerate improvements in access to and quality of care in the state's rural areas.

Appendix A. Structured Interview Participants

T. Abraham, Regional Vice President, Hospital Council Northern and Central California

Sean Atha, Senior Vice President, Business & Network Development, River City Medical Group

Doreen Bradshaw, Executive Director, Health Alliance of Northern California

Lynn Dorroh, CEO, Hill Country Community Clinic

Kimberli Frantz, MD, President, Red Oaks Medical Group, Lassen Medical Clinic

Beatrice Garcia, Imperial County Rural Legal Assistance

Dean Germano, Shasta Community Health Center

Michelle Gibbons, County Health Executives Association

Joel Grey, Anthem Blue Cross

Robin Hodgkin, Imperial County Public Health Officer

Dave Jones, CEO, Mountain Valleys Health Centers

Barsam Kasravi, Anthem Blue Cross

Lee Kemper, Former Executive Director, County Medical Services Program

Valerie Lucero, Tehama County

Meaghan McCamman, California Primary Care Association

Scott McFarland, CPCA Board and Western Sierra

Andy Miller, MD, Health Officer, Butte County

Jane Ogle, Consultant and Former Deputy Director for Healthcare Delivery Systems, Department of Health Care Services

Robert Oldham, MD, Public Health Officer and Public Health Director, Placer County

Paul Pakuckas, Anthem Blue Cross

Alicia Pimentel, Anthem Blue Cross

Tim Reilly, Pacific Health Consulting

Liza Thatranon, Staff Attorney, LSNC Health Program

Abbie Totten, California Health & Wellness

Dick Wickenheiser, MD, Public Health Officer, Tehama County

Mike Wiltermood, CEO, Enloe Regional Medical Center, Chico, Butte County

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting

Appendix B. Regression Analysis Methodology and Results

Regression analyses using patient-level data from the California Health Interview Survey (CHIS) were conducted to assess whether the managed care model was correlated with specific measures of access to care. The CHIS survey is a random-dial telephone survey conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health and the Department of Health Care Services, and includes over 20,000 Californians each year across all 58 counties. The survey includes adults, teens, and children, and it collects detailed demographic information from the respondents, such as age, gender, and level of educational attainment. The survey also asks questions on a variety of health-related topics, such as health insurance coverage and access to health-related services. The data used in the regressions included annual survey responses for the years 2014 through 2017.

Several models were developed comparing members of the Regional model MCPs against members of Medi-Cal MCPs in both the PHC north and rural comparison groups. Specifically, models were developed to test whether these MCP members differed with regard to their responses for the following survey questions:

- Member had a usual place to go to receive health care when feeling sick or needing health advice
- Member had used the ER in the past 12 months for any reason
- Member had a preventive care visit in the past 12 months
- Member had difficulty getting a doctor's appointment within two days (if needed)
- Member had difficulty finding a primary care provider
- Member had difficulty finding a specialty care provider (if needed)
- Member had difficulty understanding his or her doctor

Note that these responses are all binary, or yes/no answers to the survey question. Because of this, it was necessary to use a specialized form of regression called a logistic (or logit) regression, where the dependent variable is categorical rather than continuous. Using these responses as dependent variables, logistic models were developed that included a dummy variable to indicate whether the member belonged to a Regional model MCP (based on respondent's county of residence). A variety of other explanatory variables were also tested, including demographic variables such as the member's age, gender, race, income, and level of educational attainment, in addition to variables to capture whether the member was married or had a partner, was a native English speaker or had a high level of English proficiency, worked full-time, was clinically obese, or was a smoker. Other variables included whether the member had diabetes, asthma, high blood pressure, heart disease, or psychological distress in the past year or needed help for emotional or mental issues or alcohol or drug problems. Finally, dummy variables for the year of the survey were also included.

Testing of numerous specifications using various combinations of these explanatory variables revealed no statistically significant difference in outcomes based on the respondent's Medi-Cal managed care model (i.e., Regional model versus PHC north or rural comparison group). An example of one specification is presented in Table B1 (see page 22).

Table B1 presents numerous statistics from the logistic regression. The coefficient estimate is calculated using maximum likelihood estimation, or MLE. The odds ratio is the exponential of the coefficient estimate and can be used to compare the relative importance of the explanatory variables. The "Pct Increase in Odds" is the transformation of the logit coefficient using the formula $100(e^b - 1)$, where b is the logit coefficient, and expresses the result as a percentage. Therefore, if this value is x, one may say, "Each additional unit of the explanatory variable results in an increase of about x% in the odds of the dependent event occurring."

Table B1. Sample Regression Results

- Dependent variable: 1 if member had visited an ER in the past 12 months, otherwise 0
- Number of observations: 3,843
- Number of observations where dependent variable is 1: 1,304
- Pseudo R-square: 0.10081
- Max rescaled R-square: 0.14083

	COEFFICENT	ODDS RATIO	PERCENT CHANGE IN ODDS	WALD PROB>CHI SQ
Intercept	(2.2737)			0.0000†
Regional Plan Member	0.2350	1.2649	26.4885	0.2029
Year: 2015	(0.0053)	0.9947	(0.5262)	0.9821
Year: 2016	(0.0350)	0.9656	(3.4355)	0.8857
Year: 2017	0.0849	1.0886	8.8600	0.7500
Age	0.0126	1.0127	1.2696	0.0668*
Gender: Male	(0.0107)	0.9894	(1.0647)	0.9549
Race: White	0.1118	1.1183	11.8283	0.5479
Diabetes	0.1178	1.1250	12.5026	0.6474
Asthma	0.5935	1.8103	81.0332	0.0069†
High Blood Pressure	0.4517	1.5710	57.1011	0.0428†
Emotional or Drug Problem	0.6916	1.9969	99.6906	0.0010†
Married or Has Partner	(0.1790)	0.8361	(16.3879)	0.3507
English Speaker (Well/Very Well)	0.6941	2.0019	100.1912	0.0263†
Education of BA or Higher	(0.6367)	0.5290	(47.0960)	0.0272†
Works Full Time	(0.0947)	0.9096	(9.0375)	0.6614

*Indicates signficance at the 90% level. †Indicates statistical significance at the 95% level.

Source: Blue Sky Consulting Group Analysis of California Health Interview Survey data, 2019.

Finally, the "Wald Prob > Chi Sq" value represents 1 minus the confidence level at which the hypothesis that the coefficient value equals zero cannot be rejected — that is, the data do not indicate whether the characteristic makes it more or less likely that the event represented by the dependent variable will occur. Thus, a value of 0.05 indicates that the coefficient estimate is statistically significant at the 95% confidence level.

In this model, the dependent variable was assigned a 1 if the member's survey response indicated he or she had visited the emergency room in the prior 12 months. The CHIS data had 3,843 responses from Medi-Cal members in counties with Regional model MCPs or in similar rural counties, and 1,304 (34%) of those respondents said they had visited the ER. Of the explanatory variables tested, the only significant explanatory variables were age, whether the member had asthma or high blood pressure, whether the member had an emotional or drug problem, English proficiency, and whether the member had a bachelor's degree or higher. For example, those members who had a BA or higher were 47% less likely to respond that they had visited an ER in the past 12 months. As the results also show, members with asthma were on average 81% more likely to have visited the ER, and those with high blood pressure were 57% more likely. The variable denoting whether the respondent was a member of a Regional model MCP ("Regional Plan Member"), however, was not statistically significant.

Appendix C. Pursuing a Change in Managed Care Models

Provider frustration and concerns with the current Regional model have led some to express an interest in leaving the Regional model and joining Partnership HealthPlan of California (PHC) or forming their own County Organized Health System (COHS). While switching to a COHS model is one possibility, the Regional model counties could also switch to a traditional Two-Plan model, with one commercial MCP and a regional Local Initiative (LI). To date, no county has changed from one managed care model to another. In general, county leadership (e.g., board of supervisors, county public health and hospitals, providers) has considerable influence over the type of managed care model in their county or region. Other stakeholders in model choice would include the executive branch (California Health and Human Services Agency and DHCS) and MCPs themselves. Before a change in the model could proceed, careful consideration would need to be given to a number of issues and obstacles. Perhaps most importantly, given the lack of quantitative data suggesting systematic differences in outcomes between Regional model and comparison group counties, a stronger case would need to be made that a change is warranted. This would potentially require additional data collection and development of new measures or data sources beyond those available currently. In addition, several additional practical limitations to a model change exist, as discussed below.

Considerations for Partnership HealthPlan Expansion

Historically, the state has followed local preference when determining which model operates in a county. Moving the Regional model to a COHS structure therefore would likely require support from the various boards of supervisors and regional providers before DHCS would embark on such a change. Furthermore, the limitations in federal statute regarding the COHS model would need to be evaluated to determine whether sufficient room exists under the 16% enrollment cap to allow a COHS to enroll the Regional model population. Based on current (November 2018) enrollment data, it appears that adding the Regional model population to the existing COHS population would exceed the 16% limit on total enrollment in the COHS model.[29]

Assuming the enrollment requirement in federal statute can be met, an expansion of Partnership HealthPlan's service area would require federal approval by the Centers for Medicare & Medicaid Services (CMS). PHC also would need to assess whether expansion is viable. While the MCP already operates in many areas of rural Northern California, adding approximately 300,000 members could require significant investments in staff, information technology (IT), and other operational infrastructure. Before proceeding, the MCP would need to understand how DHCS would set the capitation rates for the Regional model members and evaluate the financial impacts of expansion.

Considerations for Creating a New COHS or LI

If PHC did not expand into the Regional model counties, the counties could explore creation of a regional governing entity to operate a new COHS. While federal statute allows for seven COHSs in California, the remaining COHS is designated for Merced County, necessitating a change in federal statute to allow another county (or group of counties) to operate the new COHS. Similar to an expansion of Partnership HealthPlan's service area, creating a new COHS would likely require changes to state statute and CMS approval of the change in the managed care model. The Regional model counties also would need to evaluate the costs of establishing a COHS. If the decision were made to proceed, implementation would still take several years (e.g., one to two years to obtain the necessary change in federal statute and an additional one to two years to launch the new COHS).

Alternatively, state and local stakeholders could consider moving to a traditional Two-Plan model structure, with one LI and one commercial MCP offering coverage to Regional model enrollees. This would require multiple counties to work together to create a regional LI through a Joint Powers Authority (JPA) or regional

health authority that would manage the LI on behalf of all the counties. These would be similar to the governance structures used by CalViva Health and Inland Empire Health Plan.[30]

If the regional counties chose not to operate the LI, they could contract with an MCP. For example, Stanislaus County's LI contracts with the Health Plan of San Joaquin, and Health Net serves as the commercial MCP. Under this approach, it is possible PHC could serve as the Local Initiative, although this would require significant operational changes at the MCP, which may not be economically feasible. In addition, as state licensure is required for all Two-Plan model MCPs, PHC would need to complete the licensure process for each of the counties, further adding to the complexity and costs of serving as the regional counties' LI.

While significant obstacles to establishment of a new COHS or LI exist, either approach would provide for local control by the counties. Implementation of the Two-Plan model also would maintain beneficiary choice, which may be important to local stakeholders.

Appendix D. Additional Measures

Table D1. Average HEDIS Score, by Category and Region, 2015–18

	REGIONAL	RURAL COMPARISON	PHC NORTH
Childhood Immunization Status — Combination 3	62%	67%	57%
Children and Adolescents' Access to Primary Care Practitioners — 12–24 Months	94%	95%	94%
Children and Adolescents' Access to Primary Care Practitioners — 25 Months–6 Years	85%	87%	84%
Children and Adolescents' Access to Primary Care Practitioners — 7–11 Years	87%	88%	83%
Children and Adolescents' Access to Primary Care Practitioners — 12–19 Years	86%	87%	84%
Immunizations for Adolescents — Combination 2	23%	31%	18%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents — Nutrition Counseling — Total	53%	70%	59%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents — Physical Activity Counseling — Total	47%	61%	52%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64%	74%	64%
Breast Cancer Screening	48%	55%	49%
Cervical Cancer Screening	49%	56%	49%
Prenatal and Postpartum Care — Postpartum Care	65%	60%	57%
Prenatal and Postpartum Care — Timeliness of Prenatal Care	82%	82%	80%
Annual Monitoring for Patients on Persistent Medications — ACE Inhibitors or ARBs	83%	86%	82%
Annual Monitoring for Patients on Persistent Medications — Diuretics	84%	86%	84%
Asthma Medication Ratio — Total	58%	64%	51%
Comprehensive Diabetes Care — Blood Pressure Control (<140/90 mm Hg)	66%	65%	63%
Comprehensive Diabetes Care — Eye Exam (Retinal) Performed	46%	55%	45%
Comprehensive Diabetes Care — HbA1c Control (<8.0%)	48%	48%	50%
Comprehensive Diabetes Care — HbA1c Poor Control (>9.0%)	41%	43%	39%
Comprehensive Diabetes Care — Hemoglobin A1c (HbA1c) Testing	84%	86%	88%
Comprehensive Diabetes Care — Medical Attention for Nephropathy	84%	87%	86%
Controlling High Blood Pressure	58%	59%	56%
All-Cause Readmissions	15%	13%	13%
Ambulatory Care — Emergency Department (ED) Visits per 1,000 Member Months	52.77	50.81	58.02
Ambulatory Care — Outpatient Visits per 1,000 Member Months	283.44	302.46	232.45
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24%	27%	32%
Screening for Clinical Depression and Follow-Up Plan — Performance Rate	0%	8%	0%
Screening for Clinical Depression and Follow-Up Plan — Reporting Rate	5%	2%	0%
Use of Imaging Studies for Low Back Pain	74%	75%	81%

Source: Blue Sky Consulting Group analysis of HEDIS data from Department of Health Care Services, *Medi-Cal Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2016–June 30, 2017 and July 1, 2017–June 30, 2018), www.dhcs.ca.gov. Results reflect the unweighted MCP average score. Results exclude Kaiser Permanente.

Table D2. CAHPS Measures Comparison, by Region

	REGIONAL		RURAL COMPARISON		PHC NORTH	
	ADULTS	CHILDREN	ADULTS	CHILDREN	ADULTS	CHILDREN
Rating of All Health Care	2.1	2.4	2.3	2.4	2.1	2.2
Rating of Personal Doctor	2.4	2.6	2.5	2.6	2.4	2.5
Rating of Specialist Seen Most Often	2.4	2.6	2.5	2.6	2.4	2.8
Getting Needed Care	2.1	2.3	2.2	2.3	2.2	2.2
Getting Care Quickly	2.2	2.4	2.2	2.4	2.3	2.4
How Well Doctors Communicate	2.5	2.6	2.5	2.6	2.6	2.7
Customer Service	2.5	2.4	2.5	2.4	2.7	2.5

Source: Blue Sky Consulting Group analysis of 2016 CAHPS data.

Appendix E. Calculation of Average CAHPS and HEDIS Measures

CAHPS results are presented using a "three-point mean" calculation. Survey respondents are asked to provide a rating on a scale of 1 to 10. These responses are then rescaled as follows: response values of 9 and 10 were given a score of 3; response values of 7 and 8 were given a score of 2; and response values of 0 through 6 were given a score of 1. These three-point scores are then averaged to create the three-point mean result reported in *2016 CAHPS Medicaid Managed Care Survey Summary Report* and presented here.

Unweighted average CAHPS and HEDIS scores were then calculated across MCPs for each regional comparison group.

Endnotes

1. Department of Health Care Services, *Medi-Cal Managed Care Request for Proposal (RFP) Schedule by Model Type*, updated March 11, 2019, www.dhcs.ca.gov.pdf. Note that re-procurement of managed care services in Regional model counties likely could not take place until current contracts expire in 2023.
2. Elaine M. Howle, *Department of Health Care Services: It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care*, California State Auditor, August 2019, www.auditor.ca.gov (PDF).
3. Howle, Department of Health Care Services, 16.
4. See, for example, Maria Panagioti, Keith Geraghty, Judith Johnson, et al., "Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction," *JAMA Internal Medicine* 178, no. 10 (October 2018): 1317–1330.
5. DHCS, *Medi-Cal Managed Care Request for Proposal (RFP) Schedule by Model Type*.
6. Robin Warshaw, "Health Disparities Affect Millions in Rural U.S. Communities," *AAMCNews*, October 31, 2017, news.aamc.org.
7. Warshaw, "Health Disparities Affect Millions in Rural U.S. Communities."
8. Xenia Shih Bion, *A Long Road to Care for Rural Californians: Stories That Caught Our Attention*, California Health Care Foundation, June 8, 2018, www.chcf.org.
9. Warshaw, "Health Disparities Affect Millions in Rural U.S. Communities."
10. National Rural Health Association, *About Rural Health Care*, accessed September 18, 2019, www.ruralhealthweb.org.
11. A list of the Regional model counties is provided in Table 1 on page 7.
12. A complete list of interviewees is provided in Appendix A.
13. Several of the data sources analyzed for Partnership HealthPlan of California (PHC), including CAHPS and HEDIS, are only available as regional reports with aggregated data across a group of counties. Specifically, PHC data are aggregated into four regions: northeast, northwest, southeast, and southwest. Because several of the counties in the two southern regions are more urbanized than the rural Northern California counties included in the Regional model, the two northern PHC regions were selected as the most directly comparable to the Regional model counties. The counties in the northern PHC regions ("PHC north") include Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity.
14. Additional details of the data analysis approach and regression results are presented in Appendix B.
15. Interviewees from the commercial MCPs commented that, while they do earn a profit, they also believe that their large size allows for economies of scale, which lower costs. In addition, effective July 1, 2019, a Medical Loss Ratio (MLR) requirement will take effect, requiring Medi-Cal MCPs to spend a minimum of 85% of revenue on patient care expenses (thereby limiting profits and administrative expenses).
16. California Department of Health Care Services, Managed Care Quality and Monitoring Division, *2016 CAHPS Medicaid Managed Care Survey Summary Report*, January 2018, www.dhcs.ca.gov.
17. Managed care model was identified based on reported county of residence.
18. Detailed regression results are presented in Appendix B.
19. Centers for Medicare & Medicaid Services, Healthcare Effectiveness Data and Information Set (HEDIS), last modified July 6, 2017, www.cms.gov.
20. For the latest report, see California Department of Health Care Services, Managed Care Quality and Monitoring Division, *Medi-Cal Managed Care External Quality Review Technical Report* (July 1, 2017–June 30, 2018), April 2019, www.dhcs.ca.gov (PDF).
21. Data on all available HEDIS measures are presented in Appendix D.
22. For measures where a lower score is better (e.g., hospital readmissions), the score was rescaled to make it comparable with the other measures by subtracting the reported value from 1.
23. Note that differences in HEDIS scores can be caused by any number of factors, only some of which are related to health plan performance or the structure of the managed care delivery model. In fact, differences due to patient characteristics, geography, the provider network, and other factors may all have larger impact on HEDIS scores.
24. Department of Health Care Services, *Compliance Assurance Report: 2018 Annual Network Certification*, accessed May 28, 2019, www.dhcs.ca.gov (PDF).
25. Howle, Department of Health Care Services, 15.
26. Howle, Department of Health Care Services, 16.
27. See, for example, Lotte N. Dyrbye, Tait D. Shanafelt, Christine A. Sinsky, et al., *Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care*, National Academy of Medicine, July 5, 2017, nam.edu.
28. In Blue Cross of California v. Maxwell-Jolly (December 2013), a settlement agreement over Medi-Cal rates extends the Anthem contract with the Department of Health Care Services in the Regional model counties until October 31, 2023.

29. As of November 2018, total Medi-Cal enrollment was 12,995,647 enrollees, with 1,837,938 enrollees enrolled in COHS plans (excluding enrollment in Health Plan of San Mateo and CenCal Health per federal law). If the 294,850 enrollees enrolled in the Regional model were transitioned into the COHS model, total COHS enrollment (excluding Health Plan of San Mateo and CenCal Health) would equal 16.4% of the total Medi-Cal population.
30. Fresno, Kings, and Madera Counties created a regional health authority to manage their LI, CalViva Health. Riverside and San Bernardino Counties created a JPA to operate their LI, Inland Empire Health Plan.

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE February 16, 2021

Departments: CAO

TIME REQUIRED 1 hour

SUBJECT Housing Update

PERSONS APPEARING BEFORE THE BOARD Robert C. Lawton, County Administrative Officer

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

In 2018, a toolbox matrix consisting of strategies to address Mono County's housing challenges was established and vetted through extensive community outreach. The toolbox matrix proposed integration of goals and strategies into potential programs and actions.

In the absence of a dedicated County housing office, staff in a range of departments have stepped in to provide momentum. Their efforts have enabled the County to be proactive and responsive despite the other demands on their time, especially during the Pandemic.

The County is now recruiting for a dedicated Housing Coordinator, and a new Supervisor has been elected to the Board since the toolbox was last reviewed.

RECOMMENDED ACTION:

Staff recommends the Board review and discuss the Housing Toolbox Prioritization set forth in 2018 for possible recommendation of staff action and amendment at a future date.

FISCAL IMPACT:

None noted at this time.

CONTACT NAME: Robert C. Lawton

PHONE/EMAIL: (760) 932-5410 / rlawton@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
Mono County Housing Toolbox Prioritization 2018-11-05

History

Time	Who	Approval
2/12/2021 10:29 AM	County Counsel	Yes
2/12/2021 9:26 AM	Finance	Yes
2/12/2021 1:17 PM	County Administrative Office	Yes

Toolbox Prioritization by Resource

Current Staffing	Additional Staffing	Funding	Partnerships/Outside County Workflow
1.1A Update opportunity site database (4-0)	**4.1A** Add dedicated staff (5-0)	**4.1A** Add dedicated staff (5-0)	**2.5A** Pursue partnerships with other agencies in the County, such as TOML (4-1)
1.1B Regulatory changes that improve housing production potential (4-0)	**1.2B** Allocate additional resources to bolster staff capacity to review applications (5-0)	**3.3C** Identify opportunities to bolster the County's Revolving Loan Fund (3-0)	**3.1A** Bolster rehabilitation loan and grant program, in collaboration with TOML (3-1)
1.2C Identify future opportunities for CEQA streamlining (3-0)	**1.1D** Reduce barriers to “tiny home” construction (5-0)	**3.1B** Consider programs that may improve housing stock quality (4-0)	**1.3A** Evaluate if off-site infrastructure investment can improve development readiness
2.5A Pursue partnerships with other agencies in the County, such as TOML (4-1)	**1.3C** Evaluate feasibility/value of creating a housing land trust	**1.1C** Reduce barriers to second dwelling unit construction	**1.3C** Evaluate feasibility/value of creating a housing land trust
1.2A Identify additional opportunities for by-right review and approval	**2.5D** Partner with other agencies and employers to ensure that new employee housing qualifies toward meeting the County’s RHNA targets	**2.4D** Establish a tax deferral program for affordable units	**2.2A** Purchase housing units at market rate, deed restrict, and then sell.
2.1A Reinstate HMO, including inclusionary requirements, along with an in-lieu fee	**3.2B** Explore how to incentivize property owners to convert short-term rentals into long-term rentals	**2.4A** Allow waivers or discounts of planning or development impact fees for affordable projects/units	**2.5D** Partner with other agencies and employers to ensure new employee housing qualifies toward meeting RHNA targets
2.3A Establish policy regarding future county land disposition	**3.3B** Review the language of deed restricting conditions to minimize unintended consequences		**2.5C** Investigate potential for developer partnerships
2.3B Prepare for disposition and development by reviewing current use and long-term needs for county-owned parcels	**3.2A** Conduct a study to evaluate the impact of short-term rentals in the County		**2.5B** Investigate potential for landlord partnerships
2.4B Identify zoning requirements for which more flexible approaches could incentivize more on-site affordable units			**1.3B** Identify opportunities for land-banking
2.4C Create density bonus beyond State maximum			
3.2C Consider further enhancing policy and enforcement of short term rentals			
3.2D Educate realtors about the short-term rental approval process			

Mono County Housing Programs Toolbox

Key: Strong Priority; Some support/mixed opinion; Neutral (no color); Not a priority

Housing Toolbox Goals	Program	Program Implementation Actions		Top Priority for BOS	Not a priority for BOS	Current Staffing	Additional Staffing	Additional Funding	Partnership	Outside County Workflow
1. Increase Overall Housing Supply, Consistent with County's Rural Character	1.1 Development Readiness	1.1A	Update opportunity site database	4	0	X				
		1.1B	Regulatory changes that improve housing production potential	4	0	X				
		1.1C	Reduce barriers to second dwelling unit construction	0	2			X		
		1.1D	Reduce barriers to "tiny home" construction	5	0		X			
	1.2 Project Review and Approval Streamlining	1.2A	Identify additional opportunities for by-right review and approval	1	0	X				
		1.2B	Allocate additional resources to bolster staff capacity to review applications	5	0		X			
		1.2C	Identify future opportunities for CEQA streamlining	3	0	X				
	1.3 Proactive Investment	1.3A	Evaluate if off-site infrastructure investment can improve development readiness	2	0				X	
		1.3B	Identify opportunities for land-banking	0	1				X	X
		1.3C	Evaluate feasibility/value of creating a housing land trust	1	0		X		X	

Housing Toolbox Goals	Program	Program Implementation Actions		Top Priority for BOS	Not a priority for BOS	Current Staffing	Additional Staffing	Additional Funding	Partnership	Outside County Workflow
2. Increase Supply of Community Housing	2.1. Inclusionary Housing	2.1A	Reinstate HMO, including inclusionary requirements, along with an in-lieu fee	2	1	X				
	2.2 Acquistions	2.2A	Purchase housing units at market rate, deed restrict, and then sell.	1	0				X	X
	2.3 Public Land Offering	2.3A	Establish policy regarding future county land disposition	2	0	X				
		2.3B	Prepare for disposition and development by reviewing current use and long-term needs for county-owned parcels	2	0	X				
	2.4 Financial and Regulatory Incentives	2.4A	Allow waivers or discounts of planning or development impact fees for affordable projects/units	1	3	X		X		
		2.4B	Identify zoning requirements for which more flexible approaches could incentivize more on-site affordable units	2	0	X				
		2.4C	Create density bonus beyond State maximum	0	0	X				
		2.4D	Establish a tax deferral program for affordable units	1	2		X	X		
	2.5 Partnerships	2.5A	Pursue partnerships with other agencies in the County, such as TOML	4	1	X			X	
		2.5B	Investigate potential for landlord partnerships	0	1				X	X
		2.5C	Investigate potential for developer partnerships	1	0				X	X
		2.5D	Partner with other agencies and employers to ensure that new employee housing qualifies toward meeting the County's RHNA targets	2	1		X	X	X	

Housing Toolbox Goals	Program	Program Implementation Actions		Top Priority for BOS	Not a priority for BOS	Current Staffing	Additional Staffing	Additional Funding	Partnership	Outside County Workflow
3. Retain Existing Community Housing	3.1 Rehabilitation Loans and Grants	3.1A	Bolster rehabilitation loan and grant program, in collaboration with TOML	3	1			X	X	
		3.1B	Consider programs that may improve housing stock quality	4	0			X	X	
	3.2 Short-term Rental Policies	3.2A	Conduct a study to evaluate the impact of short-term rentals in the County	0	1		X	X		
		3.2B	Explore how to incentivize property owners to convert short-term rentals into long-term rentals	2	0		X			
		3.2C	Consider further enhancing policy and enforcement	0	1	X				
		3.2D	Educate realtors about the short-term rental approval process	0	1	X				
	3.3 Acquisitions	3.3A	Identify opportunities to purchase and re-sell deed restricted units	1	0					X
		3.3B	Review the language of deed restricting conditions to minimize unintended consequences	1	0		X		X	
		3.3C	Identify opportunities to bolster the County's Revolving Loan Fund	3	0			X		
4. Other	4.1 Additions by BOS	4.1A	Add Dedicated Staff	5	0		X	X		