SACRAMENTO COUNTY HEALTH AUTHORITY COMMISSION

General Meeting

November 13th, 2025

Agenda Item #1:
Welcome/Opening Remarks & Updates

Agenda Item #1: Agenda Review

1. **Welcome/Opening Remarks and Agenda Review**
2. **Action: Approval of Meeting Minutes and 2026 Meeting Calendar**
3. **Discussion: County's Response to State and Federal Medicaid Changes: Sacramento County's Medically Indigent Services Program –** *Cortney Maslyn, Sacramento County Department of Health Services*
4. **Presentation, Discussion & Action: QIQA Report Back & Approval of Recommended MCP Data Request -** *NORC Consultant and Dr. Khaira*
5. **Discussion: Interviews with Prospective SCHA Chair Candidates –** *CPC Chair, Dr. Malhotra*
6. **Presentation & Action: Conflict of Interest Policy – Governance & Bylaws Ad-Hoc Committee Chair,** *Michelle Monroe*
7. **Public Comment**
8. **Closing Comments and Adjournment –** *Eddie Kirby, Acting Chair*

Agenda Item #2:

Approval of Meeting Minutes and 2026 Meeting Calendar – *Sacramento County Department of Health Services*

Sacramento County Health Authority Commission

2026 General Meeting Schedule

1. Thursday, February 19th, 2026, 3:00 – 5:00 p.m.
   Location: Sacramento Area Sewer District, Valley Oak Conference Room, 10060 Goethe Rd, Sacramento, CA 95827

2. Thursday, April 16th, 2026, 3:00 – 5:00 p.m.
   Location: Sacramento Area Sewer District, Valley Oak Conference Room, 10060 Goethe Rd, Sacramento, CA 95827

3. Thursday, June 18th, 2026, 3:00 – 5:00 p.m.
   Location: Sacramento Area Sewer District, Valley Oak Conference Room, 10060 Goethe Rd, Sacramento, CA 95827

4. Thursday, August 20th, 2026, 3:00 – 5:00 p.m.
   Location: Sacramento Area Sewer District, Valley Oak Conference Room, 10060 Goethe Rd, Sacramento, CA 95827

5. Thursday, October 15th, 2026, 3:00 – 5:00 p.m.
   Location: Sacramento Area Sewer District, Valley Oak Conference Room, 10060 Goethe Rd, Sacramento, CA 95827

6. Thursday, December 17th, 2026, 3:00 – 5:00 p.m.
   Location: Sacramento Area Sewer District, Valley Oak Conference Room, 10060 Goethe Rd, Sacramento, CA 95827

Agenda Item #3

Discussion: County's Response to State and Federal Medicaid Changes: Sacramento County's Medically Indigent Services Program – *Cortney Maslyn, Sacramento County Department of Health Services*

Agenda Item #4

Presentation, Discussion & Action: QIQA Report Back & Approval of Recommended MCP Data Request - *NORC Consultant and Dr. Khaira*

NORC at the University of Chicago

Sacramento County Health Authority General Meeting

Data Request to Plans

11.13.2025

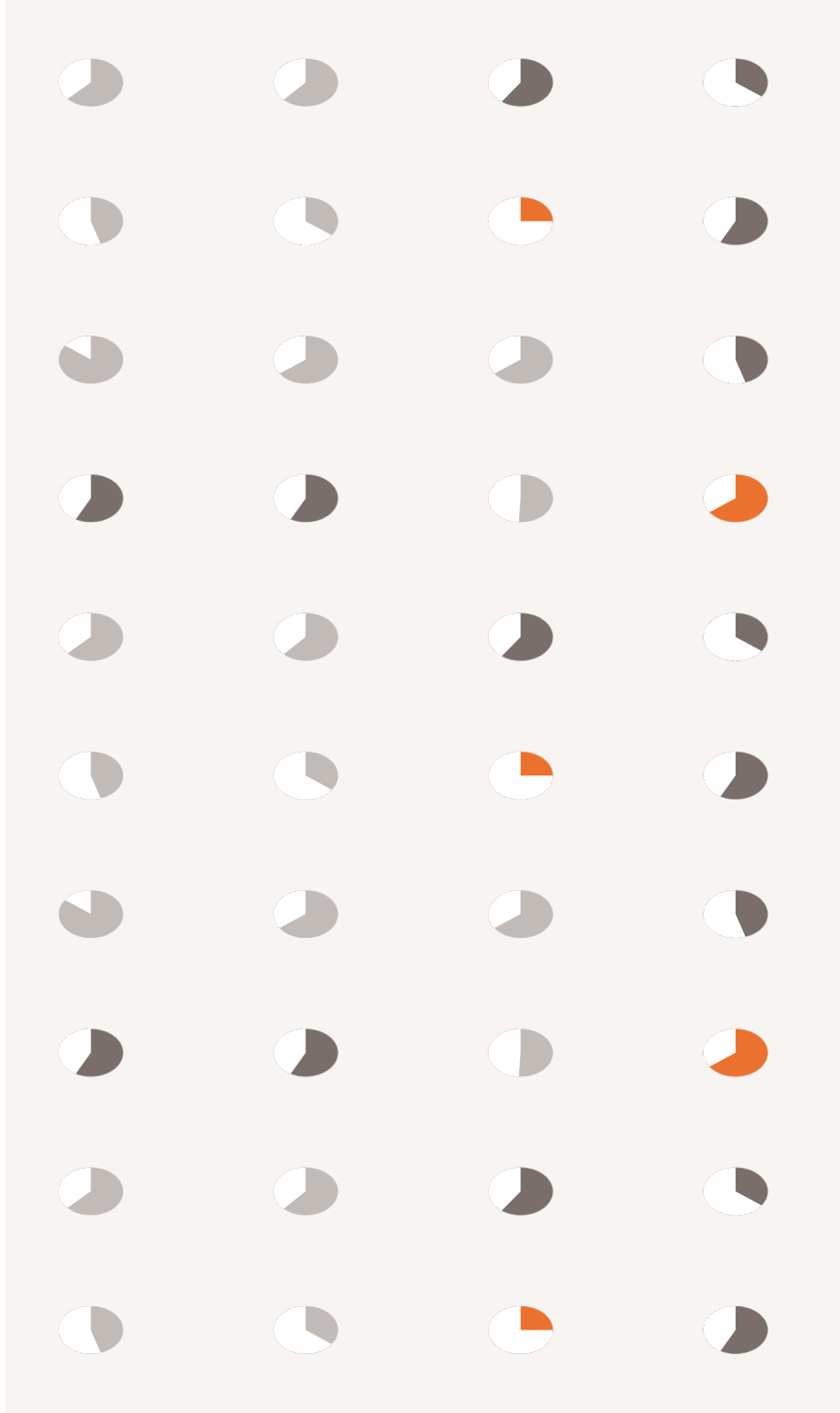
Lisa Shugarman

Overview

01 QIQA Engagement on Developing Recommendations

02 VOTE: Proposed Data Request to Plans

03 Next Steps



The goal for health plan engagement is to share data on the selected set of measures that reflect SCHA priorities with sufficient detail to study variation in performance among select subgroups of the enrolled populations and their geographic locations.

Using this information, SCHA can assess disparities in care delivery and identify areas for targeted improvement for plan/county/health system/provider collaboration.

Today's meeting objectives:

- Review the QIQA committee's work and decision
- Approval for strategy moving forward on the data request to plans

Process for QIQA Engagement on Design of Recommendations

NORC at the University of Chicago

Data Collection Process

- **The NORC team leveraged prior work conducted by the county to identify publicly available data sources and included other data sources identified by the team.**
  - NORC reviewed existing data inventory in addition to conducting an independent environmental scan to identify publicly available data related to Medi-Cal Managed Care Plan performance.
  - NORC compiled the data into a comprehensive data compendium for each measure source.
  - Data sources include EQRO Technical Reports, DHCS Preventive Services Reports, various DHCS dashboards, CAHPS reports, and data received from DMHC upon special request.

Two-Pronged Approach to Data Analysis

The NORC work includes a two-pronged approach to quantitative data:

1. **Data Compendium Maintenance and Analysis:** Produce a compendium of publicly-available data to document trends over time and use those findings to also inform requests for additional data from the plans to understand the various sub-populations enrolled in Medi-Cal in the county. As new publicly available data becomes available, NORC will update the data workbook. NORC will also work with the QIQA Committee to conduct analyses on the publicly available data present in the data compendium.
2. **Analysis of Select Measures**: A subset of measures from the compendium will be identified, which will lead to a formal request to the MCPs to share those data. NORC will conduct a series of analyses on the data to display performance at various levels of disaggregation.

Criteria Used for NORC's Recommended Measures

The criteria NORC used for selection of measures for QIQA committee consideration included:

- Focus is on MCAS measures
  - Measures with financial incentives
  - Measures that will be included in MCAS for future years
- Measures that can be disaggregated based on enrollee characteristics
- Comparative measure performance
  - Within county: plans in Sacramento not meeting the MPL
  - Across counties: plans in Sacramento compared to county comparators
- Measures aligned with county health needs assessment: diabetes, obesity, mental health
- Measures aligned with DHCS Bold Goals, QIQA Committee priorities: children's health, behavioral health, maternity care
- Minimize level of effort of plans to share data

Principles established in May 2024 for health plan monitoring are listed below. These principles were used by the QIQA committee when deliberating and voting on the measures to be included in the request to plans.

- **Align** with goal areas of focus for SCHA
- **Leverage** existing state Medi-Cal Monitoring activities, including measurement, analysis, related MCP reporting and published reports
- **Be feasible** including considerations for accessibility and timeliness of data as well as limiting administrative burden for MCPs
- **Be meaningful** with respect to equitable and quality care
- **Target** opportunities for improvement

Domain	Color
Children's Health	Blue
Reproductive Health	Orange
Cancer Prevention	Red
Chronic Disease Management	Yellow
Behavioral Health	Purple
Report Only (no MPL)	Green

List of Select Measures for QIQA Committee Consideration

Childhood Immunization Status (CIS-10)	Child and Adolescent Well-Care Visits – Total (WCV)	Lead Screening in Children (LSC)
Prenatal and Postpartum Care – Postpartum Care (PPC-Post)	Breast Cancer Screening – Total (BCS)	Cervical Cancer Screening (CCS)
Asthma Medication Ratio – Total (AMR)	Controlling High Blood Pressure – Total (CBP)	Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HbA1c Poor Control (>9.0%) (HBD-H9)
Follow-Up After Emergency Department Visit for Mental Illness – 30-Day Follow-up – Total (FUM-30)	Follow-Up After Emergency Department Visit for Substance Abuse-30-Day Follow-up – Total (FUA-30)	Plan All-Cause Readmissions Observed Readmissions – Total (PCR)

Proposed Data Request to Plans

NORC at the University of Chicago

Selected MCAS Measures to be included in the request to plans

Measure Name	# of votes
Controlling High Blood Pressure – Total (CBP)	5
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HbA1c Poor Control (>9.0%) (HBD-H9)	5
Breast Cancer Screening – Total (BCS)	4
Child and Adolescent Well-Care Visits – Total (WCV)	4
Childhood Immunization Status (CIS-10)	4
Follow-Up After Emergency Department Visit for Mental Illness – 30-Day Follow-up – Total (FUM-30)	4

Domain	Color
Children's Health	Blue
Cancer Prevention	Red
Chronic Disease Management	Yellow
Behavioral Health	Purple

Requests for measures outside of recommended MCAS measures.

The QIQA committee also voted to request the following data outside of the MCAS measure data.

Measure Request	Notes
Specialty Care/Timely Access Data	The plans are requested to supply any additional data that expands upon the data listed in the public DHCS and DMHC reports on specialty care/timely access.
Demographic Data	The table in slide 14 includes the demographic data request as approved by the QIQA committee.
Commercial Data	The QIQA committee proposes requesting plans' commercial data in the same format as the Medi-Cal data request to allow for comparisons.
IPA Level Data	The QIQA committee proposes requesting plans' data with a flag for IPA designation. This would allow for comparison at the IPA level.
Utilization Data	The table in slide 15 includes the utilization data request as approved by the QIQA committee.

Recommended Demographic Data

- **Below is the list of demographic measures to be included in the data request to plans.**

Measure Name	Categories	Justification
Age	0-<1, 1-<5, 5-11, 12-<18, 18-<40, 40-64, 65+	Evaluate age-bands on select utilization
Sex Assigned at Birth	Male, Female	Measuring disparities
Gender Identity	Male, Female, Transgender: Male-to-Female, Transgender: Female-to-Male, Non-Binary (neither Male nor Female), Another Gender Identity	Measuring disparities (where feasible)
Race/Ethnicity	Asian, Black-Not Hispanic, White-Not Hispanic, American Indian/Alaska Native, Pacific Islander/Native Hawaiian, Middle Eastern/North African, Hispanic or Latino, Other	Measuring disparities
Preferred spoken language	English, Spanish, Arabic, Chinese (combined), Farsi, Hmong, Russian, Vietnamese (Sacramento County threshold languages), Dari, Pashto	Measuring disparities
ZIP Code	N/A	Connecting to Geographic Hotspots
Aid Category	ACA Expansion Adult – Ages 19 to 64, Adoption/Foster Care, CHIP, LTC, Other, Parent/Caretaker Relative & Child, SPD/ABD	Differences in benefits/needs
Dual Eligibility Status	Dual vs Non-Dual	Differences in benefits/needs
Housing Status	Housed, Unhoused, Housing Insecure	Difficult to reach population

Recommended Utilization Data

- **These are standard utilization measures reported by DHCS; the QIQA committee included these measures in the proposed data request to plans to allow cross-tabulation with demographic factors.**

Measure Name	Justification
ER Visits/1000	Access for urgent needs
ER visits leading to admission	Access for urgent needs
Total IP admission/1000	Acuity/Access to care
OP Visits/1000*	Access to care
Mental health visits/1000	Concerns for behavioral health treatment

Source: Managed Care Performance Monitoring Dashboard Report, https://www.dhcs.ca.gov/services/Documents/MCQMD/MCPM-Dashboard-January-2024.pdf
*In discussions with the plans, the committee will ask what facility types are captured under the outpatient category. Pending the response, further detailed categories may be requested.

Motion to Vote and Public Comment on the Data Request to Plans

Action: Approve the following data request for MCPs, and delegate meeting with MCPs and approval of minor edits (not to MCAS measures, but only to available disaggregation) to QIQA.

- MCAS measures (Controlling High Blood Pressure – Total (CBP); Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HbA1c Poor Control (>9.0) (HBD-H9); Breast Cancer Screening – Total (BCS); Child and Adolescent Well-Care Visits – Total (WCV); Childhood Immunization Status (CIS-10); Follow-Up After Emergency Department Visit for Mental Illness – 30-Day Follow-up – Total (FUM-30) disaggregated by:
  - Demographic data
  - Commercial data
  - IPA level data
- Specialty Care/Timely Access Data
- Overall Demographic Data (Age, Sex Assigned at Birth, Gender Identity, Race/Ethnicity, Preferred spoken language, ZIP Code, Aid Category, Dual Eligibility Status, Housing Status)
- Utilization Data (ER Visits/1000, ER visits leading to admission, Total IP admission/1000, OP Visits/1000*, Mental health visits/1000)

Next Steps

NORC at the University of Chicago

Next Steps

1. **Engage Plans to Request Data:**
   - Data format (NORC will provide a standard reporting template for plans to submit their data to the SCHA)
   - Timeline for Submission
2. **Creation and approval of an analysis plan for the plan provided data**
   - NORC will conduct a series of analyses on the data to display performance at various levels of disaggregation
3. **Data Compendium Maintenance and Analysis:**
   - As new publicly available data becomes available, NORC will update the data compendium. NORC will also perform analyses and develop visuals of the historical and current data present in the compendium.

Appendices

NORC at the University of Chicago

Appendix A. Data Compendium Information

The data compendium NORC created a catalogue of the publicly-available data that can be used to monitor MCP performance

- For most measures, the most recent public data is from Calendar Year 2023.
- Data presented in the data compendium reflect performance under the prior MCP contract period (*start of current contract period is January 1, 2024).
- The data compendium information was shared with the QIQA subcommittee in advance of the measure selection process.
- Considerations for the data compendium:
  - A "living“ resource that will continue to evolve as more current data come online and new data sources are available (e.g., CalAIM measures)
  - Data reported at the plan/county level, where feasible.
  - The county comparators included in the data compendium include San Diego, San Joaquin, Alameda, and Orange. These counties were discussed and voted on by the QIQA committee.

Appendix B. Voting Process

- QIQA committee members were asked to vote on their top five priority measures from the set of 12. The measures were first presented during the meeting on August 28, 2025, and voted on during the September 25, 2025, and October 23, 2025, meetings. The voting process is detailed below:
  - If a measure received a “yes” vote from 60% or more of the committee (4 or more votes), it was included as a recommendation to the SCHA (Tier 1).
  - If a measure received a “yes” vote from 40-59% of the committee (3 votes), there was additional committee discussion and a second round of voting (Tier 2).
  - If a measure receives a “yes” vote from less than 39% (0-2 votes), it was not proposed as a recommendation to the SCHA (Tier 3).

All selected measures met the Tier 1 criteria.

Appendix C. QIQA Committee MCAS Measures – Voting Results

The table below contains a tally of MCAS measures selected by commissioners. The voting members were Britta Guerrero, Dr. Richard Pan, Cortney Maslyn, Dr. Ravinder Khaira, Margarita Dodatko, and Michelle Monroe, and Eddie Kirby.

Measure Name	# of votes
Childhood Immunization Status (CIS-10)	**4 (Tier 1)**
Child and Adolescent Well-Care Visits – Total (WCV)	**4 (Tier 1)**
Lead Screening in Children (LSC)	2
Prenatal and Postpartum Care – Post partum Care (PPC-Post)	2
Breast Cancer Screening – Total (BCS)	**4 (Tier 1)**
Cervical Cancer Screening (CCS)	1
Asthma Medication Ratio – Total (AMR)	1
Controlling High Blood Pressure – Total (CBP)	**5 (Tier 1)**
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HbA1c Poor Control (>9.0%) (HBD-H9)	**5 (Tier 1)**
Follow-Up After Emergency Department Visit for Mental Illness – 30-Day Follow-up – Total (FUM-30)	**4 (Tier 1)**
Follow-Up After Emergency Department Visit for Substance Abuse – 30-Day Follow-up (FUA-30)	2
Plan All-Cause Readmissions Observed Readmissions – Total (PCR)	1

Appendix D. Information on DHCS and DMHC Timely Access Reports

- DHCS and DMHC each collect data on timely access and capturing these data may not require outreach to plans if we can obtain the data from the state.

	DHCS Report	DMHC Report
Data Collected	Metrics of compliance with wait time standards	Metrics of compliance with wait time standards
Most Recent Available Data	Calendar Year 2024	Calendar Year 2023
Data Collection Entity	Third-Party Vendor	Self-Reported by Plan
Additional Information	Plan/county-level data available, including for Kaiser	Plan/county-level data available, including for Kaiser

Appendix E. DHCS Timely Access Data

Calendar Year 2024 Wait Time Standards Results by Plan and Reporting Unit Levels				
Reporting Unit	Percentage of Specialists' in-person appointment times meeting wait time standards			
	Non-Urgent (15 business days)		Urgent (4 days)	
	Adult	Pediatric	Adult	Pediatric
Statewide %	70.5%	74.0%	54.4%	60.4%
Sacramento County Results:				
Anthem Blue Cross Partnership Plan	59.7%	45.6%	16.4%	6.5%
Health Net Community Solutions, Inc.	44.0%	52.4%	18.8%	30.2%
Kaiser Permanente	90.7%	93.0%	77.8%	79.1%
Molina Healthcare of California	54.6%	53.6%	19.7%	19.6%

Source: DHCS Timely Access Report (MY2024): https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2023-24-Medi-Cal-Managed-Care-Physical-Health-External-Quality-Review-Technical-Report-Vol9-F1.xlsx

Appendix F. DMHC Timely Access Data, Medi-Cal Plans in Sacramento County

Health Plan Name	Number of Providers within County/Network	Number of Providers Attempted to be Surveyed	Target Sample Size Achieved	Rate of Compliance for Urgent Care Appointments Available within 96 Hours (Unweighted)	Rate of Compliance for Non-Urgent Appointments Available within 15 Business Days (Unweighted)
Kaiser Foundation Health Plan, Inc.	195	195	Y	83%	99%
Molina Healthcare of California	451	451	Y	50%	53%
Blue Cross of California Partnership Plan, Inc.	792	176	Y	54%	60%
Health Net Community Solutions, Inc.	474	194	Y	67%	64%
Aetna Better Health of California Inc.	130	130	N	58%	63%

Source: DMHC Timely Access Report (MY2023): https://www.dmhc.ca.gov/Portals/0/Docs/OPM/DMHCMY2023TimelyAccessData.xlsx

Appendix G. Medi-Cal Managed Care Enrollment in Sacramento County – by Plan

Date	Anthem	Health Net	Molina	Kaiser	Aetna	Total
September 2025	252,259	146,170	72,097	137,036	-	*607,562*
	41.5%	24.1%	11.9%	22.5%	N/A	
Dec 2023	233,752	142,386	59,935	127,952	25,031	*589,056*
	39.7%	24.2%	10.2%	21.7%	4.3%	

Source: Medi-Cal Managed Care Enrollment Report, September 2025
https://data.chhs.ca.gov/dataset/medi-cal-managed-care-enrollment-report
Note: For September 2025, PACE plans InnovAge PACE (533), Habitat Health Sacramento (123), WelbeHealth (54), and Sutter Senior Care (548) made up less than 1% of enrollment.
Note: 20,179 members in Sacramento County were eligible under Fee-for-Service (FFS) in September 2025. Source: https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-with-demographics-by-month/resource/2c28bf78-a385-4d0c-88d5-7d1eef09a5ab

Agenda Item #5

Discussion: Interviews with Prospective SCHA Chair Candidates – *CPC Chair, Dr. Malhotra*

Michelle Monroe
Candidate for SCHA Chair

CEO, One Community Health (FQHC), 2020 – present

COO, Vista Community Clinic (FQHC), 2015- 20

Revenue Cycle Director, Vista Community Clinic, 2011-15

Revenue Cycle Manager, Mountains Community Hospital (CAH/RHC), 2009-11

Director of Rural Health Clinics, Mountains Community Hospital, 2004-09

Executive Leadership – Operations – Revenue Cycle/Finance

Example: Development of 10 Year Strategic Plan

- New Mission, Vision and Values
- Patient Led Board
- Executive & Senior Leadership
- Patients
- Community

Question 1

Purpose

The Sacramento County Health Authority Commission (SCHA) shall serve the public interest of Medi-Cal members in the county, which includes striving to:

- Improve health care quality;
- Increase health care access and network adequacy;
- Better integrate the services of Medi-Cal managed care plans and behavioral health and oral health services;
- Promote prevention and wellness;
- Ensure the provision of cost-effective health and mental health care services;
- Reduce health disparities; and
- Ensure the operational well-being and fiscal solvency of the Health Authority

Questions 2 & 3

Healthcare is a human right, including access to healthcare – Sacramento needs to do better

Question 3

Table 4: Age-Adjusted Death Rates per 100,000, Over Time

	RY 2024 (CY 2020-22)	RY 2023 (CY 2019-2021)	RY 2022 (CY 2018-2020)	RY 2021 (CY 2017-2019)	RY 2020 (CY 2016-2018)
Sacramento County	785.2	763.4	744.6	710.5	735.7
California	670.0	657.1	625.4	592.6	608.3

Source: County Health Status Profiles 2020-2024.

Table 5: Sacramento County Age-Adjusted Death Rates, 2020-2022 (RY 2024)

INDICATOR	2020-2022 (RY 2024)			2017-2019 Sac Rate
	Sac Rank	Sac Rate	CA Rate	
ALL CAUSES	33	785.2	670.0	710.5*
ALL CANCERS	46	145.2	122.0	154.0
COLORECTAL CANCER	50	14.2	11.5	13.6
LUNG CANCER	39	25.6	20.6	30.8
FEMALE BREAST CANCER	44	20.0	17.6	21.2
PROSTATE CANCER	49	22.8	18.2	22.4
DIABETES	44	28.4	23.6	28.8
ALZHEIMER'S DISEASE	54	47.4	35.5	50.2
CORONARY HEART DISEASE	30	78.3	77.2	93.3
STROKE	54	51.0	37.0	45.3
INFLUENZA/PNEUMONIA	32	10.8	10.9	15.3
CHRONIC LOWER RESP.DIS.	27	28.6	24.5	38.1
CHRONIC LIVER DIS. AND CIRRHOSIS	22	14.8	14.4	12.6
ACCIDENTS	25	56.2	47.9	42.6
MOTOR VEHICLE TRAFFIC CRASHES	25	13.8	11.5	11.4
SUICIDE	32	11.9	10.1	13.4
HOMICIDE	40	7.4	6.1	5.7
FIREARM RELATED DEATHS	33	10.7	8.7	9.3
DRUG OVERDOSE DEATHS	32	27.6	25.3	16.8

Source: County Health Status Profile 2024, CHSP 2024 Tables 1–29 (Excel), CHSP 2023 Table 30 (Excel).

*This figure was pulled from County Health Status Profile 2021.

Kind

Accountable

Empathetic

Humble

Question 4

Agenda Item #6

Presentation & Action: Conflict of Interest Policy – *Governance & Bylaws Ad-Hoc Committee Chair, Michelle Monroe*

Agenda Item #7:

Public Comment

Agenda Item #8:

Closing Comments & Adjournment

APPENDIX

County’s Response to State and Federal Medicaid Changes: Sacramento County's Medically Indigent Services Program

Department of Health Services

Agenda

Background

- California Statutory Requirements/Indigent Programs
- Sacramento County CMISP/Healthy Partners

Impacts on Sacramento County

- State and Federal Statutory Changes Timeline
- Impacted Populations

Framing the Path Forward

- Policy Decisions

Background

Statutory Requirements

- **Welfare and Institutions Code (WIC) § 17000:** Obligates counties to provide coverage for indigent individuals, and gives counties broad flexibility, subject to certain conditions.
- **WIC § 10000**: Imposes a minimum standard of care, and gives counties discretion re how to meet this standard, subject to certain conditions.

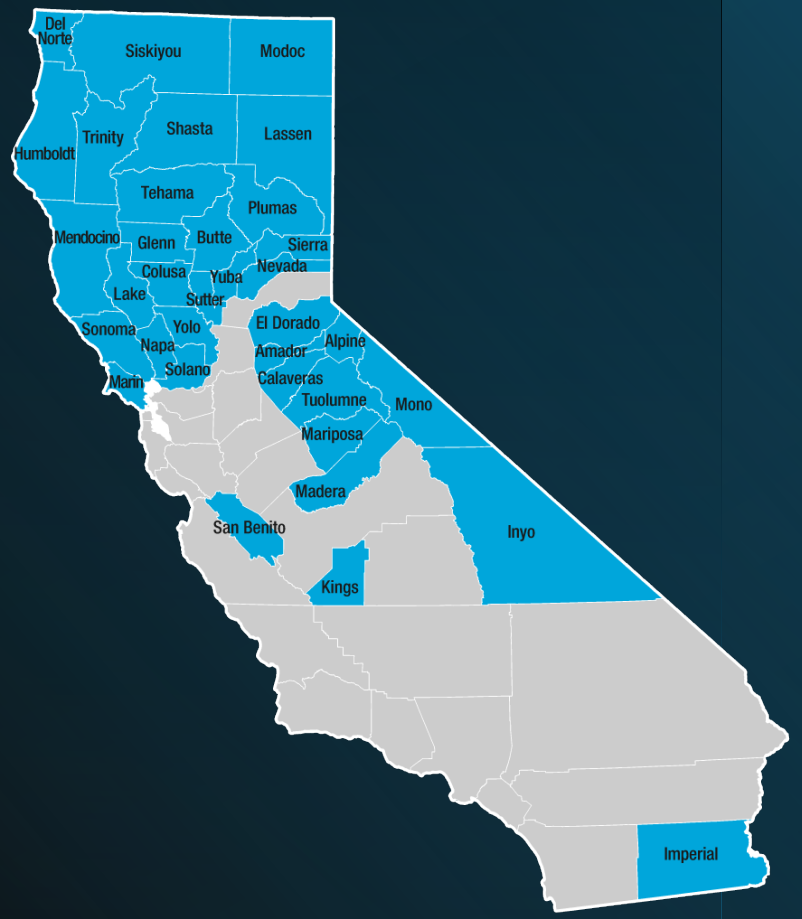
California's Indigent Programs

- **34 counties fulfill statutes via County Medical Services Program (CMSP):** Uniform eligibility criteria & benefits, administered by state, managed by contracted health plans.
- **24 counties fulfill statutes via County Medically Indigent Services Program (CMISP)**: Variety of eligibility criteria & benefits, variety of administration and management models.

See Appendix, slide 22 for more details.

Background: CMISP VS. CMSP

- **CMSP Counties** (in blue)
  - Administered by a state-level program, CMSP.
  - Follows a standardized rules set by CMSP.
  - Offer a uniform set of benefits, in a similar way to Medi-Cal.
  - Only available to counties with a population of less than 300,000
  - Counties contract with agencies (e.g., Anthem Blue Cross) to manage CMSP.
- **CMISP Counties** (in gray), Sacramento County's Program
  - Each county manages its own program independently.
  - Counties set their own rules for eligibility, benefits, and services.
  - Offer a wide range of service delivery strategies, including:
    - Provider counties (owning and operating hospitals/clinics),
    - Payer counties (contracting for services), or
    - Hybrid counties (public clinics and private hospital contracts).



Sacramento's History: Changing Over Time

2010 Affordable Care Act

Before 2009: CMISP

- Avg annual enrollment ~ 50K
- Avg # of Monthly Claims ~10K

February 2009

CMISP services for undocumented cut, due to budget

June 2013

AB 85 required funding formula changes for CMISP- Sacramento County optioned for 60/40 formula resulting in the funding for CMISP being eliminated.

March – June 2015

Board reviews CMISP program to include undocumented population, **creates Healthy Partners** to cover undocumented

January 2016

Healthy Partners program launched including undocumented population with **enrollment cap of 3,000**

January 2018

Healthy Partners Program expanded with enrollment cap to 4,000 and over 65 population, limited to 200

January 2024

Medi-Cal expansion for undocumented, ages 26-49, **membership in Healthy Partners drops to 0** (not needed)

Sacramento County CMISP

➢ Purpose: Fulfills statutory requirements

Benefits and Services

- Medically necessary primary and specialty care
- Emergency and hospital care
- Pharmacy and ancillary services
- Subject to limitations

Eligibility
(rules have changed over time)

- Residents with no other options
- Apply at time of medical service/Rx
- Subject to exclusions
- Up to 12 months
- Cost sharing 138-400% FPL
- No asset test

Enrollment, Cost & Utilization

- Pre-2014: ~50K enrolled, $50M budget*
- Post-2014: zero enrollment

*Partially paid for by state funding

See Appendix, slide 23 for more details.

Sacramento County Healthy Partner's Program

- Purpose: Created by the Board of Supervisors to provide primary and preventive health care for low-income, undocumented immigrants at the County Health Center

Eligibility
(rules have changed over time)

- Undocumented adults
- 18 years and older
- Income at or below 138% FPL
- Alongside restricted scope (emergency) Medi-Cal
- 4,000 program participant cap < 65; 200 program participant cap 65+

Benefits and Services

- Primary, BH, Women's Health Care
- Preventative and chronic conditions
- Lab, radiology and Rx
- Limited specialty
- EXCLUDES emergency and hospital

Enrollment, Cost & Utilization
(pre-2024)

- ~3,000 enrolled clients per year
- ~$2.5M budgeted per year
- ~$300K to $2M spent per year

Impacts on Sacramento County

State and Federal Statutory Change Timelines

December 31, 2025

Covered California Premium Tax Credits Expire

January 1, 2026

Undocumented Enrollment Freeze

Reinstatement of Asset Test

October 1, 2026

- Non-Citizens (i.e., Refugee/Asylee)

January 1, 2027

- Work Requirements*
- Undocumented Monthly Premiums
- Eligibility Redeterminations
- Retroactive Coverage
- Waiting Period

Fiscal Year 2025–2026

Fiscal Year 2026–2027

See Appendix, slide 24-32 for more details.

Impacted Populations

Change	Impacted Groups	Impacted Group Numbers	Effective
Enhanced Premium Tax Credits Ends	Covered California Enrollees	37,000	December 31, 2025
Undocumented Enrollment Freeze	Medi-Cal Adult Undocumented	Unknown, 36,000	January 1, 2026
Reinstatement of Asset Limit	Older Adults with Higher Incomes	Unknown	January 1, 2026
Non-Citizens	Medi-Cal Refugee/Asylee	24,000	October 1, 2026
Work Requirements	Medi-Cal Adult Expansion	174,000	January 1, 2027
Undocumented Monthly Premiums	Medi-Cal Adult Undocumented	36,000	January 1, 2027
Eligibility Redeterminations	Medi-Cal Adult Expansion	174,000	January 1, 2027
Retroactive Coverage	All Medi-Cal Enrollees	Unknown	January 1, 2027
Waiting Period	Medi-Cal Undocumented and Refugee/Asylee	50,000	January 1, 2027

Framing the Path Forward

Framing the Path Forward: Work in Progress

DHS is evaluating impacts and coverage options for Sacramento's safety net programs by

- Developing a “cost modeler” to estimate # of people impacted and potential options, for various coverage scenarios
- Drafting a comprehensive memo for the Board of Supervisors outlining key decision points, scenario options and county budget impact
- **TODAY: Soliciting SCHA’s input ahead of the December 10th Board of Supervisors meeting**

Framing the Path Forward: Policy Decisions

Your initial perspectives on trade offs, recognizing that program adjustments may be necessary, particularly in response to evolving program needs and policy shifts

Limited funding means we can't provide all services to all people – will have find the right balance of:

- Who qualifies for coverage (e.g., income, assets, etc.), exercising County's discretionary authority?
- What services are offered and for how long?

Policy Decisions: Menti Meter

- While we acknowledge that all participants may have interests related to this matter, we recognize these shared interests transparently and proceed with full awareness of potential conflicts. No abstentions are requested, as broad engagement is essential to informed decision-making
- We’ll be using Mentimeter to gather your input during today’s session.

Memory Refresh: CMISP

- Questions #1 and #2 will be about CMISP
- Purpose: Fulfills statutory requirements

Benefits and Services

- Primary and specialty care
- Emergency and hospital care
- Pharmacy and ancillary services
- Subject to limitations

Eligibility
(rules have changed over time)

- Residents with no other options
- Apply at time of medical service/Rx
- Subject to exclusions
- Up to 12 months
- Cost sharing 138-400% FPL
- No asset test

Enrollment, Cost & Utilization

- Pre-2014: ~50K enrolled, $50M budget*
- Post-2014: Zero enrollment

*Partially paid for by state funding

See Appendix, slide 23 for more details.

Memory Refresh: Federal Poverty Level (FPL)

Household Size	138% FPL	200% FPL	300% FPL	400% FPL
1	$20,783	$30,160	$45,240	$60,320
2	$28,208	$40,300	$60,450	$80,600
3	$35,632	$50,440	$75,660	$100,880
4	$43,056	$60,580	$90,870	$121,160
5	$50,481	$70,720	$106,080	$141,440
6	$57,905	$80,860	$121,290	$161,720

Question #1: CMISP Eligibility

FPL Threshold	Rationale	Considerations
138% FPL and below	Prioritizes the most **economically vulnerable**.	May exclude working poor individuals who fall just above the threshold. Could increase reliance on emergency services.
200% FPL and below	Reflects Sacramento County's **2009** CMISP income **threshold.**	Targeting those with the greatest need.
250–300% FPL and below	Aligns with peer counties such as Contra Costa and Alameda which promotes **regional consistency.**	Supports broader access for low-income residents. May reduce disparities across counties and improve continuity of care for mobile populations.
400% FPL and below	**Current policy.** Maximizes access.	Ensures coverage for moderate-income individuals who may not qualify for other programs.

Question #2: CMISP Asset Limit

Option	Rationale	Considerations
No asset limit (Current policy)	Maximum access. Aligns with Alameda County, which does not impose an asset test.	Simplifies eligibility; supports individuals with episodic income or modest emergency reserves
Retain current policy, revisit next Fiscal Year	Allows time for community input and operational planning.	Provides stability while allowing for future refinement
Institute asset limit based on net income	Aligns with Medi-Cal share-of-cost.	New verification processes; individuals with fluctuating income
Institute asset limit considering personal property	In place in Sacramento prior to 2015 Required spend down. Excluded certain personal property (e.g., primary residence, one vehicle).	Reflects prior CMISP policy
Institute asset limit based on both net income and personal property	Provides a comprehensive view of financial resources. Used in CMSP county models.	May reduce access for working poor residents

Memory Refresh: Healthy Partners Program

- Questions #3 and #4 will be about Healthy Partners
- Purpose: Created by Board to provide primary and preventive health care for low-income, undocumented immigrants at Sac County Health Center

Eligibility
(rules have changed over time)

- Undocumented adults
- 18 years and older
- Income at or below 138% FPL
- Alongside restricted scope (emergency) Medi-Cal
- 4,000 program participant cap < 65; 200 program participant cap 65+

Benefits and Services

- Primary, BH, Women's Health Care
- Preventative and chronic conditions
- Lab, radiology and Rx
- Limited specialty
- EXCLUDES emergency and hospital

Enrollment, Cost & Utilization
(pre-2024)

- ~3,000 enrolled clients per year
- ~$2.5M budgeted per year
- ~$300K to $2M spent per year

Question #3: Healthy Partners Enrollment CAP

Option	Rationale	Considerations
Retain Current Cap (4,000)	Current enrollment cap that has been in place since 2015.	May result in waitlists or unmet need
Retain Current Cap/Revisit Mid-Fiscal Year	Allows for responsive adjustments based on community need and program trends	Requires mid-year fiscal review and stakeholder engagement
Retain Current Cap/Revisit Next Fiscal Year	Allows for responsive adjustments based on community need and program trends	Aligns with broader planning and evaluation cycles
Adjust Cap based on CMISP Utilization	Connects program growth to broader system capacity and service coordination	May introduce variability in access; requires clear communication and modeling

Question #4: Healthy Partners Services

Options	Rationale / Data	Considerations
Retain current services that focus on preventative care	Currently Healthy Partners emphasizes early intervention and long-term health outcomes. Aligns with public health goals.	May reduce access to specialty or urgent care.
Adjust services to focus on catastrophic care (i.e., urgent care/follow ups after emergency room visit)	Ensures coverage for life-threatening or high-cost events. Provides a safety net for the most severe needs.	Limits access to routine or chronic care management. May increase downstream costs and worsen health disparities.

Question #5: Duration limits, either program

Option	Rationale / Data	Considerations
12 months (retain current policy)	Supports continuity of care. Used by Alameda and Contra Costa counties. Some CMSP counties (e.g., Yolo, Butte, El Dorado) also use 12-months.	Reduces administrative burden and promotes stability for individuals managing chronic or complex conditions. Encourages long-term engagement with care.
12 months, revisit next Fiscal Year	Maintains current access while allowing time for evaluation and stakeholder input.	Offers predictability with ability to make future adjustments based on community needs.
3, 4, or 6 months (align with other counties)	Some counties (e.g., San Diego, Fresno) use shorter enrollment periods to reassess eligibility more frequently.	May increase administrative workload and disrupt care continuity. Could disproportionately affect individuals with unstable housing or employment.

Question #6: Other Considerations

Do you have anything else you would like DHS to consider when determining coverage or services?

Statutory Requirements

- **Welfare and Institutions Code (WIC) § 17000:** Sets for the obligation to financially support the indigent through General Assistance (GA) and the obligation to provide health care to medically indigent persons. WIC § 17000 establishes the overarching policy of the state mandating that each county provide aid and relief to its indigent population. Counties have broad discretion to set standards for GA but must ensure that medical care is provided to indigents without imposing unrelated financial eligibility criteria. This obligation neither requires a county to satisfy all unmet needs, nor mandates universal health care. A county's discretion to set eligibility standards can only be exercised within fixed boundaries consistent, not in conflict with WIC § 17000, and reasonably necessary to effectuate its purpose.
- **WIC § 10000**: imposes a minimum standard of care, requiring that subsistence medical services be provided promptly and humanely. Counties retain discretion to determine how to meet this standard, but they may not deny subsistence medical care to residents based upon criteria unrelated to individual residents' financial ability to pay all or part of the actual cost of such care. In the case of emergency care, counties must pay for that care even if it is provided out-of-network or out-of-county. Counties must provide "medically necessary care", and such care must be "sufficient to remedy substantial pain and infection."

State Statute Changes: Undocumented

- **Undocumented Enrollment Freeze (Effective January 1, 2026**) - New enrollments into full-scope Medi-Cal will be frozen for adults aged 19 and older who lack permanent legal status. Approximately 1.6 million current enrollees will retain coverage if they maintain eligibility. Pregnant individuals and those within 12 months postpartum are exempt from the freeze. Individuals who lose coverage may re-enroll within 3 months of disenrollment without losing eligibility.
- **Monthly Premiums for Undocumented Adults (Effective January 1, 2027);** A $30 monthly premium will be required for undocumented adults aged 19–59 with unsatisfactory immigration status. Individuals who do not pay will be disenrolled but may re-enroll within 3 months by repaying the balance.

State Statute Changes: Medi-Cal Eligibility

- **Reinstatement of the Asset Limit (Effective January 1, 2026) -** The asset limit for non-MAGI Medi-Cal programs will be reinstated to 2022 levels: $130,000 for an individual and +$65,000 for each additional household member. In 2022, California raised the asset limit to these higher thresholds. By 2024, the asset test was eliminated entirely to expand access and reduce administrative burden.

Federal Statute Changes: Undocumented /Legal Immigrants

- **Five-Year Waiting Period for Immigrants -** Immigrants with "qualified" status must wait five years after obtaining that status before enrolling in Medicaid. Applies to qualified non-citizens, including:
  - Lawful Permanent Residents (green card holders)
  - Parolees (for more than one year)
  - Battered spouses, children, and parents
  - Victims of trafficking
  - Certain humanitarian categories
  - Exemptions: States may waive the five-year wait for:
    - Children
    - Pregnant individuals
- **Narrowing of Eligible Noncitizen Categories -** Limits Medicaid eligibility to:
  - Lawful Permanent Residents
  - Certain nationals from Cuba, Haiti, Micronesia, Marshall Islands, and Palau
  - Refugees, asylees, and other humanitarian groups currently eligible under federal law would no longer qualify under the new rules.

Federal Statute Changes: Medicaid Eligibility

- **Retroactive Coverage (Effective January 1, 2027) -** Reduces retroactive Medicaid coverage from 3 months to:
  - 1 month for ACA expansion group enrollees
  - 2 months for all other Medicaid enrollees
  - Estimated impact: 86,000 Californians could be affected, according to DHCS.
- **Redetermination Frequency (Effective January 1, 2027) -** Requires semiannual eligibility checks (every 6 months) for adult Medicaid expansion beneficiaries, instead of annual reviews.
  - Estimated impact: 400,000 Californians may lose coverage due to increased administrative churn, per DHCS.
- **Cost Sharing (Effective October 1, 2028) -** Requires states to impose cost sharing up to $35 per service for adults in the expansion group (incomes 100%–138% FPL).
  - Exemptions: Services provided by: Federally Qualified Health Centers (FQHCs), Behavioral Health Clinics and Rural Health Clinics

Federal Statute Changes: ACA Premium Tax Credits

- **Enhanced Premium Tax Credits End (Effective December 31, 2025)** - In 2021, the federal government increased financial help for some people for Covered California Through Enhanced Premium Tax Credits. Premium tax credits help lower insurance costs for eligible individuals and increased healthcare access. Credits are based on income and family size, making healthcare more affordable. The increased help will end on December 31, 2025.

Federal Statute Changes: Work Requirements

- **Monthly Compliance Requirement (Ages 19–64) -** Beneficiaries must demonstrate at least 80 hours/month of one or more of the following:
  - Employment
  - Community service
  - Participation in a work program
  - Enrollment in an educational program (at least half-time)
  - A combination of the above
- **Exemptions -** Certain groups are excluded from the work requirement:
  - Individuals already meeting work requirements under TANF or SNAP
  - Pregnant individuals
  - Parents/caregivers of children under 13 or individuals with disabilities
  - People with disabilities, including those with substance use disorders
  - Incarcerated individuals
  - *States may choose not to require verification of exemptions.*
- **Good Cause Exceptions -** States may temporarily exempt individuals facing:
  - Hospitalization or serious illness
  - Federally declared disasters
  - High local unemployment or other short-term hardships
- **Verification Requirements**
  - Applicants: Must verify compliance for at least 1 month (up to 3) before applying.
  - Current enrollees: Must verify compliance at least once between eligibility checks.
  - Noncompliance: Triggers a notice with 30 days to prove compliance or exemption. Coverage continues during this period. Failure to comply results in disenrollment.
- **Implementation Timeline - Begins January 1, 2027**
  - States may request extensions if they show progress toward implementation.
  - All exemptions and delays expire December 31, 2028.
- **California Impact -** According to the California Department of Health Care Services (DHCS), an estimated 3 million Medi-Cal members could lose coverage due to these work requirements.

Potential Federal Regulatory Changes: FQHCs

- **Redefinition of "Federal Public Benefits" -** The U.S. Department of Health and Human Services (HHS) has issued a proposed rule that revises the interpretation of "Federal public benefit" under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). This rescinds the 1998 interpretation and reclassifies programs like community health centers (FQHCs) as federal public benefits.
  - Immigrants with unsatisfactory immigration status may be restricted from accessing services at FQHCs and other programs newly classified as federal public benefits.
  - The rule applies to "qualified non-citizens" and may limit access for undocumented individuals unless they fall under specific exemptions.
  - PRWORA allows narrow exemptions, including:
    - Emergency services
    - Services necessary to protect life or safety regardless of immigration status or ability to pay.

*The PRWORA statute defines "Federal public benefit" as any grant, contract, loan, professional license, or commercial license provided by an agency of the US or by appropriated funds of the US. It also includes any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by an agency of the US or by appropriated funds of the US.

Existing Programs for Undocumented Immigrants

- **Medi-Cal for Emergency Services/Pregnancy Services:** Medi-Cal covers individuals with restricted scope Medi-Cal aid codes who are eligible only for emergency and pregnancy-related services, including long-term care when needed. Certain groups, such as young adults (ages 21-25), trafficking and crime victims, and individuals under Senate Bill 75, may have additional coverage options.
- **Hospital/Federally Qualified Health Center (FQHC) Coverage:** As set forth in the Emergency Medical Treatment and Active Labor Act (EMTALA) hospitals that participate in Medicare are responsible to provide care to all people, including undocumented immigrants. Undocumented immigrants use of EMTALA-related services is often covered via emergency Medicaid. Additionally, hospitals that received funding under the Hill-Burton Act must provide free or reduced-cost care to eligible patients, regardless of immigration status. Finally, FQHCs receive federal funding to provide primary care services to all individuals, including undocumented immigrants, at reduced costs. HHS issued a notice for public comment in which the interpretation of “federal benefits” would restrict access to certain federal benefits based on immigration status including FQHC coverage.