Date of Hearing: August 20, 2025

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
SB 324 (Menjivar) – As Amended July 3, 2025

Policy Committee: Health Vote: 15 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires a Medi-Cal managed care plan to contract with community providers for delivery of enhanced care management (ECM) and Community Supports, and requires the Department of Health Care Services (DHCS) to take actions to support this requirement.

Specifically, this bill:

1) Requires a Medi-Cal managed care plan:

    a) Contract with a community provider that can demonstrate it is capable of providing access and meeting Medi-Cal quality requirements for delivery of ECM and Community Supports services. Allows the Medi-Cal managed care plan to consider its network needs and a community provider's availability and experience in deciding which providers to contract with. Clarifies that this provision does not limit a Medi-Cal managed care plan's ability to contract with other providers for the same ECM population of focus, particularly local entities that provide services to Medi-Cal beneficiaries.

    b) If a contracted community provider submits a request for approval of ECM or Community Supports services, assign the member to the ECM provider if the provider can meet the needs of the member.

2) Requires DHCS to require a Medi-Cal managed care plan to set goals every other year to increase the contracting and utilization of community providers and local entities, and specifies goals must be based on data and established in consultation with DHCS.

3) Requires DHCS, in consultation with Medi-Cal managed care plans, ECM providers, and other appropriate stakeholders:

    a) Standardize contracting templates to facilitate inclusion of a community provider with limited prior experience in contracting with a Medi-Cal managed care plan or a plan's contracted providers.

    b) Develop guidance to allow a community provider to act as a primary subcontractor with a Medi-Cal managed care plan and to subcontract with other community providers as a third-tier subcontractor. Provides that a community provider acting as a primary subcontractor may provide administrative support to third-tier subcontractors, including billing, training, coordination, and other ancillary support to provide Medi-Cal services.

4) Defines "community provider" as a locally available, community-based nonprofit organization that has direct experience with providing services to Medi-Cal beneficiaries in the county in which the organization operates. Specifies a community provider offers health-related social needs services that are covered under Medi-Cal, and is authorized, rather than required, to provide additional Medi-Cal services.

5) Defines "local entity" as a locally available health, behavioral health, or human services entity, including, but not limited to, an agency, department, or independent commission, or a locally available designated public hospital and its affiliated entities, that has direct experience with providing services to Medi-Cal beneficiaries in the county in which the entity or hospital operates.

6) If a Medi-Cal managed care plan elects to cover a community support, requires the managed care plan contract with community providers that can demonstrate that they are capable of providing access and meeting quality requirements in accordance with Medi-Cal guidelines. Clarifies that this requirement does not limit a Medi-Cal managed care plan's ability to contract with other providers for the same Community Supports.

7) For purposes of enforcing item 6, above, requires DHCS require a Medi-Cal managed care plan set goals every other year in consultation with DHCS and based on the information obtained by DHCS for the level of contracting and utilization of community providers and local entities.

8) Requires DHCS develop, in consultation with Medi-Cal managed care plans, providers of Community Supports, and other appropriate stakeholders, the following: a monitoring plan and reporting templates, templates to be used by a Medi-Cal managed care plan or the plan's contracted providers to facilitate inclusion of community providers with limited prior experience, and guidance to allow a community provider to act as a primary subcontractor with a Medi-Cal managed care plan and to subcontract with other community providers as a third-tier subcontractor. The guidance must include how to resolve concerns when using a primary subcontractor that contracts with third-tier subcontractors.

9) Requires DHCS issue an existing public report quarterly, instead of annually, and specifies the report must include information, stratified by demographics, on provider types delivering ECM and Community Supports services.

10) Requires the Medi-Cal managed care plan provider directory highlight community providers.

FISCAL EFFECT:

DHCS will require six permanent, full-time positions at a cost of $1.03 million in fiscal year (FY) 2026-27 and $972,000 annually in FY 2027-28 and ongoing (50% General Fund, 50% federal funds). DHCS notes these cost estimates will need to be adjusted once salaries for the new fiscal year are finalized.

Potential additional costs of an unknown amount due to possible increases in capitated rates for Medi-Cal managed care plans to account for increased administrative costs. DHCS notes such costs might not fully qualify for federal dollars if the costs do not meet federal requirements.

COMMENTS:

1) **Purpose**. This bill is sponsored by the Medi-Cal CBO Coalition. According to the author:

> A key concept in the development of the CalAIM ECM and Community Supports initiatives was the vision that care should be delivered in the community by the community, breaking down the traditional walls of health care. We know that including trusted messengers from local community-based organizations is a crucial piece of this vision. However,…many of the ECM and Community Supports services are not being provided by community-based providers. Community providers who offer local housing, nutrition, and social supports that Medi-Cal enrollees need to get healthy are not being prioritized by Medi-Cal plans. This bill aims to standardize plan paperwork requirements, ensure that plan rates include all of the costs of providing the services, and put community providers on a level playing field with large for-profit providers who are not based in the community and at times out of state. This will allow those providers who are most effective at addressing the social drivers of health to serve Medi-Cal enrollees with the highest needs.

2) **Background**. ***CalAIM***. California Advancing and Innovating Medi-Cal (CalAIM), is a collection of major initiatives spearheaded by DHCS to improve Medi-Cal, including addressing social drivers of health, reducing program complexity and increasing flexibility, and modernizing payment structures to promote better outcomes. CalAIM went into effect January 1, 2022 and continues through December 31, 2026, although Community Supports may continue beyond 2026, and ECM is now a permanent Medi-Cal benefit.

   Community Supports. Community Supports is a component of CalAIM that addresses social drivers of health. Community Supports are services that can be provided by a Medi-Cal managed care plan as cost-effective alternatives to traditional medical services or settings. DHCS has a list of 14 Community Supports, based on experience in prior demonstration programs to address health-related social needs. These supports are designed to provide flexibility to address specific needs of complex populations. Examples of Community Supports are home modifications, adaptations, and remediation, and housing support services.

   ECM. ECM is a statewide Medi-Cal benefit available through Medi-Cal plans to provide care management to Medi-Cal enrollees with the greatest needs, known to ECM as "Populations of Focus." An ECM enrollee has a single lead care manager who coordinates all of the enrollee's health and health-related care, including physical, mental, and dental care, and social services. The lead care manager role is designed to "meet enrollees where they are" to meet their needs, build a trusting relationship, and provide intensive coordination of health and health-related services. In the third quarter of 2024, 143,000 Medi-Cal enrollees received ECM. According to a recent report by the Legislative Analyst's Office, DHCS estimated that between 3% and 5% of all Medi-Cal plan members statewide are potentially eligible for ECM. However, there is significant variation in utilization by plan and county. Some plans and counties have utilization under 0.5%, while a few are in the 3% to 5% range.

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