CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
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DATE: May 12, 2025

ALL PLAN LETTER 25-009

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: COMMUNITY ADVISORY COMMITTEE

PURPOSE:

The purpose of this All Plan Letter (APL) is to summarize the Community Advisory Committee (CAC) requirements and provide Medi-Cal managed care plans (MCP) with information and guidance regarding their responsibility to implement, maintain, and maximize Member, family, and community engagement through the CAC.

BACKGROUND:

While the MCP Contract includes detailed requirements on the duties and expectations of the CAC, this APL provides additional clarification on CAC requirements including DHCS' monitoring process of the CACs.[1]

Pursuant to Title 22 California Code of Regulations (CCR) section 53876(c), the Department of Health Care Services (DHCS) requires MCPs to maintain a CAC that serves to inform the development and implementation of the MCP's Cultural and Linguistically Appropriate Services (CLAS) program.[2] Additionally, per Title 42 Code of Federal Regulations (CFR) section 438.110(b), the CAC must include at least a reasonably representative sample of the Long Term Supports and Services (LTSS) population within the CAC.[3] The CAC can be leveraged as a forum to better engage Members in the care they receive through their MCPs. DHCS seeks to elevate the role of the CAC by clarifying its role and member composition and prescribe the MCP's role in providing support for CAC members through process enhancements and new engagement channels designed to empower Members to become more active participants in their care.

[1] MCP Contract, Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees). The MCP boilerplate contract is available at: https://www.dhcs.ca.gov/provgovpart/Documents/2024- Managed-Care-Boilerplate-Contract.pdf.
[2] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[3] The CFR is searchable at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-C/section-438.110

POLICY:

CAC Selection Committee Composition and Duties

MCPs, in consultation with their Health Equity Officer, must convene a selection committee tasked with selecting the members of the CAC and providing the recommendations to the MCP. The CAC selection committee must select all of its CAC members no later than 180 calendar days from the effective date of the MCP Contract. MCPs must demonstrate a good faith effort to ensure that the CAC selection committee is comprised of a representative sample of each of the persons below to bring different perspectives, ideas, and views to the CAC. If an MCP operates in multiple counties, it may have one or more selection committees as necessary to carry out the duties of the CAC selection committee listed in the APL. As a guide, the CAC selection committee should include:

- Persons who sit on the MCP's Governing Board as applicable and/or the MCP Executive Committee which represent the Medi-Cal line of Business
- Providers who represent Safety Net Providers including Federally Qualified Health Centers/Rural Health Centers,
- Indian Health Care Providers (IHCP), as applicable;
- Behavioral Health Providers;
- Person(s) who represent Regional Centers;
- Local Education Agencies;
- Dental Providers;
- Community Based Organizations
- Home and Community Based Service Providers; and
- Persons who are representatives of each county within the MCP's Service Area, adjusting for changes in membership diversity.

The CAC selection committee is not expected to replace existing CAC selection-type committees if those existing committees meet the requirements and expectations for the CAC selection committee noted below. The number of persons on the CAC selection committee should be sufficient to achieve the goal of selecting a diverse and reasonably representative CAC. The CAC selection committee is responsible for selecting new CAC members and/or replacing former CAC members whose position has been vacated. If a CAC member resigns or is asked to resign, the CAC selection committee must make its best effort to promptly replace a vacant CAC seat within 60 calendar days of the CAC vacancy. To support filling vacancies, the MCP can schedule an additional CAC selection committee meeting, use online voting, or use other methods to fill the vacant position. MCPs must ensure that CAC membership continues to be reflective of, and responsive to, the MCP's Service Area demographics. The CAC selection committee must make good faith efforts to ensure:

- CAC membership is composed primarily of the MCP's Members;
- CAC membership is reasonably reflective of the general MCP Member population in the MCP's Service Area;

- Adolescents and/or parents and/or caregivers of children, as appropriate, are represented on the CAC;
- Current/former foster youth and/or parents/caregivers of current/former foster youth, as appropriate, are represented on the CAC;
- MCP Members who receive LTSS, and/or individuals representing those MCP Members, as appropriate, are represented on the CAC;
- Representatives from IHCPs are represented on the CAC; and
- Diverse and hard-to-reach populations are reasonably represented on the CAC, with a specific emphasis on persons who are representative of or serving populations that experience Health Disparities such as individuals with limited English proficiency (LEP), diverse racial and ethnic backgrounds, genders, gender identity, and sexual orientation and physical disabilities.

The recommendations made by the selection committee are advisory in nature and not binding. The MCP retains the discretion and flexibility to deviate from these recommendations provided that there are preexisting policies in place to support such decisions.

CAC Membership

The CAC selection committee is not expected to replace existing CAC members if those current CAC members meet the requirements and expectations for CAC members and can successfully perform the CAC member duties noted below. CAC membership should reflect the general MCP Member population in the MCP's Service Area, including:

- Representatives from IHCPs,
- Representatives who receive LTSS and/or individuals representing LTSS recipients,
- Adolescents and/or parents and/or caregivers of children, including current and/or former foster youth, as appropriate

The general MCP Member population must be modified as the population changes to ensure that the MCP's community is represented and engaged. MCPs may implement term limits for CAC members, as appropriate and at lengths deemed necessary by the MCP, to ensure representation of the general MCP Member population in the MCP's Service Area. MCPs are encouraged to ensure representatives who receive Enhanced Care Management (ECM) and Community Support Services, as appropriate, are represented on the CAC. MCPs are also encouraged to establish a CAC sub-committee comprised exclusively of Members to ensure Member voices are paramount. Member composition of the CAC sub-committee may include, but is not limited to, adolescents and/or parents and/or caregivers of children, including current and/or former foster youth.

CAC Member Duties

The CAC must perform all duties noted in the MCP Contract including providing input, advice, and making recommendations to the MCP to address Quality of Care, Health Equity, Health Disparities, Population Health Management (PHM), children services, Community Reinvestment Plans, and Community Health Assessments (CHA)/Community Health Improvement Plans (CHIP).[4] The CAC must be included and involved in developing and updating CLAS policy and procedure decisions including those related to Quality Improvement, education, and operational and cultural competency issues affecting groups who speak a primary language other than English. The CAC may also advise on necessary Member or Provider targeted services, programs, and trainings. The CAC must provide and make recommendations to the MCP regarding the cultural appropriateness of communications, partnerships, and services. The CAC must identify and advocate for Preventive Care practices to be utilized by the MCP. Additionally, the CAC must provide input and advice, including, but not limited to:

- Culturally appropriate services or program design;
- Priorities for health education and outreach programs;
- Member satisfaction survey results;
- Plan marketing materials and campaigns;
- Communication of needs for Network development and assessment;
- Community resources and information;
- PHM;
- Quality;
- Carved Out Services;
- Development of the covered, Non-Specialty Mental Health Services (NSMHS) outreach and education plan;
- Input on Quality Improvement and Health Equity[5,6] and the Population Needs Assessment;
- Reforms to improve health outcomes, accessibility of services, and coordination of care for Members; and
- Inform the development of the MCP's Provider Manual.

MCP CAC Duties

MCPs must perform all duties pertaining to the CAC as noted in the MCP Contract, including providing sufficient resources for the CAC to support required CAC activities

[4] MCP Contract, Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees).
[5] DHCS. April 2024, Quality Improvement and Health Equity Transformation Requirements. Available in APL 24-004 or any superseding APL. APLs are searchable at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.
[6] DHCS. May 2024, CalAIM: Population Health Management Policy Guide, available on the PHM webpage at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.

and CAC members in their CAC role including engaging in listening sessions, focus groups, and/or surveys.[7] MCPs will determine the total number of established CACs reasonably necessary to ensure the fulfillment of CAC requirements and allow for meaningful engagement with Members in their service area. MCPs operating in multiple counties may have one CAC across multiple counties or separate and distinct CACs for each county as needed to support engagement.

MCPs must ensure that CAC meetings are accessible to all participants and provide appropriate accommodations allowing attendees to effectively communicate and participate in CAC meetings including providing translation and interpretation services, providing accessibility for individuals with a disability or LEP, providing transportation to CAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest CAC member participation possible. CAC meetings can be in-person, virtual, or held in hybrid formats. MCPs may impose security protocols as appropriate for all CAC meetings. MCPs must demonstrate, through the Annual CAC Demographic Report, consideration of CAC input and must inform CACs how their input has been incorporated.

Additionally, MCPs must designate a CAC coordinator and maintain a written job description detailing the CAC coordinator's responsibilities which must include having responsibility for managing the operations of the CAC in compliance with all statutory, rule, and Contract requirements. The CAC coordinator may be an employee of the MCP, Subcontractor, or Downstream Subcontractor. The MCP's CAC coordinator must not be a member of the CAC, or a Member enrolled with the MCP. The CAC coordinator's duties must include, but are not limited to:

- Ensuring CAC meetings are scheduled and committee agendas are developed with the input of CAC members;
- Maintaining CAC membership, including outreach, recruitment, and onboarding of new members, that is adequate to carry out the duties of the CAC;
- Actively facilitating communications and connections between the CAC and MCP leadership, including ensuring CAC members are informed of MCP decisions relevant to the feedback from the CAC;
- Ensuring that CAC meetings, including necessary facilities, materials, and other components, are accessible to all participants and that appropriate accommodations are provided to allow all attending the meeting, including, but not limited to, accessibility for individuals with a disability or LEP, to effectively communicate and participate in CAC meetings; and
- Ensuring compliance with all CAC reporting and public posting requirements.

[7] MCP Contract, Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees).

MCPs are required to:

- Comply with CAC meeting reporting, posting, and submission requirements outlined in the MCP Contract;[8]
- Hold their first regular CAC meeting promptly after all initial CAC members have been selected by the CAC selection committee;
- Hold CAC meetings at least quarterly;
- Make the regularly scheduled CAC meetings available for the public to attend. The meeting schedule must be posted 30 calendar days prior to the meeting date, and in no event later than 72 hours prior to the meeting;
- Provide a location for CAC meetings and all necessary tools and materials to run meetings, which may include, but is not limited to, providing onboarding materials for CAC members, providing resources to support CAC members in their CAC activities, and making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings;
- Capture written meeting notes that must be posted on the MCP's website and submitted to DHCS no later than 45 calendar days after each meeting. The MCP must retain the minutes for no less than ten years and provide to DHCS upon request;
- Submit an Annual CAC Demographic Report by April 1st of each year;
- Report on their involvement in and findings from Local Health Jurisdictions' CHAs/CHIPs and obtain input/advice from their CACs on how to use findings from the CHAs/CHIPs to influence MCPs strategies and workstream;
- Convene with their CACs to develop and inform their outreach and education plan for their Members regarding covered NSMHS as articulated in APL 24-012: Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements, or any superseding APL;
- Engage with CACs to inform Community Reinvestment planning and validate Community Reinvestment Plans prior to submission to DHCS to ensure investments are adequately targeted toward the needs of the community as noted in APL 25-004; and
- Engage with the CAC for continued diversity, equity, and inclusion training program recommendations and feedback.

While these are the minimum requirements for CAC engagement, MCPs have the discretion to engage CACs in any additional capacity for planning and decision-making.

Reporting, Monitoring, and Compliance

MCPs are required to submit an Annual CAC Member Demographic Report by April 1 of each year, which must contain membership data as of December from the previous calendar year, to ensure the CAC membership reflects the general MCP Member population in the MCP's Service Area and that the CAC's input is actively utilized in

[8] MCP Contract, Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees).

polices and decision-making by the MCP. If there are multiple CACs in the MCP's Service Area, the MCP should submit one CAC Annual Demographic Report with consolidated CAC responses. The CAC Annual Demographic Report requires MCPs to report on the following information including, but not limited to:

- The demographic composition of CAC membership;
- How the MCP defines the demographics and diversity of its Members and Potential Members within MCP's Service Area;
- The data sources relied upon by the MCP to validate that its CAC membership aligns with MCP's Member demographics;
- Barriers to and challenges in meeting or increasing alignment between CAC's membership with the demographics of the Members within MCP's Service Area;
- Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the Members within MCP's Service Area; and
- A description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, CLAS services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped the MCP's initiatives and/or policies.

MCPs must review their contractually required policies and procedures (P&Ps) to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) Contract Oversight SharePoint Submission Portal[9] within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must attach an attestation to the Portal within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The attestation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance. MCPs should review their Network Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate, to ensure compliance with this APL. For additional information regarding enforcement actions, see APL 25-007, and any

[9] The MCOD Contract Oversight SharePoint Portal is located at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx

subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Bambi Cisneros

Acting Division Chief, Managed Care Quality and Monitoring Division

Assistant Deputy Director, Health Care Delivery Systems