The Future of Public Health Population Health Financing & Investment: A Planning Guide for State & Local Public Health

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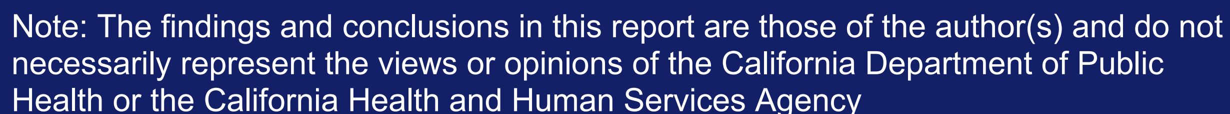

Note: The findings and conclusions in this report are those of the author(s) and do not necessarily represent the views or opinions of the California Department of Public Health or the California Health and Human Services Agency

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Executive Summary

The Future of Public Health, Population Health[1] Financing and Investment: A Planning Guide for State and Local Public Health (the Planning Guide) provides a summary of opportunities and work activities to strengthen the public health system statewide. This effort is an outgrowth of a visioning initiative in California entitled the Future of Public Health. The Planning Guide was commissioned by the California Department of Public Health (CDPH) to inform and focus state and local public health planning efforts.

Health Management Associates, Inc. (HMA) worked closely with CDPH, California Conference of Local Health Officers, and County Health Executives Association of California to develop study areas and refine study questions to inform the Planning Guide. With the aim of strengthening public health statewide, the primary study questions were:

1. What is the current financing model for local health jurisdictions? What is the gap to carry out the services that local health jurisdictions are asked to perform?
2. What are opportunities to leverage additional funding for the existing local health jurisdiction apparatus?

To the first question, HMA developed a model for the 61 local health jurisdictions to estimate the staffing levels, costs, and revenues to perform current public health activities. HMA also included staffing needs in the model to reflect the Public Health Accreditation Board's Foundational Public Health Services and Capabilities, which is considered a baseline of services and capabilities needed by modern US governmental public health agencies.

The model estimates the aggregate annual cost of core and foundational public health services performed by California's 61 local health jurisdictions to be $2.00 billion to $2.44 billion annually. These costs are offset by $1.40 billion in state-directed revenues comprised of $1.20 billion in Realignment funds[2] and $200 million in Future of Public Heath investments[3]. Costs and revenues are estimated for FY 2023-24. Remaining funding gaps for local health jurisdictions are primarily funded by categorical grants, reimbursements for services, and local general fund support.[4]

To the second question of funding opportunities, the Planning Guide includes a discussion of opportunities for local health jurisdictions to optimize revenues – both

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[1] The Centers for Disease Control and Prevention define population health as "an approach to health that aims to improve the health of an entire population." Public Health Key Terms pdf

[2] Crafted in 1991, State-Local Program Realignment (Realignment) provides dedicated revenue streams for a mix of the health and human services provided by counties.

[3] The 2022-23 Budget provided more than $200 million in investment for local health jurisdictions to strengthen their capacity and nearly $100 million for state public health.

[4] In order to fully understand the local LHJ funding picture, a review of each LHJ budget would be needed. This level of analysis was outside of the scope of this project.

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traditional public health financing approaches as well as other, existing opportunities that may be less well known or utilized. The Planning Guide attempts to highlight opportunities and provides broad recommendations, with the understanding that these opportunities will be interpreted differently based on local health jurisdiction capacity and that additional due diligence will be required by local health jurisdictions. Table 1 includes a summary of opportunities as described in greater detail in the Planning Guide.

Table 1. Summary of Current and Exploratory Revenue Opportunities Included in the Planning Guide

Opportunity	Primary Stakeholder
(Current) Medicaid Claiming: Leverage Medicaid claiming or reimbursement opportunities for qualified local public health activities. Specifically: • Targeted Case Management • County-Based Medi-Cal Administrative Activities • Maternal, Child and Adolescent Health – Federal Financial Participation program	Local health jurisdictions
(Current) Managed Care Plan-Related Opportunities: Secure reimbursement from Managed Medi-Cal plans for local public health activities. Specifically: • Roles now eligible for reimbursement (e.g., Doula, Community Health Worker) • CalAIM (Enhanced Care Management and Community Supports) • Direct Payments (developmental and trauma screenings)	Local health jurisdictions
(Current) Opportunities in the Maternal, Child, and Adolescent Health Portfolio: State-level program reform would enable material efficiencies in the use of federal funds [if not optimizing federal allocation] and enable access to matching and supplemental funds in the reauthorization of the Maternal, Infant and Early Childhood Home Visiting program. Specifically: • Maternal, Infant and Early Childhood Home Visiting • Maternal, Child and Adolescent Health – Federal Financial Participation program (see Medicaid Claiming)	CDPH Local health jurisdictions

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Opportunity	Primary Stakeholder
New Medicaid-Related Opportunities and Alternative Strategies: Earlier stage ideas to increase revenue and build necessary infrastructure (with additional due diligence and policy development required). Specifically: • Fee Schedule for Medi-Cal reimbursable services provided by public health • Enhanced Reimbursement Rates for IT Infrastructure Projects (an additional, allowable Medicaid Administrative Claiming activity)	CDPH Department of Health Care Services

The Planning Guide sets the stage for further refinement of ways to improve the funding of local health jurisdictions, as well as development of future trainings and supports to advance ideas set forth.

Current Context

California Department of Public Health and Local Health Jurisdictions – Structure, Funding and Trends

The California Department of Public Health (CDPH) and 61 local health jurisdictions have interconnected and defined roles that form the public health structure in the state. Local health jurisdictions operate under either county or city local governance (i.e., Boards of Supervisors or City Councils), which have personnel, budget, and performance oversight. The California Health and Safety Code and the California Code of Regulations mandate the types of services and responsibilities of local health jurisdictions. Additionally, local governing boards can make service requirements of local health jurisdictions as long as these requirements are not in conflict with state law. Local health jurisdictions are led by health department directors or health officers, who together with their teams carry out the bulk of public health activities and enforcement on a day-to-day basis. CDPH and the state health officer hold plenary power on the final interpretation and execution of California's public health laws, including those that apply to local health jurisdictions.

While local health jurisdictions have mandated requirements, in many instances, they have flexibility to configure operations and service levels to meet local needs. Thus, service mix, service levels, and organizational form vary among local health jurisdictions. Additionally, there is substantial variation in the size (2,000 to 10 million population), geography (46 to 20,000 square miles), and demography (7.5% to 25% population in poverty) of the populations served by local health jurisdictions.[5]

[5] Poverty percentage Table across California counties.pdf

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CDPH and local health jurisdictions have a mixture of funding sources. CDPH is funded through a mix of state general funds, federal funds, and activities that are fee-offset (i.e., health facilities inspections). Local health jurisdictions have a myriad of state and federal categorical grants and revenues from fees and patient care, and some local sources.[6] However, a key component of local health jurisdiction financing comes from a funding mechanism known as State-Local Program Realignment (Realignment).

Crafted in 1991, Realignment provides dedicated revenue streams for a mix of the health and human services provided by counties. The revenues include a share of vehicle license fees and a share of sales taxes. The service mix supported by Realignment includes social services (income support and child welfare), mental health, and health programming.

Annually, the Realignment package totals $7 billion statewide with roughly 80% of the funds supporting social services and mental health. The health component of Realignment supports a range of programming including indigent care, children's medical care, and public health. With California's implementation of the coverage expansions through the Federal Affordable Care Act (ACA), portions of the health-related Realignment funds were re-directed to the state for social services reflecting the reduced county obligation to be the "provider of last resort" for health care.[7] Table 2 details the broad allocations of Realignment funding by program area.

While Realignment revenues are a dedicated funding source supporting local health jurisdictions, they are subject to economic volatility. The funds can increase quickly in good economic times and decrease quickly when the economy slows.[8] As an indicator of how significant Realignment-funded services are to the state's health and human services safety net, the Budget Act of 2020, backfilled reduced Realignment revenue resulting from the COVID-19 pandemic and economic downturn.[9] This kind of backfill funding has not occurred in other circumstances such as the Great Recession from 2008-11.

[6] Local health jurisdictions also have interactions with other entities and can also perform service functions under contract to administer the Childrens' Medical Services program and the Child Health Disability Prevention program, for example. Local health jurisdiction activities with other entities is elaborated in Appendix C.
[7] Senate Bill 90: 1991 Realignment Report.pdf
[8] See Sales Tax chart, California Legislative Analyst at The California Legislature's Nonpartisan Fiscal and Policy Advisor webpage
[9] See State Spending Plan, California Legislative Analyst at The California Legislature's Nonpartisan Fiscal and Policy Advisor webpage

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Table 2. Realignment Allocations

2021-22 State Fiscal Year (Actuals)

Amount	CalWORKs MOE	Health	Social Services	Mental Health	Family Support	Child Poverty	Totals
Base Funding							
Sales Tax Account	$752,888	$87,215	$2,409,972	$115,314	$418,627	$251,580	$4,035,595
Vehicle License Fee Account	367,663	1,070,952	216,223	104,743	185,798	419,359	2,364,738
Subtotal Base	**$1,120,551**	**$1,158,167**	**$2,626,195**	**$220,057**	**$604,425**	**$670,939**	**$6,400,333**
Growth Funding							
Sales Tax Growth Account:	$0	$109,354	$70,065	$221,816	$0	$261,392	$662,627
Caseload Subaccount			(70,065)				(70,065)
General Growth Subaccount		(109,354)		(221,816)		(261,392)	(592,562)
Vehicle License Fee Growth Account		364		737		869	
Subtotal Growth	**$0**	**$109,718**	**$70,065**	**$222,553**	**$0**	**$262,261**	**$664,597**
Total Realignment 2021-22[1/]	**$1,120,551**	**$1,267,885**	**$2,696,259**	**$442,610**	**$604,425**	**$933,200**	**$7,064,929**

Source: Excerpt from Department of Finance, Budget Summary pdf.

As mentioned, the health Realignment component supports a mixture of health programming organized and administered by local health jurisdictions of which public health is one of the service areas, among others. The allocations to public health versus other health service areas are determined by the Board of Supervisors (or City Council where applicable) governing the local health jurisdiction. That is, local governing boards have the authority to fully or partially allocate the health Realignment funds to public health based on local priorities.

Many public health functions and mandated activities have discretionary service levels and segmented funding streams. The laws and regulations governing CDPH and local health jurisdictions detail numerous functions that must be available or provided to California residents but only in a few instances are the service levels defined. For example, the laws and regulations specify certain personnel (i.e., physician health officer, public health nursing director, public health lab director) and activities that must occur (i.e., processing of birth and death records, communicable disease investigation, health education), but for the most part, do not indicate specific outcomes or time frames. Thus, configuring service levels – the level of effort needed to address a public health concern, or the appropriate minimum staffing needed – is a significant challenge for CDPH and local health jurisdictions.

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For public health activities which have estimable volumes such as birth and death certificate processing, determining staffing levels is relatively straightforward. Similarly, determining the minimum staffing for a public health laboratory is largely identifiable. However, determining how much staff is needed to detect, investigate and respond to a disease outbreak or an environmental threat is very challenging considering the range of pathogens, the mode of spread, and the populations at risk, which can vary from focal events (i.e., small disease outbreak in a childcare center) to a community-wide or pandemic event like COVID-19. This challenge also extends to determining the appropriate staffing level for injury and chronic disease, or equity and social determinants of health activities.

The complexity of service mix and staffing levels is also intersected by the way in which public health functions are funded. Some functions, such as immunizations or vital records, are sometimes offset by reimbursement or fees, respectively. There are times when reimbursements and fees do not cover the cost of administering the program and costs must be subsidized in other ways. Other public health functions are funded by a mix of state funds, Realignment, special-purpose grants, reimbursements, and local funds. The table below provides an example of local health jurisdictions' public health functions and funding mechanisms.

Table 3. Local Health Jurisdiction Public Health Functions and Funding Mechanisms

Public Health Function	Major Funding Mechanisms	Minor Funding Mechanisms
Health Assessment and Epidemiology (Birth/death records, disease reporting, health statistics, report on community health)	Fees Realignment Local contribution	State and Federal grants
Environmental Health (Restaurant inspections, housing inspections, vector control)	Fees Realignment Local contribution	State and Federal grants
Communicable Disease Control (Tuberculosis, Sexually Transmitted Disease, acute communicable disease, vaccine-preventable disease investigation and response)	Realignment State and Federal grants Local contribution	Service reimbursement
Health Promotion (Maternal, Child and Adolescent Health, Violence and Injury Prevention, Chronic Disease)	Realignment State and Federal grants Local contribution	Service reimbursement

Note: This chart shows the broad funding options available to local health jurisdictions, and may not be the case in a specific local health jurisdiction

Public health agencies have broad and diverse responsibilities, and a committed workforce managing these responsibilities, yet gaps in the public health system and the need for strengthening and improvement have been well documented for

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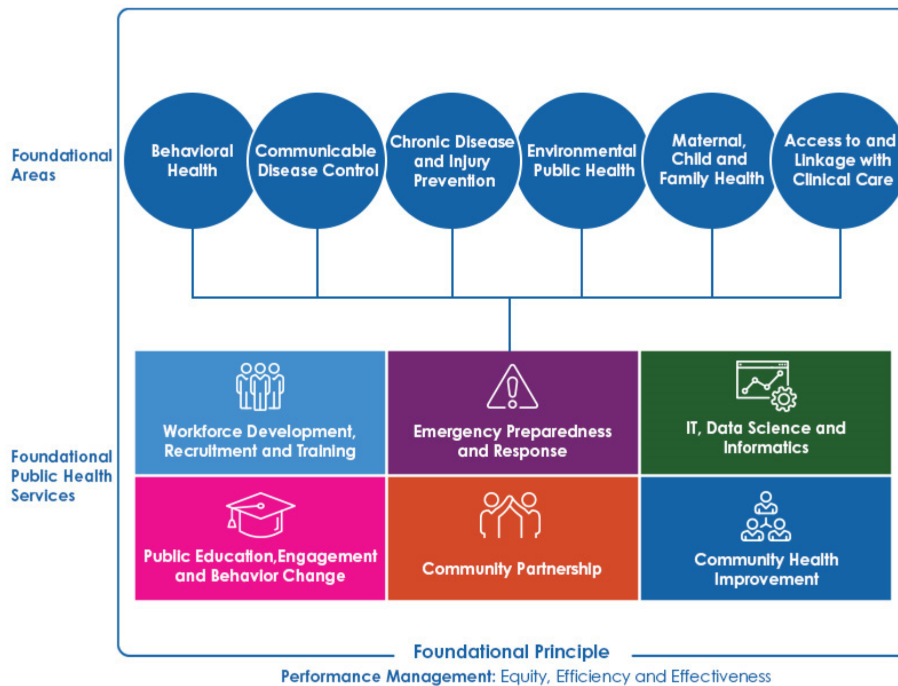
over 25 years.[10] Two of the major levers employed nationally to strengthen public health have been through funding from the Centers for Disease Control and Prevention (CDC) to state and localities under the Public Health Emergency Preparedness grant program and the Public Health Accreditation Board accreditation process. Both the Public Health Emergency Preparedness funds and the Public Health Accreditation Board processes are focused on defining the capabilities that all public health agencies should have. Accreditation is centered on a set of Foundational Public Health Services that all public health agencies should provide and Foundational Capabilities that are needed to support basic public health programs and activities.[11,12] Accreditation involves standards; measures; and documentation; and completion of a systematic Community Health Assessment, Community Health Improvement Plan, and an agency strategic plan. It should be noted that for some local health jurisdictions pursuing Public Health Accreditation Board accreditation might be cost prohibitive, but the ideals should be considered as a roadmap to strengthening and improving local health jurisdictions.

Figure 1. Foundational Public Health Services



The COVID-19 worldwide pandemic laid bare long-standing gaps in public health core capabilities required to effectively provide foundational public health services, particularly gaps in information technology and emergency

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[10] Institute of Medicine, Future of Public Health, 1988 The Future of Public Health Book
Trust for America's Health, Ready or Not Trust for America's Health Reports webpage
[11] Foundational Public Health Services (FPHS); Public Health Accreditation webpage
[12] Foundational Capabilities for Public Health Services; Public Health Accreditation webpage

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preparedness and response. The pandemic also exposed additional gaps that had previously not existed or may have gone without acknowledgement. Public health became far more politicized and, in some communities, a lack of trust took hold.[13]

Adding further to infrastructure challenges, the pandemic contributed to increased stress, burnout, and symptoms of post-traumatic stress among the workforce in state and local public health agencies. Moral injury remains rampant among the workforce and may be negatively impacting the ability of public health practitioners to sustain their commitment to public health.[14]

The Future of Public Health Initiative

The COVID-19 pandemic in California emphasized the need for adequate investment in public health and exposed significant gaps in the ability of California Department of Public Health and local health jurisdictions to respond to the needs of Californians rapidly and sustainably. In response to evident gaps in the existing public health infrastructure, the 2021 Budget Act signaled a commitment from the Administration and Legislature to invest in its fortification by including $3 million General Fund to support a public health infrastructure study to assess essential public health infrastructure needs and $300 million ongoing General Fund to fund these activities beginning in 2022-23.

- Dr. Tomás J. Aragón, Public Health Officer and Director, California Department of Public Health (January 2022 Memo)

The Future of Public Health Initiative is centered on building a robust public health system. It aims to invest the resources necessary to ensure foundational public health services and capabilities that are effective, efficient, nimble, and modern to enable and support happier, healthier, thriving individuals and communities.

In September 2021, the multi-stakeholder Future of Public Health Workgroup (Workgroup) released a memo, Investments and Capabilities Needed for the Future of Public Health System (the Memo).[15] The Memo was the product of 27 Workgroup members, including representatives of diverse local and state public health entities, varied jurisdictions, labor union representation, the California Department of Health and Human Services, County Health Executives Association of California, and Health

[13] DeSalvo K, Hughes B, Bassett M, Benjamin G, Fraser M, Galea S, Gracia JN. Public Health COVID-19 Impact Assessment: Lessons Learned and Compelling Needs. NAM Perspect. 2021 Apr 7;2021:10.31478/202104c. doi: 10.31478/202104c. PMID: 34532688; PMCID: PMC8406505.
[14] de Beaumont 2021 findings webpage
[15] Future of Public Health Memo.pdf

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Officers Association of California. The Workgroup engaged stakeholders from across California, conducting over 80 interviews to gather input for the Memo.

Future of Public Health investments are geared toward advancing CDPH and local health jurisdictions to address gaps for current and future challenges. Beginning in 2022-23, the spending plan's $300 million General Fund included $99.6 million for state operations and $200.4 million in local assistance to support local health jurisdictions.

It should be noted that the Future of Public Health annual allocation of $300 million General Fund is subject to the annual State Budget Act. The State Budget Act for FY 2024-25 made a 7.95% reduction in Future of Public Health funds due to the significant budgetary challenges facing the State.

The state's $99.6 million share of the new investment was focused on six foundational governmental public health service areas. The $200.4 million for local health jurisdictions uses an allocation methodology developed in consultation with the County Health Executives Association of California, California Conference of Local Health Officers, and Service Employees International Union. The allocation methodology focuses on the four areas of Workforce Expansion, Reducing Health Disparities, Data Collection and Monitoring, and Community Partnerships.

The Future of Public Health investment was intended to solve significant gaps in current capabilities and infrastructure, and also position California's state and local health agencies to face ongoing and emerging public health threats and challenges. In some instances, the gaps in California's governmental public health agencies are staffing shortages in core areas, while in other topical areas new capabilities are needed to address new threats and challenges such as:

- **COVID-19.** While California's state of emergency is over, COVID-19 is not over. The virus continues to mutate, requiring resources and ongoing vigilance, including attention to the effects of long COVID.
- **Other Communicable and Contagious Diseases.** The emergence of new infectious diseases, and the re-emergence of other diseases like mpox, poses an increasing threat to public health agencies with growing concern about the development of resistance to antimicrobials and vaccines.
- **Climate Change.** Climate Change is an ongoing and increasing public health threat in California with exposure to extreme weather conditions, air pollution, displacement, and food insecurity and exacerbating issues of inequity, mental health and the spread of infectious disease.
- **Behavioral Health.** Behavioral Health encompasses mental health conditions and substance misuse. Mental health conditions are common, with more than one in five adults in the U.S. currently living with a diagnosable mental health

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condition.[16] Mental health is connected to many public health outcomes, including suicide, chronic diseases, substance misuse, and violence. Poor mental health or mental health conditions increase the risk for many chronic physical health conditions, including stroke, type 2 diabetes, and heart disease.[17] Similarly, the presence of chronic conditions increase the likelihood of having or developing a mental health condition.[18] On the tail of COVID-19 pandemic, many have described the oncoming impact on mental wellbeing as a "mental health tsunami," the result of the isolation, illness and loss of life, economic downturn and uncertainty that came with the realities individuals and families faced.

- **Public Health Workforce**. The public health workforce is facing numerous challenges, including recruitment and retention of qualified staff, stress and burnout resulting from their experiences during the pandemic, and competition from the private sector. According to the American Public Health Association, the most critical shortages are found in epidemiology, nursing, laboratory science and environmental health. These fields are critical to tracking and responding the communicable and contagious diseases, providing vaccines, educating the public, and protecting air and water.[19] The American Public Health Association points out that this workforce shortage is happening at a time when public health is needed to take on more responsibility with declining resources. Of particular concern are rural and underserved areas, where adequate public health workforce may have already been a challenge and attracting and sustaining the workforce can be difficult.
- **Health Equity**. Health disparities are an ongoing challenge for public health, but the pandemic exacerbated existing disparities and created new ones. All the threats mentioned above will do the same. Investments in public health's infrastructure can support the ability to address systemic and structural inequities through better data collection, resource sharing and policy.

[16] National Institute of Mental Health webpage

[17] Chronic Illness & Mental Health External. Bethesda, MD: National Institutes of Health, National Institute of Mental Health. 2015.

[18] Chronic Illness and Mental Health. Recognizing and Treating Depression. National Institutes of Health, National Institute of Mental Health. 2021.

[19] https://www.apha.org/-/media/files/pdf/factsheets/publichealthworkforceissuebrief.ashx

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Approach

The Future of Public Health, Population Health[20] Financing and Investment: A Planning Guide for State and Local Public Health (the Planning Guide) is part of the larger Future of Public Health Financing and Investment Project.

It presents important foundational content on which the larger Future of Public Health Initiative can build. The Planning Guide looks toward a future state in California with a vision of a strengthened and improved public health system that more strongly protects and improves the health of all Californians.

In January 2023, CDPH's Office of Policy and Planning contracted with Health Management Associates, Inc. (HMA) through a competitive procurement process to provide professional strategic planning, project management, and population health management services in the development of a three-year strategic community health financing and investment report. This work includes:

- Assessment of funding for core local health jurisdiction public health functions
- Analysis to estimate the gap in funding and capacity needed to adequately resource governmental public health in order to achieve the vision of a strengthened and improved public health system
- Development of strategies to maximize revenue through new and existing funding
- Training to support the adoption of financing and investment strategies identified to strengthen public health and stabilize its funding

HMA launched the first phase of work between January and May 2023, with approval from CDPH leadership, guidance from County Health Executives Association of California, California Conference of Local Health Officers, key stakeholder feedback, a review of the literature and background research. HMA developed a strategic approach to strongly align with the priorities of local health jurisdictions and the goals of the Future of Public Health Initiative.

Stakeholder Engagement

The creation of the Planning Guide involved input from a broad range of stakeholders, including national organizations, state agencies, state organizations (i.e., statewide public health organizations or associations), health system partners (including public and commercial managed care plans and statewide health and professional organizations), local health jurisdictions, and community-based organizations, among others. Entities included within these broad categories were culled from

[20] The Centers for Disease Control and Prevention define population health as "an approach to health that aims to improve the health of an entire population." Public Health Key Terms.pdf

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recommendations made by HMA as well as stakeholder lists provided by CDPH. The stakeholder engagement process launched in early 2023 with a series of interviews. The aim of stakeholder engagement was to understand the current state and to solicit input and ideas for strengthening and improving public health.

In addition, with consent of the respective organizations, CDPH dedicated portions of existing, regular joint Executive Committee meetings of the County Health Executives Association of California and the California Conference of Local Health Officers to support the development of a financing and investment strategy. The advisory committee met on a few occasions in the winter and spring of 2023 to provide recommendations to shape the content of the Planning Guide.

Emerging from this process was the creation of a small work group comprising a subset of advisory committee members, which met weekly from June-August 2023. The small work group was created to address complex issues and influence decisions in ways that balance thorough assessment work with the practicality of producing useful resources of maximum value to the field. The small work group played a consultative and review role in framing, shaping, and clarifying HMA's deliverables.

Please refer to Appendix A for a list of public heath champions who provided their time and expertise to developing a draft of the Planning Guide.

Process of Developing the Planning Guide

HMA was tasked to focus on the following key questions:

1. What is the current financing model for local health jurisdictions? What is the gap to carry out the services that local health jurisdictions are asked to perform?
2. What are opportunities to leverage additional funding for the existing local health jurisdiction apparatus?

HMA formulated approaches to these questions through two workstreams:

Workstream 1: Assessment of Local Health Jurisdiction Infrastructure and Implications for Finance and Staffing Models

The assessment of local health jurisdiction infrastructure included the creation of a model – with input from state leaders and local health jurisdiction representatives – to estimate the investment gap in local health jurisdiction core and enhanced infrastructure functions. The model is intended as a benchmarking effort that incorporates multiple factors including local health jurisdiction size; mandates, obligations, and enhanced activities under the Public Health Accreditation Board Foundational Public Health Services Framework; and estimates of staffing, costs, and revenues. The model also includes multiple, modifiable variables – accounting for variation in local health jurisdiction size, structure, and services – to allow for local health jurisdiction planning and forecasting under different scenarios.

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Workstream 2: Revenue Maximization and Alignment Opportunities

The revenue maximization and alignment work catalogues and defines current and future opportunities for local health jurisdictions to optimize revenues. This section includes discussions of:

- Opportunities to further leverage current revenue streams
- New opportunities for revenue or reimbursement from emerging state health care initiatives
- New models and alternative strategies (understanding that some of these models and innovations will not be accessible in the immediate future as they may require new law and policy development)

The revenue maximization and alignment narratives outline opportunities wherein local health jurisdictions could financially benefit via a direct role as a service provider and/or align their local public health activities to health care reform initiatives to meet collective, larger public health objectives (e.g., improve integration of public health prevention strategies and alignment of varied and siloed community health assessments to strengthen and extend the impact of the public health process as a resource to inform action across multiple and a diverse set of partners, etc.).

Financing and Investment Training Plan

In spring 2024, HMA conducted a series of training courses for local health jurisdictions and the California Department of Public Health related to the Planning Guide. The first training track, Assessment of Local Health Jurisdiction Infrastructure and Implications for Finance and Staffing Models, focused on how local health jurisdictions can utilize the model for planning and forecasting under different scenarios. The second set of trainings, Revenue Maximization and Alignment Opportunities, detailed existing mechanisms for accessing Medi-Cal revenue, as well as opportunities wherein local health jurisdictions could financially benefit via a direct role as a service provider and/or align their local public health activities to health care reform initiatives to meet collective, larger public health objectives.

Comprehensive Assessment of Local Health Jurisdiction Infrastructure

CDPH received CDC funding to support the transformation of California's public health infrastructure to meet modern demands. With these funds, CDPH is focused on both the agency and its interactions with local health jurisdictions. HMA's work is helping to establish a foundational understanding of local health jurisdictions' staffing and funding levels.

There is no current overall reporting of local health jurisdiction staffing and funding levels. While all local health jurisdictions are budgetary units of their respective local government, there is no aggregate reporting of local health jurisdictions' total budgets that can provide an overall view of California's local public health infrastructure. Local health jurisdictions are also variable in the way in which they are configured operationally. The Public Health Accreditation Board provides some staffing estimation

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tools for public health departments, but they are expressly focused on agencies serving populations of less than 500,000.[21] Moreover, the Public Health Accreditation Board tool is not aligned with California public health laws and regulations. Thus, there is no common existing solution to determining local health jurisdictions' infrastructure needs and gaps.

HMA, in consultation with CDPH and local health jurisdictions, developed an estimation model that includes the following elements:

- Alignment of state mandates and obligations to the Public Health Accreditation Board's Foundational Areas and Capabilities to create a common framework with which to view local health jurisdictions functional areas.
- Creation of a common staffing roster for local health jurisdictions' functions, and capability to add other positions specific to a jurisdiction.
- Application of common staffing to local health jurisdictions' functional areas and segmented by local health jurisdictions' size. This is accomplished by establishing a core staffing set by local health jurisdiction. In general, marginally higher staffing levels were applied to communicable disease and maternal, child and adolescent health functions due to the mandated activities and inherent workload (i.e., case investigation) as contrasted to chronic disease and injury prevention.
  Local health jurisdictions are categorized by the following population sizes:

Type	Population Range	Number of LHJs
Very small	<50,000	15
Small	50,000 to 199,999	16
Medium	200,000 to 699,999	15
Large	700,000 to 4,999,999	14
Very large	> 5,000,000	1

- Application of cost to staffing. This is accomplished by using Los Angeles County salaries and modified by the Medicare Wage Index for a local health jurisdictions' geography. Los Angeles County salaries were used because of data availability, and the Medicare Wage Index is an adjuster to reflect health care labor cost by each county.
- Financial factors from a public health readiness assessment that adjusts costs of an LHJ to account for filling gaps in core activities or adding new needed capabilities.

[21] Public Health Accreditation webpage

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- Estimation of revenue offsets. This is accomplished by including local health jurisdictions - assumed Future of Public Health funding allocations and Realignment revenues (based on prior year amounts).[22]

Local Health Jurisdiction Model Assumptions

- Fee-Offset services such as environmental health restaurant inspections were excluded because service inventories vary significantly by local health jurisdiction, and state law provides that local health jurisdictions can recover the costs of these services.
- Technical assistance and other local assistance provided by CDPH for local health jurisdictions were not included because of scoping and timing limitations.
- The model includes adjustability for locally imposed mandates and services, uses of Realignment revenues, and includes scaling factors to reflect local health jurisdiction size.
- The model does not specify how a local health jurisdictions' service is accomplished. For example, whether a local health jurisdiction program is nurse-based or uses other skill levels of public health personnel.
- The model does not include factors for socioeconomic, environmental, and other risks which can influence the level of service response needed by a local health jurisdiction.

Appendix B provides additional details on the variables in the model.

Local Health Jurisdiction Model Outputs

The model provides information that allows local health jurisdictions to compare their current staffing against a model benchmark staffing. The following table provides model Full-Time Equivalent (FTEs) staffing outputs at the aggregate level by local health jurisdiction population.

Table 4. HMA Model Staffing Outputs by Local Health Jurisdiction Size

HMA Estimated LHJ Model Staffing

Foundational Area	Very Small (= <50,000)	Small (50,000-199,999)	Medium (200,000-699,999)	Large (700,000-4.9M)	Very Large (>5M)
Communicable Disease	5.0	8.0	39.0	113.0	279.5
Chronic Disease & Injury Prevention	4.0	8.0	19.0	52.5	129.8

[22] Note: The model does not include other LHJ-specific funding sources such as categorical grants, reimbursements for services, local general funds, or philanthropic funds.

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Foundational Area	Very Small (= <50,000)	Small (50,000-199,999)	Medium (200,000-699,999)	Large (700,000-4.9M)	Very Large (>5M)
Environmental Public Health	2.0	4.0	10.0	30.0	75.0
Maternal Child and Adolescent Health	4.5	10.0	36.0	108.0	270.0
Access to & Linkage with Clinical Care	2.0	3.0	15.0	45.0	112.5
Administrative	6.5	7.5	15.0	44.0	103.5
Total	**24**	**40.5**	**134**	**392.5**	**970.3**

Note: This chart does not include staffing associated with California Children's Services and fee offset functions which may be significant depending on the local health jurisdiction.

In terms of local health jurisdiction costs and revenues, the model estimates the aggregate annual cost of the core and foundational public health services to be performed by California's 61 local health jurisdictions is estimated to be $2.00 billion to $2.44 billion annually. The majority of LHJ costs are personnel costs, and staffing levels that form the basis for these estimates. These costs are offset by $1.40 billion in state-directed revenues comprised of $1.20 billion in Realignment funds and $200 million in Future of Public Heath investments. Costs and revenues are estimated for FY 2023-24. Remaining funding gaps for local health jurisdictions are primarily funded by categorial grants, reimbursements for services, and local general fund support.

Opportunities to Increase Revenue for the Local Health Jurisdiction Apparatus

California's local health jurisdictions have experienced significant budgetary distress that threatened their ability to perform foundational public health services and capabilities. At present, this distress is exacerbated by impending changes in COVID-10 funding given the expiration of the public health emergency. Concurrently, there are major investments and reforms taking place in California's health care system, including CalAIM, that have intersections with public health.

Below, HMA presents existing and potential opportunities for local health jurisdictions to leverage to strengthen capacity for public health activities. The mix and form of these opportunities vary. Some opportunities are revenue and service opportunities for local health jurisdictions, while others are state-level opportunities that would benefit local public health revenue. This section organizes opportunities into four categories:

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- Current/existing Medicaid opportunities (including Medicaid Administrative Claiming, managed care plan-related opportunities, and opportunities in the Maternal, Child and Adolescent Health portfolio)
- Opportunities with Medi-Cal Managed Care Plans
- New Medicaid-related opportunities (including All Payer Fee Schedule and informational technology infrastructure investments)

Current/Existing Medicaid Opportunities

Medicaid Claiming Opportunities

The Opportunity: Leverage Medicaid claiming or reimbursement opportunities for qualified local public health activities.

Primary Stakeholder: Local health jurisdictions

The Centers for Medicare and Medicaid Services offers states optional administrative claiming opportunities that provide federal financial participation (FFP) to cover activities that contribute to the efficient and effective administration of the Medicaid program. Under federal Medicaid law, FFP is only available if it is in a state's Medicaid plan and managed by the state's Medicaid program, which, in California, is under the Department of Health Care Services**.** Medicaid claiming or reimbursement opportunities can provide an ongoing, sustainable source of funding for qualified local public health activities. Indeed, several common administrative claiming activities have been accessed by local jurisdictions for decades, although not always optimized. Three such programs[23] included in California's Medi-Cal Plan are described in greater detail:

- Targeted Case Management
- County-Based Medi-Cal Administrative Activities
- Maternal Child and Adolescent Health, Federal Financial Participation program

Targeted Case Management

Targeted Case Management services are defined as "services furnished to assist individuals, eligible under the state Medicaid Plan, in gaining access to needed medical, social, educational and other services (42 CFR 440.169)." The Targeted Case Management program is authorized by sections 1905(a)(19) and 1915(g) of the Federal Social Security Act (Title XIX), and the California Welfare Institutions Code sections 14132.44, 14132.47, 14132.48 and 14132.49, and is jointly funded by Title XIX and state funds. Persons eligible for this program are those Medi-Cal beneficiaries in one of the following populations:

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[23] Other Medicaid claiming opportunities exist, such as School based Medi-Cal Administrative Activities, Mental Health Medi-Cal Administrative Activities, but those are less pertinent for local health jurisdictions, and will not be covered in this report.

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- Children under the age of 21
- Medically fragile individuals
- Individuals at risk of institutionalization
- Individuals in jeopardy of negative health or psycho-social outcomes
- Individuals with a communicable disease

According to the Code of Federal Regulations, the Targeted Case Management program includes the following service components, at least one of which must be performed by the "case manager" during every encounter:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services
2. Development (and periodic revision) of a specific care plan that addresses the service needs for the Medi-Cal individual (i.e., any of the service need categories in the assessment) and is based on the information collected through the assessment
3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services
4. Monitoring and follow-up activities to ensure the care plan is implemented and the eligible individual's needs are addressed

Federal and state regulations establish qualifications for the "local governmental agency" – a county or chartered city with a current participation agreement with the Department of Health Care Services for the provision of the Targeted Case Management program – as well as for the case managers carrying out program activities.[24] The "local governmental agency" is considered the Targeted Case Management program provider and is expected to employ staff who meet case manager qualifications. Additionally, the "local governmental agency" ensures service quality in keeping with state and federal requirements and has the capacity to be responsible for financial management of the program (including meeting all claims submission, documentation, and record retention requirements). The "local governmental agency" may subcontract with community-based organizations and other subcontractors to perform some or all of these functions. Subcontractors may participate in the program, and submit claims, but these must be submitted through the "local governmental agency." Contracts between the "local governmental agency" and the subcontractor must be in effect and delineate the scope of work, describing specific activities the subcontractors will perform, the staff that will perform the activity, and the deliverables (e.g., flyers, media announcements, meetings, and other contacts). Unless the contract specifies each of the activities and the total amount to be reimbursed to the

[24] The "Local Governmental Agency" (LGA) can directly enter into contracts with DHCS for Medicaid Claiming activities (e.g., TCM and CMAA). All local health jurisdictions are also LGAs.

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subcontractor, the subcontractor must participate in time surveys as detailed in the contract.

Additional requirements the "local governmental agency" must meet include:

- Documentation of certified public expenditures[25] to qualify for reimbursement of allowable Targeted Case Management program activities
- Annual participation prerequisites that detail the "local governmental agency's" compliance information (e.g., performance monitoring plan, signature authority, profile request, subprogram codes and requirements for each Targeted Case Management program subcontractor)
- Perpetual time study with validated time study supporting documentation submitted with each invoice
- Annual Cost Report

Examples of public health-related activities that could be potentially reimbursable under Targeted Case Management are organized below under the four (abbreviated) service components. These activities might be germane to various public health nurse programs and activities, other health promotion and injury prevention programs, and special population programs run by local health jurisdictions. For example, some local health jurisdictions access Targeted Case Management funds to reimburse the costs of Targeted Case Management-related activities that are provided during home visits. As will be discussed later, local health jurisdictions and managed care plans must ensure that services provided to the same Medi-Cal beneficiary under Targeted Case Management and Enhanced Care Management are not duplicative and not billed twice.

Table 5. Targeted Case Management and Sample Reimbursable Activities

Category	Sample Reimbursable Activities
Comprehensive assessment and periodic reassessment of individual needs	• Taking client history • Identifying the individual's health-related needs and completing related documentation • Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual

[25] Certified public expenditures (CPE) are expenses incurred by government authorities, including state agencies, local health jurisdictions, local education authorities, county hospitals, etc. In order for the state (Department of Health Care Services) to be able to claim federal financial participation, these expenses must represent actual costs incurred for the provision of Medicaid covered services or administrative activities included in the state plan. See Medicaid and CHIP Payment Advisory Committee (MACPAC) Non-federal funding brief.; and the Medicaid Finance Primer from the Government Accounting Office. Medicaid: Primer on Financing Arrangements.pdf

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Category	Sample Reimbursable Activities
Development (and periodic revision) of a specific care plan	• Specifying and documenting the goals and actions to address the medical, social, educational, and other services needed by the individual • Detailing activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals • Identifying a course of action to respond to the assessed needs of the eligible individual
Referral and related activities	• Activities that help link the individual with medical, social, educational providers, or other programs and services that can provide needed services to address identified needs and achieve goals specified in the care plan
Monitoring and follow-up activities to ensure care plan is implemented, and needs are addressed	• Ensuring services are being furnished in accordance with the individual's care plan • Ensuring services in the care plan are adequate • Identifying and documenting changes in the needs or status of the individual in the care plan • Quality assurance and performance monitoring of the Targeted Case Management program • Making necessary adjustments in the care plan and service arrangements with provider

County-Based Medi-Cal Administrative Activities

States meeting Medicaid program requirements receive federal funding in the form of federal financial participation, which is a reimbursement of actual expenditures for certain Medi-Cal services and administration. County-Based Medi-Cal Administrative Activities are also administered by the Department of Health Care Services. The federal financial participation for County-Based Medi-Cal Administrative Activities is 75 or 50 % (referred to as the enhanced[26] or unenhanced rate, respectively) of total fund

[26] Enhanced rates are permissible for activities or functions provided by skilled professional medical personnel with specified education and training, as well as their direct clerical support. Skilled professional medical personnel are prescribed by federal and state classification and duty statements and include licensed professional staff, such as nurses, physicians, dentists, physician’s assistants, nutritionists, social workers, etc. “Local government authorities,” and local health jurisdictions are eligible to access enhanced rates for appropriate staff. Community based organizations and subcontractors cannot access enhanced rates. Other government entities that contract directly with the state may access enhanced rates..

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expenditures depending on the role of staff that perform the activities (42 CFR §433.15). In particular, the federal financial participation is available to “local governmental agencies” for the cost of administrative activities that directly support efforts to identify and enroll potentially eligible persons into Medi-Cal as described in the state plan amendment with Centers for Medicare and Medicaid Services.[27] “Local government agencies” may claim for the cost of outreach and facilitating the enrollment process.

County-Based Medi-Cal Administrative Activities directly support efforts to identify and enroll potential eligible individuals into Medi-Cal, and to coordinate client health care needs with other health care providers. Table 6 below includes activity categories and examples of reimbursable activities to “local governmental agencies” and their subcontractors (as long as the activities are listed in the Medi-Cal state plan, are not eligible for third party payment and are not available to the public for free).

Table 6. Medi-Cal Administrative Activities Categories and Sample Reimbursable Activities

Category	Sample Reimbursable Activities
Providing Information about Medi-Cal and Medi-Cal Services	• Outreach for Medi-Cal programs and providers in good standing • Information on referrals to sites that can facilitate Medi-Cal enrollment • Referral to Medi-Cal service providers
Assisting with Access	• Assisting with the enrollment process • Coordinating with Medji-Cal covered services • Providing or arranging for transportation of beneficiaries to Medi-Cal services
Health Program Planning and Policy Development	• Gathering data, analysis and planning related to Medi-Cal covered services • Collaborating with others to identify and fill gaps in Medi-Cal covered services
Contracting for Medi-Cal services (“local governmental authorities” only)	• Medi-Cal Administrative Activities /Targeted Case Management coordination and “local governmental agency” claims’ administration

[27] A state plan amendment is a written submission from a state Medicaid or Children’s Health Insurance Program to the Federal government (specifically to the Centers for Medicare and Medicaid Services) requesting review and approval for how the state intends to change the program’s polices or operational approach. The state plan amendment is a requested change from the state plan, which constitutes the agreement between a state and the Federal government describing how the state administers its Medicaid or Children’s Health Insurance Program.

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Taking advantage of these reimbursement opportunities requires that program participants and their subcontractors comply with a set of requirements. At a high level, these requirements include the following:

- A formal relationship (i.e., MOU or contract, etc.) between the "local governmental agency" and applicable subcontractors, which describes the activities to be performed, the staff expected to perform the activity, and the deliverables (e.g., flyers, media announcements, meetings, and other contacts).
- A claiming plan describing in detail the Medi-Cal Administrative Activities to be claimed (i.e., specific activity codes, location of the organization, types of staff, documentation, tracking methods, discounts to be applied as appropriate). The County-Based Medi-Cal Administrative Activities claiming plan must be submitted to the Department of Health Care Services by the "local governmental agency" in the quarter in which the entity intends to begin claiming, and updated according to prescribed timeframes when a change in scope is planned.
- Documentation of certified public expenditures for the County-Based Medi-Cal Administrative Activities related functions to be matched.
- Documentation requirements prescribed by the Department of Health Care Services.
- Time surveys and studies that validate/reconcile time surveys with employee time sheets.
- Annual coding and time survey training for participants.

Maternal, Child and Adolescent Health – Federal Financial Participation

The Maternal, Child and Adolescent Health Federal Financial Participation program (sometimes referred to as MCH-Medi-Cal Administrative Activities) is similar to but separate from County-Based Medi-Cal Administrative Activities. The Maternal, Child and Adolescent Health Federal Financial Participation program allows Federal Title XIX Medi-Cal (Medicaid) funds to be used as partial reimbursement for allowable activities applicable only to women and children who are Medi-Cal beneficiaries or Medi-Cal eligible. This program is administered by CDPH, relates only to Maternal, Child and Adolescent Health programs specified in the state Medicaid plan, and is made available to local health jurisdictions. Unlike County-Based Medi-Cal Administrative Activities, in all the policies and related documentation, CDPH refers to this reimbursement program as a "matching" program. Funds for the Maternal, Child and Adolescent Health Federal Financial Participation program may be matched at either an enhanced rate (75% federal funds with 25% agency general funds/state general funds) or non-enhanced rate (50% federal funds with 50% agency general funds/ state general funds).

There are two main objectives for this program that are consistent with those for County-Based Medi-Cal Administrative Activities: 1) Assisting individuals eligible for Medi-Cal to enroll in the Medi-Cal program and 2) Assisting individuals on Medi-Cal to access Medi-Cal services.

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Comparison of Targeted Case Management, County-Based Medi-Cal Administrative Activities and Maternal, Child and Adolescent Health-Federal Financial Participation

Targeted Case Management, County-Based Medi-Cal Administrative Activities and Maternal, Child and Adolescent Health – Federal Financial Participation are among the most commonly utilized Medicaid administrative claiming programs. **All three programs allow access to Title XIX (Medi-Cal) funding as partial reimbursement for services provided to, or on behalf of, Medi-Cal enrolled or eligible individuals when there is documentation of certified public expenditures that fund those services.**

Allowable activity codes for Targeted Case Management focus on encounters with specific individuals, and as such, appear to allow for services that seem more likely to address social determinants of health for eligible populations. Allowable activities for County-Based Medi-Cal Administrative Activities focus more on population-level outreach and assistance with accessing Medi-Cal services. However, the County-Based Medi-Cal Administrative Activities codes also allow for coordination and monitoring of referrals, providing or arranging for the provision of interpretation and transportation to facilitate access to Medi-Cal services, and work to increase the capacity for and enhancement of Medi-Cal services. Allowable function codes for Maternal, Child and Adolescent Health – Federal Financial Participation include outreach, case management and care coordination, as well as quality management. The Maternal, Child and Adolescent Health – Federal Financial Participation reimbursement, however, is only available for services provided to women and children (in specific MCAH programs that are include in the Medicaid state plan). Targeted Case Management and County-Based Medi-Cal Administrative Activities are both administered by the Department of Health Care Services, while Maternal, Child and Adolescent Health – Federal Financial Participation is administered largely by CDPH (with ultimate oversight by the Department of Health Care Services as the agency statutorily responsible for the Medicaid program).

Of these two programs, Targeted Case Management is the more involved in terms of documentation requirements. This is due in large part to the level of specificity and audit oversight (at the local, state and federal level) related to time surveys (continuous) and documentation of specific activities. That level of administration, related reconciliations and audits have influenced, in part, the decision of several counties and subcontractors to avoid or discontinue involvement in the program. The administrative oversight increased significantly after discrepancies in the early-1990s resulted in the temporary suspension of program eligibility for California, and again in recent years as the state government increased requirements for fraud prevention.

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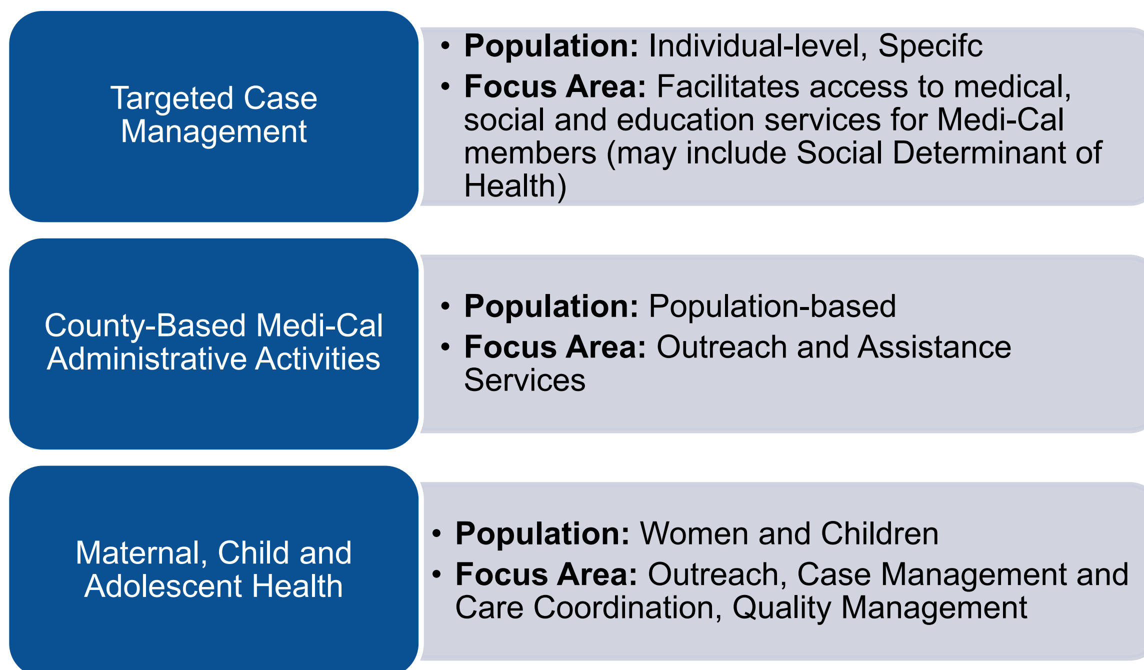
Figure 2: Comparison of Targeted Case Management, County-Based Medi-Cal Administrative Activities and Maternal, Child and Adolescent Health-Federal Financial Participation



Effective July 1, 2025, in general, Medi-Cal members will no longer be allowed dual enrollment in both Targeted Case Management and Enhanced Care Management.[28] In the interest of avoiding duplication of services and optimizing care management services, the Department of Health Care Services has issued guidance in the most current CalAIM Enhanced Care Management Policy Guide and in Policy and Procedures Letter 24-001 regarding this change. In short:

- Enhanced Care Management is viewed as the first options for comprehensive care management for these members.
- In general, Medi-Cal member previously enrolled in TCM as of July 1, 2024 will have the option of remaining enrolled in Targeted Case Management until their care plan goals are met, or transitioning care entirely to their Enhanced Care Management providers.
- A limited exception that allows dual enrollment in Targeted Case Management and Enhanced Care Managements applies only until June 30, 2025, and only for members for whom accessing communicable disease or home visiting programs is dependent on Targeted Case Management (this applies to a small number of counties).

[28] Details regarding this transition are available in the Enhanced Care Management Policy Guide.pdf and in Policy and Procedure Letter 24-001.pdf

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- Local Governmental Agencies (LGAs) may continued to provide services to the small number of Medi-Cal member who do not meet criteria for one of the CalAIM Populations of Focus, "such as adults and youth who are pregnant and postpartum who qualify for County-based TCM and are not eligible for the ECM Birth Equity [or other] POF, or children and youth who qualify for County-based TCM and are not eligible for the ECM Children and Youth POFs."

Opportunities with Medi-Cal Managed Care Plans

The Opportunity: Secure reimbursement from Managed Medi-Cal plans for local public health activities

Primary Stakeholder: Local health jurisdictions

The Medicaid program, authorized by Title XIX of the Social Security Act, is a sprawling program in California that is jointly administered by the federal (Centers for Medicare and Medicaid Services) and state government (Department of Health Care Services). It is beyond the scope of this report to provide a comprehensive overview of the Medi-Cal program, but it is important to be aware of several features of Medi-Cal programs. As a result of Medi-Cal expansions in California, many of which are covered by state-only funds (e.g., expansions that involve immigrants who would not otherwise be eligible for Federal Medicaid benefits), the State provides coverage that is nearly universal to all residents.

The traditional mechanism for securing reimbursement from Managed Medi-Cal plans has been through provider-level negotiation. **This includes local health jurisdictions (or specific county-based programs) negotiating directly with individual managed care plans. There are a number of local health jurisdictions that have already done this successfully and that remains an option.** That relationship may take different forms:

- The local health jurisdiction or programs contracting directly with the managed care plan as an independent Medi-Cal provider(s)
- The local health jurisdiction may establish a limited scope of services and reimbursement for those services within their memorandum of understanding with the Medi-Cal Managed Care Plans. County-run clinics or providers contracted as primary care providers (e.g., for counties that operate federally qualified health centers or look-alike clinics) or specialists (e.g., some communicable disease specialists may be qualified as specialty providers by managed care plans)
- Through other creative contractual methods

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Some local health jurisdictions that operate clinics providing full scope primary care services may already have an agreement with managed care plans to reimburse those services (i.e., some local health jurisdictions operate co-applicant federally qualified health centers or look-alikes, while others have other clinic models for which there may be other reimbursement arrangements).

Opportunities beyond those more traditional arrangements are highly dependent on the relationship between the local health jurisdiction and the managed care plan and the degree to which the managed care plans sees value in the services provided. That implies that the local health jurisdiction has done a more than adequate job of demonstrating that value to the managed care plan.

Included in this section is a discussion of additional opportunities for local health jurisdictions to contract with managed care plans including:

- Roles deployable in public health agencies now eligible for reimbursement
- CalAIM Enhanced Care Management and Community Supports
- Direct Payments (Adverse Childhood Experiences and developmental screenings)

Roles Deployable in Public Health Agencies Now Eligible for Reimbursement

The Opportunity: In recent years, the Department of Health Care Services approved benefits and introduced new reimbursable roles. Department guidance defines the benefit, eligibility criteria, and related provisions. Because most Medi-Cal beneficiaries are enrolled in a managed care plan, utilization of the benefit may be subject to specific contract provisions between the Medi-Cal managed care plan and the provider (including local health jurisdictions).

Primary Stakeholder: Local health jurisdictions

Community Health Worker

The Center for Medicare and Medicaid Services approved state plan amendment 22-0001 to add community health worker services as a Medi-Cal benefit; the community health worker benefit went into effect July 1, 2022. This benefit allows for preventive health services to be provided by trained, non-licensed, health representatives who work directly with Medi-Cal members, who may have difficulty understanding and/or interacting with providers due to cultural, language or other barriers. Community health workers can provide health education and health navigation. Community health worker services may address issues that include, but are not limited to:

- Health education (to promote health or address barriers to physical or mental health care; goal setting; coaching)

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- Health navigation (info, training, referrals or support to assist members to access care, understand the health system, connect to community resources to promote health, connect to translation or transportation services)
- Screening and assessment (that doesn't require a license)
- Individual support or advocacy
- Serve as cultural liaison
- Asthma preventive services
- Domestic violence and injury prevention

Community health worker services do not include clinical case management, care management, or direct client services or supports. The community health worker benefit is available to all Medi-Cal beneficiaries, whether in managed care or fee for service, who have been recommended for community health worker preventive services by a recognized licensed physician or other licensed practitioner of healing arts within their scope of practice under state law.

These services require a written recommendation by a physician or other licensed practitioner of the healing arts. A written plan of care is required for continued community health worker services after 12 units of care per beneficiary in a single year, except for services provided in the emergency department. Community health workers must be supervised by a community-based organization, local health jurisdiction, licensed provider, clinic, or hospital. The current floor for per patient reimbursement rates are determined by the number of patients for a given 30-minute period.

CHW Reimbursement Rates	(30 min.)
No. of Patients	Rate
1	$26.66
2-5	$12.66
5-8	$9.46

A community health worker providing only violence prevention services must have a Violence Prevention Professional Certification issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute. A community health worker providing services other than violence prevention has to demonstrate qualification through either the certificate pathway or work experience pathway. All community health workers must complete a minimum of six hours of continuing education training annually.

Public health has long engaged staff who represent the community in roles in their departments. While local health jurisdictions each have their own job description for what may be called a community health worker, those job descriptions may not be consistent with the new community health worker role for Medi-Cal members, for which

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services the State is now providing reimbursement. Still, local health jurisdictions that have been utilizing staff in a role consistent with the State's definition of a community health worker have almost certainly been bearing the costs of those staff with limited, if any reimbursement and could benefit from this reimbursement for a role consistent with the State's new classification. Moreover, establishing approved certification and training programs would better groom these staff for public health activities.

Local health jurisdictions could consider developing curricular materials and potentially serve as a local certification program for community health workers. That would allow local health jurisdictions to have influence over the curricular content and training consistency for this new staff type. Local health jurisdictions could provide apprenticeships for community health workers and even operate or make recommendations to set up a placement service for certified community health workers. Employing community health workers in public health programs, or in other public health work where a connection with a trusted member of the community is a vital asset.

Although most local health jurisdictions already carry out some of the functions proposed for the community health worker role, deploying community health workers will require systems to ensure the community health workers' documentation of individual services and the submission of invoices/claims for their services. Those requirements are likely to be less onerous than the administrative requirements for targeted case management (which may be a current or alternative resource for reimbursing community health worker-like staff).

Doula

Effective January 1, 2023, California added doula services to the list of preventive services available under the Medi-Cal managed care program. Doula services include emotional and physical support provided during pregnancy, labor, birth, and the postpartum period. All pregnant women enrolled in Medi-Cal (fee for service and managed care members) are eligible.[29] Doula services must be recommended by a physician or other licensed practitioner within their scope of practice.

All doulas must be at least 18 years old, possess an adult/infant CPR certification, and have completed basic HIPAA training. Doulas must complete a minimum of 16 hours of training in defined practice areas (e.g., lactation support, childbirth, etc.) or meet the requirements of the experience pathway (i.e., at least five years of active doula experience within the previous seven years, attestation to skills as demonstrated by three written letters of recommendation). Additionally, doulas must complete three hours of continuing education in maternal, perinatal, and infant care every three years.

Proposed reimbursement rates (i.e., the rate floor) were approved in the FY22-23 budget (see table at right). The Department of Health Care Services estimates that the

[29] All pregnant women are eligible for Medi-Cal if they present without health coverage during pregnancy and are eligible for one-year post-partum coverage.

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total payment per birth would be $1,154, which assumes one initial visit, up to eight perinatal visits, one labor and delivery visit and up to two postpartum visits. An additional recommendation from a physician or other licensed practitioner of the healing arts is required for more than 11 visits during the perinatal period, excluding labor and delivery and miscarriage support.

Although local health jurisdictions are not likely to employ doulas (unless the local health jurisdiction provides prenatal or post-partum services), most local health jurisdictions are heavily involved, at least as collaborators, in programs addressing pregnancy and maternal morbidity and health needs – especially programs that aim to enhance birth equity and reduce disparities. **As such, it makes sense for local health jurisdictions to explore roles their staff can play in facilitating access to programs and services and to better understand the doula benefit as a tool that supports those goals. This would most likely be facilitating access and referrals, but a few local jurisdictions may even want to operate Doula programs, or function as third party administrators.**

Doula Reimbursement	Rates
Initial visit	$126.31
Perinatal Visit	$60.48
Labor and Delivery	$544.28
Estimated Total (Per Birth)	$1,154

Medi-Cal Transformation California Advancing and Innovating Medi-Cal (CalAIM): Enhanced Care Management and Community Supports

The Opportunity: Leverage or participate in CalAIM initiatives relevant to the local health jurisdiction's needs assessments and plans.

Primary Stakeholder: Local health jurisdictions

California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by the Department of Health Care Services to improve the quality of life and health outcomes of Medi-Cal beneficiaries. The CalAIM program is a multifaceted, multiyear initiative that represents one of the most significant transformations in the Medi-Cal program in a generation. The main goals are to create an equitable health system that takes a coordinated, whole person approach, seamlessly integrating strategies that address both health and social service needs (i.e., addresses social determinants of health), standardizing benefits across the state and adopting a population health model that will

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improve the health of all Californians. While the CalAIM component initiatives have increased in number since its inception, as of this writing, the main initiatives are:

- **Behavioral Health Initiative** will focus on better integration of physical and mental health care, payment reforms and a Child and Youth Behavioral Health initiative that will transform behavioral health access for children and youth.
- **Enhanced Care Management** is a new benefit to address the physical, behavioral and social needs of high need Medi-Cal Managed Care members identified as populations of focus.
- **Population Health Management** is a cornerstone of CalAIM that establishes a statewide accountable care approach to addressing the health and social determinants of health needs of all members across the continuum of care through risk stratification, the population health management Data Service (data analytic backbone) and adoption of the National Committee for Quality Assurance, Population Health Management standards.
- **Community Supports** is a set of fourteen services aimed at reducing unnecessary time in institutional settings for individuals with chronic/complex medical and social needs or smoothing their transition from those settings back to their communities.
- **Integrated Care for Dual Eligibles** provides wrap around services to better integrate and coordinate care for members who are eligible for both Medicare and Medi-Cal.
- **Dental Initiative** provides resources and incentives to improve access to dental services and oral health outcomes targeted primarily at children, but also including underserved adults.
- **Supporting Health and Opportunity for Children and Families**, including addressing the gaps in service utilization and quality of care and reducing disparities for children, youth and families.
- **Justice Involved Initiative** ensures access to and/or continuity of care for justice involved adults and youth, providing targeted re-entry services that facilitate Medi-Cal enrollment/ reactivation and pre-release services.
- **Various Capacity Building and Technical Assistance Resources:** The Department of Health Care Services has made a variety of resources available to community-based organizations and other providers to build their capacity and infrastructure to participate in CalAIM, including the Providing Access Transforming Health program, Incentive Payment Programs, and the Technical Assistance Marketplace of approved technical assistance vendors.

Local health jurisdictions may benefit from leveraging or participating in several of the CalAIM initiatives depending upon the relevance to the local health jurisdictions' needs assessments and plans. **Because the requirements for participating as a Medi-Cal network provider are significant, decisions about the level of participation in CalAIM initiatives should only be made after serious deliberation and the**

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agreement of country leadership (see considerations below for Enhanced Care Management and Community Support).

A key feature of CalAIM is the statewide introduction of an Enhanced Care Management benefit and a menu of Community Support services for those Medi-Cal enrollees with the highest health and social needs. Managed Care Plans are responsible for developing and collaborating with a network of community-based and other providers capable of administering both Enhanced Care Management and Community Supports. Enhanced Care Management is a benefit with defined eligibility criteria whereas Community Supports are available to eligible Medi-Cal members regardless of whether they qualify for Enhanced Care Management services.

Enhanced Care Management and Community Supports are integral components of the broader transformation efforts to ensure that all Medi-Cal members have access to a continuum of services based on their clinical, social and other health-related needs and preferences. Enhanced Care Management and Community Support draw on the design and learnings from, and replaces, the Whole Person Care Pilots and Health Home Program.

The Department of Health Care Services has indicated its desire to include specific public health programs as providers in the Enhanced Care Management or Community Support networks. **While those programs may vary depending on the populations of focus, it is obvious that some of the core service components of Enhanced Care Management (see Figure 3) align well with the expertise of staff and programs within local health jurisdictions.** Some local health jurisdictions already have become Enhanced Care Management network providers. Moreover, because of the State's intense focus on avoiding duplication of services, whether a local health jurisdiction becomes an Enhanced Care Management or Community Support Medi-Cal network provider, public health program staff will undoubtedly be engaged with those providers, because they may be asked to share Medi-Cal member's assessments and coordinate care to ensure non-duplication of services.

The Department of Health Care Services began a phased rollout of the Enhanced Care Management program to address the needs of targeted populations of focus in January of 2022. There are a number of maternal, child and adolescent health populations of focus among those identified for enhanced are as outlined below in Figure 3.

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Figure 3: Enhanced Care Management Populations of Focus

Enhanced Care Management: Populations of Focus	Adults	Children
Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	X	
Individuals Experiencing Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	X	X
Individuals At Risk for Avoidable Hospital or Emergency Department Utilization (Formerly “High Utilizers”)	X	X
Individuals with Serious Mental Health and/or Substance Use Disorder Needs	X	X
Individuals Transitioning From Incarceration	X	X
Adults Living in the Community At Risk for Long Term Care Institutionalization	X	
Adult Nursing Facility Residents Transitioning to the Community		
Children and Youth Enrolled in California Children’s Services or California Children’s Services Whole Child Model with Additional Need Beyond the California Children’s Services condition	X	X
Children and Youth Involved in Child Welfare		X
Individuals with Intellectual or Developmental Disabilitites	X	X
Pregnant and Postpartum and Birth Equity Population Focus		

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The readiness criteria for the Enhanced Care Management network are more involved than for the Community Support network, in part because Enhanced Care Management providers are expected to provide all the Enhanced Care Management core service components. To assess the merits of participating in a local Enhanced Care Management or Community Support network, a local health jurisdiction should consider the following:

- Understand the scope of services required of both networks (Enhanced Care Management network providers are expected to be able to discharge services in all seven core service categories).
- Review the application/certification criteria. Several managed care plans have posted provider certification applications on their websites.[30]
- Assess the landscape of current and potential Enhanced Care Management providers in the jurisdiction to determine if LHJ participation is needed to meet potential demand and whether LHJ participation would have unintended consequences for other community-based Enhanced Care Management network providers (e.g., would LHJ participation be competing with or in any way adversely influence CBO services and long-term viability).
- The Department of Health Care Services has also issued and regularly updates policy guides for both the Enhanced Care Management and Community Support programs. These are more comprehensive and current and form the basis for the managed care plans' applications.[31]
- Review rates for the scope of services the local health jurisdiction would consider and develop an implementation budget with break-even projections. Include new job categories as described above in the budget proposal.
- Assess additional infrastructure costs required to meet network requirements including but not limited to: electronic health record systems; referral, billing and claims management systems; data and analytics resources; and related opportunity costs.
- Consider scheduling a meeting with the local managed care plans to discuss the merits of the local health jurisdiction becoming an Enhanced Care Management or Community Support provider and addressing any special consideration the local health jurisdiction may want to request.
- Whether or not the local health jurisdiction becomes an Enhanced Care Management or Community Support provider, local health jurisdiction staff may want to serve as an advisor to the managed care plans to assist them in

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[30] Health Net provider certification application for Enhanced Care Management (developed collaboratively with other health plans and used in all Health Net counties): Enhanced Care Management (ECM) Provider Certification Application.pdf and Health Net provider certification application for Community Supports.pdf
[31] CA Department of Health Care Services CalAIM Enhanced Care Management Policy Guide.pdf and Medi-Cal Community Supports, or In Lieu of Services (ILOS) Policy guide.pdf

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identifying trusted community-based organizations and non-profits who might be appropriate for meeting the needs of the Medi-Cal population.

Direct Payments (e.g., for Adverse Childhood Experiences and Developmental Screenings)

The Opportunity: Access supplemental payments for conducting developmental and trauma screenings.

Primary Stakeholder: Local health jurisdictions

In April 2022, a Medi-Cal state plan amendment made permanent supplemental payments for developmental and trauma screening that were originally approved as time limited appropriations from tobacco tax funds (Proposition 56, the California Healthcare Research and Prevention Tobacco Tax Act of 2016). State general funds are the new source of the non-federal share of these payments. Importantly, these payments are supplemental to Medi-Cal capitation and to be paid directly to eligible network providers. While developmental screening has always been included as part of the Early and Periodic Screening, Diagnostic and Treatment benefit, the Adverse Childhood Experiences (ACEs) screening became a reimbursable benefit effective July 1, 2022. The policy details for both developmental and ACEs screening supplemental, directed payments can be found in the relevant All Plan Letters.[32,33]

In many local health jurisdictions, one or more public health programs may currently be involved, or could be involved in conducting these types of screens. Programs such as home visiting and Help Me Grow (often implemented in whole or in part by local health jurisdictions) are among those where either or both types of screenings may occur. The current payment amounts for these services are not insignificant ($59.90/screen for developmental screening and $29/screen for trauma screening) and could be a potential source of revenue to local health jurisdictions.

It is worth noting that there are documentation, data sharing, and in some instances, certification requirements that must be met for provider reimbursement. Developmental screening periodicity and evidence-based tools must be utilized as detailed in (American Academy of Pediatrics /Bright Futures) guidelines at nine, 18 and 30 months of age and when medically necessary based on developmental surveillance. Managed care plans are obligated to reimburse trauma screening annually for children and once in a lifetime for adults. Individuals conducting ACEs screening must attest to completing a certified ACEs training from the State. Documentation must be maintained, and

[32] The updated policy for developmental screening is included in All Plan Letters 23-016.pdf
[33] The updated policy for ACEs screening is included in *All Plan Letters 23-017.pdf*

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encounter data must be submitted with CPT codes[34] (for developmental screening) and HCPCS codes[35] (for trauma screening) as detailed in the All-Plan Letters.

One potential barrier to accessing payments from any of the Medi-Cal managed care sources noted above is the presumption that eligible providers are managed care plan network providers as stated in the relevant policy CalAIM guides and All-Plan Letters. There are a few ways of addressing that barrier. First, public health agencies could become managed care plan network providers (i.e., in the general managed care plan network as primary or specialty care providers, or specifically in the Enhanced Care Management or Community Supports networks described in the section on CalAIM). That network provider status would position public health agencies to access these payments. Alternatively, while the State does not routinely dictate to managed care plans which specific providers are to be in the networks, the State can make a determination about the types of providers who should be included. That also might allow for some flexibility in the provider enrollment or ongoing credentialing requirements for local health jurisdiction providers.[36] **Working with the Department of Health Care Services to require managed care plans to include public health agency staff in the networks is a viable and timely possibility given that managed care plans will be required to execute MOUs with local health agency programs. Those MOUs could easily address the status of public health agency staff in a manner that would position them to be reimbursed for these services.**

Opportunities in the Maternal, Child and Adolescent Health Portfolio

CDPH is responsible for providing and administering funds to local health jurisdictions, community-based organizations, and other eligible entities to support Maternal, Child and Adolescent Health programs that promote the health of women of reproductive age, pregnant women, infants, children, and adolescents in California. The following funding sources are available to the state, and by extension to local health jurisdictions. (Note: There are unique requirements and considerations for each of these).

- Federal Title V funds
- Federal Maternal, Infant and Early Childhood Home Visiting grants
- State general funds
- Title XIX funds

[34] Current Procedural Terminology
[35] Healthcare Common Procedure Coding System
[36] This flexibility might also allow for the designation of the local health jurisdiction as the provider entity, rather than individual providers. There is precedent for that approach in the assignment of community health centers as primary care providers in certain instances (e.g., FQHCs and look-alike clinics) the local health jurisdiction would, however, be required to have a National Provider Identifier (NPI) number.

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Maternal, Infant and Early Childhood Home Visiting Program

The Opportunity: State-level program reform would enable material efficiencies in the use of federal funds [if not optimizing federal allocation] and enable access to matching and supplemental funds in the reauthorization. Access supplemental payments for conducting developmental and trauma screenings.

Primary Stakeholder: CDPH and Local health jurisdictions

In response to growing evidence about the effectiveness of home visiting programs in improving maternal and child health, supporting parenting, and reducing child abuse and neglect, the Maternal, Infant and Early Childhood Home Visiting program was enacted as part of the Affordable Care Act of 2010. The program is designed to foster a collaborative partnership between federal, state, and local entities to address the needs of at-risk pregnant and parenting persons and their infants through the use of evidence-based home visiting model programs. The initial five-year appropriation has been made permanent. The Home Visiting Evidence of Effectiveness (HomVEE) project was established as a vehicle for literature review and assessment of the evidence of effectiveness for home visiting models beyond the legacy models (e.g., Nurse Family Partnership, Healthy Families America, Parents as Teachers, etc.). Program evaluations have been conducted and a Maternal, Infant and Early Childhood Home Visiting Data and Continuous Quality Improvement program was established to meet statutory requirements and demonstrate improvement in at least four of six benchmark areas.

Six Benchmark Areas for Maternal, Infant and Early Childhood Home Visiting Program Annual Performance Reporting include:

- Improvements in maternal, newborn, and child health
- Prevention of child injuries, child abuse, neglect, or maltreatment; reductions of emergency department visits
- Improvements in school readiness and child academic achievement
- Reductions in crime or domestic violence
- Improvements in family economic self-sufficiency
- Improvements in the coordination and referrals for other community resources and supports

The Maternal, Infant and Early Childhood Home Visiting program funds are organized as formula grants based on the proportion of children born into poverty in a given state (one third of the funds); the recipient's base award amount in the previous year; and a ceiling to not deviate more than 10% from the previous year's award. The Maternal, Infant and Early Childhood Home Visiting program provides partial funding for the California Home Visiting Program; CDPH augments funding of the program with

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additional state general funds (about $50M in FY2023). These funds are subsequently reallocated to local health jurisdictions to support pregnant persons, families, and at-risk children from birth to five years through three evidence-based models identified by the state (i.e., Nurse Family Partnership, Health Families America, and Parents as Teachers).

The recent five-year reauthorization of the federal program (through the Consolidated Appropriations Act of 2023, Public Law 117-328) included a number of changes in the funding.[37]

- Maternal, Infant and Early Childhood Home Visiting program grants will now include three funding sources: base funds, matching funds (optional, beginning in FY 2024) and additional matching funds (these optional additional matching funds will start in FY 2025).
- The base funding amount was increased for the first time since the program was enacted (base funding amount is $500M in FY 2023).
- A three-to-one, federal-to-state matching requirement will be phased in, beginning in 2024.
- Federal matching funds not accessed during the previous year will be available in subsequent years as additional matching.

Given the growth in the number of evidence-based home visiting models, and the growing and varied funding sources available at the local level to support home visiting programs (i.e., First 5, other local, other state-only funded, Maternal, Infant and Early Childhood Home Visiting funded), there is a great need for flexibility to allow braiding and blending of those funding sources. The CDPH has held to the same home visiting and model allocation approach for decades. Namely, the state allocations require local health jurisdictions to deploy home visiting programs using one or more of the three evidence-based, "legacy" home visiting models (that is inclusive of the Maternal, Infant and Early Childhood Home Visiting dollars even though the program allows the use of any evidence-based home visiting model). While the state has provided general fund dollars to supplement the Maternal, Infant and Early Childhood Home Visiting allocations, there is not enough to fund the need for home visiting services. Consequently, locals generally supplement the allocations from CDPH with funds from First 5 Commissions, Title XIX funds (mostly through targeted case management), and other discretionary sources to enhance the supply of home visiting services. **Increased CDPH flexibility in home visiting allocation – including accepting/allowing other home visiting models beyond Nurse Family Partnership, Healthy Families America, and Parent as Teachers – could increase local departments' ability to**

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[37] Maternal, Infant and Early Childhood Home Visiting program reauthorization information can be found at Health Resources and Services Administration (HRSA) webpage.

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design home visiting programs that are responsive to local populations and needs. [38]

Additionally, as the state prepares for changes in the Maternal, Infant and Early Childhood Home Visiting funding structure, which will include matching and supplemental matching funds, there is an opportunity to consider how best to leverage state funds to optimize the federal draw down.

Maternal, Child and Adolescent Health – Federal Financial Participation

This opportunity involves identifying clinical services that local health jurisdiction staff provide that may be reimbursable as Medicaid benefits. These might include immunizations, lead screening, tuberculosis screening, STD screening and treatment services, and other services that local health jurisdictions may provide that are not otherwise reimbursed by public health program funding. See prior discussion of MCAH – FFP in the Medicaid Claiming section for additional detail.

New Medicaid-Related Opportunities and Alternative Strategies

This section describes new Medicaid-related opportunities and alternative revenue strategies, with the understanding some of these models and innovations will not be accessible in the immediate future as they may require new law and policy development.

All Payer Medi-Cal Fee Schedule

The Opportunity: Establish a reimbursement floor for a defined set of services and goods provided by local health jurisdictions on behalf of Medi-Cal beneficiaries

Primary Stakeholder: CDPH and DHCS

Note: This is an early concept and while preliminary work is already underway on which non-optional, Medi-Cal services might be included in the fee schedule, additional strategic discussions and procedural work would need to be accomplished for this to happen.

Local health jurisdictions provide services and goods to many individuals with Medi-Cal coverage. When those services and goods are Medi-Cal benefits, there is opportunity for reimbursement. A few local health jurisdictions already have separately negotiated provider contracts with their local Medi-Cal managed care plans that allow reimbursement for some Medi-Cal services delivered by local health jurisdictions. The concept of an all payer Medi-Cal fee schedule, ideally statewide, would establish a

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[38] The State CDPH recently expanded the evidence-based home visiting programs in their smaller California Home Visiting Program State General Fund Innovation awards to include Family Connects (FCI), and Home
Instruction for Parents of Preschool Youngsters (HIPPY).

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reimbursement floor for a defined set of services and goods provided by local health jurisdictions on behalf of Medi-Cal beneficiaries. The potential benefits would include:

- Obviating the need for individual contracts between local health jurisdictions and Medi-Cal managed care plans
- Simplifying the contracting process by eliminating or minimizing the need for individual jurisdiction rate setting
- The potential for enhanced rates for qualified clinical staff
- Creating a predictable revenue flow that would enable local health jurisdictions to focus on specific services

The process for establishing a statewide fee schedule would involve the identification of a finite list of Medi-Cal reimbursable services provided by local health jurisdictions (that list might be two-tiered to recognize that local health jurisdictions of different sizes may provide a different collection of services). The Department of Health Care Services would need to agree to require Medi-Cal managed care plans to include public health department staff as Medi-Cal network providers and would generate a fee schedule floor with which the managed care plans would abide.

It's important to clarify that counties with primary care clinic models (e.g., mostly Federally Qualified Health Centers or Look-alikes) would retain that model and not participate in the fee schedule payments. The prospective payment system or cost-based reimbursement rates realized in those settings would likely be better than fee schedule rates. Moreover, the activities and activity codes currently incorporated into the Targeted Case Management and Medi-Cal Administrative Activities, which are optional Medi-Cal benefits, would be excluded from this fee schedule option.

Enhanced Reimbursement Rates for Information Technology Infrastructure Projects

The Opportunity: Leverage state Medicaid funds for the implementation and operation of improved Medicaid management information systems.

Primary Stakeholders: CDPH and Department of Health Care Services

Medicaid administrative funds are available to states for the implementation and operation of improved Medicaid management information systems for claims, data tracking and information processing. In general, the match rate for Medicaid program administration services is set at 50%, regardless of demographics or economic conditions, but a few administrative functions, including technology (IT) infrastructure projects, are eligible for an enhanced federal match (section 1903(a)(7) of SSA). IT infrastructure development and implementation is eligible for a 90% federal match and IT routine management and operations is eligible for a 75% match (e.g., management

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information systems used to pay providers, eligibility systems, etc.).[39] A number of technology services/projects routinely provided by CDPH and local health jurisdictions are in need of more sophisticated, interoperable design and development that could conceivably be covered by Medicaid:

- IZ Registry - IZ are often required as part of the State's or the Center for Medicare and Medicaid Services' Core Measure Set (the Child Core Measurement Set will be mandatory in 2024) - Registry data would augment Medi-Cal Claims data
- Sexually Transmitted Infection/Sexually Transmitted Disease Registry – Chlamydia screening is a part of the required Child Measure set
- Disease Registries - these data can be used by managed care plans in Quality Improvement and Patient Safety (an approved, Medi-Cal admin activity) - calculation of certain Healthcare Effectiveness Data and Information Set measures
- Birth/death data (five measures related to birth outcome are part of the Core Measures)
- Diabetes Prevention and Control

Moreover, CDPH and local health jurisdictions are individually and jointly engaged in data modernization planning at the same time as the state's transformation initiatives (e.g., CalAIM, California Youth Behavioral Health Initiative, Data Exchange Framework) are advancing calls for better, more secure data exchange. Aligning these major shifts creates the opportunity for innovative collaboration that will support the goals for a statewide, streamlined approach to population health management and for beginning to better understand and address health disparities. Collaboration among state and local public health and health services on IT infrastructure design, integration, secure sharing and interoperability that improves outcomes and provides necessary data can also be financed in ways that increases the likelihood of success and realizes regulatory and other reporting requirements for all parties.

When Medicaid funding is used for shared IT infrastructure, the Department of Health and Human Services uses a cost allocation model (outlined in State Medicaid letter #11-004) and requires outcomes to be reported. For example, as the HITECH funds phased out in 2021 states were faced with how to sustain the health information exchange technology infrastructure they had developed. States submitted plans to the Department of Health and Human Services on how they would phase out HITECH funding and replace that with other funding sources. Through the Implementation Advanced Planning Documents process states were asked to propose a cost allocation formula whereby Medicaid funds could be used not for the entirety of the infrastructure but

[39] See federal match rates at the Medicaid Administrative Activities webpage

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would be shared across payers and funding sources. Cost allocation formulas could be based on payer source, provider utilization, or population characteristics.[40]

Simplification of the California Department of Public Health – Local Health Jurisdiction Contracting

Discussions among the Small Working Group also surfaced several contracting provisions that could be simplified to reduce administrative and other burdens on local health jurisdictions and smooth their access to and ability to expend funding in a timely manner. The administrative burden associated with contracting for categorical programs and other state funding is one of the main reasons some local health jurisdictions choose to forego some state funds because the costs of program administration exceed the revenue or grant funding available. It is important to acknowledge that CDPH is committed to more broadly assessing opportunities for funding reform. In support of this, the current assessment include the following examples of administrative challenges:

- Several contracts (beyond just the Maternal, Infant and Early Childhood Home Visiting program) stipulate a narrow set of evidence-based models to meet contract criteria, making it difficult to build programs and services responsive to local needs.
- While national, standardized performance measures are expected and acceptable for some programs (e.g., Title V, Maternal, Infant and Early Childhood Home Visiting program, etc.) in some instances the state has developed its own performance measures and requirements – not all of which comport with local goals and priorities. The local health jurisdictions expect to be held accountable for activities and outcomes in their programs, but it would be worth reviewing performance measurement with an eye toward reconciling state-derived with other national measures and, and where feasible, allowing some flexibility to align measures with local goals.
- State amendments often include detailed activity and outcome measurement requirements for each individual program. This creates a multiplier effect on the data gathering and reporting requirements of local health jurisdictions, regardless of whether those measures are consistent with local goals. Federal program awards to the state and awards within the state from other agencies are often much simpler. These include an allocation letter and standardized agreement that builds in accountability with some flexibility about measures.
- The California Department of Public Health frequently uses state-only funds to support some local health jurisdiction activities. There is rarely a requirement associated with these programs to maintain the same stringent level of requirements that is the case with some federal grants.
- And when those federal grants are unreasonably constrictive, the CDPH should provide feedback to federal agencies about the impact of those constraints (e.g., the requirements for pan-influenza funds).

[40] CMS Cost Allocation Formulas.pdf

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- There is a significant amount of turnover among contract managers within the California Department of Public Health. This often leads to confusion and a lack of responsiveness to the local health jurisdictions.
- Invoicing and payment delays are quite common. This is problematic for maintaining continued operations and often results in excessive end-of-fiscal year determinations. The root cause of these delays is unclear (and to what degree shifting contract managers contribute to this issue), but this seems ripe for process improvement.

As with the other Medicaid claiming activities, determination of matching or reimbursement depends on specific allowable activities, and adherence to a specific set of requirements. Allowable Federal Financial Participation program activities for Maternal, Child and Adolescent Health – Medi-Cal Administrative Activities are described using Function Codes that are similar to, but do not track exactly with the activity codes established by the California Department of Health Care Services for the Targeted Case Management and County-Based Medi-Cal Administrative Activities programs. The overlap of activity codes creates an additional consideration related to managing invoices for these programs. The allowable function code titles for MCAH – FFP have some obvious overlap with the Targeted Case Management and County-Based Medi-Cal Administrative Activities programs in areas such as outreach, program and policy development. Some alignment of these activities, while still allowing for codes that focus on areas that may be unique to the Maternal, Child and Adolescent Health-Federal Financial Participation Program may simplify administration.

Next Steps

This Planning Guide provides a more focused understanding of the current state of public health financing in California than has previously been assessed. The model and companion tool developed by HMA examines local health jurisdictions' functions and estimated costs; it will provide the public health array in California a better understanding of the complexity, limitations, fragmentation, and magnitude of shortfall for current public health funding. The HMA tool allows local health jurisdictions to assess their current programming against HMA-recommended baseline staffing. The tool can incorporate jurisdiction-specific staffing, and as more jurisdictions use it, it will become a deeper repository of information to consider whether public health is adequately funded. HMA recommends that all local health jurisdictions annually update the tool and that CDPH and local health jurisdictions collaboratively track and assess progress in closing the funding gap. This will serve as a meaningful measure of progress and can provide important information as CDPH moves forward implementing other efforts under the Future of Public Health Initiative.

Additionally, the Planning Guide outlines a detailed analysis of revenue maximization opportunities for local health jurisdictions and CDPH to consider. The revenue maximization opportunities range from activities that local health jurisdictions can do under existing programming, as well as new programming to be explored.

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HMA developed and implemented a training program available to all California local health jurisdictions from April – June 2024. The trainings focused on the cost estimation tool and the revenue maximization opportunities for local health jurisdictions outlined in this Planning Guide.

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Appendices

A. List of Stakeholders
B. Additional Detail: Comprehensive Assessment of Local Health Jurisdiction Infrastructure

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Appendix A: List of Stakeholders

California Conference of Local Health Officers (CCLHO) Executive Committee

- Anissa Davis, MD, MPH, City of Long Beach
- Nancy Williams, MD, MPH, El Dorado County
- Gail Newel, MD, MPH, Santa Cruz County
- Eric Sergienko, MD, MPH, Mariposa County
- Aimee Sisson, MD, MPH, Yolo County
- Phuong Luu, MD, MHS, FACP, Yuba/Sutter County

County Health Executives Association of California (CHEAC) Executive Committee

- Kim Saruwatari, MPH, President (thru August 2023), Riverside County
- Elsa Jimenez, MPH, Vice President (President as of September 2023), Monterey County
- Michele Stephens, MSW, Secretary/Treasurer, Humboldt County
- Colleen Chawla, MPA, Immediate Past President, Alameda County
- Colleen Rodriguez, Small County Chair, Calaveras County
- Danette York, MPH, CPH, Butte County
- David Luchini, Fresno County
- Sara Bosse, Madera County
- Elizabeth Hernandez, PhD, San Diego County
- Kelly Colopy, MPP, City of Long Beach (formerly)
- Jayleen Richards, MPA/HAS, Solano County
- Shelly Davis, MN, BSN-RN, PHN, CCHP, Siskiyou County

Small Working Group

- Kelly Colopy, Director, Department of Health and Human Services, City of Long Beach
- Kat DeBurgh, MPH, Executive Director of HOAC
- Michelle Gibbons, Executive Director of CHEAC
- Elsa Jimenez, MPH, Director, Monterey County Health Department
- Phuong Luu, MD, MHS, FACP, Yuba/Sutter County
- Kim Saruwatari, Director of Public Health, Riverside County
- Michael Sequeira, MD, Public Health Officer, San Bernardino County
- Eric Sergienko, MD, MPH, Mariposa County
- Michele Stephens, MSW, Assistant Director County Dept of Health and Human Services, Humboldt County

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California Department of Public Health Leadership

- Tomás J. Aragón, MD, DrPH, Director and State Public Health Officer
- Susan Fanelli, Chief Deputy Director – Health Quality & Emergency Response
- Caroline Kurtz, Regional Public Health Office Deputy Director
- Julie Nagasako, Office of Policy and Planning Deputy Director
- Rita Nguyen, MD, Assistant Public Health Officer – Population Health
- Jessica Núñez de Ybarra, MD, MPH, Community Health Medical Administrator
- Rohan Radhakrisha, MD, MPH, MS, Office of Health Equity Deputy Director
- Trudy Raymundo, Office of Policy and Planning, California Department of Public Health
- Christine Siador, Assistant Director, Policy, Planning & Performance

Stakeholders' Interviews

- California Accountable Communities for Health Initiative (CACHI)
- California Association of Health Plans
- California Department of Health Care Access and Information (HCAI)
- California Department of Public Health
  - Center for Healthy Communities
  - Center for Family Health
  - Center for Health Statistics and Informatics
- California Department of Social Services (CDSS)
- CCLHO
- CHEAC
- Local Health Plans of California (LHPC)
- USC Institute for Addiction Science

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Appendix B. Comprehensive Assessment of Local Health Jurisdiction Infrastructure

Objective: HMA developed a resource plan, and corresponding financial model to forecast the financial plan for local health jurisdictions in California.

Model Framework

Revenues: HMA utilized Future of Public Health amounts from the FY 2022-24 budget act, and Realignment amounts based on the period of August 2022 through July 2023. Revenue from these sources is summarized in the following table below.

Table 1. Revenue Sources

Category	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Future of Public Health Funding	200,400,000	200,400,000	200,400,000	200,400,000	200,400,000	1,002,000,000
1991 Realignment (post AB 85)	1,203,856,586	1,203,856,586	1,203,856,586	1,203,856,586	1,203,856,586	6,019,282,930
Total Revenue	1,404,256,586	1,404,256,586	1,404,256,586	1,404,256,586	1,404,256,586	7,021,282,930

Note: Year 1 Realignment derived from 2022-23 actuals; year 2-5 straight-line projected.

Future of Public Health: Future of Public Health funds are allocated to LHJs via formula and annual funding is subject to the state budget act. As of the writing of this report, the revenue assumptions reflected above are based on prior amounts but are subject to annual state budget acts.

1991 Realignment Revenue: Jurisdiction-specific Realignment revenues allocated to local health jurisdiction were included post Assembly Bill 85 redirection to State social service programs. Revenue is generated through general sales tax collections and vehicle license fees. Actual Realignment revenues allocations were used for the period of August 2022 through July 2023. This revenue category is forecasted for Years 1-5 of the model using a straight-line projection model but it should be noted that actual Realignment revenues are subject to variability based on economic activity

Limitations to Revenue Forecast: Each jurisdiction's governing entity has the authority to allocate Realignment revenue to specific local health programs. Local health jurisdictions may not receive the full amount of allocated revenues.

Expenses: HMA established a framework to forecast the baseline level of resources needed for core public health services. HMA established these baseline resources by evaluating:

1. Local Health Jurisdictions Size

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2. Foundational Area Staffing Needs
3. Staffing Cost
4. Lab Services
5. Information Technology
6. Foundational Capability Readiness Assessment

Local Health Jurisdiction Size: A tiered structure was used to classify jurisdictions by population size in creating a baseline resource model.

Table 2. Local Health Jurisdiction Size

Jurisdiction Size	Population
Very Small	Less than 50,000
Small	50,000 – 199,999
Medium	200,000 – 699,999
Large	700,000 – 4,999,999
Very Large	More than 5,000,000

Foundational Area Staffing Needs: HMA identified a standard set of staff positions required to execute core public health services. The baseline level of these staffing positions was forecasted for each of the Foundational Public Health Areas based on the local health jurisdictions' population size. The staffing needs are summarized in the table below with figures indicating Full-Time Equivalents (FTEs).

Table 3. Staffing needs by Local Health Jurisdiction Size

Foundational Area	Very Small	Small	Medium	Large	Very Large
Communicable Disease	5.0	8.0	39.0	113.0	279.5
Chronic Disease & Injury Prevention	4.0	8.0	19.0	52.5	129.8
Environmental Public Health	2.0	4.0	10.0	30.0	75.0
Maternal Child and Family Health	4.5	10.0	36.0	108.0	270.0
Access to & Linkage with Clinical Care	2.0	3.0	15.0	45.0	112.5
Administrative	6.5	7.5	15.0	44.0	103.5

The table above summarizes staffing needs without an adjustment for productivity (ex. Sick, Vacation, or Training, etc.). These levels were subsequently increased 15% for productivity corresponding with 44.2 weeks of actual FTE production.

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Staffing Cost: Compensation for core staffing requirements was based on a hybrid analysis of Los Angeles County public salary data and the U.S. Centers for Medicare & Medicaid Services Wage Index data set.

HMA indexed the base salary levels for the core staffing positions based on Los Angeles County salary schedules. Then, using Medicare Wage Index factors, these salaries were adjusted to a standardized base level. The base level salary could then be multiplied by each local health jurisdiction's unique Wage Index factor attributed to their respective Medicare geographic Core Based Statistical Area. This would allow baseline salary levels to be adjusted to wages consistent with market rates for health care services in each jurisdiction.

The forecast assumes a 4.0% annual inflation adjustment and fringe benefits equal to 40% of employee salaries. An additional 15.0% administrative expense was calculated based on total compensation.

Public Health Lab Services: Not all jurisdictions operate public health lab services internally. Jurisdictions without in-house Lab Services were assumed to have a cost of $200,000 annually to obtain outsourced lab services. The stipend was adjusted annually for inflation.

Information Technology: Each jurisdiction was given a one-time stipend to facilitate the implementation of improved and standardized information technology resources required to optimally execute core public health services. The stipend was determined by jurisdiction size (see Table 2 above).

Foundational Capability Readiness Assessment: The model includes a public health readiness assessment to be conducted by each local health jurisdiction. Depending on the result of the assessment, the model adjusts costs up to 4% to account for filling gaps in core activities or adding new needed capabilities. The core design and questions on the assessment were adapted from the Public Health Accreditation board (PHAB) readiness assessment. To be conservative, 4% was utilized in the model forecast, however not all jurisdictions will require that amount.

Limitations to Expense Forecast: Certain limitations exist to the expense forecast. The first is that the expense categories analyzed are not exhaustive, and in themselves do not represent the total cost of operations. However, it is reasonable to believe that the categories identified represent a material portion of operating expenses and are the most comparable amongst local and national standards.

The forecast utilizes population groupings and may not be accurate for each jurisdiction within a size interval. The model is conservative in that expenses were forecasted to be consistent with the population levels near the top of each interval range.

Summary Analysis: Based upon the established framework, the aggregate annual cost of the core and foundational public health services to be performed by California's 61 local health jurisdictions is estimated to be $2.00 billion to $2.44 billion annually. These

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costs are offset by $1.40 billion in state-directed revenues comprised of $1.20 billion in Realignment funds and $200 million in Future of Public Heath investments.   Costs and revenues are estimated for FY 2023-24. Remaining funding gaps for local health jurisdictions are primarily funded by categorial grants, reimbursements for services, and local general fund support.

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