Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Wednesday, February 23, 2022

3:00 p.m. – 5:00 p.m.

Teleconference Meeting

(Pursuant to Assembly Bill 361 signed by Governor Newsom, September 16, 2021)

Important notice regarding COVID-19: In the interest of public health and safety due to the state of emergency caused by the spread of COVID-19, this meeting will be conducted via teleconference. The following alternatives are available to members of the public to view this meeting and to provide comment to the Board.

1. Members of the public wishing to join the meeting may do so as follows:
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 (323) 705-3950
    Phone Conference ID: 945 766 465#

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, February 22, 2022 to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to five minutes.
    b. Public comment during the meeting, when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

3. Mute your phone during presentations to eliminate background noise.
    a. State your name prior to speaking during comment periods.
    b. Limit background noise when unmuted (i.e. paper shuffling, cell phone calls, etc.).

1. **Call to Order by Chairperson Conner. 3:00 p.m.**

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.
C. Welcome new Board member Supervisor Zach Friend, Santa Cruz County.

2. **Oral Communications. 3:05 p.m.**

A. Members of the public may address the Commission on items not listed on today's agenda that are within the jurisdiction of the Commission. Presentations must not exceed five minutes in length, and any individual may speak only once during Oral Communications.
B. If any member of the public wishes to address the Commission on any item that is listed on today's agenda, they may do so when that item is called. Speakers are limited to five minutes per item.

3. **Comments and announcements by Commission members.**

A. Board members may provide comments and announcements.

4. **Comments and announcements by Chief Executive Officer.**

A. The Chief Executive Officer (CEO) may provide comments and announcements.

Consent Agenda Items: (5. – 10J.): 3:10 p.m.

5. **Consider approving findings that the state of emergency continues to impact the ability of members to meet safely in person and/or State or local officials continue to impose or recommend measures to promote social distancing.**

- Reference materials: Staff report and recommendation on above topic.

Pages 5-01 to 5-02

6. **Accept Executive Summary from the Chief Executive Officer (CEO).**

- Reference materials: Executive Summary from the CEO; and 2022 Alliance Operating Plan.

Pages 6-01 to 6-11

7. **Accept Alliance Dashboard for Q4 2021.**

- Reference materials: Alliance Dashboard – Q4 2021.

Pages 7-01 to 7-02

8. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the twelve months ending December 31, 2021.**

- Reference materials: Financial Statements as above.

Pages 8-01 to 8-09

Minutes: (9A. – 9F.)

9A. **Approve Commission regular meeting minutes of December 1, 2021; special meeting minutes of January 18, 2022; and regular meeting minutes of January 25, 2022.**

- Reference materials: Minutes as above.

Pages 9A-01 to 9A-15

9B. **Accept Compliance Committee meeting minutes of September 15, 2021 and December 15, 2021.**

- Reference materials: Minutes as above.

Pages 9B-01 to 9B-07

9C. **Accept Continuous Quality Improvement Committee meeting minutes of October 28, 2021.**
- Reference materials: Minutes as above.

Pages 9C-01 to 9C-06

9D. **Accept Physicians Advisory Group meeting minutes of September 2, 2021.**
- Reference materials: Minutes as above.

Pages 9D-01 to 9D-05

9E. **Accept Whole Child Model Clinical Advisory Committee meeting minutes of September 16, 2021.**
- Reference materials: Minutes as above.

Pages 9E-01 to 9E-04

9F. **Accept Whole Child Model Family Advisory Committee meeting minutes of November 8, 2021.**
- Reference materials: Minutes as above.

Pages 9F-01 to 9F-07

Reports: (10A. – 10J.)

10A. **Approve recommendation authorizing the Chair to sign Amendment #49 to the Alliance's primary Medi-Cal contract number 08-85216 to implement the COVID-19 Vaccine Incentive Program.**
- Reference materials: Staff report and recommendation on above topic.

Page 10A-01

10B. **Approve recommendation authorizing the Chair to sign Amendment #45 to the Alliance's primary Medi-Cal contract number 08-85216 to implement the CY 2021 "Base Amendment" pending completion of a review of the language for acceptability and assessment of risk.**
- Reference materials: Staff report and recommendation on above topic.

Page 10B-01

10C. **Approve recommendation authorizing medical budget allocation for COVID-19 Vaccine Member Incentive and COVID-19 Related Supplies.**
- Reference materials: Staff report and recommendation on above topic.

Pages 10C-01 to 10C-02

10D. **Approve revised Whole Child Model Clinical Advisory Committee (WCMCAC) Charter and Policy #400-1112 – WCMCAC Responsibilities and Functions.**
- Reference materials: Staff report and recommendation on above topic; WCMCAC Charter; and Policy #400-1112 – WCMCAC Responsibilities and Functions.

Pages 10D-01 to 10D-08

10E. **Accept Quality and Performance Improvement Program Workplan Report for Q3 2021.**
- Reference materials: Staff report and recommendation on above topic.

Pages 10E-01 to 10E-04

10F. **Accept Utilization Management Workplan Report for Q3 2021.**
- Reference materials: Staff report and recommendation on above topic.

Pages 10F-01 to 10F-05

10G. **Accept 2021 Community Impact Report.**
- Reference materials: 2021 Community Impact Report (publication).

Pages 10G-01 to 10G-12

10H. **Accept report on Medi-Cal Capacity Grant Program (MCGP) 2021 Impact Report.**

- Reference materials: Staff report and recommendation on above topic; MCGP Theory of Change and Medium-Term Outcomes; and MCGP Performance Dashboard.

Pages 10H-01 to 10H-11

10I. **Accept Alliance Business Continuity and Disaster Recovery Program 2021 Annual Report.**

- Reference materials: Staff report and recommendation on above topic.

Pages 10I-01 to 10I-02

10J. **Accept Alliance Owned Properties 2021 Annual Report.**

- Reference materials: Staff report on above topic.

Pages 10J-01 to 10J-02

Regular Agenda Items: (11. – 13.): 3:15 p.m.

11. **Discuss agenda and arrangements for the Board's Merced County in-person meeting on April 27, 2022. (3:15 – 3:25 p.m.)**

A. Ms. Stephanie Sonnenshine, CEO, will present draft agenda topics and review arrangements and Board will discuss planning of April 27, 2022 meeting.

- Reference materials: Draft meeting agenda.

Page 11-01

12. **Discuss major Medi-Cal managed care initiatives and proposals. (3:25 – 3:45 p.m.)**

A. Ms. Sonnenshine, CEO, will review and Board will discuss major Medi-Cal managed care initiatives and proposals influential to the Alliance in 2022.

- Reference materials: Staff report on FY 2022-23 State Budget Proposal; State Budget 2022-23: Medi-Cal Budget Proposals; CalAIM Initiatives Launch Timeline as of November 2021; and CalAIM Milestones Calendar as of November 2021.

Pages 12-01 to 12-28

13. **Consider recommendation to oppose State action which contravenes County Organized Health System (COHS) model. (3:45 – 4:30 p.m.)**

A. Ms. Sonnenshine, CEO, will review and Board will consider opposing any action and/or legislation which would contravene or result in the de facto elimination of the COHS model and authorize the CEO to take any necessary advocacy steps to oppose such action and maintain the integrity of the COHS model.

- Reference materials: Staff report and recommendation on above topic; Local Health Plans of California (LPHC) Response to No-Bid Kaiser Statewide Medi-Cal Contract; LHPC Fact Sheet: Proposed Statewide, No-Bid Commercial Plan Contract; DHCS Proposal Medi-Cal Direct Contract with Kaiser Permanente; California Healthline article, 2/3/22; Los Angeles Times article, 2/4/22; and CalMatters article, 2/4/22.

Pages 13-01 to 13-20

Adjourn to Closed Session

14. **Closed session pursuant to Government Code Section 54957.6 regarding the Agency's performance evaluation of the CEO. (4:30 – 4:55 p.m.)**

A. Closed session agenda item.

- Reference materials: Evaluation of CEO Performance (Confidential).

Return to Open Session

15. Open session regarding CEO's annual performance evaluation. (4:55 – 5:00 p.m.)

A. Board will consider action regarding the CEO's annual performance evaluation.

Information Items: (16A. – 16K.)

Announcements:

Meetings of Advisory Groups and Committees of the Commission
The next meetings of the Advisory Groups and Committees of the Commission are:

- Finance Committee
  Wednesday, March 23, 2022; 1:30 – 2:45 p.m.
- Member Services Advisory Group
  Thursday, May 12, 2022; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, March 3, 2022; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee
  Thursday, March 17, 2022; 12:00 – 1:00 p.m. [*teleconference*]
- Whole Child Model Family Advisory Committee
  Monday, March 14, 2022; 1:30 – 3:00 p.m. [*teleconference*]

The above meetings will be held via videoconference from Alliance offices in Scotts Valley, Salinas and Merced unless otherwise noticed.

The next regular meeting of the Commission, after this February 23, 2022 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, March 23, 2022, 3:00 – 5:00 p.m.
  Locations: Videoconference from Alliance offices in Scotts Valley, Salinas and Merced

Locations for the meeting:

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, CA

In Monterey County:
Central California Alliance for Health
950 E. Blanco Road, Suite 101, Salinas, CA

In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, CA

Members of the public interested in attending should call the Alliance at (831) 430-5523 to verify meeting dates and locations prior to the meetings.

The complete agenda packet is available for review on the Alliance website at https://thealliance.health/about-the-alliance/public-meetings/. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-5523. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: AB 361 – Brown Act: Teleconferencing Meeting Procedures

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Recommendation. Staff recommend the Board consider making the following findings by majority vote, pursuant to Government Code § 54953 (e) (3), to allow for the Board to meet remotely through teleconferencing, due to the present state of emergency, under the permissions provided via AB 361:

(A) The Board has considered the circumstances of the state of emergency.
(B) Any of the following exists:
  (i) The state of emergency continues to impact the ability of members to meet safely in person.
  (ii) State or local officials continue to impose or recommend measures to promote social distancing.

Summary. AB 361 (Statutes 2021) amended Government Code § 54953 to modify rules requiring the physical presence of members of a public agency for the purposes of conducting a public meeting during declared states of emergency and when state or local officials have imposed or recommended measures to promote social distancing. In order to meet while implementing the permissions provided in AB 361, the Board must make the above referenced findings by majority vote and must reconsider the circumstances every 30 days.

Background. On September 16, 2021 Governor Newsom signed AB 361 (Rivas) which allows a local agency to use teleconferencing without complying with certain Brown Act requirements as long as notice and accessibility requirements are met, public members are allowed to observe and address the local agency body at the meeting, and the local agency body has a procedure for receiving and swiftly resolving requests for reasonable accommodations.

Under the provisions of AB 361, during a proclaimed state of emergency and when state or local officials have imposed or recommended measures to promote social distancing, a public body may meet via the modified teleconferencing procedures when the public body has determined by majority vote that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

Discussion. On January 25, 2022, the Board met in a regular meeting of the Commission at which time the Board reviewed the current environment regarding the COVID-19 pandemic including the statewide mask mandate in effect and the status of the Omicron surge.

Based on the circumstances present at that time, the Board agreed by unanimous vote that the state of emergency continues to impact the ability of the Board to meet safely in person allowing the Board to meet remotely through teleconferencing.

Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments. N/A

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

Governor's January Budget Proposal: State Fiscal Year 2022-23. On January 10, 2022, Governor Newsom released his budget proposal for the 2022-23 State fiscal year, beginning July 1, 2022. The Governor's $286.5B (TF) budget includes investments to respond to the COVID-19 public health effects as well as one-time and ongoing investments in healthcare and other services impacting Californians. A more detailed summary of the state budget proposal is included in Agenda Item 12 and staff will provide a report on the budget priorities at the February 23, 2022 meeting.

2022 Legislative Session. Legislators returned to the Capitol in early January to begin the second year of the current two-year legislative session. Much focus in the early days of the 2022 legislative session was on AB 1400, the bill to bring universal publicly funded healthcare to California. AB 1400 would have created CalCare, a single-payer healthcare system covering all Californians, to be administered by a nine-member board. As AB 1400 was introduced in 2021, the deadline for the bill to move out of the Assembly was January 31, 2022. However, the bill's author, Assemblymember Ash Kalra (D-San Jose), indicated that he did not have the number of votes necessary to pass the bill out of the Assembly and thus he elected not to put the bill up for a vote. This effectively ended the prospects of the bill moving forward in this legislative session.

Staff continues to monitor new legislative activity in the Board's area of focus which include: health care coverage, delivery system reform, Medi-Cal eligibility, benefits, provider payment rates, health plan revenue and relevant Medi-Cal and/or managed care policies and initiatives. The 2022 deadline to introduce new bills is February 18, 2022. Staff will work closely with the Local Health Plans of California and our representatives in Sacramento to monitor legislative activity and will provide reports to your Board throughout 2022 as issues of Board interest, importance or action arise.

Department of Health Care Services Statewide Direct Contract with Kaiser. On Friday, February 2, 2022, the Department of Health Care Services (DHCS) confirmed rumors that had been swirling regarding its proposed deal with Kaiser which would result in Kaiser being awarded a direct Medi-Cal contract, outside of the Medi-Cal managed care procurement process. As part of this agreement Kaiser will not be required to accept additional Medi-Cal members other than those who were previously covered by Kaiser's commercial insurance. Kaiser will also be awarded a Medicare Advantage D-SNP contract to care for seniors and plans to become the state-wide provider for foster children, among other terms. Staff continue to request clarification and transparency to fully understand the implications of this contract in the Alliance service area. However, staff have confirmed that Kaiser will be given a direct contract with DHCS for Medi-Cal in Santa Cruz County,

contravening the County Organized Health Systems (COHS) model. DHCS has not yet responded to our requests for information regarding other Alliance service areas including the counties of Monterey and Merced and the potential expansion counties of San Benito and Mariposa. The Administration's policy decision and process lacked transparency and communication. Staff understand that statutory change is necessary to effectuate this change in COHS counties and DHCS intends to execute this through budget trailer bill language. The Board will discuss this item at the February 23, 2022 Board meeting in Agenda Item 13. Staff will recommend that the Board take a position opposing any action and/or legislation that contravenes or would result in the de facto elimination of the County Organized Health System model and authorize the Chief Executive Officer (CEO) to take any necessary advocacy steps to oppose such action and maintain the integrity of the COHS model.

Medi-Cal Managed Care Procurement – Request for Proposal. On February 9, 2022, DHCS issued a Request for Proposal (RFP) to begin a statewide procurement process for its commercial Medi-Cal managed care plans. This process provides an opportunity for commercial plans to submit bids to provide Medi-Cal managed care plan services in the Geographic Managed Care, Regional, or Two-Plan model(s) effective January 1, 2024. As part of the RFP, DHCS has issued a new Medi-Cal managed care plan boilerplate contract template, which will apply to all Medi-Cal managed care plans beginning in 2024. Staff are reviewing and assessing this new contract and will begin a process of evaluation, analysis, and implementation to ensure that the Alliance is able to comply with any and all new contractual requirements no later than January 2024.

Student Behavioral Health Incentive Program. The Student Behavioral Health Incentive Program (SBHIP) is underway with the Alliance's submission of the Letter of Intent to DHCS to participate in the program on January 25, 2022. The Alliance is currently in the process of selecting partners to engage in the development of a behavioral health needs assessment in each county. The Alliance is required to partner with a minimum of two Local Educational Agencies (LEAs) in Merced County, three LEAs in Monterey County, and one LEA in Santa Cruz County. Other partners will likely include County Behavioral Health and the County Office of Education (COE).

Alliance staff are currently meeting with key stakeholders from the COE, County Behavioral Health and LEAs in each county. Exploratory meetings, to be co-hosted with COEs in counties where more than one LEA will be selected, are scheduled for mid-February. These meetings will provide an opportunity for LEAs to learn more about the SBHIP. LEAs attending these meetings will take part in a post-meeting survey to assess their interest in participating in the program. The Alliance will then use DHCS LEA selection criteria and input from the COEs to select LEA partners. The goal is to have a signed LOA with all partners by mid-March to be aligned with the SBHIP Partners Form due to DHCS no later than March 15, 2022.

Community Involvement. On December 9, 2021 I attended the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting and I participated in the Medi-Cal Children's Health Advisory Panel webinar. I attended a virtual meeting with Secretary Dr. Mark Ghaly and Local Health Plans of California on December 13, 2021 and I attended the DHCS virtual December All Plan CEO meeting on December 15, 2021. On December 16, 2021 I attended the virtual HIPSCC Executive Committee meeting and the virtual HIPSCC Council meeting on January 13, 2022. I attended the virtual HIPSCC Executive Committee

meeting on January 20, 2022 and I attended the ribbon cutting ceremony for the new primary care clinic in San Lorenzo Valley on January 24, 2022. On January 26, 2022 I attended the virtual MoReHEALTH Full Board meeting and I attended the Local Health Plans of California virtual January Board meeting on January 28, 2022. I attended the virtual HIPSCC Council meeting on February 10, 2022. On February 17, 2022 I attended the DHCS virtual Stakeholder Advisory Committee meeting and the virtual HIPSCC Executive Committee meeting.

Health Services

The Health Services Division is currently engaged in the DHCS Medical Audit that began February 15, 2022 and continues through March 1, 2022. Audit preparation included providing many deliverables for utilization management, grievances, and potential quality issues as well as participating in mock audits in all areas of audit review. During the audit, staff are describing Alliance programs and responding to questions about programs and deliverables.

Other current priorities and efforts include promoting COVID-19 vaccination through the COVID-19 Vaccine Incentive Program, transitioning the Medi-Cal Rx Pharmacy Carve-Out program, beginning the Enhanced Case Management (ECM) and Community Services (CS) programs which includes transitioning the Whole Person Care programs in Santa Cruz and Monterey Counites into ECM, approving new members to participate in the program, expanding and training the ECM and CS provider panel, and finalizing development of the new software programs for care management documentation and community referrals.

Utilization Management/Complex Case Management. The Complex Case Management team continues to contact members post-discharge, advance the Meal Delivery Program and monitor Recuperative Care utilization.

Inpatient/Emergency Department Utilization. Inpatient utilization trended upward in volume during December and January, in part due to normal seasonal activity, and in part due to the Omicron surge. Admissions related to Omicron generally did not result in increased ICU utilization or longer lengths of stay.

Due to the rapid spread of the Omicron variant, Skilled Nursing Facility (SNF) and Long-Term Care (LTC) exposures climbed in volume in December 2021 and January 2022. Due to required vaccination in SNF/LTC residents and milder illness with Omicron, these exposures did not result in significant increases in SNF/LTC admissions to the hospital.

Emergency department volumes continued to increase likely due to multiple factors in each county including primary care physician staffing shortages, requests for COVID-19 testing, symptomatic members seeking immediate care, and normal winter seasonal utilization.

Prior Authorization. Outpatient Authorization volumes decreased in December and January largely due to the COVID-19 surge with providers shifting emphasis to acute care needs of members. Improvements in Alliance prior authorization processing turn-around times have been achieved through the Authorization Redesign project efforts to continue modifying authorization requirements to enhance member access and decrease unnecessary provider burden.

Medi-Cal Rx Update. On January 1, 2022, all administrative services related to Medi-Cal pharmacy benefits billed on pharmacy claims from the Alliance transitioned to the centralized DHCS program administered by Magellan under Medi-Cal Rx. There have been multiple challenges with the transition and the Alliance pharmacy team has been performing the following tasks in order to identify problems and intervene as soon as possible:

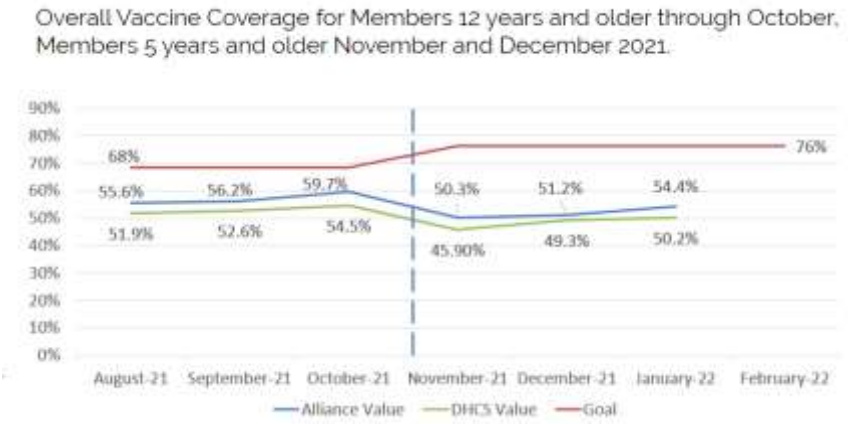
- Tracking and monitoring all members and provider inquires and issues.
- Reviewing daily data feeds from Magellan to monitor for denials and determine access issues.
- Coordinating with Magellan's Clinical Liaisons, pharmacies, and providers on any known prescription related issues.
- Identifying high-risk members and medications for proactive outreach.
- Continuing our member outreach and provider awareness of this change.
- Escalating any policy related issues to DHCS to remove barriers for our members in prescription access.
- Assisting providers and pharmacies with navigation of the Magellan processes.
- Participating in discussions with DHCS leadership regarding these concerns.

Alliance Care In-Home Supportive Services (IHSS): Prior Authorizations Delegation to MedImpact. The Alliance had a successful go-live for IHSS delegation to Alliance's Contracted Pharmacy Benefit Manager, MedImpact on January 1, 2022. MedImpact is responsible for formulary management, prior authorization, and claims processing for pharmacy services billed as pharmacy claims. The Alliance is monitoring the transition by reviewing the daily claims submissions. Any denials are being followed up with MedImpact, Provider and Pharmacy.

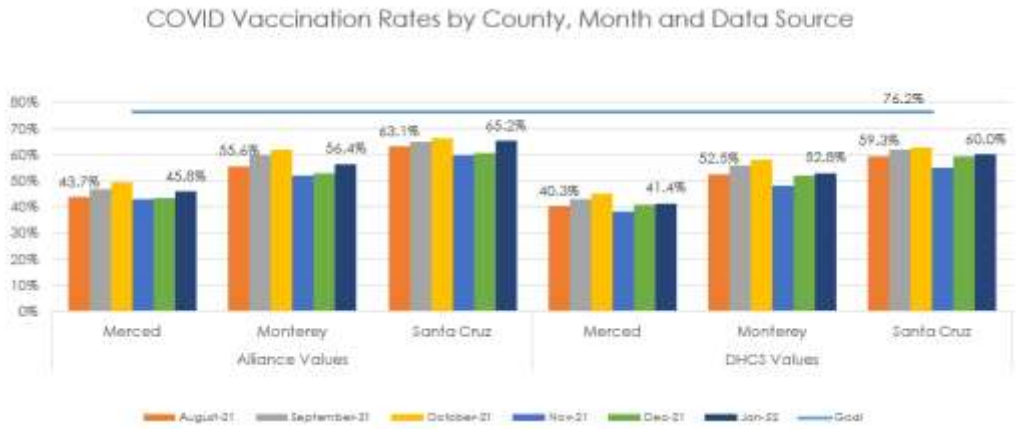
Department of Health Care Services COVID-19 Vaccination Incentive Plan. The Alliance is continuing to work on the Vaccine Incentive Program, which includes a comprehensive media plan, provider, pharmacy, and member incentives.

The following represents the progress to date (data pull: January 11, 2022):

- Increases in rates for members 12 years and older with at least one COVID-19 vaccination dose from baseline of 55.6% (August) to 59.7% (October). Note that starting in November 2021, DHCS incorporated members 5 years and older to the denominator, with a target rate of 76%. For 5-11 years old, the rate increased from 0.9% in November to 15.9% (January 2022). For overall rates of 5 years and older, there was an increase from 50.3% (November) to 54.4% (January 2022).



- Regarding county rates in November for 5 years and older, Santa Cruz has the highest rate (65.2%), followed by Monterey (56.4%), then Merced County (41.4%). Note: Alliance reported rates are slightly higher compared to DHCS due to data source capture.



- Member incentives: The Alliance launched the $50 gift card mailing in mid-December with a contracted vendor. Members were able to redeem gift cards in three different ways (phone, online, and mail). The vendor has a multilingual, multicultural call center to assist members as needed. For members who received at least one vaccine dose between September 1 – December 2021, a total of 38,800 incentives were mailed to members, and monthly mailings are planned through March 2022.
- The Alliance is co-hosting pop-up clinics in areas that have the lowest vaccination rates in high density areas where there is the greatest need (includes DHCS populations of focus) to increase access to COVID-19 vaccines. The Your Health Matters team has engaged in 26 point-of-service events (from October 21, 2021 - December 16, 2021): seven in Santa Cruz, nine in Monterey, and 10 in Merced county. The Alliance provided a total of 463 point-of-service gift card incentives at pop-up clinics across all three counties.
- In addition to pop-up clinics, the Alliance is supporting the administration of gift cards for COVID-19 vaccination by providers and community-based organizations. Its first engagement was with the Homeless Persons Health Project where 100 gift

cards were provided for distribution during street medicine activities at homeless encampments in Santa Cruz and Watsonville.

Enhanced Case Management and Community Support Services (ECM/CS). On January 1, 2022 the Alliance successfully transitioned the existing Whole Person Care Pilot members from Monterey and Santa Cruz counties to ECM and CS providers. In addition, the Alliance received many calls from members who were interested in learning about the new ECM benefit and optional CS services, and whether they were eligible to receive these services. When determined as eligible, these members are assigned to ECM and/or CS contracted providers.

In collaboration with the Provider Services Network Development team, CCC staff began on-going meetings with newly contracted ECM and CS providers to support them in the development and refinement of operational processes to support ECM and CS. Staff are also available for any ad hoc questions or needs for support from the newly developed ECM and CS provider network regarding the delivery of the core services of ECM and/or CS activities.

Quarterly meetings continue with County leadership from each Alliance county to provide updates on the implementation of ECM and CS, and to continue the preparation for Merced County go-live in July, as well as the addition of new populations of focus anticipated for go-live in January 2023 and beyond.

Eating Disorder Support Development. Work continues internally and with external partners to monitor the volume of Alliance members needing care coordination for eating disorders. The pandemic has had a negative impact on members with this condition. There are more members needing coordinated services, and members with eating disorders are needing more intensive service delivery and higher levels of care.

The Alliance continues to work collaboratively with our County Behavioral Health partners and Beacon, the Alliance's Managed Behavioral Health Organization, to support members with these needs. Additional meetings to coordinate care are arranged as needed to address the complex coordination required to support both the physical and behavioral needs of these members. Meetings are also held internally to support staff in meeting the member's needs, and to identify training opportunities for staff. Staff also coordinate with Beacon twice monthly to facilitate care coordination for Alliance members receiving services for eating disorders.

Employee Services and Communications

Alliance Workforce. As of January 31, 2022, the Alliance has 521.75 budgeted positions of which our active workforce number is 485.1 (active FTE and temporary workers). There are 27.5 positions in active recruitment, and 37.5 positions are vacant. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets. Human Resources continues to partner with Budget & Reporting to ensure alignment in FTE goals.

Human Resources completed its work with Pearl Meyer, our outside compensation consultant, to ensure alignment between our compensation ranges, and the job market. This is an important evaluation process and best practice to ensure we are competitive in

the market to attract and retain talent. Recommendations were submitted and appropriate updates made to job family pay ranges as a result of this work, effective January 1, 2022.

Human Resources is currently supporting the Q4 2021 check-in process and Annual Compensation Review. This process aligns the final 2021 year in review and merit allocation for eligible staff. Q4 2021 check-ins and merit allocation will conclude in February 2022. Eligible staff receiving merit pay will receive it on the March 4, 2022 paycheck, with merit pay retroactive to January 1, 2022.

Effective January 1, 2022, the Training & Development Department integrated with Human Resources and is now a unit within the Human Resources Department. This change allows for added emphasis and alignment in the training and developing of Alliance staff. In addition, this is an excellent way to provide focused collaboration on retaining Alliance staff. The Human Resources Department is excited about this alignment and looks forward to this new endeavor.

Facilities and Administrative Services. The remodel project for Capitola Manor, the Alliance owned skilled nursing facility located in Capitola, CA, has been cancelled due to higher than anticipated costs for materials and construction. Work ceased on the project in December 2021. Staff are currently engaged in efforts to sell the property.

Office Reopening. Facilities Department leadership worked to prepare the Alliance for office reopening, which occurred on February 1, 2022.

Communications. The "Crush COVID" paid media campaign launched December 27, 2021 and will run through the end of February 2022. The campaign has been successful in raising overall awareness of the vaccine and the Alliance. The website landing page rose to #4 and #8 on our website (English and Spanish, respectively) in terms of unique pageviews (popularity) and our Facebook posts have reached over 81,000 people during the month of January alone. In addition to these efforts, we also developed bilingual streaming and static radio ads on Pandora and iHeart radio and digital ads on mobile platforms. We also created a member-facing flyer and supplemental provider communications.

In partnership with Strategic Development staff, Communications staff worked to develop the Alliance's Strategic Plan booklet, which has been posted on our website and distributed electronically. We have also printed a small number of copies to be distributed to key partners and stakeholders. Looking ahead, a small subcommittee of Alliance staff have been established to create an easily digestible document for members that clearly explains what members will experience as a result of what is outlined in the plan. The kickoff meeting is planned for early February, with the final document planned to be released in all three languages by the end of Q2 2022.

Staff have partnered with the Grants team and Regional Operations Directors to create the Community Impact Report, included in the packet under 10G on the Consent Agenda.

Operations

The Operations Division remain adaptive to our environment as we implement new programs per DHCS guidelines and continue to execute health plan operations during the

Omicron surge. Key focus has been on supporting our members and providers to navigate these changes.

Member Services. In January, the Member Services Department saw a large increase in member calls related to the pharmacy benefit transition to Medi-Cal Rx. As preparation for the surge, Member Services actively engaged in developing and delivering thorough training to staff and established a volunteer phone queue across the organization. This collaboration ensured the Alliance was available for member questions and issues related to the transition to Medi-Cal Rx.

Additionally, Member Services staff have been working closely with our print vendor to address the paper products shortage as a result of supply chain issues. Our vendor has reported order delays upwards of three months. While we continue to find creative solutions and order supplies with as much advance notice as possible, we anticipate the paper shortage may impact timely mailing of required member materials.

Staff prepared for office re-opening for member walk-in activities in February 2022 while ensuring safety for both our members and staff aligned with public health guidelines during a pandemic. We were successful in resuming member walk-in service in our first week and assisted over a dozen members with their managed healthcare related needs. We will continue to evaluate and expand as needed while balancing public health safety concerns.

Provider Services. The Provider Services Department partnered with others from across the Alliance to ensure that a contracted network was in place for the January 1, 2022 launch of the ECM benefit and optional CS services. Through engagements with entities across Santa Cruz and Monterey Counties, staff partnered with nine organizations to secure ECM and CS contracts in advance of January. These organizations ensured continuity of care as members transitioned from Whole Person Care services to ECM and CS, and staff are working now to expand capacity through the addition of more ECM and CS providers across both counties.

Claims. As part of our ongoing effort to achieve administrative efficiency, the Claims Department continues to focus on reducing overall claims inventory and improving the payment accuracy of finalized claims. Key developments include: 1) roll-out of a productivity time report and 2) establishing a Claims Quality Program. The Productivity report will provide insight into Work Unit Per Hour data at both the team and individual level. The Claims Quality Program will look at the following categories: 1) Financial Accuracy, 2) Payment Accuracy, 3) Processing Accuracy, and 4) Overall Accuracy to ascertain payment accuracy and quality.

Regional Operations Santa Cruz, Monterey and Merced. Regional Operations continue to work toward building collaboration with community partners. In January, we released the fifth edition of The Beat, the Alliance's community newsletter which included information on how Community Based Organizations can support their clients in both becoming vaccinated and through the transition of the pharmacy benefit to Medi-Cal Rx. This edition also included the Alliance's 2022 – 2026 Strategic Plan and results from the Consumer Assessment of Healthcare Providers and Systems survey, including an award for outstanding performance in pediatric care for medium-sized health plans in 2021.

The Alliance Your Health Matters Outreach Program (YHM) ended the 2021 year with positive outcomes during a time where adaptation was a necessity. As of December 2021, there have been over 15,000 calls made and over 9,000 members reached through the various call campaigns throughout the year. The YHM team began in-person outreach attendance in August and engaged with over 4,000 members at 22 community events, including COVID-19 pop-up clinics. Community efforts continue with regular calls and collaborative work with county leaders and local organizations to support the efforts of informing and educating members during the Omicron surge.

Q4 2021 Operational Dashboard Results. The Q4 2021 *Alliance Dashboard* is comprised of 141 metrics monitoring 67 health plan core, support and managerial processes. These 67 health plan processes are rolled-up to 13 top-level (Level 1) processes for Board monitoring using a composite methodology, meaning the performance of these core processes are averaged to produce top-level process performance results, as displayed in the *Alliance Dashboard*.

In addition to Level 1 process performance, page 2 of the *Alliance Dashboard* contains a subset of the 141 metrics that the Board has requested for quarterly monitoring. The Q4 2021 *Alliance Dashboard* indicates healthy performance with a composite organizational result of 97.4%. Results for 10 of 13 Level 1 processes met or exceeded 95% of target. Exceptions to the 95% standard and other notable performance are as follows:

L1 Process	Q4 Results	Quarter over Quarter Change	Key Drivers
Engage and Support Members	94.0%	1.1%	The Level 2 process Help Members Navigate (82.0%) continued to be impacted by staff shortages leading to a reduction in service levels for incoming member calls.
Optimize the Alliance Workforce	93.4%	-0.8%	Performance is primarily the result of new employee turnover at 73.3 percent of target (up 19.1 percentage points over Q3 2021) and days to offer at 88.6 percent of target (down 11.4 percentage points over Q3 2021) which was impacted by a high volume of recruitments and holiday schedule availability.
Manage Alliance Compliance Commitments	94.1%	-1.4%	Performance is primarily the result of timely fraud/abuse reporting at 72.7 percent of target (down 27.3 percentage points over Q3 2021) and timely PHI reporting at 91.7 percent of target (up 19 percentage points over Q3 2021). Timely reporting from delegates was a contributing factor to decreased performance levels.
Manage Data	98.8%	5.6%	Improved performance is primarily the result of increased performance in complete, accurate, and timely encounter data at 100 percent of target (up 17.5 percentage points over Q3 2021) and timely EDW refresh at 97.0 percent of target (up 31.0 percentage points over Q3 2021).

2022 Operating Plan. The 2022 Operating Plan was finalized with tactics in support of our strategic objectives focusing on health equity and person-centered delivery system. We have affirmed those tactics are aligned, achievable and will be supported through our goal planning process.

Attachments.

1. 2022 Alliance Operating Plan

2022 Alliance Operating Plan

V2.1 | January 24, 2022 - *Clean*

VISION Healthy People. Healthy Communities.

MISSION Accessible, quality health care guided by local innovation

VALUES Collaboration, Equity, Improvement, Integrity

Strategic Priority 1	Strategic Goal 1
Health Equity	Eliminate health disparities and achieve optimal health outcomes for children and youth

Understand opportunities to resolve root cause disparities in pediatric health — Breakthrough **OBJECTIVE 1**

Strategic Priority 1	Strategic Goal 2
Health Equity	Increase culturally and linguistically appropriate health care for members

Enhance member engagement to gain insights aimed at improving programs, policies and practices — Breakthrough **OBJECTIVE 2**

Strategic Priority 2	Strategic Goal 3
Person-Centered Delivery System Transformation	Improve behavioral health services and systems to be person-centered and equitable

Understand gaps and opportunities to improve behavioral health system — Breakthrough **OBJECTIVE 3**

Strategic Priority 2	Strategic Goal 4
Person-Centered Delivery System Transformation	Improve the system of care for members with complex medical and social needs

Improve model of care for members experiencing homelessness, SMI/SUD and/or who are high utilizers — Breakthrough **OBJECTIVE 4**

Ongoing **OBJECTIVE** — Achieve regulatory, contractual and core program requirements

Ongoing **OBJECTIVE** — Adapt health plan operations in an evolving environment

Organizational **Tactics**

Responsive to Objectives and Grouped By Organizational Process

Engage and Support Members (7)

- Develop Org. Plan to Transform Member Engagement
- Optimize Transportation Benefit Administration
- Prepare for Alliance Service Area Expansion
- Implement Community Health Workers Benefit
- Strengthen Parity in MH and SUD Benefits for IHSS
- Implement CMS 9515 Transparency in Coverage
- Implement Medi-Cal Expansion to Adults 50 and Older

Pay Providers (2)

- Outsource Check Run Process for Supplemental Payments
- Enhance the OHC and Overpayment Recovery Process

Develop and Maintain the Provider Network (1)

- Develop ECM/CS Provider Network

Manage Compliance Commitments (1)

- Review DHCS Medi-Cal Managed Care Contract Revisions

Manage and Improve Care (11)

- Conduct Comprehensive Pediatric Health Disparity Assess.
- Conduct Comprehensive Behavioral Health System Assess.
- Implement Student Behavioral Health Incentive Program
- Enhance the Quality Improvement System
- Design and Implement ECM/CS Lifecycle
- Pilot Recuperative Care
- Implement Pharmacy Carve-Out
- Implement Dyadic Care (2)
- Execute Vaccine Incentive Plan
- Develop CalAIM Population Health Management Plan
- Facilitate Pandemic Care Task Force

Acquire and Retain Employees (3)

- Develop Post-Pandemic Workplace Design
- Develop a Comprehensive Equity Initiative
- [Placeholder] DEI Implementation Tactic(s)

Manage Technology (7)

- Retire AIS (Tech and Process) (1)
- Implement ECM/CS Data Systems & Sharing
- Upgrade HSP to Version 10.8.x
- Integrate Essette 3.6 with HSP and PDR
- Implement IDEA/ADV (1)
- Ensure Technology Failover Capabilities (BCDRP)
- Conduct 2021 HIPAA Security Assessment

Manage Data (2)

- Meet CMS Interoperability Rule Requirements
- Meet DHCS Managed Care Program Data Improvement Req

Manage Finances (1)

- Implement ECM/CS Incentives

Indicates Tactic requiring further mitigation or scoping

Legend: Breakthrough Objective 1 tactic | Breakthrough Objective 2 tactic | Breakthrough Objective 3 tactic | Breakthrough Objective 4 tactic | Divisional Tactic requiring only one Division to execute | Organizational tactic to improve or develop an operational capability | Organizational tactic required to achieve a regulatory, contractual or Board requirement | Organizational tactic required to execute or maintain an operational capability

Back to Agenda

Alliance Dashboard

Quarter 4, 2021

Purpose: To provide oversight of health plan performance across all organizational processes, to enable timely and targeted intervention as needed.

Context & Limitations: *Target* and *Threshold* levels are established by Alliance leadership and informed by contractual requirements and best practice standards (where available). This dashboard is produced using composites, meaning the performance of multiple sub-processes is combined for aggregate performance scores. All metrics are normalized to a 100 point scale to create the composites, so *Target* performance is always 100%. A subset of metrics are included on the following page, and additional context, analysis, and action plans surrounding performance trends (positive or negative) are included in the *Executive Summary from the CEO*, as applicable.

Legend | Target = desirable performance | Threshold = lowest acceptable performance | ≥ to 95% of *Target* | <95% of *Target* and >*Threshold* | <*Threshold*

Core Processes

Deliver value to our members, providers and community

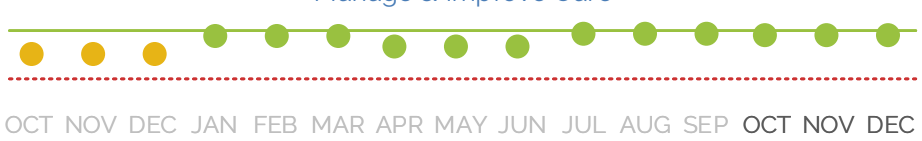
Engage & Support Members

94.0% Of Target

SUBPROCESSES
- 100 Help Members Engage
- 82.0 Help Members Navigate
- 99.9 Member Experience

Manage & Improve Care

99.2% Of Target



SUBPROCESSES
- 98.5 Manage Care Use
- 100 Improve Care

Develop & Maintain the Provider Network

99.0% Of Target

SUBPROCESSES
- 98.5 Develop the Network
- 99.6 Maintain the Network

Pay Providers

99.8% Of Target

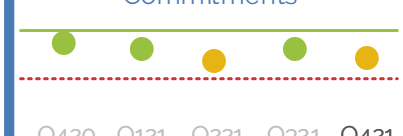
SUBPROCESSES
- 99.6 Fee-for-Service Payments
- 100 Value-Based Payments

Managerial Processes

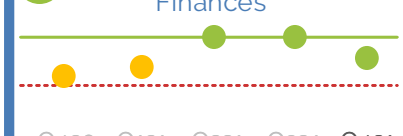
Guide the organization

97.2 Enhance Operational Effectiveness

94.1 Manage Compliance Commitments



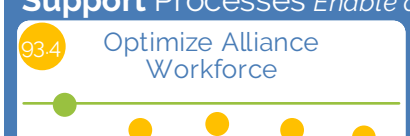
95.6 Manage Finances



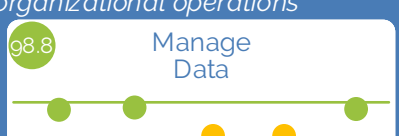
98.9 Manage Governmental & Community Relations

Support Processes *Enable organizational operations*

93.4 Optimize Alliance Workforce



98.8 Manage Data



99.7 Manage Technology

99.3 Provide Administrative Services

97.0 Communications & Organizational Branding

Alliance Dashboard – Board Metrics

Quarter 4, 2021

No.	Metric	Period	Target	Performance
1	Member Calls Answered Timely	Q421	80.0%	38.3%
2	New Member Welcome Call Completion Rate	Q321	30.0%	29.1%
3	Timely Resolution of Member Complaints	Q421	100.0%	99.5%
4	Members' Favorable Rating of Health Plan (CAHPS) (Medi-Cal)	2020	Child: 86.0% | Adult: 73.0%	Child: 88.8% | Adult: 79.8%
5	Members' Favorable Rating of Health Care (CAHPS) (Medi-Cal)	2020	Child: 84.5% | Adult: 70.5%	Child: 87.1% | Adult: 79.1%
6	Routine PCP Facility Site Reviews Completed Timely	Q421	100.0%	80.0%
7	Facility Sites Reviewed in Good Health	Q421	100.0%	100.0%
8	In Area PCP Market Share (all counties)	Q421	80.0%	85.4%
9	In Area Specialist Market Share (all counties)	Q421	80.0%	84.1%
10	Contracted PCP Open % (all counties)	Q421		58.0%
11	Overall Provider Satisfaction Rate	2021	88.0%	89.0%
12	Inpatient Bed Days/ 1,000 members/Year (Medi-Cal)	Q321	282.0	248.0
13	Admissions/1,000 Members/Year (Medi-Cal)	Q321	63.0	55.0
14	Total 30 Day All-Cause Readmissions %	Q321	11.0%	11.0%
15	Ambulatory Care Sensitive Admissions (Medi-Cal)	Q321	8.0%	6.8%
16	Average Length of Stay (Medi-Cal)	Q321	4.5	4.5
17	Emergency Department visits/1,000 members/year (all LOBs)	Q321	513.0	483.0
18	Avoidable Emergency Department visits (all LOBs)	Q321	18.0%	15.8%
19	Behavioral Health Utilization Rate by County (All Ages)	Q321	3.6%	SC: 13.7% | Mont: 7.5% | Merced: 6.8%
20	Routine Medical/Surgical Prior Authorizations Adjudicated Timely	Q421	100.0%	99.8%
21	Medical/Surgical authorization denial rate	Q421		0.6%
22	Pharmacy Cost/Member/Month - Retail, Outpatient & Specialty	Q421	$46.59	$46.20
23	Generic Prescription %	Q421	88.0%	88.8%
24	Clean Claims Processed and Paid Within 30 Calendar Days	Q421	90.0%	97.0%
25	Employee Turnover Rate	Q121-Q421	10.0%	10.3%
26	Total Staffed Workforce	Q421	90.0%	92.1%
27	Board Designated Reserves Percentage	Q421	100.0%	116.2%
28	Net Income Percentage	Q421	1.0%	4.8%
29	Medical Loss Ratio	Q421	92.0%	90.4%
30	Administrative Loss Ratio	Q421	6.0%	4.2%

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Twelve Months Ending December 31, 2021 – Unaudited as of 2/10/2022

For the month ending December 31, 2021, the Alliance reported an Operating Income of $0.8M. The Year-to-Date (YTD) Operating Income is at $136.2M, with an MLR of 86.0% and ALR of 5.4%.

The 2021 budget assumed services to rebound starting Q4 2020 and return to the 2019 level by Q1 2021. However, this assumption was not realized, and utilization continued to be suppressed through February 2021. Utilization increased from March through July. The Omicron variant has impacted utilization in recent months, with utilization continuing to trend towards the 2019 level during Q4 2021, but at a slower rate than assumed in the 2021 budget. As a result, YTD medical expenses are favorable to budget by $88.9M or 6.2%.

During the Board Finance Committee meeting on September 22, 2021, staff shared a forecast based on the YTD July financial result. Staff expects an operating income of $128M for 2021. The Alliance received an updated revenue package in July which improved revenue by 4% compared to the budget due to the pharmacy carve-out delay and associated add-on rate, the COVID-19 add-on and the extension of the long-term care add-on. The forecast assumes an increase in utilization through the end of 2021. However, due to the lower than expected utilization earlier in 2021, the overall utilization and cost for the year will be at the 2019 level. The increases in revenue rates and enrollment, and decreased utilization have resulted in favorable financial performance and forecast in 2021.

Dec-21 MTD (In $000s)

Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*387,235*	*368,326*	*18,909*	*5.1%*
Revenue	136,741	121,909	14,831	12.2%
Medical Expenses	122,192	121,063	(1,129)	-0.9%
Administrative Expenses	13,762	7,198	(6,565)	-91.2%
Operating Income/(Loss)	787	(6,351)	7,138	100.0%
Net Income/(Loss)	275	(7,035)	7,309	100.0%
MLR %	*89.4%*	*99.3%*	*9.9%*	
ALR %	*10.1%*	*5.9%*	*-4.2%*	
Operating Income %	*0.6%*	*-5.2%*	*5.8%*	
Net Income %	*0.2%*	*-5.8%*	*6.0%*	

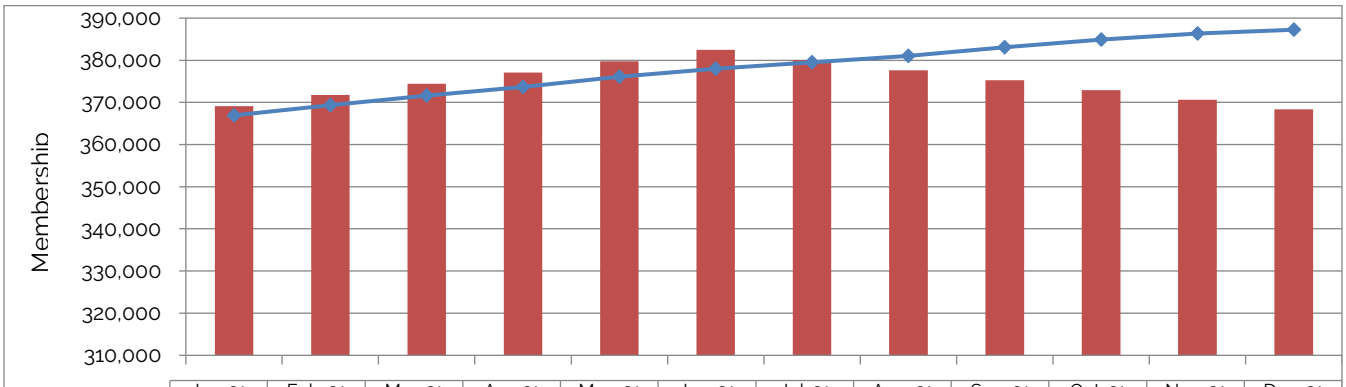
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Dec-21 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Membership	*4,537,806*	*4,499,410*	*38,396*	*0.9%*
Revenue	1,575,194	1,491,034	84,159	5.6%
Medical Expenses	1,354,168	1,443,081	88,913	6.2%
Administrative Expenses	84,795	85,564	769	0.9%
Operating Income/(Loss)	136,231	(37,610)	173,841	100.0%
Net Income/(Loss)	125,747	(45,802)	171,549	100.0%
PMPM				
Revenue	347.13	331.38	15.74	4.8%
Medical Expenses	298.42	320.73	22.31	7.0%
Administrative Expenses	18.69	19.02	0.33	1.7%
Operating Income/(Loss)	30.02	(8.36)	38.38	100.0%
MLR %	86.0%	*96.8%*	*10.8%*	
ALR %	*5.4%*	*5.7%*	*0.4%*	
Operating Income %	*8.6%*	*-2.5%*	*11.2%*	
Net Income %	*8.0%*	*-3.1%*	*11.1%*	

Per Member Per Month. Capitation revenue and medical expenses are variables based on enrollment fluctuations; therefore, the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not directly correspond with enrollment and are consequently viewed in terms of total dollar amount. At a PMPM level, YTD revenue is $347.13, which is favorable to budget by $15.74 or 4.8%. Medical cost PMPM is $298.42, which is favorable by $22.31 or 7.0%, and Administrative cost PMPM is $18.69, which is favorable by $0.33 or 1.7%. The resulting operating income is $30.02 PMPM, which is favorable by $38.38 as compared to budget.

Membership. December 2021 Member Months are favorable to budget by 5.1%. Please note that the budget assumed the Public Health Emergency (PHE) would end in June 2021. The State anticipates the PHE will expire no sooner than April 16, 2022. This will result in favorable membership and member months for the year.

Membership. Actual vs. Budget (based on actual enrollment trend for Dec-21 rolling 12 months)



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Budget	369,146	371,753	374,390	377,057	379,753	382,481	380,048	377,645	375,273	372,929	370,611	368,326
Actual	366,938	369,355	371,584	373,691	376,094	377,967	379,537	381,066	383,089	384,876	386,374	387,235
Variance	(2,208)	(2,398)	(2,806)	(3,366)	(3,659)	(4,514)	(511)	3,421	7,816	11,947	15,763	18,909
Variance %	-0.6%	-0.6%	-0.7%	-0.9%	-1.0%	-1.2%	-0.1%	0.9%	2.1%	3.2%	4.3%	5.1%

Revenue. The budgeted revenue was based on the 2021 rate package as of October 2020. Revised rates received July 13, 2021, included Pharmacy, COVID, and LTC add-ons for the entire CY 2021. This resulted in stronger and more favorable revenue.

December 2021 capitation revenue of $136.5M is favorable to budget by $14.9M or 12.2% and includes $1.6M for provider COVID-19 Vaccine Incentives and $1.7M for Direct Member Incentives & Gift Cards. December 2021 YTD revenue of $1,571.9M is favorable to budget by $84.5M or 5.7%, of which $27.3M is attributed to enrollment and $57.2M to rate variance.

Dec-21 YTD Capitation Revenue Summary (In $000s)

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	350,827	333,957	16,870	8,464	8,406
Monterey	682,679	647,333	35,346	8,881	26,465
Merced	538,399	506,104	32,295	9,977	22,318
Total	**1,571,906**	**1,487,395**	**84,511**	**27,322**	**57,189**

Note: Excludes Dec-21 YTD In-Home Supportive Services (IHSS) premiums revenue of $3.3M.

Medical Expenses. December 2021 Medical Expenses of $122.2M are $1.1M or 0.9% unfavorable to budget. December 2021 YTD Medical Expenses of $1,354.2M are favorable to budget by $88.9M or 6.2%, with an MLR of 86.0%. Of this $88.9M favorability, $101.2M is attributed to PMPM cost variance and is offset by $12.3M due to enrollment.

Dec-21 YTD Medical Expense Summary (In $000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	422,434	436,885	14,451	(3,728)	18,179
Inpatient Services (LTC)	146,571	201,594	55,022	(1,720)	56,743
Physician Services	238,145	237,055	(1,090)	(2,023)	933
Outpatient Facility	103,079	83,098	(19,981)	(709)	(19,272)
Pharmacy	209,320	209,615	294	(1,789)	2,083
Other Medical	234,618	274,834	40,216	(2,345)	42,561
Total	**1,354,168**	**1,443,081**	**88,913**	**(12,314)**	**101,227**

Note: Surgical Clinics cost was reclassified to Outpatient Facility and budget is in the Other Medical category. Other Medical includes $1.6M for provider COVID Vaccine Incentives and $1.7M for Direct Member Incentives & Gift Cards.

At a PMPM level, YTD Medical Expenses are $298.42, which is favorable by $22.31 or 7.0% as compared to budget. Please note that rate (PMPM) is the unit cost for a service, and when multiplied by the utilization for the service, equals the medical cost. The suppressed utilization contributed to the favorable rate variance.

Trended Authorization per 1,000 indicates outpatient and inpatient services were rising towards 2019 levels through Q3 2021. Outpatient services trends outpace inpatient services. This may be driven by loosened COVID-19 restrictions, resumption of outpatient surgeries and procedures, delivery of backlogged services, and members' increased confidence in seeking care outside of emergency care that may result in an inpatient stay. Q4 2021 authorizations through December indicate slightly reduced outpatient services in comparison to Q3 2021, still approaching 2019 levels. Q4 2021 inpatient services have not decreased at the same rate from Q3 2021 but remain below 2019 levels. Unknown impacts due to the Omicron variant entering California and other seasonal factors could ultimately impact utilization in Q4 2021 and further delay services causing a lower level of utilization per 1,000 trends moving into 2022. Please note that Surgical Clinics actual cost has been reclassed from Other Medical to Outpatient Facility to align with RDT, whereas the budget remains intact.

Dec-21 YTD Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	93.09	97.10	4.01	4.1%
Inpatient Services (LTC)	32.30	44.80	12.50	27.9%
Physician Services	52.48	52.69	0.21	0.4%
Outpatient Facility	22.72	18.47	(4.25)	-23.0%
Pharmacy	46.13	46.59	0.46	1.0%
Other Medical	51.70	61.08	9.38	15.4%
Total	**298.42**	**320.73**	**22.31**	**7.0%**

Administrative Expenses. December 2021 YTD Administrative Expenses are favorable to budget by $0.8M or 0.9% with a 5.4% ALR. In June 2021, a survey was conducted on time spent on Quality Improvement (QI) by the Health Services staff. CMS allows some QI expenses to be allocated to medical costs in an effort to improve the delivery of healthcare to consumers. QI expenses include care coordination, case management, outreach, community integration, and health information technology expense. Based on the June survey results, some of the administrative expenses were reclassed to medical costs resulting in a positive variance. Lastly, December 2021 YTD Total Administrative Expenses includes a Loss of Impairment, recording the discontinuance of the Capitola Manor project of $6.5M.

Non-Operating Revenue/Expenses. December 2021 YTD Total Non-Operating Revenue is unfavorable to budget by $8.0M, primarily driven by lower interest income and unrealized gain/loss on investments. This is offset by a favorable December 2021 YTD Non-Operating Expense of $5.7M, for a net loss of $2.3M.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $125.7M, with an MLR of 86.0%, and an ALR of 5.4%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Twelve Months Ending December 31, 2021
Unaudited as of 2/10/2022
(In $000s)

Assets	
Cash	$137,528
Restricted Cash	300
Short Term Investments	537,884
Receivables	245,549
Prepaid Expenses	2,197
Other Current Assets	16,105
Total Current Assets	**$939,563**
Building, Land, Furniture & Equipment	
Capital Assets	$83,668
Accumulated Depreciation	(41,249)
CIP	215
Total Non-Current Assets	**42,634**
Total Assets	**$982,197**
Liabilities	
Accounts Payable	$56,520
IBNR/Claims Payable	318,023
Accrued Expenses	1
Estimated Risk Share Payable	10,000
Other Current Liabilities	7,315
Due to State	0
Total Current Liabilities	**$391,860**
Fund Balance	
Fund Balance - Prior	$464,590
Retained Earnings - CY	125,747
Total Fund Balance	**590,337**
Total Liabilities & Fund Balance	**$982,197**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Twelve Months Ending December 31, 2021
Unaudited as of 2/10/2022
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*387,235*	*368,326*	*18,909*	*5.1%*	*4,537,806*	*4,499,410*	*38,396*	*0.9%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$136,451	$121,599	$14,852	12.2%	$1,571,906	$1,487,395	$84,511	5.7%
Premiums Commercial	290	311	(21)	-6.7%	3,288	3,640	(352)	-9.7%
Total Operating Revenue	**$136,741**	**$121,909**	**$14,831**	**12.2%**	**$1,575,194**	**$1,491,034**	**$84,159**	**5.6%**
Medical Expenses								
Inpatient Services (Hospital)	$41,668	$36,081	($5,587)	-15.5%	$422,434	$436,885	$14,451	3.3%
Inpatient Services (LTC)	13,448	17,938	4,491	25.0%	146,571	201,594	55,022	27.3%
Physician Services	20,020	19,816	(204)	-1.0%	238,145	237,055	(1,090)	-0.5%
Outpatient Facility	8,857	6,889	(1,968)	-28.6%	103,079	83,098	(19,981)	-24.0%
Pharmacy	15,153	16,730	1,577	9.4%	209,320	209,615	294	0.1%
Other Medical	23,046	23,608	563	2.4%	234,618	274,834	40,216	14.6%
Total Medical Expenses	**$122,192**	**$121,063**	**($1,129)**	**-0.9%**	**$1,354,168**	**$1,443,081**	**$88,913**	**6.2%**
Gross Margin	**$14,549**	**$847**	**$13,702**	**100.0%**	**$221,026**	**$47,954**	**$173,072**	**100.0%**
Administrative Expenses								
Salaries	$4,281	$4,985	$704	14.1%	$51,664	$56,458	$4,793	8.5%
Professional Fees	376	136	(241)	-100.0%	2,047	1,917	(129)	-6.7%
Purchased Services	1,232	880	(352)	-40.0%	10,661	10,355	(306)	-3.0%
Supplies & Other	7,444	740	(6,704)	-100.0%	13,756	8,906	(4,850)	-54.5%
Occupancy	126	108	(18)	-16.3%	907	1,323	416	31.4%
Depreciation/Amortization	303	348	45	13.0%	5,759	6,604	845	12.8%
Total Administrative Expenses	**$13,762**	**$7,198**	**($6,565)**	**-91.2%**	**$84,795**	**$85,564**	**$769**	**0.9%**
Operating Income	**$787**	**($6,351)**	**$7,138**	**100.0%**	**$136,231**	**($37,610)**	**$173,841**	**100.0%**
Non-Op Income/(Expense)								
Interest	$377	$548	($171)	-31.2%	$3,709	$6,803	($3,094)	-45.5%
Gain/(Loss) on Investments	(978)	(22)	(956)	-100.0%	(5,510)	(273)	(5,237)	-100.0%
Other Revenues	120	82	38	45.9%	1,384	1,077	307	28.5%
Grants	(31)	(1,293)	1,261	97.6%	(10,066)	(15,798)	5,732	-36.3%
Total Non-Op Income/(Expense)	**($512)**	**($684)**	**$172**	**25.1%**	**($10,484)**	**($8,192)**	**($2,292)**	**28.0%**
Net Income/(Loss)	**$275**	**($7,035)**	**$7,309**	**100.0%**	**$125,747**	**($45,802)**	**$171,549**	**100.0%**
MLR	*89.4%*	*99.3%*			*86.0%*	*96.8%*		
ALR	*10.1%*	*5.9%*			*5.4%*	*5.7%*		
Operating Income	*0.6%*	*-5.2%*			*8.6%*	*-2.5%*		
Net Income %	*0.2%*	*-5.8%*			*8.0%*	*-3.1%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Twelve Months Ending December 31, 2021
Unaudited as of 2/10/2022
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*387,235*	*368,326*	*18,909*	*5.1%*	*4,537,806*	*4,499,410*	*38,396*	*0.9%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$352.37	$330.14	$22.23	6.7%	$346.40	$330.58	$15.83	4.8%
Premiums Commercial	0.75	0.84	(0.09)	-11.3%	0.72	0.81	(0.08)	-10.4%
Total Operating Revenue	**$353.12**	**$330.98**	**$22.14**	**6.7%**	**$347.13**	**$331.38**	**$15.74**	**4.8%**
Medical Expenses								
Inpatient Services (Hospital)	$107.60	$97.96	($9.64)	-9.8%	$93.09	$97.10	$4.01	4.1%
Inpatient Services (LTC)	34.73	48.70	13.97	28.7%	32.30	44.80	12.50	27.9%
Physician Services	51.70	53.80	2.10	3.9%	52.48	52.69	0.21	0.4%
Outpatient Facility	22.87	18.70	(4.17)	-22.3%	22.72	18.47	(4.25)	-23.0%
Pharmacy	39.13	45.42	6.29	13.8%	46.13	46.59	0.46	1.0%
Other Medical	59.51	64.10	4.58	7.1%	51.70	61.08	9.38	15.4%
Total Medical Expenses	**$315.55**	**$328.68**	**$13.13**	**4.0%**	**$298.42**	**$320.73**	**$22.31**	**7.0%**
Gross Margin	**$37.57**	**$2.30**	**$35.27**	**100.0%**	**$48.71**	**$10.66**	**$38.05**	**100.0%**
Administrative Expenses								
Salaries	$11.06	$13.54	$2.48	18.3%	$11.39	$12.55	$1.16	9.3%
Professional Fees	0.97	0.37	(0.60)	-100.0%	0.45	0.43	(0.02)	-5.8%
Purchased Services	3.18	2.39	(0.79)	-33.2%	2.35	2.30	(0.05)	-2.1%
Supplies & Other	19.22	2.01	(17.21)	-100.0%	3.03	1.98	(1.05)	-53.1%
Occupancy	0.33	0.29	(0.03)	-10.7%	0.20	0.29	0.09	32.0%
Depreciation/Amortization	0.78	0.94	0.16	17.3%	1.27	1.47	0.20	13.5%
Total Administrative Expenses	**$35.54**	**$19.54**	**($16.00)**	**-81.9%**	**$18.69**	**$19.02**	**$0.33**	**1.7%**
Operating Income	**$2.03**	**($17.24)**	**$19.27**	**100.0%**	**$30.02**	**($8.36)**	**$38.38**	**100.0%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Twelve Months Ending December 31, 2021
Unaudited as of 2/10/2022
(In $000s)

	MTD	YTD
Net Income	$275	$125,747
Items not requiring the use of cash: Depreciation	303	5,003
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	(91,038)	2,180
Prepaid Expenses	864	624
Current Assets	798	3,400
Net Changes to Assets	**($89,375)**	**$6,205**
Changes to Payables:		
Accounts Payable	25,167	15,961
Accrued Expenses	-	-
Other Current Liabilities	652	(148)
Incurred But Not Reported Claims/Claims Payable	75,049	7,207
Estimated Risk Share Payable	818	(10)
Due to State	-	-
Net Changes to Payables	**$101,685**	**$23,009**
Net Cash Provided by (Used in) Operating Activities	**$12,888**	**$159,964**
Change in Investments	(81,137)	(181,774)
Other Equipment Acquisitions	5,978	2,292
Net Cash Provided by (Used in) Investing Activities	**($75,160)**	**($179,481)**
Net Increase (Decrease) in Cash & Cash Equivalents	**($62,272)**	**($19,517)**
Cash & Cash Equivalents at Beginning of Period	**$199,800**	**$157,045**
Cash & Cash Equivalents at December 31, 2021	**$137,528**	**$137,528**

SANTA CRUZ – MONTEREY – MERCED MANAGED MEDICAL CARE COMMISSION MEETING

Meeting Minutes

Wednesday, December 1, 2021

Teleconference Meeting

(Pursuant to Assembly Bill 361 signed by Governor Newsom, September 16, 2021)

Commissioners Present:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Supervisor Ryan Coonerty	County Board of Supervisors
Dr. Maximiliano Cuevas	Provider Representative
Dr. Larry deGhetaldi	Provider Representative
Ms. Julie Edgcomb	Public Representative
Dr. Charles Harris	Hospital Representative
Ms. Dori Rose Inda	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Ms. Rebecca Nanyonjo	Director of Public Health
Supervisor Josh Pedrozo	County Board of Supervisors
Ms. Elsa Quezada	Public Representative
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Dr. Joerg Schuller	Hospital Representative
Mr. Rob Smith	Public Representative
Mr. Tony Weber	Provider Representative

Commissioners Absent:

Ms. Leslie Conner	Provider Representative

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Dr. Dale Bishop	Chief Medical Officer
Mr. Scott Fortner	Chief Administrative Officer
Ms. Van Wong	Chief Operating Officer
Ms. Kathleen McCarthy	Strategic Development Director

Ms. Kathy Stagnaro Clerk of the Board

1. Call to Order by Vice Chair Jimenez.

Commission Vice Chairperson Jimenez called the meeting to order at 3:01 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

Vice Chair Jimenez acknowledged the Board service of Commissioner Ryan Coonerty. This was his last meeting. The Santa Cruz County Board of Supervisors will appoint a successor Supervisor representative at a meeting in January 2022.

2. Oral Communications.

Vice Chair Jimenez opened the floor for any members of the public to address the Commission on items not listed on the agenda.

No members of the public addressed the Commission.

3. Comments and announcements by Commission members.

Vice Chair Jimenez opened the floor for Commissioners to make comments.

Commissioner deGhetaldi mentioned the possible Watsonville Community Hospital closure in Q1 2022 and the potential impact on members. He suggested further discussion at a future Board meeting. Ms. Sonnenshine added that staff are monitoring the current situation very closely.

4. Comments and announcements by Chief Executive Officer.

Vice Chair Jimenez opened the floor for Ms. Stephanie Sonnenshine, Chief Executive Officer (CEO).

Ms. Sonnenshine provided further comment on the situation at Watsonville Community Hospital. As previously mentioned, staff are monitoring the current situation and should action be required by the Board it will be brought forward at a future meeting.

Ms. Sonnenshine recognized and thanked Commissioners for navigating Board meetings in this remote environment during the pandemic.

Ms. Sonnenshine also acknowledged Commissioner Coonerty's Board service.

Consent Agenda Items: (5. – 10F.): 3:12 p.m.

Vice Chair Jimenez opened the floor for approval of the Consent Agenda.

MOTION: Commissioner Bizzini moved to approve the Consent Agenda seconded by Commissioner Weber.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Cuevas, deGhetaldi, Edgcomb, Inda, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada, Schuller, Smith and Weber.

Noes: None.

Absent: Commissioners Conner, Coonerty, Harris, Rabago and Radner.

Abstain: None.

Regular Agenda Item: (11. - 15.): 3:12 p.m.

11. Consider approving Board meeting schedule and schedule of Board member participation in Committees and Advisory Groups for 2022. (3:12 – 3:26 p.m.)

Ms. Stephanie Sonnenshine, CEO, reviewed the proposed 2022 Alliance Board meeting schedule and Board Advisory Groups and Committee assignments. Staff recommended returning to pre-COVID-19 Brown Act compliant meetings for Board members in each of the Alliance's regional offices beginning in 2022, as permitted by public health guidance. Staff are exploring technology options to maximize opportunities for public attendance. In addition, staff recommended an all Board member in-person meeting at the Merced office in April 2022 and an all-day, in-person Board retreat in September 2022, also as permitted by public health guidance. Commissioners unable to attend in-person meetings would be considered absent.

[Commissioner Rabago arrived at this time: 3:24 p.m.]

MOTION: Commissioner Edgcomb moved to approve the Board meeting schedule and schedule of Board member participation on Alliance Committees and Advisory Groups for 2022, seconded by Commissioner Pedrozo.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Cuevas, deGhetaldi, Edgcomb, Inda, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada, Rabago, Radner, Schuller, Smith and Weber.

Noes: None.

Absent: Commissioners Conner, Coonerty and Harris.

Abstain: None.

12. Consider approving: 1) Medical Budget and 2) Administrative Budget for Alliance Calendar Year (CY) 2022. (3:26 – 4:03 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), reviewed the overall budget results and the Medical and Administrative budgets. The priorities for budget development included continuation of the Board approved Cost Containment Plan and bringing medical costs in line with revenue rate, utilization trends and industry benchmarks; maintaining operation efficiency while adequately funding administrative resources to execute regulatory requirement; and to maintain access to and quality of care for members.

[Commissioner Coonerty arrived at this time: 3:29 p.m.]

Key takeaways from the Medical budget included: 2022 budget spends are 90.7% (MLR) of the revenue on medical cost; the budget assumes the PHE ends in January 2022 and redetermination will resume; enrollment will decrease gradually and to the pre-pandemic level by December; revenue is based on the 2022 Draft Rate package received in October; the managed care efficiency and acuity adjustments reduced revenue by $15M; pharmacy, which usually accounts for 18% of the revenue will be carved out in 2022; and utilization is forecasted to pick up in 2022 and expected to be 5% higher than pre-pandemic in 2019.

[Commissioner Harris arrived at this time: 3:49 p.m.]

Ms. Ba reviewed the Administrative budget consideration which included adequately funding administrative resources to meet increased regulatory requirements and execute new State mandated programs while delivering on core health plan responsibilities; maintain organizational efficiency through department assessment, technology, and process improvement; and continued focus on long-term financial sustainability and stewardship.

Key takeaways from the Administrative budget included: 2022 Administrative costs are budgeted at $86.7M, or 6.4% ALR (ALR would have been at 5.6% had pharmacy not been carved out); the budget represents a $1.1M or 1.3% increase from the 2021 budget; and the budget seeks to balance adequate staffing to meet expanding program requirements with administrative efficiency.

MOTION: Commissioner Cuevas moved to approve the Calendar Year 2022 Medical Budget at $1,235,455,107 and the Calendar Year 2022 Administrative Budget at $86,680,278, seconded by Commissioner Edgcomb.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Coonerty, Cuevas, deGhetaldi, Edgcomb, Harris, Inda, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Quezada, Rabago, Radner, Schuller, Smith and Weber.

Noes: None.

Absent: Commissioners Bizzini, Conner and Pedrozo.

Abstain: None.

13. Consider approving Care Based Incentive (CBI) Funding for Calendar Year (CY) 2021. (4:03 – 4:10 p.m.)

Vice Chair Jimenez reminded the Board that this item carried potential conflicts of interest. Board members who perceived that they were at risk of conflicts of interest were encouraged to abstain from discussion and voting on this item.

Ms. Lisa Ba, CFO, informed the Board that each year in December, the Board approves the budget for the following year's provider incentive programs, with actual payment amounts decided upon in December of that following year. Historically, the Alliance has considered financial performance when approving the funding for the incentive programs. In June 2022, the Board approved the specialist payment at current Medicare, effective January 2021 and eliminated the Specialty Care Incentive Program.

CBI is designed to encourage promotion and implementation of the Patient Centered Medical Home model, improve access to care, and promote delivery of high-quality care. CBI offers financial incentives for improvements and outcomes in care coordination, quality of care, preventative care, and practice management. CBI is available only to contracted primary care providers (PCPs) and is a component of the overall reimbursement package for PCPs yielding Medicare rates of payment. PCPs earn CBI by improving care coordination and achieving quality measures and are provided with quarterly updates as to their performance to guide continuous improvement.

MOTION: Commissioner Askew moved to approve the Calendar Year 2021 Care Based Incentive funding at $10M, seconded by Commissioner Quezada.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Coonerty, Edgcomb, Kalantari-Johnson, Molesky, Quezada and Smith.

Noes: None.

Absent: Commissioners Conner and Pedrozo.

Abstain: Commissioners Cuevas, deGhetaldi, Harris, Inda, Jimenez, Nanyonjo, Rabago, Radner, Schuller and Weber.

14. Consider approving staff recommendations regarding Department of Health Care Services (DHCS) incentive programs. (4:10 – 4:25 p.m.)

Vice Chair Jimenez reminded the Board that this item carried potential conflicts of interest. Board members who perceived that they were at risk of conflicts of interest were encouraged to abstain from discussion and voting on this item.

[Commissioner Schuller departed at this time: 4:16 p.m.]

Ms. Stephanie Sonnenshine, CEO, introduced to the Board the CalAIM Incentive Payment Program and the Student Behavioral Health Integration Incentive. DHCS designs the incentive approach, sets the overall incentive budget, and approves the incentive program implementation plans. The Alliance Board has a role in the approval of incentive programs per Alliance delegation of authority policies.

MOTION: Commissioner Kalantari-Johnson moved to authorize staff to execute the CalAIM Incentive Plan approved by the Department of Health Care Services (DHCS); and to authorize staff to submit a Letter of Intent to DHCS to participate in the Student Behavioral Health Incentive Program and to implement the incentive program in compliance with DHCS guidelines between January 2022 through December 2024, seconded by Commissioner Askew.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Coonerty Cuevas, deGhetaldi, Edgcomb, Harris, Kalantari-Johnson, Molesky, Quezada, Rabago, Smith and Weber.

Noes: None.

Absent: Commissioners Bizzini, Conner, Pedrozo and Schuller.

Abstain: Commissioners Inda, Jimenez, Nanyonjo and Radner.

15. Consider accepting staff's report and approving staff's recommendation regarding the Medi-Cal Capacity Grant Program (MCGP). (4:25 – 4:49 p.m.)

Ms. Kathleen McCarthy, Strategic Development Director, informed the Board that a lot has changed in the health environment since the grant program was launched in 2015. Medi-Cal membership has largely stabilized and post-Affordable Care Act demands on provider capacity have eased and access has improved in many areas. The COVID-19 pandemic created a public health and economic crisis and highlighted/exacerbated health disparities.

The Alliance's new strategic priorities are closely aligned with State Administration's health-related priorities. The state is making significant investments to advance their priorities related to CalAIM, behavioral health, equity, early childhood development and housing/homelessness. Potential opportunities to evolve the MCGP included increasing investments upstream (early childhood, social determinants of health, and health care workforce and other barriers to care); consider adjustments to the original policy framework; and explore opportunities for more equitable grantmaking and inclusion of member voice to inform community investments. The Board provided ideas for future funding priorities which included investing in kids, early childhood, and their parents; providing safe places for kids to engage and connect; multi-year grants and deeper investments with an approach to philanthropy; core investment funding; and developing a healthcare workforce from within by investing in staff and their professional development.

Ms. McCarthy discussed staff's recommendation to wind down the Partners for Healthy Food Access program after the January 2022 deadline. Funding for this program has been spent down and interest has diminished. Any remaining funds are to be returned to county specific budgets.

MOTION: Commissioner Molesky moved to approve that staff return in early 2022 with a proposal for a revised program framework and new funding opportunities; and to retire the Partners for Health Food Access Program after the January 18, 2022 application deadline, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Coonerty, Cuevas, deGhetaldi, Edgcomb, Harris, Inda, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada, Rabago, Radner, Smith and Weber.

Noes: None.

Absent: Commissioners Conner and Schuller.

Abstain: None.

Adjourn to Closed Session

Vice Chair Jimenez moved the Commission into Closed Session at 4:49 p.m.

16. Closed session pursuant to Government Code Section 54956.9(d)(2) – Conference with Legal Counsel – Potential litigation (One Case).

Return to Open Session

Vice Chair Jimenez reconvened the meeting to Open Session at 5:33 p.m.

17. Open session pursuant to Government Code Section 54956.9(d)(2) – Conference with Legal Counsel – Potential litigation (One Case).

Vice Chair Jimenez reported from Closed Session that no action was taken by the Board.

The Commission adjourned its regular meeting of December 1, 2021 at 5:34 p.m. to the regular meeting of February 23, 2022 at 3:00 p.m. via videoconference from Alliance offices in Scotts Valley, Salinas, and Merced unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

SANTA CRUZ – MONTEREY – MERCED MANAGED MEDICAL CARE COMMISSION MEETING

Meeting Minutes
Special Meeting at the call of the Chairperson

Tuesday, January 18, 2022

Teleconference Meeting
(Pursuant to Assembly Bill 361 signed by Governor Newsom, September 16, 2021)

Commissioners Present:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Supervisor Ryan Coonerty	County Board of Supervisors
Dr. Larry deGhetaldi	Provider Representative
Ms. Julie Edgcomb	Public Representative
Dr. Charles Harris	Hospital Representative
Ms. Dori Rose Inda	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Ms. Rebecca Nanyonjo	Director of Public Health
Supervisor Josh Pedrozo	County Board of Supervisors
Ms. Elsa Quezada	Public Representative
Dr. Joerg Schuller	Hospital Representative
Mr. Rob Smith	Public Representative

Commissioners Absent:

Dr. Maximiliano Cuevas	Provider Representative
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Mr. Tony Weber	Provider Representative

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Dr. Dale Bishop	Chief Medical Officer
Mr. Scott Fortner	Chief Administrative Officer
Ms. Van Wong	Chief Operating Officer

Ms. Kathy Stagnaro Clerk of the Board

1. Call to Order by Chair Conner.

Commission Chairperson Conner called the meeting to order at 7:31 a.m.

Roll call was taken and a quorum was present.

2. Approve findings that the state of emergency continues to impact the ability of members to meet safely in person and/or State or local officials continue to impose or recommend measures to promote social distancing. (7:34 – 7:38 a.m.)

Ms. Sonnenshine, Chief Executive Officer (CEO), informed the Board that AB 361 permits the Board to meet by teleconference where state or local officials impose measures to promote social distancing and the Board determines that meeting in person would present imminent risk to the health and safety of attendees. Due to the California reinstated mask mandate and the Omicron surge, the Board made findings to proceed with the January 18, 2022 special meeting via teleconference.

MOTION: Commissioner Askew moved to approve to continue to meet via teleconferencing as permitted by the Brown Act, as amended in AB 361, during a proclaimed state of emergency and made the requisite findings supporting teleconferencing for the January 18, 2022 special meeting, seconded by Commissioner Jimenez.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Coonerty, deGhetaldi, Edgcomb, Harris, Inda, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada, Schuller and Smith.

Noes: None.

Absent: Commissioners Cuevas, Rabago, Radner and Weber.

Abstain: None.

3. Consider approving allocation of grant funding for Pajaro Valley Healthcare District Project (PVHDP). (7:38 – 8:24 a.m.)

Ms. Sonnenshine, CEO, provided background on PVHDP. Watsonville Community Hospital (WCH) is a 106-bed acute care facility that provides a range of medical services and provides critical hospital services to Alliance members in Santa Cruz and Monterey counties. In October 2021, WCH announced plans to file Chapter 11 bankruptcy and indicated it may have to close the hospital.

PVHDP leaders were able to bring in professional resources to negotiate operational funding for the bankruptcy. This project prevents hospital closure, creates a sustainable operating model for existing services and preserves ongoing health care access for Medi-Cal members in Santa Cruz and Monterey Counties.

[Commissioner Smith arrived at this time: 8:05 a.m.]

Given the time sensitivity of this request, the Alliance accepted this application outside of the typical application cycle. This award would be contingent on PVHDP securing the necessary financial support to complete the acquisition of WCH. PVHDP requested $3M in one-time funding to support the acquisition of WCH. Support from the Alliance would ensure future access to essential hospital services for Medi-Cal members in Pajaro Valley which includes the communities in South Santa Cruz County and North Monterey County. Staff recommended funding for the grant award be allocated from the unallocated Medi-Cal Capacity Grant Program budgets in Santa Cruz County and Monterey County. This award would be contingent on PVHDP securing the necessary financial support to complete the acquisition of WCH.

Commissioners discussed and recommended staff return with a PVHDP business plan (shared formally as needed), an annual check-in on access, and to add a physician strategy plan to the grant milestone.

The following individuals provided public comment: Mr. DeAndre James, Executive Director, Community Health Trust of Pajaro Valley; and Mr. Carlos Palacios, County Administrative Officer, County of Santa Cruz.

MOTION: Commissioner Askew moved to approve allocation of grant funding for Pajaro Valley Healthcare District Project, seconded by Commissioner Jimenez.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Coonerty, deGhetaldi, Edgcomb, Harris, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada and Smith.

Noes: None.

Absent: Commissioners Cuevas, Rabago, Radner and Weber.

Abstain: Commissioners Inda and Schuller.

4. Consider adopting a position of support for Senate Bill 418 (Laird) and direct staff to send Letter of Support to the author(s). (8:24 – 8:27 a.m.)

Ms. Sonnenshine, CEO, discussed the legislative action required to authorize the formation of the PVHCD. Local Legislators, including Senator Caballero and Assemblymembers Rivas and Stone, have joined with Senator Laird as coauthors on a bill that would authorize the formation of the PVHCD.

The bill will lay out the boundaries of the district, make clear that the new district will be subject to the oversight of the Santa Cruz and Monterey County Local Agency Formation Commissions, and direct the initial district Board of Directors to establish zones for the eventual election of future directors. Additionally, the new PVHCD would be subject to all of the requirements and authorities of other California healthcare districts, as contained in Health and Safety Code Section 32000.

MOTION: Commissioner Jimenez moved to approve adopting a position of support for Senate Bill 418 (Laird) and direct staff to send Letter of Support to the author(s), seconded by Commissioner Smith.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Coonerty, deGhetaldi, Edgcomb, Harris, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada and Smith.

Noes: None.

Absent: Commissioners Cuevas, Rabago, Radner and Weber.

Abstain: Commissioners Inda and Schuller.

5. Consider establishing a regular meeting of the Commission for Tuesday, January 25, 2022. (8:27 – 8:32 a.m.)

Ms. Sonnenshine, CEO, recommended adding a regular meeting to be scheduled for Tuesday, January 25, 2022. The proposed agenda would include a recommendation on AB 361 findings enabling the February Board meeting to occur by remote teleconference, an update on the status of the Capitola Manor project, and possible Closed Session.

MOTION: Commissioner Bizzini moved to approve establishing a regular meeting of the Commission for Tuesday, January 25, 2022 at 7:30 a.m., seconded by Commissioner Quezada.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Coonerty, deGhetaldi, Edgcomb, Harris, Inda, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada, Schuller and Smith.

Noes: None.

Absent: Commissioners Cuevas, Rabago, Radner and Weber.

Abstain: None.

The Commission adjourned its special meeting of January 18, 2022 at 8:32 a.m. to the regular meeting of January 25, 2022 at 7:30 a.m. via teleconference unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

SANTA CRUZ – MONTEREY – MERCED MANAGED MEDICAL CARE COMMISSION MEETING

Meeting Minutes

Tuesday, January 25, 2022

Teleconference Meeting

(Pursuant to Assembly Bill 361 signed by Governor Newsom, September 16, 2021)

Commissioners Present:

Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Supervisor Ryan Coonerty	County Board of Supervisors
Dr. Larry deGhetaldi	Provider Representative
Ms. Julie Edgcomb	Public Representative
Dr. Charles Harris	Hospital Representative
Ms. Dori Rose Inda	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Ms. Rebecca Nanyonjo	Director of Public Health
Supervisor Josh Pedrozo	County Board of Supervisors
Ms. Elsa Quezada	Public Representative
Mr. Rob Smith	Public Representative
Mr. Tony Weber	Provider Representative

Commissioners Absent:

Supervisor Wendy Root Askew	County Board of Supervisors
Dr. Maximiliano Cuevas	Provider Representative
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Dr. Joerg Schuller	Hospital Representative

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Dr. Dale Bishop	Chief Medical Officer
Mr. Scott Foster	Chief Administrative Officer
Ms. Van Wong	Chief Operating Officer

Ms. Kathy Stagnaro Clerk of the Board

1. Call to Order by Chair Conner.

Commission Chairperson Conner called the meeting to order at 7:32 a.m.

Roll call was taken and a quorum was present.

2. Approve findings that the state of emergency continues to impact the ability of members to meet safely in person and/or State or local officials continue to impose or recommend measures to promote social distancing. (7:34 – 7:37 a.m.)

Ms. Sonnenshine, Chief Executive Officer (CEO), informed the Board that AB 361 permits the Board to meet by teleconference where state or local officials impose measures to promote social distancing and the Board determines that meeting in person would present imminent risk to the health and safety of attendees. Due to the California reinstated mask mandate and the Omicron surge, the Board by majority vote made findings to proceed with the February 23, 2022 regular meeting via teleconference.

[Commissioner Pedrozo arrived at this time: 7:36 a.m.]

MOTION: Commissioner Weber moved to approve to continue to meet via teleconferencing as permitted by the Brown Act, as amended in AB 361, during a proclaimed state of emergency and made the requisite findings supporting teleconferencing for the February 23, 2022 regular meeting, seconded by Commissioner Quezada.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Conner, Coonerty, deGhetaldi, Edgcomb, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada, Smith and Weber.

Noes: None.

Absent: Commissioners Askew, Cuevas, Harris, Inda, Rabago, Radner and Schuller.

Abstain: None.

[Commissioner Inda arrived at this time: 7:36 a.m.]

[Commissioner Harris arrived at this time: 7:37 a.m.]

3. Oral Communications. (7:37 a.m.)

Chair Conner opened the floor for any members of the public to address the Commission on items not listed on the agenda.

No members of the public addressed the commission.

4. Comments and announcements by Commission members.

Chair Conner opened the floor for Commissioners to make comments.

Chair Conner reported on the Santa Cruz Community Health ribbon cutting ceremony for the new primary care clinic in San Lorenzo Valley held on January 24, 2022. Commissioner deGhetaldi spoke in support of the project.

5. Comments and announcements by Chief Executive Officer.

Chair Conner opened the floor for Ms. Stephanie Sonnenshine, Chief Executive Officer (CEO).

Ms. Sonnenshine, CEO, reminded Board members to complete their annual Statement of Economic Interest - Form 700 and to complete the CEO evaluation survey sent by the Chief Administrative Officer.

She informed the Board that the state budget was issued and the legislative process is underway. Staff plan to keep the Board informed through consent agenda staff reports. Commissioners with relevant items of note or interest were encouraged to share them with the CEO.

6. Discuss status of Capitola Manor Project. (7:40 – 7:49 a.m.)

Ms. Sonnenshine, CEO, indicated that this item was intended as an informational update as to the status of the Capitola Manor project, to make the Board aware of recent inquiries about potential future use for low income housing and to hear the Board's thoughts for other areas of exploration. Any actual disposition will be brought to the Board at future regularly scheduled meetings.

The Board was made aware at the end of 2021 that the projected costs to complete the Capitola Manor project far exceeded the amount approved by the Board and determined the project would be canceled. Staff informed the Department of Healthcare Access and Information (formerly Office of Statewide Health Planning and Development) and received confirmation that the jurisdiction for future construction, fire and safety inspections falls to the City of Capitola. Staff have been in contact with the City of Capitola.

Staff had informed Covenant Care that the in the absence of proceeding with construction, the building was potentially unsafe. The costs of securing the facility and removing safety requests were higher than demolishing the building. Staff inquired whether Covenant Care would be interested in purchasing or had other ideas for the property and determined that purchasing the land and completing development would not be the right fit. The City of Capitola has asked that the Alliance maintain the property while preparing for sale or other use.

Alliance staff reached out to MidPen Housing who the Alliance have partnered with on two capital implementation projects and one capital planning project funded through the grant program to explore their thoughts as well as on-going active dialog with the City of Capitola.

Information and discussion item only; no action was taken by the Board.

The Commission adjourned its regular meeting of January 25, 2022 at 7:49 a.m. to the regular meeting of February 23, 2022 at 3:00 p.m. via teleconference unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, September 15, 2021
9:00 – 10:30 a.m.

Via Videoconference

Committee Members Present:

Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Chris Morris	Operational Excellence Director
Dale Bishop	Chief Medical Officer
Dianna Diallo	Medical Director
Gordon Arakawa	Medical Director
Jenifer Mandella	Compliance Officer (Chair)
Jordan Turetsky	Provider Services Director
Joy Cubbin	Accounting Director
Kate Knutson	Compliance Manager
Kathleen McCarthy	Strategic Development Director
Kay Lor	Provider Payment Director
Lilia Chagolla	Regional Operations Director, Monterey County
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Luis Somoza	Member Services Director
Marina Owen	Chief Operating Officer
Mary Brusuelas	UM and Complex Case Management Director
Maya Heinert	Medical Director
Michelle Stott	Quality Improvement and Population Health Director
Rick Dabir	Application Services Director
Ronita Margain	Regional Operations Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Scott Fortner	Chief Administrative Officer

Committee Members Absent:

Committee Members Excused:

Danita Carlson	Government Relations Director
Frank Song	Analytics Director
Jennifer Mockus	Community Care Coordination Director
Navneet Sachdeva	Pharmacy Director
Stephanie Sonnenshine	Chief Executive Officer
Van Wong	Chief Information Officer

Ad-Hoc Attendees:

Kat Reddell	Compliance Specialist II
Sara Halward	Compliance Specialist II
Paige Harris	Compliance Specialist III

1. **Call to Order by Chairperson Mandella.**

   Chairperson Jenifer Mandella called the meeting to order at 9:03 a.m.

2. **Review and Approval of August 18, 2021 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of August 18, 2021 meeting with a modification to clarify Ronita Margain's attendance.

3. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Regulatory and All Plan Letter Updates**
   3. **Revised Compliance Pan**

   Mandella, Compliance Officer, pulled the Revised Compliance Plan for the Consent Agenda and reviewed key changes to the document.

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. **Regular Agenda**

   1. **Program Integrity Quarterly Report**

   Knutson, Compliance Supervisor, presented the Q2 2021 Program Integrity Activity Report and reviewed select Matters Under Investigation (MUIs). Knutson reported that 15 concerns were referred to Program Integrity in Q2 2021, 11 of which resulted in the opening of an MUI. There were 53 active MUIs in Q2 2021.

   Knutson reviewed referral trends for the period noting that of the 11 referrals which resulted in a MUI: 8 were provider specific related to billing concerns, Beacon referrals and monitoring results; 2 were member specific related to pharmacy fraud and identity theft; and 1 was waste related.

   Knutson reviewed performance of the Program Integrity metrics from the Q2 Alliance Dashboard, noting that performance was above threshold for the quality metric. The

efficiency metric was again below the performance threshold due to lack of timely reporting to Program Integrity. Knutson pointed out that the Beacon referrals were submitted via their quarterly reporting process, resulting in late reporting to the Department of Health Care Services. Beacon was reminded of their obligation to report potential Fraud, Waste and Abuse (FWA) to the plan within 5 business days of identification. In response, Beacon developed an action plan to correct the concern, and have since submitted new referrals timely. Knutson advised the committee that the Alliance Learning Center (ALC) Compliance Training is undergoing revisions which address the obligation for Alliance staff to report suspected FWA immediately.

Knutson reviewed 3 exemplar cases, highlighting investigative measures taken and next steps for completion of MUI investigation. The Committee discussed opportunities for Provider Services to assist Compliance staff with resolution of one of the cases.

COMMITTEE ACTION: Committee reviewed and approved the Q2 2021 Program Integrity Report.

2. Internal Audit & Monitoring Quarterly Report

Halward, Compliance Specialist II, presented the Q2 2021 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 6 reviews were conducted, 3 of which received a passing score.

Halward reviewed one exemplar internal audit focused on ensuring that Grievances and Appeals are acknowledged and resolved timely and acknowledgement content meets all requirements. The audit received a passing score and resulted in no required actions.

Halward reviewed outcomes of the monitoring of 32 Alliance Dashboard metrics related to regulatory requirements, noting that 28 metrics met their established thresholds and 4 did not meet their established thresholds in Q2 2021. Staff have requested additional information from departments for the metrics that did not meet threshold where more information was needed,

Halward reviewed the Alliance received final findings report from the Department of Managed Health Care in regards to the 2020 Medical Survey, noting that 12 of 15 findings remain uncorrected and will be assessed at a Follow-up Survey which typically occurs approximately 18 months from the final report.

COMMITTEE ACTION: Committee reviewed and approved the Q2 2021 Internal Audit & Monitoring Report.

The meeting adjourned at 9:27 a.m.

Respectfully submitted,

Robin Sihler
Administrative Assistant - Compliance

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, December 15, 2021
9:00 – 10:30 a.m.

Via Videoconference

Committee Members Present:

Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Chris Morris	Operational Excellence Director
Dale Bishop	Chief Medical Officer
Danita Carlson	Government Relations Director
Dianna Diallo	Medical Director
Frank Song	Analytics Director
Gordon Arakawa	Medical Director
Jenifer Mandella	Compliance Officer (Chair)
Jennifer Mockus	Community Care Coordination Director
Jordan Turetsky	Provider Services Director
Kate Knutson	Compliance Manager
Kay Lor	Provider Payment Director
Lilia Chagolla	Regional Operations Director, Monterey County
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Luis Somoza	Member Services Director
Mary Brusuelas	UM and Complex Case Management Director
Michelle Stott	Quality Improvement and Population Health Director
Navneet Sachdeva	Pharmacy Director
Rick Dabir	Application Services Director
Ronita Margain	Regional Operations Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Scott Fortner	Chief Administrative Officer
Stephanie Sonnenshine	Chief Executive Officer
Van Wong	Chief Information Officer

Committee Members Absent:

Joy Cubbin	Accounting Director
Kathleen McCarthy	Strategic Development Director

Committee Members Excused:

Ad-Hoc Attendees:

Ilsa Branch	Government Relations Manager
Sara Halward	Compliance Specialist II
Paige Harris	Compliance Specialist III
Kat Reddell	Compliance Specialist II
Rebecca Seligman	Compliance Supervisor

1. **Call to Order by Chairperson Mandella.**

   Chairperson Jenifer Mandella called the meeting to order at 9:03 a.m.

2. **Review and Approval of November 17, 2021 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of November 17, 2021 meeting.

3. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Regulatory and All Plan Letter Updates**
   3. **Policy Hub Charter**

   Mockus inquired as to why there was no Community Care Coordination Department staff noted in the Policy Hub charter. Mandella indicated a need to assess Hub membership in greater detail, which will occur in 2022.

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda. Mandella to assign review of Hub membership to Compliance staff in 2022.

4. **Regular Agenda**

   1. **Program Integrity Quarterly Report**

   Knutson, Compliance Manager, presented the Q3 2021 Program Integrity Activity Report and reviewed select Matters Under Investigation (MUIs). Knutson reported that 22 concerns were referred to Program Integrity in Q3 2021, 10 of which resulted in the opening of an MUI. There were 49 active MUIs in Q3 2021.

   Knutson reviewed referral trends for the period noting that of the 10 referrals which resulted in a MUI: 6 were provider specific, related to referrals and billing concerns and 4 were member specific, related to eligibility and non-medical transportation fraud, identity theft, and phishing schemes.

Knutson reviewed performance of the Program Integrity metrics from the Q3 Alliance Dashboard noting that both efficiency and quality metrics met or exceeded target threshold.

Knutson reviewed 2 exemplar cases, highlighting investigative measures taken and next steps for completion of MUI investigation.

Knutson reported that Program Integrity Financial Reporting was re-instated in Q3 2021 after being suspended in Q4 2020. Knutson reviewed retrospective data for previous quarters and noted total recoveries for Q3 2021 as well as for the period where financial reporting was omitted.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2021 Program Integrity Report.

2. Internal Audit & Monitoring Quarterly Report

Halward, Compliance Specialist II, presented the Q3 2021 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 9 internal reviews were conducted, 6 of which received a passing score.

Halward reviewed one exemplar internal audit focused on ensuring employee permissions for staff who have been terminated or changed positions had their access removed immediately or updated. The audit received a passing score and recommendations were made to develop a process to ensure timely removal of consultant permissions and to implement a process to ensure documentation is readily available.

Halward reviewed outcomes of the monitoring of 32 Alliance Dashboard metrics related to regulatory requirements, noting that 30 metrics met their established thresholds and 2 did not meet their established thresholds in Q3 2021.

Halward presented the 2022 Internal Audit & Monitoring workplan, which incorporates existing risks from the 2021 workplan and inclusion of potential new risks, including newly implemented requirements, audit findings, and enforcement actions levied by regulators during 2021. The 2022 Internal Audit & Monitoring workplan includes 31planned focused reviews, of which 20 are high risk areas, 8 are medium risk areas and 2 are low risk areas, in addition to a planned one-time audit.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2021 Internal Audit & Monitoring Report and the 2022 Internal Audit & Monitoring Workplan.

3. APL Process Improvement

Knutson, Compliance Manager, presented an overview of APL process improvement implementation highlighting the process move to C360 and updates to the workflow. Knutson advised the committee that Compliance staff will provide work instructions and

training and requested departments review process documentation and connect with Compliance for required training.

The meeting adjourned at 10:05 a.m.

Respectfully submitted,

Robin Sihler
Administrative Assistant - Compliance

CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

Meeting Minutes
Thursday, October 28, 2021
12:00 – 1:30 p.m.

Virtual Meeting / Web Conference

Committee Members Present

Dr. Caroline Kennedy	Provider Representative
Dr. Casey Kirkhart	Provider Representative
Dr. Eric Sanford	Provider Representative
Dr. Minoo Sarkarati	Provider Representative
Dr. Oguchi Nkwocha	Provider Representative
Dr. Stephanie Graziani	Provider Representative

Guests Present:

Christine Rohrkemper	PMO Project Manager II
Oscar Sanchez	Quality Improvement Project Specialist

Committee Members Absent:

Dr. Amy McEntee	Provider Representative
Dr. Madhu Raghavan	Provider Representative
Ms. Allyse Gilles	Hospital Representative
Ms. Rohini Mehta	Hospital Representative
Ms. Susan Harris	Hospital Representative

Staff Present:

Dr. Maya Heinert	Chair, and Medical Director
Dr. Dianna Diallo	Medical Director
Dr. Gordon Arakawa	Medical Director
Mr. Amit Karkhanis	Quality & Performance Improvement Manager
Mr. Chris Morris	Operational Excellence Director
Ms. Deborah Pineda	Quality and Health Programs Manager
Ms. Hilary Gillette-Walch	Quality and Population Health Manager
Ms. Jacqueline Van Voerkens	Administrative Specialist
Ms. Jordan Turetsky	Provider Services Director
Mr. Luis Somoza	Member Services Director
Ms. Mary Brusuelas, RN	UM & Complex Case Management (CCM) Director
Ms. Michelle Stott, RN	QI & Population Health Director
Ms. Navneet Sachdeva, Pharm. D	Pharmacy Director
Ms. Ronita Margain	Regional Operations Director
Ms. Tammy Brass, RN	UM & CCM Manager - Authorizations
Ms. Viki Doolittle, RN	UM & CCM Manager - Concurrent Review

1. **Call to Order by Dr. Maya Heinert, Medical Director**
   Dr. Maya Heinert called the meeting to order at 12:00 PM, welcomed the members and established a quorum. Dr. Heinert welcomed CQIC's newest member, Dr. Minoo Sarkarati, Clinical Director of Quality for County of Santa Cruz Health Services Agency.

2. **Consent Agenda**
   Dr. Maya Heinert introduced the consent agenda.

   July 29, 2021 CQIC Meeting Minutes

Dr. Maya Heinert presented the July 29, 2021 CQIC Minutes. No edits requested at this time.

Subcommittee/Workgroup Meeting Minutes

- Continuous Quality Improvement Workgroup – Interdisciplinary (CQIW - I) Minutes (Q2 2021)
- Continuous Quality Improvement Workgroup (CQIW) Minutes (Q2 2021)
- Pharmacy and Therapeutic (P&T) Committee – Q3 2021Formulary and Q2, 2021 minutes
- Utilization Management Workgroup (UMWG) Minutes (Q3 2021)

Workplans:

- Q2 2021 Utilization Management Work Plan Executive Summary
- Q2 2021 Utilization Management Work Plan
- Q2 2021 Quality and Performance Improvement Program Work Plan Executive Summary
- Q2 2021 Quality and Performance Improvement Program Work Plan

Policies:

Approval Required		
Policy Number	**Title**	**Significant Changes**
401-1521	Physical Accessibility Review	• Updated policy in accordance with Medi-Cal Contract Amendment 42
404-1101	Utilization Management Program	• Policy updated to align with: o SB 855 (pg. 4, & 19) o Medi-Cal RX Carve Out updates (pg. 4, 16, & 18) o ECM/CS updates (pg. 17)

The following are included in consent agenda meeting packet.

IHA Code Changes: Beginning in the Fall of 2021, the Initial Health Assessment (IHA) will apply coding updates to better capture services being rendered to our members. The coding updates will include changes to the ICD-10 and CPT codes, impacting the Provider Portal Reports, and Care-Based Incentive (CBI) program.

Delegate Oversight Report (BEACON): Q2-2021 delegate oversite summary. The Alliance continues to monitor the Corrective Action Plan.

DHCS Performance Improvement Plan: The Alliance will continue with the current two PIPs that began in Fall 2020 to increase percentage of well-care visits for members ages 3-17 years old linked to the Los Banos clinic at Golden Valley Health Centers and, increase percentage of children compliant with the HEDIS measure Childhood Immunization Status (CIS) Combination 10 at Castle Family Health Center. In addition, the Alliance continues to work on a PDSA project focused on increasing Breast Cancer Screening rates in Merced county and a COVID QIP.

PQI Trend Executive Report: Q1 & Q2 2021 Facility Site Review and Potential Quality Issues trends, accomplishments and outcomes.

DHCS 2021 Promising Practices Report: DHCS will post the **2021 Promising Practices Report** on the DHCS QI Toolkit via SharePoint; it will be merged with a similar report from 2019 and 2020.

Committee Decision: April 29, 2021 CQIC minutes were approved as written. Consent agenda items approved.

3. Regular Agenda

A. Emerging Issues/Announcements:

I. At the DHCS/HSAG Quality Conference, DHCS announced that the Alliance received the Consumer Assessment Award for the child survey for medium-scale plans.

The Consumer Assessment awards are based on the health plans' results on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult and Child survey results. There are two sets of CAHPS awards, one set based on results from the child survey and one from the adult survey; awards results are calculated by DHCS. Based on a methodology similar to the calculation for the overall best performance awards, the small, medium and large scale MCPs with the highest standardized Global Rating and Composite Measures on the adult and child CAHPS surveys will each receive an award, for a total of six awards. The CAHPS awards are given out every two years.

II. Medi-Cal Rx 101: Webinar and materials are available in the Provider Newsletter**.** The Medi-Cal Rx 101 webinar shares what is changing for prescribers and pharmacy providers, what is staying the same, what providers need to know and where to go to learn more.

Some topics that are covered include transition background, provider portal registration, prior authorizations, CDL, and beneficiary details.

III. Mammogram Screening scheduling wait times are presently 2-4 months for some facilities. Committee discussed considering ordering the screening mammograms early so that the patients can receive the screening on time. Patients with symptoms and/or exam findings should be scheduled for a diagnostic mammogram which can be scheduled sooner.
Action: Alliance will follow up with Dr. Kennedy.
Action Complete.

IV. Committee discussed vaccine implementation at their clinics, and refocusing on primary care services to focus on preventative health.

V. Committee discussed the current Medical Assistant staffing issue, provider / clinician and staff burnout, inequity, and member treatment injustices (ex: 20-minute limit for appointments).

VI. Committee discussed the possibility of allowing providers to distribute vaccination incentives in real time. This would be especially beneficial for the homeless population (Homeless Person's Health Project) that do not have a stable mailing address.

VII. Mental health concerns among children and teens; increase in cases during the pandemic.

B. COVID Vaccine Incentives

The Department of Health Care Services (DHCS) has announced incentive opportunities for health plans to support members and providers in increasing COVID-19 vaccination rates. In response, the Alliance has launched incentive programs for Members, Providers, and Pharmacists for COVID-19 vaccination efforts, for services beginning in September 1, 2021 through February 28, 2022. An overview of the DHCS Vaccine Response Plan (VRP), population of focus, Provider and Pharmacy incentives, member incentive eligibility, was reviewed with the committee.

Pont of Service member incentive distribution is available by CBO's and Providers participating in the Vaccine Incentive Program (VIP) in geographic areas with the greatest need, lowest vaccination rates, and harder-to-reach populations.

Outreach and Communications include:

I. Outreach Efforts
   1) Public Health, Schools, CBOs, etc.
   2) Equity prioritized (communities of color, geographic disparities, younger population)

II. Media Campaign
   1) Crush COVID
   2) Social Media, Radio, Billboards

C. Objectives and Strategies of the PNA Action Plan

The Population Needs Assessment (PNA) Action Plan/Education Campaign updates was presented to the Committee as an action item from the previous quarter. Four areas of opportunity are included in the PNA are Access to Care, Cultural and Linguistics, QI/Health Education, and Health Disparities. The objectives, strategies, status updates, and items in progress, were presented to the committee.

Committee discussed implementation of mechanism to informing the PCP's when their patients participate in Alliance educational programs.

D. Utilization Management Criteria:

I. Provider Code Look-up (PCL) Tool

The PCL go live date was 10/6/21. Two methods are available to access the tool:
   1) User Interface located in Provider Portal
   2) PDF of PCL is located on the Alliance external website.

Communication distributed to providers included:
   1) Announcement on the Alliance website
   2) Provider newsletter
   3) Provider Relations team is continually updating providers
   4) Prior Authorization team is providing education when providers call for procedure code information
   5) Provider feedback intake in process with Provider Relations and Prior Authorization team

II. WPATH Guidelines

The World Professional Association for Transgender Health (WPATH) promotes the highest standards of health care for individuals through the articulation of Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People. The SOC are based on the best available science and expert professional consensus.

The overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the SOC may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

SB 855: MH and SUD Coverage and APL 20-018 Ensuring Access to Transgender Services and the WPATH Training Program were reviewed with the Committee.

E. Long COVID

Long COVID, also known as post-COVID-19 syndrome, or chronic COVID syndrome, is a condition characterized by a long-term condition (that persist more than four weeks after first being infected with the virus that causes COVID-19) which is the consequence of a previous disease appearing, or persisting after the typical recovery period of COVID-19. Long COVID can affect nearly every organ system, as well as respiratory system disorders, nervous system and neurocognitive disorders, mental health disorders, metabolic disorders, cardiovascular disorders, gastrointestinal disorders, malaise, fatigue, musculoskeletal pain, and anemia. A wide range of symptoms are commonly discussed, including fatigue, headaches, shortness of breath, anosmia, parosmia, muscle weakness, low fever and cognitive dysfunction.

It is estimated that 10-30% of all people who develop COVID go on to prolonged symptoms. LONG COVID is more common in those with serious initial infection. Prevention of Long COVID includes avoid exposure, receiving vaccination, social distancing, and masking.

Action: Dr. Heinert will distribute the Long COVID presentation.
Action Complete.

4. Future Topics/Open Forum

Future topics include:
A. ECM/Community Supports
B. CGM

Suggestions:
A. Barriers in relation to HIPPA rules/Data Sharing /information sharing for health care providers
B. Medical Assistant best practices
C. Workforce training
D. Correlation between Chronic Lyme Disease and Long COVID

Committee members are encouraged to submit items for discussion at any time to Michelle Stott or Mary Brusuelas.

Next Meeting: Thursday, January 27, 2022 12:00 p.m. – 1:30 p.m.

The meeting adjourned at 1:30 p.m.

Minutes respectfully submitted by,

Jacqueline Van Voerkens
Administrative Specialist

California Department of Health Care Services

Consumer Satisfaction Award 2021 - Child

Medium Scale Plan

Presented to

Central California Alliance for Health

On October 27, 2021

In recognition of your efforts for going above and beyond for Medi-Cal managed care members on behalf of the Managed Care Quality and Monitoring Division, Department of Health Care Services.

Palav Babaria

Deputy Director and Chief Quality Officer, DHCS

Physicians Advisory Group

Meeting Minutes

Thursday, September 2, 2021
12:00 - 1:30 p.m.

Teleconference Meeting
(Pursuant to Governor Newsom's Executive Order N-29-20)

Group Members Present:

Dr. Anjani Thakur	Provider Representative
Dr. Misty Navarro	Provider Representative
Dr. Scott Prysi	Provider Representative
Dr. Barry Norris	Provider Representative
Dr. Amy McEntee	Provider Representative
Dr. Casey Kirkhart	Provider Representative
Dr. Devon Francis	Provider Representative
Dr. Shirley Dickinson	Provider Representative
Dr. Patrick Clyne	Provider Representative
Dr. Michael Yen	Provider Representative

Group Members Absent:

Dr. Chuyen Trieu	Provider Representative
Dr. Caroline Kennedy	Provider Representative
Dr. Jennifer Hastings	Provider Representative
Dr. Salvador Sandoval	Provider Representative
Dr. James Rabago	Board Representative

Staff Present:

Dr. Dale Bishop	Chief Medical Officer
Dr. Gordon Arakawa	Medical Director
Dr. Maya Heinert	Medical Director
Ms. Jennifer Mockus	Community Care Coordination Director
Ms. Jordan Turetsky	Provider Services Director
Ms. Michelle Stott	QI & Population Health Director
Ms. Kristen Rohlf	Quality Improvement Program Advisor
Ms. Lila Chagolla	Regional Operations Director
Mr. Jim Lyons	Provider Relations Manager
Ms. Ronita Margain	Regional Operations Director
Ms. Mary Brusuelas	Utilization Management/CCM Director
Ms. Jacqueline Van Voerkens	Administrative Specialist
Ms. Tracy Neves	Clerk of the Advisory Group

Public Representatives Present:

Ms. Becky Shaw	Public Representative
Dr. Joerg Schuller	Provider Representative

1. Call to Order by Chairperson Dr. Dale Bishop.

   Group Chairperson Bishop called the meeting to order at 12:05 p.m.
   Roll call was taken.

   No supplements or deletions were made to the agenda.

2. Oral Communications.

   Chairperson Bishop opened the floor for any members of the public to address the Group on items not listed on the agenda.

   No members of the public addressed the Group.

Consent Agenda

3. The group reviewed the June 3, 2021 Physicians Advisory Group (PAG) minutes.

   Minutes approved as written.

4. **Old Business**
   A. Pharmacy Carve-Out Update
      Navneet Sachdeva noted the pharmacy carve-out is scheduled for January 1. 2022 and the Alliance is working with Magellan. Providers will be contacted by Magellan regarding provider training so they may become acquainted with the portal. The Alliance will send a letter to providers regarding the pharmacy carve-out and information will be posted on the Alliance provider page. The Alliance will notify providers by the end of the month and the Department of Health Care Services (DHCS) will also send information. Providers can subscribe to DHCS' Monthly Newsletter for updates.

5. **New Business**
   A. COVID Vaccine Promotion
      Dr. Heinert presented on COVID Vaccines. The Alliance vaccine strategy was based on population health principals and risk stratification. The Alliance currently has a 53% overall vaccination rate for all 3 counties - Monterey 56%, Merced 43% and Santa Cruz 63%. Additional vaccination data was share with the Group regarding gender, race/ethnicity and by age group. The Alliance used claims data to identify members with CDC-defined health risk factors and established a relative risk score for each member. Alliance members were grouped by risk score and geography to create rosters for member outreach. Outreach transitioned from member education and resources sharing to vaccine promotion. The Alliance is using the Social Vulnerability Index (SVI) score with

zip code mapped along with current vaccination rate data. Vaccination rates and SVI by county was shared with the Group that denoted regions of high social vulnerability. Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health, such as natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

Alliance provider engagement included early outreach to all partners to advocate for equitable distribution of vaccines, sharing of current DHCS and Centers for Disease Control & Prevention (CDC) guidance, assessing barriers and assisting with solutions and providing support and resources for member engagement. The Alliance community strategies included working closely with county health departments, community partners and providers. The Your Health Matters team conducted member outreach. Your Health Matters includes a volunteer program of 30+ trained staff with skillsets to deliver messages to members on health resources and with the ability to shift priorities. The team focused and updated real-time messaging based on feedback from local health departments. Internal resources available to Your Health Matters staff are updated daily (vaccination sites, pop-up clinics, CDC guidelines, county updates). **Action:** Provider requested data for Merced County, Ronita will reach-out to the provider.

Provider noted they are trying to reach patients in the emergency department (ED) and inquired whether the Alliance could assist. Provider noted that Doctors on Duty is administering vaccines. Another provider is requesting that the hospital try to vaccinate patients before they are discharged but is having some issues. **Action:** The Alliance will work on closing gaps in care. Lilla noted that Your Health Matters is going out into communities conducting outreach, and informed the Group to contact her if the Alliance can support vaccine pop-up clinics and events.

Dr. Bishop noted that the state has requested that plans administer a vaccination promotion plan, and the Alliance has submitted their plan for approval. Incentives include member and provider incentives that could be provided at sites of care,

B. Care Based Incentives (CBI) Update
Dr. Bishop shared that in 2021 there was a CBI payment adjustment put into place. The CBI metric was established to encourage providers above the 50th percentile for Medicare nationwide. The Alliance conducted an evaluation in

2019 and developed a CBI payment tier system approved by the Board in spring 2020. The CBI measure was established with the caveat if metrics were unachievable, the metrics would not be put into place. It appeared in 2019, approximately 25% of providers fell below the 50th percentile.

Adolescent Immunization data was shared with the Group from Q4 2019 to Q2 2021 for all 3 counties which indicted performance from 2020 through 2021 declined. Immunizations for Children experienced the same decline. Well Child Visits declined due to the pandemic as well with numbers increasing slightly in 2021.

Care challenges shared with Alliance staff were also shared with the Group and Dr. Bishop asked for the Group's input. Provider noted they started to see patients in March through May but due to COVID testing they are unable to see as many patients. Another provider noted he is seeing sick patients after 3:00 PM but the majority are coming in for COVID testing. In addition, there are staffing issues with employee's family members also becoming ill. Provider noted it is difficult to get children scheduled for well visits without disruption to the child's school day.

Staffing limitations are being experienced as well as availability of appointments and shifting of resources for testing. Some patients being seen for well visits need to be rescheduled if they are experiencing a cough which further delays care. Provider is also seeing patients that have not been seen since 2019 so there is a backlog of visits, and trying to catch-up patients on well visits. The Combo-10 requirement also makes it difficult to achieve measures. Provider is experiencing shortage of Medical Assistants (MAs) and referring patients to telehealth. One provider noted this is the single biggest problem they are experiencing along with onsite testing. The MA shortage was an issue before the pandemic but is now exacerbated by COVID. Another issue facing providers is the two negative test results required for students to return to school.

Dr. Bishop noted testing will likely continue to be an issue throughout the school season. Testing congestion will possibly see some relief when vaccines are available for school aged children and there is a lessen need. Provider noted testing sites have reached capacity, and inquired whether the Alliance could assist with testing site promotion. Also noted, was CBI performance will continue to be unachievable if providers are overwhelmed by the pandemic and staffing shortages.

It was concluded that due to the pandemic and resulting efforts and challenges facing primary care providers (PCPs) that staff will recommend discontinuation of the adjustment for 2021 to the Alliance Board.

6. **Open Discussion**

Chairperson Bishop opened the floor for the Group to have an open discussion. There was no additional discussion.

The meeting adjourned at 1:20 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Group

The Physicians Advisory Group is a public meeting governed by the provisions of the Ralph M. Brown Act. As such, items for discussion and/or action must be placed on the agenda prior to the meeting.

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, September 16, 2021
12:00 p.m. - 1:00 p.m.

Teleconference Meeting
(Pursuant to Governor Newsom's Executive Order N-29-20)

Committee Members Present:

Jennie Jet, MD	Provider Representative
John Mark, MD	Provider Representative
Patrick Clyne, MD	Provider Representative

Committee Members Absent:

Salem Magarian, MD	Provider Representative
Cal Gordon, MD	Provider Representative

Staff Present:

Dianna Diallo, MD	Medical Director
Gordan Arakawa, MD	Medical Director
Jennifer Mockus, RN	Community Care Coordination Director
Lilia Chagolla	Regional Operations Director, Monterey
Ronita Margain	Regional Operations Director, Merced
Michelle Stott, RN	QI & Population Health Director
Kelsey Riggs, RN	Complex Case Management Supervisor
Jacqueline Van Voerkens	Administrative Specialist
Tracy Neves	Clerk of the Committee

Hospital Representatives Present:

Salvador Sandoval, MD	Provider Representative
Mike Barrett	Aveanna Healthcare
Kaitlyn Krentz	Aveanna Healthcare

1. **Call to Order by Chairperson Diallo.**
   Chairperson Dr. Dianna Diallo called the meeting to order at 12:04 p.m.
   Roll call was taken.

2. **Oral Communications.**
   Chairperson Dr. Diallo opened the floor for any members of the public to address the Committee on items not listed on the agenda.

   No members of the public addressed the Committee.

3. Consent Agenda Items.

A. Approval of WCMCAC Minutes
Minutes from the June 17, 2021 meeting were reviewed.

B. Grievance Update
Grievance data was provided to the Committee.

M/S/A Consent agenda items approved.

4. New Business.

A. Age-Out Process/California Children's Services (CCS) Referrals from Q1 & Q2:
Kelsey Riggs, RN provided an update on CCS Eligibility & Referrals. The CCS team continues to see an increase in CCS members and referrals The CCS team recently developed a new report that allows the team to see more detail in our internal referral activity. For quarter 2, there were 516 referrals received and reviewed. for potential CCS membership with 396 referred to CCS. In Quarter 2, there was a total of 7,285 new and existing CCS members and 305 new CCS members added.
CCS Age-Out Process: The age-out process now begins at age 17. In quarter 1, the CCS team outreached to 59 members and in quarter 2 to a total of 86 members. The process changed in June and monthly member outreach has doubled. In quarter 2 2021, there were a total of 1,489 Individualized Care Plans (ICPs) completed for high-risk members. ICPs completed by county: Merced 516 members, Monterey 741 members and Santa Cruz 232 members.

B. Enhanced Care Management (ECM) & In Lieu of Services (ILOS)
Dianna Diallo, MD gave a presentation on ECM & ILOS. ECM aims to provide person centered support which goes beyond case management, care coordination and disease management and services are arranged by community base providers ECM will become a Medi-Cal benefit beginning January 1, 2022. ECM is high-touch, face-to-face work in the community with frequent member contact and extends beyond standard case management, care coordination and disease management activities. It is person-centered, goal-oriented and culturally relevant and is integrated with other care coordination processes and assumes responsibility for all primary, acute, behavioral, developmental, oral, and long-term services and supports regardless of setting.

The goals of ECM include:
- Improving care coordination
- Integrating services
- Facilitating community resources
- Improving health outcomes
- Addressing social determinants of health
- Decreasing inappropriate medical utilization

Phase I
- Individuals and Families Experiencing Homelessness.
- High Utilizer Adults.

- Adults who have serious mental illness (SMI) and substance use disorder (SUD) conditions.

Phase II
- Adults & Children/Youth Transitioning from incarceration.
- Eligible for long-term care and at risk for institutionalization.
- Nursing Facility Residents who want to transition back to the community.

Phase III
- Children and Youth who are high utilizers, serious emotional disturbance (SED), CCS with needs beyond physical needs, and child welfare.

In Lieu of Services (ILOS)

According to Federal Medicaid program rules, "in lieu of services" are medically appropriate and cost-effective alternatives to services that can be covered if:
- Services are focused on medical/social determinants of health as a substitute for, or to avoid, hospital/nursing facility admissions, discharge delays, and avoidable emergency department use.
- Services are optional for members and they are not required to use the ILOS.
- Each service will have defined eligible populations, code sets, potential providers, restrictions, and limitations.
- Services are optional for the managed care plan to provide.

ILOS Planning & Next Steps Include:
- DHCS is proposing statewide implementation over time, focusing in the short term on infrastructure development.
- DHCS is strongly encouraging Health Plans to continue ILOS implemented during Whole Person Care pilots.
- Health Plans can add new ILOS in 6-month intervals.
- The State will provide technical assistance to Health Plans to prepare for this new set of services.

Whole Person Care Pilot (WPC)

WPC pilots began in 2017 throughout California and pilots are administered by the counties. The goal was to improve member health and wellbeing through more efficient and effective use of resources. The targeted populations are high-cost, high utilizers of emergency departments (ED) and inpatient services who are chronically homeless and have mental illness and/or SUD. The program focuses on coordinated health, behavioral health, and social services, in a patient-centered manner. WPC incorporates case management, care coordination, and data sharing infrastructure.

Provider noted he recently worked closely with the Alliance regarding a terminal patient and coordination of care went smoothly. Provider also noted efforts are happening through the rescue mission in Merced, and a center is opening for individuals with SUD.

5. Open Discussion.

Chairperson Diallo opened the floor for the Committee to have open discussion.

Provider noted transition of care from CCS to adult care is going more smoothly. Provider asked about the information being provided to transitioning members. Kelsey noted an Alliance letter will go out to members in addition to phone outreach introducing members to the transition process. It was noted members are requesting pediatric and adult care nurses attend MTP virtual meetings. Dr. Diallo noted that the age was lowered for member outreach due to member complex needs and to address gaps before they happen with transition at age 21 out of CCS. Provider noted the importance of beginning outreach early due to complexities and conservatorships and difficulty finding providers. Also noted, was the importance of providers understanding they are part of a care team.

Provider noted there are a low number of pediatric COVID admissions at Stanford and the adult side has 36 patients in the hospital. The last several weeks they are seeing patients with RSV. Dominican Hospital has 10 COVID patients in the hospital, mostly non-vaccinated. Dr. Diallo noted the Alliance began our flu campaign.

Provider noted there are 96 COVID patients with the local hospital with about half that number and others are going to nearby county for care. There are currently RSV cases at Valley Children's Hospital but no numbers of RSV/COVID cases.

The meeting adjourned at 12:50 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Committee

The Whole Child Model Clinical Advisory Committee is a public meeting.

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, November 8, 2021

1:30p.m. – 3:00p.m.

Teleconference Meeting
(Pursuant to Governor Newsom's Executive Order N-29-20)

Chairperson: Janna Espinoza, Chair and CCS WCM Family Member

CCAH Support Staff Present: Lilia Chagolla, Regional Operations Director**;** Maria Marquez, Administrative Specialist

WCMFAC Committee Present: Elsa Quezada, CCAH Board Member; Deadra Cline, CCS WCM Family Member; Manuel López Mejia, Monterey County – CCS WCM Family Member; Kim Pierce, Monterey County – Local Consumer Advocate; Christine Betts, Monterey County – Local Consumer Advocate

WCMFAC Committee Absent: Ashley Gregory, Santa Cruz County – CCS WCM Family Member; Cindy Guzman, Merced County – CCS WCM Family Member; Cristal Vera, Merced County – CCS WCM Family Member; Cynthia Rico, Merced County – CCS WCM Family Member; Frances Wong, Monterey County – CCS WCM Family Member; Susan Skotzke, Santa Cruz – CCS WCM Family Member; Viki Gomez, Merced County – CCS WCM Family Member

CCAH Staff Present: Gabina Villanueva, Members Services Supervisor; Kelsey Riggs, RN, Complex Case Management Supervisor; Navneet Sachdeva, Pharmacy Director; Sarah Sanders, Grievance and Quality Manager; Tammy Brass, Utilization Management and Complex Case Management Manager – Authorizations (RN)

Agenda Topic	Minutes	Action Items
Meeting Administration Lilia Chagolla	• Lilia Chagolla, Regional Operations Director (ROD) welcomed the group.	
Call to Order Janna Espinoza	• Janna, Committee Chair called the meeting to order.	
Roll Call Maria Marquez	• Committee introductions and roll call was taken.	
Oral Communications Janna Espinoza	• Janna Espinoza, Committee Chair opened the floor for any members of the public to address the Committee on items not listed on the agenda. No members of the public addressed the Committee. • Janna Espinoza, Committee Chair welcomed staff to reach out to her or Lilia Chagolla, Regional Operations Director for the Alliance in the interim of meeting for an update on pending items or to include agenda topics for the following meeting. • Janna Espinoza, Committee Chair opened the floor for members/staff in attendance to make comments.	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, November 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items

	• Janna Espinoza, Committee Chair provided updates and feedback from the health summit. Shared the panel was composed of different members from various Whole Child Mode Family Advisory Committees (WCMFAC) throughout the state. Encouraged other committee members to participate. Key takeaways:
	  • How the Alliance WCMFAC can collaborate with offices of education and school districts to ensure parents and youth are more involved.
	  • Discussions about a "red card" for children with special needs to skip triage and get connected to the pediatrician on-call, like a fast tracking.
	  • New Medi-Cal approved services – providing doula and midwife services.
	  • Assembly Bill 988, which is also called Miles Hall Lifeline Act. AB 988 creates a new easy-to-remember three-digit phone line, 988, as the new 911 for suicidal and immediate mental health crises. With 988, callers will be connected with around-the-clock intervention, including mobile crisis teams staffed by trained mental health professionals and trained peers instead of law enforcement.	

Consent Agenda Items: Accept WCMFAC Meeting Minutes from Previous Meeting Janna Espinoza	• Janna Espinoza, Committee Chair opened the floor for approval of the meeting minutes of the previous meeting on September 13, 2021. Motion to approve the consent agenda by Elsa Quezada, seconded by Deadra Cline.	
WCMFAC Resource Flyer Updates Lilia Chagolla	• Lilia Chagolla shared the updates and solicited feedback from committee members on the FAC resource flyer. • Motion to approve the resource flyer by Elsa Quezada, seconded by Deadra Cline.	Distribute the updated and approved WCMFAC Resource Flyer – Maria Marquez

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, November 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	• L. Chagolla encouraged the WCMFAC to share the resource flyer with Community Based Organizations and well as with parents of newly diagnosed children. • L. Chagolla mentioned that the WCMFAC resource flyer is being shared with Alliance contracted hospitals in Merced, Monterey County and Santa Cruz county, during the Joint Operations Committee meetings. Hospitals and Clinics have been asked to share the flyer with families that they encounter who are newly diagnosed with children with special needs. Correspondingly, the flyers are being shared at face-to-face outreach events. • Deadra Cline enquired if the Alliance will be able to add the resource flyer as part of other regular member mailings. L. Chagolla will connect with the Alliance's Member Services and Complex Case Management departments to see where the best fit will be to include the resource flyer with other mailings. At the very least to capture families with children 21 years of age and younger. • If any committee members have issues printing the resource flyer, or don't have access to printing they were asked to contact Maria Marquez, administrative specialist for the Alliance. Maria will be able to mail out printed copies as requested. Email your request to mmarquez@ccah-alliance.org • Next steps: Maria Marquez to distribute the final and approved resource flyer to the Committee Members and redistribute with links to the digital flyers.	Research to see if the WCMFAC Resource flyer can be included with other planned mailings for members – Lilia Chagolla
Pharmacy Carve Out Navneet Sachdeva	• Navneet Sachdeva presented on the Pharmacy Carve Out. Shared on the background of the Medi-Cal Rx, the Alliance internal process, member notifications and outstanding concerns. • Initially, effective January 1st of 2021. The Department of Health Care Services (DHCS) was requiring the transition of pharmacy services from managed care	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, November 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items

	plans like the Alliance to medical fee-for-service delivery system. This date has been delayed and the new date for the go live is 1/1/2022.
	• Magellan Medicaid Inc. has been contracted to administer the services. Magellan will be responsible for administering the following when billed by a pharmacy on a pharmacy claim:
	  • Covered Outpatient Drugs
	  • Medical Supplies
	  • Enteral Nutritional Products
	Anything that's being filled in a doctor's office, the hospital or infusion centers are to be continued with the Alliance. An example was shared.
	• Discussed the transition policy with Magellan. Medication does not cover under Magellan will continue to be covered for 3 months, chronic medication will be covered for 6 months.
	• DHCS has indicated that Magellan will have both a 24/7 call center and a team of clinical liaisons to the plans. These clinical liaisons will help resolve any urgent concerns that come up.
	• Shared on the Alliance's internal process to ensure all aspects are covered.
	• Alliance members will be receiving a 60-day notice from DHCS. 30-days prior to go-live, the Alliance will be sending notices to its members.
	• Questions or concerns can be addressed to Navneet Sachdeva, Pharmacy Director for the Alliance at nsachdeva@ccah-alliance.org	

Alliance Member Grievances Sarah Sanders	• Sarah Sanders presented on the Alliance's grievances and elaborated on what is a grievance or an appeal and how to file. Further detailed the process and explained what happens next after a grievance or an appeal has been filed. • Shared on the total number of grievances and appeals received for in 2020 and 2021.	Sarah Sanders to see if the Alliance has access to CCS historical data.

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, November 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	• Shared on the rates of grievances and appeals received and outlined the data by county. Shared on the percentages per types grievances received such as transportation, DME, appeal, provider or other. Deadra Cline expressed her concern on the number of appeals submitted for genetic testing in all three counties and suggested that the WCMFAC has a conversation in the future regarding these. • Elaborated on how the Alliance responds once a grievance or an appeal has been filed. • Janna Espinoza asked if the Alliance has reviewed previous types of grievances submitted to CCS prior to the Alliance taking over for trends. The Alliance does not have availability to view old CCS claims system, Sarah will take this back to see if there's a way to retrieve that historical data.	
5-11-year-old COVID-19 Vaccination Update Lilia Chagolla	• Lilia Chagolla reported on the COVID-19 vaccination for children 5-11-year-old. • The Centers for Disease Control and Prevention (CDC) has recommended Pfizer COVID-19 vaccine for the use in people 5+ years of age effective, Wednesday, November 3, 2021. • County Health Departments and County Office of Education across the Alliance service area have begun planning for vaccination pop-up clinics. • Shared on the Alliance Member Incentive Program. • Alliance members who get a single dose of the COVID-19 vaccine will be mailed a $50 Target gift card. • This member reward is available for all members who get their first or second dose between September 1, 2021 and February 28, 2022. • The Alliance Your Health Matters Outreach Program is to attend at least three community events in each county and deliver member incentives. This is to	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, November 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	motivate and encourage the community to get vaccinated and increase vaccination rates. • Elaborated on the incentives also available for contracted providers for vaccinating Alliance members. • Shared on the Alliance membership vaccination rates by county.	
Community Partner Feedback | COVID-19 Impact on Members	• Open forum for Committee members to share COVID-19 impact. • Janna Espinoza, Committee Chair opened the floor for members/staff in attendance to share COVID-19 impact on members and added that anyone can shared feedback at any time if something comes up in the interim even if it is outside this meeting.	
CCS Advisory Group Representative Report Lilia Chagolla	• Lilia Chagolla ROD communicated that Skotzke was unable to attend and will be covering this topic in her absence. • Expanded on the benefits of attending the CCS Advisory Group meetings. These are great networking and collaboration meetings to address some of the concerns and share some of the work the Alliance WCMFAC is doing. • Briefly shared on the DHCS CCS Advisory Group meeting agenda topics as follows: update on the Medical RX, update on California Advancing and Innovating Medi-Cal (CalAIM): Enhanced Care Management (ECM) and County Oversight and Monitoring. Shared implementation timelines. Additionally, Medical Therapy Programs (MTP) – State coordination efforts. DHCS quality monitoring on CMS core set measures and Classic CCS and Whole Child Model dashboards.	
Other Business **Incentive program to increase behavioral health** Lilia Chagolla	• Lilia Chagolla, ROD shared on the Alliance efforts with a new incentive program the state has included on their budget. This is funding to DHCS to implement an incentive program through Medi-Cal Managed Care to	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, November 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	build infrastructure for establishing partnerships with school and county behavioral health. The goal is to increase the number of students receiving behavioral health services with a particular focus on prevention and early intervention services. This is topic that Lilia Chagolla will bring back to a future WCMFAC meeting.	
Future Agenda Items Lilia Chagolla	• Health Summit Update – Janna Espinoza, WCMFAC Chair • Revisit the number of appeals submitted for Genetic testing. This will be a topic added to a WCMFAC meeting in Q1 2022 – Sara Sanders, Grievance and Quality Manager • Review the Roadmap – Lilia Chagolla, Regional Operations Director • Incentive program to increase behavioral health services – Lilia Chagolla, Regional Operations Director	
Review Action Items Maria Marquez	• Maria Marquez reviewed the action items.	
Adjourn (end) Meeting Janna Espinoza	The meeting adjourned at 3:01p.m.	
Minutes Submission	The meeting minutes are respectfully submitted by Maria Marquez, Administrative Specialist	

Next Meeting: January 10, 2022 at 1:30p.m.

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Department of Health Care Services Medi-Cal Contract Amendment 08-85216 A-49

Recommendation. Staff recommend the Board authorize the Chair to sign Amendment #49 to the Alliance's primary Medi-Cal contract number 08-85216 to implement the COVID-19 Vaccine Incentive Program (VIP).

Background. The Alliance contracts with the Department of Health Care Services (DHCS) to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey and Merced counties. The Alliance entered into the primary Agreement 08-85216 with DHCS on January 1, 2009. The amendment has subsequently been amended via written amendments

Discussion. DHCS has prepared an amendment to the Alliance's primary agreement, 08-85216, to incorporate the COVID-19 VIP. As reported to your Board at the September 22, 2021 meeting, DHCS implemented a VIP to include both provider incentives and direct member incentives. The direct member incentive program includes a $50 gift card for all members who receive at least one vaccine dose between September 1, 2021 and February 28, 2022.

The Alliance received DHCS approval for a point of service incentive in geographic areas with the greatest need and lowest vaccination rates through providers and Community Based Organizations (CBOs) serving those geographic areas and hard to reach populations. Eligible Alliance members receive their gift card either at the point of service from their providers' or CBOs' vaccine sites that are participating in the VIP, or through the mail from the Alliance for vaccines received from any other provider.

The Alliance will report to DHCS a list of members for whom an incentive has been provided to receive payment from DHCS. DHCS has drafted an amendment to the Alliance's contract to effectuate payment.

Board authorization for the Chair to sign the Amendments is required.

Fiscal Impact. The Alliance expects the vaccine incentive expense will be covered by the incentive revenue.

Attachments. N/A

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Department of Health Care Services Medi-Cal Contract Amendment 08-85216 A-45

Recommendation. Staff recommend the Board authorize the Chair to sign Amendment #45 to the Alliance's primary Medi-Cal contract number 08-85216 to implement the CY 2021 "Base Amendment" pending completion of a review of the language for acceptability and assessment of risk.

Background. The Alliance contracts with the Department of Health Care Services (DHCS) to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey and Merced counties. The Alliance entered into the primary Agreement 08-85216 with DHCS on January 1, 2009. The amendment has subsequently been amended via written amendments.

Discussion. DHCS has prepared an amendment to the Alliance's primary agreement, 08-85216, to incorporate DHCS required language related to federal financial participation and defined contractual terms, as well as language changes to plan contractual requirements related to:

- Provider contract termination
- Screening for childhood lead poisoning
- Written member information
- Cost avoidance and Post-Payment Recovery
- Third-Party Tort, Workers' Compensation Liability and class action claims recovery

Board authorization is required for the Chair to sign the amendments. Final review of the language is underway, and staff recommend that the Board authorize the Chair to execute the amendment pending completion of review of the language for acceptability and assessment of risk.

Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments. N/A

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Dale Bishop, MD – Chief Medical Officer

SUBJECT: COVID-19 Booster Vaccine Member Incentive and COVID-19 Related Supplies

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Recommendation. Staff recommend the Board authorize medical budget allocation of $3M for the purpose of: 1) implementing and executing a new member vaccine incentive for COVID-19 boosters, and 2) offering funding of $1 per member per County for masks and/or test supplies.

Background. With the recent surge of the COVID-19 Omicron variant Alliance staff have recognized, and Local Health Department leaders have confirmed, that Alliance members are not receiving booster vaccine at the same rates as the community. Offering a member incentive for receiving a booster has been identified as a likely successful strategy to close that gap. Regarding a recently identified need for COVID-19 related supplies, Alliance public health partners, community organizations and providers have requested funding for COVID-19 supplies including lab tests and highly effective masks.

As approved by your Board in September, the Alliance implemented the Vaccine Response Plan (VRP) through the Department of Health Care Services. The VRP included a $50 gift card member incentive to promote vaccination for those members who are eligible and have not received a vaccine or completed the initial series of two vaccines, however it did not include incentives to receive the booster vaccine. From experience with the Omicron variant in December 2021 and January 2022, it has been recognized that receiving the booster vaccine is important to decrease morbidity and mortality from Omicron and new COVID-19 variants that are likely to develop.

During the recent Omicron surge it was noted that Alliance members had limited access to supplies that would assist them in detecting infections with COVID-19. Local Medical offices, emergency departments, and testing sites became overwhelmed with requests for tests in our service area. Rapid antigen test kits and at-home tests are now being requested. County partners and providers have also expressed the need for high quality masks for adults and children. It has also been pointed out by our Public Health partners that a disproportionate number of Alliance members, especially those in Healthy Places Index high-need geographic areas do not have access to high quality N-95, KN-95 or KF-94 masks for adults or an adequate supply of pediatric masks.

In consideration of these concerns and requests, Finance has endorsed the allocation of $3M from the medical budget surplus for support of a member incentive for COVID-19 boosters and funding for COVID-19 related supplies.

Discussion. The Alliance proposes an allocation of $2.61M for a new member incentive for COVID-19 boosters using Alliance medical funds. Based on members who have already received vaccines and are now eligible for, but have not received a booster, it is estimated

that this amount of funding will provide for approximately 17,000 members per month to receive the booster and be incentivized with $50 gift cards during a span of three months from March 1, 2022 to May 31, 2022.

To support requests for supplies from our community partners, Alliance staff propose allocation of $1 per member per County, totaling $389,561, to assist with emerging local needs, such as purchasing COVID-19 tests and high-quality masks. Each county has expressed their specific needs. Some have a higher need for high quality masks for adults and children and others need more at-home tests available to members.

Fiscal Impact. The total cost associated with the proposal is $3M with a COVID-19 booster member incentive of $2,610,439 and $389,561 for supplies to be covered through the Alliance medical budget. Finance has endorsed the allocation of $3M from the medical budget surplus for these purposes.

Attachments. N/A

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Dale Bishop, Chief Medical Officer

SUBJECT: Whole Child Model Clinical Advisory Committee Charter and Policy #400-1112 – WCMCAC Responsibilities and Functions

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Recommendation. Staff recommend the Board approve the revised Whole Child Model Clinical Advisory Committee (WCMCAC) Charter and Policy #400-1112 – WCMCAC Responsibilities and Functions.

Background. The WCMCAC provides clinical advice and perspective on issues relating to diagnosis and treatment of California Children's Services (CCS) conditions as well as to review and offer advice about policies, programs, and initiatives relating to care of members in the CCS program. An Alliance Medical Director, Board Certified in Pediatrics or the Chief Medical Officer will serve as meeting Chair.

Discussion. The WCMCAC provides feedback to assist in meeting the six goals of the Whole Child Model: 1) support patient and family-centered approaches to care, 2) improve care coordination through an organized delivery system, 3) maintain quality of services, 4) streamline care delivery, 5) build on lessons learned and provide quality, and 6) cost effective services. The WCMCAC reviews the charter and policy annually and submits them to the Board for approval.

Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments.

1. WCMCAC Charter
2. Policy #400-1112 – WCMCAC Responsibilities and Functions

	COMMITTEE CHARTER
Committee: Whole Child Model Clinical Advisory Committee (WCMCAC)	
Original Date: February 2018	**Last Revision Date:** January 2022
Approved by: Alliance Board	

Purpose	The Whole Child Clinical Advisory Committee (WCMCAC) is an advisory committee providing input and recommendations to the health plan on important strategic issues that impact California Children's Services (CCS) members, families, and providers. The WCMCAC will provide feedback to assist in meeting the six (6) goals of the WCM: • Support Patient and Family-Centered Approaches to Care • Improve Care Coordination through an Organized Delivery System • Maintain Quality of Services • Streamline Care Delivery • Build on Lessons Learned • Provide Quality, Cost Effective Services
Authority and Responsibility	The primary responsibility of the WCMCAC is to to advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisers on other clinical issues relating to CCS conditions. The WCMCAC will provide perspective on issues relating to diagnosis and treatment of Alliance members with conditions that have been traditionally covered through the California Children's Services (CCS) program. In addition, the WCMCAC will review and offer advice about policies, programs and initiatives relating to care of members with CCS eligible diagnoses enrolled in the Whole Child Program.
Membership	WCMCAC are appointed by the Alliance Board. Membership includes:

	COMMITTEE CHARTER
Committee: Whole Child Model Clinical Advisory Committee (WCMCAC)	
Original Date: February 2018	**Last Revision Date:** January 2022
Approved by: Alliance Board	

	Alliance Chief Medical Officer Alliance Medical Directors Each County's CCS Medical Director At least four (4) CCS paneled providers with representation from each of the Alliance counties served. Membership will reflect demographic representation within practical limits, including geographic distribution, primary care and specialists. Members are recruited several ways including, but not limited to: 1. Recommendation of CCS staff representing each County. 2. Volunteer by individual physician. 3. Physicians with specific expertise may be invited to assist with the committee's work. WCMCAC members will be appointed by the Alliance Board. Alliance staff, including, but not limited to the, Utilization Management/CCM Director, Quality Improvement & Population Health Director, Community Care Coordination Director, Provider Services Director, Member Services Director and other staff may attend depending upon agenda items.
Terms	Members will be appointed to a one-year term. At the end of the term the member may be reappointed to a subsequent one-year term or terms. Physicians unable to attend at least half of meetings will be encouraged to yield their seats to others with more compliant schedules.
WCMCAC Chair	An Alliance Medical Director Board Certified in Pediatrics or the CMO will serve as Chair.
Meetings	The WCMCAC will meet quarterly, with a minimum

	of three (3) meetings per year.
Meeting Compensation	WCMCAC members may receive a stipend for participation in the WCMCAC.
Agenda, Minutes, Reports	Alliance staff will work in collaboration with the Chair to develop the agenda for each meeting. Alliance staff are responsible for agenda and meeting material production and distribution. Agendas and meeting materials will be published and distributed to WCMCAC members and posted publicly at least seventy-two (72) hours prior to each meeting. Alliance staff will record minutes of meetings which will be approved by the WCMCAC members at each subsequent meeting.
Open and Public Meetings	WCMCAC meetings are open to the public.
Meeting Location	Meetings will be held via teleconference utilizing Microsoft Teams. Meeting participants may also participate telephonically.
Translation and Interpreter Services/Assistive Devices	Requests for translation and interpreter services, including sign-language interpretation or other assistive devices such as real-time captioning, note takers, reading or writing assistance and conversion of meeting materials into Braille, large print or computer flash drive can be made available if requested at least ten (10) business days prior to the meeting.

	COMMITTEE CHARTER
Committee: Whole Child Model Clinical Advisory Committee (WCMCAC)	
Original Date: February 2018	**Last Revision Date:** January 2022
Approved by: Alliance Board	

Review of Charter	The WCMCAC shall review this charter at least annually. Any proposed changes shall be submitted to the Board for approval.

Revision History:

Review Date	Revised Date	Changes Made By	Approved By
11/8/2018	12/6/2018	Danita Carlson, Government Relations Director	
12/13/2021	12/13/2021	Dianna Diallo, MD Medical Director	

	POLICIES AND PROCEDURES
Policy #: 400-1112	**Lead Department:** Health Services
Title: Whole Child Model Clinical Advisory Committee Responsibilities and Functions	
Original Date: January 8, 2017	**Policy Hub Approval Date:**
Approved by: Utilization Management Work Group (UMWG)	

Purpose:

To delineate the functions and responsibilities of Central California Alliance for Health's (the Alliance) Whole Child Model Clinical Advisory Committee (WCMCAC).

Policy:

The primary responsibility of the WCMCAC is to give clinical advice and provide perspective on issues relating to diagnosis and treatment of California Children's Services (CCS) conditions as well as to review and offer advice about policies, programs and initiatives relating to care of members in the CCS program.

Membership: At least four (4) paneled CCS providers representing each of the Alliance Counties, Alliance Medical Director, and County CCS Medical Directors. All physicians and members of the public are welcome to participate. An opportunity for public comment will be offered and agendas and meeting materials will be published and distributed to WCMCAC members and posted publicly at least 72 hours prior to each meeting.

The Utilization Management/Complex Case Management Director, Quality Improvement & Population Health Director, Provider Services Director, Member Services Director, Community Care Coordination Director, and other staff may attend depending upon agenda items. The specific number of participating physicians shall be determined by the group annually as needed.

Demographic Representation: Membership will reflect demographic representation within practical limits, including geographic distribution, Primary Care and Specialists.

Selection of Members: Members are recruited several ways including, but not limited to:

1. Recommendation of CCS staff representing each County.

2. Volunteer by individual physician.
3. Physicians with specific expertise may be invited to assist with the committee's work.

Term: WCMCAC members serve a one-year term, renewable by the Commission. Physicians unable to attend at least half of meetings will be encouraged to yield their seats to others with more compliant schedules.

Chair: An Alliance Medical Director Board Certified in Pediatrics or the Chief Medical Officer.

Frequency of meeting: Quarterly, with a minimum of three meetings per year.

Reports to: The Commission, through Committee Minutes as well as recommendations for policy revisions and innovations.

Definitions:

Commission: The Alliance Board of Commissioners (Alliance Board). The Alliance's 21-member governing board, the Santa Cruz-Monterey-Merced Managed Medical Care Commission, sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan.

References:

Alliance Policies:

Impacted Departments:

- Community Care Coordination
- Member Services
- Provider Services
- Quality Improvement & Population Health
- Utilization Management/Complex Case Management

Regulatory:

Legislative:

- Senate Bill (SB) 586 Children's Services (Hernandez)

	**POLICIES AND PROCEDURES**
Policy #: 400-1112	**Lead Department:** Health Services
Title: Whole Child Model Clinical Advisory Committee Responsibilities and Functions	
Original Date: January 8, 2017	**Policy Hub Approval Date:**
Approved by: Utilization Management Work Group (UMWG)	

Contractual:
DHCS CCS Whole Child Model MOU
DHCS All Plan or Policy Letter:
NCQA:
Supersedes:
Other References:
Attachments:

Lines of Business This Policy Applies To	**LOB Effective Dates**
☒ Medi-Cal	(01/01/1996 – present)
☐ Alliance Care IHSS	(07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
02/15/2019	02/15/2019	Dale Bishop, MD, CMO	UMWG
06/10/2020	06/10/2020	Dale Bishop, MD, CMO	UMWG
06/09/2021	06/09/2021	Dale Bishop, MD, CMO	UMWG
02/09/2022	02/09/2022	Dale Bishop, MD, CMO	

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Michelle N. Stott, Quality Improvement and Population Health Director

SUBJECT: Quality and Performance Improvement Program Workplan – Q3 2021

Recommendation. Staff recommend the Board accept the Quality and Performance Improvement Program (QPIP) Workplan report for Q3 2021.

Summary. This report provides pertinent highlights, trends, and activities from the Q3 2021 QPIP Workplan.

Background. The Alliance is contractually required to maintain a QPIP to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (the Board) is accountable for all QPIP activities. The Board has delegated to the Continuous Quality Improvement Committee (CQIC), the authority to oversee the performance outcomes of the QPIP. This is monitored through quarterly and annual review of the QPIP Workplan, with review and input from CQIW-I.

The 2021 QPIP Workplan was developed to align with the Alliance Strategic Plan of Member Wellness, Access to Care, and Promotion of Value. This is accomplished through the following initiatives:

I. Projects and Initiatives	**Status**
A. Department of Healthcare Services (DHCS) Performance Improvement Project (PIP): Immunizations	**In progress**
B. DHCS PIP: Child and Adolescent Well Care Visits	**In progress**
C. DHCS Plan-Do-Study-Act (PDSA): Breast Cancer Screening, COVID Quality Improvement Project (QIP)	**In progress**
D. Healthier Living Program	**Goal met**
II. Operational Performance	**-**
A. FSR Management	**Goal partially met**
B. Grievance and PQI Management	**Goals met**
C. Cultural and Linguistic Services	**Goals met**
D. Population Health	**In progress**

Discussion.

Department of Health Care Services Performance Improvement Projects.
1) Immunizations: The Alliance continues to focus on increasing the Healthcare Effectiveness Data and Information Set Childhood Immunization Status (CIS) rates in Merced County. For 2021, the goal is to increase the CIS rates by at least five percentage points from 19.71% to 24.71% for children 2-years of age. The Alliance has partnered with Castle Family Health Center (CFHC) on a PIP to increase their CIS rates from 12.22% to 19.51% by December 2022. The CIS rate in Merced county

slightly increased from the previous quarter to 18.79% but was still below the baseline. The CIS rate for CFHC increased by more than three percentage points from the previous quarter to 15.38%.

2) Child and Adolescent Well Care Visits: The Alliance has partnered with Golden Valley Health Center at their Los Banos clinic on a PIP to increase the number of child and adolescent members 3-17 years of age who receive at least one adolescent well care visit with a primary care physician or OB/GYN practitioner from 32.65% to 48.56%. The child and adolescent well care visit rate increased this quarter to 33.57% from 30.62% in the previous quarter.

Limited provider engagement due to conflicting priorities with the COVID-19 vaccine and member hesitancy to resume preventative care continue to be challenges in improving the CIS rate as well as the child and adolescent well care visits.

Breast Cancer Screening Plan-Do-Study-Act. DHCS required all health plans to conduct a PDSA rapid cycle project on a single performance measure that focuses on preventive care, chronic disease management or behavioral health MCAS measure impacted by COVID-19. The Alliance decided to focus on increasing the Breast Cancer Screening (BCS) rate as the measure needing most improvement and set the global aim to be above the National Committee for Quality Assurance (NCQA) Medicaid 50th percentile benchmark in Merced county. The PDSA Cycle 1 intervention resulted in improving the screening compliance rate at Gettysburg Medical Clinic from 26.89% to 39.50%, exceeding the 10% improvement goal. The PDSA Cycle 2 intervention resulted in improving the screening compliance rate at Apex Medical Group from 60.92% to 77.82%, exceeding the 15% improvement goal.

DHCS recently provided an update on quality improvement activities and submission requirements for 2021 – 2022. In response to these requirements, the Alliance decided to continue with the BCS PDSA and completed the PDSA Cycle 3 intervention during this quarter. This resulted in a further improvement of 13% in the screening compliance rate at Gettysburg Medical Clinic, exceeding the 10% improvement goal.

COVID-19 Quality Improvement Plan. In response to the recent DHCS submission requirements for 2021 – 2022, the Alliance made the initial submission for the COVID-19 Quality Improvement Plan (COVID QIP) this quarter. This included the following three strategies:

1. Member incentive for completing the second dose of the flu vaccine in children between the ages 7-months to 2-years to improve the CIS Combination 10 rate.
2. Reminder letters prior to the child's 11th, 12^{th,} and 13th birthday to improve adolescent well-care visits.
3. Leveraging the Healthy Mom and Healthy Babies program for BIPOC/low-rate populations to improve PPC – postpartum/maternal mental health.

Population Needs Assessment. The Alliance 2021 Population Needs Assessment (PNA) was completed on August 13, 2021, under the oversight of the Alliance Quality Improvement and Population Health Department as required by DHCS and described in the All Plan Letter 19-011 Health Education and Cultural & Linguistic Population Needs Assessment. The PNA report provides an overview of the Alliance Medi-Cal member health status and behaviors. The findings determine if we are meeting member needs, specifically to find service gaps and identify health disparities with the overall goal of improving member health outcomes. Based on the findings outlined in the 2021 PNA report, a 2021-2023 PNA Action Plan of activities for the Alliance's tri-county service areas was created. To learn more about the PNA report and review the Alliance

2021-2023 PNA Action Plan please visit our website at https://thealliance.health/for-providers/manage-care/cultural-and-linguistic-services/

Operational Performance. The QPIP includes surveillance to maintain and improve the clinical safety of services to members. Two key clinical safety operational functions Facility Site Reviews (FSR) and Potential Quality Issues (PQI) programs are reported below.

Facility Site Review 100% complete, 100% Critical Element resolved, 100% Corrective Action Plans submitted, 100% Corrective Action Plans completed. The FSR team monitors all primary care providers within the network to ensure that facilities are safe and accessible, care is evidence-based, prevention-focused and safe for our members. The FSR team set out to achieve all operational goals at 100% compliance for 2021. Twelve sites or 60% (N=20) completed a full site review within three years of the last FSR. When Critical Element Corrective Action Plan (CAPs) were issued at a review, 0 out of 1 site (0%) had the CAP resolved within 10 business days. Critical Elements require near immediate resolution, including items like infection control practices. The clinics issued a CAP 100% (N=12) and were able to submit a CAP plan within forty-five calendar days to the Alliance. Four out of five practices (80%) with a CAP (FSR) were able to complete all planned actions within 90 calendar days. Some clinics report that lack of childcare and other barriers continues to impact their ability to have a timely implementation of CAPs. The team continues to work with a California health plan collaborative to create a webinar to orient and educate providers on the updated All Plan Letter 20-006.

The PQI team reviewed 100% of the 97-member grievances in Q3 2021 and accepted additional reports of patient safety concerns from across the Alliance. Examples include a member who falls while inpatient, failure to follow through on lab results, inappropriate opioid prescribing that result in injury to the member. The aim is to complete investigation of cases within 90 calendar days of receipt and the team was successful for 99% of PQIs (N=135). All member grievances (N=103) opened as PQIs in Q3 were closed within Grievance department's timeframe of 25 days or less. During Q3 the team held an MD peer to peer interrater reliability study and resulted in 100% agreement of reviewed cases. Also, during Q3 the Medical Director Review of member complaints resolved by the RNs resulted in 97% approval, indicating that cases are being appropriately routed to Medical Directors for oversight. Challenges facing the program included staffing shortages due to resignations. Additionally, at the end of Q3 the Medical Director assigned to primary oversight of the program was changed to Dr. Arakawa. The team is evaluating existing administrative procedures, quality study assignments and case review cadence to optimize medical director and staff time.

Cultural and Linguistic Services. The goal is to increase Provider and Staff Utilization of the Alliance Language Assistance Services program by 5% compared to the previous year's utilization. Current utilization numbers are detailed in the QPIP Workplan. In brief, when compared to Q1 2021 utilization, Q3 2021 telephonic interpreting services decreased among providers, Alliance staff, and contracted Alliance vendors; decreased in face-to-face interpreter services; and increased in translation service by 20.4%. Efforts are underway to promote the Alliance Language Assistance Services among members and providers.

Population Health Management Program. In early 2021 the QIPH program initiated planning to develop a Population Health Management Program (PHMP) for the Alliance. The Program's strategy planning is a part of work preparing for the DHCS CalAIM initiative and is based on outcomes from staff's NCQA population health gap analysis, review of literature and requirements from DHCS. The current objective is to meet the DHCS CalAIM Population Health Management

requirements through a fully socialized and adopted Population Health Strategy. Recently a group of internal subject matter experts were engaged to provide feedback on the program description and its goals developed to date. Their feedback will be incorporated into the program's development. One issue has been identified; both the PHMP and the Enhanced Care Management will require resources to segment and stratify the Alliance's membership to ensure that all Alliance members are appropriately matched with supports and services. Finally, with the recent approval of the Strategic Plan, ensure that there is alignment between these two important bodies of work.

Conclusion. The QPIP Workplan does not have any critical areas of concern that require further intervention or follow-up. There is continued progress toward goals for the initiatives and operational metrics, including addressing any barriers to achieve outcomes. The pandemic continues to impact provider staffing and active engagement; however, there are efforts in participation and the team is providing support as needed.

Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments. N/A

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Mary Brusuelas, RN, UM and Complex Case Management Director

SUBJECT: Utilization Management Workplan - Q3 2021

Recommendation. Staff recommend the Board accept the Utilization Management Workplan (UMWP) report for Q3 2021.

Summary. This document provides an overall summary of the UMWP activities for the Q3 2021 highlights and outcomes.

Background. The Utilization Management Workgroup provides guidance and direction to the Utilization Management Program and operates under the authority of the Continuous Quality Improvement Committee. This quarterly summary continues to reflect the outcomes of the changes to the UMWP established for 2021. In addition, projects and initiatives carried forward from 2020 continue to be monitored and updated for progress toward goals.

Variances in goal achievement are documented in the quarterly UMWP with evaluation of issues influencing outcomes. In areas where interventions are adjusted or changed, documentation is described in the quarterly recommendations.

Q3 2021 Workplan Outcomes and Evaluation

Project and Initiative Outcomes:

> Pediatric Case Management. The ongoing optimization of our Whole Child Model California Children Services (CCS) program is reflected in the continued increase in the total number of CCS eligible members, with the third quarter at 7,479 members. This represents a 4% increase of CCS eligible members over the first quarter of 2021. In consideration of the Department of Health Care Services (DHCS) All Plan Letter (APL 21-005) updates, staff anticipate a continued increase in diagnostic CCS eligible members. This is related to the increasing number of approvals for referrals in the diagnostic period that have historically been denied for CCS eligible members. Additional work is also underway for earlier identification and redirection of CCS potential members receiving care with non-paneled providers. Focused outreach and county collaboration will continue in this area, with endocrinology as a specialty of focus.
>
> System Transformation Development/Community Care Coordination. Internal staff have secured information from DHCS for draft Enhanced Case Management (ECM) rates for the Alliance service area, as well as rate ranges for Community Services (CS). A provider engagement session was co-facilitated by Community Care Coordination and Provider Services Directors on August 25, 2021. Interested

community providers submitted responses to the Alliance's provider engagement questionnaire. Contract templates for ECM and CS are in development. The Alliance expects final ECM rates at the beginning of the fourth quarter.

Reducing Readmissions Initiative

Post Discharge Meal Delivery Program (PDMDP). Enrollment into the PDMDP in the third quarter represented an increase of 5.5% over the previous quarter. Of the 111 members enrolled, there was a 14% increase in the members completing the program as compared to the previous quarter. 70% of enrollees completed the 12-week program in the third quarter.

30% of the members enrolled in the PDMDP during the third quarter were disenrolled for a variety of reasons. These reasons included readmissions for 20 members and the death of one member. Third quarter reflected a decrease of 4.5% in the number of members disenrolled as compared to the number of members who disenrolled in the previous quarter.

The readmission rate after enrollment for Q3 was 24%, which is a decrease of 3% as compared to the previous quarter.

Recuperative Care Program (RCP). During the third quarter, there was a significant increase in the number of members enrolled in the RCP. Enrollment was up by 79% as the program advanced to include Merced County. Overall length of stays ranged from 1-60 days.

Recommendation. The upward trend of admissions to the RCP was due to the opening of Mission Merced in August of 2021. Monterey County program was also launched in August of 2021 but had no admissions in the third quarter. The Utilization Management team will continue to monitor trends and provide ongoing education to the Monterey County program to encourage enrollment.

Operational Performance Outcomes:

Operational Performance includes regulatory performance monitoring metrics that are reported on the organizational dashboard in addition to the UMWP. These include the following:

Authorization Turn Around Times (TAT). Recommendation is to continue current practices with use of Essette authorization activity reports for twice daily TAT overview and assignments. Authorization reduction/redesign efforts continue to support higher TAT performance rates. Most recent changes inclusive of the provider code look up tool (PCL) on the portal have resulted in decreases in "no prior authorization required" unnecessary submissions.

Goal: 100%
Goal not met at 99.7%

Prior Authorization Request Determination Metrics. While total authorization volumes appear lower than in the previous quarter, the increase noted in the second

quarter was also reflective of NTR (no TAR required) authorization submissions either voided or approved to not delay care. Provider engagement in using the newly implemented PCL tool is noted in the steady increase of correctly submitted authorizations and slight reductions in void activity. Overall, third quarter data reflects a 2% increase over first quarter authorization activity, with void activity consistently coming in at 16% and overall denial rates remaining low at 1.5%. Of the 604 denials noted in the third quarter, 53 came back as appeals. Of those, 32 were upheld, while 21 were overturned in favor of the member.

Top 10 Prior Authorization Requests Resulting in Medical Necessity Denials. Third quarter denial activity was lower than the previous quarter, though is reflective of typical denial patterns. Higher rates of denials were noted in consultation requests, many of which reflect Out of Area/Non-Contracted provider requests and care that may be redirected to locally available, in network providers. Genetics continues as a higher volume denial category with providers requesting unspecified or unlisted large panel testing. Durable Medical Equipment (DME) denials specific to wheelchair accessories were higher in both the second and third quarters. In-home/on-site DME evaluations are typically coordinated for these members to identify medically necessary DME needs.

Utilization Performance Outcomes:

Inpatient Utilization. Average length of stay, bed-days and readmissions are stable. Ambulatory care sensitive admissions settled into average between the first and second quarters.

Goal: Bedday per thousand/per year (PKPY) 282
Goal met at 248 PKPY

Ambulatory Care Sensitive Admission. Decreases in Monterey and Merced Counties are probably real; however, the slight increase in Santa Cruz numbers could be due to simple variations from this smaller population. In Monterey and Merced Counties, decreases could be attributed to discussions in our Clinic and Hospital Joint Operations Committee Meetings.

Goal: Dashboard target goal is 8.0 (threshold 8.9)
Goal met at 6.8

Readmissions. No real change from the previous quarter. Rates remain stable.

Goal: Dashboard target 11%, (threshold is 12.2%.)
Goal met at 11%

Alternatives to Acute Inpatient Days – Skilled Nursing Facilities (SNF). Third quarter SNF and short-term rehabilitation (STR) bed days have decreased by 4% over Q3 2020. Of the 259 members admitted to SNF/STR in the third quarter, 21% of members were readmitted to the hospital within 30 days.

This readmission rate represents a 5% increase from the third quarter of the previous year.

SNF/STR bed days that resulted in the utilization of STR LOC 1 to cover the increased care associated with members in COVID-19 isolation or were COVID-19 positive was no longer ongoing during the third quarter. Recommendation is to continue monitoring for trends anticipating the pandemic surges decreasing in the fourth quarter.

Long Term Care (LTC). The number of third quarter new admissions to LTC decreased 39% as compared to the third quarter of the prior year. Medi-Medi members comprised 83% of total members in LTC reflecting a decrease of 4% when compared to the third quarter of the prior year. New admissions to LTC have decreased significantly. This could be a result of claims lag and post authorization submission as the September 2021 totals for LTC were tagged in Tableau reporting as low due to claims lag. The continued pandemic is also affecting new admissions to LTC. Staff continue to monitor for trends.

Emergency Department (ED) Utilization Metric. ED visits increased to 483 per thousand/per year in the third quarter, which is still well below pre-COVID-19 volumes. As noted in the previous quarter, the upward trend in all three counties may indicate that members were continuing to return to the ED as COVID-19 conditions improved.

Pharmacy Utilization. Per member/per month (PMPM) for retail increased by 1.7% compared to the previous quarter, and a 5% increase compared to the third quarter in the previous year. CCS accounts for only 2% of Medi-Cal membership, but 16% of Medi-Cal spend (and 27% of Medi-Cal specialty spend). CCS PMPM increased by 11.5% since the third quarter of last year. For IHSS, PMPM continues to increase, 3% higher from the previous quarter and 2.6% higher from this quarter in 2020 ($92.89), primarily due to members starting high cost specialty drugs. Staff continue to monitor until the transition to Medi-Cal Rx. There is a plan to delegate IHSS LOB to MedImpact for formulary and prior authorization management.

Out of Network (OON) Specialist Utilization Metric. An additional assessment has been added and is in use for review of OON requests in the Essette platform. Increases in OON requests over Q1 2021 are reflective of members resuming care, with over 64% of these requests approved and the remaining denied for redirection to local in network specialists. The Peds CCM team continues the collaborative approach with Provider Services in identifying and supporting outreach to encourage increases in CCS paneled providers. Continued internal referrals to Case Management for denials and redirection where indicated.

Under/Over Utilization Tracking and Reporting

1. Nerve Conduction Tests (95905-95913): 322 approved authorizations were received this quarter, which is slightly below the previous quarter.
2. EMG (95885-59887): 125 approved authorizations were received, which is slightly above the previous quarter.
3. Neurology & Neuromuscular Procedures (95782-96020): 0 approved authorizations were received this quarter.

Staff will continue to monitor existing services (above) and utilize reporting of emerging under and over utilization analysis for identification of additional areas of focus which will be added to the quarterly tracking.

Emerging Under/Over Utilization Analysis

Report drawn for Q3 2021 shows the top five average claims received in the last 30 days as:

1. Psychotherapy, 60-minute sessions (10,341)
2. Behavioral Health Day Treatment (4,074)
3. Psychotherapy, 30-minute sessions (2,391)
4. Frames, Purchases (1,582)
5. Oxygen Concentrator (1,234)

As this is a new measure, we will monitor data as it is available for trends. While this portion of the reporting indicates appropriate utilization, no new areas of focus have been identified in the third quarter.

Delegate Oversight Outcomes:

Delegated Oversight Quarterly Report Summary. All reports were received on time and no recommendations were made.

Behavioral Health. The penetration rates lag by one quarter for claims. This information represents mild-moderate MH utilization rates for Q2 2021. Counties fall within or exceed the Goal range.

We will continue to monitor utilization rates.

Goals: 100%
Goals met

Beacon Utilization Management File Audit. The UM file audits are conducted in the quarter following the audit quarter. The UM file audit for the third quarter was conducted in December 2021. Overall, Beacon passed this audit. However, Beacon continues to need to work on the following deficiency: documentation of evaluating the member for referral to case management and the determination of whether case management is needed.

Goal: 100%
Goal met: 99%

Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments. N/A

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH®

2021 Community Impact Report

HEALTHY PEOPLE. **HEALTHY** COMMUNITIES.

Central California Alliance for Health (the Alliance) is committed to building healthy communities.

The Alliance's **Medi-Cal Capacity Grant Program (MCGP)** provides grants to health care and community-based organizations to increase the availability, quality and access of health care and supportive services for Medi-Cal members in Merced, Monterey and Santa Cruz counties.

Your Health Matters is the Alliance's member outreach program. Through outreach and education at community events in the counties the Alliance serves, the Your Health Matters program helps members understand their health care options and how to access the services and resources they need.

A MESSAGE from our **CEO**

The Alliance is pleased to share our community impact in 2021. In the following pages, we share highlights of the Alliance's impact through our community engagement, grant-making and outreach programs. The Alliance's community engagement efforts were instrumental in meeting the immediate needs created by the COVID-19 pandemic, while also advancing access to quality services for our Medi-Cal members.

In 2021, the Alliance's MCGP supported access to critical care and integration of social supports to meet members' physical, mental and social needs through investments in both infrastructure and upstream prevention.

The Alliance's outreach program, Your Health Matters, prioritized engagement with our members and county partners to ensure that members had the information and resources they needed to navigate this year's challenges.

We are proud of what we achieved and are pleased to share these highlights with you. We continue to be inspired by the agility and determination of our community partners to transform challenge into opportunity. By working together, we are confident that we can achieve the Alliance's vision of Healthy People. Healthy Communities.

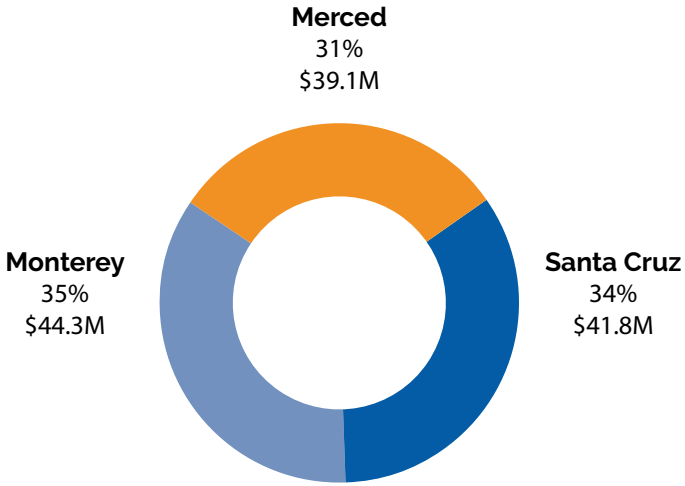
Stephanie Sonnenshine

Stephanie Sonnenshine, CEO

GRANT **AWARDS**

Since 2015, the Alliance has awarded **562** grants totaling **$125,247,492** to **138** organizations in the Alliance's service areas.

Awards to Date



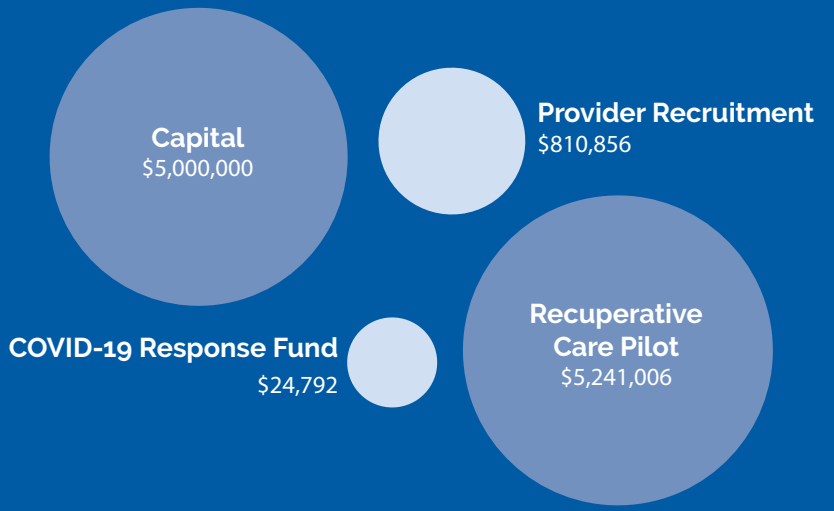
2021 Grant Awards

$11.1M awarded

6,225 Alliance members impacted

14 grants awarded

Total Awarded by Program

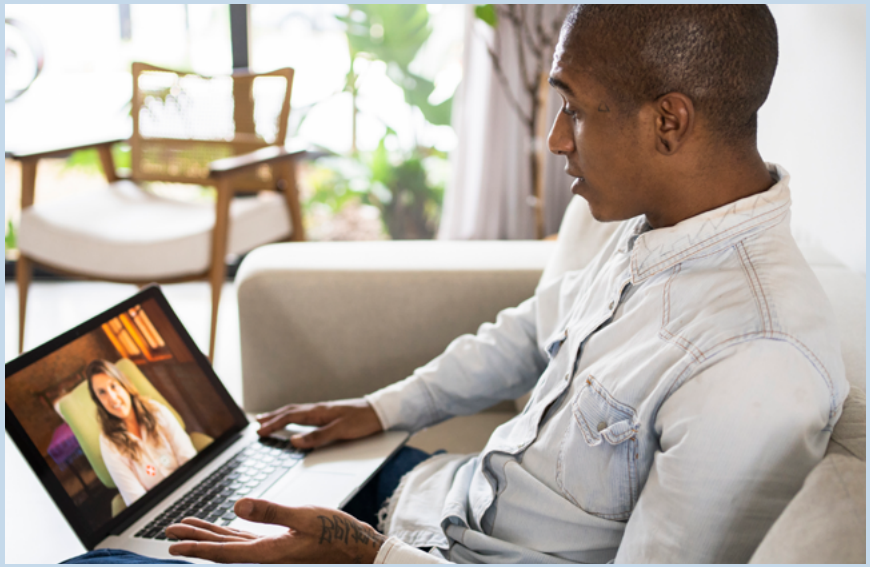


Please visit www.thealliance.health/grants-program-descriptions/ for more information about grant programs.

A Focus on Women and Children

The MCGP supported expanded access for women and children. **Soledad Community Health Care District (SCHCD)** received a grant from the Alliance for its new Women's Health Center. The center focuses on enhanced prevention and detection services, including new mammography services enabled by an Alliance-funded digital imaging unit. The center will also allow SCHCD to expand OB/GYN services from 3 to 5 days per week. With a grant from the MCGP, **Coastal Kids Home Care** opened a new location in Salinas. This expanded and renovated facility increases pediatric home health, palliative care and behavioral health services for children and families in Monterey County.

Coastal Kids Home Care's newly expanded facility in Salinas includes three therapy rooms to provide physical and occupational therapy as well as behavioral health services. (Featured: Coastal Kids Farms mural by Monterey artist Paul Richmond.)



Connecting Through Technology

With MCGP support, grantees implemented new technology to manage protected health information and connect members to needed services. **Family Service Agency of the Central Coast** established an electronic health record (EHR) system to improve access, quality and care coordination for members and community partners. It also allows behavioral health clinicians to provide treatment via telehealth during the pandemic. **Mercy Medical Center Merced** implemented an electronic community referral system using the Unite Us platform. The *Connected Community Network* allows networked medical care providers and community organizations to refer members to services. The network has 34 organizations and three government entities serving Merced County, and it continues to grow.

HEALTHY Food, **HEALTHY** People

Left: CHI's Food for Families program provides coaching and in-person classes for children and their families on healthy eating and lifestyle. **Right:** *Project Grow* operates the People's Fridge, Merced County's first community fridge to provide free, fresh food to all available 24/7.

Food security remained a priority for the Alliance in 2021. Several MCGP grantees implemented projects that helped children and families receive healthy food and develop a healthy lifestyle.

Community Health Innovations (CHI), in partnership with **Food Bank for Monterey County**, enrolled 108 children in *Food for Families* who screened positive for food insecurity and at risk for diabetes. This program provides telephonic coaching and in-person classes for children and their families on healthy eating and lifestyle. They receive weekly groceries and recipes for six months, along with scales and pedometers to track progress. Forty-three percent of participants decreased their BMI percentile by the end of the six-month program. CHI ensures that all participants are connected to sustainable food resources like food bank sites, CalFresh and/or WIC.

United Way of Merced County's *Project Grow* addresses nutritious food security through a variety of dynamic strategies. It engages families with peer-led Facebook Live videos on topics such as: purchasing the most nutritious food at local markets on a tight budget; ideas for fun and healthy kids' snacks; and how to access services like CalFresh and WIC. They run a weekly Pop-Up People's Pantry that provides donated fresh fruits and vegetables. *Project Grow* also operates the People's Fridge, Merced County's first community fridge that provides free, fresh food to all, available 24/7. The People's Fridge expanded to two more locations (Delhi and Winton) in 2021. *Project Grow* promotes sustainable models to engage the community in accessing healthy food while reducing food waste.

"Through new partnerships, we worked to establish outdoor events to promote food security (like home gardens, pantry, free-fridge) and social media collaborations. The resulting community reach and support exceeded our imagination!"

– Steve Roussos, *Project Grow*

HOUSING and HEALTH

The Alliance continued to support its members experiencing homelessness with a continuum of housing and care provided by homeless service organizations across our three counties and funded by the MCGP.

The Recuperative Care Pilot launched in 2021. This short-term housing solution is an alternative to hospital care for individuals experiencing homelessness who no longer need hospital care for an illness or injury but whose medical needs would worsen by living on the street or in a shelter. Recuperative care reduces hospital readmission rates by allowing people to heal while accessing medical treatment and other supportive services like case management and housing navigation. The pilot sets the stage for the Alliance to offer recuperative care and short-term, post-hospitalization housing as Community Supports. Our pilot partners are **Community Homeless Solutions** in Monterey County, **Housing Matters** in Santa Cruz County and **Mission Merced** in Merced County. Mission Merced completed construction of its Hope Respite Care facility, an Alliance grant-funded capital project, at the end of the year.

The Merced County Navigation Center opened in March with funding to the **County of Merced** from a MCGP capital grant to support the construction of a low-barrier navigation center. The center provides transitional housing, case management and supportive services to individuals experiencing homelessness, with capacity to serve 150 people annually. The 15,000 sq. ft. facility has 75 beds to safely house participants temporarily while they are linked to permanent supportive and affordable housing units. The pet-friendly center also has kitchen and dining facilities, laundry, classroom, and clinic and office space for service providers.

Mission Merced led a tour of the new 32-bed Hope Respite Care facility for the Social Services Department at Mercy Medical Center Merced.

Your Health Matters Outreach Program

Your Health Matters (YHM) is the Alliance's community outreach program. The program is made up of Alliance employees who volunteer their time to make a difference in the lives of our members and the communities we serve. This program informs and educates our members, communities and the public about Alliance services. In 2021, we attended in-person and virtual events throughout Merced, Monterey and Santa Cruz counties.

During the COVID-19 pandemic, the Alliance collaborated with public health and other county and local organizations across our service areas to better understand available resources and to support the coordination of services for the Alliance's most vulnerable populations. The Alliance participated in regular calls to collaborate with county leaders and local organizations to improve county health equity measures in our service area. The Alliance mobilized staff from the Your Health Matters program to provide critical outreach calls to our most vulnerable members. These calls in the member's primary language allowed members to engage in dialogue and have many of their questions answered by trained staff who are culturally in tune with their needs.

The Alliance relied on large-scale, direct member outreach efforts to provide essential information to encourage members to take a safe approach to preventing infection. When the vaccine became available, we were positioned to quickly transition from education and resource sharing, to vaccine promotion.

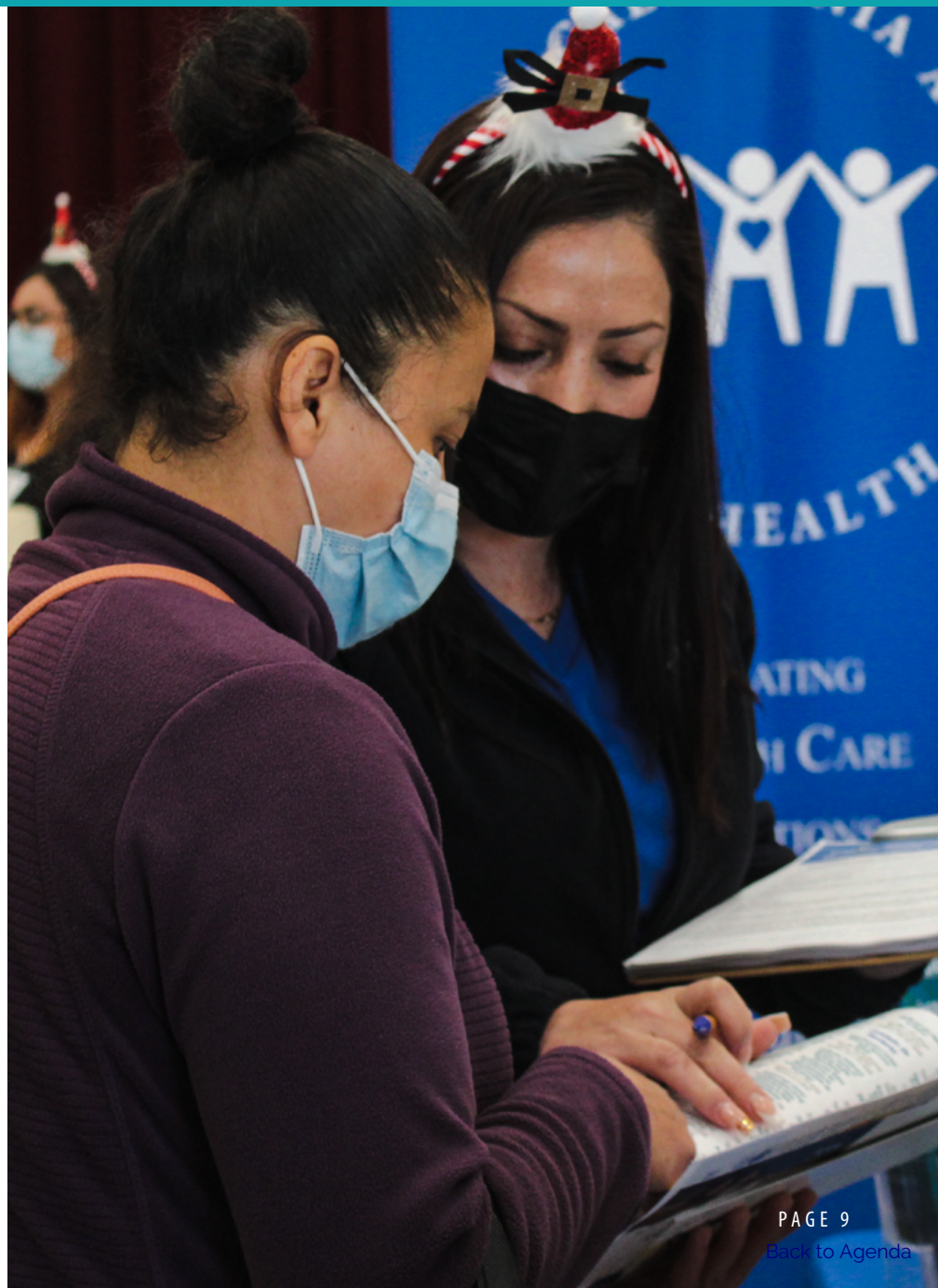
The program's ability to rapidly shift efforts as information and guidelines changed proved to be an asset during a challenging year. Staff reached over 9,500 members through the call campaigns. As social distancing restrictions lifted, the Your Health Matters team began to provide face-to-face outreach in our service areas. The Alliance attended 22 outreach events and reached 13,500 members across all outreach efforts.

Your Health Matters Outreach Program

The Alliance attended **22** outreach events.

Reached over **9,500** members through the call campaigns.

Reached **13,500** members across all outreach efforts.



COMMUNITY ENGAGEMENT | At a glance

Keeping Connected with our Community-Based Organizations

To keep our community partners connected to what's happening at the Alliance and in our communities, we launched The Beat. The Beat is our bi-monthly newsletter for community partners who share our vision of healthy people and healthy communities. Stay up to date on the activities, services and programs that positively impact the health of the communities we serve.


AEROPOSTALE
NY


CENTRAL CALIFORNIA


EXIT
BULLS

About the Alliance

Central California Alliance for Health (the Alliance) is a regional Medi-Cal managed care health plan, established in 1996 to improve access to health care for nearly 390,000 members in Santa Cruz, Monterey and Merced counties.

For more information, please visit

www.thealliance.health/for-communities

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Kathleen McCarthy, Strategic Development Director

SUBJECT: Medi-Cal Capacity Grant Program 2021 Impact Report

Recommendation. Staff recommend the Board accept this report on the Medi-Cal Capacity Grant Program's (MCGP) impact in 2021.

Summary. This report focuses on the MCGP's impact in 2021 and highlights strategic investments made to improve the health and wellbeing of the members we serve. This report also includes an update on the Alliance's progress towards the MCGP outcomes, and the attached *MCGP Performance Dashboard* includes overall MCGP and program-specific metrics as of December 31, 2021. Included in the February 2022 Board packet is the abbreviated *2021 Community Impact Report* publication, which includes highlights of the MCGP's impact, that will be shared with the community and posted on the Alliance's website.

Background. The Alliance established the MCGP in July 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act. Through investment of a portion of the Alliance's reserves, the MCGP provides grants to local organizations to support efforts to increase the availability, quality and access of health care and supportive services for Medi-Cal members in Merced, Monterey, and Santa Cruz counties.

Since 2015, the Alliance has awarded 562 grants totaling $125,247,492 to 138 organizations in the Alliance's service area under the MCGP's four focus areas: 1) Provider Capacity; 2) Behavioral Health and Substance Use Disorder Services; 3) High Utilizer Support Resources; and 4) Promoting Healthy Eating and Active Living. Over the past six and a half years, the MCGP has developed a portfolio of 12 funding opportunities designed to advance the goals in each focus area. Several funding opportunities have been retired as funding has run low and eligible applicant interest in the programs has been maximized.

The MCGP plays an important role in advancing the Alliance vision, mission and strategic priorities. It is a vehicle for the Alliance to invest in areas outside of core health plan responsibility and where other funds are not available. The MCGP also serves as an incubator for new ideas and provides a framework and funding for the Alliance to test new concepts that could be integrated into health care system in the future (e.g. Post-Discharge Meal Delivery, Recuperative Care). Through the MCGP, the Alliance has made significant investments to increase access to care and address social determinants of health throughout Merced, Monterey and Santa Cruz counties.

Discussion. In 2021, the Alliance awarded 14 grants totaling $11.1M to community organizations. This was a lower volume of awards compared to previous years due to retirement of several programs in 2020, resulting in a limited number of available funding

opportunities. Grant awards in 2021 were made under the Capital Implementation, Recuperative Care Pilot, Provider Recruitment and COVID-19 Response Fund funding opportunities. In addition to grants awarded, many projects funded in previous years reached completion in 2021 and achieved a positive impact in the community.

2021 Program Highlights.

- The COVID-19 Response Fund was created in April 2020 to address the urgent challenges facing Alliance members during the pandemic. In 2021, the Alliance awarded the remaining funds in the program's $1M budget to community organizations to meet members' needs, including funding to facilitate vaccine storage and provision of healthy food to Medi-Cal members. One grantee, Merced Lao Family Community, held three cultural food distributions between April and June 2021, providing locally-grown produce to 1,022 individuals, 90% of whom were Medi-Cal members. Merced Lao Family Community leveraged these opportunities to partner with Merced County Public Health on a COVID-19 vaccination clinic and to increase their mental health referrals.

- The Provider Recruitment Program supported the hiring of six providers in 2021. Due to limited remaining funds in 2021, awarded Provider Recruitment Program grants were focused on high need provider types. Awards were made in Merced County to hire primary care providers, including a Pediatrician, to reduce wait times for appointments. In Santa Cruz County, a grant award was made to support the recruitment of an Orthopedics and Minimally Invasive Spine Surgeon.

- In 2021, five Capital Program projects were completed and ten more were in progress. As in 2020, some Capital grants experienced delays or other challenges due to the COVID-19 pandemic, but all projects are moving forward. In December 2021, Mission Merced wrapped up construction of their new recuperative care facility, Hope Medical Respite Care, located on their new 5-acre campus called Village of Hope which will also provide transitional housing. The new facility will increase recuperative care bed capacity by 220% to 32 beds. Hope Medical Respite Care is expected to open for operations in February 2022. Additionally, the County of Merced began operations of the new Homeless Navigation Center in May 2021. In Monterey County, Soledad Community Health District's new Women's Health Clinic opened in April 2021, and Coastal Kids Home Care went live with Coastal Kids Clinic in June 2021. In Santa Cruz, Dominican Hospital welcomed patients to their new Community Wellness Center in July 2021.

- The Infrastructure Program had four projects reach completion in 2021, all of which had a positive impact on connectivity for improved service delivery in the COVID-19 environment. Projects focused on new and optimized electronic health records systems, updated technology to better communicate with members, and a collaborative system to coordinate referrals to care among provider partners. One grantee, Santa Cruz Volunteer Center's Community Connection program, was able to overcome extreme challenges posed by the pandemic and wildfires to leverage two of the project's original outcomes (rewiring infrastructure in their building and installing new computer systems) to adapt to the virtual telehealth model during the

pandemic. They already had a training plan for the staff for new computer systems and were able to leverage this for telehealth training as well. The new technology provided a safe way for clients to access critical services for managing the extreme anxiety and depression that accompanied social isolation during the pandemic.

- The Partners for Healthy Food Access Program grantees were key partners in 2021 as nutritious food distribution continued to be a pressing need during the COVID-19 pandemic. Six projects completed in 2021 and there are five other active projects that will continue in 2022 to improve food security in the Medi-Cal population. One notable project was the partnership between Healthy House and Mercy Medical Center Merced to train eight resident physicians at Family Care Center to screen Medi-Cal patients with, or at risk for, diabetes and to provide those who identify as food insecure with produce prescriptions. There were 220 individuals who redeemed their produce prescriptions at the Make Someone Happy mobile market located at the clinic and worked with on-site promotoras to receive nutrition education and enroll in CalFresh. There was a 56% decrease in patients reporting 'often/sometimes' food insecure and 72% increase in patients reporting increased knowledge of nutritional value, where to buy and how to prepare fresh produce. Additionally, Healthy House added 40 community garden beds for its collective of Hmong gardeners to help source produce for the project.

- The Recuperative Care Pilot (RCP) was launched in mid-2021. The RCP funds recuperative care (also known as medical respite) and temporary housing for Alliance Medi-Cal members who are currently homeless and recovering from an illness or injury. The RCP also includes funding for bridge housing, or temporary housing, for members who are exiting recuperative care and awaiting a more permanent housing placement. Through the RCP, the Alliance is building capacity to offer recuperative care and temporary housing as CalAIM Community Supports by partnering with organizations in each county who operate recuperative care facilities: Community Homeless Solutions' Central Coast Respite Center (CCRC) in Monterey County, Mission Merced Incorporated's (formerly known as Merced County Rescue Mission) Hope Respite Care in Merced County and Housing Matters' Santa Cruz Recuperative Care Center (RCC) operated in partnership with the Homeless Persons' Health Project (HPHP) in Santa Cruz County. As of December 31, 2021, 51 members have received recuperative care services, 33% of whom transitioned to bridge housing.

- The Technical Assistance Program had three projects complete in 2021 aimed at improving access to behavioral health services. The Diversity Center in Santa Cruz completed an organizational assessment resulting in a behavioral health services partnership with a licensed third party for its youth LGBTQ+ clients and strengthening of organizational policies, practices and data collection. Monterey County Office of Education expanded their Youth Mental Health First Aid program by providing training to 21 new instructors to teach 157 First Aiders, adults who interact frequently with youth, who in turn referred 377 youth to appropriate resources to address exhibited mental health challenges. CSU Monterey Bay improved access, coordination, and integration of services by fortifying their Master of Social Work curriculum with content on maternal mental health, strengthening the capacity of

their field sites to train students in maternal mental health diagnosis and treatment, and developing inter-professional learning opportunities for integrative maternal-infant mental health care.

Measuring Impact of the MCGP. The impact of the MCGP has been measured since 2016 using a theory of change model. The MCGP Theory of Change, attached to this report, serves as a guide for connecting and evaluating the impact of our strategies (i.e. funding opportunities) to the outcomes we seek to achieve through grantmaking and other Alliance strategies. Short-term outcomes are reported three times a year on the MCGP Performance Dashboard which highlights successes, such as number of providers recruited and various types of projects completed. Staff also monitor medium-term outcomes through key indicators to show progress toward positive change. These are influenced by both short-term outcomes of the MCGP and other internal and external factors.

Since the launch of the MCGP in 2015, access-related indicators have improved. While there has been some improvement in indicators used to measure well-coordinated care and reduction in preventable illness, this is still an area for additional focus. The pandemic significantly impacted the 2020 results for several indicators, and we anticipate the same will be true for 2021 making it more challenging to assess the impact of the Alliance's MCGP investments. Despite this challenge, it is clear that investments made through the MCGP over the last six and a half years have resulted in improved access and quality of care for Alliance Medi-Cal members. For additional detail, please find *Medium-Term Outcomes* attached to this report.

Evolving the MCGP. The MCGP has proven to be a strategic tool to advance the Alliance's vision and mission. In 2021, in alignment with the Alliance's strategic planning efforts, staff gathered insights into how the current MCGP framework and funding priorities could be evolved to increase the program's impact on member and community health, and to align with the organizational priorities adopted by the Board in the 2022-2026 Strategic Plan. Staff also assessed opportunities to fill gaps in capacity building and leverage opportunities provided by CalAIM. Staff will return to the Board in 2022 with recommendations for how to evolve the grant program to increase the impact of the Alliance's funding and advance the Alliance's vision of *Healthy People, Healthy Communities*.

Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments.

1. Medi-Cal Capacity Grant Program Theory of Change and Medium-Term Outcomes
2. Medi-Cal Capacity Grant Program Performance Dashboard

MCGP THEORY OF CHANGE

Focus Areas

- Provider Capacity
- Behavioral Health/ Substance Use Disorder Services
- High Utilizer Support Resources
- Healthy Eating & Active Living

Short-Term Outcomes

- Increased number of providers
- Increased number of health access points
- Increased adoption of PCMH practices
- Expanded provider capacity to serve members with unique needs
- Increased integration of services
- Engaged members who self-manage health
- Increased food security
- Increased awareness of benefits of healthy eating and physical activity

Medium-Term Outcomes

- Timely access to health care services
- Members receive enhanced access to a care team
- Greater number of patient-centered health care options
- Members receive well-coordinated services
- Reduction in preventable illness
- Members increase consumption of nutritious food

Long-Term Outcomes

- Improved health outcomes
- Full integration and coordination of health care system
- Improved quality, efficiency, and patient and provider experience
- Reduction in health system costs

Impact

Accessible, quality health care guided by local innovation.

MCGP Medium-Term Outcomes

Medium-Term Indicators	2015	2016	2017	2018	2019	2020	2021	Progress
Avoidable emergency department visits.	19.10%	17.92%	17.86%	16.19%	15.45%	11.00%**	Data not yet available	
Availability of a third next available appointment within 10 business days for primary care.	40%	45%	32%	55%	11%*	33%**	Data not collected	
Availability of a third next available appointment within 15 business days for specialty care providers.	38%	47%	45%	48%	19%*	9%**	Data not collected	
Percentage of members (adults) that indicate they are usually or always able to get care quickly.	75.00%	No Survey Conducted	76.70%	73.70%	76.30%	80.30%	84.5%	
Percentage of members (child) that indicate they are usually or always able to get care quickly.	76.40%	No Survey Conducted	81.60%	82.4%	80.90%	86.80%	83.1%	
Percentage of 30-day readmissions.	13.96%	14.50%	13.49%	14.56%	14.53%	14.6%**	Data not yet available	
Percentage of ambulatory care sensitive admissions.	11.05%	11.17%	10.09%	8.89%	11.21%	6.79%**		
Behavioral health utilization rate (mild to moderate).	3.11%	3.70%	4.37%	4.71%	5.43%	5.35%		
Provider satisfaction with number of specialists in the Alliance's network.	28.4%	36.4%	36.90%	37.70%	41.80%	41.8%	41.1%	

*2019 data showed a marked decline in contrast to other health plan measurements of access to care, all of which improved in 2019 compared to previous years.

**2020 data significantly impacted by COVID-19 pandemic.

Back to Agenda

Medi-Cal Capacity Grant Program

PERFORMANCE DASHBOARD

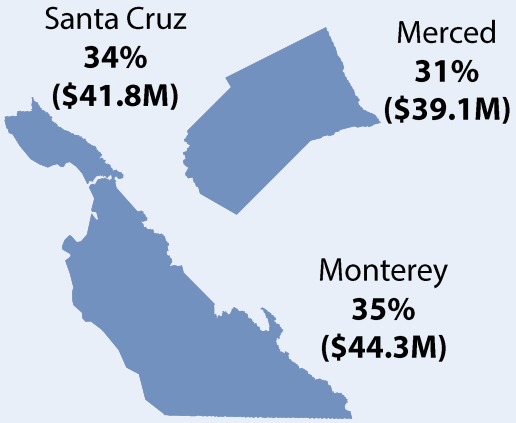
October 2015 through December 2021

About MCGP

The Alliance established the Medi-Cal Capacity Grant Program (MCGP) in July 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act (ACA). We offer grants to local organizations to support efforts to increase the availability, quality and access to health care and supportive services for Medi-Cal members in Merced, Monterey, and Santa Cruz counties. Grants are awarded to address the goals of the four focus areas: (1) Increasing Provider Capacity; (2) Expanding Access to Behavioral Health and Substance Use Disorder Services (BH/SUD); (3) Developing and Strengthening High Utilizer Support Resources; and (4) Promoting Healthy Eating and Active Living (HEAL).

Total Awarded:

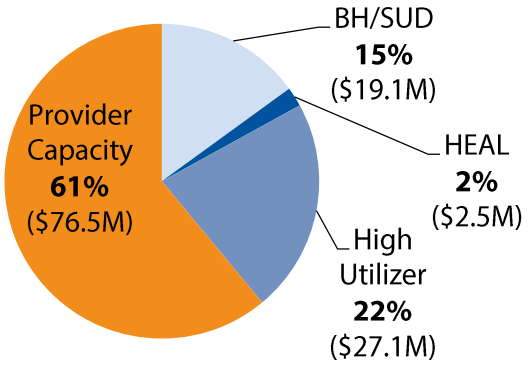
$125.2M



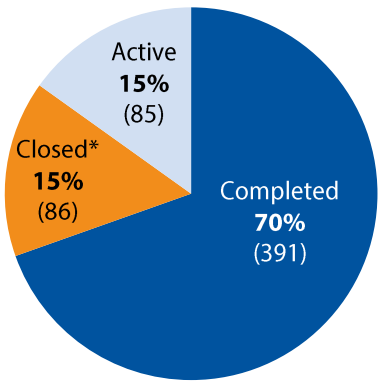
Number of Organizations Awarded:

138

Awards by Focus Area

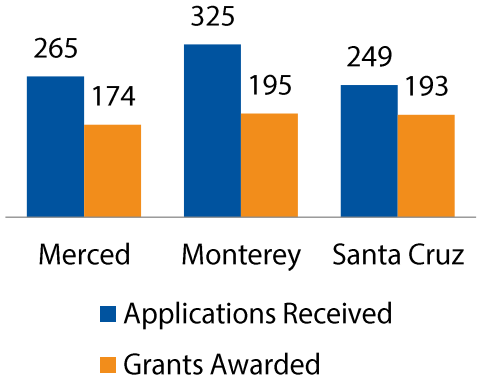


Award Status



* Withdrawn by grantee/terminated.

Total Grants Awarded: 562



Provider Recruitment Program

275 grants totaling $33.3M awarded to subsidize recruitment expenses for new health care professionals to serve the Medi-Cal population.

194 new providers hired to date.

79% retention of new recruits.

22 recruited primary care physicians specialize in Pediatrics.

38% increase in primary care sites open to accepting new members.

	Merced		Monterey		Santa Cruz		Total	% of Total
Type Recruited	Physician	Non-Physician	Physician	Non-Physician	Physician	Non-Physician		
Primary Care	25	19	19	18	12	6	99	51%
Specialty Care	5	4	25	2	12	2	50	25%
Allied		8				3	11	6%
Behavioral Health	1	1	3		8	8	21	11%
Dental	3				4		7	4%
Other				3		3	6	3%
Total Recruited	34	32	47	23	35	23	194	100%
	34% of total		36% of total		30% of total			

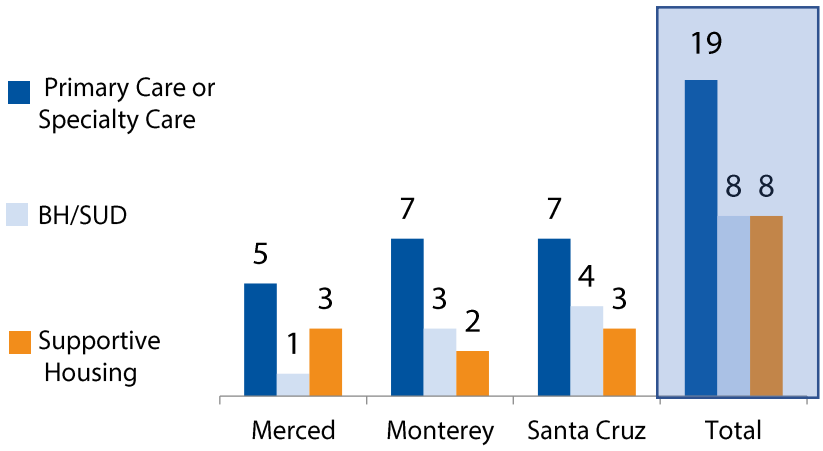
Specialties Recruited

Capital Program

57 grants* totaling $70.8M awarded for the expansion, construction, renovation, and/or acquisition of health care facilities that will serve the Medi-Cal population in the Alliance service area. Capital grants are also available for projects that expand access to Medi-Cal services through transitional or permanent supportive housing for the Alliance's most medically fragile Medi-Cal members.

* Applicants may apply for both planning and implementation grants for one project.

35 Capital Projects



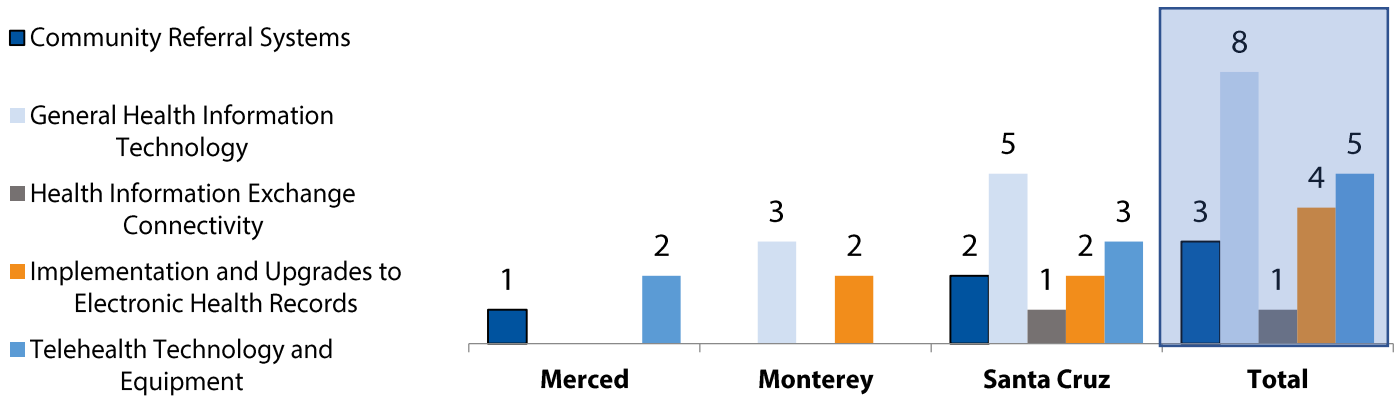
163K Medi-Cal members anticipated to be served by new and expanded facilities.

Infrastructure Program

29 grants* totaling $3.8M awarded for information technology systems that expand Medi-Cal capacity in the Alliance service area.

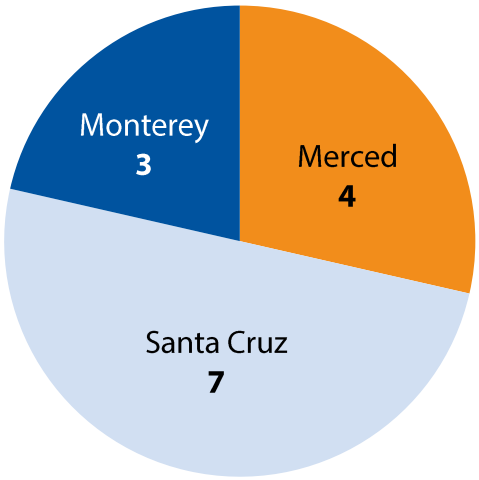
* Applicants may apply for both planning and implementation grants for one project.

21 Infrastructure Projects



Partners for Healthy Food Access Program

15 grants totaling $1.8M awarded to support a variety of innovative partnerships between health care providers, community-based organizations and/or government agencies to improve food security in the Medi-Cal population.



Total Number of Projects: 14

Food Access Projects Focus On:

Food Insecurity Screening
Healthy Food Distribution

- Food Bank Access Point
- Mobile Market/Farmstand
- Produce Box Home Delivery

Referrals to Supportive Services

- Cal-Fresh Enrollment

Knowledge & Skill Building

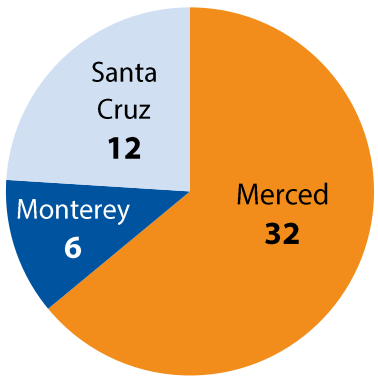
- Nutrition/Health Classes
- Community Gardening
- Cooking Classes

Recuperative Care Pilot

3 grants totaling $3.6M awarded to community-based organizations to support 30-60 day recuperative care stays for Medi-Cal members who are currently homeless and recovering from an illness or injury. This short-term housing solution is an alternative to hospital care for individuals experiencing homelessness who no longer need hospital care, but have medical needs that would worsen if living on the street or in a shelter. **1 grant totaling $26.6K** to support bridge housing renovations in Monterey County.

Funding also supports **temporary bridge housing** for members who are exiting recuperative care temporary housing while awaiting a more permanent housing placement.

Total Number of Recuperative Care Beds: 50



Workforce Development Investments

2 grants totaling $911K awarded to support the development of new educational programs for licensed health care professionals that will serve the Medi-Cal population.

- **29** Physician Assistant graduates to date (starting 2020).
- Master of Science - Physician Assistant Program, CSU Monterey Bay.
- Serves Monterey and Santa Cruz counties.

- **55** Family Nurse Practitioner graduates to date (starting 2019).
- Master of Nursing - Family Nurse Practitioner Program, CSU Stanislaus.
- Serves Merced County.

Retired Programs

Equipment Program: 103 grants totaling $1.7M awarded to subsidize equipment purchases that expand health care provider's capacity to serve the Medi-Cal population in the Alliance service area and impact direct patient care. Program was retired as of October 2017.

Practice Coaching Program: 23 grants totaling $619K awarded to practices for consultant engagements to adopt the Patient Centered Medical Home (PCMH) model of care. Program was retired as of October 2017.

Intensive Case Management Program: 11 grants totaling $4.9M awarded to high-volume primary care practices to add staff to provide intensive case management services for medically complex Medi-Cal patients within the patient centered medical home. Three-year pilot launched 01/01/18 and was retired on 12/31/20.

Post-Discharge Meal Delivery Pilot: 3 grants totaling $651K awarded to fund the delivery of 12 weeks of ready-made, nutritious meals to Medi-Cal members recovering from an inpatient hospital stay. Two-year pilot launched 11/01/18. The Alliance Board approved the transition of the successful pilot to an Alliance-only Medi-Cal benefit, effective 01/01/21.

COVID-19 Response Fund: 27 grants totaling $1M awarded to community-based organizations to meet the basic health-related needs of Medi-Cal members impacted by COVID-19, such as food, hygiene and sanitation supplies. Program was retired as of April 2021.

Technical Assistance Program13 grants totaling $470K awarded to provide support for training or consulting engagements that directly result in increased access, coordination of care and integration of services. Program was retired as of April 2020.

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Business Continuity and Disaster Recovery Program 2021 Annual Report

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Recommendation. Staff recommend the Board accept the Business Continuity and Disaster Recovery Program (BC&DRP) 2021 annual report.

Background. The purpose of the program is to manage emergency incidents having a potential impact to services which may put the organization at risk. When an incident occurs, the Emergency Management Team (EMT) convenes to engage, assess, and manage the incident to the best of their abilities. The BC&DRP is designed to ensure ongoing operations and recovery of critical functions, minimize loss, maintain compliance with regulatory and contractual requirements and to support employee safety.

Summary of 2021 Activities

COVID-19 Pandemic. As the pandemic continued throughout 2021, Alliance staff worked from home as a safety precaution, with critical functions being completed onsite as needed. While our offices were closed, staff maintained a presence in the community by attending outreach events, business meetings and community events as needed and when safe to do so. Throughout the pandemic, we continued to stay apprised of the virus and its impact to operations. Alliance offices reopened on February 1, 2022 for onsite member support and onsite meetings.

Ongoing Alliance measures implemented in response to the pandemic included:

- Daily performance metrics and surveys to assess and respond to any impacts to business operations.
- Assessment of critical functions and developed process modifications where needed.
- Online resources for staff, members, and providers with COVID-19 resources.
- Resources to online tools for staff to stay engaged and connected while working remotely.

Service Disruptions. On July 6, 2021, the Scotts Valley office experienced a temporary service disruption causing impact to the telephone system. Staff within Information Technology departments worked with our service provider to resolve issue within two hours.

Another service disruption was experienced at our Merced office location on September 8, 2021. The incident impacted employees on virtual computers and was resolved within two hours.

Alliance measures implemented in response to the outages:

- Review incidents, document steps taken and outcomes, and update plans where/when needed.
- Train staff on changes to ongoing BC&DRP procedures following the events.

Wildfires and Power Outages. On January 18, Santa Cruz County experienced a high wind advisory resulting in minor wildfires impacting 247 acres. The EMT convened and assessed impacts to services and staff. The Scotts Valley office was unimpacted, yet 45 employees experienced a short-term loss of electrical power. Utilization Management immediately implemented emergency protocols for prior authorizations that focused on high risk members. The incident ended without significant impact to operations or staff.

Alliance measures implemented in response to the wildfires and power outages:

- Outreach to high risk members, ensuring access to providers and medications.
- Engaged county for local emergency response.
- Ensured providers were paid timely.

Emergency Management Team Meetings and Exercises Conducted:

- Emergency Management Team meetings were held quarterly in 2021
- "Lessons Learned" exercises were conducted for the purposes of updating existing BC&DRP policies and procedures with regard to documenting responses to events in 2021.

Focus Areas for 2022:

- The EMT will assess program maturity and alignment with the Business Continuity Management System ISO 22301 standard.
- The Technology Team will continue to work toward updating the organization's critical systems redundancy plan.

Fiscal Impact. There is no fiscal impact associated with this report.

Attachments. N/A

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Alliance Owned Properties 2021 Annual Report

Recommendation. There is no recommended action associated with this agenda item.

Background. In 2004, the Board approved the purchase of an office space for Alliance operations in Santa Cruz County. The basis for the Board's decision at that time included the investment opportunity of an appreciable asset, the reliability of fixed office space costs, the retention of the investments made on leasehold improvements, the receipt of steady income from tenants and the opportunity for the Alliance to expand as needed. Since that time, the Board has approved additional office building purchases in Monterey and Merced Counties, as well as the 2016 purchase of Capitola Manor, a skilled nursing facility in Santa Cruz County. At the June 2018 Board meeting, Commissioners ratified the Chief Executive Officer's (CEO) authority to execute, acknowledge and deliver on behalf of the Commission any and all leases and related documents for the lease of real property owned by the Alliance to tenants.

Summary of Property Holdings and Status. The CEO signed six new agreements in 2021 to lease office space at 1800 Green Hills Road, five being new tenants and one being an existing tenant leasing additional office space. All but one of the new agreements are for multiple years. Sixty-three percent of the available office space in the 1800 building was leased as of December 2021, which is an increase of 22% over last year. In addition, one tenant of 950 E. Blanco Road vacated the building, leaving 25% of the available office space which is now currently listed on market.

The Alliance currently owns five buildings with a total of 280,859 square feet of office space of which nearly 70% is occupied by the Alliance. The remaining 30% of office space is currently leased or available on market. Current tenants range from short-term leases of 2-3 years to long-term leases through the year 2028.

Santa Cruz County

Scotts Valley

- 1600 Green Hills Road: 100% Occupied by the Alliance
- 1700 Green Hills Road: 100% Occupied by the Alliance
- 1800 Green Hills Road: 63% Leased to Tenants, 37% Vacant

Capitola

- 1098 38th Avenue (Capitola Manor): The remodel project for Capitola Manor, the Alliance owned skilled nursing facility located in Capitola, CA, has been cancelled due to higher than anticipated costs for materials and construction. Work ceased on the project in December 2021. Staff are currently engaged in efforts to sell the property.

Monterey County

- 950 East Blanco Road, Salinas: 75% Occupied
  - 56% Occupied by the Alliance
  - 19% Leased to Tenants
  - 25% Vacant

Merced County

- 530 West 16th Street, Merced: 100% Occupied
  - 91% Occupied by the Alliance
  - 9% Leased to Tenant

Fiscal Performance and Impact.

2021 Financial Performance:

- Annual Gross Rental Income: $1,071,093.23
- Annual Rental Expenses: $ 509,438.33
- Annual Net Revenue: $ 561,654.90

Attachments. N/A

Santa Cruz – Monterey – Merged Managed Medical Care Commission

Meeting Agenda (Draft)

Date: Wednesday, April 27, 2022

Time:

Call to Order:	11:00 a.m.
Catered Lunch:	12:00 – 1:00 p.m.
Adjourn:	3:00 p.m.

Location: Los Banos Community Center
645 7th Street
Los Banos, CA 93635

1. **Welcome and Call to Order by Chairperson**
   A. Roll call; establish quorum.
   B. Oral communications and announcements.

2. *Annual Election of Officers*

3. *Network: What is the MCP Network of Today and of the Future*

4. *Equity and Quality*

5. *Medi-Cal Capacity Grant Program*

6. **Adjourn**

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: FY 2022-23 State Budget Proposal

Recommendation. There is no recommended action associated with this agenda item.

Background. On January 10, 2022, Governor Newsom released his proposed budget for the upcoming state fiscal year 2022-23. Due to higher than expected California State revenue for the second year in a row, the Governor has proposed emergency investments in order to respond to the public health effects of COVID-19 as well as to support one-time and ongoing investments in healthcare and other services impacting Californians.

A snapshot of the overall 22-23 state budget includes:

- Total Funds (TF): $286.5B; General Fund (GF) $213.1B
- Budget Surplus: $45.7B of which $20.6B is discretionary spending
- Budget Reserves: $34.6 billion in budgetary reserves
- Medi-Cal Budget: $132.7B TF; $34.9B GF

Discussion. Highlights of some of the significant Medi-Cal budget items include:

- Medi-Cal Eligibility Expansion: Expansion of Medi-Cal eligibility to all income eligible Californians (adding those ages 26 to 49) regardless of immigration status, effective 1/1/24
- CalAIM: Ongoing funding for CalAIM, specifically $2.8B TF; $982.6M GF in FY 22-23 and $2.4B TF; $876.4M GF
- Proposition 56: $176M in ongoing permanent funding for services currently funded through Prop 56 funds
- Children and Youth Behavioral Health Initiatives (CYBHI).
    - $87M TF; $41M GF to implement Dyadic Services effective 1/1/23
    - $429M GF for evidenced-based behavioral health practices
    - $450M GF for school based behavioral health partnerships and capacity.
    - $230M GF for the Behavioral Health Services and Supports Platform and related e-Consult service and provider training.
- Eligibility Redetermination: $73M TF; $37M GF in both FYs 2021-22 and 2022-23 to support increased county workload to redetermine eligibility for individuals that remained enrolled in Medi-Cal due to the continuous coverage requirement during the COVID-19 Public Health Emergency.

- Equity and Practice Transformation Payment: $400M to support practice transformation to promote Patient Centered Medical Home models of care in pediatric, primary care, obstetrics and gynecology, and behavioral health settings and to align with the goals of the Medi-Cal Comprehensive Quality and Equity Strategy.

The attached chart includes additional detail on these and other significant health related proposals which staff will monitor.

Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments.

1. State Budget 2022-23: Medi-Cal Budget Proposals
2. CalAIM Initiatives Launch Timeline as of November 2021
3. CalAIM Milestones Calendar as of November 2021

State Budget 2022-23: Medi-Cal Budget Proposals

Budget Item	Description	Proposed Funding	Comments
Medi-Cal Eligibility			
Medi-Cal Eligibility Expansion	Expand full-scope Medi-Cal coverage to all income-eligible adults aged 26 through 49 regardless of immigration status effective no sooner than Jan 1, 2024.	$819 million ($614 million GF) in FY 23-24; and $2.3 billion ($1.8 billion GF) in future year	Trailer Bill language pending
Eligibility Determination	Support increased county workload to redetermine eligibility for individuals that remained enrolled in Medi-Cal due to the continuous coverage requirement during the COVID-19 PHE.	$73 million ($37 million General Fund) in both FYs 2021-22 and 2022-23	Trailer Bill language pending
CalAIM			
CalAIM Implementation*	Provide ongoing funding for CalAIM implementation as previously allocated.	$2.8 billion ($982.6 million GF) in FY 22-23; $2.4 billion ($876.4 million GF) in FY 23-24	Trailer Bill language pending
PATH Funding*	Provide funding in addition to what previously proposed to support capacity building, technical assistance, collaboration and planning by county and correction entities.	$50 million ($16 million General Fund) in FY 2022-23	Trailer Bill language pending
Behavioral Health			
CYBHI	Provide ongoing funding to implement CYBHI, specifically: 1) Dyadic Services effective January 1, 2023. 2) Evidence-based behavioral health practices. 3) School behavioral health partnerships and capacity. 4) Behavioral Health Services and Supports Platform and related e-Consult service and provider training.	1) $87 million ($41 million General Fund) 2) $429 million General Fund 3) $450 million General Fund 4) $230 million General Fund	
Mobile Crisis Services	Add qualifying 24/7 community-based mobile crisis intervention services as a mandatory Medi-Cal benefit as soon as January 1, 2023. The benefit will be implemented through county behavioral health delivery systems by multidisciplinary mobile crisis teams in the community.	$108 million ($16 million General Fund)	
Behavioral Health Bridge Housing	Purchase and install tiny homes, as well as providing time-limited operational supports in various bridge housing settings. The funding will address the immediate housing and treatment needs of people experiencing unsheltered homelessness with serious behavioral health conditions.	$1.5 billion General Fund ($1 billion in FY 2022-23 and $500 million in FY 2023-24)	

Budget Item	Description	Proposed Funding	Comments
Aging Population			
Cognitive Health Assessment	Add annual cognitive health assessment as a Medi-Cal benefit for beneficiaries who are 65 years of age or older, if they are ineligible for such service under Medicare, effective July 1, 2022.	$341,000 ($171,000 General Fund)	
Alzheimer's Healthy Brain Initiative	Support current grants and establish new grants in six additional local health jurisdictions.	$10 million one-time General Fund	
Master Plan for Aging	Support implementation of the Master Plan for Aging's Data Dashboard to drive outcomes and sustain public engagement for statewide initiatives through the Department of Aging.	$2.1 million ($1.8 million General Fund)	
Other Proposals or Budget Items			
Equity & Practice Transformation Payments	These payments will support practice transformation and promote patient-centered models of care in pediatric, primary care, obstetrics and gynecology, and behavioral health settings and to align with the goals of the Medi-Cal Comprehensive Quality and Equity Strategy.	One-time $400 million ($200 General Fund)	
Prop 56 Incentive Payment	Propose to continue incentive payments for current Prop 56 supplemental payment services.	$176 million GF in FY 22-23;	

Budget Item	Description	Proposed Funding	Comments
Health Care Workforce - Community Health Worker	Fund to recruit, train, and certify 25,000 new community health workers by 2025, with specialty certifications in areas that include climate health, homelessness, and dementia.	$350 million GF	
Health Care Workforce - Psychiatric Resident Program	Create training positions for psychiatric residents, psychiatric mental health nurse practitioners, psychology interns/fellows, and psychiatric nurses.	$120 million GF	
Home and Community-Based Alternatives (HCBA) Waiver	Implement HCBA Waiver, including: 1) Expand the Community Transition Service 2) Add Assistive Technology and Paramedical Services 3) Add Pediatric Day Health Centers (PDHCs) licensed to operate a Transitional Health Care Needs Optional Service Unit 4) Increase the rate paid to Personal Care Agencies	$304 million ($152 million General Fund) in FY 2022-23	
Elimination of Certain AB 97 Provider Rate Reductions	Proposes to eliminate the AB 97 provider rate reductions for eight provider types based on COVID-19 Pandemic impacts, including: 1) Nurses of all types 2) Alternative birthing centers 3) Audiologists and hearing aid dispensers 4) Respiratory care providers 5) Durable medical equipment providers 6) Chronic dialysis clinics 7) Non-emergency medical transportation providers 8) Emergency medical air transportation providers	$20.2 million ($9 million General Fund) in 2022-23 and $24 million ($10.7 million General Fund) annually thereafter	

CalAIM Initiatives Launch Timeline as of November 2021

This is a "living" document that reflects the CalAIM team's expected timing of launches. In some instances, program launch dates are contingent upon timely CMS approval. Because these dates may shift, the document will be updated regularly to reflect any changes.

CONTEXT:

California Advancing and Innovating Medi-Cal, or CalAIM, is a transformational plan to modernize the State's Medicaid program. It will improve the quality of life and health outcomes of Medi-Cal enrollees, including those with the most complex health and social needs. CalAIM includes a series of far-reaching initiatives that together represent broad reforms of Medi-Cal's programs and systems. Department of Health Care Services (DHCS) will implement it in partnership with Medi-Cal providers, Managed Care Plans (MCPs), Counties, Community-Based Organizations and other stakeholders. These changes will span a multi-year period, with the first reforms coming in January 2022 and additional reforms phased in through 2027.[1]

This CalAIM Initiatives Launch Timeline is a "living" document that reflects DHCS' expected timing of initiative launches across the implementation period. In some instances, program launch dates are contingent upon timely Centers for Medicare and Medicaid Services (CMS) approval. Because these dates may shift as policies are finalized, the document will be updated regularly to reflect any changes. Stakeholders are encouraged to check the DHCS CalAIM website for updates to ensure access to the most up-to-date information.

ORIENTATION:

This document is organized in three sections:

- A high-level summary timeline of initiative go-live dates
- A more detailed matrix of initiative go-live dates
- Brief descriptions of each initiative organized by broader categories of impact.

[1] See the DHCS CalAIM Webpage for additional details.

CalAIM Initiatives Launch Timeline as of November 2021

This is a "living" document that reflects the CalAIM team's expected timing of launches. In some instances, program launch dates are contingent upon timely CMS approval. Because these dates may shift, the document will be updated regularly to reflect any changes.

CalAIM Initiatives Launch Timeline – Summary of Go-Live Dates

CalAIM Initiatives -- Go-Live Dates (pending readiness and federal approvals)							*Updated: November 2021*	
Initiative	**1/22**	**7/22**	**1/23**	**7/23**	**1/24**	**1/25**	**1/26**	**2027**
Administrative Integration of SMH and SUD	Starts							Fully Integrated
Benefits Standardization	Transplant In/MSSP out		LTC					
Dental (new benefits and P4P)	X							
Enhanced Care Management (ECM)/Community Supports (ILOS)[1]	X	X	X	X				
Incentive Payments	X		X		X			
Mandatory Managed Care Enrollment	Non-Duals		Duals					
PATH Funds (ECM, Community Supports, Justice-Involved)	X							
Regional Capitation Rates and Shared Savings/Risk	X		X		X	X	X	
Specialty Mental Health Services - Criteria for Services	X							
DMC-ODS Renewal and Policy Improvements	X							
Behavioral Health No Wrong Door		X						
Contingency Management		X						
SMI/SED IMD Waiver		Earliest to CMS		X				
Population Health Management (including Service)			X					
Behavioral Health Standard Screening and Transition Tools			X					
Behavioral Health Documentation Redesign			X					
Improving Beneficiary Contact and Demographic Information			X					
County Eligibility and Oversight			X					
Transition to Statewide LTSS and D-SNP (CCI ends)			CCI Counties				Non-CCI Counties	Statewide MLTSS
Justice-Involved Package			X					
Behavioral Health Payment Reform				X				
County CCS Oversight				X				
NCQA Accreditation							X	
Full Integration Plans								X
Foster Care Model of Care (TBD)								
DMC-ODS Traditional Healers and Natural Helpers (TBD)								
Behavioral Health Regional Contracting (TBD)								

CalAIM Initiatives Launch Timeline as of November 2021

This is a "living" document that reflects the CalAIM team's expected timing of launches. In some instances, program launch dates are contingent upon timely CMS approval. Because these dates may shift, the document will be updated regularly to reflect any changes.

CalAIM Initiatives Launch Timeline – Details of Go-Live Dates

Go-Live Date	Initiative[2]	Go-Live
January 2022[3]	**Enhanced Care Management (ECM)**	Enhanced care management (ECM) services become available for select Populations of Focus in Whole Person Care (WPC) Pilot and Health Home Program (HHP) counties, including for Individuals & Families Experiencing Homelessness; High Utilizer Adults; Adults with Severe Mental Illness or Substance Use Disorder (SMI/SUD); and Adults & Children/Youth Transitioning from Incarceration in WPC Pilot counties only, where the services provided in the Pilot are consistent with those described in the ECM Contract.
	Community Supports (ILOS)[4]	MCPs begin to offer preapproved Community Supports (also known as "In Lieu of Services" or "ILOS") to members.
	Incentive Payments	Program Year 1 begins on January 1, 2022 and the first round of performance incentive payments are expected to be issued to MCPs no sooner than February 2022.
	Benefits Standardization	All major organ transplants will be covered by MCPs statewide. The Multipurpose Senior Services Program (MSSP) will no longer be covered by MCPs in certain counties.[5]
	Mandatory Managed Care Enrollment	Certain members will be required to enroll into managed care. Other members will be required to move from managed care into fee-for service.[6]
	Regional Capitation Rates and Shared Savings/Risk	Transition from county-based rates to regional rates in targeted groups of counties ("Phase 1 counties").

[2] Includes CalAIM Proposal initiatives and key related initiatives.
[3] In some instances, January 2022 go-live dates are dependent upon CMS approval of Section 1115 & 1915(b) waivers in December 2021.
[4] DHCS is transitioning to the name Community Supports to refer to CalAIM ILOS.
[5] Only in Coordinated Care Initiative (CCI) counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara.
[6] See CalAIM Proposal Appendix F.

CalAIM Initiatives Launch Timeline as of November 2021

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Go-Live Date	Initiative[2]	Go-Live
	Specialty Mental Health Services – Criteria for Services	Updated and clarified criteria for Specialty Mental Health Services (SMHS) for both adults and children are implemented.
	Dental (new benefits and P4P)	New dental benefits become available (including a caries risk assessment bundle for young children and Silver Diamine Fluoride for children and certain high-risk and/or institutional populations) and pay-for-performance initiatives to reward preventive services and continuity of care implemented statewide.
	Providing Access and Transforming Health (PATH) Funds (ECM, Community Supports, Justice-Involved)	First PATH payments issued for the WPC Services and Transition to Managed Care Mitigation Initiative.
	Drug Medi-Cal Organized Delivery System (DMC-ODS) Renewal and Policy Improvements	DMC-ODS added to the state plan, delivery system authorized by the Section 1915(b) waiver (subject to CMS approval), and certain DMC-ODS policies clarified or changed. These will include: updates to DMC-ODS services (i.e., revisions to the definition of residential treatment; expansion of types of clinicians who can provide and claim for Clinician Consultation Services (formerly Physician Consultation Services); new DMC-ODS criteria (per AB 133); and information and clarification regarding requirements for DMC-ODS services.
July 2022	**Enhanced Care Management (ECM)**	ECM services become available for select Populations of Focus in counties with neither WPC Pilot nor HHPs, including for Individuals & Families Experiencing Homelessness; High Utilizer Adults; and Adults with SMI/SUD.
	Behavioral Health No Wrong Door	Updated documentation requirement guidance for SMHS and SUD services published, no wrong door policy and co-occurring treatment policy go live.
	Behavioral Health Documentation Redesign	Revised, simplified, and streamlined mental health documentation requirements implemented to align with medical provider requirements, improve efficiency and decrease provider burnout.

CalAIM Initiatives Launch Timeline as of November 2021

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Go-Live Date	Initiative[2]	Go-Live
	Contingency Management	Launch of contingency management pilot in select DMC-ODS counties that will run until March 2024.
January 2023	**Population Health Management (including Service)**	Launch of Population Health Management (PHM) Program, which is a cohesive approach for keeping members healthy, improving outcomes, and reducing disparities across the continuum of care. The PHM Service will launch at the same time to support the Program.
	Enhanced Care Management (ECM)	ECM services become available for select Populations of Focus in all counties, including for Individuals Transitioning from Incarceration (adults and children/youth); Members Eligible for long-term care (LTC) and at risk of Institutionalization; and Nursing Home Residents Transitioning to the Community.
	Incentive Payments	Program Year 2 begins on January 1, 2023.
	Benefits Standardization	LTC services will be provided by all MCPs statewide.
	Mandatory Managed Care Enrollment	All full dual individuals, except share of cost or restricted scope, and all dual and non-dual individuals receiving LTC services moved into Medicaid managed care.[7]
	Regional Managed Care Capitation Rates and Shared Savings/Risk	Earliest implementation of shared savings/risk via a Seniors and Persons with Disabilities (SPD)/LTC blended rate and retrospective financial savings/risk calculation.
	Transition to Statewide LTSS and D-SNP (CCI ends)	Medi-Cal MCPs operating in Coordinated Care Initiative (CCI) counties will be required to operate Medicare Dual Eligible Special Needs Plans (D-SNPs). Cal MediConnect (CMC) demonstration program transitions to exclusively aligned enrollment D-SNPs.

[7] See CalAIM Proposal Appendix F.

CalAIM Initiatives Launch Timeline as of November 2021

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Go-Live Date	Initiative[2]	Go-Live
	Behavioral Health Standard Screening and Transition Tools	Standardized screening and transition of care tools implemented.
	County Eligibility and Oversight	DHCS begins monitoring counties' performance against eligibility performance standards.
	Improving Beneficiary Contact and Demographic Information	DHCS issues plan of action to improve the accuracy and flexibility of updating beneficiary contact and demographic information in eligibility and enrollment systems/databases.
	Justice-Involved Package: Pre-Release Medi-Cal Application Process in County Jails	County jails and youth correctional facilities implement pre-release Medi-Cal application process to ensure that incarcerated individuals who are eligible for Medi-Cal and need ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. This process is already implemented in state prisons.
	Justice-Involved Package: Behavioral Health Referrals for County Facilities	County jails and youth correctional facilities implement process for facilitated referral and linkage from county jail release to health plans (MCPs, County mental health plans, DMC-ODS counties) and providers (non-specialty mental health, SHMS, and SUD), in cases where the incarcerated individual was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.
	Justice-Involved Package: Medi-Cal Coverage in State Prisons, County Jails and Youth Correctional Facilities in the Facilities 90 Days Prior to Release	Select Medi-Cal-eligible individuals become eligible for Medi-Cal coverage 90-days prior to their release from county jails, state prisons and youth correctional facilities, and eligible to receive limited Medi-Cal services during the 90-day pre-release period. Individuals will have a re-entry plan including referrals to ECM, Community Supports, clinical supports and behavioral health linkages.

CalAIM Initiatives Launch Timeline as of November 2021

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Go-Live Date	Initiative[2]	Go-Live
July 2023	**Enhanced Care Management (ECM)**	ECM services become available for additional children and youth Populations of Focus.
	Benefits Standardization	SMHS fully carved out to County mental health plans (MHPs).
	SMI/SED IMD Waiver	DHCS will receive federal matching funds for services provided to Medi-Cal beneficiaries in institutions for mental disease (IMDs); additional federal funding will provide opportunities to improve service delivery and outcomes across the behavioral health continuum of care.
	Behavioral Health Payment Reform	Specialty mental health and SUD services transition from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, Current Procedural Terminology (CPT). Counties transition from cost-based reimbursement funded via Certified Public Expenditure (CPE) methodologies to fee-for-service reimbursement funded via Intergovernmental Transfers (IGTs).
	County CCS Oversight	New monitoring and oversight approach implemented following the execution of DHCS/county Memorandum of Understanding.
January 2024	**Incentive Payments**	Program Year 3 begins on January 1, 2024 and ends on June 30, 2024.
	Regional Managed Care Capitation Rates and Shared Savings/Risk	Earliest transition from county-based rates to regional rates statewide ("Phase 2 counties"). Continued implementation of shared savings/risk via SPD/LTC blended rate and retrospective financial savings/risk calculation.

CalAIM Initiatives Launch Timeline as of November 2021

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Go-Live Date	Initiative[2]	Go-Live
January 2025	**Regional Managed Care Capitation Rates and Shared Savings/Risk**	Continued implementation of regional rates statewide and shared savings/risk via SPD/LTC blended rate and retrospective financial savings/risk calculation.
January 2026	**Regional Managed Care Capitation Rates and Shared Savings/Risk**	Earliest implementation of shared savings/risk through a prospective rate methodology.
	Transition to Statewide LTSS and D-SNP (CCI ends)	All Medi-Cal MCPs required to establish D-SNPs unless determined otherwise by 2022 D-SNP Feasibility Study.
	NCQA Accreditation	All MCPs and their health plan subcontractors must have National Committee for Quality Assurance (NCQA) Health Plan Accreditation and NCQA Health Equity Accreditation.
January 2027 or Beyond	**Full Integration Plans**	Full integration of physical health, behavioral health, and oral health in one MCP, meaning beneficiaries would obtain services from one plan and DHCS would have all services consolidated under a single contract.
	Transition to Statewide LTSS and D-SNP (CCI ends)	Managed long-term services and supports (MLTSS) implemented statewide in Medi-Cal managed care.

CalAIM Initiatives Launch Timeline as of November 2021

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Go-Live Date	Initiative[2]	Go-Live
	Administrative Integration of SMH and SUD	Administration of specialty mental health and SUD services fully integrated into one behavioral health managed care program. This initiative is a multi-year effort that begins with the implementation of other CalAIM behavioral health policies, starting in 2022, including Criteria for SMHS, the DMC-ODS Policy Improvements and Behavioral Health Payment Reform initiatives.
TBD	**Foster Care Model of Care**	DHCS and California Department of Social Services develop a long-term plan of action for children and youth in foster care, which may involve budget recommendations, waiver amendments, state plan changes, or other activities.
	Behavioral Health Regional Contracting	New counties begin to participate in DMC-ODS leveraging regional contracting approaches where possible. County MHPs leverage other forms of regional contracting (e.g., Joint Powers Authority, Administrative Services Organization/ Third-Party Administrative Services).
	DMC-ODS Traditional Healers and Natural Helpers	Traditional healers and natural helpers can deliver existing DMC-ODS services.

CalAIM Initiatives Launch Timeline as of November 2021

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CalAIM Initiatives Descriptions

Population Health Initiatives
Population Health Management (including Service): Implement new PHM Program, which will be a cohesive approach for keeping all enrollees healthy, improving health outcomes, and reducing disparities in access and care. MCPs will be required to implement a whole-system person-centered PHM strategy that includes assessments of each enrollee's health risks and health-related social needs, focuses on wellness and prevention, and provides processes for case management and care transitions across delivery systems and settings. To support PHM, DHCS will launch a PHM Service to ensure that care management plans are data-informed, and to enable data sharing across multiple delivery systems (e.g., physical, behavioral health, oral health systems) and with Medi-Cal enrollees, providers, human services programs, and other partners.
Enhanced Care Management (ECM): Implement ECM benefit within Medi-Cal managed care, which will address both the clinical and non-clinical needs of the highest-need, highest-cost Medi-Cal enrollees through intensive coordination of health and health-related services, performed largely in person and in the community. Through ECM, enrollees will have a single care manager with responsibility for coordinating all clinical and non-clinical services, including Community Supports (described below).
Community Supports (ILOS): Adopt Community Supports, new statewide services that MCPs may elect to offer to their members as medically appropriate, cost-effective alternatives to traditional medical services or settings. Community Supports are services addressing social drivers of health, which build on and scale existing work in the Whole Person Care Pilots and Health Home Program. California is rolling out 14 Community Supports, including housing-related services, services that support transition from institutional settings to the community, medically tailored meals/food, and recuperative care.
Incentive Payments: Develop a pathway for MCPs to invest in necessary delivery system infrastructure, build appropriate and sustainable ECM and Community Supports capacity, and achieve improvements in cross-delivery system quality performance.
NCQA Accreditation: Require all MCPs and their health plan subcontractors to have NCQA Health Plan Accreditation and NCQA Health Equity Accreditation by 2026. As part of the preparation for this requirement, DHCS must consider elements for deeming in relation to annual Audits and Investigations Division compliance audits and align all applicable processes with NCQA. Components of NCQA accreditation, such as for PHM, are required in advance of 2023.

CalAIM Initiatives Launch Timeline as of November 2021

This is a "living" document that reflects the CalAIM team's expected timing of launches. In some instances, program launch dates are contingent upon timely CMS approval. Because these dates may shift, the document will be updated regularly to reflect any changes.

Managed Care Initiatives
Benefits Standardization: Standardize the benefits that are provided through Medi-Cal MCPs statewide, so that regardless of a beneficiary's county of residence or plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.
Mandatory Managed Care Enrollment: Enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program by standardizing which groups will require mandatory managed care enrollment versus mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. This will happen in two phases, with the following populations in Phase 1: Trafficking and Crime Victims Assistance Program (excluding share of cost), accelerated enrollment individuals, Child Health and Disability Prevention infant deeming, pregnancy-related Medi-Cal, American Indians/Alaskan Natives, beneficiaries with other health care coverage, and beneficiaries living in rural zip codes. Phase 2 would include dual eligible beneficiaries in 31 counties.
Regional Capitation Rates and Shared Savings/Risk: Transition from county-based rates to regional rates in targeted groups of counties (Phase 1; 1/1/2022) and then regional rates statewide (Phase 2; no sooner than 1/1/2024). Implementation of retrospective (no sooner than 1/1/2023), and ultimately prospective (no sooner than 1/1/2026), sharing of savings and risk to create mutual incentives for commitment to and investments in ECM, Community Supports, and MLTSS.
Full Integration Plans: Test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity through a Pilot program to address the current fragmented delivery system. DHCS will be engaging with stakeholders to assess the various components necessary for fully integrating health care services.

Behavioral Health Initiatives
SMI/SED IMD Waiver: Develop and submit to CMS a Section1115 demonstration waiver to receive federal matching funds for short-term residential treatment services provided to Medicaid beneficiaries with an SMI or Serious Emotional Disturbance (SED) in an IMD, as part of a broader continuum of care.
Behavioral Health Payment Reform: Transition counties from cost-based reimbursement funded via CPEs to fee-for-service reimbursement funded via IGTs. Transition specialty mental health and SUD services from existing HCPCS Level II coding to Level I CPT coding.
CalAIM Behavioral Health Policies: Update and clarify policies for SMHS, develop standardized screening and transition tools, and implement a "no wrong door" policy to ensure beneficiaries receive treatment regardless of the delivery system in which they seek care. In addition, streamline documentation requirements for SMHS and SUD services.

CalAIM Initiatives Launch Timeline as of November 2021

This is a "living" document that reflects the CalAIM team's expected timing of launches. In some instances, program launch dates are contingent upon timely CMS approval. Because these dates may shift, the document will be updated regularly to reflect any changes.

Behavioral Health Initiatives
Administrative Integration of SMH and SUD: Improve outcomes for beneficiaries and reduce administrative and fiscal burdens for counties, providers, and DHCS by integrating the administration of specialty mental health and SUD services into one behavioral health managed care program.
Behavioral Health Regional Contracting: Encourage counties that don't currently participate in DMC-ODS to participate through regional approaches. Encourage County MHPs to leverage other forms of regional contracting (e.g., Joint Powers Authority, ASO/TPA).
Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements: Clarify or change DMC-ODS policies to improve beneficiary experience, increase administrative efficiency, and ensure cost-effectiveness and achieve positive beneficiary health outcomes, and encourage new counties to opt into DMC-ODS.

County Oversight Initiatives
County Eligibility and Oversight: Implement a phased approach to working with counties to increase program integrity with respect to eligibility and enrollment. To accomplish this, DHCS is reinstating county performance standards and developing updated processes for monitoring, reporting, and corrective action measures.
Enhancing County Oversight and Monitoring – CCS and HCPCFC: Provide enhanced monitoring and oversight of all 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach) to ensure continuous, and unwavering optimal care for children and youth. To implement the enhanced monitoring and oversight of the California Children's Services (CCS) program and the Health Care Program for Children in Foster Care (HCPCFC) in all counties, DHCS will develop a robust strategic compliance program to ensure consistency is applied across the counties/cities.
Improving Beneficiary Contact & Demographic Data: Accurate contact and demographic information is critical for ongoing Medi-Cal eligibility, enrollment, and care management. To ensure that relevant entities (including MCPs and providers) can more easily share and obtain up-to-date beneficiary information, DHCS intends to reconvene the workgroup of interested stakeholders to develop a set of recommendations for ensuring that updated contact and demographic information can be used across all eligibility and enrollment systems and databases.

LTC/MLTSS/Duals Initiatives
Transition to Statewide LTSS and D-SNP (CCI ends): Transition the CCI, inclusive of Cal Medi-Connect (CMC), which is currently only available in seven counties, to a statewide MLTSS and D-SNP aligned enrollment structure. This will provide better coordination of care, improve care integration and person-centered care.

CalAIM Initiatives Launch Timeline as of November 2021

This is a "living" document that reflects the CalAIM team's expected timing of launches. In some instances, program launch dates are contingent upon timely CMS approval. Because these dates may shift, the document will be updated regularly to reflect any changes.

LTC/MLTSS/Duals Initiatives
Additionally, this transition will create both program and financial alignment, simplify administration and billing for providers and plans, and provide a more seamless experience for dual eligible beneficiaries by having one plan manage both sets of benefits for the member. CMC members will be automatically transitioned to the Medicare D-SNP and Medi-Cal plan affiliated with their CMC plan.

Other Initiatives
Dental (new benefits and P4P): Implement a caries risk assessment bundle for young children, Silver Diamine Fluoride for children and specified high-risk and/or institutional populations and pay-for-performance initiatives to reward preventive services and continuity of care.
Foster Care Model of Care: Explore new ways to improve the model of care for foster youth, specifically to address the complex medical, behavioral, oral and developmental needs of children and youth involved in the child welfare system (children and youth, former foster care youth, and youth transitioning out). DHCS has launched a Foster Care Workgroup to inform long-term recommendations for these Medi-Cal enrollees.
Justice-Involved Package: • All counties and youth correctional facilities implement a pre-release Medi-Cal application process to ensure that incarcerated individuals who are eligible for Medi-Cal and need ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. • Pending CMS approval, DHCS would provide Medi-Cal coverage—with limited Medi-Cal services—to select individuals in the 90-days prior to their release from county jails, state prisons and youth correctional facilities. • The justice-involved behavioral health linkages proposal would require all county jails and youth correctional facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the incarcerated individuals was receiving behavioral health services while in a county facility, to allow for continuation of behavioral health treatment in the community. • ECM services for justice-involved populations of focus for coordinated re-entry. • Community Supports (e.g., housing support) for justice-involved populations upon re-entry. • Access to recovery services for individuals, including for justice-involved populations. • Enhancements for facilitating data sharing, including for justice-involved populations.

CalAIM Initiatives Launch Timeline as of November 2021

This is a "living" document that reflects the CalAIM team's expected timing of launches. In some instances, program launch dates are contingent upon timely CMS approval. Because these dates may shift, the document will be updated regularly to reflect any changes.

Other Initiatives
Providing Access and Transforming Health (PATH) Funds (ECM, Community Supports, Justice-Involved): Support capacity building, including payments for infrastructure, interventions, and services to complement and ensure access to the array of services and benefits that are part of successful implementation of ECM and Community Supports, as well as a number of intersecting CalAIM initiatives designed to ensure continuity of health care coverage and care for individuals leaving prisons and county jails and re-entering the community, all of which are key components of CalAIM.

California Advancing and Innovating Medi-Cal (CalAIM) Milestones Calendar as of November 2021

CONTEXT:

California Advancing and Innovating Medi-Cal, or CalAIM, is a transformational plan to modernize the State's Medicaid program. It will improve the quality of life and health outcomes of Medi-Cal enrollees, including those with the most complex health and social needs. CalAIM includes a series of far-reaching initiatives that together represent broad reforms of Medi-Cal's programs and systems. Department of Health Care Services (DHCS) will implement it in partnership with Medi-Cal providers, Managed Care Plans (MCPs), Counties, Community-Based Organizations and other stakeholders. These changes will span a multi-year period, with the first reforms coming in January 2022 and additional reforms phased in through 2027.[1]

This CalAIM Milestones Calendar is a "living" document that reflects DHCS' expected timing of upcoming milestones through the first quarter of 2022. In some instances, program launch dates are contingent upon timely Centers for Medicare and Medicaid Services (CMS) approval. Because dates may shift as policies are finalized, the document will be updated regularly to reflect any changes. Stakeholders are encouraged to check the DHCS CalAIM website for updates to ensure access to the most up-to-date information.

[1] See resources on the DHCS CalAIM Webpage and the Section 1115 Demonstration Application and 1915(b) Waiver Webpage for additional details.

California Advancing and Innovating Medi-Cal (CalAIM) Milestone Calendar as of November 2021

To support stakeholders in their planning, this schedule is a "living" document that reflects DHCS expected timing of upcoming milestones. Because these milestone dates may shift, the document will be updated regularly to reflect any changes. CalAIM Initiatives for which no major milestones are currently expected before Q1 2022 have been excluded from the table.

KEY: * Document Release; ^ Submission Deadline; + Program Launch

Initiatives[2]	CalAIM Major Milestones				
	Q4 2021		Q1 2022		
	November	December	January	February	March
Cross-Initiative Milestones[3]	--	• Current waiver ends; target approval by CMS of CalAIM Section 1115 Demonstration & Section 1915(b) Waiver	• 1115 Demonstration and 1915(b) Waiver target effective date+ (January 1)	• Final Managed Care Plan (MCP) Request for Proposals (RFP) for 2024 implementation year*	--
Population Health Initiatives					
Population Health Management (including Service)	--	--	--	• RFP for PHM Service Vendor released+[4]	• PHM Strategy & Roadmap Document+[5]

[2] Includes CalAIM proposal initiatives and key related initiatives. In some instances, program launch dates and related milestones are contingent upon timely CMS approval. Initiatives for which no major public-facing milestones are anticipated before Q1 2022 have been excluded from the table. These include: NCQA Accreditation, Full Integration Plans, Contingency Management, DMC-ODS Natural Healers and Traditional Helpers, Behavioral Health Regional Contracting, Enhancing County Oversight and Monitoring: Eligibility, and Improving Beneficiary Contact & Demographic Data. For a timeline of implementation dates for all CalAIM initiatives showing when programs will go live, please see the CalAIM Initiatives Launch Timeline available on the DHCS CalAIM Webpage.

[3] Cross-initiative milestones include those related to the 1115 Demonstration & 1915(b) Waiver and MCP Contract Amendment & Procurement process.

[4] RFP timeline is being finalized and is subject to change.

[5] PHM Strategy & Roadmap Document will be published following a public advisory process.

California Advancing and Innovating Medi-Cal (CalAIM) Milestone Calendar as of November 2021

To support stakeholders in their planning, this schedule is a "living" document that reflects DHCS expected timing of upcoming milestones. Because these milestone dates may shift, the document will be updated regularly to reflect any changes. CalAIM Initiatives for which no major milestones are currently expected before Q1 2022 have been excluded from the table.

KEY: * Document Release; ^ Submission Deadline; + Program Launch

Initiatives[2]	CalAIM Major Milestones				
	Q4 2021		Q1 2022		
	November	December	January	February	March
Enhanced Care Management (ECM)/ Community Supports[6] (ILOS)	--	• ECM/Community Supports Data Sharing Authorization Guidance* • MCPs send ECM New Benefit Notice* • MCPs send updated Evidence of Coverage (EOC) to managed care members*	• Statewide launch of Community Supports+ • ECM goes live in WPC Pilot Counties for: ○ Members enrolled in a WPC Pilot identified by WPC Lead Entity as currently receiving Care Coordination services in the WPC pilot[7] ○ Select ECM Populations of Focus+[8] • ECM goes live in HHP Counties for: ○ Members enrolled in HHP[9]	--	--

[6] DHCS is transitioning to the name Community Supports to refer to CalAIM In Lieu of Services (ILOS).
[7] Includes children and youth currently served by WPC Pilot.
[8] Includes Individuals & Families Experiencing Homelessness; High Utilizer Adults; Adults with Serious Mental Illness (SMI) /Substance Use Disorder (SUD). Also includes Adults & Children/Youth Transitioning from Incarceration in WPC Pilot counties only, where the services provided in the Pilot are consistent with those described in the ECM Contract.
[9] Includes children and youth currently served by HHP.

California Advancing and Innovating Medi-Cal (CalAIM) Milestone Calendar as of November 2021

To support stakeholders in their planning, this schedule is a "living" document that reflects DHCS expected timing of upcoming milestones. Because these milestone dates may shift, the document will be updated regularly to reflect any changes. CalAIM Initiatives for which no major milestones are currently expected before Q1 2022 have been excluded from the table.

KEY: * Document Release; ^ Submission Deadline; + Program Launch

Initiatives[2]	CalAIM Major Milestones				
	Q4 2021		Q1 2022		
	November	December	January	February	March
			○ Select ECM Populations of Focus+[10]		
Incentive Payments	--	• MCPs Gap/Need Assessment and Gap-Filling Plan Submissions to DHCS^	• Program Year 1 goes live+	• First incentive payments issued+	--
Managed Care Initiatives					
Benefits Standardization	• Final Approval of MCP Major Organ Transplant (MOT) Carve-In and Multipurpose Senior Services (MSSP) Carve-Out Deliverables re: Transition Readiness^ • MCP review of 2022 Contract Amendment for MOT and MSSP*	• MSSP Beneficiary Notices to be mailed to impacted beneficiaries* • Managed care rates for MOT to be sent to CMS^	• MOT Carve-In goes live+ • MSSP Carve-Out goes live+	--	--

[10] Populations of Focus include Individuals and Families Experiencing Homelessness; High Utilizer Adults and Adults with SMI/SUD.

California Advancing and Innovating Medi-Cal (CalAIM) Milestone Calendar as of November 2021

To support stakeholders in their planning, this schedule is a "living" document that reflects DHCS expected timing of upcoming milestones. Because these milestone dates may shift, the document will be updated regularly to reflect any changes. CalAIM Initiatives for which no major milestones are currently expected before Q1 2022 have been excluded from the table.

KEY: * Document Release; ^ Submission Deadline; + Program Launch

Initiatives[2]	CalAIM Major Milestones				
	Q4 2021		Q1 2022		
	November	December	January	February	March
Mandatory Managed Care Enrollment	• Second Mandatory Managed Care Enrollment (MMCE) Beneficiary Notice to be mailed to impacted beneficiaries* • Choice Packets mailed to impacted beneficiaries to choose an MCP* • MCP review of 2022 Contract Amendment for MMCE*	• Final Approval of MCP Deliverables List re: Transition Readiness^	• Mandatory managed care enrollment goes live for Phase 1 populations+[11] • Mandatory fee-for-service enrollment goes live for select populations+[12]	--	--
Regional Capitation Rates and Shared Savings/Risk	--	• Regional Capitation Rates: Phase 1 Regional Rate Certification to CMS^	• Regional Capitation Rates: Phase 1 Regional Rate Setting Methodology and Calendar Year (CY) 2022 Rates Go Live+	--	--

[11,12] See Section 1915(b) Waiver Proposal, Attachment II.

California Advancing and Innovating Medi-Cal (CalAIM) Milestone Calendar as of November 2021

To support stakeholders in their planning, this schedule is a "living" document that reflects DHCS expected timing of upcoming milestones. Because these milestone dates may shift, the document will be updated regularly to reflect any changes. CalAIM Initiatives for which no major milestones are currently expected before Q1 2022 have been excluded from the table.

KEY: * Document Release; ^ Submission Deadline; + Program Launch

Initiatives[2]	CalAIM Major Milestones				
	Q4 2021		Q1 2022		
	November	December	January	February	March
Behavioral Health Initiatives					
Behavioral Health Payment Reform	--	• Behavioral Health Information Notice with updated Billing Manual and Coding Guidance*	--	--	--
Specialty Mental Health Services – Criteria for Services	• Information Notice re: Criteria for Specialty Mental Health Services (SMHS)*	• Information Notice re: Criteria for Access to Psychiatric Inpatient Hospital and Psychiatric Health Facility Services/ Concurrent Review* • Updated Information Notice 19-026 (SMHS Authorization)*	• Criteria for SMHS Go Live+	--	--
Behavioral Health No Wrong Door	--	--	• Information Notice re: no wrong door and co-occurring treatment*	--	--
Behavioral Health Documentation Redesign	--	--	• Information Notice re: provider documentation requirements* • Updated reasons for recoupment released*	--	--

California Advancing and Innovating Medi-Cal (CalAIM) Milestone Calendar as of November 2021

To support stakeholders in their planning, this schedule is a "living" document that reflects DHCS expected timing of upcoming milestones. Because these milestone dates may shift, the document will be updated regularly to reflect any changes. CalAIM Initiatives for which no major milestones are currently expected before Q1 2022 have been excluded from the table.

KEY: * Document Release; ^ Submission Deadline; + Program Launch

Initiatives[2]	CalAIM Major Milestones				
	Q4 2021		Q1 2022		
	November	December	January	February	March
Drug Medi-Cal Organized Delivery System (DMC-ODS) Renewal and Policy Improvements	--	--	• Information Notice re: DMC-ODS*[13] • DMC-ODS renewal and policy improvements (2022-2026) go live+ • ASAM level of care determination guidance released*	--	--
Long-Term Care (LTC)/Managed Long Term Services and Supports (MLTSS)/Duals Initiatives					
Transition to Statewide LTSS and D-SNP (CCI ends)		• Network Guidance to Plans* • Care Coordination Guidance to Plans*	--	--	• Draft State Medicaid Agency Contract to Plans, Sister Agencies, and Key Stakeholders*
County Initiatives					
County CCS Oversight	--	• Launch electronic submissions portal for	• Establish stakeholder workgroup to inform development of county CCS Memorandum of	--	--

[13] Information Notice to include updates to DMC-ODS services (i.e., revise the definition of residential treatment; expansion of types of clinicians who can provide and claim for Clinician Consultation Services (formerly Physician Consultation Services); include the new DMC-ODS criteria (per AB 133); and provide information and clarification regarding requirements for DMC-ODS services.

California Advancing and Innovating Medi-Cal (CalAIM) Milestone Calendar as of November 2021

To support stakeholders in their planning, this schedule is a "living" document that reflects DHCS expected timing of upcoming milestones. Because these milestone dates may shift, the document will be updated regularly to reflect any changes. CalAIM Initiatives for which no major milestones are currently expected before Q1 2022 have been excluded from the table.

KEY: * Document Release; ^ Submission Deadline; + Program Launch

Initiatives[2]	CalAIM Major Milestones				
	Q4 2021		Q1 2022		
	November	December	January	February	March
		Plan and Fiscal Guidelines+	Understanding and monitoring/oversight policies and procedures		
Other Initiatives					
Dental (new benefits and P4P)	--	• Dental All-Plan Letter (APL)* • Dental Provider Bulletins/ Provider Manual* • CY 2022 Final Dental Managed Care Rates and Certification to CMS^	• Dental policy goes live+[14]	--	--
Foster Care Model of Care	--	--	• Release proposal to public as part of Governor's budget*	--	--
Justice-Involved Package	• Establish stakeholder advisory group to inform development of justice-involved policies and programs	• Policy design approach for 90 days pre-release services	• Data Exchange Between Correctional Facilities and County- & Community-Based Providers Guidance*	--	--

[14] Includes new dental benefits (including a caries risk assessment bundle for young children and Silver Diamine Fluoride for children and certain high-risk and/or institutional populations) and pay-for-performance initiatives statewide to reward preventive services and continuity of care.

California Advancing and Innovating Medi-Cal (CalAIM) Milestone Calendar as of November 2021

To support stakeholders in their planning, this schedule is a "living" document that reflects DHCS expected timing of upcoming milestones. Because these milestone dates may shift, the document will be updated regularly to reflect any changes. CalAIM Initiatives for which no major milestones are currently expected before Q1 2022 have been excluded from the table.

KEY: * Document Release; ^ Submission Deadline; + Program Launch

Initiatives[2]	CalAIM Major Milestones				
	Q4 2021		Q1 2022		
	November	December	January	February	March
			• Data Exchange Funding Opportunity and Program Requirements Guidance*		
Providing Access and Supporting Health (PATH) Funds (ECM, Community Supports, Justice-Involved)[15]	--	--	• Final PATH Program Requirements and Parameters* • Applications from WPC Lead Entities for WPC Services and Transition to Managed Care Mitigation Initiative^ • First payments issued for the WPC Services and Transition to Managed Care Mitigation Initiative+	--	--

[15] Milestones and go-live dates are dependent upon CMS approval.

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Recommendation to oppose State action which contravenes the County Organized Health System Model

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Recommendation. Staff recommend the Board oppose any action and/or legislation which would contravene or result in the de facto elimination of the County Organized Health System (COHS) model and authorize the Chief Executive Officer to take any necessary advocacy steps to oppose such action and maintain the integrity of the COHS model.

Background. The COHS model was established in California in 1982 in support of the Congressional goal to expand Medicaid managed care programs. The abiding purpose of the COHS model is to meet the problems of the delivery of publicly assisted medical care in the county or counties it serves and to demonstrate ways to promote both quality care and cost efficiency. COHS were developed to serve as adaptive organizations that will meet the needs of people with Medi-Cal, the providers who serve them and their respective communities.

The COHS model is created by a County Board of Supervisors and is governed by an independent public commission. Counties establish the commission to negotiate an *exclusive* contract to arrange for the provision of health care services. The Commission is bound by the terms of the contract that the Commission holds with the State for plan operations. State statute and federal regulation permits the State to establish exclusive contracts with the COHS.

COHS have historically provided services to the broadest range of Medi-Cal beneficiaries, including those who are dually eligible in Medicare and Medi-Cal and seniors and persons with disabilities. COHS have consistently expanded operations to provide access for additional populations and people in support of the State's goals of expanding Medi-Cal coverage, while providing an ever-expanding range of services. This included embracing the transition of children previously enrolled in the Healthy Families program, supporting County implementation of the Low-Income Health Plans, meeting the needs of the newly enrolled Affordable Care Act members as well as most recently, ensuring access to care for newly enrolled undocumented children (and soon to be adults). The State has further relied solely on COHS plans to serve vulnerable populations such as children with special health care needs receiving services through the California Children's Services program through the establishment of the Whole Child Model program.

The COHS model is unique and powerful in its deep connection to the County and the public health and safety net delivery system. Governed locally by county government, providers, members and community stakeholders, the model supports adaptation of the local delivery system to meet the needs of people with Medi-Cal through collaboration and partnership, with a primary focus on the people and communities it serves. The COHS

model seeks to increase member access to high quality care by leveraging both the traditional and safety net providers who have historically served lower income people and by bringing in additional provider capacity in to the network.

COHS plans achieve this expanded capacity by paying better than fee-for-service Medi-Cal, offering quality based incentive programs, by providing exceptional, local customer service and by engaging with the providers in advising policy for the health plan. COHS plans also engage with members locally, including soliciting member voice through advisory groups, expanding benefits to meet local Medi-Cal beneficiary needs and offering member incentives to support member engagement in care. As public plans, the COHS model reinvests net income back into the delivery system through enhanced member benefits, provider payments, quality-based incentives and most recently Medi-Cal capacity grants. Additionally, the COHS model is transparent, accountable and responsive to the public; making its policy decisions in public meetings in which beneficiaries, providers and community stakeholders engage. The COHS model is exemplary in demonstrating how a single payer system can successfully operate; through a primary focus on the beneficiary, through local and public governance, and in partnership with key stakeholders to guide policy to be responsive to local needs and circumstances.

Summary of Direct Deal. On February 3, 2022, the Department of Health Care Services (DHCS) informed Medi-Cal Managed Care plans that it intended to directly contract with Kaiser Permanente for a state-wide Medi-Cal contract to be effective in 2024. The contract will be for a five-year term and allows Kaiser to expand into new geographic areas in which it does not currently serve people with Medi-Cal (but does serve commercial), DHCS staff stated that the contract also allows Kaiser to expand its current Medi-Cal enrollment/assignment statewide by 25% (approximately 225,000). The contract does not require Kaiser to be open to enrollment for any member in the area in which it serves, thus Kaiser is not required to accept all enrollees who wish access to the Kaiser plan.

DHCS documentation indicates the problem it is solving through this deal is to address Kaiser's inability to participate in the broader commercial plan RFP because of limitations to Kaiser's physical capacity and its fixed geographic locations, which are key features of the Kaiser model (staff model in certain geographic locations). It appears that there is some perceived threat of Kaiser walking away from the Medi-Cal population in the absence of this deal. DHCS cites advantages to the Medi-Cal program, and identifies no assessment or consideration of negative impacts to the delivery system or the people the program serves.

Written information regarding this deal is limited to a three-page summary provided by DHCS which includes few details. There is no information available about the implementation plans for this significant change. At the time of the drafting of this report, DHCS has not responded to inquiries for clarification as to which Alliance service area counties the commercial plan will grow its enrollment in either (or both) the Medi-Cal program or the pending D-SNP program.

Discussion. A direct contract between the State and a commercial entity directly contravenes the COHS model and represents the de facto end of the model. The COHS model was created specifically to address problems in the Medi-Cal delivery system through an *exclusive* contract between local and state government, with public

accountability for improvements in access, quality and cost. The State's unilateral decision, negotiated in private, with an emphasis on the benefit to a private commercial entity and not to the Medi-Cal members or safety net delivery system stands in stark contrast to the locally governed, public plan model of the COHS.

Conclusion. Over the course of its 26-year history, the Alliance has successfully implemented the COHS model in three counties with local members, providers, county and community partners in commitment to local control and self-determination. The collective efforts have resulted in improvements to the Medi-Cal delivery system. Prior to the Alliance's existence in its current three county service area provider experience in Medi-Cal was characterized by low and slow reimbursement from the State and a lack of provider participation as well as competitive issues barring the type of partnership that yields true transformation. By leveraging the COHS model, the Alliance brought partners together to work collectively towards a sustainable delivery system providing high quality health care. The Alliance's vision of *Healthy People. Healthy Communities*. and its commitment to Health Equity and Person-Centered Delivery System Transformation will be hampered by State policy which prioritizes commercial interests over the voice of the member and the safety net. The State's purported objectives for this direct contract could be achieved without the end of the COHS model and should be explored in earnest through transparent identification of the issues and a disciplined approach to collective problem solving with the traditional Medi-Cal delivery system at the table.

Fiscal Impact. The fiscal impact associated with this agenda item is yet to be determined as there are potential administrative costs associated with activities related to an oppose position.

Attachments.

1. LHPC Response to No-Bid Kaiser Statewide Medi-Cal Contract
2. LHPC Fact Sheet: Proposed Statewide, No-Bid Commercial Plan Contract
3. DHCS Proposal Medi-Cal Direct Contract with Kaiser Permanente
4. California Healthline article, February 3, 2022
5. Los Angeles Times article, February 4, 2022
6. CalMatters article, February 4, 2022

FOR IMMEDIATE RELEASE
February 4, 2022

Contact: Alexandra Angel
alexandra@nkestrategies.com | (916) 225-1598

LHPC Response to No-Bid Kaiser Statewide Medi-Cal Contract

SACRAMENTO, CA -- On behalf of the Local Health Plans of California (LHPC), a group representing 16 of the not-for-profit local health plans that serve more than 70 percent of Californians enrolled in Medi-Cal managed care, CEO Linnea Koopmans offered comment on Kaiser Permanente being awarded a no-bid statewide Medi-Cal contract:

> "Offering a statewide, no-bid contract on a silver platter to a commercial plan undercuts the local public health infrastructure while paving a path for large-scale corporate health plan expansion in Medi-Cal. This prioritizes the interests of big businesses over the interests of the safety net Medi-Cal delivery system, that exists only to serve the underserved, is held accountable only to the public and which continuously works to improve the Medi-Cal delivery system because it is the right thing to do, and no other motivation.
>
> "CalAIM's commitment to equity and transformation stands in stark contrast to the decision to reward a plan who has historically focused on the commercially insured with scarce experience in serving the most vulnerable, high-risk Medi-Cal populations like the unhoused, those with serious mental illness, and the justice-involved population. The interests of the public are not being considered through this arrangement.
>
> "Local plans are a vital component of the public health delivery systems in the counties they serve and, in most cases, serve as the public health care option in their region. They are governed by local members, providers, and partners, and are accountable for ensuring their enrollees have timely access to quality medical and dental care, behavioral health services, and, now under CalAIM, community supports. Local plans embrace this assignment and are committed to the success of CalAIM because they believe it will improve overall health while addressing entrenched health disparities. Awarding a no-bid Medi-Cal contract to a statewide commercial plan with a track record of limited enrollment, limited access to behavioral health and community support benefits not only conflicts with the intent and goals of CalAIM but undermines publicly organized health care."

"Kaiser's claims of capacity limitations rings hollow considering their capacity for Covered California, Medicare, and private industry enrollment. Apparently, in Medi-Cal they just don't have capacity for the people with the most need. The infirmity of the logic behind this decision is apparent.

"Contrary to what is being said, continuity of care for Kaiser exists today. In areas where Kaiser has chosen to participate in the Medi-Cal delivery system, members who becomes eligible for Medi-Cal have the choice to select Kaiser through their local plan. No change is necessary to preserve continuity of care. Kaiser has had and could continue to have the opportunity to participate in Local Plan networks and should be required to do so.

"If there had been a public process, it would have examined disruption to the existing local public health care infrastructure of medical, behavioral and social supports. It would require the contractor to willingly accept Medi-Cal enrollees regardless of their health care needs."

###

BACKGROUND:

- Nearly all California's local Medi-Cal plans are publicly organized, created through local ordinances and governed by public boards. They are subject to a high degree of transparency and public accountability. Most local plans are the public health care option in their region.

- Local plans directly reinvest their revenue in their communities. They were early adopters of the types of social supports required in CalAIM and have advocated for the inclusion of all eligible individuals, regardless of their immigration status.

- Approximately 60% of the total Kaiser subcontracted members are children and adults while less than 4% are seniors and person with disability members without full Medicare benefits, these individuals have some of the highest health care needs and Kaiser has not been willing to serve them equitability across the state. (Note: Kaiser serves more SPDs with full Medicare benefits; no coincidence given that Medicare is a more profitable line of business).

- The closed-door deal that was reached between the state and Kaiser would strip approximately 11% of local plans in the counties in which Kaiser operates, however, in some counties this means stripping 20% to 30% of local plan membership.

- Medi-Cal rates and financing is highly complex, but this approach impacts local plan finances in the following ways:

- Kaiser's Medi-Cal membership includes individuals who had commercial coverage before their Medi-Cal eligibility or who have a family member with Kaiser coverage. These restrictions on Kaiser's Medi-Cal enrollment leaves them with relatively low-risk, low-cost Medi-Cal enrollment. As a result, local plans will carry an even higher percentage of high acuity enrollees, who need high-cost care and supports.

- In two-plan counties, Medi-Cal averages rates between each plan. This average rate comprises the vast majority of the rate the plan is paid. This results in plans with higher rates for having enrollees with higher health care expenses transferring funds to the plans with the lower risk enrollment. With Kaiser's enrollment limitations, they are virtually guaranteed that lower risk population and will financially benefit.

- Gov. Newsom has prioritized behavioral health with a record $13 billion investment and Medi-Cal plays a significant role in supporting that care, particularly through CalAIM. Kaiser's inability to offer adequate access to mental health services is well known.

    - Last fall, Kaiser therapists said in an open letter, "As providers, it is devastating for us to acknowledge that the ethical care and accessibility needed to best serve our patients is not what we are able to provide -- far from it."

- Local plans have had to supplement Kaiser's limited Community Support benefits under CalAIM. Under this direct contracting arrangement, Kaiser will be required to provide Community Supports at the same level as other plans. However, is unclear the extent to which these services will be provided given Community Supports target members with the highest levels of acuity and social needs who will continue to be underrepresented in Kaiser's membership.

- In some regions, Kaiser's network is very limited with clinic locations in only a few cities within the region. Medi-Cal enrollees will be forced to travel farther to get their care.

About LHPC

Local Health Plans of California (LHPC) is a statewide trade association that represents all 16 of the publicly managed, not-for-profit health plans that provide access to critical and comprehensive health care services for low-income populations enrolled in California's Medicaid program, "Medi-Cal," in 36 out of 58 counties in the state. With over 7 million enrollees, our plans serve approximately 70 percent of all Medi-Cal managed care beneficiaries. Our member plans cover more lives than 49 other states' entire Medicaid programs. More here.

LHPC Local Health Plans of California

FACT SHEET

Proposed Statewide, No-Bid Commercial Plan Contract

PROPOSAL SUMMARY

- Proposed statewide, no-bid contract with Kaiser **effective January 1, 2024**
- **Grow Kaiser's Medi-Cal membership by 25%,** adding individuals who:
  - → Previously had commercial Kaiser coverage
  - → Are dually eligible for Medi-Cal and Medicare
  - → Are foster youth
- **Kaiser Medi-Cal enrollment allowed to expand** into any areas KP has commercial business, including areas where Kaiser does not currently participate in Medi-Cal
- Contract to result in nearly **$5 billion of combined Medi-Cal and Medicare revenue** for Kaiser

PROBLEMATIC PROCESS & POLICY

- **Developed behind closed doors** without any input from Legislature or impacted stakeholders
- **Undercuts local public health care infrastructure** & expands the reach of a large commercial plan
- Codifies **limitations on enrollment that excludes enrollment of members with the deepest and most complex needs**
- Will have **unintended consequences on access, the Medi-Cal safety net, and local plan finances**

SPECIFIC CONCERNS & IMPACTS

Inequitable Enrollment Rules

- **Continuity of care** upholds Kaiser's existing policy and endorses their enrollment of healthier beneficiaries
- **Integrating care for duals happens without this agreement** under CalAIM. Growing Kaiser's duals' population could increase their **annual Medicare revenue by $1.6 billion**
- **Kaiser is not equipped to meet needs of the foster care population**, whose needs are primarily related to social determinants and behavioral health rather than high-cost medical conditions

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Back to Agenda

FACT SHEET

Excludes Acute Populations

- **Medi-Cal members with complex health and social conditions will not be served by Kaiser,** including those who are unhoused, are re-entering the community from incarceration, or have a serious mental illness
- **Local plans will continue to serve the highest acuity Medi-Cal members** as they do today. Currently, Kaiser's population is disproportionately children and families, with low enrollment of members with higher levels of acuity

Adversely Impacts the Safety Net

- Kaiser's need to leverage contracts with safety net providers would **shift resources and reduce access for non-Kaiser members**
- Safety net providers will serve fewer but more acute members, **destabilizing the carefully balanced local safety net**

Local Plan Financial Impacts

- Local plans will **cover an even higher percentage of high acuity enrollees** who need high-cost care and supports
- Losing significant revenue due to a shift of healthy members would result in **fewer resources to invest in CalAIM implementation**

About LHPC

Local Health Plans of California (LHPC) is a statewide trade association that represents all 16 of the publicly managed, not-for-profit health plans that provide access to critical and comprehensive health care services for low-income populations enrolled in California's Medicaid program, "Medi-Cal," in 36 out of 58 counties in the state. With over 8 million enrollees, our plans serve approximately 70 percent of all Medi-Cal managed care beneficiaries. Our member plans cover more lives than 49 other states' entire Medicaid programs. More here.

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Medi-Cal Direct Contract with Kaiser Permanente

Department of Health Care Services - 2022-23 Governor's Budget Proposal

Proposal

The Department of Health Care Services (DHCS) proposes to enter into a direct contract with Kaiser Permanente (Kaiser) as a Medi-Cal managed care plan within new geographic regions of the State, effective January 1, 2024 for a five year contract term, with potential contract extensions. Under the new contract, subject to federal approvals, Kaiser would operate as a full-risk, full-scope Medi-Cal managed care plan, consistent with other Medi-Cal managed care plans. Kaiser will no longer be granted specific exceptions or alternative standards. The only exception will be that Kaiser will not be open through the traditional Medi-Cal plan choice methods.

DHCS is proposing trailer bill language to clarify its statutory authority to maintain and expand direct, full-risk contracts with Kaiser, defined under current state law as an Alternate Health Care Service Plan. Subject to federal approval, the direct contracts would be available in any geographic areas in which Kaiser operates (including COHS/single plan model counties, two-plan model counties, regional model counties and Geographic Managed Care model counties).

Background

On February 9, 2022, DHCS will release a Request for Proposal (RFP) for select commercial Medi-Cal managed care plan contracts. Through this competitive process and resultant contracts, the state is embarking on new relationships with managed care plans to redefine how care is delivered, what leads to health equity and healthy communities, how to better hold the health care delivery system accountable for transparency, quality and results, and ultimately how the state achieves a Healthy California for All. Under this RFP, approved Medi-Cal managed care plans, in the "Two-Plan", "Regional" or "Geographic Managed Care" model counties, must take all enrollees that wish to enroll with them in their contractual service areas.

Problem Statement

Kaiser, which serves close to 900,000 Medi-Cal enrollees, participates as a subcontractor with 12 local Medi-Cal managed care plans (in 17 counties) and has a direct Geographic Managed Care (GMC) contract that covers five counties. In 2021, DHCS announced it would limit the number of prime plans in GMC model counties. However, due to limitations in Kaiser's physical capacity as well as fixed geographic locations, Kaiser is not in a position to be listed on Medi-Cal enrollment choice forms for all Medi-Cal beneficiaries.

If Kaiser is unable to participate in the RFP due to its network's physical capacity, the Medi-Cal program would lose its highest quality plan, its integrated model and clinical expertise. In addition Kaiser's enrollees in at least the GMC counties (Sacramento, San Diego, Amador, El Dorado, and Placer) would need to change health plans. This is a unique problem that requires a unique solution.

DHCS is making this announcement prior to the release of the Medi-Cal managed care RFP to provide transparency to potential bidders in the impacted geographic regions.

Advantages to the Medi-Cal Program

Under the proposal, Kaiser would be subject to ***all*** terms of the new managed care contract as commercial plans selected through the RFP except it would not be open through the traditional Medi-Cal plan choice methods.

Existing Kaiser Medi-Cal members will have the option to stay with Kaiser. In addition, Kaiser will commit to growth of new Medi-Cal members of 25 percent from the start of the contract term to the end of the contract term (five years) mostly through continuity of members who exit their other lines of business, where Kaiser has a physical network presence but not currently enrolling Medi-Cal beneficiaries, dual eligibles (those eligible for both Medicare and Medi-Cal), and foster youth. This growth would apply in the 22 counties where Kaiser currently participates as Medi-Cal managed care plan and the 10 counties where Kaiser has another line of business[i]. DHCS and Kaiser will work together on this plan for growth.

In addition, this proposal would leverage Kaiser's expertise and augments its contribution to Medi-Cal:

- Kaiser will implement CalAIM Enhanced Care Management (ECM) and Community Supports in a manner consistent with other Medi-Cal managed care plans. Kaiser will leverage more community presence with other providers (e.g., county departments, public hospitals and health systems, and community health centers) and not solely provide all ECM and Community Supports internally. Kaiser will also commit to broad uptake of Community Supports, consistent with other Medi-Cal managed care plans and will implement at least the same number of Community Supports as other Medi-Cal managed care plans in the area.

- Kaiser will support FQHCs across the state to implement a robust portfolio of population health management, social health and practice transformation solutions to augment clinical outcomes for patients cared for in this vital community-based system. Furthermore, Kaiser will implement an eConsult system for specialty care in partnership with FQHCs across the state which

should leverage Kaiser specialty care expertise for the benefit of patients in other parts of the Medi-Cal system. This bolsters the strengths of two systems: The breadth of community presence and cultural and equity excellence of the FQHCs and the practice transformation and approach to quality care of Kaiser.

- DHCS and Kaiser will identify the highest need specialties and geographic areas where Kaiser will provide, by Kaiser physicians, a limited number of in-person, ambulatory based, outpatient specialty care visits, and associated needs such as diagnostic testing and outpatient procedures for non-Kaiser members. These services may be provided at locations other than Kaiser facilities (for example at FQHCs). Similar to above, this would leverage Kaiser's clinical expertise and integrated model to support underserved areas and would test out models and partnerships to deliver specialty care.

This proposal is consistent with DHCS' overarching goals for Medi-Cal:

- **Preserves Member Continuity.** Kaiser members will have a more seamless transition to and from Covered California and employer-based coverage, as well as far better alignment for those enrolled with Kaiser for their Medicare and Medi-Cal coverage. Importantly, for these members, the payer source of coverage would not matter, they can maintain Kaiser at their option.

- **Quality Outcomes.** Kaiser consistently scores as one of the highest in quality scores. This proposal grows Medi-Cal's partnership with a high quality plan and leverages Kaiser's expertise to improve care for non-Kaiser members.

- **Reduce Disparities.** Kaiser's commitment as part of this agreement to partner with FQHCs recognizes and couples the advantage of FQHCs being embedded in communities and trusted providers and Kaiser's ability to deliver effective and quality primary care and add additional specialty care access in areas traditionally underserved.

- **Removes layers of complexity, bureaucracy, and cost.** This proposal is a step forward in the path of simplification of health coverage in the state as it reduces unneeded layers of administration and bureaucracy by (1) eliminating the 12 subcontracts and corresponding administrative overhead between Kaiser and other managed care plans, (2) eliminating consumer confusion regarding subcontracting arrangements between Kaiser and the other managed care plans, and (3) allows DHCS to have direct oversight of a plan with nearly 1 million Medi-Cal beneficiaries rather than working through another managed care plan which makes for

greater accountability and more efficient processes such as data reporting and collection.

[i] Kaiser currently participates as Medi-Cal managed care plan in Alameda, Amador, Contra Costa, El Dorado, Kern, Los Angeles, Marin, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Ventura, and Yolo,
Counties where Kaiser has another line of business and does not participate as a Medi-Cal managed care plan: Fresno, Imperial, Kings, Madera, Mariposa, Santa Cruz, Stanislaus, Sutter, Tulare, and Yuba.

STATE INKS SWEETHEART DEAL WITH KAISER PERMANENTE, JEOPARDIZING MEDICAID REFORMS

State Inks Sweetheart Deal With Kaiser Permanente, Jeopardizing Medicaid Reforms
California Healthline
By Bernard J. Wolfson and Angela Hart and Samantha Young
February 3, 2022

[Editor's note: KHN, which produces California Healthline, is not affiliated with Kaiser Permanente.]

SACRAMENTO — Gov. Gavin Newsom's administration has negotiated a secret deal to give Kaiser Permanente a special Medicaid contract that would allow the health care behemoth to expand its reach in California and largely continue selecting the enrollees it wants, which other health plans say leaves them with a disproportionate share of the program's sickest and costliest patients.

The deal, hammered out behind closed doors between Kaiser Permanente and senior officials in Newsom's office, could complicate a long-planned and expensive transformation of Medi-Cal, the state's Medicaid program, which covers roughly 14 million low-income Californians.

It has infuriated executives of other managed-care insurance plans in Medi-Cal, who say they stand to lose hundreds of thousands of patients and millions of dollars a year. The deal allows KP to limit enrollment primarily to its previous enrollees, except in the case of foster kids and people who are eligible for both Medicare and Medi-Cal.

"It has caused a massive amount of frenzy," said Jarrod McNaughton, CEO of the Inland Empire Health Plan, which covers about 1.5 million Medi-Cal enrollees in Riverside and San Bernardino counties. "All of us are doing our best to implement the most transformational Medi-Cal initiative in state history, and to put all this together without a public process is very disconcerting."

Linnea Koopmans, CEO of the Local Health Plans of California, echoed McNaughton's concerns.

Insurance plans got wind of the backroom talks when broad outlines of the deal were leaked days before the state briefed their executives Thursday.

Dr. Bechara Choucair, Kaiser Permanente's chief health officer, argued in a prepared written response on behalf of KP that because it operates both as a health insurer and a health care provider, KP should be treated differently than other commercial health plans that participate in Medi-Cal. Doing business directly with the state will eliminate complexity and improve the quality of care for the Medi-Cal patients it serves, he said.

"We are not seeking to turn a profit off Medi-Cal enrollment," Choucair said. "Kaiser Permanente participates in Medi-Cal because it is part of our mission to improve the health

of the communities we serve. We participate in Medi-Cal despite incurring losses every year."

His statement cited nearly $1.8 billion in losses in the program in 2020 and said KP had donated $402 million to help care for uninsured people that year.
Kaiser Permanente, the state's largest managed-care organization, is one of Newsom's most generous supporters and close political allies.

The new, five-year contract, confirmed to KHN by administration officials and expected to be announced publicly Friday, will take effect in 2024 pending approval from the legislature — and will make KP the only insurer with a statewide Medi-Cal contract. It allows KP to solidify its position before California's other commercial Medi-Cal plans participate in a statewide bidding process — and after those plans have spent many months and considerable resources developing their bidding strategies.

Other health plans fear the contract could also muddle a massive and expensive initiative called CalAIM that aims to provide social services to the state's most vulnerable patients, including home-delivered meals, housing aid for homeless people, and mold removal from homes. Under its new contract, KP must provide some of those services. But some executives at other health plans say KP will not have to enroll a large number of sick patients who need such services because of how it limits enrollment.

Critics of the deal noted Newsom's close relationship with KP, which has given nearly $100 million in charitable funding and grant money to boost Newsom's efforts against homelessness, covid response, and wildfire relief since 2019, according to state records and KP news releases. The health care giant was also one of two hospital systems awarded a no-bid contract from the state to run a field hospital in Los Angeles during the early days of the covid pandemic, and it got a special agreement from the Newsom administration to help vaccinate Californians last year.

Jim DeBoo, Newsom's executive secretary, used to lobby for KP before joining the administration. Toby Douglas, a former director of the state Department of Health Care Services, which runs Medi-Cal, is now Kaiser Permanente's vice president for national Medicaid.

Still, many critics agree that Kaiser Permanente is a linchpin of the state's health care system, with its strong focus on preventive care and high marks for quality of care. Many of the public insurance plans upset by the deal subcontract with KP for patient care and acknowledge that their overall quality scores will likely decline when KP goes its own way.

Michelle Baass, director of the state Department of Health Care Services, said Medi-Cal had risked losing KP's "high quality" and "clinical expertise" altogether had it been required to accept all enrollees, as the other health plans must. But she said KP will have to comply with all other conditions that other plans must meet, including tightened requirements on access, quality, consumer satisfaction, and health equity.

The state will also have greater oversight over patient care, she said.

"This proposal is a way to help ensure Kaiser treats more low-income patients, and that more low-income patients have access to Kaiser's high-quality services," Baass said.

Though Kaiser Permanente has 9 million enrollees, close to a quarter of all Californians, only about 900,000 of them are Medi-Cal members.
Under the current system, 12 of the 24 other managed care insurance plans that participate in Medi-Cal subcontract with KP to care for a subset of their patients, keeping a small slice of the Medi-Cal dollars earmarked for those patients. Under the new contract, KP can take those patients away and keep all of the money.

In its subcontracts, and in counties where it enrolls patients directly, KP accepts only people who are recent Kaiser Permanente members and, in some cases, their family members. It is the only health plan that can limit its Medi-Cal enrollment in this way.

The new contract allows KP to continue this practice, but it also requires Kaiser Permanente to take on more foster children and complex, expensive patients who are eligible for both Medi-Cal and Medicare. It allows KP to expand its geographic reach in Medi-Cal to do so.

Baass said the state expects KP's Medi-Cal enrollment to increase 25% over the life of the contract.

KP defended the practice of limiting enrollment primarily to its previous members, arguing that it provides "continuity of care when members transition into and out of Medi-Cal."

The state has long pushed for a larger KP footprint in Medi-Cal, citing its high quality ratings, its strong integrated network, and its huge role on the broader health care landscape.

"Kaiser Permanente historically has not played a very big role in Medi-Cal, and the state has long recognized that we would benefit from having them more engaged because they get better health outcomes and focus on prevention," said Daniel Zingale, a former Newsom administration official and health insurance regulator who now advises a lobbying firm that has Kaiser Permanente as a client.

But by accepting primarily people who have been KP members in the recent past, the health system has been able to limit its share of high-need, expensive patients, say rival health plan executives and former state health officials.

The executives fear the deal could saddle them with even more of these patients in the future, including homeless people and those with mental illnesses — and make it harder to provide adequate care for them. Many of those patients will join Medi-Cal for the first time under the CalAIM initiative, and KP will not be required to accept many of them.

"Awarding a no-bid Medi-Cal contract to a statewide commercial plan with a track record of 'cherry picking' members and offering only limited behavioral health and community support benefits not only conflicts with the intent and goals of CalAIM but undermines publicly organized health care," according to an internal document prepared by the Inland Empire Health Plan.

The plan said it stands to lose the roughly 144,000 Medi-Cal members it delegates to KP and about $10 million in annual revenue. L.A. Care, the nation's largest Medicaid health plan,

with 2.4 million enrollees in Los Angeles County, will lose its 244,000 KP members, based on data shared by the plan.

The state had been scheduled on Wednesday to release final details and instructions for the commercial plans that are submitting bids for new contracts starting in 2024. But it delayed the release a week to make the KP deal public beforehand.

Baass said the state agreed to exempt KP from the bidding process because the standardized contract expected to result from it would have required the insurer to accept all enrollees, which Kaiser Permanente does not have the capacity to do.

"It's not surprising to me that the state will go to extraordinary means to make sure that Kaiser is in the mix, given it has been in the vanguard of our health care delivery system," Zingale said.

Having a direct statewide Medi-Cal contract will greatly reduce the administrative workload for KP, which will now deal with only one agency on reporting and oversight, rather than the 12 public plans it currently subcontracts with.

And the new contract will give it an even closer relationship with Newsom and state health officials.

In 2020, KP gave $25 million to one of Newsom's key initiatives, a state homelessness fund to move people off the streets and into hotel rooms, according to a KHN analysis of charitable payments filed with the California Fair Political Practices Commission. The same year, it donated $9.75 million to a state covid relief fund.

In summer 2020, when local and state public health departments struggled to contain covid spread, the health care giant pledged $63 million in grant funding to help contract-tracing efforts.

KP's influence extends beyond its massive charitable giving. Its CEO, Greg Adams, landed an appointment on the governor's economic recovery task force early in the pandemic, and Newsom has showcased KP hospitals at vaccine media events throughout the state.

"In California and across the U.S., the campaign contributions and the organizing, the lobbying, all of that stuff is important," said Andrew Kelly, an assistant professor of health policy at California State University-East Bay. "But there's a different type of power that comes from your ability to have this privileged position within public programs."

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NEWSOM ADMINISTRATION DRAWS FIRE OVER NO-BID KAISER PERMANENTE CONTRACT

Newsom Administration Draws Fire Over No-bid Kaiser Permanente Contract
Los Angeles Times
BY MELODY GUTIERREZ STAFF WRITER
February 4, 2022 6:41 PM PT

SACRAMENTO — California would hand Kaiser Permanente a no-bid statewide contract to serve Medi-Cal enrollees under a deal struck behind closed doors by Gov. Gavin Newsom's administration, raising questions among other healthcare plans about the preferential treatment of a generous supporter of the governor.

The secrecy of the special accommodation for Kaiser outraged other providers, some of which are in the middle of a public bidding process as the state overhauls its healthcare program that serves nearly 14 million low-income residents. Meanwhile, local health plans say the contract will allow Kaiser to cherry-pick healthier enrollees, leaving other care providers to cover a higher percentage of the state's sickest and most costly patients.

The Newsom administration said it will seek authority from the Legislature to approve the contract, which has yet to be made public.

"This prioritizes the interests of big businesses over the interests of the safety net Medi-Cal delivery system, that exists only to serve the underserved, is held accountable only to the public and which continuously works to improve the Medi-Cal delivery system because it is the right thing to do — and no other motivation," said Linnea Koopmans, chief executive of Local Health Plans of California, which represents 16 local health plans that serve more than 70% of Californians enrolled in Medi-Cal managed care.

State officials attempted Friday to tamp down on claims that Kaiser is receiving a "sweetheart deal," as reported Thursday by Kaiser Health News, saying the healthcare company would be subject to the same terms as other plans required to go through the bidding process. However, Kaiser will maintain several provisions that allow the plan to exclude most Medi-Cal enrollees. For example, Kaiser generally does not accept new Medi-Cal enrollees unless the person has a recent history with the insurer or a family member with coverage.

In the new agreement, Kaiser would continue to limit which Medi-Cal enrollees are accepted, while also offering coverage to youth in foster care and those eligible for Medicare.

"If you have a situation where you are able to pick and choose the members who are healthier, it puts an added strain on the safety net public system," said Jarrod McNaughton, chief executive of the Inland Empire Health Plan. "It's a lot easier to have higher-quality scores for a healthier population than for those most in need. That disparity is what concerns us."

Kaiser, which serves 9 million Californians, has built a formidable political presence in the state Capitol, routinely giving millions to politicians and their causes. Last year, Newsom tapped Kaiser to assist the state's vaccine program. In 2020, Kaiser was the top donor of

behested payments to Newsom, giving $35.5 million in charitable donations on behalf of the governor.

Michelle Baass, director of the state Department of Health Care Services, which oversees Medi-Cal, said the contract with Kaiser is part of a larger effort by the state to rework its healthcare program and improve health quality and equity. Since Kaiser is both an insurer and a healthcare provider, Baass said its system is limited in how many patients it can serve and where it can physically care for enrollees. That complicated Kaiser's ability to be part of the formal bidding process with other plans, Baass said.

Without creating a separate avenue for Kaiser, state officials said they risked losing its highest-quality plan, which would affect 900,000 Medi-Cal enrollees who are currently with Kaiser. Under the new deal, Kaiser would commit to growing new Medi-Cal enrollment by 25% over the five-year contract in 32 counties where it currently operates.

"The proposal recognizes that they have a unique structure and because of that we are proposing to enter into this direct contracting relationship," Baass said.

Dr. Bechara Choucair, chief health officer at Kaiser, said the new contract will allow the healthcare company to offer quality care to more people who rely on the state's safety net system.

"The goal is not for Kaiser Permanente to compete with the safety net, but to support it," Choucair said. "We are not competing with other Medi-Cal plans for members, nor are we seeking to turn a profit off Medi-Cal enrollment. Kaiser Permanente participates in Medi-Cal because it is part of our nonprofit mission to improve the health of the communities we serve."

The change, however, means local health plans would lose hundreds of thousands of enrollees that Kaiser was caring for through subcontracts with the local plans. With the local health plans cut out, they stand to lose millions of dollars.

For the Inland Empire Health Plan, the Kaiser contract could mean the loss of 144,000 Medi-Cal enrollees in Riverside and San Bernardino counties. That translates to a loss of $9 million to $10 million a year to the Inland Empire plan for community supports not offered by the commercial plan and for administrative fees, McNaughton said.

Critics have questioned why the state would offer the expanded contract to serve California's neediest residents to Kaiser given the healthcare company has long faced criticism — and state sanctions and fines — for its mental health care.
Anthony Wright, executive director of the advocacy group Health Access California, said the contract would allow the state more oversight of Kaiser, which he said is "a step in the right direction."

"As much as Kaiser does well on many quality metrics, it can and should do better," Wright said. "The arrangement between [the state] and Kaiser should include requirements to maintain or improve Kaiser's record on quality and equity as they take on more of this vulnerable population, especially given their spotty record on behavioral health."

CALIFORNIA'S NO-BID CONTRACT WITH KAISER TRIGGERS CONCERNS

California's No-bid Contract with Kaiser Triggers Concerns
CalMatters
By ANA B. IBARRA
February 4, 2022

State health officials have proposed a no-bid contract that will allow Kaiser Permanente to expand its Medi-Cal coverage area, triggering anger from other health insurance plans and questions from a key legislator.

The proposed contract, which would begin in 2024, allows Kaiser Permanente to skip a bidding process required for other commercial insurers to participate in Medi-Cal, the state's health insurance program for low-income residents. The bidding process for all other insurers starts Wednesday.

As first reported by Kaiser Health News, the state's special deal with Kaiser Permanente has raised concerns among other Medi-Cal plans. They say Kaiser Permanente is getting special treatment that bypasses state procedures and allows it to cover only certain portions of the population.

Nonprofit local health plans, which cover the majority of Medi-Cal enrollees, estimate that Kaiser's expansion could strip them of up to 30% of their members in some counties.

"Offering a statewide, no-bid contract on a silver platter to a commercial plan undercuts the local public health infrastructure while paving a path for large-scale corporate health plan expansion in Medi-Cal," Linnea Koopmans, chief executive officer of the Local Health Plans of California, said in a statement. Her organization represents 16 local health plans, which will not have to bid for a contract since they are nonprofits.

The contract would have to be approved by the Legislature and federal officials before it would be implemented.

Sen. Richard Pan, a Sacramento Democrat who chairs the Senate Health Committee, said the state's move raises many questions. Because local Medi-Cal plans usually report to counties and public boards as well as the state, he wants to know whether Kaiser will engage in a similar process to answer to the local communities they serve.

Pan also has questions about how the state's payments to Kaiser and other health plans will reflect the potential differences in their mix of patients they end up serving.

"If the counties are concerned and they start calling their legislators there might be a lot of questions about this," Pan said. "Kaiser Permanente is a good system, and I'm not saying this is a bad idea, but there are a lot of things here we have to understand."

As part of the agreement, Kaiser Permanente will only have to cover three main groups of people: existing Kaiser members, foster youth and people who are dually eligible for Medi-Cal and Medicare, which covers seniors and people with disabilities, according to officials at the state's Department of Health Care Services.

One of the biggest concerns of the other health insurers is that if Kaiser is only responsible for certain types of patients, then the sickest and most costly patients could be left to them. Health plans say that allowing Kaiser to limit its enrollment to certain people could mean that their population will be healthier, less costly and easier to manage.

State officials, however, pointed out that Kaiser would have to serve people on both Medicare and Medi-Cal, known as dual eligibles, which are among the most complex patients because they have disabilities or are 65 and older. "So this is definitely not a low-risk population, and similarly with foster youth," said Michelle Baass, director of the state's Department of Health Care Services, said in a call with reporters.

Kaiser's Medi-Cal enrollment is expected to grow by 25% under the contract, serving 32 counties.

"The reason we're proposing to enter into this situation with Kaiser is that they are a unique plan partner, they are both a plan and a provider and are bound by their physical capacity," Baass said.

Baass said Kaiser's unique structure does not allow it to build out a network of providers like other health plans can. "We know they provide our highest performing plans in terms of quality and consumer satisfaction and want to recognize that and their unique situation," she said.

But Koopmans said "Kaiser's claims of capacity limitations rings hollow considering they have capacity for Covered California, Medicare, and private industry. Apparently, in Medi-Cal they just don't have capacity for the people with the most need."

Dr. Bechara Choucair, Kaiser's chief health officer, said "the goal is not for Kaiser Permanente to compete with the safety net but to support it. We are not competing with other Medi-Cal plans for members, nor are we seeking to turn a profit off Medi-Cal enrollment."

Choucair said Kaiser has participated in Medi-Cal for decades despite incurring losses from it every year. "It's one of the many ways we work to help improve access to health care for people who otherwise cannot afford the care they need," he said.

Among the people who would be allowed to join Kaiser's Medi-Cal plan are those who were Kaiser members but lost their job-sponsored health insurance and are new to Medi-Cal, state health officials explained. This provision would allow them to keep their doctors. Health advocates say the agreement is concerning given Medi-Cal's expanded role under the state's CalAIM initiative, which is supposed to help address social issues for vulnerable populations such as homelessness.

"We urge the department to require Kaiser to do more in Medi-Cal, including further diversifying future enrollment," said Kiran Savage-Sangwan, executive director of the California Pan-Ethnic Health Network.

Medi-Cal insurance plans have to meet certain standards of transparency, quality, access and equity set by the state health department.

Information Items: (16A. – 16J.)

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: February 23, 2022

TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Alliance in the News

Alliance in the News
Santa Cruz Sentinel
January 25, 2022

Santa Cruz County commits additional $5M to Pajaro Valley Healthcare District Project

Upcoming deadlines to have heavy bearing on future of Watsonville hospital

WATSONVILLE — With a donation approved by its Board of Supervisors on Tuesday, the County of Santa Cruz has now given $5.5 million toward the Pajaro Valley Healthcare District Project's quest to acquire and operate Watsonville Community Hospital.

This will help the health care district project — made up of the county, the city of Watsonville, the Community Health Trust of the Pajaro Valley and Salud Para La Gente — organize all of its funding streams before a Feb. 14 bid deadline. The bid deadline is the latest hearing of Watsonville Hospital Corp.'s Chapter 11 bankruptcy case. The project was formed after the hospital's ownership announced in November that unless it could find a buyer by early this year, it would be closing its doors.

"While the hospital remains open and offers a range of medical services to South County residents, under the current private ownership model it faces financial difficulties and is at imminent risk of closure," the county said of its second donation, a larger undertaking than the $500,000 offered in November. "With 250,000 unique patient visits per year, the hospital provides critical services to an underserved population, including numerous census tracts ranking in the bottom quartile of the California Healthy Places Index.

Project head Mimi Hall told the Sentinel on Tuesday that while the support was expected, its arrival didn't mean any less.

"We are super excited because what this really means, to us, is that this project is a community wide effort," Hall said. "This is just adding that much more weight to the community collective of partners that are slowly coming together to show support."

Along with the county's two contributions, the project recently benefited from a $3 million capital planning grant from the Central California Alliance for Health during a special meeting of its board this month. The Alliance, as it is casually known, is a Medi-Cal managed care health plan for members in Merced, Monterey and Santa Cruz counties.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

"We put together a grant application in a very short amount of time and we had the support of Monterey County, so these dollars will (have been) dollars allocated from both Santa Cruz and Monterey counties," Hall said.

Additionally, the Community Health Trust of Pajaro Valley made a $4.5 million donation just after the nonprofit project was created, Hall said. This means at least $13 million has been invested in the future of access to health care in south county to date.

These funds have helped the project clear one requirement of becoming a qualified bidder: Providing a good-faith deposit.

"We have a high-level business plan that identifies the total amount of capital we are (aiming for) as well as sources," Hall said. "We have met with numerous partners, public and private, about specific asks. Not all of them are about money. There are things that we could use beyond acquisition to (reduce) cost and improve the quality of care. So far, these have been really productive conversations."

One of those sources is the state, Hall said, but the project team is not willing to approach officials at that level with their hands out. State representatives want proof that agencies supporting the project want to be part of the solution to improve health care for Pajaro Valley residents, not the entire solution.

"They made it clear to us that for us to get any state support they really want to see the whole community come together, from health systems to nonprofits…" Hall said. "What happened today is just one more step in the right direction.

Careful concessions

Even if the health care district project is awarded the successful bid at a scheduled auction Feb. 17, it will need support from agencies such as the state to bear one condition of its tentative agreement with current management Halsen Healthcare — The taking on of a $25 million debtor and possession loan, the mystery funding announced last month that kept medical workers employed and services running.

Hall said that part of the preliminary agreement was to keep doors open until March 31 to give the project leaders time to put together a financial campaign. By that date, a sale agreement must be in place. The project board has until Aug. 31 to actually close the sale.

"We are saying, 'We will cover those costs as a part of the sale as it is important to keep the hospital open. If the hospital closed even for one day it would be nearly impossible to reopen," Hall said as she lamented about the ideas of having to rehire back an entire staff or apply for licensure all over again. "To me, that's money well spent."

Between the generosity of the community and the recent emergence of Senator John Laird's Senate Bill 418, which would officially create a health care district serving the

southernmost part of Santa Cruz County and the northernmost part of Monterey County, the project is in a good place.

“Our next biggest hurdle is getting dollars allocated to this effort for acquisition to support the local funds we are trying to get together,” Hall said. “Every little bit helps.”

Watsonville Community Hospital One Step Closer to Staying Open
Alliance in the News
KION 5/46 News Channel
January 20, 2022

WATSONVILLE, Calif. (KION) Watsonville Community Hospital is on life support — however, it is one step closer to finding a buyer thanks to a bill that's making its way to the California Assembly Floor.

The hospital's current owners, Halsen Healthcare, filed for bankruptcy in December 2021, and the Pajaro Valley Healthcare District Project (PVHDP) is currently the primary bidder for the hospital.

"We only have two hospitals in Santa Cruz County," said Mimi Hall, the Chair for the PVHDP Board of Directors. "If we lose one, especially the one that serves our most vulnerable communities, it will have a severe critical impact on everybody."

The Pajaro Valley Healthcare District Project is a nonprofit formed by Santa Cruz County, the City of Watsonville, Community Health Trust of Pajaro Valley and Salud Para La Gente.

They are working to form their own healthcare district — which is a local government entity separate from cities and counties. But in order for that to happen, emergency legislation authored by State Sen. John Laird must pass through the California Senate.

Wednesday night, the bill, S.B. 418, unanimously passed in the Assembly Local Government Committee. It now goes to the Assembly floor, and then hopefully the Senate. The deadline to pass is February 14, 2022.

"If we don't have legislation passed by then, which it is a key benchmark in bankruptcy that the legislation moves ahead, we will not be a qualified bidder," said Hall. "And because this is a quick and an urgency kind of measure, it requires a two-thirds vote. So, we hope that we have the support."

Hall says the hospital has been privately owned for over 20 years, but their healthcare district is looking to change that.

"When there is private equity ownership, you have to make money and you're also accountable to shareholders. In a public district hospital model, who you're accountable to is the community," said Hall. "So the services that you provide are the services that the board members, who are elected members of the public and stewards of the community, deem are the necessary services for the people that we serve."

The closest hospital, Dominican Hospital, is 20 minutes north, so many rely on Watsonville Community Hospital for their care.

"This hospital serves 50% Medi-Cal and another 30% Medicare. It is the hospital that serves our essential worker population, our farmworkers, and those who are monolingual non-English speakers," said Hall.

On Tuesday, PVHDP received a $3 million grant from the Central California Alliance for Health to help with the acquisition of the hospital. Hall says they're also seeking funds from other local public and private organizations to help with the acquisition.

"Most organizations don't put together a plan to buy a hospital in a number of weeks. We've really had to work at rapid speed without a whole lot of resources. We have a really small team. We're not a big health system, we're a brand new nonprofit organization. So what we're doing is we're seeking support for the acquisition for the capital cost of the acquisition," said Hall.

If S.B. 418 doesn't pass and the sale doesn't go through, the hospital will be at risk of closing.

"If the hospital closes even for one day, the license shares, the certifications, all of those have to be started from scratch. It's expensive and it's time-consuming. It's not easy. And in that time, the nurses, the physicians, the other staff, they're all going to find other jobs. It will be nearly impossible to open the hospital again," said Hall.

As part of the current agreement, Hall says the owners of the hospital have agreed to keep their doors open until March 31, 2022 to help give PVHDP time to take over.

Watsonville Hospital: New Owner Could Be Chosen Soon
Alliance in the News
Watsonville Patch
January 20, 2022

WATSONVILLE, CA — If everything goes as planned, the bankrupt Watsonville Community Hospital will have a new owner by the end of next month.

Who that will be depends on the outcome of an auction sale authorized in San Jose last week by M. Elaine Hammond, U.S. Bankruptcy Judge of the Northern District of California. What's uncertain is how many bidders will participate.

In an order signed Jan. 10, Hammond set a Feb. 14 deadline for pre-qualified bidders to submit bids, with the court-supervised auction sale to be conducted on Feb. 17 and a hearing to approve the sale scheduled for Feb. 23.

A sale could write the end to a two-decade saga of money problems at the 106-bed, for-profit regional hospital, which provides critical health care services to a diverse rural population. In 2020 the hospital served 23,000 patients in its emergency room and provided surgical services to 1,800 patients, state data shows.

So far the only identified bidder is Pajaro Valley Healthcare District Project (PVHDP), a nonprofit corporation formed last summer by Santa Cruz County, the City of Watsonville, Community Health Trust of Pajaro Valley and Salud Para Le Gente, a healthcare provider to farm workers and other underserved populations.

But Judge Hammond was told at a Jan. 7 hearing there may be others interested in purchasing the hospital.

Court documents show that Cowan & Company, a New York investment bank retained to find other potential buyers, had sent out more than 120 solicitations and received at least nine responses from companies willing to sign nondisclosure agreements permitting them to examine the hospital's internal financial records. It is unknown how many, if any, of those expressing interest will actually submit bids.

For several months PVHDP has been in discussions with the hospital's owner about purchasing the facility and three weeks after the bankruptcy was filed a purchase agreement was negotiated. If PVHDP is the successful bidder and a healthcare district is formed, ownership would ultimately be transferred to the district.

Last November Santa Cruz County committed $500,000 to PVHDP for preliminary work on hospital acquisition and formation of a healthcare district.

However, that agreement contained several conditions including certain milestones for the state legislature to approve a bill creating the healthcare district and the requirement for a $4.4 million deposit at the time the PVHDP bid is submitted.

The first step in the legislative process was taken Wednesday when the State Assembly Standing Committee on Local Government unanimously approved sending a bill creating the district to the full assembly, which is expected to vote next week. If approved, the bill would head to a senate vote.

That bill was authored by state Sen. John Laird, who testified time was of the essence in passing his bill. "The (hospital's) bankruptcy bought time," Laird told the committee, "but it's urgently needed because it allows for the purchase to happen bids are being prepared."

One reason for the urgency of legislative action revolves around conditions on a loan of several million dollars made to the hospital by MPT to insure the hospital would stay open through March, providing time for the sale. That loan will be repaid from proceeds of the sale.

Mimi Hall, a former Santa Cruz County health official and now PVHDP's president, testified that committee approval of the bill was "crucial to residents of the area," pointing out that Watsonville Community was one of only two hospitals in the county with emergency rooms and nearly half its patients were on Medi-Cal.

Money to cover the deposit was secured when one of PVHDP's member organizations — the Community Health Trust of Pajaro Valley — committed enough for the deposit. On Tuesday the Central California Alliance for Health board of directors approved an additional

$3 million grant to PVHDP to support the purchase.

The Alliance, which is the Medi-Cal managed health plan for Santa Cruz, Monterey and Merced Counties, said in a statement that the funds were made available through a grant program.

"PVHDP's proposal to create a healthcare district and to purchase the hospital fully aligns with our mission of accessible, quality health care guided by local innovation, said Alliance CEO Stephanie Sonnenshine in the statement. "We're pleased that our board voted to make grant funding available to support local action to ensure that Pajaro Valley residents keep access to needed health care services in the community."

For more than two decades under private ownership the hospital has experienced ongoing fiscal problems since its purchase by Community Health Systems in 1998. Financial disclosures filed with the state show the hospital continued bleeding even more money after Halsen Healthcare, an obscure Southern California hedge fund, acquired the facility in 2019 from Quorum Health Corporation for $40 million.

Quorum was created as a spinoff by Community Health during a restructuring in 2015 and itself filed bankruptcy in 2020.

As part of its acquisition from Quorum, Halsen sold the hospital property and building to Medical Properties Trust (MPT), an Alabama-based real estate investment trust, which immediately leased the facility back to Halsen, a transaction that has complicated the hospital's bankruptcy.

Halsen operated the hospital through at least two subsidiary companies until MPT removed Halsen from its management role early last year for failure to meet various financial obligations. Prospect Medical Holdings of Los Angeles took over hospital management.

Financial reports submitted to the California Department of Health Care Access show the hospital lost $14.3 million in 2019 and $17.9 million in 2020. Last year the hospital lost more than $32 million, court documents show.

Proposed health care district gets financial boost, lawmakers' help
Alliance in the News
Good Times
January 19, 2022

The Central California Alliance for Health has provided a $3 million grant to Pajaro Valley Healthcare District Project (PVHDP) to help purchase Watsonville Community Hospital.

The grant is made available through the Alliance's Medi-Cal Capacity Grant Program.

"Watsonville Community Hospital is a critical provider of needed health care services to Pajaro Valley residents, many of whom are Alliance members," Alliance CEO Stephanie Sonnenshine stated in a press release. "PVHDP's proposal to create a healthcare district and

to purchase the hospital fully aligns with our mission of accessible, quality health care guided by local innovation. We are pleased that our board voted to make grant funding available to support local action to ensure that Pajaro Valley residents keep access to needed health care services in the community."

WCH in December reached a preliminary agreement to sell its operations to the new healthcare district sponsored by PVHDP, a nonprofit created by the County of Santa Cruz, the City of Watsonville, the Community Health Trust of Pajaro Valley and Salud Para La Gente.

PVHDP must still get approval by state lawmakers. That would come in the form of Senate Bill 418, introduced this year by Senators John Laird and Anna Caballero.

The urgency legislation has passed through the Senate, received unanimous support by the Assembly Local Government Committee and on Wednesday advanced to the Assembly floor for a full vote.

SB 418 would form a health care district establishing public oversight should the Pajaro Valley Healthcare District Project be successful in its attempts to acquire the hospital from current ownership, Laird stated in a press release.

Co-authors also include Assemblymembers Robert Rivas and Mark Stone.

"The successful passage of SB 418 will ensure the continued provision of vital services to the community and protect the jobs of those who work tirelessly to keep Pajaro Valley residents and their loved ones healthy," Laird stated. "It is our responsibility as a state to ensure no person, parent, or child is left without access to care."

Central California Alliance for Health (the Alliance) is a regional Medi-Cal managed care health plan, established in 1996 to improve access to health care for nearly 380,000 members in Merced, Monterey and Santa Cruz counties.

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Alliance in the News
The Pajaronian
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Elderday will move to downtown Watsonville

Alliance in the News
The Pajaronian
December 23, 2021

WATSONVILLE - After operating for years in Santa Cruz, Elderday Adult Day Health Care will soon relocate to Watsonville.

The move comes thanks to a $2.5 million grant from Central California Alliance for Health, which Elderday will use to purchase and modernize the space at 521 Main St.

Elderday, a program of Community Bridges, currently provides care for about 150 older adults with medical conditions such as dementia, and people with disabilities, allowing them to stay in their own homes and out of institutional care.

The new space offers an additional 3,600 square feet than its current location.

Organizers also say the larger facility—located in a more accessible location in downtown Watsonville—will allow Elderday to serve more people and help meet the needs of a growing aging county population.

The program is staffed by a team that includes nurses, social workers and physical and occupational therapists, with services such as medical, preventive and social care, therapeutic activities, personal care, hot meals and nutritional counseling. Transportation to and from the center is also available.

A study released by the National Council on Aging in March 2021 found that social isolation increased mental and physical health problems in older Americans, exacerbated poverty for those unable to work, and increased food insecurity.

This means the demand will be higher for services like Elderday for some time to come.

During the pandemic when in-person services were limited, Elderday met the needs of clients through telehealth and other remote services.

The organization also partnered with Santa Cruz County Parks and Recreation Departments and libraries to create Senior Center Without Limits (SCWOL), which offers virtual services to any older adult in the county to help them stay connected with activities and friends even as they sheltered in their own homes.

While those virtual services will remain in place, Elderday has begun to gradually bring participants back to the center for in-person services.

“Elderday provides our members who are seniors and people with disabilities in Santa Cruz County a place to meet their social, mental and physical health needs,” said Alliance CEO Stephanie Sonnenshine. “Access to the array of supportive services offered at Elderday is critical to maintaining health for these members, and for their family and caregivers.”

Community Bridges CEO Raymon Cancino said that such care is particularly important after the Covid-19 pandemic forced many into “extreme isolation.”

“We expect to see demand for adult day services grow as seniors feel safer to gather together again,” Cancino said. “During this season of gratitude, we are extremely grateful for the partnership and support that Central California Alliance for Health has provided for the future of Elderday. They are among those organizations for whom Community Bridges is most thankful this holiday season.”

For information, visit www.communitybridges.org and www.thealliance.health.

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Alliance in the News
Newsbreak
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pajaronian.com

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Name Dropping | Van Wong Named new COO
Alliance in the News
Santa Cruz Sentinel
December 19, 2021

Van Wong new COO

Central California Alliance for Health announced Van Wong as the alliance's Chief Operating Officer. Wong joined the Central California Alliance for Health in 2019 as chief information officer and brings more than 20 years of health care IT experience to the role.

During her tenure as CIO, she supported the Alliance in advancing data management, enhanced use of business software and delivered a technology roadmap to ensure the organization had the technology necessary to meet business needs.

"Van's broad experience will support the Alliance's performance in both operational and strategic objectives," said Alliance CEO Stephanie Sonnenshine in a prepared release.

Wong holds a Master of Healthcare Administration from the University of Southern California and Bachelor of Arts in molecular and cell biology and psychology from the University of California Berkeley.

Leaders reflect on Gonzales health facility's impact

Alliance in the News
Salinas Valley Tribune
November 29, 2021

COMMUNITY GETS LOOK INTO TAYLOR FARMS FAMILY HEALTH AND WELLNESS CENTER'S HISTORY, GROWTH

GONZALES — Community leaders recently gathered at the Taylor Farms Family Health and Wellness Center in Gonzales to reflect on the significant impact the recently expanded facility has had on community health and wellness in South Monterey County and surrounding region.

Salinas Valley Memorial Healthcare System President/CEO Pete Delgado empathized the ongoing commitment to the facility, which SVMHS opened six years ago this month. Delgado commented that with support from Gonzales city leaders, the Health and Wellness Center quickly integrated with the population it serves.

"This Center is a living, breathing, always evolving venture," Delgado said. "It was created with the support of truly dedicated partners, such as Taylor Farms, and recently expanded with a sizable grant from the Central California Alliance for Health."

Other speakers at the Nov. 9 event included Joel Hernandez Laguna, SVMHS Board of Directors; Dr. Christine Ponzio, Taylor Farms Family Health and Wellness Center; Jeff Wardwell, CEO, Salinas Valley Memorial Hospital Foundation; and Tiffany DiTullio, Blue Zones Project Monterey County.

After the brief program, which included a video recounting the project history and growth of the Health and Wellness Center, attendees toured the facility and the many health services it offers the community.

According to Delgado, the Gonzales facility holds a special place within SVMHS's network of care.

Taylor Farms Family Health and Wellness Center originally opened in November 2015 as a hospital-based Rural Health Clinic to improve access to primary care in underserved areas and improve the health and quality of life for families in and around Gonzales.

As physicians and staff worked to close the gap in healthcare disparities, it tripled in physical size to more than 30,000 square feet. The expansion accommodated a wider range of specialty care, preventative health and wellness classes and modern community gathering space.

"We are proud of the reputation and growth it has seen in such a relatively short period of time," Delgado said. "Current board members, such as Joel Hernandez Laguna and others, are just as passionate about our commitment to rural health services as the Board of Directors which initially approved the project. The community response has been remarkable."

Blue Zones Project Monterey County, sponsored by SVMHS, Taylor Farms and Montage Health, recently expanded its health and wellness program to the area with a commitment to make the healthy choice, the easy choice. Blue Zones Project is part of an international effort to engage the individuals, families and the community in evidence-based practices that support health and longevity.

The expanded facility offers a variety of services with trusted providers affiliated with Salinas Valley Medical Clinic and SVMHS. Podiatry, general surgery, orthopedic surgery, OB/GYN – women's health, behavioral health and diabetes education are just some of the additional health care resources.

SVMHS and the Monterey County Health Department host annual free community flu vaccine clinics at the Taylor Farms Family Health and Wellness Center and recently held a clinic offering free flu and Covid-19 vaccines.

Leaders reflect on Gonzales health facility's impact

Alliance in the News
California News Times
November 29, 2021

Gonzales — Community leaders recently gathered at the Taylor Farm Family Health and Wellness Center in Gonzales to recall that the recently expanded facility has had a significant impact on the health and wellness of the communities in South Monterey County and its surrounding areas.

Pete Delgado, President and Chief Executive Officer of the Salinas Valley Memorial Healthcare Systems, sympathized with SVMHS's ongoing commitment to the facility it opened six years ago this month. Delgado commented that with the support of Gonzales city leaders, the Health and Wellness Center quickly integrated with the population it serves.

"This center is a vibrant, ever-evolving venture," said Delgado. "It was created with the support of a truly dedicated partner, such as Taylor Farm, and has recently been expanded with a large grant from the Central Coast Alliance for Health."

Other speakers at the November 9th event included SVMHS Board Joel Hernandez Laguna. Dr. Christine Ponzio, Taylor Farms Family Health and Wellness Center; Salinas Valley Memorial Hospital Foundation, CEO, Jeff Wardwell. Blue Zone Project Tiffany Diturio in Monterey County.

After a brief program that included a video explaining the history of the project and the growth of the Health & Wellness Center, participants toured the facility and the many medical services it provides to the community.

According to Delgado, the Gonzales facility occupies a special place within the SVMHS care network.

The Taylor Farms Family Health and Wellness Center is a hospital-based rural area to improve access to primary care in poorly serviced areas and to improve the health and quality of life of families in and around Gonzales. It was opened in November 2015 as a health clinic.

When doctors and staff strove to close the medical gap, it tripled in physical size to over 30,000 square feet. This expansion accommodates a wider range of specialized medical care, preventive health and wellness classes, and modern community gathering spaces.

"We are proud of the reputation and growth we have seen in such a relatively short period of time," said Delgado. "Current board members, such as Joel Hernandez Laguna, are as passionate about local health care services as the board that originally approved the project. The community response is noteworthy."

The Blue Zone Project Monterey County, sponsored by SVMHS, Taylor Farm and Montage Health, has recently promised to extend its health and wellness program to the region to make healthy and easy choices. The Blue Zone Project is part of an international effort to involve individuals, families and communities in evidence-based practices that support health and longevity.

The expanded facility offers a variety of services with the Salinas Valley Medical Clinic and trusted providers affiliated with SVMHS. Podiatry, General Surgery, Orthopedics, OB / GYN – Women's Health, Behavioral Health, Diabetes Education are just a few of the additional healthcare resources.

SVMHS and the Monterey County Health Department host an annual free Community Influenza Vaccine Clinic at the Taylor Farm Family Health and Wellness Center, and recently hosted a clinic offering free influenza and Covid-19 vaccines.

AROUND TOWN: Hope arrives in the form of new campus for Rescue Mission
Alliance in the News
Merced County Times
November 26, 2021

The first phase of the Merced County Rescue Mission's new Village of Hope campus in Merced is nearing its final stages of development and is expected to open at the start of the new year.

The grand opening will honor the Mission's decade-long effort for a larger residential program to help people who are homeless take the next steps toward independence.

"God has done great things because we started with nothing," says Bruce Metcalf, the Mission's executive director. "For years and years, the Mission has tried to find land that was acceptable by neighbors, and the city, and the county. And then, about five years ago, we lost the main building that we had on Canal Street, and the Mission was homeless. So we started renting houses to conduct our programs, and then finally in December of 2018 we were able to purchase five acres of land — and without that land, our dream of a new campus was nothing more than a pipe dream."

The new campus location is in south Merced, between East Childs Avenue and West Cone Avenue, just behind the old Calvary Cemetery. Once the Mission acquired that land, Metcalf says the project started to attract increased community support and much-needed grants.

"It kind of snowballed, and it's just been incredible how it's developed," he says.

The Mission has received a total $4.5 million in grant money from organizations such as the Central California Alliance For Health (the county's medical provider) and the Dignity Health Medical Group, among others. A groundbreaking ceremony was held in August of 2020, and development immediately started on about three acres. The total cost of the project is estimated to be $7.5 million, and the Mission continues to fundraise to reach that goal.

Meanwhile, the first three buildings on the new campus are almost ready to open. The Hope Respite Care center will be dedicated to recuperative care for homeless people who are discharged hospitalization at Mercy Medical Center.

"We will take them in, help them get to doctors' appointments, help them get better, and help them figure out housing for the future."

The building features recovery rooms and bathrooms for 20 men and 12 women. An on-site clinic will be operated by Golden Valley Health Centers. The site also features separate male and female "sobering rooms" that will serve as place where law enforcement officers can bring homeless people who are in need of drug detox. The Mission is working with the county's Behavioral Health Department, Golden Valley Health Centers and local law enforcement agencies to develop a cooperative agreement to operate the sobering rooms. Sobering rooms, Metcalf says, have had proven success in other cities, and they can be an alternative to expensive hospital stays or even a night in jail.

Hope Respite Care also features a full-on kitchen / cafeteria that can be used as a multipurpose room for other rescue mission programs or events.

Another building near completion features 10 one-bedroom apartments for homeless veterans. The fully-equipped apartments have access to a laundry facility, outdoor patio areas, and the nearby cafeteria. It's considered permanent supportive housing for veterans, so once the county places a veteran in one of the apartments, the veteran can seek other housing options or stay on the premises indefinitely.

The third building is identical to the one for homeless veterans, only it has 10 one-bedroom apartments dedicated for homeless families with children. At present, local government agencies offer one- to three-week motel vouchers for struggling families who are seeking shelter. The Mission plans to work with county officials to place these families in the apartments where they will have access to kitchens, laundry facilities, and even extra hideaway beds. A children's playground is also planned outside the apartments. Metcalf says the new facility will improve the process to get homeless families back on their feet and in improved living conditions.

Metcalf says the opening of the Village of Hope campus could not come at a better time. The number of people who are homeless in Merced County has continued to grow. The

number of people on waiting lists for Mission programs also continues to grow. And the COVID-19 pandemic has forced closures at other facilities that serve the homeless, including the new Navigation Center that opened last March.

Today, in addition to the new Village of Hope campus, the Merced County Rescue Mission has 24 residential sites across the county to serve the homeless and provide faith-based programming for those men and women who are struggling with addiction. They have about 85 total employees and will probably hire at least two more for the new campus.

“I believe this new campus belongs to the whole community of Merced and Merced County,” Metcalf says. “It’s really a whole group of people — organizations and government agencies — that have rallied together to make this happen.”

Alliance Fact Sheet
January 2022

ABOUT THE ALLIANCE

The Alliance is an award-winning regional non-profit health plan, established in 1996, with **over 26 years** of successful operation. Using the State's County Organized Health System (COHS) model, we currently serve **386,980 members** in Merced, Monterey and Santa Cruz counties. We work in partnership with our contracted providers to promote prevention, early detection and effective treatment, and improve access to quality health care for those we serve. This results in the delivery of innovative community-based health care services, better medical outcomes and cost savings. The Alliance is governed with local representation from each county on our Board of Commissioners.

Quick Facts[2]

1996
Year Established

486
Number of Employees

$1.6 B
YTD Revenue

5.0%
Spent on Administration

Service Area:
Merced, Monterey and Santa Cruz counties.

Membership by Program

Total Membership: **386,980**[3]

386,464
Medi-Cal

516
Alliance Care IHSS

OUR VISION

Healthy People,
Healthy Communities.

OUR MISSION

Accessible, quality health care guided by local innovation.

WHAT WE DO

The Alliance is a health plan that was developed to improve access to health care for lower income residents who often lacked a primary care "medical home" and so relied on emergency rooms for basic services. The Alliance has pursued this mission by linking members to primary care physicians (PCPs) and clinics that deliver timely services and preventive care, and arrange referrals to specialty care.

WHO WE SERVE

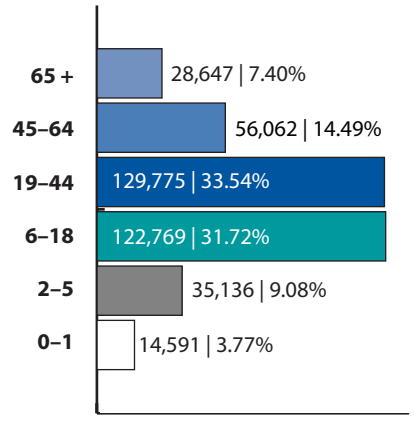
Our members represent 40 percent[1] of the population in Merced, Monterey and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income mothers and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled, and low-income, childless adults ages 19–64.

Our programs currently include Medi-Cal Managed Care serving Merced, Monterey and Santa Cruz counties and Alliance Care In-Home Supportive Services (IHSS) in Monterey County.

PROVIDER PARTNERSHIPS

The Alliance partners with more than 11,990 providers to form our provider network, with 85 percent of primary care physicians and 84 percent of specialists within our service area contracted to provide services to our members.

Membership by Age Group



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EXECUTIVE LEADERSHIP

Stephanie Sonnenshine
Chief Executive Officer

Lisa Ba
Chief Financial Officer

Dale Bishop, MD
Chief Medical Officer

Scott Fortner
Chief Administrative Officer

Van Wong
Chief Operating Officer

Chief Information Officer
Open until filled

GOVERNING BOARD

The Alliance's 21-member governing board, the Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan. In alphabetical order, current Board members are:

- **Supervisor Wendy Root Askew,** County of Monterey
- **Dorothy Bizzini,** Public Representative
- **Leslie Conner,** Executive Director, Santa Cruz Community Health Centers – Alliance Board Chairperson
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas
- **Larry deGhetaldi, MD,** President, Santa Cruz Division, Palo Alto Medical Foundation (Sutter Health)
- **Julie Edgcomb,** Public Representative
- **Supervisor Zach Friend,** County of Santa Cruz
- **Charles Harris,** MD, Interim Chief Executive Officer, Natividad Medical Center
- **Dori Rose Inda,** Chief Executive Officer, Salud Para La Gente
- **Elsa Jimenez,** Director of Health, Monterey County Health Department - Alliance Board Vice Chairperson
- **Shebreh Kalantari-Johnson,** Public Representative
- **Michael Molesky,** Public Representative
- **Rebecca Nanyonjo,** Director of Public Health, Merced County, Department of Public Health
- **Supervisor Josh Pedrozo,** County of Merced
- **Elsa Quezada,** Public Representative
- **James Rabago,** MD, Merced Faculty Associates Medical Group
- **Allen Radner,** MD, Salinas Valley Memorial Healthcare System
- **Joerg Schuller,** MD, Vice President Medical Affairs, Mercy Medical Center
- **Rob Smith,** Public Representative
- **Tony Weber,** Chief Executive Officer, Golden Valley Health Centers
- **Vacant,** Health Services Administrator of Santa Cruz County

AWARDS

The Alliance is a multi-award winning organization for outstanding health plan performance, quality and leadership in health care.

State Quality Awards:

Over the years, the Alliance has received numerous awards including the Department of Health Care Services (DHCS) Quality Awards for performance in the state's annual Healthcare Effectiveness Data Information Set (HEDIS®) measures for Medi-Cal managed care plans. The recent awards include:

DHCS 2021

- Consumer Satisfaction Award for going above and beyond in children's care for medium-sized health plans in 2021

2019

- Outstanding Performance for Medium-sized Plan

2018

- Most Improved Runner Up for Santa Cruz/Monterey Counties
- Innovation Award for Academic Detailing

Customer Service Honors:

- DHCS 2011 Gold Quality Award for Outstanding Service and Support

Employer Workplace Distinctions:

- American Heart Association 2016 Workplace Health Achievement Gold Level Award as a "Fit and Friendly Workplace"
- Second Harvest Food Bank, Santa Cruz County – CEO Cup 2018, 2017; Titanium Award 2015, 2014, 2013
- United Way of Santa Cruz County 2018, 2013 Corporate Campaign Gold Award
- 2020 Certified California Green Business - Program Participant since 2008
- 2020 Blue Zones Project Approved Worksite
- Recognized by the Santa Cruz County Breastfeeding Coalition and Community Bridges WIC for being a model for employee lactation accommodation, 2021

[1]County population data source: U.S. Census Bureau 2019 population estimate (as of Jul. 1, 2020). Membership percentage by county: Merced (50 percent); Monterey (40 percent); Santa Cruz (28 percent).
[2]Fact sheet data as of January 1, 2021., [3]Fact sheet data as of January 1, 2021.

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1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Ste. B
Merced, CA 95240-4710
209-381-5300

2021
ANNUAL REPORT
TO THE SANTA CRUZ, MONTEREY, AND MERCED COUNTY BOARD OF SUPERVISORS
FROM
THE SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSION

Central California Alliance for Health (the Alliance) is a locally governed and operated public agency established by Ordinances adopted by the counties of Santa Cruz, Monterey, and Merced. The Alliance is governed by the Santa Cruz – Monterey – Merced Managed Medical Care Commission (the Commission), whose members are appointed by the Boards of Supervisors in each county.

- The Alliance's Vision: Healthy people. Healthy communities.
- The Alliance's Mission: Accessible, quality health care guided by local innovation.
- The Alliance's Values: Improvement, Integrity, Collaboration, Equity

The Commission seeks to achieve the Alliance's mission through operation of a County Organized Health System (COHS) health plan, currently serving over 380,000 members in Santa Cruz, Monterey and Merced counties.

Commission Structure

The Alliance is governed by the Santa Cruz – Monterey – Merced Managed Medical Care Commission, a twenty-one member commission appointed by the counties' Boards of Supervisors, with seven members from each county representing interests of the public, providers, and government. Additionally, the Commission has established advisory groups consisting of member and physician representatives, which advise the Commission on policy matters.

The Commission meets regularly in public meetings governed by open meeting laws afforded through the Brown Act. In 2021, the Commission held 8 regular board meetings which were conducted via video and teleconferencing and accessible to all members of the public telephonically or otherwise electronically in compliance with the Governor's Executive Orders N-25-20 and N-29-20, as well as Assembly Bill 361 signed by Governor Newsom on September 16, 2021. During these meetings, the Commission discusses and decides upon policy issues and receives reports regarding on-going operations from Alliance staff. In June, the board held an in-person all day retreat to discuss and decide upon the Alliance's 5-year strategic plan.

At the April 2021 Commission meeting, Ms. Leslie Conner, Executive Director of Santa Cruz Community Health Centers, was elected to serve as the Commission Chairperson and Ms. Elsa Jimenez, Director of Health for the Monterey County Health Department, was elected to serve as the Vice Chairperson.

See Attachment A for a list of Commissioners who served during 2021, including each Commissioner's category of representation, and Attachment B for a report of Commissioners' meeting attendance during 2021.

Commission Activities and Accomplishments in 2021

2021 brought another year of challenges for the health care delivery system as we entered the second year of the COVID-19 pandemic. Early in 2021, the Alliance's priorities and activities shifted to ensuring an awareness of and access to the COVID-19 vaccine for our most vulnerable members. Alliance staff worked in conjunction with local community health care leaders and legislative representatives to advocate for an equitable vaccine distribution.

With a continued focus on supporting Alliance members, providers and community organizations to address healthcare needs within the community, activities and accomplishments of the Commission and the Alliance during 2021 included:

1. **Medi-Cal Capacity Grants.** The Alliance governing board awarded 14 grants totaling $11.1M to community partners to expand Medi-Cal capacity in the Alliance service area through investment of a portion of the Alliance fund balance. Grants awarded in 2021 are estimated to impact 6,225 Alliance members through: 1) recruitment of six new primary and specialty care providers to the service area; 2) renovation of a new Adult Day Health Care facility in Watsonville and construction of 120 units of permanent supportive housing for chronically homeless individuals in Santa Cruz; 3) increased access to recuperative care and bridge housing services for members experiencing homelessness in the service area; and 4) essential services to Medi-Cal members affected by the COVID-19 crisis.

2. **Recuperative Care Pilot.** The Alliance launched the Recuperative Care Pilot in 2021. The pilot utilizes Medi-Cal Capacity Grant Program funding to provide recuperative care (also known as medical respite) and temporary housing for Alliance Medi-Cal members who are currently homeless and recovering from an acute illness or injury. This short-term housing solution is an alternative to hospital care for individuals experiencing homelessness who no longer need

hospital care for an illness or injury but whose medical needs would worsen by living on the street or in a shelter.

3. **CalAIM.** Throughout 2021, Alliance staff across the organization undertook efforts to prepare for the new Enhanced Care Management benefit and Community Support services that are a component of the DHCS Cal-AIM program starting in January 2022. These programs will support members with complex medical, behavioral and social needs though care management and other supportive services that are provided within the community by community providers.

4. **Voluntary Rate Range Program.** With approval of the federal Centers for Medicare and Medicaid Services and DHCS, using the Alliance's Medi-Cal managed care contract as a funding mechanism, the Alliance facilitated the receipt and distribution of over $45.7M in federal funds to county public health departments and public hospitals by leveraging local funds contributed by interested, qualified governmental agencies through intergovernmental transfers.

5. **Preventive Care.** The Alliance Care Based Incentives and Proposition 56 funded value-based payment program resulted in over $12M in payments to providers for the provision of timely preventive to Alliance members.

6. **Access to Care.** The Alliance demonstrated to regulatory oversight agencies a contracted provider network that fully meets state and federal standards for network adequacy as indicated by receiving a full passing score on its 2021 annual network certification submission to DHCS.

7. **Diversity Equity and Inclusion (DEI) Initiative.** In 2021, the Alliance partnered with external consultants to lead efforts in developing a comprehensive diversity, equity, and inclusion (DEI) framework that seeks to eliminate disparities in outcomes for members and promote equity in the Alliance workforce. This work included assessing current DEI policies, programs, and perceptions via a global assessment, as well as receiving recommendations to further develop programs, internally and externally. The goal is to achieve health equity and results for Alliance members through a diverse, inclusive, and representative workforce.

8. **Quality of Care.** Alliance providers achieved 4 high performance levels for Healthcare Effectiveness Data and Information Set (HEDIS)/Managed Care Accountability Set (MCAS) and noted statistically significant improvements in

10 individual measures across all counties in the domains for prevention and screening, access and availability, and utilization.

9. **Consumer Satisfaction.** The Alliance received the Department of Health Care Services (DHCS) Consumer Satisfaction Award 2021 – medium scale plan (Child category).

10. **COVID-19 Vaccine Incentive Program.** In September, the Alliance developed and launched a Vaccine Response Program (VRP) approved by DHCS that includes a Vaccine Incentive Program which offers incentives to providers for provision of the COVID-19 vaccination to Alliance members as well as a direct member incentive program which offers $50 gift cards to Alliance members that receive their first or second dose of the COVID-19 vaccine.

11. **Geographic Expansion of Services.** In early 2021, San Benito and Mariposa counties initiated conversations with the Alliance regarding the counties' interest in having the Alliance expand its services to their counties in 2024 when DHCS issues new contracts for managed care plans. Discussions between staff, the Alliance board, representatives of the respective counties and the County Board of Supervisors, resulted in each county Board of Supervisors adopting County Ordinances to form a five-county Managed Medical Care Commission to facilitate this process.

Alliance Members

As of December 31, 2021, the Alliance served approximately 386,000 Medi-Cal beneficiaries and 516 Alliance Care IHSS members.

Membership by County

- In Santa Cruz County, the Alliance has approximately 75,000 Medi-Cal members.
- In Monterey County, the Alliance has approximately 172,000 Medi-Cal members and 514 Alliance Care IHSS members.
- In Merced County, the Alliance has approximately 139,000 Medi-Cal members.

Alliance Medi-Cal Members

Alliance Medi-Cal members are lower income persons in eligible aid categories (e.g. aged, disabled, single-parent, childless adult), and include nearly all Medi-Cal beneficiaries in the region. The Alliance's Medi-Cal members represent the following demographic composition:

- 67.13% are Latino, 15.31% Caucasian, 7.58% Filipino, 2.61% Asian/Pacific Islander, 2.23% African American, and 5.14% are other or not reported.

- 54.60% report primary language as English, 43.0% as Spanish, 0.70% as Hmong and 1.70% as other or not reported.
- 53.11% are female and 46.89% are male.
- 46.7% are 19 years old and younger, while 7.40% are 65 years or older

Alliance Care IHSS members
Alliance Care IHSS members are in-home caregivers that provide home care services for the recipients of IHSS program services in Monterey County.

Alliance Member Services

The Alliance Member Services Department engages and supports members through operation of a call center to respond to member requests, a Grievance System to resolve member issues, and an Operations Unit to maintain member data and execute member informing materials. Member Services staff reside in all three counties served by the Alliance and many staff are bilingual in English/Spanish or English/Hmong. Staff provide high quality service and support to Alliance members, providers, and community-based partners. Staff educate Alliance members about how to access Alliance health care benefits within the managed care environment. This includes providing new member orientations, helping members understand their benefits, answering questions, and resolving member concerns. Member Services develops and distributes member identification cards and member handbooks.

The Member Services Department assists in the facilitation of two public committees that seek feedback from members to inform programs and procedures, including the quarterly Member Services Advisory Group (MSAG) and the bi-monthly Whole Child Model Family Advisory Committee (WCMFAC). Member Services staff are also responsible for reviewing and resolving plan enrollment data issues through collaboration with the local county Medi-Cal offices, the Social Security Administration, and the Department of Health Care Services (DHCS).

Member Outreach

The Alliance's "Your Health Matters" outreach team implemented a robust outbound call campaign to members who reside in zip codes with a high number of COVID-19 cases. The messaging detailed the newly released COVID-19 vaccine and the various vaccine distribution phases. Over 9,500 members were reached during these call campaigns.

Furthermore, in-person outreach to members began in late summer to inform and educate members regarding access to vaccinations and the importance of getting vaccinated, as well as COVID-19 safety precautions. 850 members were directly reached.

Moreover, in September, the Alliance launched a Vaccine Incentive Program which included providing direct member incentives at COVID-19 vaccine clinics. Over 450 members were given a $50 Gift Card at the point of service and over 38,800 Alliance members received a gift card by mail after receiving either a first or second dose of the COVID-19 vaccine.

Alliance Health Services Division

The Alliance's Health Services (HS) Division is responsible for ensuring that members receive the right care in the right place at the right time and assures that the care provided is evidence-based. The Alliance works closely with its network of providers including physicians, hospitals, pharmacies, and ancillary providers, to ensure members receive appropriate and timely access to care. Dale Bishop, MD serves as the Alliance's Chief Medical Officer. Drs. Maya Heinert, Gordon Arakawa and Dianna Diallo continued to cover Medical Director duties for the HS team in 2021. In addition, Dr. Robert Dimand rejoined the MD team as a consultant in November after Dr Heinert transitioned from her position at the Alliance to a teaching position. Physician clinical oversight responsibilities include Quality Improvement & Population Health (QI/PH), Utilization Management/Complex Case Management, Community Care Coordination and Behavioral Health. Under the supervision of Dr. Bishop, the Pharmacy Department oversees the Pharmacy and Therapeutics Committee (P&T).

The Alliance maintains a Quality Improvement (QI) System to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The QI/PH Department monitors the quality of health care services provided and is able to review quality of care at the individual member level, as well as for the Alliance's member population as a whole. The QI/PH department leads the Alliance's population health strategy and effectiveness efforts as well as efforts to increase the provision of preventive care services for members. Performance in these areas is measured through the National Committee for Quality Assurance (NCQA) HEDIS/MCAS measures and the Alliance rewards provider performance through its Care Based Incentives (CBI) program and Proposition 56 funded value-based payments.

The QI/PH Department manages the Alliance's clinical safety program, including review of Potential Quality Issues, Facility Site Review audits, and on-going quality monitoring activities. To support providers with clinical improvement efforts, QI/PH provides technical assistance through practice coaching, learning collaboratives, and continuously accessible durable webinars. In addition, QI/PH offers health

education and cultural and linguistic programs to support members with preventive care and chronic care management interventions.

The Alliance Community Care Collaboration (CCC) Department led Alliance-wide preparations to provide the new Enhanced Care Management benefit and new Community Support services that are available as part of the DHCS Cal-AIM population health program starting in January 2022. These programs will support members with complex medical, behavioral, and social needs though care management and other supportive services that are to be provided in the community by community providers.

It is notable that on January 1, 2022, the Department of Health Care Services carved the pharmacy benefit out of Medi-Cal managed care plan administration. This change was made pursuant to Governor Newsom's Executive Order (N-01-19) The pharmacy benefit for people with Medi-Cal is now managed at a state-wide level through the DHCS contractor Magellan. Significant effort was expended by the Alliance's pharmacy staff over the course of 2021 to inform the DHCS readiness planning, to prepare internal operations for the transition and to communicate with Alliance members and providers to ensure their awareness of this significant transition. The Alliance will remain engaged in supporting members in navigating this change and coordinating to support their access to pharmacy services through 2022.

Alliance Providers

The Alliance recognizes the critical importance of its providers in furthering its mission to ensure access to quality health care for members. The Alliance's contracted network of providers includes Primary Care Providers (PCPs), federally qualified health centers and community clinics, specialists, hospitals, ancillary health services providers, pharmacies, and long-term care facilities. The Alliance continues its efforts to strengthen its provider capacity to provide services, providing a robust network across all three counties in its service area. In 2021, the Alliance added 511 new providers to its provider networks including: 29 PCPs, 125 specialists, 71 non-physician medical practitioners, 47 allied providers, 14 provider organizations, and 225 facility-based providers.

In 2021, the Alliance once again conducted its annual provider satisfaction survey to learn more about its providers' experience with the Plan. The 2021 survey indicated that 89% of physicians surveyed rated the Alliance as completely or somewhat satisfactory, and 99% indicated that they would recommend the Alliance to other physicians' practices. These are the highest levels of Alliance provider satisfaction recorded.

During the third and fourth quarters of 2021, Alliance staff prepared for the implementation of Enhanced Care Management (ECM) and Community Supports (CS), in part by building a contracted network to support the provision of these new services. Through development of new contracts, community engagement sessions, and numerous one-on-one meetings with interested organizations, the Alliance successfully recruited an ECM and CS network and ensured a seamless transition of Whole Person Care services on January 1, 2022.

Alliance Financial Performance

The Alliance's 2021 operating revenue was $1.4B through November 30, 2021.

The Alliance operated with a Medical Loss Ratio (MLR) of 85.6% and an Administrative Loss Ratio (ALR) of 4.9% of revenue for this period. Utilization of routine and elective health care services remained suppressed in 2021 due to the COVID-19 pandemic. As such, the Alliance has reported a net income of $125.5M for the eleven-month period through November 30, 2021.

The Alliance must maintain adequate financial reserves to ensure that the health plan has sufficient funds to cover incurred claims liabilities. The Commission has established a target reserve fund balance for this purpose. As of November 30, 2021, the Alliance was operating at 115% of its targeted reserve fund balance.

Alliance Staff

The Alliance employs 522 individuals in the following divisions: Administration, Employee Services and Communications, Finance, Health Services, Information Technology Services, and Operations. Throughout 2021, the Alliance focused on ensuring the health and safety of staff via a fulltime telecommuting environment while ensuring delivery of services and support to our members and providers. A small number of essential employees work onsite performing duties that cannot be completed remotely.

Alliance in the Community

The COVID-19 pandemic has brought health inequities to the forefront. Early in 2021 with the release of the COVID-19 vaccine, access to the vaccine for underserved populations was challenging due to lack of transportation, lack of distribution sites in rural areas, misinformation, language and other barriers. The Alliance engaged regularly in collaboration with county leaders and local organizations to improve equity measures in our service area. The Alliance's Your Health Matters outreach team shifted efforts from face to face engagement in the community to telephonic engagement by making calls to members within the populations identified within each county as needing additional support. The staff provided essential information needed to assure that members take a safe approach in avoiding COVID-19

infection. When COVID-19 vaccinations became available, the Alliance was strongly positioned to quickly transition from education and resource sharing to vaccine promotion. The ability to quickly shift efforts as information and guidelines changed was an important asset during these challenging times. One on one calls in the member's primary language allowed members to engage in dialogue and have many of their questions answered by trained, culturally competent staff.

Additionally, during 2021, the Alliance and its staff continued involvement in a number of regional and community coalitions and collaboratives that address public health issues, health care access, community networking and eligibility outreach in the Alliance service area. This includes Alliance involvement and participation in the following groups:

In Santa Cruz County

- Cabrillo College Community Health Workers – Program Advisory Committee
- Communications and Education for Farmworkers during COVID-19
- Disaster Recovery Collaborative
- Healthcare Leadership Briefing COVID-19
- OES Community Partner Update Meeting
- Whole Person Care Advisory Council
- Health Improvement Partnership of Santa Cruz Co. (HIPSC)
- Santa Cruz County Operational Call COVID-19
- Santa Cruz Community Prevention Partner Updates
- Vaccine Strategy and Planning Santa Cruz County

In Monterey County

- Access and Functional Needs collaborative
- Active Referral Network
- Aging & Disability Resource Connection
- Blue Zones Project – Wellness Champion Committee
- Disaster Recovery Collaborative
- Community Alliance for Safety and Peace (CASP)
- COVID Collaborative
- CHWs and COVID Outreach Project
- Monterey County Caring Partners (MCCP)
- Monterey County Access and Functional Needs
- Monterey County Census 2020
- Monterey County Commission on Disabilities
- Monterey County COA Protecting Farmworkers from COVID-19
- Monterey County Operational Area Coordination Call

- Monterey Regional Health Development Group, Inc. (MoReHEALTH)
- Nutrition & Fitness Collaborative of the Central Coast
- Preventing Alcohol Related Trauma - South County & Monterey Peninsula
- Safety Net Integration Meeting
- Whole Person Care Social and Clinical Committee

In Merced County

- All in for Health
- Behavioral Health and Recovery Services (BHRS)
- Binational Health Planning Committee
- Community Action to Fight
- Merced County COVID-19 Updates for Healthcare Providers
- Merced County Health Care Leadership Council
- Merced County Local Complete Count Committee
- Merced County A Coalition Counteracting Tobacco (ACCT)
- Merced Mariposa County Asthma Coalition

Local Campaigns for Community Benefit

Alliance staff continued involvement with community food banks and United Way campaigns within Santa Cruz, Monterey, and Merced counties in 2021. Alliance staff raised 206,341 pounds of food and donated $38,689 to the food banks in the three-county service area as part of its holiday food drive efforts and raised $16,434 in contributions to the United Way.

Looking Ahead

The Alliance will focus attention and effort in 2022 and beyond on expanding its service area to San Benito and Mariposa counties in 2024 as well as towards the remaining delivery system transformation envisioned through the state's multi-year CalAIM initiative which includes the development of a Medicare Advantage Special Needs Plan for individuals dually eligible for Medicare and Medi-Cal, the implementation of a Student Behavioral Health Incentive program, and the inception of a new program for housing and homelessness as designed by DHCS.

During 2021, the Alliance engaged in a strategic planning process to develop the organization's next Strategic Plan. Over the next 5-years, the Alliance will pursue two strategic priorities: Health Equity and Person-Centered Delivery System Transformation.

The long-term goals to advance Health Equity include:

1) Eliminate health disparities and achieve optimal health outcomes for children and youth; and

2) increase member access to culturally and linguistically appropriate health care.

The long-term goals to advance Person-Centered Delivery System Transformation:

1) Improve behavioral health services and systems to be person-centered and equitable; and

2) improve the system of care for members with complex medical and social needs.

With a focus on these strategic priorities the Alliance will be prepared to meet future challenges and opportunities presented.

Clearly, there is work to be done to continue efforts towards priorities laid out by the Newsom administration towards delivery system transformation and health equity, and the Commission and staff of the Central California Alliance for Health appreciate the continued support of the Boards of Supervisors as we work towards these goals in the communities which we serve.

Attachment A

Santa Cruz-Monterey-Merced Managed Medical Care Commission
Roster for Year 2021

The Alliance has twenty-one board members (seven from Santa Cruz County, seven from Monterey County and seven from Merced County), in categories of representation including County government and health services, physicians, clinics, hospitals and the public. Board members during 2021 included:

From Santa Cruz County:

Dan Brothman *(effective through 03/09/21)*	Hospital Representative
Leslie Conner, Chair	Provider Representative
Ryan Coonerty	Board of Supervisors
Larry deGhetaldi, MD	Provider Representative
Mimi Hall (*effective through 10/31/21*)	Health Services Agency Director
Dori Rose Inda (*effective 4/27/21*)	Hospital Representative
Shebreh Kalantari-Johnson	Public Representative
Michael Molesky	Public Representative

From Monterey County:

Wendy Root Askew (*effective 01/12/21*)	Board of Supervisors
Maximiliano Cuevas, MD	Provider Representative
Julie Edgcomb	Public Representative
Gary Gray, DO *(effective through 06/04/21)*	Hospital Representative
Charles Harris, MD (*effective 7/27/21*)	Hospital Representative
Elsa Jimenez, Vice Chair	Director of Health
Elsa Quezada	Public Representative
Allen Radner, MD	Provider Representative

From Merced County:

Dorothy Bizzini	Public Representative
Josh Pedrozo *(effective 01/26/21)*	Board of Supervisors
Rebecca Nanyonjo	Public Health Director
James Rabago, MD	Provider Representative
Joerg Schuller, MD	Hospital Representative
Rob Smith	Public Representative
Tony Weber	Provider Representative

Santa Cruz-Monterey-Merced Managed Medical Care Commission - 2021 Meeting Attendance Log

Commissioner	Total Absences	Attendance Rate	2.24.21 [Regular]	3.24.21 [Regular]	4.28.21 [Regular]	5.26.21 [Regular]	6.23.21 [Regular]	9.22.21 [Regular]	10.27.21 [Regular]	11.17.21 [Special]	12.1.21 [Regular]
Askew, Wendy Root	1	89%	Present	Present	Present	Present	Present	Present	EA	Present	Present
Bizzini, Dorothy	0	100%	Present	Present	Present	Present	Present	Present	Present	Present	Present
Brothman, Dan	1	0%	X	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Conner, Leslie	1	89%	Present	Present	Present	Present	Present	Present	Present	Present	EX
Coonerty, Ryan	2	78%	Present	Present	Present	Present	Present	EX	Present	X	Present
Cuevas, Maximilliano	3	67%	Present	EX	Present	EX	X	Present	Present	Present	Present
deGhetaldi, Larry	0	100%	Present	Present	Present	Present	Present	Present	Present	Present	Present
Edgcomb, Julie	2	78%	Present	EX	Present	Present	Present	EX	Present	Present	Present
Gray, Gary	0	100%	Present	Present	Present	Present	N/A	N/A	N/A	N/A	N/A
Hall, Mimi	2	70%	Present	Present	Present	Present	EX	Present	EX	N/A	N/A
Harris, Charles	0	100%	N/A	N/A	N/A	N/A	N/A	Present	Present	Present	Present
Inda, Dori Rose	2	70%	N/A	N/A	EX	Present	Present	Present	Present	X	Present
Jimenez, Elsa	0	100%	Present	Present	Present	Present	Present	Present	Present	Present	Present
Kalantari-Johnson, Shebreh	2	78%	Present	Present	Present	EX	Present	Present	Present	EX	Present
Molesky, Michael	0	100%	Present	Present	Present	Present	Present	Present	Present	Present	Present
Nanyonjo, Rebecca	3	67%	Present	Present	EX	Present	Present	X	X	Present	Present
Pedrozo, Josh	1	89%	Present	Present	Present	Present	Present	X	Present	Present	Present
Quezada, Elsa	2	78%	Present	Present	Present	EX	EX	Present	Present	Present	Present
Rabago, James	0	100%	Present	Present	Present	Present	Present	Present	Present	Present	Present
Radner, Allen	1	89%	Present	Present	Present	Present	Present	Present	Present	EX	Present
Schuller, Joerg	1	89%	EX	Present	Present	Present	Present	Present	Present	Present	Present
Smith, Rob	0	100%	Present	Present	Present	Present	Present	Present	Present	Present	Present
Weber, Tony	2	78%	Present	Present	Present	X	Present	X	Present	Present	Present

X = Unexcused
EX = Excused
"N/A" indicates person was not a Commissioner at this time.

Back to Agenda

1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Suite 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

November 23, 2021

Ms. Donna Chin, MSN, RN, SPHN, CLS
Nursing Director
Merced County Department of Public Health
CHVP
260 E. 15th Street
Merced, CA 95341

Dear Ms. Chin:

With this letter I confirm my commitment to the Merced County California Home Visiting Program (CHVP)-Healthy Families Merced County & Parents as Teachers Community Advisory Board (CAB) for the 2020-2021 fiscal year. I understand the CAB is a group of committed individuals/organizations who share a passion for the program and whose expertise can advise, support, and sustain the program over time. My commitment includes:

- Representation in quarterly meetings by myself or an agency representative with similar knowledge of inter/intra agency relationships.
- Participation in discussions of issues important to the implementation and sustainability of the Healthy Families Merced County Program, Parents as Teachers, and Maternal, Child, and Adolescent Health.
- Partnering with Healthy Families Merced County & Parents as Teachers in coordination and collaboration of resources for the Maternal, Child, and Adolescent populations in Merced County by leveraging, promoting, and assessing program goals and services.
- Communicating the program overview and sustainability needs, maintaining the program's standards and model fidelity, identifying gaps in services, and working toward solutions to address those gaps.

As the Chief Executive Officer of the Central California Alliance for Health, I support the goals to provide leadership to improve the health and well-being of families in Merced County, improve the coordination and referrals for community resources and supports, promote maternal health and well-being, promote prevention and intervention services, improve infant and child health and development, and strengthen family functioning.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

1600 Green Hills Road, Ste. 101
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950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
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530 West 16th Street, Ste. B
Merced, CA 95240-4710
209-381-5300

December 17, 2021

Mr. Tony Weber
Golden Valley Health Centers
1350 San Miguel Way
Merced, CA. 95350

Dear Mr. Weber,

As approved by the governing board of Central California Alliance for Health (the Alliance), the County Organized Health System that operates in Merced County, I offer this letter of support for Golden Valley Health Centers (GVHC) to establish a PACE Organization (PO) to serve designated areas of Merced County.

Additionally, the Alliance board is supportive of the Department of Health Care Service submitting the requisite amendment(s) to the appropriate federal waiver to allow the independent operation of GVHC as a specified PO in Merced County.

GVHC has been a partner with the Alliance since the plan's inception providing health care services to enrolled Medi-Cal beneficiaries through contract with the Alliance since 2009. The Alliance appreciates GVHC's commitment to the Medi-Cal beneficiaries they serve, and we support GVHC's effort to offer a PACE program available to Merced County beneficiaries. The Alliance understands that the PACE program offers an opportunity to help seniors maintain their independence and eliminate or delay the need for institutionalization and the Alliance wholeheartedly supports this goal.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

Member Appeals and Grievance Report
Q4, 2021

Q4 2021 Appeals and Grievances: 529

Appeals: 12% [63% in favor of Plan; 37% in favor of Member]
Exempt: 4%
Grievances: 80%
Other: 4% [Inquiries, Duplicates, Withdrawn]

Category Figures
Transportation: 43%
Quality of Care: 12%
Billing: 11%
Provider/Staff Attitude: 6%
Provider Availability: 4%
Authorization: 2%
Other: 22%

Analysis and Trends
- A high percentage of grievances involved transportation issues for late, missed rides and quality of service issues.
- No other significant trends noted for grievances in Q4 2021.

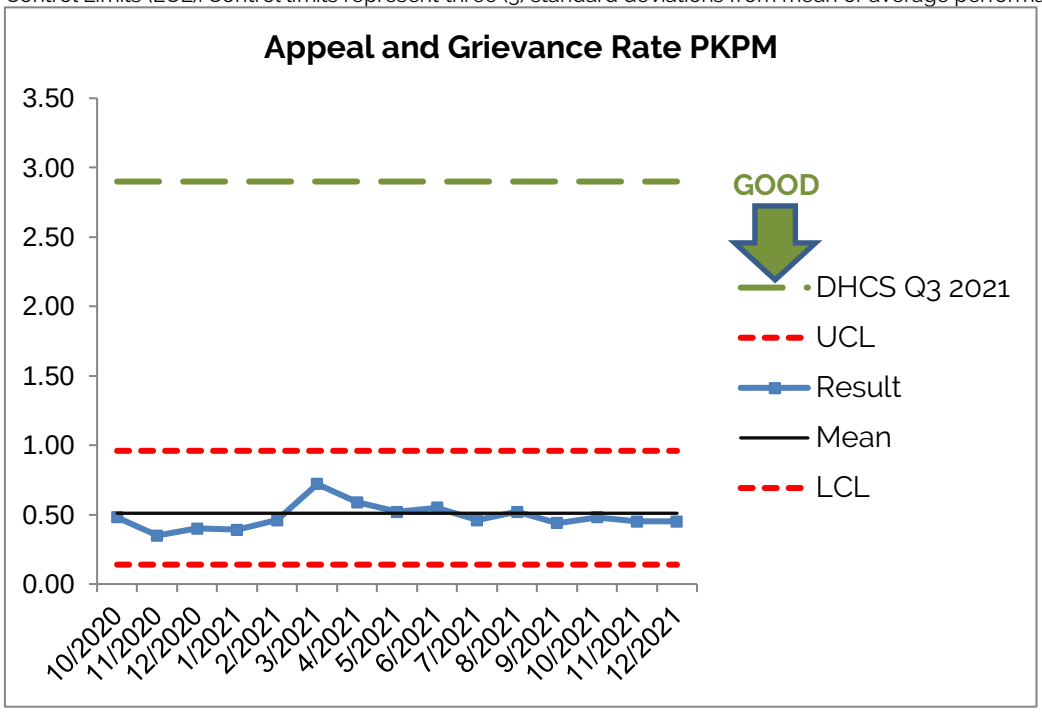
Highest Grievances Filed by County
1. Merced: 42%
2. Monterey: 39%
3. Santa Cruz: 19%

Behavioral Health Beacon Grievances:
- Member Grievances: 10

IHSS Summary:
- Member Grievances: 4

☒ **In Control**
☐ **Not in Control**

A lower rate demonstrates a good or positive result when compared to Upper Control Limits (UCL) and Lower Control Limits (LCL). Control limits represent three (3) standard deviations from mean or average performance.



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	**Oct**	**Nov**	**Dec**
2020 Enrollment	334,394	337,611	337,444	341,861	346,268	350,131	352,983	355,570	358,607	359,810	362,135	364,785
A&G Issues	173	167	141	107	108	162	187	157	183	173	126	146
Rate PKPM*	0.52	0.49	0.42	0.31	0.31	0.46	0.53	0.44	0.51	0.48	0.35	0.40
2021 Enrollment	367,138	369,438	371,533	373,656	376,289	377,759	379,413	380,883	383,027	**384,795**	**385,980**	**387,028**
A&G Issues	145	170	269	222	195	206	173	197	167	**184**	**172**	**173**
Rate PKPM*	0.39	0.46	0.72	0.59	0.52	0.55	0.46	0.52	0.44	0.48	0.45	0.44

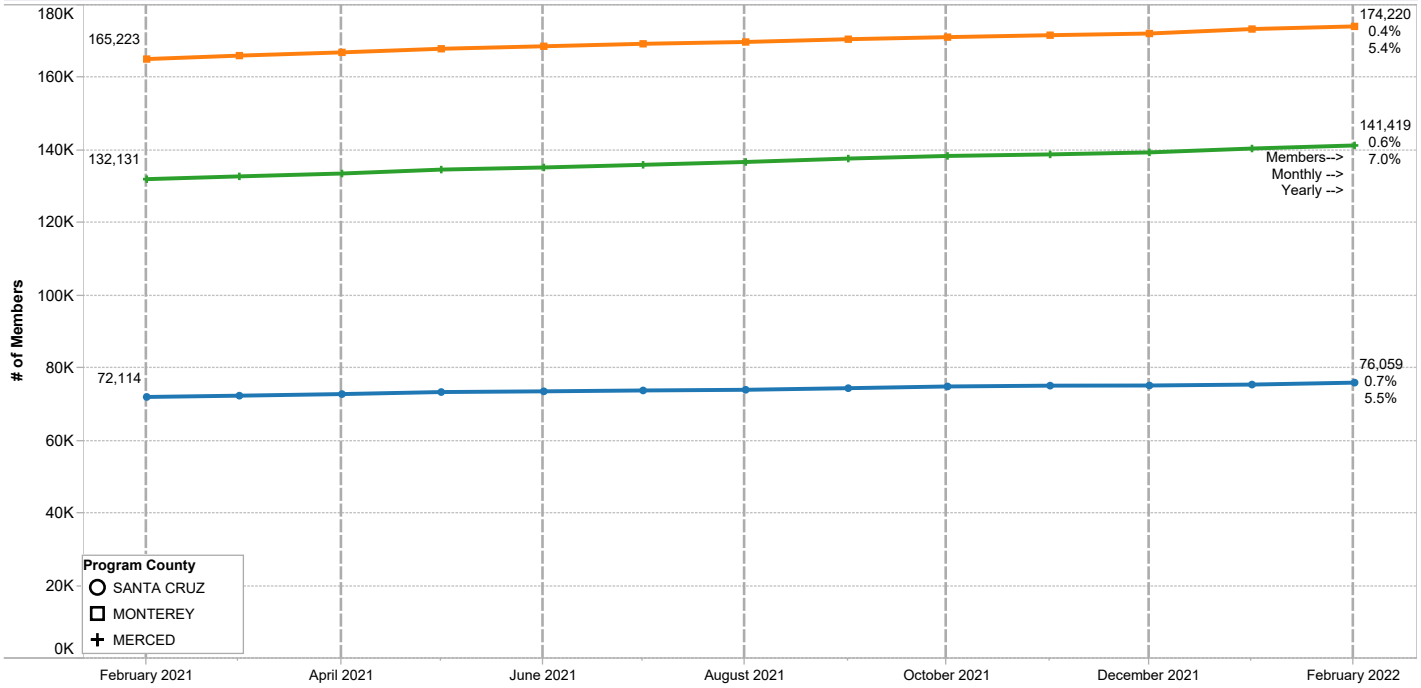
*Grievances Per 1,000 Member Month

Enrollment Report

Year: *2017 & 2018* **County:** *All* **Program:** *IHSS & Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *2/2/2022*

StaticDate
2/1/2021 12:00:00 AM to 2/28/2022 11:59:59 PM

Membership Totals by County and Program, % Change Month-over-Month and % Change Year-over-Year



Program..	ProgramCo..	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022
Medi-Cal	SANTA CRUZ	72,114	72,466	72,908	73,466	73,664	73,904	74,088	74,531	75,003	75,229	75,271	75,527	76,059
	MONTEREY	164,694	165,657	166,551	167,554	168,245	168,929	169,422	170,176	170,752	171,284	171,741	172,985	173,710
	MERCED	132,131	132,894	133,685	134,764	135,349	136,082	136,864	137,804	138,527	138,952	139,499	140,571	141,419
IHSS	MONTEREY	529	516	512	505	501	498	509	516	513	515	517	511	510
Total Members		**369,468**	**371,533**	**373,656**	**376,289**	**377,759**	**379,413**	**380,883**	**383,027**	**384,795**	**385,980**	**387,028**	**389,594**	**391,698**

Santa Cruz County Board of Supervisors

Proclamation

RECOGNIZING SANTA CRUZ COUNTY COMMUNITY PARTNERS FOR PANDEMIC VACCINATION EFFORTS

WHEREAS, it has been nearly one year since the roll out of the COVID-19 vaccine; and

WHEREAS, recognizing the pandemic's great impact on individual lives and the community's vitality, a broad coalition of agencies and organizations mobilized to vaccinate 197,589 individuals with at least one dose of a vaccine, or approximately 72% of Santa Cruz County; and

WHEREAS, the following were responsible for mass vaccination efforts, including, but not limited to, Kaiser Permanente, Sutter Health and Palo Alto Medical Foundation, Dignity Health, Dominican Hospital, Salud Para La Gente, Santa Cruz Community Health Centers, CruzMedMo, Santa Cruz County Health Services Agency, Santa Cruz County Office of Education, Santa Cruz County Medical Reserve Corps, Watsonville Community Hospital, and Safeway, CVS, Rite Aid, Walgreens, Westside, and Horsynder Pharmacies; and

WHEREAS, to all the community partners for their outreach and education efforts to make these mass vaccinations possible, including, but not limited to, Community Bridges, the City of Watsonville, Cradle 2 Career, Community Action Board of Santa Cruz County Inc., Pajaro Valley Prevention and Student Assistance, Santa Cruz Barrios Unidos Inc., Rotary Club of San Lorenzo Valley, Boulder Creek Business Association, FoodWhat, Santa Cruz County Office of Education, Central California Alliance for Health, Community Health Trust of Pajaro Valley, Santa Cruz County Farm Bureau, Community Foundation of Santa Cruz County, Health Improvement Partnership of Santa Cruz County, and Pajaro Valley SAVE Lives; and

WHEREAS, to all other groups for their instrumental support with data collection and logistics, including, but not limited to, Santa Cruz Volunteer Center and the University of California Santa Cruz;

NOW, THEREFORE, I, Bruce McPherson, Chairman of the Santa Cruz County Board of Supervisors, hereby commend and give thanks to all the above-mentioned agencies and organizations for their dedication and efforts to assist the citizens of Santa Cruz County in receiving timely vaccinations.

THE GREAT SEAL OF THE COUNTY OF SANTA CRUZ 1850 SINE PRAEJUDICIO

Bruce McPherson

Chairperson, Board of Supervisors

November 24, 2021

Date