CONCEPT PAPER:

STRENGTHENING MEDI-CAL COMMUNITY COLLABORATION THROUGH A REIMAGINED POPULATION NEEDS ASSESSMENT

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

Contents

I. Vision

California is transforming the Medi-Cal program to ensure that Californians get the care they need to live healthier lives, including through a set of initiatives called CalAIM. The Department of Health Care Services (DHCS) launched the Population Health Management (PHM) Program in January 2023 as a cornerstone of its transformation strategy.[1] The PHM Program is focused on Medi-Cal managed care plans (MCPs),[2] which are expected to serve virtually all Medi-Cal beneficiaries by 2024.[3] Under a cohesive statewide framework, the PHM Program requires MCPs to respond to members' health and social needs and their preferences, across the continuum of care.

To support the success of the PHM Program and broader transformation efforts, DHCS is reimagining the Population Needs Assessment (PNA) to include a central requirement that MCPs collaborate with local health departments (LHDs). The PNA is the existing mechanism[4] that MCPs use to identify priority needs of their members, including health disparities. DHCS' proposed modifications to the PNA seek to advance the development of upstream interventions that look beyond the four walls of health care and deepen understanding of the social drivers of health (SDOH) within local communities. Doing this work effectively requires strong and sustained partnerships between health care and public health entities in particular, as well as with the social services sector. Thus, DHCS' vision for the reimagined PNA is that closer collaboration with the public health system, as well as with hospitals, tribal partners, community clinics, community-based organizations (CBOs), members, and other community stakeholders will deepen each MCP's understanding of its members and strengthen its relationship with the communities it serves. This collaboration will ultimately enhance MCPs' ability to improve the lives of their members.

Research shows that diverse actors are more likely to achieve a goal when working together in a structured way than when working in silos.[5] Several studies highlight how multisectoral collaboration supports improved outcomes, including reduced preventable deaths, reduced

emergency department visits for children with asthma, increased school attendance, reduced youth alcohol use, reduced lead poisoning rates, reduced teen pregnancy, and reduced infant mortality, and the evidence base continues to grow.[6,7,8,9] DHCS expects stronger public health/managed care plan partnerships to yield multiple benefits by:

- Averting duplication, community fatigue, and wasted resources by coalescing multiple data collection and stakeholder engagement processes, not just among public health and health care sectors but also among multiple MCPs when they operate in the same community.
- Supporting public health's focus on equity by bringing Medi-Cal data to the table, given that the Medi-Cal population comprises over one-third of California's population and carries a disproportionate burden of social and medical complexity.
- Supporting public health's response to emerging trends and hotspots (e.g., sexually transmitted infection (STI) outbreaks and COVID-19), especially in areas where MCPs can intervene by providing coverage, education, and outreach.
- Aligning multiple efforts under way (notably new cross-sector partnerships for Enhanced Care Management and Community Supports delivery) to better respond to member health and social needs and preferences on a "whole person" basis.

The purpose of this concept paper is to share DHCS' proposed approach and to invite stakeholder review and comment. The sections below describe current-state requirements from the perspective of MCPs, LHDs, and nonprofit hospitals;[10] outline the proposed changes; and pose specific questions for stakeholder feedback. While the proposed approach focuses primarily on MCPs, there are implications for LHDs as well as nonprofit hospitals, tribal partners, county behavioral health agencies, and other community stakeholders. Thus, DHCS seeks comments from all interested stakeholders and will be pursuing engagement activities tailored to different stakeholder groups and tribal partners to gather meaningful input over the coming months.

DHCS recognizes that its vision will take time to implement, as it relies on building new relationships as well as shifting and bridging cultures. As part of Medi-Cal's broader transformation, there are additional efforts under way to align and update other community assessment and planning processes beyond managed care (e.g., the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan planning process).[11] DHCS has engaged in consultations with the California Department of Public Health (CDPH) and the Department of Health Care Access and Information (HCAI) in preparation for the release of this paper.

II. Existing Requirements to Assess Community Needs

A. Requirements of MCPs

All Medi-Cal MCPs are required to obtain full Health Plan Accreditation and Health Equity Accreditation with the National Committee for Quality Assurance (NCQA) by January 1, 2026. Both preexisting DHCS PNA requirements and NCQA requirements emphasize MCPs' knowledge of their plan membership, which may cross multiple counties and communities in the state.

DHCS Requirements. For over 20 years, DHCS has required MCPs to conduct regular assessments of their membership and submit data to DHCS.[12] These DHCS requirements were developed primarily to ensure that MCPs were meeting federal and state requirements on cultural and linguistic considerations, health education, performance metrics, and data collection.[13] DHCS' proposed approach for the modified PNA—alongside other PHM Program deliverables—remains consistent with these state and federal requirements.

Under the most recent PNA requirements outlined in APL 19-011,[14] MCPs have been expected to:

- **Collect data on their plan-specific membership and submit their findings in an annual PNA report to DHCS inclusive of a "PNA Action Plan"** describing how findings from their assessment will inform targeted strategies around health education, cultural and linguistic issues, and quality improvement programs, including those designed to reduce health disparities.
- **Use specific data sources,** e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and health disparities data provided by DHCS, which are primarily focused on their own members. Some MCPs have relied on other data sources.
- **Solicit input from their Consumer Advisory Committees** (CACs) on the PNA and share findings with contracted health care providers, practitioners, and allied health care personnel.

Although MCPs are not required to leverage public health or broader community information as part of the PNA, they are encouraged to do so. And some MCPs have integrated this type of data into their assessments.[15] Historically, MCPs also have not been required to share their PNA deliverables in the public domain, although many have made them available online.

NCQA Requirements. As part of Health Plan Accreditation, NCQA requires every plan nationally—not just Medicaid managed care plans, and not just those in California—to develop a "PHM Strategy" describing how it will meet the needs of its members over the continuum of care, with certain aspects being measured and updated annually. To inform its

PHM Strategy, each plan must annually complete an assessment of member needs and characteristics, including identification of subpopulations based on characteristics and need. NCQA does not stipulate the specific types of data to be used to develop a population assessment, but encourages relying on integrated data from diverse sources, including information on SDOH.[16] While NCQA emphasizes the importance of using the annual assessment to identify community resources and establishing linkages to those resources for plan members,[17] its standards do not specify stakeholder types to be involved in the assessment itself. Although DHCS' proposed approach for the modified PNA does not change NCQA requirements, it seeks to reduce duplication and promote alignment with NCQA while also ensuring that policy priorities specific to Medi-Cal PHM are addressed.

B. Requirements of LHDs and Nonprofit Hospitals

Public health entities and nonprofit hospitals have a long history of emphasizing assessment of community needs to motivate local action.[18] These assessments are referred to as *community health assessments (CHAs)*—the term often used by public health—or *community health needs assessments (CHNAs)*—the term often used by nonprofit hospitals. CHAs/CHNAs are accompanied by implementation plans to improve community health and wellbeing.

Requirements of LHDs. Public health's unifying mission—to protect the health of all Californians—serves to bridge disparate and sometimes competing interests. In California and across the country, many public health entities—including state, tribal, and local health departments—conduct CHAs and Community Health Improvement Plans (CHIPs), often collaborating with a broad array of community stakeholders.[19] The CHAs describe the status of population health, and the CHIPs describe action plans for improving health outcomes.[20] CHA/CHIPs often rely upon documented best practices to promote collaboration and integrate diverse data sources and community voices. Both CHAs and CHIPs are publicly available documents that are actively shared with the community, and often posted on the public health entity's website.

California's 61 LHDs[21] are responsible for public health functions at the local level, overseen by CDPH. CDPH leverages CHAs and CHIPs to inform the state-level State Health Assessment and Improvement Plan. LHDs also complete a CHA/CHIP when seeking to obtain and maintain voluntary Public Health Accreditation Board (PHAB) accreditation.[22] Under the 2022 Budget Act, all LHDs must submit a "public health plan," which should be informed by a CHA and CHIP, to CDPH by December 30, 2023, and by July 1 every three years thereafter.[23] According to a recent CDPH survey, nearly all LHDs expect to complete a CHA by the end of 2023 and a CHIP by 2026.[24]

Although California's LHDs use different data sources to inform their CHAs, they often emphasize wide community input and rely upon primary[25] and secondary[26] data as well as quantitative and qualitative data on various topics (e.g., social and economic factors, health systems, public health and prevention, health disparities, health inequities, and/or community resources and assets). For example, the most recent San Diego CHA (2019-2021) includes, but

is not limited to; data on educational attainment, unemployment rates, crime, air quality, distance to a public park, climate change, food insecurity, community engagement levels (i.e., volunteerism), and community resources, as well as statistics on COVID-19 and more traditional health measures on mortality, morbidity, life expectancy, chronic disease, infectious disease, STIs, behavioral health, and health disparities.[27] The San Diego CHA examines this data through various lenses, including health equity, paying attention to SDOH, disparities, and the role of racism.[28] Other CHAs also include data on adverse childhood experiences,[29] intimate partner violence,[30] and maternal health equity.[31] These processes often leverage best practices to gather and analyze a broad sample of community input; and may involve multiple interviews, assessments, surveys, and listening tours.[32]

Although CHA/CHIP governance structures vary across LHDs, they often comprise a broad array of stakeholders from the community, including hospitals, local governmental agencies, academic institutions, foundations, health care provider organizations, social services organizations, and CBOs.[33] The CHA/CHIP may be governed by a steering or planning committee and supported by smaller work groups.[34]

Requirements of Nonprofit Hospitals. Nationally, all nonprofit hospitals must complete a CHNA (sometimes also referred to as a CHA) and an accompanying implementation strategy every three years to meet the requirements under the Affordable Care Act (ACA)[35] and state law, as applicable, and to maintain tax-exempt status. The rationale for the ACA's augmentation of requirements around hospital tax-exempt status emerged out of growing recognition of the importance of investing in community health, prevention, and identification of root causes and inequities.[36,37] Hospital CHNA processes must be made widely available to the public and are similar to LHD CHA/CHIP processes, although the geographical areas are generally smaller and cycles may be shorter. California has 229 nonprofit hospitals, which together constitute approximately 55% of all hospitals in the state.[38] California has required nonprofit hospitals to develop and submit a CHNA and a community benefit plan to maintain their tax-exempt status, extending back to 1994.[39] The community benefit plan must be submitted annually to HCAI, which has authority to impose fines for noncompliance.[40]

In recent years, the significant overlap between the sets of requirements described above has led many California LHDs and nonprofit hospitals to begin collaborating on their assessment processes, especially when these organizations are aligned in geographic coverage and timelines.[41] For example, since 1994, San Francisco hospitals and the San Francisco Department of Public Health and other partners have worked together as part of a collaborative to develop a CHNA every three years.[42] While there are some examples of MCPs also participating in these processes—including but not limited to San Diego,[43] Riverside,[44] and Ventura counties[45]—these collaborations currently do not generally extend to shared workflows between MCPs, LHDs, and nonprofit hospitals, in part because the MCP PNA process described above has to date taken a plan population-based approach as opposed to an approach more grounded in geographic communities. As a result, there is presently duplication of effort, undue burden on communities asked to participate in various

assessments, and missed opportunities for shared effort, all of which DHCS seeks to address in the proposed approach described below.

III. DHCS' Proposed Approach for the Modified PNA

As set out above, LHDs' and nonprofit hospitals' assessment processes span entire resident populations on a local level and rely on diverse data sources, with a strong emphasis on health equity and upstream factors. Today these CHA and implementation plans are largely siloed from the PNA processes conducted by MCPs.

Starting in 2024, DHCS proposes that MCPs[46] will fulfill their PNA requirement to DHCS by participating meaningfully in the collaborative CHA/CHIP processes already led by county LHDs, in counties where they have contracts. Many MCPs already have long-term roots in California communities and can demonstrate sustained collaboration with community partners beyond traditional health care networks, including in response to COVID-19. DHCS' vision for the modified PNA seeks to build on those existing efforts and extend them to all MCPs.

Under the proposed approach, where multiple MCPs serve the Medi-Cal population in a single county, all MCPs will be expected to participate in the single LHD CHA/CHIP process for that county. When an MCP has contracts in several counties, that MCP will participate in LHD CHA/CHIP processes for each county it serves.

The proposed MCP CHA/CHIP participation requirement will apply wherever MCPs serve members. In California, most of the 61 LHDs operate at the county level, with three operating at the city level.[47] DHCS is interested in stakeholder feedback about how this approach will best apply.

Comparison Point: Oregon

Since 2020, Oregon Medicaid has required each of its 16 Coordinated Care Organizations (CCOs) to conduct a single, shared CHA and CHIP with local public health authorities, nonprofit hospitals, and any other CCOs operating in the same region.* Like California's MCPs, Oregon's CCOs are Medicaid payers at full financial risk.

The impetus for this approach was to reduce duplication, promote alignment, and alleviate community fatigue.**Although the Oregon example is still early in its implementation, one of the key lessons is that it is critical for organizations involved to err on the side of flexibility and adapt to community needs rather than being wedded to a standardized approach for the purposes of overall consistency. Additionally, these processes take time, so it is important to start early and focus on a few priorities. These processes also require investment of resources and adequate capacity.***

*For more information on Oregon's approach—including guidance documents and learning collaborative materials—please see the Oregon Health Authority Transformation Center's website, available here. Examples of CCO CHA/CHIP submissions are available here.

** Interview with staff at Oregon Health Authority Transformation Center.

***Interview with staff at Oregon Health Authority Transformation Center; webinar recording; Lessons Learned from Conducting a Shared CHA & CHIP, available here.

The county LHD, in most cases, will serve as the anchor to align and integrate other assessments as part of its preexisting CHA/CHIP process. LHDs are appropriate anchors for the shared assessment process for several reasons. By definition, LHDs are focused on the overall population and environment of a local geography as opposed to being focused on smaller subsets of the population. LHDs' CHAs/CHIPs generally already have established relationships and partnerships with a wide array of stakeholders, use processes to leverage robust community input, and pull in diverse data sources to form a holistic picture of community needs and strengths where CHA/CHIP regions either overlap or comprise large geographic areas.

DHCS recognizes that under the proposed approach, LHDs themselves are likely to need additional support to continue to grow their CHAs/CHIPs and to integrate MCPs. DHCS seeks comment about what such support would need to entail.

In order to "participate meaningfully," MCPs will be required to provide available MCP-specific data on a de-identified basis to the CHA/CHIP, on the guiding principle that a joint approach to understanding the population through the CHA/CHIP process will help deepen the

collective understanding of a county's Medi-Cal population and identify better community-based solutions to pressing problems. Current and historical Medicaid data could include (but is not necessarily limited to) aggregated claims and encounters data, Healthcare Effectiveness Data and Information Set (HEDIS) measures, and/or CAHPS survey data. MCPs' member data when combined with public health data (e.g., housing needs, food insecurity, violence, trauma, and/or climate markers), as well as data available to a public health entity from its role as a direct service provider, will facilitate a richer and more nuanced understanding of members' health, social needs and social services use, and disparities at the individual and population levels. Similarly MCP-specific data will help inform public health efforts (e.g., de-identified aggregate claims data on patient discharge, emergency department utilization, maternal health, and/or children and youth health). DHCS seeks comment on the types of MCP data that should be required inputs for CHAs/CHIPs.

Beyond the provision of data, meaningful participation could also entail:[48]

- Participating in or leading the CHA/CHIP steering committee or decision-making body
- Participating in or leading one or more CHA/CHIP work groups
- Exploring how to meaningfully engage with tribal partners in CHA/CHIP processes via MCP tribal liaisons
- Providing staff support to core activities, including project management and coordination, data analytics, stakeholder engagement, and writing and publishing of the CHA/CHIP report
- Providing funding to support convenings, project management, and/or analytics
- Collaborating with LHD and other local leadership to develop joint action plans to address public health issues when MCPs have a role to contribute

Under this proposal, MCPs will sync with existing LHD CHA/CHIP timelines. Currently, county LHDs complete CHAs/CHIPs on different cycles and timelines, with most completing every three years to align with hospital requirements or every five years per accreditation requirements. Since timelines will vary, MCPs will attest to DHCS the frequency with which each LHD is completing the CHA/CHIP, with annual progress updates. The proposed approach would be different from what is outlined in the current MCP Contract, which states that MCPs must submit a PNA every three years, starting in 2025. DHCS invites comments on this proposed approach. Over the longer term, DHCS will collaborate with key partners to see if there is an opportunity to standardize CHA/CHIP frequency and timelines statewide.

Overall, DHCS seeks stakeholder feedback on the specific areas where MCPs can add value to the CHA/CHIP process; specific areas that public health collaboration can add value to MCPs' PHM programs, member engagement efforts (including through MCPs' CACs), and other plan operations; and how flexibly or prescriptively MCP "participation" requirements should be defined to measure genuine engagement without adding undue administrative burden.

As set out in the MCP Contract, the reimagined PNA and the PHM Strategy are distinct. Under this proposal, the two deliverables will relate to each other as follows.

- **PNA.** MCPs' PNA requirement will be met through the publication in each county of the LHD CHA/CHIP itself. MCPs will be expected to publish all LHD CHAs/CHIPs in their areas of operation on their website along with a brief description of how they participated in the CHA/CHIP process.
- **PHM Strategy.** Based on findings from their participation in communitywide assessments and use of other available data, MCPs will develop and annually update a brief PHM Strategy. This is a new requirement for MCPs to demonstrate meaningful community engagement as well as provide other updates on their PHM programs for DHCS monitoring purposes. MCPs will be able to leverage large components of their NCQA PHM Strategy submission as part of their DHCS PHM Strategy deliverable. The first PHM Strategy will be due in Q3 of 2023 and will be a streamlined submission serving as a precursor to the annual PHM Strategy submission that will be due in 2024. DHCS is proposing that the 2023 PHM Strategy will include the following elements:
  - An MCP-LHD collaboration goal for each county in which the MCP operates. The goal will be both aligned with DHCS' strategies (specifically the DHCS Clinical Quality Strategy Clinical Focus Areas[49] and Bold Goals[50]) and support a related county LHD project that is currently being implemented or about to be launched. The goal should be specific, measurable, achievable, relevant, and time-bound (SMART).
  - Description of how the MCP either has started or will start to participate as part of the LHD's CHA/CHIP process in the counties where the MCP has a contract, documenting the current timeline of the LHD CHA/CHIP processes.
  - Attestation that the MCP has completed or will complete an NCQA PHM Strategy and population assessment by the end of 2023.

DHCS envisions that components of each MCP's PHM Strategy will be made public.

IV. Next Steps and Stakeholder Input

DHCS is interested in meaningful input from a broad range of stakeholders on the concepts presented in this paper. As an immediate next step, DHCS invites the public to comment on this draft concept paper. See below for questions to which DHCS is particularly interested in responses. Comments are due by **5 p.m. PT, June 2, 2023**. Comments may be submitted to PHMSection@dhcs.ca.gov with the subject line "Comments on PNA Concept Paper."

DHCS also will be meeting with various groups over the next few months—including MCPs, public health entities, hospitals, tribal partners, CBOs, and other community stakeholders—to gather input on the proposed approach.

Alongside the release of this paper, a new APL will replace APL 19-011 and provide near time guidance on the modified PNA and new PHM Strategy. Finalized policies on the PNA and the PHM Strategy will be published in the PHM Policy Guide, which will be updated in Q2 to include more detailed guidance on the 2023 PHM Strategy and will be updated by the end of the calendar year to provide updated guidance on the modified PNA and the PHM Strategy due in 2024 and beyond. DHCS will also make contract amendments, as needed, to ensure that MCPs' contractual obligations are consistent with the finalized policies for the PNA and the PHM Strategy. DHCS encourages the public to visit the CalAIM PHM website for regular updates.

Stakeholder Questions:

For All Stakeholders:

- What is promising about the approach proposed in this paper? What are the challenges?
- Beyond MCPs, LHDs, and nonprofit hospitals, what should be the role of other organizations/stakeholders in the proposed approach? Specifically:
  - Medi-Cal members?
  - Tribal partners?
  - Social services entities—including but not limited to CBOs and county/local governmental entities providing social services (e.g., housing supports/services)?
  - Other payers serving Medi-Cal members (e.g., D-SNPs, PACE organizations, etc.)?
- Beyond the proposed approach in this paper, are there additional ways that DHCS should consider aligning other health-related assessments and planning processes (outside of MCP PNAs and LHD/nonprofit hospital CHAs/CHIPs) at the community level?
- Especially for LHDs and MCPs, what technical assistance is needed for successful implementation of the proposed approach?
- Given that county LHDs complete CHAs/CHIPs on different cycles and timelines, the proposed approach requires MCPs to attest to DHCS the frequency with which each LHD is completing the CHA/CHIP, with annual progress updates. What are the challenges and benefits of this approach?
- Under the proposed approach, does it make sense to focus on counties or should there also be flexibility to consider more regional approaches?

For MCPs:

- Beyond CHA processes, how have you collaborated with LHDs until now? How does the proposed approach present an opportunity to strengthen these relationships?

- Recognizing that NCQA requirements demand significant resources to fulfill, what are other ways to promote alignment between the proposed approach and NCQA's requirements?
- What types of public health data would strengthen your ability to serve your members?
- What role should an MCP's CAC play in the proposed approach to the modified PNA and in development of the PHM Strategy?

For LHDs:

- Does the approach of LHDs serving as the anchor institutions make sense? What additional supports would LHDs need to fulfill this role? Would there be a need to delegate to another entity in cases where there is limited bandwidth?
- What data should MCPs bring to the table?
- Would LHDs feel supported if MCPs were to meaningfully participate in the ways delineated in this paper? What are other ways that MCPs could support LHDs?
- Does your current CHA/CHIP focus on Medi-Cal members? How would a focus on this population help promote equity?

For Nonprofit Hospitals:

- What are the benefits and challenges of participating in the county LHD process to fulfill federal and state CHNA and community benefit/implementation strategy requirements?

V. Appendix: Summary of Public Health and Nonprofit Hospital Requirements

The terms "community health assessment (CHA)" and "community health needs assessment (CHNA)" are sometimes used interchangeably. Public health entities tend to use the former, whereas hospitals tend to use the latter.

Sector	Public Health	Nonprofit Hospitals
Requirements	• Community health assessments (CHAs)/Community health improvement plans (CHIPs)	• Community health needs assessments (CHNAs)/CHIPs/Community Benefit Plans
Controlling Guidance/ Authority	• Public Health Accrediting Board (PHAB) voluntary accreditation standards • CA law: California Budget Act of 2022	• Federal law: ACA, Section 501(r)(3) of the IRS Code • CA law: Health and Safety Code Section 127350
Jurisdiction	• Jurisdiction of health department (county, city, state, tribal, territorial)	• Community served by hospital
Goal	• Describe health challenges and assets of community; encouraged to focus on SDOH, health equity, and health disparities	
Frequency	• PHAB: At least every five years (but could be every three years) • CA Budget Act: Public health plans are due every three years; must be informed by the most current CHA/CHIP	• Every three years
Data	• Broad parameters, but encouraged to use diverse data sources (primary and secondary data, quantitative and qualitative data, SDOH data)	
Stakeholder Engagement	• Broad parameters, but robust stakeholder input encouraged	

[1] For more information on the PHM Program, see DHCS PHM Program website.
[2] In this paper, the term "MCPs" is inclusive of plan delegates.
[3] DHCS Issue Brief: Transforming Medi-Cal Managed Care Through Statewide Procurement (February 2022).
[4] Prior to the release of this paper, the most recent PNA requirements were outlined in APL 19-011.
[5] Several scholars have studied the components of successful coalitions, including: Kania J. & Kramer M. (2011). Collective Impact. *Stanford Social Innovation Review*; Kania J., Williams J., et al. (2022). Centering Equity in Collective Impact. *Stanford Social Innovation Review*; Roussos S.T. & Fawcett S.B. (2000). A Review of Collaborative Partnerships as a Strategy for Improving Community Health. *Annual Review of Public Health*; Wolff T., Minkler M., et al. (2016). Collaborating for Equity and Justice: Moving Beyond Collective Impact. *The Nonprofit Quarterly*.
[6] Mays, G.P., Mamaril C.B., et al. (2016). Preventable Death Rates Fell Where Communities Expanded Population Health Activities Through Multisector Networks. *Health Affairs*.
[7] Milken Institute of Public Health & the Funders Forum on Accountable Health. (2021). The Power of Multisector Partnerships to Improve Population Health: What We Are Learning About Accountable Communities for Health.
[8] Centers for Disease Control and Prevention. (2022). Making the Case for Collaborative Community Health Improvement.
[9] Roussos S.T. & Fawcett S.B. (2000). A Review of Collaborative Partnerships as a Strategy for Improving Community Health. *Annual Review of Public Health*.
[10] This paper focuses on nonprofit hospitals, meaning those that receive "charitable hospital" designation and 501(c)(3) status from the IRS and are exempt from federal or state corporate income taxes. As described in Section 11.B, nonprofit hospitals must meet both federal requirements (i.e., to develop a community health needs assessment (CHNA) and implementation plan) and state requirements (i.e., to develop a CHNA and a community benefit plan). See Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3), *IRS website*. Even though California public hospitals—including county, health care district, and University of California hospitals—are exempt from California's requirements to develop a community benefit plan and assessments, those with 501(c)(3) status must develop a CHNA and an implementation plan per federal requirements. See California Hospital Association, Comparison of California and IRS Requirements for Community Health Assessments and Plans.
[11] For more information on California's Behavioral Health Modernization proposal, see DHCS' webpage Modernizing Our Behavioral Health Initiative.
[12] DHCS requirements evolved over time, from a five-year General Needs Assessment (GNA) (see APL 17-002) to the more recent PNA requirement (see APL 19-011).

[13] Title 22 of the California Code of Regulations (CCR), Sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2). The CCR is searchable here. Title 42 of the Code of Federal Regulations (CFR), Sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2). 42 CFR, Part 438 is available here.
[14] APL 19-011.
[15] For example, Inland Empire Health Plan, in addition to developing its PNA, published its first community health assessment (CHA) in 2022, working alongside a robust group of stakeholders to gather diverse sources in Riverside and San Bernadino counties. Development of the CHA was overseen by the 2002 Inland CHA Stakeholder Committee, which comprised local public health departments, hospitals, and community stakeholders in Riverside and San Bernadino counties. The CHA reported on burden of disease, vital conditions, and certain populations of focus (addressing health disparities), and relied upon diverse data sources, including key informant interviews and facilitated listening sessions with community residents as well as data derived from its data platform ("IP3").
[16] NCQA & Janssen. (2019). Population Health Management: Roadmap for Integrated Delivery Network.
[17] Ibid.
[18] See Appendix 1 for a comparison of public health and nonprofit hospital requirements.
[19] These entities conduct CHAs/CHIPs to meet voluntary accreditation by PHAB. See PHAB Accreditation Standards (Version 2022).
[20] For example, many CHAs and accompanying implementation plans (e.g., San Diego County and Imperial County) rely on the Mobilizing for Action through Planning and Partnerships (MAPP) framework (available here), a community-driven planning process for improving community health that was developed by the National Association of County and City Health Officials (NACCHO) in collaboration with the Centers for Disease Control and Prevention (CDC). Others (e.g., Pasadena County) have relied on the American Hospital Association Community Health Improvement (ACHI) Assessment Toolkit (available here), which supports collaboration among diverse partners working on CHAs/implementation plans. The Public Health Advisory Board (PHAB) lists both MAPP framework and the ACHI Community Health Assessment Toolkit as frameworks to support robust collaboration and community input.
[21] For a list of local health service departments, see CDPH's listing of local health services/ offices.
[22] See PHAB Accreditation Standards (Version 2022).
[23] Per the CA Budget Act of 2022, "As a condition of funding, each local health jurisdiction shall, by July 1, 2023, and every three years thereafter, be required to submit a public health plan to the department pursuant to the requirements of subsection (c). Each local plan should be tied to the Community Health Assessment and Community Health Improvement Plan, including proposed evaluation methods and metrics."
[24] CDPH survey of LHDs.

[25] Primary data means new data collected or directly observed from firsthand experience (e.g., interviews, surveys, focus groups, town halls). For more details, see PHAB Accreditation Standards (Version 2022).
[26] Secondary data sources means data that has already been collected and published by another party (e.g., publicly reported state and national data sources). For more details, see PHAB Accreditation Standards (Version 2022).
[27] Live Well San Diego CHA (2019-2021).
[28] Ibid.
[29] See, for example, 2018 Humboldt County CHA and 2020 Plumas County CHA.
[30] See, for example, 2020 Plumas County CHA.
[31] See, for example, 2022 Santa Barbara County CHNA.
[32] See, for example, 2022 Santa Barbara County CHA (which involved a county-wide survey and a listening tour); Live Well San Diego Live Well CHA (2019-2021) (which used MAPP assessments and involved multiple community surveys, in-person community forums, and a tele-town hall); and 2022 Pasadena County CHNA (which involved key informant interviews).
[33] See, for example, the 2022 San Francisco CHNA, which was conducted as part of the San Francisco Health Improvement Partnership, a collaborative that includes academic institutions, hospitals, and CBOs.
[34] See, for example, 2017-2021 Imperial County CHA & CHIP (which was overseen by a steering committee that provided direction to a broader group of participating community partners and was also supported by workgroups focused on key health priority areas).
[35] US Government. Patient Protection and Affordable Care Act, Pub L No. 111–148, § 9007 (2010). See also Community Health Needs Assessment for Charitable Hospital Organizations - Section 501(r)(3),.
[36] Ibid. Failure to comply with the ACA provisions, elaborated under IRS § 501(r)(3), can result in fines or revocation of a facility's tax-exempt status.
[37] Cramer, G.R., Singh S.R., et al. (2017). The Progress of US Hospitals in Addressing Community Health Needs. *American Journal of Public Health*.
[38] For a list of all licensed health care facilities, please see CalHHS Licensed Healthcare Facility Listing. To look up hospital ownership, please see HCAI's Licensed Facility Information System.
[39] Health and Safety Code Section 127350.
[40] Hospital Community Benefit Plans.
[41] In California, examples of LHD and nonprofit hospital collaboration include, but are not limited to, San Francisco, San Diego County, Ventura County, Mono County, Humboldt County, Pasadena City, Plumas County, Santa Barbara County, and Solano County.
[42] This collaboration has since evolved to form the San Francisco Health Improvement Partnership (SFHIP).

[43] See Live Well San Diego, a robust collaborative with over 500 partners. Live Well San Diego collaborates with the County of San Diego Health and Human Service Agency to produce the Live Well San Diego CHNA. Live Well includes several MCP partners.
[44] See Strategic Health Alliance Pursuing Health Equity (SHAPE) Riverside County, a collaborative that developed the Riverside CHA. Shape Riverside County MCP partners include but are not limited to: Inland Empire Health and Molina Healthcare.
[45] See, for example, Ventura County CHA, a product of the Ventura County Community Health Improvement Collaborative (VCCHIC). Gold Coast Health Plan is one of the VCCHIC members.
[46] Please note that all proposed requirements will apply equally to plan delegates as to MCPs.
[47] For a list of local health service departments, see CDPH's listing of local health services/ offices.
[48] The 2023 amended MCP Contract and 2024 MCP Contract outline a series of stakeholders that an MCP must collaborate with as part of developing its PNA. The proposed approach for the modified PNA, as outlined in this paper, would serve as fulfillment of this contractual requirement, given the diverse stakeholders involved as part of the LHD CHA/CHIP processes. MCP boilerplate contracts are available at https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.
[49] The DHCS Comprehensive Quality Strategy Clinical Focus Areas include children's preventive care, maternity care and birth equity, and behavioral health integration.
[50] The DHCS Bold Goals 50x2025 Initiative includes the following objectives: 1) close racial/ethnic disparities in well child visits and immunizations by 50%; 2) close maternity care disparity for Black and Native American persons by 50%; 3) improve maternal and adolescent depression screening by 50%; 4) improve follow-up for mental health and substance use disorder by 50%; and 5) ensure all health plans exceed the 50th percentile for children's preventive care measures. For more details, see the DHCS Comprehensive Quality Strategy.