

**MINUTES**  
**CMSP GOVERNING BOARD**  
Thursday, September 24, 2020

Via Zoom

**MEMBERS PRESENT**

Patrick Blacklock, County Administrator, Yolo County  
Sanja Bugay, Health and Human Services Director, Kings County  
Birgitta Corsello, County Administrator, Solano County  
Richard Egan, County Administrator, Lassen County  
Elizabeth Kelly, Health and Human Services Director, Colusa County  
Leonard Moty, County Supervisor, Shasta County  
Jennifer Vasquez, Health and Human Services Director, Yuba County  
Brad Wagenknecht, County Supervisor, Napa County  
Christine Zoppi, Health and Human Services Director, Glenn County  
Brendan McCarthy, Assistant Secretary, California Health and Human Services Agency

**MEMBERS ABSENT**

Richard Forster, County Supervisor, Amador County

**Welcoming Remarks and Request for Public Comments**

Brad Wagenknecht, Board Chair, opened the meeting and asked Board members to introduce themselves. The members listed above announced their participation at the meeting except for Brendan McCarthy who had technical difficulty. Mr. Wagenknecht asked if the Board had received any public comments via email submissions. Meegan Forrest, Accounting Manager, reported that fifteen (15) letters had been received from various medical professionals (see attached). Mr. Wagenknecht invited a representative of the chiropractors attending the meeting to provide public comment.

Dr. Srikanth Kolli, Doctor of Chiropractic Medicine, was invited to provide comments to the Governing Board. Dr. Kolli spoke to the importance of including chiropractic care services in CMSP and the importance of making it possible for chiropractic service providers to participate in the Governing Board's educational loan forgiveness program.

**Agenda and Correspondence and Consent Calendar**

Mr. Wagenknecht invited a motion to approve the Board meeting agenda and the Consent Calendar.

ACTION MSC: Governing Board approve the September 24, 2020 Board agenda and the Consent Calendar.

APPROVED

Votes:

Aye 8

Nay 0

Abstain 1 (Egan)

### **Report on Closed Session**

Cathy Salenko, CMSP General Counsel, reported that the Governing Board met in Closed Session and provided direction to the Administrative Officer concerning contract terms pertaining to negotiations with specified health care providers, and took one action that will be considered later during today's meeting and one action item that will be addressed at the next Board meeting. The Board also considered the Administrative Officer's performance evaluation and took no action.

### **Report from Legislative Representative**

Karen Lange, of Shaw Yoder Antwih Shmelzer & Lange, reported that the end of the 2020 legislative session was pretty messy due to delays resulting from Senate staff testing positive for COVID-19; and, due to various end of session bills that revisited the adopted state budget. Many measures that seemed likely didn't get passed (i.e. Prop 63 overhaul, housing package) and numerous bills did not get back to their houses of origin. And, finally, one Senate Republican member who was exposed to COVID exposed other colleagues, which forced a Zoom session that made dynamics even more complicated.

The myriad disasters from the pandemic to the most recent fires have delayed the Governor's action on various bills. The Governor's final actions on legislation are expected shortly.

Ms. Lange advised that there was a \$750 million backfill for counties for lost sales tax revenue under Realignment, which is flowing to counties in increments based upon counties meeting specified conditions for receipt of the funds. There is an additional \$250 million available if the federal government does another package, which now appears unlikely.

Finally, at the end of session, a key juvenile justice realignment proposal, SB 823, became a problem for counties because final language agreed to by counties did not align with what was published in the final version of the bill. As a consequence many counties have been sending in letters requesting the Governor's veto. The Governor has not taken action on the bill yet and counties continue to be encouraged by their legislative representatives to ask the Governor to commit to fixing the various problems, if he signs it.

Paul Yoder, of Shaw Yoder Antwih Shmelzer & Lange, spoke to two ballot initiatives. The Public Policy Institute of California (PPIC) released polling to date on Proposition 15, the so-called split roll tax initiative, is now showing 51% approval. Ads in favor of the proposition have started to run on TV. Undecided voters are apparently down to only 9%, which means most people are aware of the initiative. Proposition 20 would revisit Propositions 47 and 57, enacted under former Governor Jerry Brown, who reportedly has contributed over \$1 million of his own money to defeat the proposition.

In other news, Mr. Yoder reported that state expenses for Medi-Cal and other programs are coming in lower than expected and lower than previous recessions, and this is a positive outcome for the State Budget. Looking forward, the State has an estimated amount of \$20 billion in available borrowing, but the coming months will provide more information about the need for such borrowing. One recent estimate indicates the State could use all of this borrowing and face a deficit of \$8 to \$10 billion in FY 2021-22.

### **Operation Access Update**

Jason Beers, Executive Director of Operation Access, provided a briefing on the status of Operation Access' efforts to expand access to specialty care in CMSP counties. Attached is a copy of Mr. Beers' presentation.

Board Member Richard Egan left the meeting.

### **Conflict of Interest Code**

Ms. Salenko reported that the Political Reform Act requires every multi-county agency to review its Conflict of Interest Code biennially and to submit a notice to its code reviewing body [the Fair Political Practices Commission (FPPC) in the case of the Governing Board] that specifies if the code is accurate, or if the code must be amended. The Governing Board was asked to review and consider the proposed CMSP Governing Board Conflict of Interest Code, which is unchanged from the existing code.

ACTION MSC:           Governing Board approve the proposed Conflict of Interest Code, which is unchanged from the current code.

APPROVED           Votes:           Aye 8  
  Nay 0

### **Board Member Terms and Elections**

Kari Brownstein, Administrative Officer, reported that the terms of the following Governing Board members end December 31, 2020:

- Richard Forster, Supervisor, Amador County
- Patrick Blacklock, Administrative Officer, Yolo County
- Christine Zoppi, Health and Human Services Director, Glenn County
- Elizabeth Kelly, Health and Human Services Director, Colusa County

Ms. Brownstein asked the Board to authorize elections for these positions.

ACTION MSC:           Governing Board authorize that elections for these Board Member positions be conducted.

APPROVED           Votes:           Aye 8

Nay 0

**Proposed Revisions to Rates for Health Care Services Policy**

Ms. Brownstein stated that the Governing Board's current Rates for Health Care Services Policy, amended and adopted December 14, 2017, presents the methodology for making payments to contracting and non-contracting hospital and non-hospital providers. Among other matters, this policy provides specified adjustments for inpatient acute care hospital rates effective through 2020.

Ms. Brownstein stated that in order for CMSP rates for inpatient acute care hospital services to keep pace with inflation, it is proposed adjustments to these rates for contracting and non-contracting hospital providers, consistent with prior year adjustments, are needed. Toward this end, Ms. Brownstein presented a proposal for an annual two percent (2%) rate increase for inpatient acute care hospital services for contracting and non-contracting providers for each of the following calendar years: 2021, 2022, and 2023.

Separately, Ms. Brownstein presented clarifications to the existing policy that the CMSP rates for outpatient services provided by contracting physicians and CMSP rates for services provided by participating Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Tribal Health Program (THP) are the rates for all CMSP benefit programs and pilot projects. This would include the CMSP standard benefit program, Path to Health and the new Connect to Care benefit program. The attached revised Rates for Health Care Services Policy proposes these changes (see attached).

ACTION MSC:      Governing Board approve the proposed revised Rates for Health Care Services Policy that would increase rates for inpatient acute care hospital services for contracting and non-contracting providers and make other clarifying changes pertaining to rates paid for contracting physicians and FQHC, RHC and THP providers.

APPROVED          Votes:          Aye 8  
Nay 0

**Provider Amendment for Member Enrollment in CMSP Benefit Programs**

Ms. Brownstein provided background information on the new Connect to Care benefit program. In April 2019 the Board approved development and implementation of the program, which is intended to extend primary care services to residents of CMSP counties who are uninsured and otherwise eligible for CMSP but have not applied for CMSP. The income range for the new program is incomes over 138% FPL and up to 300% FPL, and benefit coverage is the same set of primary care services available to CMSP members. The term of enrollment is up to six months, which is the same as the Path to Health Pilot Project.

Ms. Brownstein noted that applicants will submit applications for Connect to Care at participating Community Health Centers through a new, on-line eligibility/enrollment system. These enrollment sites will work with applicants to gather and submit necessary verifications (such a driver's license and income documents), and Governing Board eligibility staff in the Board's Sacramento office will process and review all applications and make eligibility determinations. The Governing Board has contracted with Alluma for development of the new eligibility/enrollment system and Connect to Care is scheduled to go live December 1, 2020. Social services departments within the 35 CMSP counties will continue to enroll clients in the standard CMSP program.

For the Governing Board's consideration, Ms. Brownstein presented a proposed DRAFT Amendment to the CMSP Participating Physician, Physician Group and Community Health Center Agreement to authorize Community Health Centers to serve as CMSP Enrollment Providers for CMSP benefit programs, including Connect to Care.

ACTION MSC:           Governing Board approve the proposed Amendment to the CMSP Participating Physician, Physician Group and Community Health Center Agreement to authorize Community Health Centers to serve as CMSP Enrollment Providers for CMSP benefit programs, including Connect to Care.

APPROVED               Votes:           Aye 8  
                                      Nay 0

### **Proposed Marketing Request for Proposals**

Alison Kellen, Program Manager, stated that the Governing Board, in 2018, approved the hiring of a contractor to provide marketing services in support of the Path to Health Pilot Project, including developing branding for and awareness of Path to Health and updating the CMSP brand and website. JP Marketing was selected through an Request for Proposals (RFP) process.

Ms. Kellen presented a new RFP for marketing services for consideration by the Governing Board. The proposed RFP seeks the services of qualified California-based marketing firms to support the new Connect to Care benefit program and provide an overall marketing approach for the combined set of programs, including CMSP, Path to Health and Connect to Care. Discussion among Board members ensued.

ACTION MSC:           Governing Board approve the Marketing RFP and authorize the Administrative Officer to proceed with its release.

APPROVED               Votes:           Aye 8  
                                      Nay 0

## **Proposed Services Agreements**

Ms. Brownstein made a presentation to the Governing Board on three different proposed Services Agreements.

### JP Marketing: Amendment to Services Agreement

JP Marketing has been the Governing Board's marketing vendor since the Fall of 2018. Among its duties, JP Marketing has raised awareness of the Path to Health Pilot Project and updated branding and websites for CMSP and Path to Health. Most recently, JP Marketing developed a logo for the new Connect to Care program launching in December 2020 and is working to develop the Connect to Care website.

The current agreement term with JP Marketing ends October 31, 2020. The proposed no-cost Amendment would extend the term of the Agreement to December 31, 2020. This extension will assure that marketing services continue uninterrupted as the Board conducts a new Request for Proposal process for another marketing vendor. The selected marketing firm's new agreement is anticipated to start January 1, 2021. Among other potential vendors, JP Marketing may apply to continue serving as the Board's marketing vendor.

### Shaw, Yoder, Antwih, Schmelzer & Lange: Amendment to Services Agreement

The Governing Board's Services Agreement with Shaw, Yoder, Antwih, Schmelzer & Lange for legislative representation services ends December 31, 2020. The proposed Amendment with the firm would continue the provision of services for two years, through December 31, 2022, with a three percent increase in the monthly fee in year one and year two.

### eSecurity Solutions: Services Agreement

Prior to the launch of Path to Health in February 2019, eSecurity Solutions was the vendor selected to carry out a series of penetration tests to ensure the security of the Path to Health website, Path to Health enrollment system and the CMSP website.

eSecurity Solutions has again been selected as the vendor to ensure the security of the Connect to Care website and Connect to Care enrollment system. Attached is the proposed Agreement with eSecurity Solutions to carry out these tasks for a total cost of \$3,500.

Governing Board Chair Brad Wagenknecht asked for a motion to approve the three services agreements.

**ACTION MSC:** Governing Board approve the proposed amendments to the Services Agreements with JP Marketing and Shaw, Yoder,

Antwih, Schmelzer & Lange; and approve the proposed Services Agreement with eSecurity Solutions.

APPROVED           Votes:           Aye 8  
  Nay 0

### **Local Indigent Care Needs (LICN) Grant Program**

Anna Allard, Grants Manager, reported that Round 1 LICN Planning Project grantees are operating under three different start dates due to the COVID-19 pandemic. In light of this, Ms. Allard presented a proposal that multiple LICN Implementation Grant RFPs be released for these Round 1 Planning Grantees only. This approach would allow all Round 1 Planning Grantees the appropriate amount of time to complete their planning projects before submitting an Implementation Grant proposal. It would also assure that the already approved Planning Project grantees have the opportunity to obtain Implementation Grant funding before grant applications are considered from counties that have not received Planning Grants.

Ms. Allard noted that if all 20 LICN Planning Project grantees are awarded Implementation Grants in a future funding round, in combination with Implementation and Planning Grant amounts already approved in Round 1, total LICN grant awards would be over \$45 million. The Board’s approved budget for the LICN program is \$45 million.

Several Planning Project grantees are or will soon be ready to apply for an Implementation Grant. To accommodate this need, CMSP staff has updated the LICN Implementation Grant RFP and created a more streamlined submission process.

Ms. Allard stated that the proposed RFP will be released in October 2020 (Fall 2020 Round) and again in the Spring of 2021 with eligibility limited to Planning Project Grantees that received funding in Round 1. For Planning Project Grantees that started in October 2020, another release would be planned in the Summer of 2021 if needed. Other rounds of funding for Implementation Grants would depend on the Board approving additional funding for the LICN program.

**ACTION MSC:**           Governing Board approve the proposed LICN Grant Program RFP, which would be limited to Round 1 LICN Planning Project Grantees, and the proposed release timelines.

APPROVED           Votes:           Aye 8  
  Nay 0

### **COVID 19**

Ms. Brownstein reported that the COVID-19 Emergency Response Grant (CERG)

program designated \$10,145,976 to provide emergency COVID-19 funding for CMSP counties to carry out a variety of emergency response and remediation activities. To date, 32 out of 35 counties have applied for the CERG program. A brief description of the counties' CERG requests are listed below:

- 21 counties plan to purchase and distribute PPE.
- 25 counties are committed to providing supportive quarantine services to underserved individuals in their communities.
- 27 counties plan to utilize CERG funds to cover the cost of public employees needed for emergency response.
- 11 counties will be partnering with local non-profit agencies to meet their project goals.
- 13 counties plan to pay for outreach materials regarding COVID-19 resources in their area.

With regard to the COVID-19 Clinic Bridge Loan Program, Ms. Brownstein reported that no applications for Bridge Loans were received.

With regard to CMSP benefits and enrollment impacted by COVID-19, Ms. Brownstein stated that CMSP will be following the approach taken by Medi-Cal regarding the treatment of \$300 in additional lost wages income. CMSP will not treat this as income or an asset in determining eligibility, and an ACL is under development to address this matter.

### **Wellness and Prevention Grants Update**

Laura Moyer, Grants Analyst, stated that this CMSP grant program started in 2017 with 31 projects. Fifteen (15) completed their projects in December 2019 and fourteen (14) will be completing their projects by December 2020. Two projects terminated early. Ms. Moyer provided a report on the activities of the 15 completed projects.

### **Connect to Care Update**

Ms. Brownstein introduced Karalyn Foster, who has joined the CMSP staff as an Eligibility Analyst. Ms. Foster will be carrying out various eligibility functions for Connect to Care and CMSP generally.

Ms. Brownstein also reported that work is actively underway with Alluma to develop the Connect to Care enrollment and eligibility systems, and efforts are underway with both AMM and MedImpact to assure effective implementation of the new benefit program.

### **Path to Health Pilot Project Update**

Ms. Kellen stated that Path to Health enrollment continues to grow. Presently there are 7,740 Path to Health enrollees. One clinic has exceeded its enrollment cap, and CMSP staff are working to increase the cap for this clinic. In late October another invitation to



participate in Path to Health will be sent out to encourage additional community health centers to participate. Operation Access, which has received grant funding from the Governing Board to expand access to specialty care services in a variety of counties, has additionally partnered with CMSP to encourage more clinics to participate in Path to Health, particularly in the Central Valley.

## CMSP Financial Reports

### CMSP Balance Sheet

Meegan Forrest, Accounting Manager, presented financial statements for July and August 2020. The CMSP Balance Sheet shows:

ITEM	July	August
Total CMSP Funds	\$402,781,923	\$400,383,368
Total Assets	\$403,335,634	\$401,490,791
Total Liabilities and Equity	\$403,335,634	\$401,409,791

### FY 2020-21 Program Budget Expenditures Year-to-Date

Ms. Forrest presented a report on year-to-date actual versus budgeted Program expenditures. As of July 30, 2020 there were expenditures of \$1,837,416 (accrual basis). As of August 31, 2020 there were expenditures of \$4,190,177 (accrual basis). The approved Program Budget for FY 20120-21 is \$41,497,000.

### FY 2020-21 Administrative Office Budget Expenditures Year-to-Date

Ms. Forrest presented a report on year-to-date actual versus budgeted Administrative Office expenditures. As of July 30, 2020 there were expenditures of \$211,490 (accrual basis). As of August 31, 2020 there were expenditures of \$381,640 (accrual basis). The approved Administrative Office Budget for FY 2020-21 is \$5,447,000.

## Governing Board Meeting Date Options for 2021

To facilitate calendaring for Board members, Ms. Brownstein presented two options for Governing Board Meetings in 2021:

Option A:	Option B:
January 28	February 25
March 25	April 22
May 27	June 24
July 22	August 26
September 23	October 28
December 16	December 16

Discussion among Board members ensued. There were some concerns about January, June and the end of October. Ms. Brownstein stated she will bring back a proposed 2021 meeting schedule at the next meeting.

### **Public Comments**

Mr. Wagenknecht asked for public comments and there was one additional public comment. Ms. Forrest read a comment from David Kane, Western Center on Law and Poverty (see attached).

The next meeting is December 17, 2020.

### **Adjournment**

The meeting adjourned at 12:42 pm.



Dear CMSP board members

My name is Dr. Bahareh Daneshbod, D.C. and I am one of the 6 Doctors of Chiropractic serving the patients at Ampla Health which is a Federally Qualified Community Health Center. I currently work at its Yuba City branch, 40 hours per week, and on an average I see 100 patients per week including pediatrics, and pregnant patients.

Via this letter I would like to inform you of the reasons why I strongly believe that Chiropractic Medicine and Doctors of Chiropractic should be of no exception when it comes to being able to receive the CMSP Loan Repayment Program.

As Doctors, just like any other type of physician working in a non-profit setting at a community health center, my colleagues and I dedicate our daily lives serving the underserved and needy sects of the community. Vast majority of our patients are farm workers, Cannery workers, truck drivers, caregivers, and housekeepers. Taking into consideration that many of our patients have history of opioid addiction, have addictive personalities, have certain chronic diseases or conditions that disable them from being able to take certain pain medications, or simply do not wish to choose the invasive method of treatment as their initial treatment option, Chiropractic Medicine has made a huge difference in these patients' lives as an alternative pain management method of treatment.

My colleagues and I, receive daily referrals from the patients' primary care providers to address patients' spinal joint problems, as we are specialists who evaluate and naturally treat patients' spines. Our patient care, including the duration of the current pandemics, has included regular patient flow plus the existence of emergency walk-ins on daily basis. During the pandemic, being an essential worker, every day, we present to work at our designated clinics, passionate about visiting our patients and reducing their pain, having been unable to have virtual visits with the patients. I would also like to mention that as Doctors of Chiropractic, we always have the option of having a private practice with many more financial privileges, nonetheless, as the lifelong goal & passion of myself, my colleagues, and any other doctor who has chosen to work at a nonprofit setting as such has been to be at service to the underserved, we work at this setting.

Having been a doctor who has attended Medical School prior to changing my field to Chiropractic (having been able to compare the curriculums), I can assure you that the education of a doctor of Chiropractic, and the effort put in becoming a doctor is no less than that of a doctor of Medicine.

At Ampla Health, as a team with the other providers, the MDS, NP-Cs, and the PAs, our goal as Doctors of Chiropractic has been and always will be to present the best of patient care which is the result of an amazing collaborative work between us all providers.

As I believe that Ampla Health and any other Federally Qualified Health Center which has included Chiropractic care as a part of their organization would be offering the most excellent and thorough patient care as far as pain management, I would highly believe that Doctors of Chiropractic should be considered/included in any county related benefits which would be available to the other providers. Via this letter I would like the most respected board members to note that a Doctor of Chiropractic is of no difference in the eyes of their patients, when it comes to care, than a patient's other providers. In other words, patients value their doctor of Chiropractic no less than their other providers when it comes to satisfaction with care, patient education, or their gain from a treatment.

On average, Chiropractic School would cost \$356,000 based on the data collected from my colleagues and myself, the reason being that all Chiropractic Schools are private at this time. Our financial loan repayment obligations are of no difference than that of the other types of doctors and specialists. Thus, we are reaching out to you as a request of considering us as a part of the collaborative team of providers whom you have been assisting with their loan repayment.

My final word would be that as a sworn doctor whose mission is to help serve her patients for life, I would hope that the county and the CMSP members realize the value of me and my colleagues' work & our dedication as a part of the greater patient care here at Ampla Health.

I thank you very much for your care & consideration

Sincerely;

**Dr. Bahareh Daneshbod, D.C.**  
**Doctor of Chiropractic at Ampla Health, Yuba City Medical Center**  
**Tel: (530)673-9420, Ext: 1322, Fax: (530)673-9451**  
**Email: [bdaneshbod@amplahealth.org](mailto:bdaneshbod@amplahealth.org)**

Esteemed members of the CMSP board,

I am Dr. Alan Riley DC, ACN and I currently work for Ampla Health as a part of the Oroville, Magalia and Los Molinos care teams. Ampla Health is a 501(c)3 network of community-based Federally Qualified Health Centers, offering comprehensive medical, dental, behavioral health, and numerous specialties in Butte, Colusa, Glenn, Sutter, Tehama, and Yuba counties. Chiropractic was added as a pilot in 2017 through a third party. We exceeded expectations so much that Ampla Health elected to hire us as direct staff. In 2019 we averaged 5500 patients among each of the four full time providers and are still growing. The initial reason for adding chiropractic care was to provide an alternative form of pain relief/management to further mitigate the opioid epidemic. However, we continue to educate our employers and the community with our knowledge in nutrition, physical therapies, ergonomics, and general well-being.

There is vast amounts of research that shows chiropractic as the leading care for headaches, neck and back pain management, as well as numerous injuries to the extremities for its effectiveness in resolving or managing these conditions with little to no side effects, particularly when compared to the medical alternative. The majority of our patients choose chiropractic because they do not want to become another addict, undergo surgery, or simply not add another pill and instead they want to treat the cause of their pain or dysfunction. Chiropractic is included in many of our suboxone recovery programs to lessen the effects of withdrawal, treat the pain that started their route to addiction, and decreasing their search to alter their reality by improving their general well-being.

Our patients clean our buildings, launder our sheets, grow, harvest, prep and serve our food, and take care of our friends and family all in addition to their own. They are vital cog in our economic machine and they do this with the drive to survive. We help them to thrive by allowing them to work more efficiently at significantly less cost. That money saved can be used to enhance their lives and therefore that vital cog. When you ask any of our patients, you will hear how chiropractic care has truly changed their lives.

The County Medical Services Program (CMSP) Loan Repayment Program is designed to increase the number of primary care physicians, dentists, physician assistants, and nurse practitioners practicing in federally designated California Health Professional Shortage Areas (HPSA). I am reaching out to encourage you to include chiropractors into this program since we are currently not covered under your list nor any other California Loan Repayment Programs (CSLRP, APHLRP, or AHLRP.)

Our student loan average is \$356,000 since Chiropractic programs are private schools only. What is concerning is that we work alongside our medical colleagues, helping the same patients over the same amount of hours in order to pay off similarly large amounts of student loans. Yet our medical colleagues are eligible to apply for such loan reimbursement programs in addition to their higher salaries. Lower salaries with no opportunities for loan repayment, often leads us to looking for supplemental incomes during down time that could be spent recuperating from or strengthening ourselves to meet the physical demands of our profession, or allowing us to spend more quality time with our families. Therefore, I ask for the addition of Doctors of Chiropractic into the County Medical Services loan repayment programs after the board realizes the value of our services and the financial inequality that is prevalent in the health care work force.

Thank you for your time,

Dr. Alan Riley DC, ACN

Doctor of Chiropractic | Applied Clinical Nutritionist | Certified Health Coach

[ariley@amplahealth.org](mailto:ariley@amplahealth.org) | 530-350-7500 ext2080 | Fax: 530-743-3286

Ampla Health Oroville, Magalia, Los Molinos | 2800 Lincoln Blvd | Oroville, CA 95966

Dear Loan Repayment Program Supervisor,

During these difficult times of opioid crisis I have a stronger appreciation of pain management techniques, such as chiropractic treatment, which allows my patients to find pain relief without relying solely on pain medications. The rigors of graduate education leave many of us with a lifelong burden of paying off education loans. Those who serve patients in underprivileged areas have the opportunity to apply for loan repayment programs which helps lessen some of this burden. However, this opportunity is currently not open to Doctors of Chiropractic medicine and I would like to make a request that they be included in the application process. Doctors of Chiropractic medicine are a valuable asset to our community and oftentimes provide pain relief when medications fail.

Over the past several years I have witnessed the great success that Dr. Srikanth Kolli has achieved with his patients. I strongly believe that the hard work that he and his colleagues have done and the academic rigor involved in obtaining their degrees deserve equal treatment and consideration when considering candidates for the Loan Repayment Program. It is important that we value all of our medical colleagues equally and give them the recognition they deserve. Thank you for your time and consideration!

Sincerely,

Dr. Anamika Doma, D.O.

Department of Emergency Medicine

Northern Sacramento VA Hospital

(916)843-2855

September 21, 2020

Re: CMSP LRP

Dear CMSP Governing Board,

I am contacting you regarding accepted providers eligible for the County Medical Services Program Loan Repayment Program (CMSP LRP). My name is Bimaljit Mann, PA-C and work for Ampla Health (A Federally Qualified Health Clinic, FQHC) where my colleague Dr. Srikanth Kolli D.C. also provides his chiropractic services. Where my Patients in the past we not able to seek additional care for such ailments such as back pain and always getting referred to Pain Management; his services allow for our low income patients to have a quality of life without narcotics on board. For many years before Dr. Kolli joined our practice, there was no additional outlet of care especially failure of physical therapy or if insurance companies only provided a maximum of 2 physical therapy sessions. His Chiropractic work is not only essential in recovery with hands on techniques; his ability to read x-rays and treat appropriately is unmatched. Many times he has caught subtleties within the x-rays to indicate other processes which exist. With his services I have seen a tremendous amount of my Patients able to regain a lot of the mobility back if not all. None which would have been possible if his practice was private. Chiropractic work is an essential collaborative part of Patient care. Therefore, Chiropractors without hesitancy should be included in the Loan Repayment Program. These providers would benefit from the program to help alleviate the burden of their student loans whilst providing care to the underprivileged. As a recipient myself of a Loan Repayment Program I am able to continue to work at such a clinic versus private care in which I would like to continue to see Dr. Kolli and all other Chiropractors deserve such a chance by adding them to the accepted providers eligible for the Loan Repayment Program.

Sincerely,

Bimaljit K Mann, PA-C, MPAS



I am a primary care provider in a Community Health Center in rural California. Having a chiropractor on our team is an asset as we manage patients with both acute and chronic musculoskeletal pain. It helps us have a tool besides medication management to assist these patients with disabling chronic pain. For subacute pain, the Chiropractor can often see and help the patient much sooner than physical therapy or specialists, providing quicker treatment and return to productivity for injured patients. Although we all receive training in musculoskeletal disorders it is very helpful to have a Chiropractor who was received more focused training in this subject to both treat the patient as well as to consult on the etiology and the treatment plan.

I strongly support adding Doctors Of Chiropractic to the CMSP LRP program, so that we can provide a benefit which keeps these providers in the Community Health Centers rather than forcing them into private industry in order to repay their loans.

Sincerely,

*Eric Crizer*  
*FNP*  
*Ampla Health Inc.*  
*2800 Lincoln Blvd*  
*Oroville, CA 95966*  
[\*ecrizer@amplahealth.org\*](mailto:ecrizer@amplahealth.org)  
*530-534-7500, ext 2064*

To Whom This May concern:

I am writing this in support of chiropractors being included in the student loan repayment program. At the rural clinic where I work chiropractors are highly sought after for the services they provide for our patient's. They spend the years needed to educate themselves to be of service and accumulate the high, often burdensome student loans that other people studying medicine do. It only makes sense they be included and have the same opportunity.

Sincerely,

Jennifer Inglet PA-C



**TO: CMSP Governing Board**  
**FROM: John Fleming, Director of Planning & Development**  
**DATE: Friday, September 21, 2020**  
**RE: California Loan Repayment Program Coverage**

A handwritten signature in black ink, appearing to read "John Fleming", is positioned to the right of the email header text.

CMSP Governing Board,

Ampla Health is a network of non-profit Health Resources and Services Administration (HRSA) funded migrant and community health centers (MHC/CHC) providing primary health care services to the residents of six rural northern California counties (Butte, Colusa, Glenn, Sutter, Tehama and Yuba). Ampla Health currently operates fourteen medical facilities, and six dental clinics. Within the 8,315 square mile service area, Ampla Health is the largest provider of primary health care for Migrant Seasonal Farmworkers (MSFW) and other low-income people in a total population over 500,000.

One area of important medical service to this population has been Chiropractic. Since 2017 we have added six chiropractic providers serving most of our clinic locations including clinics in Butte, Glenn, Colusa, Yuba and Sutter counties. Since then we have successfully served thousands of patients with back, joint, and pain issues. A critical component to the successful placement and retention of our chiropractic providers is assisting in medical school debt. Partnering with the County Medical Services Program Loan Repayment Program is essential in leveraging our existing and future talent.

Thank you for discussing and considering Ampla Health's potential chiropractic addition to the accepted provider list for the CMSP Loan Repayment Program. I can be reached at 530.751.3740 if you have questions about the services we provide.

Members of the CMSP Board,

My name is Joseph Iaccino. I have been serving at the Colusa and Gridley clinics for Ampla Health since January. Prior to this position I was on teaching staff at the University of Western States in the graduate department for human nutrition and functional medicine. Throughout my tenure with the university, I also was in private practice and consulted with various clinics on nutrition and supplementation for various conditions.

Over the past decade, chiropractic care has demonstrated to be very effective in treating many conditions including low back pain, neck pain, headaches, and various other joint and pain conditions. Chiropractic is now offered at many of the Veterans Administration clinics around the country and has also been added into many of the FQHC clinics around the state of California. This inclusion has provided a great benefit to the patients we currently serve. The other providers within our clinics readily refer patients to us and on many occasions we work together to coordinate better care and outcomes for our patients. Along with chiropractic treatment we often provide our patients with nutritional advice, exercises, and other wellness related topics aimed at increasing the quality of their life.

The CMSP Loan repayment program would offer a great benefit to attracting and keeping the best chiropractic providers within these clinics. The student loan debt within our group is very high. This is due to the fact that all of the chiropractic education institutions in this country at this moment are private institutions. This debt issue also makes it difficult to pursue the opportunity of home ownership within these communities due to debt to income ratios. I believe the assistance will help attract the best chiropractic providers possible and also allow for better opportunities to become residents of these communities. I strongly encourage the CMSP Board to consider including chiropractic providers currently serving in many of the counties your board serves.

Thank you for your time and consideration. If you have any follow-up questions please feel free to contact me at [jiaccino@amplahealth.org](mailto:jiaccino@amplahealth.org).

Best Regards,

Joseph Iaccino DC, MS

CMSP Governing Board,

I would like to make a proposition for inclusion of Doctors of Chiropractic into the CMSP LRP program. I, along with 5 other Chiropractors have been honored to be part of the Ampla Health care team providing an alternative and complementary means of pain management for an underserved community. Ampla Health an FQHC provides health care services in the greater Northern California region across 6 counties and is fortunate to be part of your program considering the financial burden that is put upon medical professionals due to student loans. Currently your program provides financial assistance benefits to nearly all other medical professionals with the exclusion of Doctors of Chiropractic. This is a trend that is set across the board where loan assistance programs are not provided to Chiropractors. I would like to discuss the evidence based background on the clinical effectiveness, cost-effectiveness, patient satisfaction, and education relating to Chiropractic care. I have high hopes that you will come to see the value that it offers our nation and consider its addition to your program.

Spinal related medical complaints which plague our nation account for the third highest amount of healthcare spending at \$87.6 billion as outlined by the Journal of the American Medical Association (JAMA)(US Spending on Personal Health Care and Public Health, 1996-2013 - December 27, 2016). Whether it be traditional Medicine, Chiropractic care, Physical therapy, Massage, Acupuncture, etc., all have been shown to have positive effects for these types of ailments, though results may be variable amongst individuals. We have to take into account that everyone's body is different, and that different practices may result in better outcomes for different people. This is where the multidisciplinary team approach becomes even more valuable in patient management producing better care and reduced overall healthcare expenditures. This is what we strive to achieve at Ampla Health. The Nation is amidst a trending change where chiropractic is becoming widely accepted and included as a valuable asset to healthcare teams. Chiropractic continues to become more prevalent within major organizations across the nation including but not limited to FQHCs, hospitals, VAs, Google, Facebook, PG and E, etc. I would like to present some recent studies regarding the effectiveness of Chiropractic care and its position within the Medical model.

Many studies have found that Chiropractic care is just as good as traditional Medicine at relieving spinal related medical issues, but can significantly reduce the cost to the American people. One study conducted by Lilledahl et al., in the *Journal of Manipulative and Physiological Therapeutics*, analyzed 85,000 Blue Cross Blue Shield beneficiaries in Tennessee over a two-year span and concluded that back pain initiated with a Doctor of Chiropractic saves 20 to 40 percent on health care costs when compared with care initiated through a medical doctor. Another study conducted in 2015 by Schneider et al., in the *Spine Journal* concluded that "94 percent of manual-thrust manipulation recipients under chiropractic care had a 30 percent reduction in low back pain at week four while only 56 percent of medical care recipients had a 30 percent reduction in low back pain at week four. This represents a 38 percent (94% – 56%) increase in effectiveness by seeing a doctor of chiropractic first. The study also determined that patients are best served when informed of non-pharmacological therapies for low back pain before electing riskier, less effective treatments. Manual-thrust manipulation, performed by doctors of chiropractic, achieves a greater short-term reduction in pain compared with common medical treatments." Where these are just two of the many studies that have been conducted on Chiropractic care they shine some light on the future of healthcare in regard to these types of health concerns. Not only is it an effective means of treatment for spinal complaints and cost-effective, it is reflected in overall patient satisfaction.

The 2009 Consumer Report survey analyzed satisfaction ratings of over 14,000 subscribers measuring satisfaction ratings of the most commonly sought after medical treatments for low back pain. In consecutive order of being most satisfied with the treatment they received was Chiropractic, Physical Therapy, Acupuncture, Physician (specialist), Physician (Primary Care). In the most recent Consumer Report survey (2017) of more than 3,500 back-pain sufferers a similar conclusion was found: Nearly 90 percent of people who tried spinal manipulation found it helpful. Though it is effective, safe, sought after, and can reduce the nation's healthcare spending, there are multiple limiting factors that inhibit the growth and success of Chiropractic in healthcare.

There are three main levels of exclusion that account for a larger financial hardship for Chiropractors. Arguably the highest limiting factor is that insurance companies are behind the times excluding chiropractic care or providing minimal coverage limiting accessibility to patients that would otherwise like to utilize the service. This has limited the overall country wide "12-month median utilization to 9.1% of the population (interquartile range (IQR): 6.7%-13.1%), which remained stable between 1980 and 2015," according to a review of the literature conducted by Beliveau et. al (2017). However, we all know insurance companies work hard to limit or not pay for anything they can legally exclude. Many limitations start in Washington where money is allotted to certain programs. Thankfully in the FQHC setting throughout California the government has taken positive steps to provide Chiropractic care to an underserved population in great need creating a sustainable career opportunity for chiropractors in this environment. For this we are grateful to see a paradigm shift.

The second limiting financial factor is the degree of student debt that is accrued in order to get a Doctor of Chiropractic Degree. Consider the average student debt that the 6 chiropractors in our organization have accrued is \$356,000. Interest rates on this amount make repayment unattainable for many Chiropractors as our average salaries do not reflect positively on the debt to income ratio. As with other Doctoral programs accredited by the US Department of Education, Chiropractors dedicate a substantial amount of time and money to improve the lives of others and deserve a wage that is suitable to pay off educational loans in a reasonable period of time and there are many factors that make this difficult.

Third is the availability of Loan Repayment Programs which are readily available in multiple settings for most healthcare practitioners and nearly nonexistent for Doctors of Chiropractic. The only program that is available is through FQHCs which requires completion of a minimum of 10 full years of service at 40 hours per week to be considered. I have searched through all programs that offer additional support to most healthcare professionals and was saddened to find that chiropractors were not held in the same regard.

In summary, Chiropractic care is an effective evidence based treatment option for spinal related ailments. These types of complaints account for a huge portion of overall healthcare spending. Chiropractic is cost-effective and safe. Chiropractors are underutilized, underpaid and may be undervalued. Student debt accrued is substantial. People find it helpful and have higher levels of satisfaction compared with other medical professionals in the same scope of practice. Chiropractic frees up more time for Medical Doctors to focus on more serious medical concerns reducing healthcare expenditures. There is a shortage of Medical Doctors in our nation. Co-management within multidisciplinary medical practices provides an even higher level of patient care and satisfaction. Where there are many factors that need to be addressed to ensure the financial success of the Chiropractic profession, education is key to understanding the current position of Chiropractors within the healthcare workforce. Inclusion of Doctors of Chiropractic within the CMSP LRP program would be a huge step in creating a more sustainable profession along with incentivizing integration in the

Multidisciplinary healthcare setting resulting in better patient care. We have high hopes and would be forever grateful if you would consider us for inclusion in your program. Thank you for your time.

Best regards,

Joshua Kinney, DC, BS  
Ampla Health  
680 Cohasset Rd.  
Chico, CA 95926  
[jkinney@amplahealth.org](mailto:jkinney@amplahealth.org)  
(530) 342-4395

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CMSP Governing Board,

I am contacting you regarding accepted providers eligible for the County Medical Services Program Loan Repayment Program (CMSP LRP). I was informed that my colleague Dr. Srikanth Kolli D.C. was unable to apply for this program. Currently I work with Dr. Kolli at Ampla Health Lindhurst Medical Center, in Olivehurst, CA. The addition of Chiropractic to our clinic systems has been an asset to our communities. Typically our underprivileged patients would not be able to afford this service, which has helped with a large spectrum of musculoskeletal disorders. Prior to the addition of Dr. Kolli D.C., I have not had any experiences with chiropractic and did not refer patients to this service. After working with him for over three years I have seen the benefits our communities have gained with the addition of Chiropractic to our clinic systems. I feel that Doctor of Chiropractic should be added to the list of accepted providers eligible for the County Medical Services Program Loan Repayment Program, and I encourage the board to make the appropriate changes. Thank you for your time.

Kaneshka Alamshahi MD  
Ampla Health  
530-743-4611  
[kalamshahi@amplahealth.org](mailto:kalamshahi@amplahealth.org)



CMSP Governing Board,

My name is Kimberlee Fritz FNP and I am a medical provider that currently works for Ampla Health Lindhurst Medical Center, in Olivehurst, CA. I am writing regarding my colleague Dr. Srikanth Kolli D.C. and his hopes to add Doctors of Chiropractic to the current list of accepted providers eligible for the County Medical Services Program Loan Repayment Program (CMSP LRP). The addition of Chiropractic care to our facility has tremendously benefited our clinic and patients. Having chiropractors as a readily available service covered under Medical, Medicare, private insurance, and those under our Sliding Fee Program has offered an alternative and valuable option for our patients. The opioid crisis places an immense strain on primary care providers but chiropractors offer a safe alternative to physical conditions such as lower back pain, neck pain, headaches, and so much more. Chiropractors, without a doubt, should be included in the Loan Repayment Program. These providers would benefit from the program to help alleviate the burden of their student loans. Your serious consideration is appreciated.

Respectfully,

Kimberlee Fritz FNP

To Whom It May Concern:

My name is Olusola Asafa PA-C, a CMSP LRP awardee, and a practicing physician assistant at Ampla Health Family Practice Clinic in Oroville, CA.

I am writing to support the addition of Doctors of Chiropractic to the list of accepted professionals for the CMSP LRP.

Chiropractic care is an integral part of the comprehensive medical care delivered at our busy clinic serving a patient population with diversely different educational, ethnic, cultural, and economic backgrounds. Many of my patients have benefitted from care provided by our Chiropractors who are very much involved in holistic patient care and our daily medical team effort with unrivaled commitment toward rehabilitation of chronic pain patients back to their premorbid functional condition when possible. Several patients have attested to the immense impact of Chiropractors in pain alleviation, enhancement of range of joint motion, and more importantly overall improvement in patients' quality of life.

Therefore, I strongly recommend and support the addition of Doctors of Chiropractic to the list of accepted professionals for the CMSP LRP.

Sincerely,

Olusola Asafa PA-C

To whom it concerns

I understand you are seeking information regarding the benefits of chiropractic care in a multidisciplinary setting. I work in two such settings and would like to offer my insights.

Published clinical guidelines for pain, including spine and musculoskeletal pain, recommend multiple non-pharmacological approaches as the first choice and emphasize restoration of physical function. Chiropractic doctors can perform or order almost all of these first line management strategies. Further, their training gives them the ability to examine, diagnose, order diagnostic tests, place patients on (or take them off) disability, allowing them to fill multiple rolls from triage to collaboration with other team members.

In its simplest form, a seamless multidisciplinary team approach to spine and musculoskeletal pain serves patients better than standard care. Bringing together experts in chiropractic, neurosurgery, pain management and rehabilitation services, as an example of a multidisciplinary group, offers a team-based approach to care. It permits whole-person care, coordinated planning, and treatment based on the concept of the right practitioner at the right time, as no single treatment or management type is suitable for all patients.

Thank you for the opportunity to contribute to your request.

Robb

Robb Russell, D.C.

Assistant Vice President & Clinical Chief of Staff, SCU Health

Southern California University of Health Sciences

Attending Chiropractic Doctor, PM&R, Veterans Administration Medical Center, West Los Angeles

To Whom it may Concern:

I am writing on behalf of Dr. Srikanth Kolli D.C. and for chiropractors in the Yuba-Sutter community. The addition of chiropractic treatment has been integral in improving the daily lives and the health and wellness of my patient population. Their ability to function with less pain in conjunction with reducing their need for pain medications, which can be sedating and have other side effects, is phenomenal. I am grateful to have the ability to offer patients an alternative approach to managing acute and chronic pain. Thus, the addition of doctors of chiropractic to the accepted provider list for the County Medical Services Program Loan Repayment Program (CMSP LRP) is essential.

Sincerely,

*Sara Skinner, FNP-C*

*Family Nurse Practitioner*

***Ampla Health – Lindhurst***

*4941 Olivehurst Ave*

*Olivehurst, CA 95961*

*Phone: (530) 743-4614*

*Fax: (530) 743-5770*

*[sskinner@amplahealth.org](mailto:sskinner@amplahealth.org)*

Esteemed CMSP board members,

My name is Dr. Srikanth Kolli D.C., and last week I submitted a request to add Doctors of Chiropractic into the County Medical Services Program (CMSP) Loan Repayment Program. Last Wednesday (9/16/2020), I was informed the Board was meeting on 9/24/2020 and was given a deadline of 5:00PM to submit a document for the boards' consideration. The rest of that day was spent seeing patients and composing the letter you received. This was followed by only five days of trying to reach out for support from fellow colleagues. As you read the letters of support, I hope the board sees the unity amongst the providers and staff within our clinics, as well as associated providers and members of other facilities that have joined our cause. If I had more time I would have a larger support system, as I know many members of the medical and professional fields that believe there should be equality.

Doctors of Chiropractic medicine have joined the FQHC clinics recently and helped bridge a gap that has benefited both the communities we serve and the staff that serve them. The addition of Chiropractic providers allowed patients to have a safe alternative to the previous avenues of pain management. The current acute and chronic pain management avenue taken by other primary providers can have detrimental outcomes for patients. Not only effects on systemic health but mental health. This in turn increases the cost of healthcare. Chiropractic having a non-invasive approach to recovery has helped many patients and reduced health care costs. It has given our fellow medical providers options for the treatment and recovery of pain, allowing them to focus on systemic dysfunctions. We not only address low back pain but have helped with multiple musculoskeletal disorders. What discipline does the CMSP program support for pain management which over 80% of our population will eventually need?

The underprivileged communities we serve typically can not afford, nor do they have access, to the services we render. We are covered under Medical, Medicare, private insurance, and for those in need have a Sliding Fee program. Doctors of Chiropractic do not need referrals and are considered primary care portal of entry doctors. There have been multiple occasions in which I have referred patients to their medical doctors regarding findings on x-rays, physical exams, and history which was out of my scope of practice. Examples are, but not limited to, iron/nutritional deficiency symptoms, kidney/liver related symptoms, uterine fibromas, fractures, arterial calcifications noticed on imaging, etc. The fluid level of communication and unified effort to achieve and elevate the standard of care for the communities we serve, united, should be an example for others to follow.

Student loans are a crippling burden that currently affects everyone. Medical providers are in the top of crippling student loan debt with outlandish loan amounts. My personal debt is roughly \$330,000 with a 6.5% interest rate. The interest alone will never allow me to overcome this burden without help.

By adding Doctors of Chiropractic to the accepted disciplines for FQHC and underprivileged board selected clinics, you will be making a service that is typically unavailable, accessible. This will also help providers continue to work for these underprivileged areas and encourage others to serve their communities. Creating equality among those that do not have access to the services we have to offer.

The Board is given powers to help our communities and the providers that serve them. This power to make a change for equality is something to be taken very seriously as the lives of others are impacted by your decisions. We must look forward for progression of the medical field, for the united purpose to care for the communities we serve. In the past with each addition of accepted disciplines there was a decision to be made. The members at that time sought progress and made the bold decision to strive for it. We are asking for equality for those serving the community in the board selected facilities. I implore the members to look

forward and make the right decision to help all the members of our communities by adding Doctors of Chiropractic to the accepted disciplines. Thank you for your time and consideration.

Dr. Srikanth Kolli D.C.

[Skolli@amplahealth.org](mailto:Skolli@amplahealth.org)

Doctor of Chiropractic

Ampla Health Lindhurst | 4941 Olivehurst Ave | Olivehurst, CA 95961

Direct Phone: 530-743-4611 Ext:1813 | Fax: 530-743-3286



# Expanding specialty care access

- We arrange **elective, outpatient** procedures by leveraging donated care.
- Our patients are **low-income, uninsured, unfunded** adults.
- We move care upstream of the emergency department and improve **community health outcomes**.



**OPERATION ACCESS**



# Linking clinic referrals with specialists



Community Health Center

- Refers patient
- Provides ongoing care



Medical Volunteers and Partners

- Physician specialists volunteer time and expertise
- Hospitals, surgery centers, and ancillary medical groups donate care

- Matches patient with specialist
- Navigates patient through all appointments
- Provides interpreter
- Evaluates results and impact

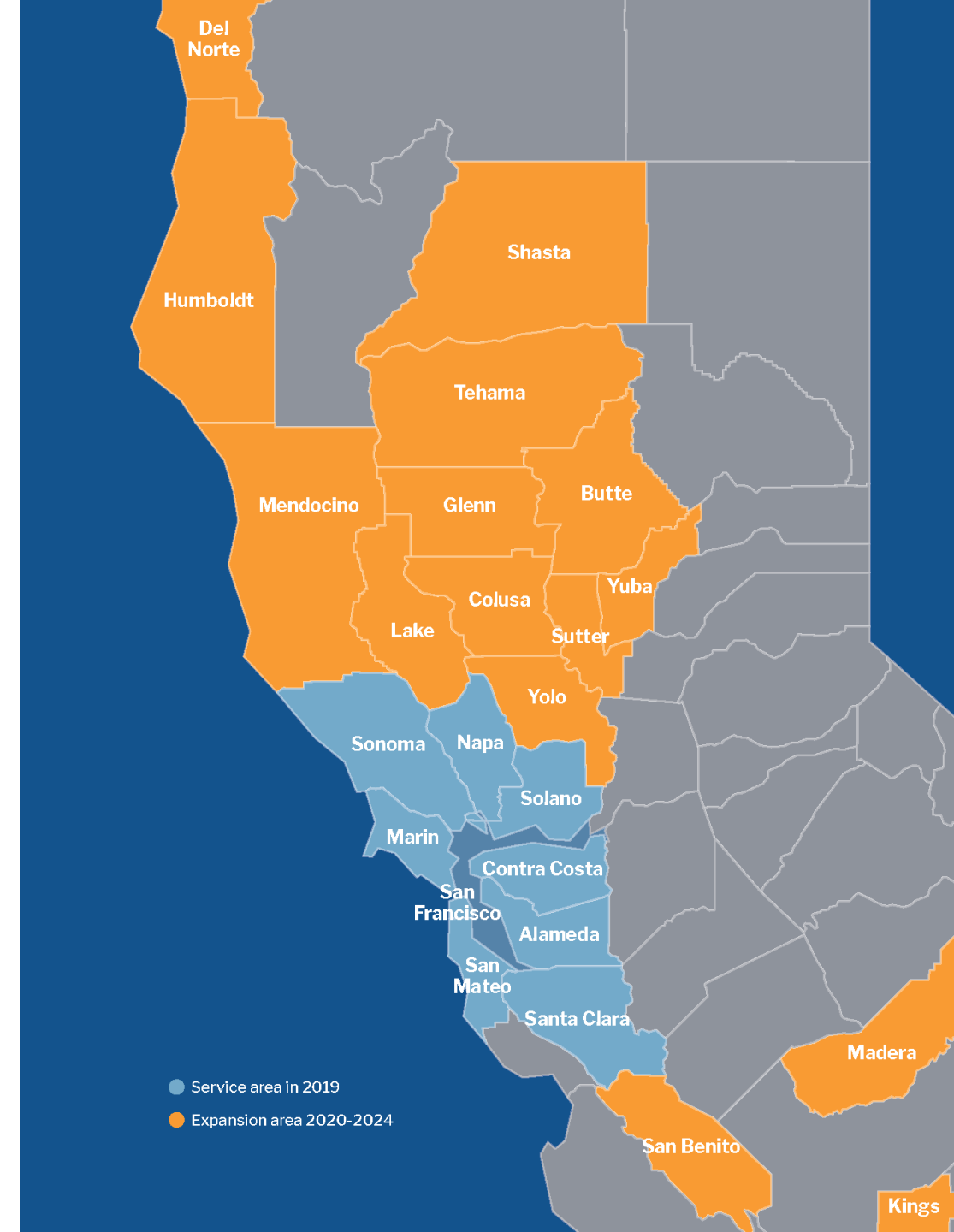
# We are Expanding

Thanks to **CMSP's support**, we are introducing our **model of care coordination across Northern California**.

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“Expansion will bring the organization’s high-quality services to a larger population of people who otherwise could not afford health care.”

-Geoff McHugh, Board Chair



# 5-year specialty access CMSP grant

- Grow to serve patients in **nineteen CMSP counties**.
- Provide referral pathway for Path to Health members and patients up to 300% of federal poverty level, who are not eligible for Medi-Cal, Medicare or CMSP full-scope coverage.
- Partner with community clinics, specialists, hospitals, and medical societies.
- Increase impact in geographic scope and volume of care.

# COVID impact

- Referral volume disrupted
- Specialty providers impacted
- Added complexity (COVID tests, safety protocols)
- Outreach must be virtual

# Our strategies

- Video conference clinic trainings; continuing to accept all eligible referrals
- Rapid rebuilding of specialty capacity
- More time devoted to patient navigation of COVID protocols
- Greater use of phone/video consultation and interpretation

# Mario's story

- Mario is a vineyard worker in Sonoma County who lived with a growing basal cell carcinoma on his face for six years.
- Dr. Erik Cabral at the California Skin Institute in Santa Rosa performed Mohs surgery.
- "I am in love with what your organization does; it's magical. Not everything in life is about money when love exists. Thank you so much!"



# Outcomes in first half of 2020

- **Services 75% under target** in April; only **11% under target** over the full six months. Over \$10 million in care to be provided in 2020.
- Wait times at high end of our target (90 days to specialty visit, 120 days to procedure).
- **New, cloud-based case management database** launching Sep 28.
- **Residents of nine CMSP counties** served in first half of 2020.
- Partnership discussions underway.
- We anticipate services will be available in **twelve counties in 2021**, and the **final seven counties in 2022-2023**.



**Rates for Health Care Services Policy  
County Medical Services Program**

**Effective January 1, 2021  
(Originally Adopted September 22, 2005;  
This amendment adopted on September 24, 2020)**

The rates of payment reflected in this **Rates for Health Care Services Policy** (Policy) shall be for the dates specified herein; rates of payment for prior dates not specified herein shall be as specified in the preceding version of this Policy as amended December 14, 2017, and effective January 1, 2018.

The County Medical Services Program Governing Board (Board) sets the rates of payment for the provision of medically necessary health care services to County Medical Service Program (CMSP) members. The Board entered into a contract with a benefits administrator, Advanced Medical Management, Inc. (Administrator), for the administration of CMSP medical and dental benefits as of April 1, 2015. (This Policy does not address pharmacy services.)

**PART A. CONTRACTING PROVIDERS**

The Board, or the Administrator on behalf of the Board, may enter into contracts with providers for the provision of medically necessary health care services to CMSP members. These providers shall be located in CMSP Counties and counties contiguous to CMSP Counties unless otherwise approved by the Board or its designated representative. These contracts will be at the rates set forth below, as may be revised by the Board from time to time. Payments made pursuant to these contracts, net any share of cost collections, shall constitute payment in full to these providers.

The Board shall not pay for services that are not medically necessary.

**I. Outpatient Services**

A. Physician Services Provided by Contracting Physicians

Effective April 1, 2015, the CMSP rates for all CMSP benefit programs shall be equal to the Medi-Cal rates for such services in effect on July 1, 2007, plus twenty percent (20%). Such rate shall be adjusted annually by the Medicare Economic Index (MEI) adjustment approved for Federally Qualified Health Centers.

For selected primary care and specialty providers, the Administrator may enter into a contract at alternative rates to promote the availability of such physician, subject to approval by the Board or its designated representative.



B. Hospital Outpatient Services Provided by Contracting Hospitals

Effective April 1, 2015, the CMSP rates shall be equal to the CMSP rates in effect on December 31, 2011, plus five percent (5%). Such rates shall be made available to all contracting providers through the Administrator.

C. Services Provided by Contracting Federal Qualified Health Centers and Rural Health Clinics (FQHC/RHC)

Effective January 1, 2012, the CMSP rate shall be equal to the CMSP rate in effect on December 31, 2011. Such rate shall be an encounter based rate that is equivalent to the Medi-Cal rate for such services. Such rate shall be adjusted annually by the Medicare Economic Index (MEI). Any other adjustments shall be made bi-annually.

Only the following services shall be paid with the encounter based rate: covered medical services and covered dental services for all CMSP benefit programs.

D. Services Provided by Contracting Tribal Health Program Providers (THP)

Effective January 1, 2012, the CMSP rate shall be equal to the CMSP rate in effect on December 31, 2011. Such rate shall be equivalent to the Medi-Cal rate for such services. Any adjustments to this rate shall be made annually.

Only the following services shall be paid with the encounter based rate: covered medical services and covered dental services for all CMSP benefit programs.

Updates to the rates described in A-D in this Section I. of Part A shall be made by the Administrator from time to time subject to the approval of the Board or its designated representative. Such updates may include provisional rates for CPT codes when such codes are established or become obsolete.

## **II. Inpatient Hospital Services**

Effective January 1, 2009, the Board established an all-inclusive per diem payment methodology in contracts for inpatient hospital services that provides hospital-specific per diems for specified bed types and does not require any subsequent audit and cost settlement process to reconcile overpayments and underpayments. With the exception of payment for implants/devices as provided herein, the per diem shall be all-inclusive and the hospital shall not be entitled to any additional payment. Per diem payment amounts shall be based upon the level of hospital care required for each day of care provided based upon medical necessity.

A. Services Provided by Contracting California Hospitals

1. Inpatient Hospital Services (excluding inpatient mental health services)

Beginning with dates of service on or after January 1, 2009, payment for inpatient hospital services shall be based upon per diem payment rates established by the Administrator as set forth herein for each contracting hospital. Depending on the hospital and the actuarial sufficiency of the paid claims data, per diem payment rates shall be set for the following bed types:

- a. Intensive Care Unit (ICU);
- b. Trauma;
- c. Burn;
- d. Acute Care (Med/Surg);
- e. Percutaneous Transluminal Coronary Angioplasty (PTCA)/Cardiac Catheterization (Cath);
- f. Cardiovascular Surgery; and,
- g. Subacute Care.

All inpatient bed types not otherwise specified above, including but not limited to acute rehabilitation, shall be paid at the Acute Care (Med/Surg) per diem payment rate. Per diem payment amounts shall be based upon the level of hospital care required for each day of care provided based upon medical necessity.

Payment for the following implants/devices shall be paid separately from any per diem payment: Hip; Knee; Pacemaker; Automatic Implantable Cardioverter Defibrillator (AICD); and Spine. Payment for these implants/devices shall be limited to manufacturer or distributor invoice price plus ten percent (10%), subject to reasonable maximum allowances as determined by the Board.

Per diem payment rates for each hospital shall be the payment amounts in effect for each hospital on December 31, 2013 ("base per diem rates"). For dates of service on January 1, 2014, through December 31, 2023, these base per diem rates shall be adjusted as follows:

- Service Year 1 – (January 1, 2014, through December 31, 2014) – the product of the base per diem rate and 1.02. Stated as an equation:  $\text{Base per diem rate} \times 1.02$  ("Service Year 1 per diem rate")
- Service Year 2 – (January 1, 2015, through December 31, 2015) – the product of the Service Year 1 per diem rate and 1.02. Stated as an equation:  $\text{Service Year 1 per diem rate} \times 1.02$  ("Service Year 2 per diem rate")
- Service Year 3 – (January 1, 2016, through December 31, 2016) – the product of the Service Year 2 per diem rate and 1.02. Stated as an equation:  $\text{Services Year 2 per diem rate} \times 1.02$  ("Service Year 3 per diem rate")

- Service Year 4 – (January 1, 2017 through December 31, 2017) – the product of the Service Year 3 per diem rate and 1.02. Stated as an equation: Services Year 3 per diem rate x 1.02.
- Service Year 5 – (January 1, 2018 through December 31, 2018) – the product of the Service Year 4 rate and 1.02. Stated as an equation: Services Year 4 rate x 1.02.
- Service Year 6 – (January 1, 2019 through December 31, 2019) – the product of the Service Year 5 rate and 1.02. Stated as an equation: Services Year 5 rate x 1.02.
- Service Year 7 – (January 1, 2020 through December 31, 2020) – the product of the Service Year 6 rate and 1.02. Stated as an equation: Services Year 6 rate x 1.02.
- Service Year 8 – (January 1, 2021 through December 31, 2021) – the product of the Service Year 7 rate and 1.02. Stated as an equation: Services Year 7 rate x 1.02.
- Service Year 9 – (January 1, 2022 through December 31, 2022) – the product of the Service Year 8 rate and 1.02. Stated as an equation: Services Year 8 rate x 1.02.
- Service Year 10 – (January 1, 2023 through December 31, 2023) – the product of the Service Year 9 rate and 1.02. Stated as an equation: Services Year 9 rate x 1.02.

Beginning January 1, 2018, administrative days shall be paid at a rate of three hundred seventy-five dollars (\$375.00) per day. Beginning January 1, 2019, administrative days shall be paid at a rate of three hundred eighty-three dollars (\$383.00) per day. Beginning January 1, 2020, administrative days shall be paid at a rate of three hundred ninety-one dollars (\$391.00) per day. Beginning January 1, 2021, administrative days shall be paid at a rate of three hundred ninety-nine dollars (\$399.00) per day. Beginning January 1, 2022, administrative days shall be paid at a rate of four hundred and seven dollars (\$407.00) per day. Beginning January 1, 2023, administrative days shall be paid at a rate of four hundred and fifteen dollars (\$415.00) per day. Payment of such rate shall be limited and payable subject to requirements approved by the Board.

Subject to approval by the Board or its designated representative, the Administrator may enter into a contract with a hospital for the sole purpose of providing certain high-level procedures, such as organ transplant services, complex orthopedic surgeries, catastrophic burn care and similar complex tertiary services not otherwise available in the community. For such a specified tertiary hospital, the payment rates shall be based upon

per diems for each hospital in accordance with the provisions set forth herein or as otherwise approved by the Board.

## 2. Inpatient Hospital Mental Health Services

The rate shall utilize a two-tiered (higher-level of care and lower-level of care), all-inclusive per diem structure that incorporates the following:

a. If the hospital has negotiated an all-inclusive per diem rate under Medi-Cal through a contract with the county where the hospital is located:

(i) Beginning January 1, 2009, the higher-level of care rate shall be based on the hospital's greater revenue code rate on file effective April 1, 2005, for revenue code 114 (room and board – private, psychiatric), revenue code 124 (room and board – semi-private 2 bed psychiatric), and revenue code 204 (intensive care, psychiatric). Beginning January 1, 2014, the rate will be the higher of these revenue codes, less one percent (1%). Beginning January 1, 2015, the rate will be the higher of these revenue codes, plus one percent (1%). Beginning January 1, 2016, the rate will be the higher of these revenue codes plus three percent (3%). Beginning January 1, 2017, the rate will be the higher of these revenue codes plus five percent (5%).

(ii) Beginning January 1, 2009, the lower-level rate of care rate shall be based on the hospital's greater revenue code rate on file effective April 1, 2005, for revenue code 134 (room and board – semi-private 3 or 4 bed psychiatric) and revenue code 154 (room and board – ward (medical or general), psychiatric). Beginning January 1, 2014, the rate will be the higher of these revenue codes, less one percent (1%). Beginning January 1, 2015, the rate will be the higher of these revenue codes, plus one percent (1%). Beginning January 1, 2016, the rate will be the higher of these revenue codes plus three percent (3%). Beginning January 1, 2017, the rate will be the higher of these revenue codes plus five percent (5%).

b. If the hospital has not negotiated an all-inclusive per diem rate under Medi-Cal through a contract with the county where the hospital is located, the rates referenced shall be the regional all-inclusive per diem rate established by the California Department of Mental Health for inpatient acute psychiatric care for the hospital:

(i) Beginning January 1, 2009, the higher-level of care rate shall be based on the hospital's greater revenue code rate on file effective April 1, 2005, for revenue code 114 (room and board –

private, psychiatric), revenue code 124 (room and board – semi-private 2 bed psychiatric), and revenue code 204 (intensive care, psychiatric). Beginning January 1, 2014, the rate will be the higher of these revenue codes, less one percent (1%). Beginning January 1, 2015, the rate will be the higher of these revenue codes, plus one percent (1%). Beginning January 1, 2016, the rate will be the higher of these revenue codes plus three percent (3%). Beginning January 1, 2017, the rate will be the higher of these revenue codes plus five percent (5%).

(ii) Beginning January 1, 2009, the lower-level rate of care rate shall be based on the hospital's greater revenue code rate on file effective April 1, 2005, for revenue code 134 (room and board – semi-private 3 or 4 bed psychiatric) and revenue code 154 (room and board – ward (medical or general), psychiatric). Beginning January 1, 2014, the rate will be the higher of these revenue codes, less one percent (1%). Beginning January 1, 2015, the rate will be the higher of these revenue codes, plus one percent (1%). Beginning January 1, 2016, the rate will be the higher of these revenue codes plus three percent (3%). Beginning January 1, 2017, the rate will be the higher of these revenue codes plus five percent (5%).

This payment rate shall apply only to hospitals that maintain licensed acute psychiatric care beds.

Updates to inpatient hospital mental health services rates described in this Section may be made by the Administrator from time to time subject to the approval of the Board or its designated representative. Such updates may include provisional rates for CPT codes when such codes are established or become obsolete.

**B. Services Provided By Contracting Hospitals and Hospital Based Physicians and Other Providers in Non-CMSP California Counties or Contiguous Counties**

**1. Hospital Services**

Subject to approval by the Board or its designated representative, the Administrator may enter into a contract with a California hospital that is not located in a CMSP County or a county contiguous to a CMSP County for the provision of medically necessary health care services to CMSP members.

The rate for inpatient hospital services shall be determined pursuant to the criteria set forth in Part A, Section II.A(1). If there is insufficient data to use the methodology set forth in Part A, Section II.A(1), then the rate shall

be the most recent average contract payment rate published by the California Medical Assistance Commission (CMAC) for the Standard Consolidated Statistical Area (SCSA) for the hospital plus two percent (2%). Rates for hospital outpatient services shall be set in accordance with Part A, Section I.B. Rates for inpatient mental health services shall be set in accordance with Part A, Section II.A(2).

2. Hospital Based Physicians and Other Providers

Subject to approval by the Board or its designated representative, the Administrator may enter into a contract with hospital based physicians and other providers for the provision of medically necessary health care services to CMSP members at a California hospital that has a contract to provide services and is not located in a CMSP County or a California county contiguous to a CMSP County. Rates of payment shall be those set forth in Part A, Sections I.A and IV, as appropriate to the service provided, or as otherwise approved by the Board or its designee.

**III. Dental, and Home Infusion Services (Excluding FQHC/RHC and THP Providers)**

A. Dental Services

Effective January 1, 2012, the CMSP rates shall be the CMSP rates in effect on December 31, 2011. Such rates shall be made available to all contracting providers through the Administrator. Such rates are comparable to the Medi-Cal rates for such services in effect on July 1, 2007.

For selected specialty providers, the Administrator may enter into a contract at an alternative rate to promote the availability of such provider, subject to approval by the Board or its designated representative.

Updates to these rates shall be made by the Administrator from time to time subject to the approval of the Board or its designated representative. Such updates may include provisional rates for CPT codes when such codes are established or become obsolete.

B. Home Infusion Services

Effective January 1, 2012, the CMSP rate shall be comparable with the rate for such services in effect for CMSP on April 1, 2005. The payment structure is a "per-diem-plus" basis meaning that total payment for the service is composed of two components: the per-diem, which provides payment for services and supplies, plus payment for the medication. The payment rate for the medication is average wholesale price minus ten percent (AWP-10%).

The services and supplies that are included in the per-diem payment include: pharmacy compounding fees, therapy-related medical supplies (syringes, tubing,

catheters, dressings, etc.), equipment rental (pump, pole, etc.), medication and supply delivery, clinical pharmacy services and kinetic dosing, and 24 hour on-call availability. Multiple per diems for services to individual CMSP members on a single day shall be discounted.

Updates to the rates described in A and B in this Section shall be made by the Administrator from time to time subject to the approval of the Board or its designated representative. Such updates may include provisional rates for CPT codes when such codes are established or become obsolete.

#### **IV. All Other Services**

These services include, but are not limited to: laboratory, home health, durable medical equipment, ground medical transportation, and ambulatory surgery centers. These services do not include the services listed in I, II and III above or the prescription drug benefit services provided by MedImpact Health Systems, Inc. (MedImpact).

Effective January 1, 2012, the CMSP rates shall be equal to the CMSP rates in effect on December 31, 2011. Such rates shall be made available to all contracting providers through the Administrator. Such rates are comparable to the Medi-Cal rates for such services in effect on July 1, 2007.

The Administrator may enter into a contract with such providers at an alternative rate subject to approval by the Board or its designated representative.

#### **PART B. NON-CONTRACTING "OUT OF NETWORK" PROVIDERS**

For medically necessary emergency services provided to members by non-contracting providers, payment for these services shall be made as set forth below. These payment rates may be revised by the Board from time to time. Payment made for such services, net any share of cost collections, shall constitute payment in full to these providers.

The Board shall not pay for either (a) non-emergency services; or (b) emergency services that are not medically necessary.

#### **I. Non-Contracting "Out of Network" Hospitals in California and Designated Border State Areas for Emergency Services**

Effective January 1, 2014, the Board or its designated representative shall direct the Administrator to pay a non-contracting California hospital and a non-contracting hospital in the Designated Border State Areas (as defined below) the following rates for medically necessary emergency services provided to a member:

- a. For inpatient hospital services, the rate shall be eighty-five percent (85%) of the average amount paid to California hospitals for non-contracted hospital emergency inpatient services based upon their service region and facility type, as published by the California Department of Health Care Services (DHCS)

in 2012 (“base rate”). For dates of service on April 1, 2015, through December 31, 2023, these base rates shall be adjusted as follows:

- Partial Service Year 2<sup>1</sup> – (April 1, 2015, through December 31, 2015) – the product of the base rate and 1.02. Stated as an equation: Base rate x 1.02 (“Partial Service Year 2 rate”)
- Service Year 3 – (January 1, 2016, through December 31, 2016) – the product of the Partial Service Year 2 rate and 1.02. Stated as an equation: Services Year 2 rate x 1.02 (“Service Year 3 rate”)
- Service Year 4 – (January 1, 2017 through December 31, 2017) – the product of the Service Year 3 rate and 1.02. Stated as an equation: Services Year 3 rate x 1.02.
- Service Year 5 – (January 1, 2018 through December 31, 2018) – the product of the Service Year 4 rate and 1.02. Stated as an equation: Services Year 4 rate x 1.02.
- Service Year 6 – (January 1, 2019 through December 31, 2019) – the product of the Service Year 5 rate and 1.02. Stated as an equation: Services Year 5 rate x 1.02.
- Service Year 7 – (January 1, 2020 through December 31, 2020) – the product of the Service Year 6 rate and 1.02. Stated as an equation: Services Year 6 rate x 1.02.
- Service Year 8 – (January 1, 2021 through December 31, 2021) – the product of the Service Year 7 rate and 1.02. Stated as an equation: Services Year 7 rate x 1.02.
- Service Year 9 – (January 1, 2022 through December 31, 2022) – the product of the Service Year 8 rate and 1.02. Stated as an equation: Services Year 8 rate x 1.02.
- Service Year 10 – (January 1, 2023 through December 31, 2023) – the product of the Service Year 9 rate and 1.02. Stated as an equation: Services Year 9 rate x 1.02.

b. For outpatient hospital services, including but not limited to emergency department services and professional services delivered in the emergency department or other outpatient hospital setting, the rate shall be

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<sup>1</sup> For convenience purposes, Service Years correspond to the time periods described in Part A, Section II.A.1, above; Part A, Section II.A.1 shall not apply to Part B Non-Contracting “Out of Network” Providers.



eighty-five percent (85%) of the CMSP rate for such services on December 31, 2011.

c. As a condition for receiving payment for services, the hospital provider must notify the Administrator within twenty-four (24) hours of admitting the member into the emergency department, and such services are determined to be medically necessary emergency services. Post-stabilization services require prior authorization.

For the purposes of this Policy, “Designated Border State Areas” is defined as the out-of-state areas of the states of Oregon, Nevada and Arizona that are within 30 miles of the California border.

## **II. Non-Contracting “Out of Network” Physicians and Other Providers for Emergency Services in California and Designated Border State Areas**

Effective January 1, 2018, for all non-contracting providers in California and in the Designated Border State Areas, excluding non-contracting hospitals, the rate shall be eighty-five percent (85%) of the CMSP rate for such services in the year services are delivered.

As a condition for receiving payment for services, the hospital provider must notify the Administrator within twenty-four (24) hours of admitting the member into the emergency department, and such services are determined to be medically necessary emergency services. Post-stabilization services require prior authorization.

## **III. Non-Contracting “Out of Network” Hospital Based Physicians Providing Services During an Authorized Hospital Stay at a Contracting Hospital**

Effective January 1, 2018, if a non-contracting hospital based physician renders medically necessary services to a member during a hospital stay approved in writing by the Administrator at a contracting hospital, the non-contracting hospital based physician shall be paid the CMSP rate for such services in effect in the year services are delivered.

## **IV. Non-Contracting “Out of Network” Providers Outside of California and Designated Border State Areas for Emergency Services**

For any and all services provided to CMSP members by hospitals outside of California and the Designated Border State Areas, no payment shall be provided.

For any and all services provided to CMSP members by any physicians and other providers outside of California and the Designated Border State Areas, no payment shall be provided.



Good afternoon!

Just a quick follow-up public comment on item XIII-C. On the DMHC emergency regulation, CMSP should also confirm its COVID-19 testing criteria adhere to federal law. The DMHC regulations are supplementary guidance. Testing still must be provided according to federal law:

The Families First Act clearly prohibits health plans from imposing cost-sharing or utilization management on COVID-19 diagnostic testing during the Public Health Emergency. Section 6001(a)(1) of the Families First Act (Pub. L. No. 116-127 (2020)) provides in pertinent part that “[a] group health plan and a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan (as defined as section 1251(e) of the Patient Protection and Affordable Care Act) shall provide coverage” for COVID-19 diagnostic testing. Under this section, health plans also “shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements” for COVID-19 testing furnished during the emergency period. As of the date of this letter, we are still in the Public Health Emergency period as declared by U.S. Secretary of Health and Human Services on January 31, 2020, and extended on July 23, 2020.

As the Congressional Research Service has interpreted Section 6001: “The [testing] coverage must be provided without consumer cost-sharing, including deductibles, copayments, or coinsurance. Prior authorization or other utilization management requirements are prohibited. Congress authorized the Secretary of Health and Human Services, Secretary of Labor, and Secretary of the Treasury to “implement the provisions of this section through sub-regulatory guidance, program instruction or otherwise.” Sec. 6001(c). Sub-regulatory guidance issued by these three federal agencies on April 11, 2020, instruct that testing “must be covered without cost sharing when medically appropriate for the individual, as determined by the individual’s attending healthcare provider in accordance with accepted standards of current medical practice.”

We await DMHC updating its guidance and are happy to work with CMSP to ensure policies are compliant.

Thanks,  
David