Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Date: Wednesday, April 27, 2022

Time:
Call to Order: 10:45 a.m.
Catered Lunch: 12:05 – 12:35 p.m.
Adjourn: 3:00 p.m.

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

Masks are not required to attend this meeting but are strongly encouraged.

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 12:00 p.m. on Tuesday, April 26, 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. In person, 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.

1. **Call to Order by Chairperson Conner. 10:45 a.m.**

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.

2. **Oral Communications. 10:50 a.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 individuals 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. – 8D.): 10:55 a.m.

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

- Reference materials: Executive Summary from the CEO.

Pages 5-01 to 5-08

6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the second month ending February 28, 2022.**

- Reference materials: Financial Statements as above.

Pages 6-01 to 6-09

Minutes: (7A. – 7C.)

7A. **Approve Commission meeting minutes of March 23, 2022.**

- Reference materials: Minutes as above.

Pages 7A-01 to 7A-07

7B. **Accept Compliance Committee meeting minutes of January 19, 2022.**

- Reference materials: Minutes as above.

Pages 7B-01 to 7B-04

7C. **Accept Finance Committee meeting minutes of October 27, 2021.**

- Reference materials: Minutes as above.

Pages 7C-01 to 7C-05

Reports: (8A. – 8D.)

8A. **Approve recommendation authorizing the Chairperson to sign the agreement between the Alliance and the Monterey County In-Home Supportive Services Public Authority (Public Authority) to provide covered services to eligible and enrolled In-Home Supportive Services (IHSS) providers for the period July 1, 2022 through June 30, 2023.**

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

Page 8A-01

8B. **Approve recommendation to adopt a position of support on AB 1944 (Lee) and direct staff to send a letter of support for this bill.**

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

Pages 8B-01 to 8B-02

8C. **Accept Medi-Cal Capacity Grant Program (MCGP) Performance Dashboard – October 2015 through March 2022.**

- Reference materials: MCGP Performance Dashboard.

Pages 8C-01 to 8C-07

8D. **Approve Medi-Cal Capacity Grants: Funding Recommendations.**

A. Action on grants with no Board member affiliation.

- Reference materials: Staff report and recommendation on above topic; and Recommendation Summaries by Organization.

Pages 8D-01 to 8D-04

Regular Agenda Items: (9. – 15.): 11:00 a.m.

9. **Annual Election of Officers of the Commission. (11:00 – 11:10 a.m.)**

A. Board will nominate and elect Chairperson and Vice Chairperson.

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

Page 9-01

10. **Discuss key issues in Medi-Cal Financing. (11:10 – 11:40 a.m.)**

A. Ms. Lisa Ba, Chief Financial Officer, and Ms. Jennifer Lopez. Director of Health Plan Financing, Local Health Plans of California, will review and Board will discuss key issues in Medi-Cal financing.

11. **Discuss Member Engagement Transformation. (11:40 a.m. – 12:05 p.m.)**

A. Ms. Van Wong, Chief Operating Officer (COO); Mr. Luis Somoza, Members Services Director; and Ms. Lilia Chagolla, Regional Operations Director, will review and Board will discuss Member Engagement Transformation.

- Reference materials: Staff report on above topic; and Member Experience Journey Map.

Pages 11-01 to 11-06

Lunch: 12:05 – 12:35 p.m.

12. **Discuss Evolution of the Medi-Cal Managed Care Plan Network. (12:35 – 1:00 p.m.)**

A. Ms. Wong, COO, and Ms. Jordan Turetsky, Provider Services Director, will review and Board will discuss evolution of the Medi-Cal Managed Care Plan.

- Reference materials: Staff report on above topic.

Pages 12-01 to 12-06

13. **Discuss Equity and Quality in the Medi-Cal Managed Care Environment. (1:00 – 1:40 p.m.)**

A. Dr. Dale Bishop, Chief Medical Officer (CMO), and Ms. Michelle Stott, Quality Improvement and Population Health Director, will review and Board will discuss equity and quality in the Medi-Cal Managed Care environment.

- Reference materials: Staff report on above topic.

Pages 13-01 to 13-04

Break: 1:40 – 1:55 p.m.

14. **Consider approving proposed changes to Alliance's Care-Based Incentives (CBI) for 2023. (1:55 – 2:15 p.m.)**

A. Dr. Bishop, CMO, will review and Board will consider approving proposed changes to Alliance CBI for 2023.

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

Pages 14-01 to 14-02

15. **Discuss evolution of the Medi-Cal Capacity Grant Program (MCGP): Framework for Goal Setting. (2:15 – 3:00 pm.)**

A. Ms. Kathleen McCarthy, Strategic Development Director, will review and the Board will discuss the evolution of the MCGP: Framework for Goal Setting.

- Reference materials: Staff report on above topic.

Pages 15-01 to 15-03

Information Items: (16A. – 16D.)

A.	Alliance in the News	Page 16A-01
B.	County/Stakeholder Letters of Opposition	Page 16B-01
C.	Letters of Support	Page 16C-01
D.	Membership Enrollment Report	Page 16D-01

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, May 25, 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, June 2, 2022; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee
  Thursday, June 16, 2022; 12:00 – 1:00 p.m. [*teleconference*]

- Whole Child Model Family Advisory Committee
  Monday, May 9, 2022; 1:30 – 3:00 p.m. [*teleconference*]

The above meetings will be held in person and via livestream unless otherwise noticed.

The next regular meeting of the Commission, after this April 27, 2022 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, May 25, 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 www.ccah-alliance.org/boardmeeting.html. 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: April 27, 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

Alternate Health Care Service Plan (AHCSP): AB 2724 (Arambula). The AHCSP trailer bill language has been introduced into a policy bill, AB 2724, authored by Assemblymember Arambula to enable the proposed direct statewide contract between the Department of Health Care Services (DHCS) and Kaiser for Medi-Cal managed care services. The bill authorizes the department to enter into comprehensive risk contracts with an AHCSP to serve as a Medi-Cal managed care plan in geographic regions designated by DHCS. The policy bill mirrored the trailer bill language initially introduced to support the direct deal. The bill was amended again on April 7, 2022 to expand foster youth eligibility to include former foster youth, to expand the definition of family linkage, and to prohibit the AHCSP from disenrolling members on its own. Staff continue advocacy efforts in opposition to this proposal. The legislative proposal has garnered a significant amount of opposition, which includes counties, clinics, and associations, including all three of the Alliance current service area counties as well as San Benito and Mariposa County. Related communications, including opposition letters from counties and other stakeholders, are included in the Board packet as Exhibit 16B for your Board's reference. AB 2724 is being heard in the Assembly Health Committee on April 19, 2022 where I will provide testimony in opposition.

2022 Legislative Session. Staff continues to track and monitor legislation of interest and potential impact on the Alliance members, providers and health plan operations. As approved by your Board at the March meeting, staff submitted letters of support for ABs 1995, 1900 and 2402 and SB 966, which are included as Exhibit 16C in the Board packet for your reference. In addition, staff recommend the Board take a position of support for AB 1944 (Lee) as summarized in agenda item 8B on the Consent Agenda for the April 27, 2022 Board meeting.

Hospital Directed Payment and Voluntary Rate Range Programs. The Alliance works in coordination with DHCS, contracted hospitals and other qualified entities to implement a variety of pass through and directed payment programs leveraging available federal funds as authorized by the Centers for Medicare and Medicaid Services. The Alliance has received $218.5M from DHCS for the Hospital Directed Payment Programs ($103.8M), including the Private Hospital Directed Payment Program, the Enhanced Payment Program and the Quality Improvement Program and the Voluntary Rate Range Program ($114.7M) which are passed through to eligible, contracted, qualified providers. Funds received are based on encounter data submitted and services provided throughout the 19-month period of July 2019-December 2020. Upon review and reconciliation of funds received for the above period, payments to providers will be completed this month.

Student Behavioral Health Incentive Program. Following the launch of the Student Behavioral Health Incentive Program (SBHIP) in January, the Alliance selected Local Educational Agencies (LEAs) in each county to partner with on the development of a behavioral health needs assessment. The selected LEAs in each county include:

- Merced County: Atwater Elementary School District and Los Banos Unified School District,
- Monterey County: Alisal Union School District, Soledad Unified School District and Salinas City Elementary School District
- Santa Cruz County: Pajaro Valley Unified School District

Other SBHIP partners in each county include County Behavioral Health and the County Office of Education (COE), as well as Pajaro Valley Prevention and Student Assistance in Santa Cruz County.

Alliance staff held kickoff meetings with all partners in March and early April to provide an overview of the required milestones to accomplish this year and are currently meeting with the key stakeholders of each LEA to review the DHCS needs assessment components in greater depth.

All selected partners have received a Letter of Agreement (LOA) outlining the milestones, deliverables and payment schedule. The first incentive payment will be issued upon receipt of the signed LOA.

Community Involvement. On April 14, 2022 I attended the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting and the Local Health Plans of California April Board meeting on April 18, 2022 in Sacramento. I attended the virtual Housing for Health Partnership Policy Board meeting on April 20, 2022 and the virtual HIPSCC Executive Committee meeting on April 21, 2022. On April 22, 2022 I attended the Mission Merced Village of Hope ribbon cutting ceremony.

Health Services

The Health Services Division current priorities and efforts include finalizing reporting for the COVID-19 Vaccine Incentive Program, beginning with the Alliance booster incentive, and evaluating opportunities to increase Adverse Childhood Experience (ACE) screening, Work continues as additional members are added to the Enhanced Case Management (ECM) and Community Services (CS) program.

COVID Report

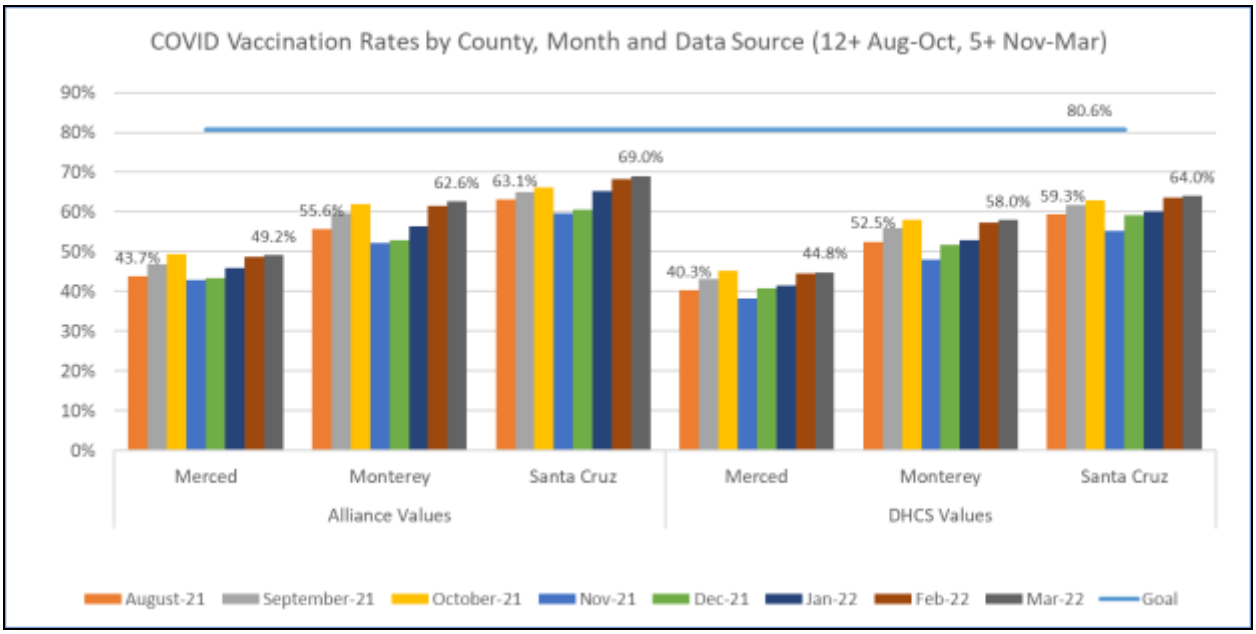
Alliance Immunization Rates as of March 29, 2022:

ALLIANCE COVID-19 IMMUNIZATION RATES BY COUNTY

Region	% of Alliance members with at least one dose	% of county residents with at least one dose	% of Alliance members fully vaccinated	% of county residents fully vaccinated	% of Alliance members partially vaccinated	% of county residents partially vaccinated
Santa Cruz	69.2%	84.3%	63.9%	77.8%	5.3%	6.5%
Monterey	62.6%	83.3%	56.4%	74.9%	6.2%	8.4%
Merced	49.2%	67.3%	42.2%	53.5%	7.0%	13.8%

Data as of 03/29/2022

Booster Dose Incentive Program for Members. Alliance data (tri-county) showed as of March 1, 2022, our eligible membership 12 years and older had a booster rate of 29.6%. Using the California Department of Public Health data, we identified that the overall county rate of fully vaccinated persons with booster doses was 49.6% on the same date. Based on this data, Health Services wants to achieve a rate of 40% of members receiving a COVID-19 vaccine booster dose by May 31, 2022. Members are eligible for a $50 gift card at local Point of Service venues or will receive the gift card by mail for the period March 1, 2022 to May 31, 2022.



Provider Incentive Results from September 1 - December 31, 2021. For the First Reporting Period, September 1 - December 31, 2021, the Provider Incentive Program paid out $263,585. Distribution of funds by county:

- For the first incentive, CalVax enrollment after August 31, 2021: There were three recipients ($10k each) for a total of $30,000.
- For the second incentive, FFS payments, 21 sites received payment (6,373 members), $159,325 total.
- For the third incentive, the programmatic payments, Alliance paid out $74,260. For the calculated rates for the 125 sites participating, 16 sites met the 70% rate and just one site met the 85% threshold. There were 132,383 compliant members overall and site immunization rates ranged from 39.43% - 86.49%.

Program Name	Payment Amount
Santa Cruz Medi-Cal Managed Care Program	$ 106,495.00
Monterey Medi-Cal Managed Care Program	$ 90,890.00
Merced Medi-Cal Managed Care Program	$ 66,200.00
	$ 263,585.00

Utilization Management/Complex Case Management (UM/CCM)

Inpatient/Emergency Department Utilization. Inpatient utilization has continued to trend downward in March, most likely reflecting the decreased impact of COVID-19 following the Omicron surge.

Emergency department volumes continue to trend downward, likely reflecting the combination of improved COVID-19 conditions following the Omicron surge and the waning of normal winter seasonal utilization.

Prior Authorization. Outpatient authorization volumes remained gross stable in March compared to the previous five months. No overall change is noted in transportation-related authorization volumes in March. There is no evidence of overutilization in authorizations involved in the Authorization Reduction Project. There was an increase in referral authorization form volume in March, possibly reflecting a shift to return-to-care needs of members.

Pharmacy

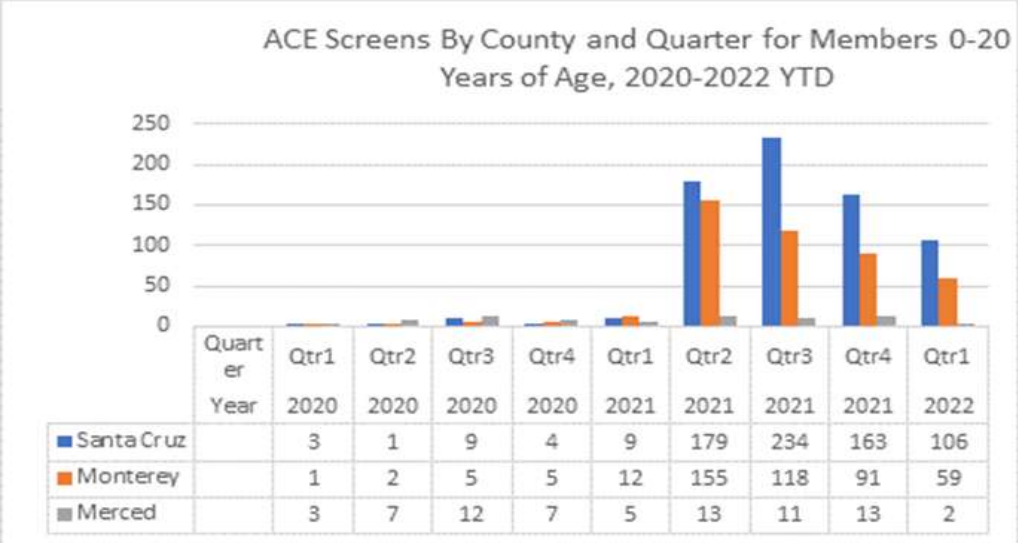
The issues with medication access under Medi-Cal Rx has significantly slowed down due to reject code waivers at point of sale and DHCS prior authorization policy changes. Currently, the backlog of prior authorizations with Magellan has been cleared, and Magellan is meeting its 24-hour turnaround time. To prevent similar issues in the future, the Alliance, with the help of Local Health Plans of California, is advocating to not remove waivers until Magellan is prepared operationally to handle the impact.

The Alliance raised a concern with DHCS on crossover claims submitted to us from Centers for Medicare & Medicaid Services. The Alliance is still receiving crossover claims for drugs that are typically seen on pharmacy claims. DHCS's guidance to pay for those crossover claims conflicts with their Medi-Cal Rx policy to exclude pharmacy claims from Managed Care Plans (MCPs). DHCS is further exploring this issue and will be providing clarification to MCPs.

The Alliance Pharmacy team has initiated their work on Post Medi-Cal Rx roles and responsibilities, which is to build clinical programs that provide oversight of the medication management for our members.

1. *Beneficiary Care Coordination Program* is in progress to support our pharmacies and providers with any prescription related issues with Medi-Cal Rx.
2. *Medication Reconciliation Program* will begin for our high risk and high-cost members. It will help mitigate any discrepancies in medication lists at transition of care for members with complex needs.
3. *Retrospective Drug Utilization Review* will be continued with a focus on members on opioids/benzodiazepines combination, opioids/antipsychotics combination and antipsychotic use in children.
4. *Site of Care Program* will be initiated to create a delivery system for administration of Physician Administered drugs for members in the comfort of their homes and/or their physicians' office.
5. *Provider Coaching Program* pilot with county clinics led to improved member health outcomes. This program will be expanded to provide support to our providers.
6. *The Clinical and Operational Oversight of IHSS Delegation to MedImpact* is in progress. The metrics will be reported on a quarterly basis in the UM Workplan and on a yearly basis under the Compliance Delegate Oversight program.

Quality Improvement and Population Health. The ACEs Aware published a report on ACE screenings by the Medi-Cal MCP Network for the period July 1, 2020 to June 30, 2021 which indicated negligible (<1%) rates for Central California Alliance for Health compared to other plans for children (0-20 years) and adults (21-64 years). The data below demonstrated an uptick in the second quarter and more ACE screenings may be performed in the clinics as the report requires 12 months continuous enrollment and rendered by a primary care provider only. Barriers to implement ACE screening include difficulty in implementing new processes in the context of COVID-19 priorities, a need for additional information related to billing and referral workflows, and allotted time to complete ACE training and attestation.



	Quarter	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1
	Year	2020	2020	2020	2020	2021	2021	2021	2021	2022
Santa Cruz		3	1	9	4	9	179	234	163	106
Monterey		1	2	5	5	12	155	118	91	59
Merced		3	7	12	7	5	13	11	13	2

The Alliance has taken steps to increase ACE screenings including an environmental scan of Merced County conducted by Health Improvement Partnership to assess barriers and resources, an exploratory care-based incentive measure in 2022 with a proposal to activate the measure in 2023, and various promotional efforts such as at clinical Joint Operating Committees, provider bulletin and member newsletter articles, and fax blasts for external grants. An ACE training video for non-clinical staff was posted on the provider website as requested by ACEs Aware grantees in Santa Cruz County and recently, an ACE Continuing Medical Education was provided in March 2022 along with Alliance resources and best practices. ACE screening was added to the 2022 Quality Improvement System Workplan for continued monitoring and an action plan.

Community Care Coordination (CCC)

Enhanced Case Management and Community Support Services. The ECM/CS team continues to work with other internal partners and the consultant Health Management Associates to support contracted community providers in the delivery of ECM/CS.

To ensure ECM/CS provider capacity and availability to accept new members for ECM/CS, the Alliance has completed contracting efforts to onboard three new contracted providers in Santa Cruz and Monterey Counties. The ECM/CS team has been working with the Provider Services team to assist with the orientation and onboarding support needed to prepare these new providers to deliver the ECM core services and required CS activities. It is expected that they will begin ECM/CS service delivery late this month. Additional efforts are underway to contract with an additional three providers in Santa Cruz and Monterey

Counties, as well as work to identify potential partners for ECM/CS delivery in Merced County, beginning in July 2022.

Lastly, the Alliance was able to go-live with the care coordination software platform, *Activate Care,* earlier this month. ECM/CS provider access to a care coordination software platform assures that the Alliance will meet one of DHCS' Incentive Payment Program (IPP) measures of provider's ability to obtain a certified EHR technology or a care management documentation system that can generate and manage a patient care plan. The scope of work and implementation of the two closed loop referral systems, Unite Us and Smart Referrals, is also underway. This is another example of infrastructure development that is a goal of the IPP.

Behavioral Health. Many efforts are underway to address changes that are being made by DHCS and the Department of Managed Health Care (DMHC) to assure the strengthening of behavioral health (BH) services to Medi-Cal members. The Alliance's team is currently working with County BH partners on these CalAIM efforts to assure members a no wrong door approach to accessing BH services, and further defining how coordination of care should be implemented for members with eating disorders. Updates to existing memorandum of understandings are in process to support a shared understanding of each organization's roles and responsibilities.

The Alliance has also identified a need to add a BH Director position within the organization. CCC staff have collaborated with other internal departments to develop the position description and other guiding documentation, and the position was posted the beginning of this month. This position supports the expansion of BH initiatives within CalAIM, as well as the increased emphasis of BH within the Alliance Strategic Plan Goal of Improved Behavioral Health Services and Systems to be Person-Centered and Equitable, within the Priority Area Person-Centered Delivery System Transformation.

Employee Services and Communications

Alliance Workforce. As of March 28, 2022, the Alliance has 521.55 budgeted positions of which our active workforce number is 493.9 (active FTE and temporary workers). There are 22 positions in active recruitment, and 41 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.

With Alliance offices reopening in the upcoming months, Human Resources is assessing and updating all onboarding processes to align with our hybrid work environment. Our goal is to create an enriched employee experience, which begins with the onboarding of new staff. We will focus on employee engagement and integration to ensure new Alliance employees are onboarded effectively and efficiently.

In response to feedback from the 2021 Employee Engagement Survey results, Human Resources is commencing work on a competency and career development/pathway system designed to focus on position competency and career navigation and growth. We are excited about this new body of work and will be focusing on this project beginning April 2022.

Communications. On the heels of the vaccine campaign and after the recent Board approval, staff worked on a new paid media campaign to promote the COVID-19 booster incentive. The campaign slogan "Stay one step ahead of COVID-19" has refreshed

messaging and visuals. The bilingual paid media campaign launched on April 11, 2022 and will run through the duration of the vaccine incentive. Paid media components will consist of digital ads and streaming Pandora radio ads in all three counties, billboard posters in all three counties, and interior bus ads in every bus (154 buses total) in both Monterey and Santa Cruz counties (Merced does not offer bus advertising options). In addition, staff has created a website landing page in all three languages and is working on member-facing flyers in all three languages, as well as messaging to providers. A press release announcing the incentive was also sent to local media on March 30, 2022. Staff will be tracking pageviews for the landing page as well as visits to the MyTurn state website through a tracking code embedded in the online ads.

Staff has begun working on an Executive Summary of the Strategic Plan. This one-page, two-sided document will provide a succinct overview of our Strategic Priorities and Goals and will be available in digital format and printed in hard copy to be distributed to a variety of external stakeholders and partners. Staff expects to have these ready for distribution in late May or early June.

Facilities and Administrative Services. 38th Avenue Property: A permit application for demolition of the existing structure has been submitted to the City of Capitola. The permit is still in review. PGE was scheduled to disconnect utilities on April 5, 2022.

Alliance Office Reopening: The Workforce and Workplace Planning and Design Committee has continued to meet every other week to plan for our offices to fully reopen following the COVID-19 pandemic. On April 4, 2022 we reopened for approximately 250 of our 500 employees. On May 2, 2022 the other half of the organization will be allowed office access. For staff who are unvaccinated, we have implemented a process whereby unvaccinated employees must submit proof of a negative test for COVID-19 prior to entering our buildings. As we reopen fully, we are focusing on continued flexibility options to ensure work/life balance and also retain staff. Analysis shows that a very high percentage of employees will be taking advantage of these offerings by working from their home office (see below).

# of Days in the Office	# of Employees	% of Workforce
5	17	3.3%
4	1	0.2%
3	9	1.8%
2	69	13.5%
1	68	13.3%
Fulltime Telecommuters	348	68.0%
Total:	512	

Operations

Member Services. Since January, the Member Services Department has seen a steady increase in member calls. As such, Member Services continues to review Call Center processes in order to ensure Member Services is adequately staffed and has the capacity to assist our members thoroughly and timely. Further, Member Services is in the process of onboarding two new Member Services Representatives, which will help support the increase in member calls as well as lower the amount of time members wait to speak to a representative.

Claims. Claims inventory continues to rise as members start resuming care. Average claims inventory increased by 7.22% from February to March. Since January, we have seen our average daily receipts to work increase by 12.62% (January - March). Four temporary associates will start on May 4, 2022 and assist with addressing the increased receipt volume and help to reduce claims inventory. We have also utilized some short-term incentive programs aimed at increasing production to address the claims inventory as well. This resulted in an increase in average daily production of 5.76% (February - March). As it relates to standing up our Claims Quality program, we are currently recruiting for two Claims Quality Analyst positions. These analysts' focus will be on launching our Monthly Financial Accuracy, Payment Accuracy, Processing Accuracy, and Overall Accuracy metrics at the HSP Platform (Alliance claims management system) level. We are still on target to produce our first set of metrics for the month of June 2022.

Provider Services. The Provider Services Department continues to collaborate with other Alliance staff to expand the Enhanced Care Management (ECM) and Community Supports (CS) network in Santa Cruz and Monterey, and to build the ECM and CS network in Merced. An additional three organizations who will serve Monterey and Santa Cruz are newly contracted, and nine organizations within Merced have indicated interest in contracting. As an immediate next step, staff are assessing completed readiness forms submitted by interested entities in Merced, and staff will be sending contracting and credentialing materials in mid to late April to those who are able to provide services effective July 1. Training and support of ECM and CS providers is robust and covers topics ranging from member outreach and engagement, to care plan development, and to billing and authorization support. Provider Services staff are meeting with ECM and CS organizations weekly to ensure that questions and issues are answered and resolved timely.

On March 31, 2022, the annual Timely Access Filing (TAF) was submitted to the DMHC. The TAF is an annual effort which includes the extensive Provider Appointment and Availability Survey (PAAS) which measures provider appointment timeliness for urgent and non-urgent services. The Alliance works with a vendor to administer the PAAS through a hybrid model annually, and then compiles and validates the results with a third-party validator. The PAAS data and related policies, procedures, and reports are then submitted to DMHC, representing the culmination of over six months of staff work.

Regional Operations Santa Cruz, Monterey & Merced. Community collaboration and member outreach in the Alliance service areas continued for the month of March. The Your Health Matters team attended COVID-19 clinics in both counties incentivizing members who were receiving their booster vaccines. Collaborative work continues with County Health Departments and local school districts to identify and support vaccination efforts to the most affected members in our community. Staff also participated in the Ciclovia event in Salinas and Week of the Young Child in both Los Banos and Merced. Events were well attended by the respective communities who hosted. A total of 19 events were attend by the Your Health Matters team in March. The Alliance also conducted outreach activities at Merced College and UC Merced.

In March, the latest issue of The Beat was distributed and included the Alliance Community Impact Report, articles regarding Medi-Cal expansion to older adults, and in celebration of Doctor's Day, a section spotlighting our Medical Directors.

DATE: April 27, 2022

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Second Month Ending February 28, 2022

For the two months ending February 28, 2022, the Alliance reported an Operating Income of $16.9M. The Year-to-Date (YTD) Operating Income is $24.1M, with a Medical Loss Ratio (MLR) of 85.3% and an Administrative Loss Ratio (ALR) of 5.1%.

For February 2022 YTD, an operating income of $24.0M was expected based on the 2022 budget. The actual operating income is favorable to budget by $0.1M or 0.5%, driven primarily by $5.8M in favorable revenue rate variances offset by unfavorable medical expense rate variances of ($7.3M). Increased enrollment as compared to budget drove offsetting revenue and medical expense variances of $4.3M and ($3.7M), respectively.

The 2022 budget assumed utilization levels to return to the 2019 level by Q1 2022, incrementally increasing each quarter and ending at a 5% increase from pre-pandemic levels. Staff expected that utilization would rise as members resumed delayed elective procedures, surgeries, and specialist referrals in 2022. Actual utilization continues to rebound from the lowest observed levels from 2020 and is heading towards 2019 levels. The 2022 budget additionally assumed that the LTC rate increase which was implemented in response to the PHE would be discontinued, which has not been realized.

	Feb-22 MTD (In $000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*390,866*	*381,158*	*9,708*	*2.5%*
Revenue	125,194	118,726	6,469	5.4%
Medical Expenses	101,752	95,755	(5,997)	-6.3%
Administrative Expenses	6,557	6,641	85	1.3%
Operating Income/(Loss)	16,886	16,330	556	3.4%
Net Income/(Loss)	14,894	15,094	(199)	-1.3%
MLR %	*81.3%*	*80.7%*	*-0.6%*	
ALR %	*5.2%*	*5.6%*	*0.4%*	
Operating Income %	*13.5%*	*13.8%*	*-0.3%*	
Net Income %	*11.9%*	*12.7%*	*-0.8%*	

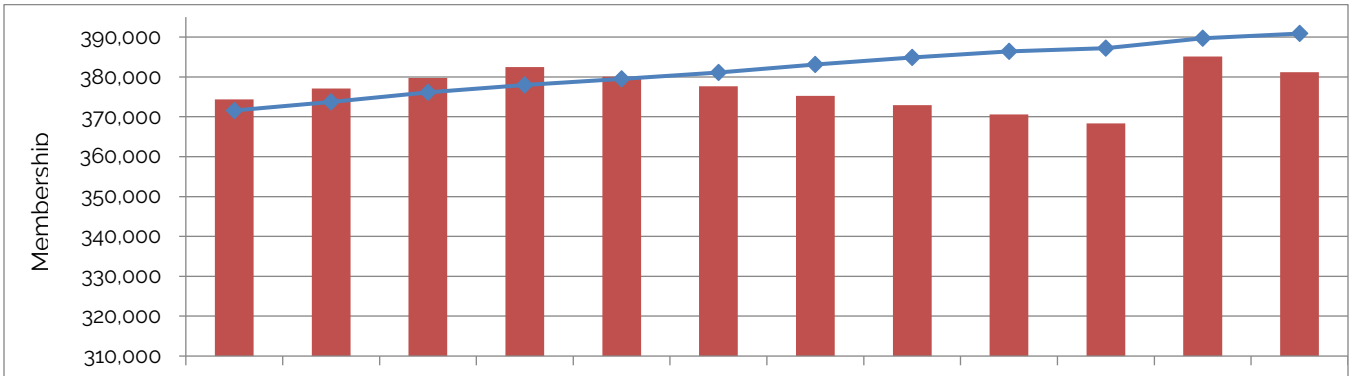
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Feb-22 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*780,533*	*766,266*	*14,267*	*1.9%*
Revenue	248,882	238,702	10,181	4.3%
Medical Expenses	212,185	201,093	(11,092)	-5.5%
Administrative Expenses	12,614	13,641	1,027	7.5%
Operating Income/(Loss)	24,083	23,967	(116)	0.5%
Net Income/(Loss)	18,492	21,495	3,003	-14.0%
PMPM				
Revenue	318.86	311.51	7.35	2.4%
Medical Expenses	271.85	262.43	(9.41)	-3.6%
Administrative Expenses	16.16	17.80	1.64	9.2%
Operating Income/(Loss)	30.85	31.28	(0.42)	-1.4%
MLR %	85.3%	*84.2%*	*-1.0%*	
ALR %	*5.1%*	*5.7%*	*0.6%*	
Operating Income %	*9.7%*	*10.0%*	*-0.4%*	
Net Income %	*7.4%*	*9.0%*	*-1.6%*	

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 $318.86, which is favorable to budget by $7.35 or 2.4%. Medical cost PMPM is $271.85, which is unfavorable by $9.41 or 3.6%, and Administrative cost PMPM is $16.16, which is favorable by $1.64 or 9.2%. The resulting operating income is $30.85 PMPM, which is unfavorable by $0.42 as compared to budget.

Membership. February 2022 Member Months are favorable to budget by 2.5%. Please note that the 2022 budget assumed the Public Health Emergency (PHE) would end in January 2022 and redetermination would resume. Therefore, it was expected that enrollment would decrease gradually to the pre-pandemic level by December 2022 at a rate of approximately 1 percent per month. The State anticipates the PHE will expire no sooner than July 2022. This will result in favorable membership and member months for the first half of the year, with the percentage variance anticipated to increase monthly.

Membership. Actual vs. Budget (based on actual enrollment trend for Feb-22 rolling 12 months)



	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Budget	374,390	377,057	379,753	382,481	380,048	377,645	375,273	372,929	370,611	368,326	385,108	381,158
Actual	371,584	373,691	376,094	377,967	379,537	381,066	383,089	384,876	386,374	387,235	389,667	390,866
Variance	(2,806)	(3,366)	(3,659)	(4,514)	(511)	3,421	7,816	11,947	15,763	18,909	4,559	9,708
Variance %	-0.7%	-0.9%	-1.0%	-1.2%	-0.1%	0.9%	2.1%	3.2%	4.3%	5.1%	1.2%	2.5%

Revenue. The 2022 revenue budget was based on the 2022 Department of Health Care Services rate package received in October 2021. The rate package included funding for Enhanced Care Management (ECM) and Community Supports (CS); both are new programs in 2022 and are assumed to be budget-neutral in the 2022 budget. Pharmacy revenue was removed from 2022 rates in alignment with the Medi-Cal Rx carve-out effective January 1, 2022.

February 2022 capitation revenue of $124.9M is favorable to budget by $6.5M or 5.4%. Favorability to budget is attributed to increased enrollment revenue of $3.1M, Maternity prior month adjustment of $1.1M, MCO Tax of $1.1M, COVID vaccine incentives of $0.5M and miscellaneous rate adjustments of $0.7M.

February 2022 YTD revenue of $248.3M is favorable to budget by $10.1M or 4.3%, of which $4.3M is attributed to enrollment and $5.8M to rate variance. This includes funding for various programs not yet finalized when preparing the 2022 budget, including rapid genome sequencing and the expansion of Medi-Cal benefits to undocumented Californians age 50 and older.

Feb-22 YTD Capitation Revenue Summary (In $000s)

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	56,128	53,927	2,201	891	1,310
Monterey	106,467	101,533	4,934	1,805	3,129
Merced	85,716	82,707	3,009	1,611	1,398
Total	**248,310**	**238,166**	**10,144**	**4,307**	**5,837**

Note: Excludes Feb-22 YTD In-Home Supportive Services (IHSS) premiums revenue of $0.6M.

Medical Expenses. February 2022 Medical Expenses of $101.8M are $6.0M or 6.3% unfavorable to budget. February 2022 YTD Medical Expenses of $212.2M are unfavorable to budget by $11.1M or 5.5%, with an MLR of 85.3%. Of this $11.1M unfavorability, $3.7M is due to enrollment and $7.3M is attributed to PMPM cost variance.

Feb-22 YTD Medical Expense Summary (In $000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	86,592	77,254	(9,338)	(1,438)	(7,899)
Inpatient Services (LTC)	27,772	23,406	(4,366)	(436)	(3,930)
Physician Services	40,843	41,786	943	(778)	1,721
Outpatient Facility	23,956	25,509	1,553	(475)	2,028
Pharmacy	(1,382)	120	1,503	(2)	1,505
Other Medical	34,405	33,018	(1,387)	(615)	(772)
Total	**212,185**	**201,093**	**(11,092)**	**(3,744)**	**(7,348)**

Note: Other Medical includes Allied Health, Non-Claims HC Cost, transportation, ECM, ILOS, BHT, Lab, and other medical cost.

At a PMPM level, YTD Medical Expenses are $271.85, which is unfavorable by $9.41 or 3.6% 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.

Throughout the second half of 2021, Trended Authorization per 1,000 was indicating that utilization was rebounding from the most extreme suppressed levels observed in 2020 but not yet reaching 2019 levels. This trend has continued into 2022, possibly 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. The 2022 budget assumed utilization would return to the 2019 level during Q1 2022 and increase 5% over 2019 by year-end.

Actual overall 2022 utilization has not achieved the 2019 level through February. However, February 2022 Inpatient (Hospital) utilization is approaching 2019 levels and represents approximately 40% of medical expenses. Additionally, $2M in retroactive claims payments from 2019 and 2020 and $5.2M in Incurred but Not Reported increases due to recent October and November 2021 payments have driven Inpatient Services costs higher than budget both on a PMPM and dollar basis.

The 2022 budget further assumed that the LTC rate increase implemented in response to the PHE would be discontinued. This assumption has not been realized, and an additional 4% LTC rate increase was assumed for 2022. Unknown impacts from the continuation of the PHE in Q1 2022 could further impact utilization and will drive continuing variances in actual versus budgeted LTC costs.

Feb-22 YTD Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	110.94	100.82	(10.12)	-10.0%
Inpatient Services (LTC)	35.58	30.55	(5.04)	-16.5%
Physician Services	52.33	54.53	2.20	4.0%
Outpatient Facility	30.69	33.29	2.60	7.8%
Pharmacy	(1.77)	0.16	1.93	100.0%
Other Medical	44.08	43.09	(0.99)	-2.3%
Total	**271.85**	**262.43**	**(9.41)**	**-3.6%**

Administrative Expenses. February 2022 YTD Administrative Expenses are favorable to budget by $1.0M or 7.5% with a 5.1% ALR. Salaries, Wages, & Benefits are favorable by $0.5M or 5.5% due to Benefits running lower than budget and vacant positions savings. Non-Salary Administrative Expenses are favorable by $0.5M or 12.2% due to the timing of expenses versus budget for projects in the new year.

Non-Operating Revenue/Expenses. February 2022 YTD Total Non-Operating Revenue is unfavorable to budget by $4.9M, primarily driven by unrealized gains/loss on investments. This is offset by a favorable February 2022 YTD Non-Operating Expense of $1.8M, resulting in an unfavorable net loss of $3.1M.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $18.5M, with an MLR of 85.3%, and an ALR of 5.1%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Second Month Ending February 28, 2022
(In $000s)

Assets	
Cash	$107,870
Restricted Cash	300
Short Term Investments	562,104
Receivables	163,010
Prepaid Expenses	5,048
Other Current Assets	16,840
Total Current Assets	**$855,172**
Building, Land, Furniture & Equipment	
Capital Assets	$83,315
Accumulated Depreciation	(41,809)
CIP	273
Total Non-Current Assets	**41,779**
Total Assets	**$896,951**
Liabilities	
Accounts Payable	$32,167
IBNR/Claims Payable	243,423
Accrued Expenses	1
Estimated Risk Share Payable	11,667
Other Current Liabilities	8,407
Due to State	0
Total Current Liabilities	**$295,666**
Fund Balance	
Fund Balance - Prior	$582,793
Retained Earnings - CY	18,492
Total Fund Balance	**601,285**
Total Liabilities & Fund Balance	**$896,951**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Second Month Ending February 28, 2022
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*390,866*	*381,158*	*9,708*	*2.5%*	*780,533*	*766,266*	*14,267*	*1.9%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$124,909	$118,458	$6,450	5.4%	$248,310	$238,166	$10,144	4.3%
Premiums Commercial	286	268	18	6.8%	572	535	37	6.9%
Total Operating Revenue	**$125,194**	**$118,726**	**$6,469**	**5.4%**	**$248,882**	**$238,702**	**$10,181**	**4.3%**
Medical Expenses								
Inpatient Services (Hospital)	$39,207	$35,218	($3,989)	-11.3%	$86,592	$77,254	($9,338)	-12.1%
Inpatient Services (LTC)	12,466	11,514	(952)	-8.3%	27,772	23,406	(4,366)	-18.7%
Physician Services	19,930	20,587	657	3.2%	40,843	41,786	943	2.3%
Outpatient Facility	12,969	12,588	(381)	-3.0%	23,956	25,509	1,553	6.1%
Pharmacy	(26)	55	81	100.0%	(1,382)	120	1,503	100.0%
Other Medical	17,206	15,792	(1,414)	-9.0%	34,405	33,018	(1,387)	-4.2%
Total Medical Expenses	**$101,752**	**$95,755**	**($5,997)**	**-6.3%**	**$212,185**	**$201,093**	**($11,092)**	**-5.5%**
Gross Margin	**$23,443**	**$22,971**	**$472**	**2.1%**	**$36,698**	**$37,609**	**($911)**	**-2.4%**
Administrative Expenses								
Salaries	$4,685	$4,616	($68)	-1.5%	$8,936	$9,453	$518	5.5%
Professional Fees	106	183	77	42.1%	250	373	123	33.0%
Purchased Services	696	649	(47)	-7.2%	1,249	1,330	81	6.1%
Supplies & Other	720	807	87	10.8%	1,447	1,709	262	15.3%
Occupancy	70	101	32	31.3%	172	207	34	16.6%
Depreciation/Amortization	281	285	4	1.4%	561	570	9	1.6%
Total Administrative Expenses	**$6,557**	**$6,641**	**$85**	**1.3%**	**$12,614**	**$13,641**	**$1,027**	**7.5%**
Operating Income	**$16,886**	**$16,330**	**$556**	**3.4%**	**$24,083**	**$23,967**	**$116**	**0.5%**
Non-Op Income/(Expense)								
Interest	$375	$316	$59	18.8%	$852	$631	$221	35.0%
Gain/(Loss) on Investments	(2,235)	(238)	(1,996)	-100.0%	(5,679)	(476)	(5,203)	-100.0%
Other Revenues	93	83	10	12.1%	229	167	62	37.5%
Grants	(225)	(1,397)	1,171	83.9%	(993)	(2,794)	1,800	64.4%
Total Non-Op Income/(Expense)	**($1,992)**	**($1,236)**	**($756)**	**-61.1%**	**($5,591)**	**($2,473)**	**($3,119)**	**-100.0%**
Net Income/(Loss)	**$14,894**	**$15,094**	**($199)**	**-1.3%**	**$18,492**	**$21,495**	**($3,003)**	**-14.0%**
MLR	*81.3%*	*80.7%*			*85.3%*	*84.2%*		
ALR	*5.2%*	*5.6%*			*5.1%*	*5.7%*		
Operating Income	*13.5%*	*13.8%*			*9.7%*	*10.0%*		
Net Income %	*11.9%*	*12.7%*			*7.4%*	*9.0%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Second Month Ending February 28, 2022
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*390,866*	*381,158*	*9,708*	*2.5%*	*780,533*	*766,266*	*14,267*	*1.9%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$319.57	$310.78	$8.78	2.8%	$318.13	$310.81	$7.31	2.4%
Premiums Commercial	0.73	0.70	0.03	4.1%	0.73	0.70	0.03	4.9%
Total Operating Revenue	**$320.30**	**$311.49**	**$8.81**	**2.8%**	**$318.86**	**$311.51**	**$7.35**	**2.4%**
Medical Expenses								
Inpatient Services (Hospital)	$100.31	$92.40	($7.91)	-8.6%	$110.94	$100.82	($10.12)	-10.0%
Inpatient Services (LTC)	31.89	30.21	(1.68)	-5.6%	35.58	30.55	(5.04)	-16.5%
Physician Services	50.99	54.01	3.02	5.6%	52.33	54.53	2.20	4.0%
Outpatient Facility	33.18	33.03	(0.15)	-0.5%	30.69	33.29	2.60	7.8%
Pharmacy	(0.07)	0.14	0.21	100.0%	(1.77)	0.16	1.93	100.0%
Other Medical	44.02	41.43	(2.59)	-6.2%	44.08	43.09	(0.99)	-2.3%
Total Medical Expenses	**$260.32**	**$251.22**	**($9.10)**	**-3.6%**	**$271.85**	**$262.43**	**($9.41)**	**-3.6%**
Gross Margin	**$59.98**	**$60.27**	**($0.29)**	**-0.5%**	**$47.02**	**$49.08**	**($2.06)**	**-4.2%**
Administrative Expenses								
Salaries	$11.99	$12.11	$0.13	1.0%	$11.45	$12.34	$0.89	7.2%
Professional Fees	0.27	0.48	0.21	43.6%	0.32	0.49	0.17	34.2%
Purchased Services	1.78	1.70	(0.08)	-4.6%	1.60	1.74	0.14	7.8%
Supplies & Other	1.84	2.12	0.28	13.0%	1.85	2.23	0.38	16.9%
Occupancy	0.18	0.27	0.09	33.0%	0.22	0.27	0.05	18.2%
Depreciation/Amortization	0.72	0.75	0.03	3.9%	0.72	0.74	0.03	3.4%
Total Administrative Expenses	**$16.77**	**$17.42**	**$0.65**	**3.7%**	**$16.16**	**$17.80**	**$1.64**	**9.2%**
Operating Income	**$43.20**	**$42.84**	**$0.36**	**0.8%**	**$30.85**	**$31.28**	**($0.42)**	**-1.4%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Second Month Ending February 28, 2022
(In $000s)

	MTD	YTD
Net Income	$14,894	$18,492
Items not requiring the use of cash: Depreciation	281	561
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	(2,156)	82,539
Prepaid Expenses	(1,855)	(2,850)
Current Assets	(338)	(735)
Net Changes to Assets	**($4,349)**	**$78,953**
Changes to Payables:		
Accounts Payable	15,131	(24,773)
Accrued Expenses	-	-
Other Current Liabilities	668	1,093
Incurred But Not Reported Claims/Claims Payable	(69,222)	(81,326)
Estimated Risk Share Payable	833	1,667
Due to State	-	-
Net Changes to Payables	**($52,589)**	**($103,340)**
Net Cash Provided by (Used in) Operating Activities	**($41,763)**	**($5,335)**
Change in Investments	1,835	(24,220)
Other Equipment Acquisitions	(5)	(103)
Net Cash Provided by (Used in) Investing Activities	**$1,831**	**($24,323)**
Net Increase (Decrease) in Cash & Cash Equivalents	**($39,933)**	**($29,658)**
Cash & Cash Equivalents at Beginning of Period	**$147,802**	**$137,528**
Cash & Cash Equivalents at February 28, 2022	**$107,870**	**$107,870**

SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, March 23, 2022
3:00 – 5:00 p.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California

Commissioners Present:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Dr. Maximiliano Cuevas	Provider Representative
Ms. Julie Edgcomb	Public Representative
Dr. Charles Harris	Hospital Representative
Ms. Dori Rose Inda	Hospital Representative
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Ms. Mónica Morales	County Health Services Agency Director
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. Tony Weber	Provider Representative

Commissioners Absent:

Dr. Larry deGhetaldi	Provider Representative
Supervisor Zach Friend	County Board of Supervisors
Ms. Elsa Jimenez	County Health Director
Mr. Rob Smith	Public Representative

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Mr. Scott Fortner	Chief Administrative Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
Ms. Danita Carlson	Government Relations Director
Ms. Jenifer Mandella	Compliance Officer
Ms. Kathleen McCarthy	Strategic Development Director
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Conner.

Commission Chairperson Conner called the meeting to order at 3:07 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

Chair Conner welcomed Ms. Mónica Morales, Santa Cruz County Health Services Agency Director, to the Board.

2. Oral Communications.

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.

3. Comments and announcements by Commission members.

Chair Conner opened the floor for Commissioners to make comments.

Commissioner Nanyonjo shared that Merced County signed on to the Department of Health Care Services (DHCS) Alternate Health Care Services Plan trailer bill opposition letter.

4. Comments and announcements by Chief Executive Officer.

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

Ms. Sonnenshine, CEO, welcomed Commissioners back to in-person meetings. She noted that this was the first hybrid presentation meeting with some staff presenting virtually and others in person. Questions and comments for virtual presenters were held to the end of each presentation.

She reminded Commissioners that the April 27, 2022 meeting is in person in Los Banos and Commissioners should plan for an entire day to include travel time.

Consent Agenda Items: (5. – 9A.): 3:13 p.m.

Chair Conner opened the floor for approval of the Consent Agenda.

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

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Edgcomb, Harris, Inda, Molesky, Nanyonjo, Pedrozo, Quezada, Radner, Schuller, and Weber.

Noes: None.

Absent: Commissioners deGhetaldi, Friend, Jimenez, Kalantari-Johnson, Morales, Rabago and Smith.

Abstain: None.

Regular Agenda Item: (10. - 14.): 3:14 p.m.

10. Consider approving the Alliance's legal and regulatory Compliance Program Report for CY 2021, consider approving revised Alliance Code of Conduct, and receive required Board training in Compliance. (3:14 – 3:40 p.m.)

Ms. Jenifer Mandella, Compliance Officer, presented the Alliance Compliance Program Report for 2021 and provided required annual Board training in compliance.

[Commissioner Morales arrived at this time: 3:17 p.m.]

Key takeaways from the training included 1) a highly regulated and ever-changing environment; 2) the Compliance Program mitigates risk through prevention, identification and corrective action; and 3) the Alliance Board is a key participant in the Compliance Program, providing oversight and ensuring an effective program.

[Commissioner Kalantari-Johnson arrived at this time: 3:29 p.m.]

Key accomplishments from the 2021 Compliance Report included process development, leveraging data for program integrity, and adapting to a remote environment.

[Commissioner Rabago arrived at this time: 3:34 p.m.]

No revisions were made to the Compliance Plan and minor changes were made to the Code of Conduct for 2022.

MOTION: Commissioner Molesky moved to approve the Alliance's legal and regulatory Compliance Program Report for CY 2021, and approve the revised Alliance Code of Conduct, seconded by Commissioner Kalantari-Johnson.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Edgcomb, Harris, Inda, Kalantari-Johnson, Molesky, Morales, Nanyonjo, Pedrozo, Quezada, Rabago, Radner, Schuller, and Weber.

Noes: None.

Absent: Commissioners deGhetaldi, Friend, Jimenez, and Smith.

Abstain: None.

11. Consider approving recommendations regarding the Medi-Cal Capacity Grant Program (MCGP). (3:40 – 4:12 p.m.)

Chair Conner advised the Board that in order to manage any risk of conflict of interest, staff separated the approval actions for the Medi-Cal Capacity Grant Program recommendations into two separate items.

Ms. Kathleen McCarthy, Strategic Development Director, discussed considerations for new grantmaking focus areas of: 1) Access to Care, 2) Healthy Beginnings, and 3) Healthy Communities. Two recommended MCGP policy changes that would support Alliance partners applying for grant funding were to: 1) remove one-time project funding from eligibility criteria, and 2) allow indirect costs in project-based grant budgets.

MOTION: Commissioner Molesky moved to approve new grantmaking focus areas and two new policy changes, seconded by Commissioner Quezada.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Edgcomb, Harris, Inda, Kalantari-Johnson, Molesky, Morales, Nanyonjo, Quezada, Rabago, Radner, Schuller, and Weber.

Noes: None.

Absent: Commissioners deGhetaldi, Friend, Jimenez, Pedrozo and Smith.

Abstain: None.

Chair Conner remined Commissioners that those who perceived they were at risk for conflict of interest were advised to abstain from discussion and voting on this item.

Ms. McCarthy reviewed recommendations for two refined funding opportunities. The first recommendation included changes to the Provider Recruitment Program. Staff recommended revising the program to focus on recruitment of high-need specialty and behavioral health providers, add a linguistic competence incentive of $10K, and to allocate an additional $8M from the unallocated MCGP budget.

The second recommendation refined the Partners for Healthy Food Access program. Staff have refined the funding opportunity to narrow funding to projects that more closely align with a "Food Prescription" model, support services not currently funded under a CalAIM Community Support and to allocate $2M from the unallocated MCGP budget to continue to offer Food Access grants.

MOTION: Commissioner Molesky moved to approve implementation of two refined MCGP programs with funding allocations from the MCGP unallocated budget, seconded by Commissioner Edgcomb.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioners deGhetaldi, Friend, Jimenez, Radner, and Smith.

Abstain: Commissioners Conner, Cuevas, Harris, Inda, Morales, Nanyonjo, Rabago, Schuller and Weber.

12. Consider accepting 2022 Legislation Report, adopting certain positions of support and direct staff to send position letters. (4:12 – 4:28 p.m.)

Ms. Danita Carlson, Government Relations Director, reported on the beginning of the 2022 legislative session, including an overview of key dates in the legislative calendar, and a discussion of the process by which staff identify, track and monitor legislation of interest and relevance to the Alliance.

Five bills (AB 1900. AB 1995, AB 2402, SB 966 and AB 2449) which staff recommended the Board take an advocacy position were highlighted and discussed.

Ms. Sonnenshine provided an update for the Board on the DHCS Alternate Health Care Services Plan trailer bill and the Board received information as to the communication letter expressing the Board's opposition to the DHCS trailer bill that would enable a statewide direct contract with Kaiser in contravention of the County Organized Health System model. Staff have met with Senators Laird and Caballero, Assemblymember Rivas in addition to County CEOs/CAOs, the Governors Deputy Cabinet Secretary and the DHCS Director. Merced, Mariposa and Yolo counties have since signed on to the joint county opposition letter.

The Board did not adopt a position on AB 2449 and instead recommended staff review AB 1944 (Lee) relating to public meeting flexibilities.

MOTION: Commissioner Inda moved to accept the staff report on the 2022 legislation and adopt positions of support on AB 1900, AB 1995, AB 2402, SB 966 and direct staff to send position letters, seconded by Commissioner Molesky.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Edgcomb, Harris, Inda, Kalantari-Johnson, Molesky, Morales, Nanyonjo, Pedrozo, Quezada, Rabago, Radner, Schuller, and Weber.

Noes: None.

Absent: Commissioners deGhetaldi, Friend, Jimenez, and Smith.

Abstain: None.

13. Consider authorizing staff to engage with MidPen Housing towards a formal partnership agreement for the purpose of developing the 38th Avenue (formerly Capitola Manor) property, and direct staff through that partnership to assess the feasibility of a proposed project and direct staff to return with a recommendation for final disposition of the property. (4:28 – 4:40 p.m.)

Mr. Scott Fortner, Chief Administrative Officer, provided an update on the 38th Avenue (formerly Capitola Manor) property. In January 2022 staff had informed the Board of various outreach activities regarding possible disposition of the property. Mid Pen Housing expressed interest in further exploration of affordable housing via purchase of the 38th Avenue property and have submitted a Letter of Interest to further explore a possible purchase of the property. Staff plan to further engage with MidPen Housing and predict the overall process leading up to potential purchase of the property to be one year.

MOTION: Commissioner Kalantari-Johnson moved to authorize staff to engage with MidPen Housing towards a formal partnership agreement for the purpose of developing the 38th Avenue property (formerly Capitola Manor), and direct staff through that partnership to assess the feasibility of a proposed project and direct staff to return with a recommendation for final disposition of the property, seconded by Commissioner Weber.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Edgcomb, Harris, Inda, Kalantari-Johnson, Morales, Nanyonjo, Pedrozo, Quezada, Rabago, Schuller, and Weber.

Noes: None.

Absent: Commissioners deGhetaldi, Friend, Jimenez, and Smith.

Abstain: Molesky and Radner.

14. Discuss Department of Health Care Services (DHCS) CalAIM Implementation. (4:40 – 5:02 p.m.)

Ms. Stephanie Sonnenshine, CEO, provided a high-level overview of DHCS CalAIM.

Commissioners were encouraged to reach out to Ms. Sonnenshine with questions or for further discussion.

[Commissioner Molesky departed at this time: 4:54 p.m.]

[Commissioner Rabago departed at this time: 4:58 p.m.]

[Commissioner Nanyonjo departed at this time: 5:00 p.m.]

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

The Commission adjourned its regular meeting of March 23, 2022 at 5:02 p.m. to the regular meeting of April 27, 2022 at 11:00 a.m. in Los Banos.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, January 19, 2022
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Bob Trinh	Technology Services Director
Bonnie Liang	Controller
Dale Bishop	Chief Medical Officer
Danita Carlson	Government Relations 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
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
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:

Committee Members Excused:

Bryan Smith	Claims Director
Dianna Diallo	Medical Director

Ad-Hoc Attendees:

Sara Halward	Compliance Specialist II
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 9:04 a.m.

2. Review and Approval of December 15, 2021 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of December 15, 2021 meeting.

3. Consent Agenda.

1. **Policy Hub Approvals**
2. **Regulatory and All Plan Letter Updates**
3. **Quarterly Policy Monitoring**
4. **Compliance Committee Charter**

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. Delegate Oversight Quarterly Report

Knutson, Compliance Manager, presented the Delegate Oversight Q3 2021 Quarterly Activity Report.

Q1 2021 Continuous Oversight Activities
Staff recommended approval of the following documents received from delegates:

- Beacon/CHIPA: Provider Disputes
- VSP: Provider Disputes

COMMITTEE ACTION: Committee reviewed and approved the Q1 2021 Continuous Oversight Activities.

Q2 2021 Continuous Oversight Activities
Staff recommended approval of the following documents received from delegates:

- VSP: Member Grievance
- Beacon/CHIPA: Utilization Management

COMMITTEE ACTION: Committee reviewed and approved the Q2 2021 Continuous Oversight Activities.

Q3 2021 Continuous Oversight Activities
Staff recommended approval of the following documents received from delegates:

- Beacon/CHIPA: Claims, Credentialing, Member Connections, Network Adequacy, Provider Disputes, QI and UM
- ChildNet: Credentialing
- LPCH: Credentialing
- MedImpact: Claims, Network Adequacy and Provider Disputes
- PAMF: Credentialing
- SVMC: Credentialing
- UCSF: Credentialing
- VSP: Claims, Credentialing, Member Connections, Member Grievances, Provider Disputes and QI

Staff recommended holding approval of the following activities pending staff review of documentation as described below:

- Beacon/CHIPA: Member Grievances

COMMITTEE ACTION: Committee reviewed and approved the Q3 2021 Continuous Oversight Activities and assigned the following action items:

- Sanders to review Beacon/CHIPA Member Grievances documentation upon receipt and complete quarterly review.

Additional Oversight Activities
Knutson reviewed the Q3 2021 Beacon Performance Guarantees noting that, while one performance guarantee did not meet Beacon's target requirement, they did meet the plan's requirement. As such, no follow-up actions are recommended at this time.

Knutson reported MedImpact met all Performance Guarantees for Q3 2021.

Knutson reported on the Beacon Quality Corrective Action Plan (CAP), noting that 3 of 7 actions items remain completed on Timely Access and 18 of 19 action items (up from 14 of 19 in the prior quarter) were completed on Coordination of Care. Knutson advised the committee that this CAP will remain open until data related to the CAP's performance improvement plan efficacy is assessed.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2021 Delegate Oversight Quarterly Report.

2. Review of MedImpact Member Connections Documentation

Knutson, Compliance Manager, reviewed the Committee's approved delegation of Utilization Management (UM) services specific to the Alliance's In-Home Support Services (IHSS) line of business to MedImpact, which took place in January, 2021.

Knutson reported that staff had determined that Member Connection services may be performed in related to delegated UM services, therefore, an assessment of MedImpact's policies and procedures (P&Ps) was conducted in September, 2021 to ensure MedImpact's processes met the Plan's minimum requirements. Staff determined that MedImpact's documentation related to Member Connections services met Alliance standards and

recommend approval of MedImpact's performance of select Member Connection activities as it relates to the delegation of the UM function.

COMMITTEE ACTION: Committee reviewed and approved MedImpact's performance of select Member Connection activities as they relate UM.

3. Annual Compliance Committee Participant Training

Mandella, Compliance Officer, presented Annual Compliance Committee Member Training. Mandella reviewed Compliance Program guiding principles and provided an overview of Compliance Committee structure and oversight responsibilities emphasizing specific activities and committee roles directly related to the Compliance Program.

4. DHCS Medical Audit Update

Knutson, Compliance Manager, reported on the production of deliverables for the upcoming DHCS Medical Audit noting that 176 items were requested covering many areas of the Plan and organization. Knutson recognized the ~40 staff members involved in producing more than 2500 documents and acknowledged their contributions to timely submission. Knutson advised the Committee of upcoming mock-audit interviews in preparation for the onsite audit which is scheduled to take place virtually February 14-March 1, 2022. Knutson reported that DHCS has requested Beacon participate in the Behavioral Health audit interview and for vendor Call the Car to participate in the NEMT/NMT audit interview.

The meeting adjourned at 9:35 a.m.

Respectfully submitted,

Robin Sihler
Administrative Assistant - Compliance

FINANCE COMMITTEE
SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, October 27, 2021

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

Members Present:

Ms. Elsa Jiménez	County Health Director
Mr. Michael Molesky	Public Representative
Allen Radner, MD	Provider Representative
Mr. Tony Weber	Provider Representative

Members Absent:

Ms. Mimi Hall	County Health Services Agency Director

Staff Present:

Ms. Lisa Ba	Chief Financial Officer
Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Dulcie San Paolo	Finance Administrative Specialist

1. Call to Order by Chairperson Molesky. (1:33 p.m.)

Chairperson Molesky called the meeting to order at 1:33 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:33 – 1:35 p.m.)

Chairperson Molesky 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.

Consent Agenda Items:

3. **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. (1:35 – 1:37 p.m.)**

   FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the 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.

   MOTION: Commissioner Jiménez moved to approve the findings, seconded by Commissioner Weber.

   ACTION: The motion passed with the following vote:

   Ayes: Commissioners Jiménez, Molesky, Radner, Weber

   Noes: None

   Absent: Commissioner Hall

   Abstain: None

4. **Approve minutes of the September 22, 2021 meeting of the Finance Committee. (1:37 – 1:38 p.m.)**

   FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the September 22, 2021 meeting.

   MOTION: Commissioner Jiménez moved to approve the minutes, seconded by Commissioner Radner.

   ACTION: The motion passed with the following vote:

   Ayes: Commissioners Jiménez, Molesky, Radner, Weber

   Noes: None

   Absent: Commissioner Hall

   Abstain: None

Regular Agenda Items:

5. **Year-to-date August 2021 Financials. (1:38 – 1:48 p.m.)**

   Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioners on the Alliance's most recent financial performance. For the eight months ending on August 31, 2021, there was an operating income of $105M. Revenue is 4% favorable to budget due to the pharmacy carve-in as well as the COVID and Long-Term Care (LTC) add-ons for the duration of the Public

Health Emergency (PHE). Medical cost is favorable by 8% primarily due to utilization continuing to be suppressed as a result of the pandemic.

In summary, Ms. Ba noted that the 2021 budget assumed that resumption of care would begin to return to the 2019 levels in the first quarter of 2021. However, this assumption was not realized and was further impacted by the Delta variant. With increased enrollment bringing down the medical cost at the PMPM level and increases in revenue due to the pharmacy carve-in and COVID and LTC add-ons, the operating income is favorable to budget at $105M.

Ms. Ba opened the floor for questions and discussion.

6. Preliminary 2022 Budget. (1:48 - 2:25 p.m.)

Ms. Ba explained that, although the 2022 budget is not yet finalized, a preview of that budget will be shared at this meeting for the Finance Committee's consideration and comment. The finalized budget will be presented for review and approval at the December Board Meeting.

The CFO went on to provide a review of the plan's historical financial performance, and summarized that losses were incurred in 2018 and 2019 and then, in 2020, with the pause in utilization brought on by the pandemic, the plan achieved a small operating income. The current forecast includes an operating income of $128.5M for 2021 as the PHE continued longer than was expected and assumed in the 2021 budget. The preliminary 2022 budget includes a $41M operating income or 3%.

Next, Ms. Ba went on to review the budget assumptions related to enrollment, revenue and medical cost. Beginning with enrollment, the assumption is that the PHE will end on December 31, 2021 and that redetermination will begin January 1, 2022 and take place over a 12-month period. It is expected that, by December of next year, the membership will return to pre-pandemic levels ending at 344K members.

Commissioner Elsa Jiménez inquired about the upcoming Medi-Cal expansion to undocumented individuals aged 50 and older and asked whether that was considered in the 2022 budget. Ms. Ba explained that the potential newly qualified population under that Medi-Cal expansion was not included in the 2022 budget assumptions. She went on to explain that, with the effective date being no earlier than May 2022, combined with the relatively small population who would potentially qualify in our counties, is not expected that this would present a significant impact on the Alliance's net financial performance.

Next, the CFO went on to orient the committee to the revenue and medical cost assumptions for 2022, The preliminary rate package was received in October. Changes that will impact revenue include managed care efficiency adjustments, the pharmacy carve-out, the removal of the LTC and COVID add-ons from prior year and the addition of new Enhanced Care Management (ECM) and Community Supports (CS) programs. In terms of costs, the ECM and Community Supports programs are assumed to be budget neutral as ECM has revenue that will cover the costs and Community Supports will generate savings from a covered Medi-Cal benefit. Ms. Ba explained that an acuity adjustment has been incorporated because, as members disenroll, costs will increase. Internal reports have indicated that costs associated with members who are newly enrolled since the onset of the

pandemic are lower than the costs of members enrolled prior to that. It is therefore expected that, as those newly enrolled members roll out of the system, costs will increase.

Commissioner Jiménez asked for clarification around the redetermination process and inquired if there is a program in place to help ensure that members are made aware when their renewal period is coming up to help prevent any lapse between eligibility and re-enrollment so that coverage is not lost and continuity of care can be assured. Ms. Stephanie Sonnenshine, Chief Executive Officer (CEO) responded to Commissioner Jimenez's question and advised that the topic was addressed at a recent Department of Healthcare Services (DHCS) Stakeholder Advisory Committee meeting. She relayed that, at that meeting, there was discussion about a plan to outreach to counties regarding ensuring that enrollee records are updated with current contact information in preparation to support the upcoming redetermination process.

An overview of the Medical Expense Budget by category of service was presented. Of note, Ms. Ba reminded the commissioners that, with pharmacy removed, the largest category of service for the 2022 budget is Inpatient Hospital/Outpatient Facilities which will now account for more than half of the medical cost. It will therefore be vital for staff to continue executing the Board approved Cost Containment Plan as that portion of services will count for the majority of expenses moving forward.

The Administrative Budget is targeted at $86.7M for 2022. Compared against the 2021 budget of $85.6M this reflects an increase of $1.1M or 1%. With a reduced revenue base next year due to the pharmacy carve-out, the Administrative Loss Ratio (ALR) is expected to increase.

A view of the current Tangible Net Equity (TNE) was presented. Ms. Ba reported that with the removal of the pharmacy revenue and the requirement to maintain a reserve of three times that cost, the required reserve will be lower. The projected operating reserve is $159M. Ms. Ba explained that the current accumulation of the operating reserve has allowed for the offset of losses incurred in 2018 and 2019. However, Ms. Ba advised that we will need to be prepared for potential financial uncertainty in 2023 and 2024 when DHCS sets the rates based on the low-cost base years of 2020 and 2021, In addition, the regional rates will be implemented in 2024 and we will need to bring our cost to the peer level.

In summary, the draft budget assumes that, as redetermination resumes in 2022, enrollment will return to pre-pandemic levels by December of next year. With the reduction in enrollment the acuity will in turn increase and translate to increased medical cost. The 2022 budget assumes that the resumption of care will continue throughout 2022 and that the overall annual utilization will be 5% above the 2019 level. The operating income is expected to be $41M or 3%. Staff continues to review all of the assumptions and is finalizing the budget for Board approval on December 1, 2021.

Ms. Ba opened the floor for questions and discussion.

Commissioner Michael Molesky commented on the use of telehealth visits during the PHE and noted that this seemed to be an efficient way to improve access to care for members. He asked if funding for those types of visits is expected to continue for Medi-Cal programs. Ms. Ba noted that at this time it is unknown as this would be something that would have to be approved by DHCS and included on the fee schedule. Ms. Sonnenshine added that, with

greater flexibility given to providers to rely upon telehealth to provide services to their patients during the PHE, it became evident that this method was effective and desired by patients. To that point, the Alliance, along with other local health plans, through the Local Health Plans of California (LHPC), are contributing to a workgroup that is developing advice to present to DHCS to explore if this can continue post-PHE to expand flexibility for members.

Commissioner Molesky inquired if there are future plans to look at the grant program in relation to supporting efforts for the Master Plan for Aging and ECM programs. Ms. Sonnenshine noted that strategic planning work is underway and information will be brought to the Board in the near future to inform on the possible evolution of the grant program and to request the Board's consideration and input.

Commissioner Molesky thanked Ms. Sonnenshine for the Alliance's continued support of community activities and opened the floor for any other questions. No additional questions were received.

Adjourn:

The Commission adjourned its meeting of October 27, 2021 at 2:25 p.m.

Respectfully submitted,

Ms. Dulcie San Paolo
Finance Administrative Specialist

DATE: April 27, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Contract with Monterey County In-Home Supportive Services Public Authority

Recommendation. Staff recommend the Board authorize the Chairperson to sign the agreement between the Alliance and the Monterey County In-Home Supportive Services Public Authority (Public Authority) to provide covered services to eligible and enrolled In-Home Supportive Services (IHSS) providers for the period July 1, 2022 through June 30, 2023.

Background. The Alliance has offered the Alliance Care IHSS product under an agreement with the Public Authority since July 1, 2005. Alliance Care IHSS provides comprehensive health coverage, including hospital, outpatient, primary and specialty care prescription drug and mental health services to providers of IHSS services in Monterey County who meet the County's eligibility criteria and are enrolled by the County into coverage. Alliance staff meet with County representatives at least annually to discuss program experience and performance and to determine if contract terms, conditions or monthly premiums require adjustment.

Discussion. The benefit year covered under the current agreement with the Public Authority ends June 30, 2022 and the contract must be renewed to support the ongoing provision of services. Staff and County representatives have reviewed contract provisions, program performance and medical costs and utilization and have determined that no changes are needed to the contract terms, conditions or per member per month premiums.

Fiscal Impact. The premium is set to achieve a minimum breakeven performance based on the available information.

Attachments. N/A

DATE: April 27, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Assembly Bill 1944 (Lee): Support

Recommendation. Staff recommend the Board adopt a position of support for Assembly Bill (AB) 1944 (Lee) and direct staff to send a letter of support for this bill.

Background. Brown Act rules governing public meetings require local government business to be conducted at open and public meetings and include restrictions and limitations with regard to the participation of local officials in meetings via teleconference. Each teleconference location must be identified in the notice of the meeting and in the agenda and must be accessible to the public.

In March 2020, in response to the COVID-19 pandemic, Governor Newsom issued an Executive Order waiving the Brown Act teleconferencing requirements. This order has since expired.

AB 361 (Rivas – 2021) provided legislative bodies of local agencies flexibility to meet virtually and remotely during a state-declared state of emergency, under specified circumstances, without having to comply with the standard noticing and public access requirements related to teleconferencing. However, the legislative body is required to make specified findings related to the state of emergency by majority vote every 30 days in order to continue allowing members to participate virtually without meeting existing Brown Act requirements.

Discussion. Throughout the COVID-19 pandemic, the Alliance Board utilized the flexibilities offered via the Governor's Executive Order and, later, AB 361 to meet remotely via teleconference. With COVID-19 local mandates and restrictions lifted, the Board began meeting in March, in-person, at locations accessible to the public, in compliance with Brown Act provisions. The experience of the Alliance Board throughout this period has been that less restrictive teleconferencing provisions allowed for greater public access and participation in Board meetings as well as increased board member attendance and participation.

AB 1944 would allow for local agency legislative bodies to vote to allow members to teleconference from a private location without requiring noticing of and public access to the location.

AB 1944 would further require that, if members participate in meetings via teleconference, the meeting must be livestreamed to provide access to members of the public to observe and participate in the meeting and allow for the public to address the public body either through call-in or video option to ensure equitable participation.

AB 1944 would allow members of local bodies to utilize current technology to fully and safely participate in the public meeting process while offering increased access to members of the public wishing to participate.

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

Attachments. N/A

Medi-Cal Capacity Grant Program

PERFORMANCE DASHBOARD

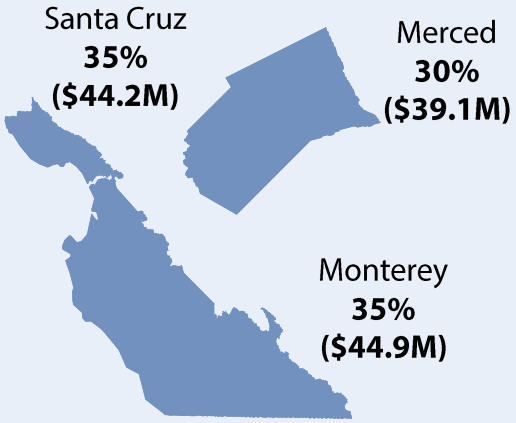
October 2015 through March 2022

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:

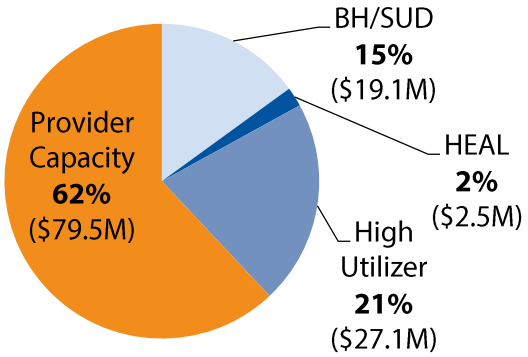
$128.2M



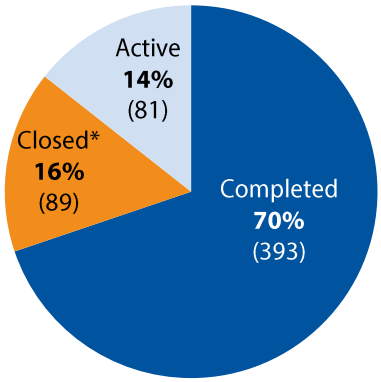
Number of Organizations Awarded:

128

Awards by Focus Area

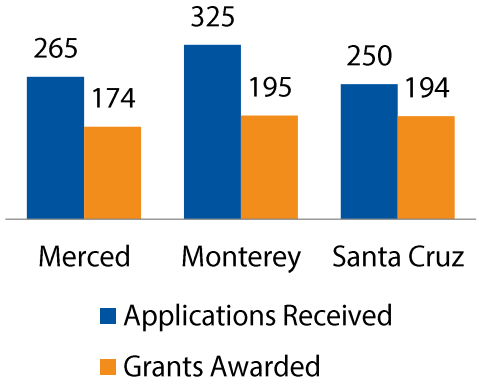


Award Status



* Withdrawn by grantee/terminated.

Total Grants Awarded: 563



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.

81% 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	4	4	26	2	12	3	51	26%
Allied		8				2	10	5%
Behavioral Health	1	1	3		8	8	21	11%
Dental	3				4		7	4%
Other				3		3	6	3%
Total Recruited	33	32	48	23	36	22	194	100%
	33% of total		37% of total		30% of total			

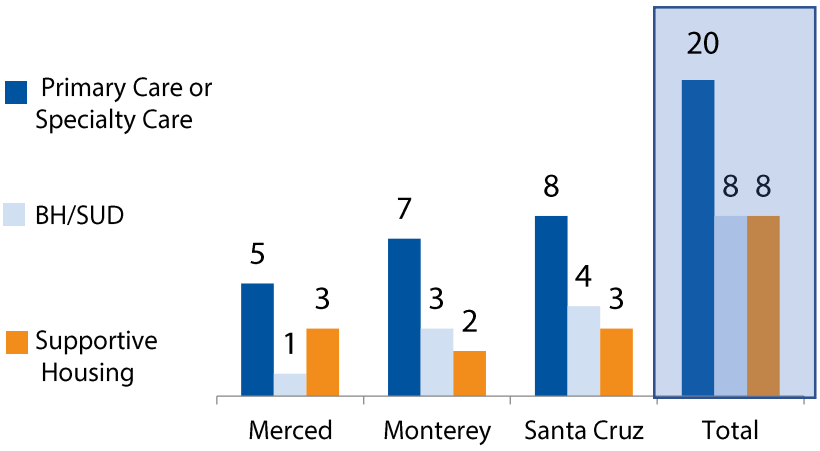
Specialties Recruited

Capital Program

58 grants* totaling $73.8M 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.

36 Capital Projects



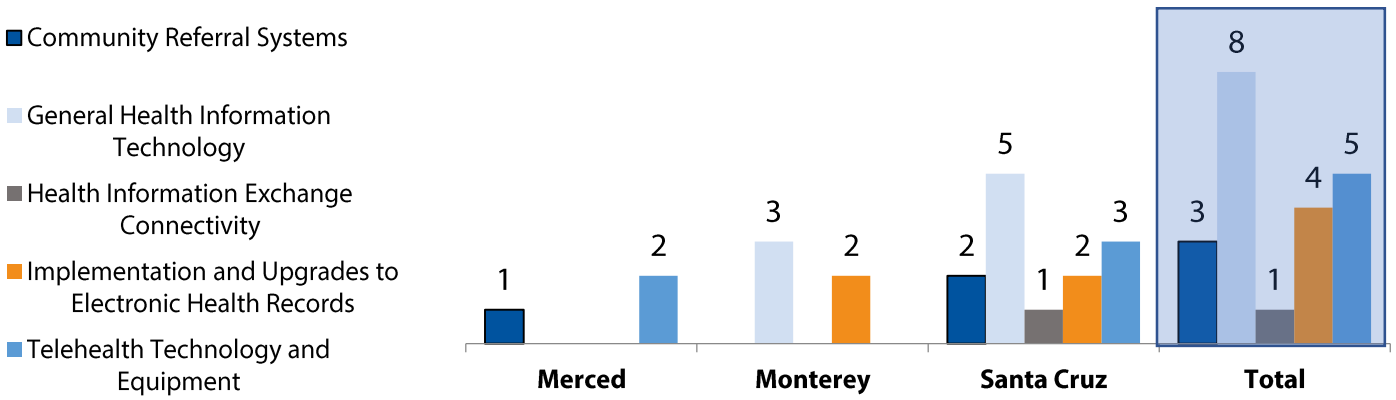
179.5K Medi-Cal members anticipated to be served by new and expanded facilities.

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.

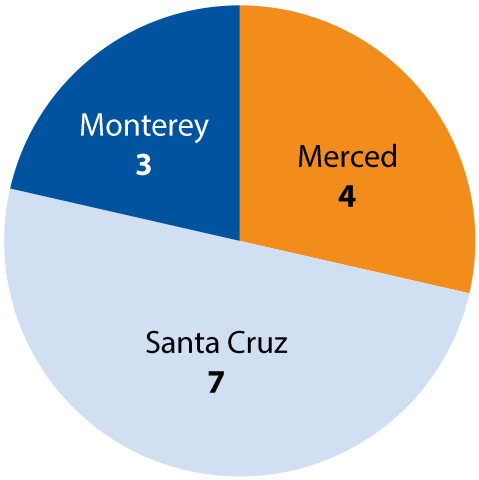
21 Infrastructure Projects



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.

* One grant terminated.



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

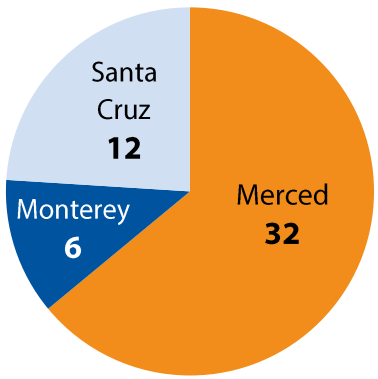
- Nutrition/Health Classes
- Community Gardening
- Cooking Classes

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.

Grants in the Community

Partners for Healthy Food Access

Healthy House Within a MATCH Coalition was awarded a Partners for Healthy Food Access grant for their project, Food to FoRx, to connect members identified as food insecure by the Family Medicine Residency Program at the Family Care Clinic at Mercy Medical Center Merced to nutritious food and health education.

Healthy House developed a clinical workflow and trained 8 resident doctors, who screened Medi-Cal members for BMI at or above the 85th percentile for their age or had prediabetes/diabetes or hypertension and answered affirmatively to food insecurity questions. Members who met these criteria and wanted to participate in the program received a 6-month prescription redeemable for fresh produce at an onsite mobile market. Food for the mobile market was provided by Merced County Food Bank and from a community garden maintained by Hmong Elders at Shepherd of the Valley Church. Under Food to FoRx, the garden was expanded by 40 raised beds and a hydroponic bed built by UC Merced engineering students.

220 members redeemed their Food to FoRx Food prescription to receive healthy food, nutrition education and resources, which also benefited their family members. Participants reported a 72% increase in knowledge of nutritional value, where to buy and how to prepare fresh produce. The project is continuing past the grant term, and Healthy House is working with doctors to expand the project to the Kids Care Clinic across the street. Healthy House's project is testimony to how multi-sector collaboration can improve the health and well-being of its community members.

Infrastructure Implementation

Hospice of Santa Cruz County (Hospice) received an Infrastructure Implementation grant for a telehealth program to provide access, support and services to palliative and hospice care patients. The phone or tablet-based application, TapCloud, includes video conference, symptom and medication tracking, record sharing with the care team and family members and electronic medical record (EMR) system integration. It also empowers patients to take an active role in their health management. The project allowed Hospice to be ready for telehealth deployment across the organization when the COVID-19 pandemic began. As a result of the grant, Hospice is now serving more Alliance members in their palliative program.

Grants in the Community

Workforce Development Investments

California State University, Monterey Bay (CSUMB) received Workforce Development funding for implementation of a new Master of Science Physician Assistant (MSPA) program. There were 29 students in the inaugural class of 2021 who successfully completed their master's degrees and passed the national boards. Before graduation, many students had already received informal job offers from local Medi-Cal providers including Doctors on Duty, Salinas Valley Memorial Healthcare System, Prime Care and Mee Memorial Hospitals. The 30 students in the 2022 cohort are now actively rotating through training placements at clinics and hospitals in the region, 90% of which are high-volume Medi-Cal sites in Monterey and Santa Cruz Counties.

CSUMB selects applicants using a holistic admissions process to select students who represent underserved populations and demonstrate a strong desire to work in primary care in underserved communities. Approximately 62% of selected students are self-identified as meeting the HRSA definition of disadvantaged, and 45% are the first in their family to attend college.

The PA program has been recognized nationally as one of two programs in the country to successfully integrate Spanish into the curriculum which also includes courses in cultural humility. Students are effectively using their Spanish to provide patient care to Spanish-speaking populations in the region.

Overall, the MSPA program at CSUMB has increased the number of available physician assistants in the Alliance service area with extensive education and experience in delivering comprehensive, coordinated, patient-centered care. Of the 29 graduates, 11 are currently employed in Santa Cruz and Monterey counties. 52% are currently employed in primary care and 7% in behavioral health. Areas of practice where alumni are employed outside of primary care include emergency medicine, cardiovascular surgery, orthopedics, trauma surgery, vascular surgery, dermatology, reconstructive surgery, otolaryngology, and endocrinology.

DATE: April 27, 2022

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

FROM: Kathleen McCarthy, Strategic Development Director

SUBJECT: Medi-Cal Capacity Grants: Funding Recommendations

Recommendation. Staff recommend the Board approve grant recommendations that total $349,623 in funding recommendations under Consent Agenda Item 8D.

Summary. This report includes a brief background on the Alliance's Medi-Cal Capacity Grant Program (MCGP) awards to date, an overview of the grant review process and award recommendations for the current funding cycle.

Background. Since the launch of the MCGP in July 2015, the Alliance Board has approved 563 grants for a total of $128.2M to expand Medi-Cal capacity in the Alliance service area in the MCGP's four priority focus areas: Provider Capacity, Behavioral Health and Substance Use Disorder Services (BH/SUD), High Utilizer Support Resources and Healthy Eating and Active Living (HEAL). Consent Agenda Item 8C includes the MCGP Performance Dashboard which provides details on grants awarded to date.

Discussion.

Grant Application Review and Recommendation Process. Grant applications in the current round of funding were due on January 18, 2022. The Alliance received 10 applications from seven organizations in this funding cycle. Staff carefully reviewed each application to determine eligibility and recommend approval of two out of the seven eligible applications received.

An internal committee reviewed and selected applications to recommend to the Board for approval based on the eligibility and program criteria previously approved by the Board. The internal review committee included: Stephanie Sonnenshine, Chief Executive Officer; Dr. Dale Bishop, Chief Medical Officer; Lisa Ba, Chief Financial Officer; Van Wong, Chief Operating Officer; Jordan Turetsky, Provider Services Director; and Kathleen McCarthy, Strategic Development Director. All applicants received a letter notifying them as to whether or not their application was being recommended for approval in April 2022.

The two eligible grant applications being recommended for approval are from organizations in Monterey County. Both applications are for Partners for Healthy Food Access grants under the HEAL focus area. The two grant applications recommended for approval are as follows:

Organization	**Award Amount Recommended**
Soledad Community Health Care District	$200,000
Sun Street Centers	$149,623
Total	**$349,623**

Final grant awards will depend on verification of actual expenses but will not exceed the recommended award amount.

Grant Award Recommendations. Funding recommendations are normally grouped into two separate approval actions so that Board members with a conflict may abstain from voting where applicable. However, in this funding cycle, neither of the two recommended applications are affiliated with Board members and do not pose a conflict.

Fiscal Impact. Recommended grant awards totaling $349,623 would be funded by the MCGP budget which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan's reserves to create the MCGP.

Attachments.

1. Recommendation Summaries by Organization.
    - Detailed application summaries of grant award recommendations organized alphabetically by organization. Application summaries were prepared by Alliance staff based on information in the grant application.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Soledad Community Health Care District**	
County:	Monterey	
Grant Award History:	Capital Planning (1)	$48,532
	Capital Implementation (1)	$2,500,000
	Equipment (2)	$40,000
	Provider Recruitment (5)	$473,396

Partners for Healthy Food Access Program

Project Name:	Harvest Fresh Rx
Project Partners:	Aggrigator, Inc.
Proposed Start/End Dates:	7/1/2022 - 6/30/2023 (12 months)
Total Project Budget:	$235,695
Request Amount:	**$200,000**
***Recommended Award:**	**$200,000**

Proposal Summary: Soledad Community Health Care District (SCHCD) intends to expand the Harvest Fresh Rx program, first piloted in December 2019. The program is a food access and nutrition education/counseling intervention for food-insecure families at Soledad Medical Clinic with the goal of providing lasting improvement in patients' health. All of the grant funds would be used to purchase healthy, nutritious and culturally appropriate food boxes from SCHCD's new partner, Aggrigator, Inc.

A provider at the Soledad Medical Clinic will initially screen and identify patients who are food insecure. SCHCD will then enroll the patient and their family into the Harvest Fresh Rx program. They will be scheduled for follow up visits depending on need, with a minimum of a 3-month follow up to be scheduled with their provider to assess health status indicators, such as BMI, and rescreen for continued food insecurity. The Registered Dietician on staff will meet with patients individually to complete a nutrition assessment and provide tailored nutritional counseling. They will also include screening questions about enrollment into CalFresh, and if appropriate, WIC.

For healthy food box distribution, SCHCD will partner with Aggrigator, a company that sources high quality, fresh fruits and vegetables from local farms. Since many of SCHCD's patients are not only food insecure but have underlying health issues, they will be able to use Aggrigator to provide medically tailored food boxes, a service that has been proven to improve health outcomes. Aggrigator assembles and delivers the customized boxes to the clinic. Each box contains helpful recipes to support families in consuming all of the food in their box. Patients will need to attend monthly nutritional classes in order to receive their next food box. Additionally, the Food Smarts Program curriculum is being used, which focuses on nutritional support for patients to care for their underlying medical conditions.

Objectives: The project objectives are to: 1) provide food boxes to food insecure, Medi-Cal families; 2) survey patients to identify their food security scale score; and 3) improve BMI, blood pressure and A1C in at least 30% of the patients who received boxes of healthy, nutritious meals.

Impact: The Harvest Fresh Rx program will serve 267 individuals and their families annually mostly in Soledad, 90% of whom will be Medi-Cal members. Participants will receive monthly boxes for one year.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Sun Street Centers**	
County:	Monterey	
Grant Award History:	Infrastructure Implementation (1)	$38,448
	COVID-19 Response Fund (1)	$24,000
	Capital Implementation (1)	$2,500,000
	Provider Recruitment (2)	$103,428

Partners for Healthy Food Access Program

Project Name:	Nutritional Support for Families in Recovery
Project Partners:	Food Bank for Monterey County
Proposed Start/End Dates:	7/1/2022 – 6/30/2024 (24 months)
Total Project Budget:	$149,623
Request Amount:	$149,623
***Recommended Award:**	$149,623

Proposal Summary: Sun Street Centers seeks to combat chronic nutrition-based health issues that coexist with and are exacerbated by substance use disorders (SUDs), by expanding nutritional support provided to clients during their stay in Monterey County residential treatment programs. Grant funds would support the Program Manager, Program Aide and Kitchen Manager for their roles in program development and implementation, including training and establishing standards of nutrition-related practices for recovery counselors. Grant funds would also be used for a nutrition consultant to train staff and support menu development and food distribution expenses.

Sun Street Centers will identify residential clients with existing comorbidities that can be managed with healthy eating habits, train clients in the preparation of healthy meals, and arrange for transition to medical care to manage acute and chronic diseases while continuing in recovery from SUD. Additionally, Sun Street Centers will distribute healthy food to residential program alumni and their families.

Food insecurity and health conditions will be identified during intake and assessment for each client, covering health history and current physical health needs. During residential treatment, clients will learn about medically-supportive nutrition and learn healthy coooking skills. Once a client is discharged from residential treatment, they will work with the Recovery Services Manager and counselors to include nutrition and health goals in their care plan and connect to supportive resources. Clients will be able to pick up food boxes at Sun Street's Salinas, Marina and King City sites once a week for up to 12 weeks. Food will be provided by Food Bank of Monterey County and supplemented with items purchased by Sun Street Centers. Counselors will work with each client to determine eligibility for CalFresh and/or WIC and enroll them as needed. Further support is provided by the Program Aide through food preparation education and support with grocery shopping.

Objectives: The project objectives are to: 1) improve health outcomes through nutrition education in residential clients with comorbidities and substance use disorder (SUD); and 2) prepare identified clients to be successful in meeting health goals after program discharge.

Impact: The project will serve approximately 225 individuals annually (100% Medi-Cal members; 50% from Salinas area). Clients will complete person-centered goal planning around nutritional health outcomes and 75% of those clients will improve these outcomes as a result.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

DATE: April 27, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Annual Election of Officers of the Commission

Recommendation. Staff recommend the Board nominate one member of the Santa Cruz-Monterey-Merced Managed Medical Care Commission (SCMMMMCC) to serve as Chairperson and one member to serve as Vice Chairperson.

Background. The SCMMMMCC is due for its annual election of Chairperson and Vice Chairperson, pursuant to section 3.2 of the bylaws.

Discussion. The SCMMMMCC shall elect officers (Chairperson and Vice Chairperson) for one-year terms, at the first meeting in April of each year. Officers shall serve a term which begins on the day of the election and ends at the first meeting in April of the following calendar year.

Commissioners may be nominated by other Commissioners or may nominate themselves for offices.

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

Attachments. N/A

DATE: April 27, 2022

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

FROM: Van Wong, Chief Operating Officer

SUBJECT: Transforming Member Engagement

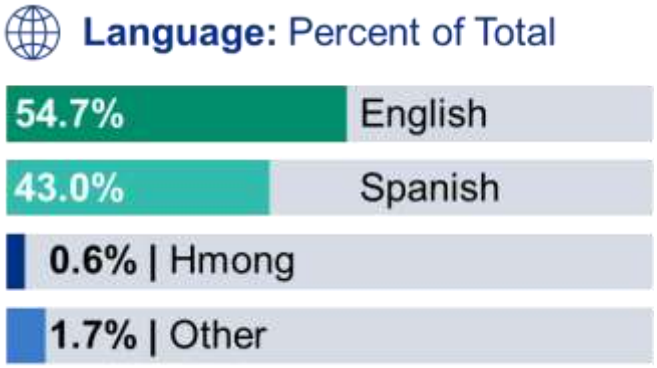
Recommendation. There is no recommended action associated with this agenda item.

Summary. The Alliance identified Health Equity as a strategic priority through 2026. To ensure Alliance members have a fair and just opportunity to be as healthy as possible, the Alliance will address root cause of disparities and take an inclusive approach in ensuring equity in its policies, practices and programs. This approach includes creating opportunities for member inclusion in the Plan's decision-making processes to improve organizational policies to yield health equity. The Alliance will solicit member experience and incorporate their individual voice to guide our programs and policies aimed at addressing their needs. That practice entails intentional and meaningful member engagement activities that are both culturally and linguistically appropriate. This report provides background regarding current Alliance member engagement efforts and plans to transform member engagement.

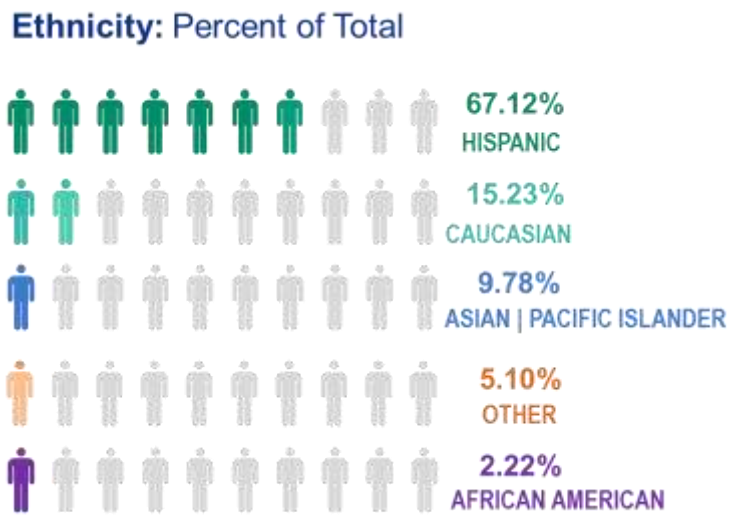
Background. The Alliance's strategic plan outlines our priorities to achieve the Alliance's bold vision of Healthy people, Healthy communities. Specifically, our strategic priorities aim to improve the health equity of our members, particularly for Black, Indigenous, and people of color (BIPOC) and to provide a person-centered healthcare experience for each of our members. The Alliance is committed to ensuring that members receive health care services that are high quality, culturally competent and guided by cultural humility. This undertaking requires the Alliance to evaluate current member engagement practices for opportunities to consistently incorporate member voice, while assessing the effectiveness of those engagements from our members' perspective.

The Alliance service area covers three counties: Santa Cruz, Monterey, and Merced; each with their distinct communities illustrating the diversity of cultural and ethnic representation of our population. Alliance members speak more than 29 different languages and represent a wide variety of cultures. Individuals have better experiences and outcomes when health care is provided with a person-centered approach where an individual's culture and beliefs are understood and respected as part of that approach. The below tables illustrate the diversity of our membership from both the languages spoken to the ethnicity.

ALLIANCE MEMBERSHIP BY LANGUAGE



ALLIANCE MEMBERSHIP BY ETHNICITY



Information delivery is also an important contributing factor to an improved experience, especially when it is provided in the individual's preferred and/or primary language and delivered via the most effective channel for that individual. Alliance members engage with our healthcare system via various mechanisms including direct patient care from our providers and community-based organizations. Members also interact with our member-facing staff and through our third party contracted vendors. Each of these interactions offer an opportunity to ensure a person-centered approach that is culturally and linguistically appropriate. Our aim is to provide a positive and consistent experience for our members regardless of the communication channel and improve health literacy of our members.

In 2019, staff initiated several initiatives aimed at incorporating member voice to better inform our member engagement activities. Since then, the Alliance has leveraged existing forums and implemented numerous initiatives including but not limited to the following:

- Member Services Advisory Group: The Member Services Advisory Group (MSAG) focuses on how to improve Alliance policies. It is also responsible for advising the Alliance's Board of Directors on member care. The group is made up of Alliance members and representatives of county and community agencies. MSAG's goal is to help support friendly, effective and high-quality medical care for members of the Alliance. MSAG fosters open communication between the Alliance and our members. MSAG members advise the Alliance on issues and concerns of members and the community and make policy recommendations to the Alliance based on member and community feedback. It is a forum where the Alliance collects the voices of Alliance members who might not be heard otherwise.

- Whole Child Model Family Advisory Committee: The Whole Child Model Family Advisory Committee (WCMFAC) advises the Alliance on policies and issues that affect children and their families served through the Alliance's WCM program. It is a forum where families with children who have special health care needs, Alliance leadership, and local family support providers have open communication and serve as a mutual learning forum for committee members and Alliance staff to make a positive difference in the care the health plan provides to California Children's Services beneficiaries.

- Your Health Matters (YMH): 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. The Alliance attended 22 outreach events and reached 13,500 members across all outreach efforts, all while operating under a public health emergency.

- At Risk Member Outreach Engagement Campaigns: Staff identifies at risk, vulnerable members and conduct telephonic outreach to provide information of appropriate resources and health education.

- Member Onboarding via Outreach Vendor: Through this vendor, the Alliance conducts initial outreach and welcome calls when a member is first enrolled in the plan. During these calls, the vendor advises members about selecting a primary care physician and setting up an initial health assessment, completing their health information form, if applicable, and verifying member contact information.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): The Alliance conducts a CAHPS member experience survey on an annual basis. CAHPS represents a standardized approach to gathering, analyzing and reporting information on patients' experiences and results offer an indication of how well health care organizations and health plans meet member expectations. There are two well tested and regarded metrics from the Health Plan CAHPS survey that help quantify this global concept of member engagement: our members Rating of Health Care, and Rating of Health Plan. Each of these metrics is measured separately for our adult and child populations.

In 2021, the Alliance showed improvement over our 2020 results in both key metrics: Rating of Health Plan and Rating of Health Care. Initiatives launched in prior years were contributing factors to the increased member experience and satisfaction with the Alliance

and our partners. While results, except for the Child rating of Health Care, were over California benchmarks, the Alliance's percentile rankings in relation to the 2021 Quality Compass All Plans National and California Benchmarks were not in the 90% or higher. That gap represents an opportunity to engage our members even more meaningfully.

Survey Population	Rating of Health Plan				
Response Rate: 18.6%	**2021**	**2020**	**2021 CA Benchmark**	**2021 CA %tile Rank**	**2021 US Benchmark**
Child	88.80%	86.50%	87.80%	$50^{th} - 75^{th}$	86.70%
Adult	79.80%	75.60%	76.30%	$50^{th} - 75^{th}$	78.30%

Survey Population	Rating of Health Care				
Response Rate: 18.6%	**2021**	**2020**	**2021 CA Benchmark**	**2021 CA %tile Rank**	**2021 US Benchmark**
Child	87.10%	82.00%	88.70%	Below 25^{th}	88.90%
Adult	79.10%	69.70%	75.30%	$50^{th} - 75^{th}$	77.60%

***Note**: Response rate represents percentage of responses received out of a total eligible sample size of 1,350 adult members and 1,650 child members.*

Discussion. The Alliance will focus on partnering with our members, as active stakeholders, through two-way communication to inform our decision-making. Successful member engagement presents as empowered members who make choices with positive impacts on their health and quality of life.

The Alliance will continue to leverage various existing health indicators, such as level of preventive services and chronic disease management to assess the overall health disparity of our population. In addition, the Alliance will assess our member's perception of equitable treatment and cultural competency at her doctor's office based on the member's ethnicity and/or language spoken. Our goal is to establish a baseline in 2022 and target relative improvement year over year. Three statements were incorporated into the Alliance's CAHPS survey to capture this data:

1. In the last 6 months, how often were you treated unfairly at your personal doctor's office because you did not speak English very well?
2. In the last 6 months, how often have you been treated unfairly at your personal doctor's office because of your race or ethnicity?
3. In the last 6 months, how often did your personal doctor (or office staff) say or do something that made you feel that they did not understand your culture or language?

Our Approach. In order to achieve our goals over the next five years, the Alliance intends to optimize our engagement strategies by focusing our efforts on the following:

1. Outreach to Targeted Members: Member segmentation through a detailed health profile which also includes preferences, motivations, barriers to care and other critical elements to personally engage them. The more personalized the engagement strategy, the bigger the impact is on the member's health outcome. Focusing on rising risk and high-risk members who are currently not engaged in their own health care would allow for targeted involvement as oppose to those who are already compliant and engaged.

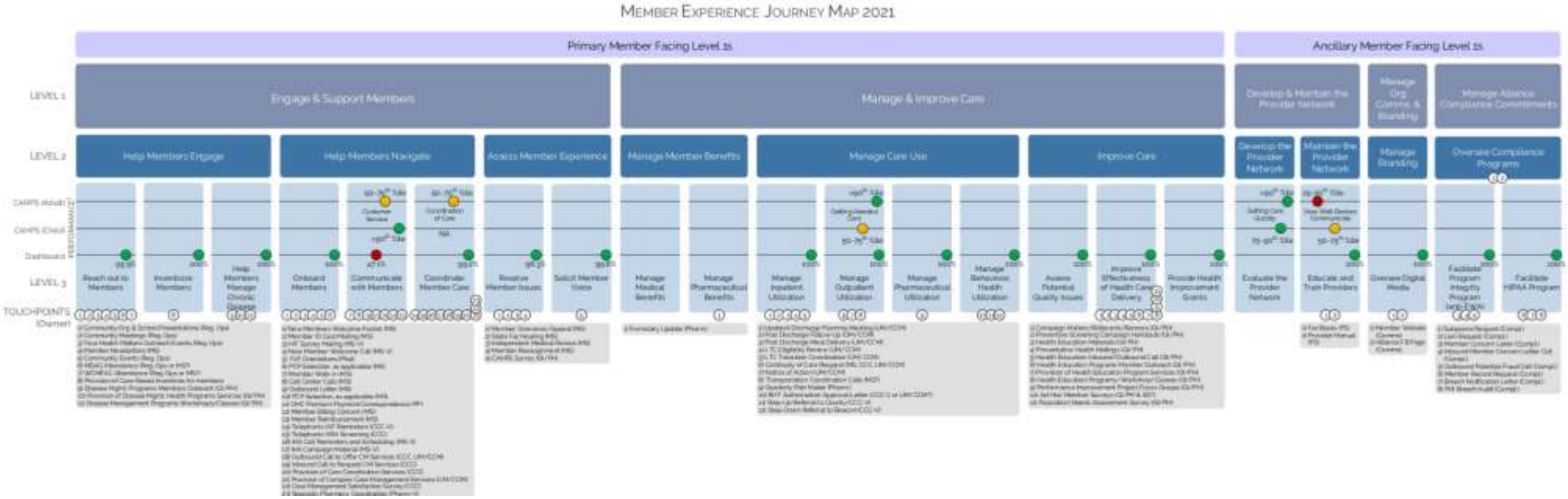
2. Appropriate Communication Channels: Adopting the right communication channel for the member is critical to ensuring relevant healthcare information is received and acted upon. In 2019, the Alliance conducted a preferred communication method with a member focus group and found that over 75% of those surveyed (n = 84) preferred phone/mobile while less than 10% preferred traditional mail. In addition to traditional communication methods already in place (mail, phone, in-person), the Alliance will explore alternative options of member communication, including but not limited to text messaging, chat, video conferencing and self-service member portal.

3. High-Impact Activities for All Members: Tailored efforts to drive action at an individual level to close specific gaps in health care and health education produce a high impact. For example, collaborating with community-based organizations and other partners to provide intentional outreach to those members who have low or no health literacy to be able to navigate the healthcare system more effectively.

In 2022, we will finalize our Member Experience Journey Map (see attachment) that incorporates the definition of Member Engagement inclusive of passive/active touchpoints for a consistent member experience. Active touchpoints are those directly performed by Alliance staff inclusive of our member engagement forums – MSAG, WCMFAC; while passive touchpoints are those performed by our provider, community-based organization and vendor partners. The Alliance will also evaluate current member engagement forums and implement any necessary community advisory activities as it relates to the Department of Health Care Services contract requirement effective 2024. Each touchpoint will have a member voice component to solicit continuous feedback aimed at improving touchpoint outcomes. A key deliverable in 2022 will the development of a five-year roadmap for areas of focus outlined in our approach above.

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

Attachments.
1. Member Experience Journey Map



HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: April 27, 2022

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

FROM: Van Wong, Chief Operating Officer

SUBJECT: Evolution of the Medi-Cal Managed Care Plan Network

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

Summary. California Advancing and Innovating Medi-Cal (CalAIM), the Department of Health Care Services' (DHCS) multi-year plan to transform the Medi-Cal program, implements various changes to managed care impacting health plan provider networks. Medi-Cal managed care provider networks, which historically have leaned heavily on a traditional medical model, are now evolving and expanding to reflect new benefits, services and the inclusion of non-traditional providers. The Alliance meets required network adequacy standards determined by DHCS but recognizes emerging needs to grow and develop a more robust provider network, reflecting the state's goals of increased integration and coordination across all delivery systems. The Board was last briefed fully regarding the Alliance network during the May 2020 Board meeting. This report provides updated performance in various network adequacy metrics and addresses the evolving nature of the Medi-Cal provider network.

Background. California was the first state to pilot managed care in Medicaid. The implementation of Medi-Cal managed care models across the State was driven by different health care delivery and financing systems in different counties of the state. The unique nature of local medical delivery systems resulted in the implementation of six different models of Medi-Cal managed care plans, of which the Alliance's County Organized Health System (COHS) model is one.

Over time, California has transitioned more Medi-Cal beneficiaries into managed care as part of its effort to deliver high quality, accessible healthcare while managing cost and continuously expanding the types of services available to Medi-Cal beneficiaries. Today, approximately 13.9 million Medi-Cal beneficiaries in all 58 California counties receive their health care through Medi-Cal managed care. To date, the Alliance services 396,054 Medi-Cal beneficiaries across three counties, served by a robust provider network of more than 13,750 providers (10,800 medical, 2,950 behavioral health and vision) charged with providing quality and accessible healthcare that meets members' needs in a culturally and linguistically appropriate manner.

Provider Network Adequacy. At the most basic level, the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS) hold plans accountable to geographic and timeliness standards. DHCS and DMHC assess health plan network adequacy against time and distance standards, appointment timeliness standards, provider to member ratios, availability of mandatory provider types, etc. The tools to assess the adequacy of the provider network are:

1. Provider Availability and Appointment Survey (PAAS) Results (note that PAAS is a component of the Timely Access Filing (TAF),
2. Annual Network Certification (ANC) Results, and
3. Provider Satisfaction Survey (PSS) Results.

The Alliance maintains a high percentage of practicing physicians in our network ready and available to serve our members across the tri-counties. The below represents the Alliance's market share of Primary Care Providers (PCPs) and specialists in our service area as of March 2022. Annual goals and targets are developed as part of the annual access plan to boost provider market share and increase access to certain specialty services based on member needs especially in Merced County and south Monterey County.

ALLIANCE PROVIDER NETWORK MARKET SHARE				
Provider Type	**Tri-Counties**	**Santa Cruz**	**Monterey**	**Merced**
PCP	85%	93%	85%	71%
Specialist	84%	90%	81%	84%

The Alliance has a strong market presence and partners closely with our providers to ensure members have timely access to quality care as represented by our PAAS Results. Across several provider categories and appointment types, MY 2021 compliance rates improved. The Alliance made some notable improvements relative to MY 2020 in some key areas such as access to PCP and Non-Physician Mental Health (NPMH) appointments timely while access to specialists and psychiatry appointments were likely impacted in due to the pandemic. Although there are no passing standards established by either DHCS or DMHC on PAAS results, the Alliance have established targets and thresholds for monitoring timely access.

PROVIDER AVAILABILITY & APPOINTMENT SURVEY RESULTS

Category	**MY 2020 Compliance Medi-Cal** (sample size)	**MY 2021 Compliance Medi-Cal** (sample size)
Urgent Appointment		
PCP	96% (329)	99% (644)
Specialist	54% (97)	45% (157)
NPMH	65% (165)	70% (103)
Psychiatry	59% (22)	33% (3)
Routine Appointment		
PCP	98% (330)	99% (644)
Specialist	66% (100)	58% (179)
Ancillary	94% (18)	86% (21)
NPMH	84% (188)	80% (118)
Psychiatry	74% (27)	47% (15)

The Annual Network Certification process is used by DHCS to evaluate the Alliance's compliance with provider to member ratios, mandatory provider types, and time or distance standard requirements. The Alliance received a full pass for our 2021-2022 ANC. At present, access gaps remain for three specialties in four zip codes in southern Monterey for which an Alternative Access Request have been submitted. As noted earlier, the 2022 annual access plan seeks to address this gap through targeted recruitments of these specialists.

The Alliance conducts an annual Provider Satisfaction Survey (Survey) in order to assess contracted providers' overall satisfaction with core health plan operations. In-area contracted PCPs and Specialists were surveyed. In 2021, the overall satisfaction score was the highest yet recorded (all but one measure were in the 100th percentile relative to other plans) demonstrating the Alliance's strong partnership with and support of our provider network during the pandemic.

Member Experience. In addition to standard measures by DMHC and DHCS, the Alliance relies on member experience indicator based on their perception about their ability to get care quickly which is captured in the Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS is an annual survey which is used for rating a patient's health care experiences. 2021 CAHPS results show mixed results compared to 2020 but remains high relative to all California health plans, especially for our adult population which represents more than half our membership. This speaks to the availability of our vast provider network for our members to access care when needed.

Survey Population	Getting Needed Care				
Response Rate: 18.6%	**2021**	**2020**	**2021 CA Benchmark**	**2021 CA %tile Rank**	**2021 US Benchmark**
Child	83.10%	86.80%	80.70%	Above 75th	86.90%
Adult	84.5%[1]	80.30%	75.20%	Above 90th	81.80%

[1] *Current year score is significantly higher than 2020 score*

***Note**: Response rate represents percentage of responses received out of a total eligible sample size of 1,350 adult members and 1,650 child members.*

As we look towards the horizon with the expansion to Mariposa and San Benito counties by 2024, these network adequacy indicators and our prior experience will provide a strong foundation for building out a provider network to meet the needs of the residents in these counties.

Evolution of the Provider Network. Traditional provider types include PCP, including federally qualified health clinics and rural health centers, specialists, hospitals, and allied providers that deliver preventive and/or diagnostic care to our members. Over time, as DHCS transitioned more services to the managed care model in order to facilitate more coordinated member care and manage rising healthcare cost, the Alliance expanded our provider network in order to meet those needs, including the inclusion of allied physicians to provide holistic care to manage members' health which include physical therapists, occupational therapists, speech therapists and acupuncturists.

The timeline below represents notable benefit changes from the last decade impacting the Alliance's provider network. Note that this is high-level and is not intended to be comprehensive, as there have been several minor changes throughout the last 20 plus years.

TIMELINE	BENEFIT	PROVIDER NETWORK IMPACT
2012	Community-Based Adult Services (CBAS) expands to Managed Care under the California Bridge to Health Care Reform waiver	CBAS formerly known as Adult Day Health Care
2014	Mild/Moderate Behavioral Health Services are added to Managed Care via amendment of Section 14189 of the Welfare and Institutions Code	Mental health providers, including LCSWs, LMFTs, psychologists. - Subcontract with Beacon for administration of the benefit
2017	Non-Emergency Medical Transportation (NEMT) & Non-Medical Transportation (NMT) added as a benefit via amendment of Section 14132 of the Welfare and Institutions Code (WIC)	Contract with Call the Car for provision of NMT services NEMT providers
2018	Whole Child Model is added to the Alliance (*COHS or Regional Health Authority only*) via Senate Bill 586	California Children's Services (CCS)-paneled providers; MOU with Counties explaining Division of Responsibilities (DOR)
2022	Prescription Drugs that are not administered at a physician's office are carved out of managed care	Alliance's subcontract with MedImpact, a pharmacy benefit manager is impacted
2022	Enhanced Care Management (ECM) is person-centered care management provided to the highest-need Medi-Cal enrollees, primarily through in-person engagement where enrollees live, seek care, and choose to access services Community Support (CS) offered as cost-effective alternatives to traditional medical services or settings. Community Supports are designed to address social drivers of health	Community Based Organizations (CBO), housing entities, other non-traditional provider types
2022	Community Health Workers (CHW) added as compensable provider type under preventive services; CHWs are trained health educators who work with members who may have difficulty understanding providers due to cultural or language barriers; Focus is on health education and health navigation	CHW - must be supervised by either a community-based organization or a licensed provider, clinic, or hospital. Introduction of CBOs as a new provider type recognized by DHCS;
2023	Doulas added as compensable provider type under preventive services	Doulas

Discussion. Under CalAIM's directive to modernize California's Medicaid program, the Medi-Cal Network will evolve from a medical delivery system to a person-centered delivery system encompassing medical, behavioral and social supports which is achieved via coordination and integration across silos. These sweeping changes are outlined in a multi-year roadmap with the first reform occurring in 2022 as outlined in the timeline noted above in the Background portion of this report.

The focus on reducing health disparities and ensuring health equity for all is another big component of the bold goals outlined by CalAIM. To achieve that goal, the Alliance is looking to strengthen the cultural competency of our provider network and will work to ensure that the provider network meets the cultural preferences of Alliance members. Cultural competency has always been a component of the provider network as demonstrated by the Alliance's Cultural and Linguistic Services Program (CLSP). The CLSP encompasses the Alliance Language Assistance Services for members, cultural competency, sensitivity, and diversity training for staff, providers, and subcontractors. As more integration occurs within the healthcare continuum, we can engage the assistance of the non-traditional, culturally competent providers such as, doulas, health navigators and community health workers to help bridge any cultural competency gaps through increased education and two-way communication.

As noted, the network of providers has broadened to encompass all who support an enrollee's physical and mental health while addressing the social drivers of health such as food and housing security. These changes impact the whole healthcare ecosystem and those who are part of the service delivery. We are seeing several forces at play in the healthcare industry today which presents challenges and has implications for the future as we look to transform to an integrated delivery system that addresses the person as a whole and not just the physical health.

- The Patient Centered Medical Home is evolving through an expanded care team through the inclusion of non-traditional providers, e.g., doulas and CHW and telehealth providers as part of the member's care coordination. It is yet to be seen who should be at the center of that care team for coordination.
- The addition of novel provider types by DHCS for which current infrastructure within the health care system is being developed and/or for which DHCS has not fully defined the scope of practice/scope of the benefit, e.g., CHW and doulas creates challenges for how best to certify, onboard and train the providers timely. More importantly, there is a need to communicate these new benefits to members clearly such that it can be utilized timely and effectively.
- The impact of regional rates on provider reimbursement may compromise a consolidated network that is dealing with increased costs of practicing due to inflation and related impacts of the COVID-19 pandemic, which may not be aligned with health plan revenue. This translates to an increase in the volume of rate enhancement requests which the Alliance is receiving and, if not met, may impact access.
- There is increased regulatory oversight of provider networks, including potential comparison to commercial networks, CMS oversight and additional criteria for how network adequacy is measured.

- Across our service area, there is a shortage of clinic office staff due to the COVID-19 pandemic which impacts clinic wait times and availability.
- The capability, both knowledge and technical infrastructure, of non-traditional provider types to perform administrative responsibilities under the managed care environment such as billing, eligibility and data exchange will need to be bolstered.
- And while the Alliance provider network today is strong and meets all standards of network adequacy as defined by DMHC and DHCS, the trend of market consolidation through acquisition of private practices into larger health care provider systems across our region reduces competition and is compounded by increasing retirement of local providers and related practice closures which may compromise already lean services. It also presents a challenge for hospital/group-level negotiations on a go forward basis as we are seeing trends of termination as a negotiation tactic being used more broadly across hospitals and health systems. The need to ensure access for our members while being fiscally responsible and financially sound is a tough balancing act and necessitates adequate rates from the State.

The Alliance has always focused on maintenance, development and expansion of the provider network. We recognize the need to partner with new provider types to achieve the goals of CalAIM. Actions to deliver a network which meets member needs will be shaped not only through requirements from DHCS, but by continued prioritization of network capacity to deliver high quality, culturally competent care. The Alliance is committed to partnering with our providers and community-based organizations to address these challenges.

As noted earlier in this report, the Alliance monitors various access indicators, survey results, utilization trends, market share, and other available data inputs to inform its annual network development strategy captured in an annual access plan. Given the Alliance's strategic goal around culturally competent care, a new key data input will be the newly added survey questions aimed at members' perception of equitable treatment at a provider's office based on ethnicity and language. See details in the Transforming Member Engagement report at item 11. The Alliance will also monitor the ongoing development of CalAIM and incorporate any new DHCS provider network requirements into our network development strategy. Specifically, for 2022, the focus of the annual access plan is on: 1) expanding capacity of ECM and Community Support providers to support additional populations of focus, 2) recruitment of new provider types such as doulas and CHW, and 3) expansion of access to NEMT service providers in our tri-counties

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

Attachments. N/A

DATE: April 27, 2022

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

FROM: Dale Bishop, MD, Chief Medical Officer
Michelle N. Stott, RN, MSN, Quality Improvement & Population Health Director

SUBJECT: Equity and Quality in the Medi-Cal Managed Care Environment

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

Summary. As a result of the pandemic, and examples of racial violence that raised the consciousness of the nation, a compelling vision for future equity has emerged that includes improving healthcare for all. Closing inequities in healthcare begins with identification of quality metrics attributable to populations of focus and proceeds with taking a population health approach to developing solutions. The 2022 five-year Alliance Strategic Plan and the recently released Department of Health Care Services (DHCS) Quality Strategy are aligned in prioritizing achievement of equity and improving quality in the managed care environment. In this discussion, we will consider the relationship of equity to quality and review results of Alliance quality metrics relative to racial, geographic, statewide Medi-Cal, nationwide Medicaid, and commercial plan results. We will also discuss strategies to improve quality and equity including the Alliance Quality Improvement System (QIS), initiating a population health program, the Alliance Diversity, Equity, Inclusion and Belonging program, and the Care Based Incentive program.

Background. Over its 25-year history, the Alliance has successfully improved quality and access to health care for Alliance members through innovation and partnerships with local providers and organizations. From stakeholder engagement in the development of the Alliance five-year Strategic Plan, staff recognized opportunities to improve member health through prioritizing equity and transforming the delivery system to put our member's goals and needs at the center of their health care. To fully address health inequities, the health care system will need to shift practices and policies that have traditionally benefitted some populations and left others out. Ensuring the health and wellness of all Alliance member populations is a key step towards health equity for the communities the Alliance serves.

Discussion. To improve healthcare equity in the Medi-Cal Managed Care Environment, it is critical to consider what equity means and the relationship of equity to quality and population health. The DHCS vision for improving equity is to eliminate racial, ethnic, and other disparities within the Medi-Cal population, and support policy efforts including those driven by social determinants of health, between Medi-Cal beneficiaries and commercial populations. The DHCS vision is to be achieved through partnerships with members, providers, communities, CBOs, schools, Public Health Agencies, Counties and Health Care Systems as developed through the CalAIM program, utilizing a Population Health approach, and setting quality goals through the DHCS Quality Strategy.

The DHCS Quality Strategy begins with an emphasis on racial disparity and has set bold goals for improved performance statewide by 2025 in the following areas of focus:

- Children's preventive care
- Behavioral Health Integration
- Maternal outcomes and equity

DHCS "bold" goals in the Quality Strategy include:

- Close racial and ethnic disparities in well-child visits by 50% (State level)
- Close maternity care disparity for Black and Native-American Persons by 50% (State level)
- Improve maternal and adolescent depression screening by 50% (State level)
- All health plans to exceed the 50th National Committee for Quality Assurance (NCQA) Medicaid percentile for all children's preventive care measures (Plan level).

The Alliance five-year Strategic Plan priorities align with the DHCS Quality Strategy as the Alliance Health Equity priorities are to eliminate health disparities and achieve optimal health outcomes for children and youth, and to increase member access to culturally and linguistically appropriate health care. Alliance Person-Centered Delivery Transformation strategic plan priorities are to improve behavioral health services and systems to be person-centered and equitable and to improve the system of care for members with complex medical and social needs.

Tactics in 2022 to address health equity priorities are captured in the Alliance Quality Improvement System (QIS) workplan. Alliance QIS efforts applicable to equity and quality include monitoring of CAHPS and HEDIS quality measure performance by race/ethnicity stratification with special attention to child access, maternal and children's preventive care, child immunizations, Adverse Childhood Experience screening and to improve care for members with eating disorders. QIS efforts in areas of person-centered delivery transformation include performance improvement projects, provider utilization of cultural and linguistic services, and the annual population needs assessment (PNA).

Disparities identified in populations of focus from the QIS will be further evaluated and addressed as part of the 2022 CalAIM initiative for Plans to develop a population health program which is required to align with NCQA requirements. The goal of the program is to create a system of care that proactively addresses member needs across the continuum of care by focusing on upstream health and wellness/prevention strategies, understanding local needs and solutions, addressing health disparities and social determinants of health, and embracing intersectoral actions and partnerships. This would include risk stratification by identifying risk levels for all members and segmenting populations for interventions including health education, basic case management, complex care management as well as enhanced care management, and community supports. To support population health, integration of patient assessment tools and use of multiple data sources (i.e., claims, business intelligence tool, clinical data, etc.) will be used to predict risk levels, including incorporation into the electronic Alliance care management systems to guide outreach efforts and care needs. Population Health Program development will be designed to achieve health outcomes for individual members and the segmented populations, support providers in managing care and treatment, align with community efforts and solutions, and action plans based on the annual population needs assessment.

Results of Alliance quality measures overall indicate most metrics are above the DHCS Minimum Performance Level (MPL) of Medicaid nationwide. Compared to commercial population results, Alliance results for many measures are comparable in Monterey and Santa Cruz Counties but below in Merced. For example, well-child visit rates are lower in Merced County compared to Santa Cruz/Monterey and although comparable to average commercial plan rates in Monterey and Santa Cruz, are lower than commercial and the DHCS MPL in Merced. In addition to geographic disparities, results show race/ethnicity disparities for Black (smaller population), and Whites compared to LatinX and Asians in well-child visits, immunizations, and diabetes control across all counties. There are higher well-child visit rates in geographic areas of Watsonville, South Monterey County (some lower density areas), Salinas, and city of Merced, possibly correlated with higher LatinX and Asian populations residing in those areas. For spoken language, Arabic and Hmong have lower rates of well-child visits compared to Spanish, Vietnamese, and English speakers. These findings are consistent with a DHCS *Asian Subpopulations Health Disparities Focused Study Report (1/11/21)* in which Hmong speakers had lower rates in certain MCAS measures compared to other Asian sub-populations,

Alliance Care-Based Incentive (CBI) quality metrics evaluate primary care provider medical home care and include selected MCAS metrics with emphasis on pediatric preventive care, care of diabetes and asthma, depression screening, as well as care coordination and access. CBI metrics are aligned with DHCS priority MCAS results and benchmarks for 2022 and 2023. Historic Alliance performance on the current indicators reflects overall above average performance in Monterey and Santa Cruz compared to state and national Medicaid benchmarks with a geographic disparity evident in Merced. Newly defined MCAS metrics include fluoride varnish application which has been a CBI metric since 2021. Adverse Childhood Experience screening has not been started by most PCPs throughout the Alliance region.

It is important to consider where the Alliance Quality Improvement System is heading in 2022 and beyond to achieve expected continued improvement. Guiding principles in Alliance QIS efforts include coordinating efforts to achieve maximal impact, offering whole person care through a population health approach stratifying risk, prioritizing efforts. and keeping in mind that primary care is the critical starting point to improvement. Plans for this year are to continue improving quality, equity through QIS projects and other efforts including CBI, and the Alliance Diversity, Equity, Inclusion and Belonging initiative.

A well-child visit rapid cycle Asian Disparity pilot project has been implemented in 2022 for a Merced provider with 75% (34) visits completed. In the QIS, provider utilization of cultural and linguistic services increased in 2021 for telephonic (by 4.3%) and face-to-face (by 24.4%) interpreter services as well as translation and readability requests (by 51.2%). The Alliance conducted a population needs assessment and developed an action plan to address the top concerns by members including health literacy, addressing obesity and access to food and nutrition education, mental health services, homelessness, and oral health care. The QIS activities continued within the context of the COVID-19 pandemic, and the Alliance implemented several member outreach efforts as well as promotion of the COVID-19 vaccine (through the DHCS COVID-19 vaccine incentive program) to close health disparity gaps in Blacks, American Indian/Alaska Native, geographical regions, homeless members, and by age bands.

The goal of the Alliance Diversity Equity Inclusion and Belonging is a diverse, inclusive, and representative workforce capable of achieving health equity in outcomes for Alliance members. This would be accomplished through breakthrough objectives to create DEIB shared language across the Alliance, build psychological safety to enable direct communication, and incorporate staff voices into higher level decisions.

We are looking beyond traditional QI practice coaching and member activation interventions by aligning with the DHCS Health Equity Framework and NCQA Health Equity standards by initially risk stratifying members by race/ethnicity for interventions, incorporating CBI measures to close health disparity gaps, access to culturally and linguistic care as an Alliance strategic priority, and population health program development. The work that needs to be done will continue to evolve as we dive deeper into understanding and addressing health disparities for vulnerable populations.

Upcoming CalAIM requirements complimentary to promoting equity and quality improvement include completing NCQA Health Plan and NCQA Health Equity accreditations in 2026. This effort will begin with the Populating Health Program in 2022 and in 2023, a formal NCQA project will kick off beginning with a baseline gap analysis, and readiness assessment for both accreditations.

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

Attachments. N/A

DATE: April 27, 2022

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

FROM: Dr. Dianna Diallo, Medical Director

SUBJECT: Care-Based Incentive 2023

Recommendation. Staff recommend the Board approve the 2023 Care-Based Incentive Proposal as described in detail below.

Summary. This report provides an overview of the CBI program and makes a recommendation for structural program changes to CBI 2023.

Background. Since 2010, the Alliance's CBI program has encouraged primary care physicians to adopt and implement the Patient Centered Medical Home model. CBI aligns with the Alliance's Strategic Priorities for Health Equity and Person-Centered Delivery System Transformation, offering an upside-risk value-based payment to primary care providers to promote better health outcomes, improved access to care and promotes the delivery of high-value care. These health outcomes are reflected in part by the health plan's annual reporting to the Department of Health Care Services (DHCS) for National Committee for Quality Assurance (NCQA)'s Healthcare Effectiveness and Data Information Set (HEDIS), referred to as Managed Care Accountability Set (MCAS), which includes measures from both HEDIS and the Centers for Medicare and Medicaid Services Medicaid Adult and Child Core Measure Sets.

Historically CBI has aligned with many DHCS mandated reported measures, but other state policies have also impacted measure selection including the California State Auditor's reports, DHCS All Plan Letters (APL), California Governor directives, and directives during the Public Health Emergency. Measures selection for CBI has also taken into consideration those preventive service measure gaps and focus in health equity under the DHCS Quality Strategy to select new measures or modifications to support the Medi-Cal population.

Discussion.

Proposed changes to 2023 programmatic measures are:

- Add Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents
- Add Health Plan Health Disparity
- Retire Unhealthy Alcohol Use in Adolescents and Adults
- Retire Asthma Medication Ratio

Proposed changes to Fee-For-Service measures are:

- Add $200 FFS measure for provider completion of the ACEs training and attestation

Proposed changes to 2023 exploratory measures are:

- Add Colorectal Cancer Screening
- Retire 90-Day Referral Completion
- Retire Tuberculosis (TB) Risk Assessment

For 2023 programmatic Care Coordination - Hospital Access measures, staff recommend no change.

The proposed 2023 programmatic Care Coordination - Access measures will add the Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents measure, transitioning from an exploratory to a programmatic status. Recommended for retirement is the Unhealthy Alcohol Use in Adolescents and Adults measure, which has made limited impact in improving overall screening rates and is not a required reporting measure by the health plan. In retiring the Unhealthy Alcohol Use in Adolescents and Adults measure, those points can be distributed to help improve low ACEs screening rates within the Alliance population.

In terms of 2023 programmatic Quality of Care measures, the following are recommended to remain unchanged: Body Mass Index Assessment: Children & Adolescent; Breast Cancer Screening; Cervical Cancer Screening, Child and Adolescent Well-Care Visit, Diabetic HbA1c Poor Control (>9%); Immunizations: Adolescents; Immunizations: Children (Combo 10); Screening for Depression and Follow-up Plan; and Well-Child Visit in the First 15 Months. Asthma Medication Ratio is recommended for retirement following general high performance over the past couple of years, as well as the removal from being held to the minimum performance level by DHCS starting in reporting year 2022.

For 2023, it's recommended that the health plan health disparity measure change from an exploratory measure to a programmatic measure that will set aside approximately 5% of the overall CBI payment which will be distributed if we achieve the health plan challenge to close each of the racial/ethnical gaps for the designated measure. Currently the health plan health disparity measure reviews overall Alliance rates among the Child and Adolescent Well-Care Visit to determine whether different ethnic groups had or did not have equal access to primary care, relative to our largest member population. The recommended change is to instead focus on closing gaps to the 50th and 75th percentile, that would distribute money to all CBI groups if a 50% closure can be achieved for race/ethnic groups currently below the 50th percentile and a 50% closure to the 75th percentile for race/ethnic groups currently above the 50th percentile. Each race/ethnicity that reaches the gap closure goal will distribute 1% of set aside 5% payment.

Fee-for-Service Measures are recommended to add an additional $200 measure for completion of the certified ACEs Aware Core Training and attestation. This measure intended to provide compensation for the time spent in completing the DHCS required training and attestation needed in order to begin screening and billing the health plan for ACEs. The payment will be $200 per clinician, and the Alliance will pay for each CBI group that the clinician practices under. This payment would be retroactive for all rendering providers who have already completed their training and attestation with the state and received through confirmation to the Alliance.

Recommended additions to exploratory measures include Colorectal Cancer Screening. Recommendations for retirement are the 90-Day Referral Completion, and Tuberculosis (TB) Risk Assessment.

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

Attachments. N/A

DATE: April 27, 2022

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

FROM: Kathleen McCarthy, Strategic Development Director

SUBJECT: Medi-Cal Capacity Grant Program Evolution: Framework for Goal Setting

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

Summary. At the March 23, 2022 Board meeting, staff proposed key changes to evolve the Alliance's Medi-Cal Capacity Grant Program (MCGP) to increase the impact of the Alliance's funding in the community and advance the Alliance's vision of *Healthy People, Healthy Communities.* The Board approved three new grantmaking focus areas: 1) Access to Care; 2) Healthy Beginnings; and 3) Healthy Communities. These focus areas were selected because they address unmet and emerging Medi-Cal needs and align with opportunities identified in the Alliance's 2022-2026 Strategic Plan. The new focus areas, once fully developed, will replace the current focus areas that were established in 2015 (i.e., Provider Capacity, Behavioral Health and Substance Use Disorder Services, High Utilizer Support Resources and Healthy Eating and Active Living). At the April Board meeting, staff will solicit input from the Board to inform the development of funding goals for each new focus area and a new theory of change that will connect strategies and anticipated outcomes.

Background. The Alliance established the MCGP in 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act (ACA). 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.

MCGP Investment Framework. The Alliance Board established key criteria for the Alliance's MCGP investments in the community. These criteria will be used to guide planning for future MCGP investments:

- Medi-Cal Purpose: To comply with State law, all grants must benefit Medi-Cal beneficiaries.
- Service Area: Grantees must maintain ongoing operations, including staffing and programs, in the Alliance service area.
- Focus Areas: Funded projects must be associated with at least one of the MCGP focus areas and support the identified goals for that focus area.
- Alignment with Mission: Grants are awarded to advance the Alliance's vision, mission and strategic priorities.
- Funding Allocations: MCGP funding is allocated by county and funding opportunity.
- Supplanting: Alliance funding should not be used to supplant or duplicate other funding in order to focus investments on areas where limited funding is available or where other funding sources can be leveraged to have a greater impact.

Development of New Focus Areas. Given the significant changes in the health care environment since the MCGP was first launched and the insights gained through the recent strategic planning process, staff identified several opportunities to evolve the Alliance's grantmaking strategy to align with the organizational priorities in the 2022-2026 Strategic Plan, leverage opportunities provided

by CalAIM and ensure that the MCGP continues as an impactful strategic tool to advance the Alliance's vision and mission.

In 2021, staff gathered stakeholder insights into how the current MCGP framework could be evolved to increase the program's impact on member and community health. The three new MCGP grantmaking focus areas include opportunities identified by stakeholders and align with Alliance and State priorities to address unmet and emerging needs. The new focus areas will: 1) direct investments in areas outside of core health plan responsibility where other funds are not available; 2) will increase investments upstream towards root causes and prevention; and 3) will engage partners in collectively meeting member and community health needs.

Brief descriptions of each focus area are below, along with a list of possible areas in which the Alliance could direct resources.

New Focus Areas
Access to Care The Alliance will focus on strengthening and expanding the provider workforce to address provider shortages and increase the number of providers that reflect the diversity of the Alliance's membership. The Alliance will also make investments to address other barriers to care to ensure that Medi-Cal members are able to access high-quality care when, where and how they need it. Possible areas the Alliance could direct resources: • Medical education and training programs • Provider recruitment support • Capacity building for community health workers and doulas (new Medi-Cal benefit) • Medical innovations to manage care (home monitoring, patient equipment)
Healthy Beginnings The first five years of life are critical to health and brain development. Providing safe, nurturing environments for children in these early years can help establish the foundation for lifelong health, and has proven benefits for children, families and society. By investing in early childhood development and wellness, the Alliance will positively impact the health and well-being of its youngest members and their families and ensure they have the resources and support needed to thrive. Possible areas the Alliance could direct resources: • Voluntary home visiting programs • Parenting education programs • Parent engagement and leadership development • Newborn Medi-Cal enrollment and new parent kits • Children's college/vocational savings accounts
Healthy Communities Social, economic and environmental factors shape individual health and influence risk for chronic conditions such as diabetes, asthma, cardiovascular disease. By investing in the non-medical factors that impact health, such as food and housing, the Alliance can ensure that children and families have access to what is needed to live their healthiest lives. Creating communities where healthy choices are easy and available to all can reduce health disparities, support healthy and active lifestyles and reduce risk of chronic disease. Possible areas the Alliance could direct resources: • Access to nutritious food (e.g., community-based access and education, community and school gardens) • Physical activity programs and safe places to play • Temporary and permanent supportive housing • Medical-legal partnerships

Discussion. At the April 27, 2022 Board meeting, staff will engage the Board in a facilitated discussion to inform the development of focus area goals. Goals for each focus area will:

- Ensure that the grant program is grounded in the Board's vision and identified priorities;
- Increase the effectiveness of the Alliance's grantmaking and enable program evaluation of the intended impact; and
- Support partnerships by clearly articulating what the Alliance aims to achieve for its members.

For each focus area, Board members will consider:

- *What impact would we like to have? How will we know the grants have made a difference?*
- *Where should we direct our resources?*

Next Steps. After intaking the Board's direction, staff will return with proposed goals for the three new focus areas and a new MCGP Theory of Change which connects focus areas to short-, medium- and long-term outcomes and creates a roadmap for future strategies.

After the Board approves the Theory of Change, the evolution of the MCGP in 2022 will include development of specific funding opportunities, as well as policy development for allocation of the MCGP budget. Further MCGP evolution will include exploring opportunities for more equitable grantmaking and inclusion of the member voice to inform community investments.

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

Attachments. N/A

Information Items: (16A. – 16D.)

A. Alliance in the News Page 16A-01
B. County/Stakeholder Letters of Opposition Page 16B-01
C. Letters of Support Page 16C-01
D. Membership Enrollment Report Page 16D-01

April 2022 Board Report

Total National TV Audience
18,770

Total National TV Publicity
USD $5,739

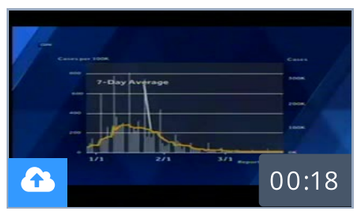
Total Local TV Audience
18,770

Total Local TV Publicity
USD $5,739

Total Online + Print Audience
10,995,823

Total Online + Print Publicity
USD $178,179

Total Number of Clips 18



KSBW Action News 8 at 11

1

Time Mar 31, 2022 2:03 AM EDT
Local Broadcast Time 11:03 PM PDT
Category News
Call Sign KSBWDT2 (ABC)
Market DMA: 126 Monterey, CA
Language English

Est. National Audience 1,159
Est. National Publicity Value USD $428

Est. Local Audience 1,159
Est. Local Publicity Value USD $428

than 14- hundred people are in the hospital with covid statewide. that's compared to more than 11- thousand patients early last month.### the **central california alliance for health** is offering a new incentive for people who get their first booster shot through the end of may. members can receive a 50-dollar target gift card. you're also eligible if you received your

KSBW Action News 8 at 11

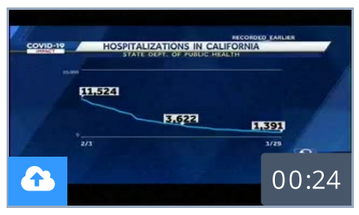
2

Time Mar 31, 2022 2:03 AM EDT
Local Broadcast Time 11:03 PM PDT
Category News
Call Sign KSBW (NBC)
Market DMA: 126 Monterey, CA
Language English

Est. National Audience 7,543
Est. National Publicity Value USD $2,776

Est. Local Audience 7,543
Est. Local Publicity Value USD $2,776

percent. fewer than 14- hundred people are in the hospital with covid statewide. that's compared to more than 11- thousand patients early last month.### the **central california alliance for health** is offering a new incentive for people who get their first booster shot through the end of may. members can receive a 50-dollar target gift card. you're also eligible if



KSBW Action News 8 at 11

3

Time Mar 31, 2022 4:41 AM EDT
Local Broadcast Time 1:41 AM PDT
Category News
Call Sign KSBW (NBC)
Market DMA: 126 Monterey, CA
Language English

Est. National Audience 1,821
Est. National Publicity Value USD $606

Est. Local Audience 1,821
Est. Local Publicity Value USD $606

1-point-3 percent. fewer than 14- hundred people are in the hospital with covid statewide. that's compared to more than 11- thousand patients early last month.### the **central california alliance for health** is offering a new incentive for people who get their first booster shot through the end of may. members can receive a 50-dollar target gift card. you're also eligible if you received your first booster sometime this month. people will be notified by mail.

Elderday Project Off to Smashing Start

4

Back to Agenda

Date Collected Mar 28, 2022 7:48 PM EDT
Category Local
Source Good Times Santa Cruz
Author Todd Guild

Est. Audience 9,255
Est. Publicity Value USD $171
Market Santa Cruz, CA
Language English

... care for older adults can cost $70,000 per year.

"It's growing every year, and there are families who are trying to decide whether they can stay in their homes," Caput said. "This larger, new facility is a win for the entire community."

The move was made possible by a $2.5 million grant from **Central California Alliance for Health**.

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 ...

Breaking down the county's 'siloed' homelessness response: New task force brings together varied stakeholders

5

Date Collected Mar 28, 2022 5:32 PM EDT
Category
Source Lookout Santa Cruz
Author Source, Grace Stetson Covers Affordability, Equity Issues For Lookout. She Earned A Master S Degree While Focusing On Housing Issues At Northwestern S Medill School. After A Stint With Nbc In New York, Grace Is Happy To Have Returned To Her Native Bay Area, Wandered Over The Hill To Explore The Cost Equation.

Market United States
Language English

... will meet at least six times per year, with the first public meeting scheduled for April 20; the H4HP team will host a public session Wednesday to describe its forthcoming goals.

Three of H4HP's new members each personify the changes the new approach seeks.

Stephanie Sonnenshine, CEO for the **Central California Alliance for Health**

Sonnenshine brings unique perspectives on homelessness to the policy board, especially addressing the issues surrounding Medi-Cal managed care, said Ratner. She became CEO five years ago, after joining the alliance in 2009.

Sonnenshine's organization offers enhanced case-management services to ...

KSBW Action News 8 Weekend Sunrise

6

Time Mar 27, 2022 10:28 AM EDT
Local Broadcast Time 7:28 AM PDT
Category News
Call Sign KSBW (NBC)
Market DMA: 126 Monterey, CA
Language English

Est. National Audience 8,247
Est. National Publicity Value USD $1,929

Est. Local Audience 8,247
Est. Local Publicity Value USD $1,929

elderday currently has 90 participants but at one time there were as many as one hundred fifty people "we are making a comeback! we are working really hard to have everybody get back at get as strong as possible..." that comeback began today, during a symbolic ground breaking ceremony to upgrade this former furniture store the six million dollar project received a two and a half million dollar grant from **central california alliance of health** it will add more than thirty five hundred square feet to help clients "we pay 1.95 for the building and we're going to put almost 4 million dollars into our renovation that's our current renovation budget. we hop to be under that budget to all constructiion projects, close to 6 million dollars." this is luis garcia's second week participating in the program but he hopes to grow along with the project. "somebody told me about this program and so i came

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Elderday project off to smashing start

7

Date Collected Mar 25, 2022 9:06 PM EDT
Category Local
Source Register Pajaronian
Author Todd Guild

Est. Audience 2,057
Est. Publicity Value USD $39
Market Watsonville, CA
Language English

... care for older adults can cost $70,000 per year.

"It's growing every year, and there are families who are trying to decide whether they can stay in their homes," Caput said. "This larger, new facility is a win for the entire community."

The move was made possible by a $2.5 million grant from **Central California Alliance for Health**.

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 ...

New Challenges As Santa Cruz County's Age Demographics Shift

8

Date Collected Mar 22, 2022 7:48 PM EDT
Category Local
Source Good Times Santa Cruz
Author Johanna Miller

Est. Audience 9,255
Est. Publicity Value USD $41
Market Santa Cruz, CA
Language English

... a regional hub for senior services. Elderday Adult Day Health Care, a program of nonprofit Community Bridges, is moving into Watsonville. On March 25, a groundbreaking ceremony will be held for their new center at 521 Main St.

The $6 million project, aided by a $2.5 million grant from the **Central California Alliance for Health**, will add an additional 3,600 square feet of space and allow the program to expand its services.

"We're just really excited because this means that we're going to serve lots of seniors with medically complex needs, have daily access to nurses, to therapists, social workers, to help support their ...

Driscoll's Matching Contributions for Health Care District

9

Date Collected Mar 17, 2022 11:51 PM EDT
Category Local
Source Good Times Santa Cruz
Author Todd Guild

Est. Audience 9,255
Est. Publicity Value USD $250
Market Santa Cruz, CA
Language English

... an additional $25 million has been committed through local governments, nonprofits and local health care partners.

The County of Santa Cruz has offered $5 million, the County of Monterey $3 million and the Pajaro Valley Community Health Trust has kicked in $6 million.

Other donations include:

Central California Alliance for Health: $3 million
Kaiser Foundation Health Plan: $3 million
Stanford Children's Hospital: $1.084 million
Dominican Hospital/Common Spirit: $300,000
The City of Watsonville: $130,000

Anyone wanting to make a donation can contact the Community Foundation at 831-662-2000 or visit cfscc.org/ ...

Driscoll's matching contributions for health care district

10

Date Collected Mar 17, 2022 5:06 PM EDT
Category Local
Source Register Pajaronian
Author Todd Guild

Est. Audience 2,057
Est. Publicity Value USD $57
Market Watsonville, CA
Language English

WATSONVILLE—Efforts by a local nonprofit to purchase and run Watsonville Community Hospital have gained momentum, with several jurisdictions and organizations pledging money.

Now, Driscoll's berry company has stepped forward, offering $1.75 million to match all donations through May 1 to the Pajaro Valley Healthcare District Project (PVHDP).

Driscoll's Chair and CEO Miles Reiter says he recognizes the role that PVHDP could play in bringing health care services to the community.

"After an already tumultuous past two years, the last thing we want to see is disruption to our community's ...

Wise Investment

11

Date Collected Mar 16, 2022 5:50 AM EDT
Category Local
Source Monterey County Weekly
Author Pam Marino

Est. Audience 32,736
Est. Publicity Value USD $417
Market Seaside, CA
Language English

... approved by the Board of Supervisors in 2021 has been in the works for six years, with a groundbreaking taking place Thursday, March 10. The city of Salinas agreed to a land swap to make the facility possible. It received $16.25 million from the county for construction, as well as funds from the **Central California Alliance for Health** and the California Mental Health Services Act, approved by voters in 2004.

In addition to medical treatment, the center will bring mental health services to East Salinas in both English and Spanish. Services provided will include screening and assessment, counseling, case management, support ...

Back to Agenda

Editorial; Watsonville hospital off to promising start

12

Powered by LexisNexis

Date Collected Mar 12, 2022 6:31 AM EST
Category Local
Source Monterey County Herald (CA)

Est. Audience 9,000
Est. Publicity Value USD $92
Market United States
Language English

... of donors continues to expand, starting with the Santa Cruz County Board of Supervisors who agreed to direct $5 million toward the purchase and operation. Then a succession of contributors have come forward: the County of Monterey $3 million, the Community Health Trust of Pajaro Valley $6 million, **Central California Alliance for Health** $3 million, Kaiser Foundation $3 million and Stanford Children's Hospital $1 million. Dominican Hospital and Common Spirit pledged $300,000 and the City of Watsonville directed $130,000. Watsonville-based Driscoll's also has announced the berry company would match up to $1.75 million in donations ...

Online News

Editorial | Impressive start to fundraising campaign to save Watsonville's hospital

13

Date Collected Mar 11, 2022 9:10 AM EST
Category Local
Source Santa Cruz Sentinel

Est. Audience 24,681
Est. Publicity Value USD $276
Market Santa Cruz, CA
Language English

... of donors continues to expand, starting with the Santa Cruz County Board of Supervisors who agreed to direct $5 million toward the purchase and operation. Then a succession of contributors have come forward: the County of Monterey $3 million, the Community Health Trust of Pajaro Valley $6 million, **Central California Alliance for Health** $3 million, Kaiser Foundation $3 million and Stanford Children's Hospital $1 million. Dominican Hospital and Common Spirit pledged $300,000 and the City of Watsonville directed $130,000. Watsonville-based Driscoll's also has announced the berry company would match up to $1.75 million in donations ...

Mental health services for children and youth are poised to expand in Monterey County.

14

Date Collected Mar 10, 2022 4:55 AM EST
Category Local
Source Monterey County Weekly
Author Pam Marino

Est. Audience 4,113
Est. Publicity Value USD $49
Market Seaside, CA
Language English

... approved by the Board of Supervisors in 2021 has been in the works for six years, with a groundbreaking taking place Thursday, March 10. The city of Salinas agreed to a land swap to make the facility possible. It received $16.25 million from the county for construction, as well as funds from the **Central California Alliance for Health** and the California Mental Health Services Act, approved by voters in 2004.

In addition to medical treatment, the center will bring mental health services to East Salinas in both English and Spanish. Services provided will include screening and assessment, counseling, case management, support ...

BUSINESS INSIDER

Alliant International University and Healthcare Information and Management Systems Society (HIMSS) Partner to Launch New Healthcare Data Analytics Course

15

Date Collected Mar 9, 2022 4:04 PM EST
Category Trade
Source Business Insider

Est. Audience 10,746,358
Est. Publicity Value USD $175,307
Market United States
Language English

... , and abuse reduction to improve operational efficiency
How to build, grow and develop a robust analytical capacity towards a mature analytical organization to support insight-driven operation

This course is led by Dr. Frank Song, CSML's Adjunct Professor and Data and Analytics Director for the **Central California Alliance for Health**, will provide participants with powerful skills to enhance their careers and open every door of opportunity.

The self-paced online course spans 12 weeks, Monday, March 28, to Sunday, June 19, 2022.

Registration is available here through Thursday, March 17, 2022.

For more information on the ...

Online News

Watsonville corporation to match donations to health care district project

16

Date Collected Mar 7, 2022 5:29 PM EST
Category Local
Source Santa Cruz Sentinel
Author Melissa Hartman

Est. Audience 24,681
Est. Publicity Value USD $327
Market Santa Cruz, CA
Language English

... of Watsonville Community Hospital is just the last of many generous donations from local businesses, community organizations and governmental entities.

The County of Santa Cruz has allocated $5.5 million, the County of Monterey $3 million, the Community Health Trust of Pajaro Valley $6 million, **Central California Alliance for Health** $3 million, Kaiser Foundation $3 million, Stanford Children's Hospital $1 million, Dominican Hospital and Common Spirit $300,000 and the City of Watsonville $130,000.

This amounts to nearly $22 million. Certain donors, who have made up for $3 million more in fundraising, have yet to be identified ...

Bakersfield.com

Activate Care Expands Presence in California, Delivering Social Risk Management Technology and Services to Address Medi-Cal Population's SDoH

17

Date Collected Mar 7, 2022 5:12 PM EST
Category Local
Source Bakersfield.com

Est. Audience 97,694
Est. Publicity Value USD $827
Market Bakersfield, CA
Language English

-

Activate Care®, a leader in social risk management solutions, today announced it is further expanding its presence in California, as it adds **Central California Alliance for Health**, Monterey County and Health Plan of San Joaquin to the list of organizations who have chosen its CareHub platform to proactively manage their population's social determinants of health (SDoH).

Active Care offers everything communities need to drive improved outcomes for their at-risk populations ... resources, we can re-direct that 80% of medical care spent on SDoH today, drive better health outcomes and improve care delivery. Together with our partners, we are driving quantifiable results, such as a 28% decrease in chronic homelessness and 54% reduction in emergency service transport calls."

Central California Alliance for Health (The Alliance)

Central California Alliance for Health is an award-winning regional non-profit health plan that serves members in Santa Cruz, Monterey and Merced counties. They work to promote prevention, early detection and effective treatment for their members, and to improve ...

Online News

Name dropping | Watsonville Band preps for concert series

18

Date Collected Mar 5, 2022 6:07 PM EST
Category Local
Source Santa Cruz Sentinel
Author Santa Cruz Sentinel

Est. Audience 24,681
Est. Publicity Value USD $326
Market Santa Cruz, CA
Language English

... education in Spectrum communities across the country.

Funds from Spectrum will meet the connectivity and digital education needs of low-income families of seriously ill children.

Spectrum is a suite of advanced communications services offered by Charter Communications Inc.

Newton joins alliance

Central California Alliance for Health announced Cecil Newton as the Alliance's Chief Information Officer, filling the position of Van Wong, who recently became Chief Operating Officer of the Alliance. Newton joined the Alliance in March 2022 and brings more than 20 years of IT experience in health care and information security to the ...

April 13, 2022

The Honorable Jim Wood
Chair, Assembly Health Committee
1020 N Street, Room 390
Sacramento, California 95814

Re: AB 2724 (Arambula) Medi-Cal: Alternate Health Care Service Plan – LHPC Oppose

Dear Assemblymember Wood,

On behalf of the Local Health Plans of California ("LHPC") – which represents the 16 non-profit, community-based health plans which cover 70% of all Medi-Cal managed care enrollees – we write today in opposition to AB 2724. The bill grants broad authority to Department of Health Care Services ("DHCS") to enter into a no-bid, statewide Medi-Cal contract with Kaiser Permanente, or the Alternate Health Care Services Plan (herein referred to as "Kaiser"). The policy changes in AB 2724 are flawed and deeply concerning. **The bill undercuts the public plan model which has existed in California for nearly 40 years, makes changes to the Medi-Cal delivery system that are inequitable for Medi-Cal enrollees, and harms the local safety net while advancing the growth and interests of a single commercial health plan. For these reasons, LHPC must respectfully oppose AB 2724.**

Undermines Local Governance

Local plans have a long history of serving their local communities. The County Organized Health Systems ("COHS") and Local Initiative ("LI") plans were formed through county ordinance to meet the health care needs of underserved populations in their communities through a unique model that is publicly operated. Since the early 1980s, 15 COHS and LIs were established across 35 counties in California for this purpose. This model is consistent with California's approach to Medi-Cal, which recognizes that counties and local stakeholders understand the needs of their communities and are best suited to design a local delivery system to meet those needs. Local plans are also locally governed and accountable, with their boards including county supervisors and provider safety net leaders, among others. The COHS and LI model has been so effective that 14 additional counties went through a year-long public process, which culminated in the passage of county ordinances, to join an existing COHS or LI in 2024.

AB 2724 fundamentally alters California's public plan model and represents a de

1215 K Street, Suite 2230 ● Sacramento, CA 95814
Phone: (916) 448-8292 ● Fax: (916) 448-8293 ● www.lhpc.org

facto end to the COHS model. The hallmark of a COHS plan is that it serves all Medi-Cal managed care beneficiaries in a county, a feature which is characterized in federal statute, recognized in authorizing state statute, and described in every federal waiver authorizing Medi-Cal managed care. **AB 2724's direct, statewide contract between Kaiser and DHCS bypasses local process, undermines the critical role of counties and local stakeholders in deciding what works best for their communities, and erodes California's public plan model.**

Inequitable Enrollment Rules Guarantees the Safety Net Will Serve Sicker and Costlier Patients

AB 2724 seeks to give Kaiser the ability to enroll the healthiest Medi-Cal members. The only Medi-Cal beneficiaries who will be able to enroll into Kaiser under this proposal are those who were recently commercially insured by Kaiser, have an immediate family member enrolled in Kaiser, individuals dually eligible for Medi-Cal and Medicare, and foster youth. The continuity of care rules leave out some of the most vulnerable and medically complex Medi-Cal populations, including those who are unhoused, justice-involved, or who do not have satisfactory immigration status. Meanwhile, the bill grants Kaiser unlimited enrollment of duals who are a more profitable population due to their Medicare coverage, and foster youth who generally have a high level of behavioral health needs and whose services will be provided and paid for by county behavioral health plans, not Kaiser.

In addition to creating an inequitable system for Medi-Cal enrollees, these enrollment rules result in local plans and their contracted safety net providers serving populations that have higher health and social needs, the very populations that are a focus of CalAIM. This disparity already exists in counties where local plans contract with Kaiser today. In fact, in those counties, the population of seniors and persons with disabilities – the group with the most complex and costly health conditions – enrolled in local plans is nearly 50% more acute (in need of more and more intensive services) than the same population that is enrolled in Kaiser. **As Kaiser continues to grow its coverage of healthier Medi-Cal enrollees, the populations served by local plans, public hospitals, and federally qualified health centers will be even more disproportionately sick and costly.**

Risks Shifting Access Rather than Creating New Access

While not directly addressed in AB 2724, the Administration's Budget proposal commits DHCS to helping Kaiser grow its Medi-Cal enrollment by 25% over the contract term. This will exacerbate the acuity discrepancy between members served by local plans and Kaiser, as described above. In addition, in order keep pace with their growing Medi-Cal enrollment, Kaiser may expand their contracting with non-Kaiser Medi-Cal providers rather than ensuring services are delivered through its integrated, closed network. This practice would run counter to the logic of the proposal, which indicates that Kaiser cannot compete in procurement because of its physical limitations and unique role as a plan and provider. More importantly, it means that Kaiser may provide limited new access in the Medi-Cal program. **The extent to which Kaiser contracts with non-Kaiser providers to ensure access for its Medi-Cal members has direct consequences for Medi-Cal beneficiaries not enrolled in Kaiser. Access will simply shift from one entity to another, meaning decreased access to care for non-Kaiser members.**

Grants Overly Broad Authority to DHCS

Finally, AB 2724 includes language that grants DHCS broad authority to contract with Kaiser in any geographic area of the state. Not only does this undermine the local plan model, but it also means that **DHCS could make**

changes to its contracting arrangement with Kaiser without any corresponding changes in statute, and thus without consultation with the Legislature, counties, local plans, and other Medi-Cal stakeholders.

In closing, through its collective wisdom, California's state and local leadership have long acknowledged that health care is most effective when counties and local stakeholders are given the opportunity to design a system that will meet the needs of their communities. **AB 2724 supports the interests of a commercial health plan at the expense of the public Medi-Cal delivery system and the beneficiaries it serves. Although LHPC recently submitted amendments to the committee and author's office and welcomes further discussion about our proposed language, we currently remain opposed given the gravity of our concerns with the bill.**

Sincerely,

Linnea Koopmans
Chief Executive Officer

Cc: Assemblymember Arambula
Members, Assembly Health Committee

April 11, 2022

Dr. Joaquin Arambula
Member, California State Assembly
1021 O Street, Suite 6240
Sacramento, CA 95814

RE: Assembly Bill 2724 (Arambula): Medi-Cal: Alternate Health Care Service Plan
As Amended on April 7, 2022 – OPPOSE
Set for Hearing April 19, 2022 – Assembly Health Committee

Dear Assembly Member Arambula,

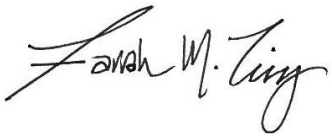
The California State Association of Counties (CSAC) regretfully must OPPOSE AB 2724 as amended on April 7. Our counties appreciate your long-term commitment to health care access and your willingness and time to discuss the Governor's proposal to offer a no-bid statewide contract to Kaiser Permanente for the care of certain Medi-Cal beneficiaries.

Our counties historically provided health care to low-income and medically indigent residents, and this century-long experience has evolved into today's current and diverse county-led system of health care service delivery. Counties developed multiple structures for ensuring health care access, including County Organized Health Systems (COHS) and participation in two-plan or other models. Each model is led by the county or a county subsidiary tasked with ensuring access to quality health care for all low-income residents.

AB 2724 would exempt Kaiser from this model of local planning and oversight by allowing the company to directly contract with the state for the provision of Medi-Cal managed care services. Our counties oppose AB 2724 because it would effectively cleave Kaiser from the locally organized health care safety net and terminate county input and/or oversight for Kaiser operations within each county.

Counties are committed to ensuring access to quality care for every person in our communities. Kaiser plays a key role in providing quality care, but we remain concerned that AB 2724 would undermine our local safety net responsibilities by exempting Kaiser from local health care planning and oversight. It is for these reasons that CSAC respectfully opposes AB 2724.

Sincerely,



Farrah McDaid Ting
Senior Legislative Representative for Health and Behavioral Health
California State Association of Counties
fmcting@counties.org

cc. Michelle Baass, Director, Department of Health Care Services
Linnea Koopmans, Executive Director, Local Health Plans of California

April 12, 2022

The Honorable Jim Wood
Chair, Assembly Health Committee
1020 N St., Room 390
Sacramento, CA 95814

Re: AB 2724 (Alternative Health Care Service Plan) – OPPOSE

Dear Chair Wood:

On behalf of the Boards of Supervisors of Ventura, San Mateo, Santa Barbara, Monterey, Santa Cruz, Sonoma, Mariposa, Merced, San Luis Obispo, and Yolo counties, we are writing to express our opposition to AB 2724 (Alternative Health Care Service Plan) by Assemblyman Arambula. We request the Committee's reconsideration of the bill, based on our considerations of the harms it could cause to the safety net health systems in our counties, and the Medi-Cal beneficiaries we serve.

A County Organized Health System (COHS) plan and local initiative plans (LI) are publicly governed, Medi-Cal managed care plans authorized under federal and state law and created under local ordinance. As such, COHS and LI models, which has been operational in California for almost forty (40) years, is a unique and time-tested model of publicly accountable managed care. Pursuant to federal, state, and local authority, the COHS and LI plans organize the local delivery system, complies with all requirements set forth in the DHCS contract, and is governed by a public commission operating pursuant to the requirements of California's Brown Act. The COHS and LI model has been so effective that 14 additional counties passed county ordinances last year to join an existing COHS or LI in 2024. **COHS and LI plans and their partner counties exemplify transparent and accountable governance that directly leads to optimal outcomes for the vulnerable populations they serve.**

Currently, Medi-Cal recipients in our counties receive their services through COHS or LI plans, which is a local public health plan. We believe the proposed bill proposed will be disruptive to local safety net networks and potentially harmful to our critical county health systems. If Kaiser or any other entity contracts directly with the State, the local public plans would have no oversight of care delivered to members served by that entity. If one integrated system contracts directly with the State, it sets a precedent for further fracturing of community collaborations. Our local plans have spent years building strong and trusted community partnerships, working with local community-based organizations to respond directly to emerging needs at the neighborhood level, and plan with the community for solutions that meet the unique needs of diverse residents. We are concerned that a contract brokered directly between the State and a national health plan will not bring the local solutions that our communities have engendered over decades and that our communities need to achieve wellness as we come out of a global pandemic. **A closed system that excludes vulnerable populations is inequitable, where any reinvestment of net earnings would not inure to the benefit of the members excluded from the closed system, especially those who have higher needs and require that additional investment.**

It is unclear how the proposal will impact current patients served by our counties, but we presume some portion of the patients we serve may choose Kaiser if they meet the criteria outlined in the draft trailer bill language. Our counties also have concerns with how enrollment into Kaiser will be effectuated. **How will the enrollment process work so that Kaiser is assigned patients with higher acuity levels and more complex physical, behavioral, and socio-economic needs versus giving the existing safety net**

system and local plans, who do not exclude populations, a disproportionate share of complex and costly patients? The State should reevaluate how to measure quality scores and equity across systems serving vastly different acuity levels. A system serving mostly working and healthy beneficiaries is quite different than a system serving historically underserved members experiencing complex physical health, mental health, and social conditions including individuals experiencing homelessness, individuals with serious mental health conditions, individuals with multiple co-morbidities and complex care needs, and individuals and families involved with the justice system.

The value of the COHS and LI models are that they understand their members and know how to coordinate care for the entire Medi-Cal population. Introducing multiple entities will lead to duplicative contracting, member and provider confusion, and runs counter to the State's integration and standardization goals through the California Advancing Innovation in Medi-Cal (CalAIM) transformation. Our local plans have spent decades cultivating strong and trusted relationships with our community-based organizations that serve our most vulnerable Medi-Cal members. Kaiser would not be able to do this quickly, so new Kaiser members would not have access to these critical services when they need it. **Further, the intention of the legislature has been to support models that can best meet member needs locally in a health plan that is publicly governed and directly accountable to the communities it serves.** We continue to support such models and believe these networks are crucial to the success of CalAIM.

Additionally, as enrollment is diverted away from COHS and LI plans, it will reduce the Medi-Cal supplemental payments that public providers receive – thereby impacting future funding for public hospitals, clinics, and public health departments necessary to sustain critical public health systems that responded so well to the pandemic. Currently, Medi-Cal supplemental payments are used to bolster low Medi-Cal rates for public providers and are based on enrollment in COHS and LI plans. We anticipate that our county systems could lose millions of dollars in supplemental funding if this proposal was to be implemented.

For the reasons described above, Ventura, San Mateo, Santa Barbara, Monterey, Santa Cruz, Sonoma, Merced, San Luis Obispo, Mariposa, and Yolo counties must oppose the Alternative Health Care Service Plan proposal and uphold the integrity of the COHS model. We request the State's reconsideration of the proposal, based on our considerations of the harms it could cause to the safety net health systems in our counties, and the Medi-Cal beneficiaries we serve. Thank you for your time and attention to this matter.

County Descriptions

Ventura County operates a Level II Trauma Center with 180 bed acute care hospital. The county also operates a 49-bed campus in Santa Paula and 18 Federally Qualified Health Centers (FQHCs), 7 urgent care centers for a total of 35 clinic locations including specialty clinics. San Mateo County operates a 105-bed acute hospital with an additional 32 skilled nursing beds along with five FQHC sites. Santa Barbara County operates 5 FQHCs and clinics at 3 homeless shelters. Monterey County operates a Level II Trauma Center with a 172-bed acute care hospital. The County operates 10 FQHCs, the D'Arrigo Family Specialty Clinic with over 15 specialties, and Natividad Medical Group. Santa Cruz County operates three FQHCs, and through the County Behavioral Health Division, provides the Specialty Mental Health care for Medi-Cal and other beneficiaries. The County is also home to the newly-formed Pajaro Valley Health Care District, which is the court-approved buyer for the Watsonville Community Hospital.

Approximately 6,000 Medi-Cal enrollees in Ventura are Kaiser members through a subcontract with Gold Coast. The Ventura County health system currently serves 40-45% of Medi-Cal enrollees and 100% of foster youth. San Mateo serves about 50% of the Medi-Cal enrollees in the county where Health Plan of San Mateo has delegated about 11,000 of their 150,000 Medi-Cal beneficiaries to Kaiser. CenCal Health in Santa Barbara County is responsible for 146,243, or 88% of the total Medi-Cal Population in the county. The Monterey County health system currently serves 40-45% of the County's Medi-Cal managed care enrollees and 100% of foster care youth. The Federally Qualified Health Centers operated by the County of Santa Cruz serve 13,100 Medi-Cal beneficiaries or 18% of the county's Medi-Cal managed care enrollees. Partnership HealthPlan in Sonoma covers 122,373 Medi-Cal beneficiaries with 26,088 delegated to Kaiser. Merced County operates two acute care hospitals with 226 beds between them. The County operates 2 FQHCs and one look alike clinic, and through the County Behavioral Health Division, provides the acute psychiatric care in a 16-bed inpatient facility. 1 in 2 Merced County residents are enrolled in Medi-Cal managed plans, and 39% are served by the 3 County community health centers. Mariposa County has 6,221 Medi-Cal beneficiaries with 4,418 being adults and 1,802 being children under 21.

Sincerely,

Carmen Ramirez, Chair
Ventura County Board of Supervisors

DocuSigned by:
Mary Adams
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Mary L. Adams, Chair
Monterey County Board of Supervisors

Don Horsley, President
San Mateo County Board of Supervisors

DocuSigned by:
Manu Koenig
43369812764640D...

Manu Koenig, Chair
Santa Cruz County Board of Supervisors

DocuSigned by:
Joan Hartmann
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Joan Hartmann, Chair
Santa Barbara County Board of Supervisors

James Gore, Chair
Sonoma County Board of Supervisors

Angel Barajas, Chair Yolo County Board of Supervisors	DocuSigned by: Rosemarie Smallcombe EEE9F94B55214DC... Rosemarie Smallcombe, Chair Mariposa County Board of Supervisors
Bruce Gibson, Chair San Luis Obispo Board of Supervisors	Lloyd Pareira, Chairman Merced County Board of Supervisors

cc: The Honorable Joaquin Arambula, Author
Members, Assembly Health Committee
Scott Bain, Consultant – Assembly Health Committee
Consultant, Assembly Republican Caucus

COUNTY OF SAN BENITO

BOARD OF SUPERVISORS

481 FOURTH STREET, HOLLISTER, CA 95023
PHONE: (831) 636-4000 FAX: (831) 636-4010

Betsy Dirks	Kollin Kosmicki	Peter Hernandez	Bob Tiffany	Bea Gonzales
District No. 1	District No. 2	District No. 3	District No. 4	District No. 5

April 12, 2022

The Honorable Jim Wood
Chair, Assembly Health Committee
1020 N St., Room 390
Sacramento, CA 95814

Re: AB 2724 (Alternative Health Care Service Plan) – OPPOSE

Dear Chair Wood:

On behalf of the San Benito County Board of Supervisors, I am writing to express our opposition to the Alternative Health Care Service Plan proposal (i.e., the single statewide Medi-Cal contract for Kaiser). We request the State's reconsideration of the proposal, based on our considerations of the harms it could cause to the safety net health systems in our county, and the Medi-Cal beneficiaries we serve.

A County Organized Health System (COHS) plan is a publicly governed, Medi-Cal managed care plan authorized under federal and state law and created under local ordinance. As such, the COHS model, which has been operational in California for almost forty (40) years, is a unique and time-tested model of publicly accountable managed care. Pursuant to federal, state, and local authority, the COHS plan organizes the local delivery system, complies with all requirements set forth in the DHCS contract, and is governed by a public commission operating pursuant to the requirements of California's Brown Act. COHS plans and their partner counties exemplify transparent and accountable governance that directly leads to optimal outcomes for the vulnerable populations they serve.

The Central California Alliance for Health (CCAH) has been operating since 1996, and currently serves over 390,000 Medi-Cal beneficiaries in Santa Cruz, Monterey, and Merced counties. CCAH has received conditional approval to expand its COHS model to San Benito and Mariposa counties in 2024.

The trailer bill and the deal it enables represents the de facto end of the COHS model. The proposed Alternative Health Care Service Plan contract will be disruptive to local safety net networks and potentially harmful to our critical county health system. If Kaiser or any other entity contracts directly with the State, the local public plans would have no oversight of care delivered to members served by that entity. If one integrated system contracts directly with the State, it sets a precedent for further fracturing of community collaborations. The current local COHS have spent years building strong and trusted community partnerships, working with local community-based organizations to respond directly to emerging needs at the neighborhood level, and plan with the community for solutions that meet the unique needs of diverse residents. We are concerned that a contract brokered directly between the State and a national health plan will not bring the local solutions that our communities have engendered over decades and that our communities need to achieve wellness as we come out of a global pandemic.

A closed system that excludes vulnerable populations is inequitable, where any reinvestment of net earnings would not inure to the benefit of the members excluded from the closed system, especially those who have higher needs and require that additional investment. A system serving mostly working and healthy beneficiaries is quite different than a system serving historically underserved members experiencing complex physical health, mental health, and social conditions including individuals experiencing homelessness, individuals with serious mental health conditions, individuals with multiple co-morbidities and complex care needs, and individuals and families involved with the justice system.

The value of the COHS model is that a single entity is coordinating care for the entire Medi-Cal population. Introducing multiple entities will lead to duplicative contracting, member and provider confusion, and runs counter to the State's integration and standardization goals through the California Advancing Innovation in Medi-Cal (CalAIM) transformation. Our current local COHS have spent decades cultivating strong and trusted relationships with our community-based organizations that serve our most vulnerable Medi-Cal members. Kaiser would not be able to do this quickly, so new Kaiser members would not have access to these critical services when they need it. The intention of the legislature has been to support a single model that can best meet member needs locally in a health plan that is publicly governed and directly accountable to the communities it serves. We continue to support such a model and believe these networks are crucial to the success of CalAIM.

Further, this legislation contradicts the State's proclaimed commitment to equity. Equity requires removing obstacles to health and shifting practices and policies that have traditionally benefitted some and left out others. An action which primarily seeks to protect a commercial entity's interests over the interests of the public delivery system and the people it serves does not advance equity.

Additionally, as enrollment is diverted away from COHS plans, it will reduce the Medi-Cal supplemental payments that public providers receive – thereby impacting future funding for public hospitals, clinics, and public health departments necessary to sustain critical public health systems that responded so well to the pandemic. Currently, Medi-Cal supplemental payments are used to bolster low Medi-Cal rates for public providers and are based on enrollment in COHS plans. We anticipate that our county system could lose millions of dollars in supplemental funding if this proposal was to be implemented.

For the reasons described above, San Benito County must oppose the Alternative Health Care Service Plan proposal and uphold the integrity of the COHS model. We request the State's reconsideration of the proposal, based on our considerations of the harms it could cause to the safety net health systems in our county, and the Medi-Cal beneficiaries we serve. Thank you for your time and attention to this matter.

Sincerely,

Bea Gonzales, Chair
San Benito County Board of Supervisors

cc: The Honorable Joaquin Arambula, Author
Members, Assembly Health Committee
Scott Bain, Consultant – Assembly Health Committee
Consultant, Assembly Republican Caucus

Salud Para La Gente
Working Together for a Healthy Community

P.O. Box 1870
Watsonville, CA 95077
831-728-8250
www.splg.org

March 31, 2022

Honorable Anna Caballero
Capitol Office
1021 O Street, Suite 7620
Sacramento, CA 95814

Subject: Alternate Health Care Service Plan Trailer Bill – OPPOSE

Dear Senator Caballero:

On behalf of Salud Para La Gente, I am writing to express our opposition to the Department of Health Care Services (DHCS) proposed Alternate Health Care Service Plan (AHCSP) trailer bill legislation.

Salud Para La Gente (Salud) is a Federally Qualified Health Center and Patient Centered Medical Home serving nearly 28,000 patients, primarily low-income and vulnerable populations that reside in California's Pajaro Valley in Santa Cruz County, including those who face extreme levels of poverty, high-uninsured rates, language, literacy and immigration barriers. Salud provides access to comprehensive health care – including dental, optometry, behavioral health and chiropractic care – for our patients, many of whom are farmworkers. Salud participates in the Central California Alliance for Health (Alliance), a County Organized Health System (COHS) operating since 1996.

A COHS is a publicly governed, Medi-Cal managed care plan specifically established under state statute to meet the problems of the delivery of publicly assisted medical care and to demonstrate ways of promoting quality care and cost efficiency through an exclusive contract to arrange for the provision of health care services.[1] As a COHS plan, the Alliance places no limitations on Medi-Cal beneficiary enrollment into its plan, partners with all willing and qualified providers, including both traditional Medi-Cal safety net and private providers, and leverages cost efficiency and local innovation to expand member benefits, increase provider reimbursements and expand delivery system capacity. Since the 1980's and through the present day, counties across California have worked with the State and Federal authorities to form COHS plans to improve the Medi-Cal delivery system through local transparent governance, partnership and collaboration.

The trailer bill and the deal it enables represents the de facto end of the COHS model. The trailer bill language contradicts the COHS model exclusive contracting provided for in statute. This legislation, if enacted, authorizes DHCS to enter into a direct, no-bid contract with a private, commercial entity to provide statewide Medi-Cal managed care plan services, even in counties already served by a COHS (or by a local initiative health plan). This action stands in stark contrast

[1] *Welfare and Institutions §14087.54(a)) and (Welfare and Institutions §14087.54(b)(1).*

to the COHS model, characterized by public governance, beneficiary and provider engagement, and reliance on the voice of the people most impacted by policy to guide its efforts.

If such an action were permitted to stand, it creates an impermissible precedent of State action in concert with private commercial entities to materially alter significant State policy regarding public programs without the kind of public process historically relied upon to protect the public interest.

While the Alliance's purpose as codified in statute is to meet the problems of publicly assisted care, the "problem" being solved through this legislation is the commercial entity's self-imposed inability to meet the existing requirements applicable to other commercial plans engaged in Medi-Cal managed care. The State's action to address the problem experienced by a private commercial entity exacerbates the very problems of publicly assisted care that COHS are intended to solve.

The proposed arrangement prioritizes private commercial entity interests over the interests of public entities and the people they serve. Through this legislation, the State and a commercial entity are claiming unilateral authority to grow the commercial entity's business in areas in the State where the entity has historically prioritized commercial business and not service to Medi-Cal beneficiaries. This will create a two-tier Medi-Cal delivery system, one which prioritizes the desires of a commercial entity and the limited enrollees it chooses to serve over the needs of the public traditional, safety net delivery system and the members the safety net has, and always will, serve.

This commercial prioritization will exacerbate the negative impacts of market competition across commercial entities in the delivery system and will not encourage their engagement in a sustainable delivery system for the public good. This risks a return to the Medi-Cal member experience of the 1990s, where the delivery system limited access to people with Medi-Cal to what the organization perceived of as their "fair share" as opposed to looking towards what collectively the organization could provide to the community in partnership with their peer competitors. When the Alliance began operations 26 years ago, competition across private, commercial providers was a significant factor in the absence of a comprehensive, sustainable Medi-Cal delivery system. Fewer than 10 private physicians served people with Medi-Cal in Santa Cruz County. Advantaging one commercial entity over others can reasonably be expected to result in an entrenchment in private provider competitive position as opposed to maintaining a commitment to collective problem solving and collaboration to ensure access to care.

The provider ecosystems in rural communities like those the Alliance serves are delicate. Disruption to the partnership that the Alliance's COHS model has been able to engender between public and private entities, wherein all entities work together to strengthen the delicate system, is not the kind of disruption that will advance the interests of the Medi-Cal beneficiary and, in fact, will result in loss of access to care to those who most need it.

Further, this legislation stands in contradiction to the State's proclaimed commitment to equity. Equity requires removing obstacles to health and shifting practices and policies that have traditionally benefitted some and left others out. An action that primarily seeks to protect a commercial entity's interests over the interests of the public delivery system and the people it serves does not advance equity.

In forming the Alliance, our communities made informed decisions through a public process and with input from all stakeholders about how to best meet the needs of our most vulnerable residents while ensuring the stability and viability of the Medi-Cal safety net. A unilateral decision by the State to bypass the COHS model threatens the stability of our safety net network, erodes the trust built over the past 26 years, unnecessarily exacerbates strains on the provider network, and presents unnecessary challenges to advancing the Medi-Cal delivery system transformation the State has put forward as a key priority.

For these reasons, the Board of Salud Para La Gente strongly urges you to oppose any proposal that fails to uphold the integrity of the COHS model.

Thank you for your consideration.

Sincerely,

Dori Rose Inda
Chief Executive Officer

cc: The Honorable Gavin Newsom, Governor of California
The Honorable Toni G. Atkins, Senate President Pro Tempore
The Honorable Anthony Rendon, Assembly Speaker
The Honorable Phil Ting, Assembly Budget Committee Chair
The Honorable Jim Wood, Assembly Health Committee Chair
The Honorable Nancy Skinner, Senate Budget Committee Chair
The Honorable Richard Pan, Senate Health Committee Chair
Secretary Mark Ghaly, MD, MPH, California Health and Human Services Agency
Director Michelle Baass, Department of Health Care Services
Chief Deputy Director, Jacey Cooper, Department of Health Care Services
Linnea Koopmans, CEO, Local Health Plans of California
Salud Para La Gente Board of Directors
Central California Alliance for Health Board

Natividad
Inspiring healthy lives

April 1, 2022

The Honorable Joaquin Arambula
Chair, Assembly Budget Subcommittee No. 1
1021 O Street, Suite 6240
Sacramento, California 95814

The Honorable Susan Eggman
Chair, Senate Budget & Fiscal Review Subcommittee No. 3
1021 O Street, Suite 8530
Sacramento, California 95814

Re: Alternative Health Care Service Plan Assembly Bill 2724 – OPPOSE

Dear Chair Arambula and Chair Eggman:

On behalf of the Natividad Medical Center, I am writing to express opposition to the Alternative Health Care Service Plan proposal (i.e., the single statewide Medi-Cal contract for Kaiser). Natividad Medical Center (NMC) is the public safety net hospital, owned by the County of Monterey. This proposal will negatively impact the safety net health systems in our county, and the Medi-Cal beneficiaries we serve.

A County Organized Health System (COHS) plan is a publicly governed, Medi-Cal managed care plan authorized under federal and state law and created under local ordinance. As such, the COHS model, which has been operational in California for almost forty (40) years, is a unique and time-tested model of publicly accountable managed care. Pursuant to federal, state, and local authority, the COHS plan organizes the local delivery system, complies with all requirements set forth in the DHCS contract, and is governed by a public commission operating pursuant to the requirements of California's Brown Act. **COHS plans and their partner counties exemplify transparent and accountable governance that directly leads to optimal outcomes for the vulnerable populations they serve.**

The Central California Alliance for Health (CCAH) has been operating since 1996, and currently serves over 390,000 Medi-Cal beneficiaries in Santa Cruz, Monterey, and Merced counties. CCAH has received conditional approval to expand its COHS model to San Benito and Mariposa counties in 2024. Natividad Medical Center has had a representative on CCAH's board for over twenty years. **As the current NMC board member, I work collaboratively with CCAH and other safety net entities for the well being of our community. We proactively work to ensure healthy outcomes for all and are quick to act when the needs such as the pandemic require community action.**

Natividad
Inspiring healthy lives.

The trailer bill and the deal it enables represents threatens the existence of the COHS model. The proposed Alternative Health Care Service Plan contract will be disruptive to local safety net networks and potentially harmful to our critical county health system. If Kaiser or any other entity contracts directly with the State, the local public plans would have no oversight of care delivered to members served by that entity. If one integrated system contracts directly with the State, it sets a precedent for further fracturing of community collaborations. Our local COHS has spent years building strong and trusted community partnerships, working with local community-based organizations to respond directly to emerging needs at the neighborhood level, and plan with the community for solutions that meet the unique needs of diverse residents. We are concerned that a contract brokered directly between the State and a national health plan will not bring the local solutions that our communities have engendered over decades and that our communities need to achieve wellness as we come out of a global pandemic. **A closed system that excludes vulnerable populations is inequitable, where any reinvestment of net earnings would not inure to the benefit of the members excluded from the closed system, especially those who have higher needs and require that additional investment.** A system serving mostly working and healthy beneficiaries is quite different than a system serving historically underserved members experiencing complex physical health, mental health, and social conditions including individuals experiencing homelessness, individuals with serious mental health conditions, individuals with multiple co-morbidities and complex care needs, and individuals and families involved with the justice system.

The value of the COHS model is that a single entity is coordinating care for the entire Medi-Cal population. Introducing multiple entities will lead to duplicative contracting, member and provider confusion, and runs counter to the State's integration and standardization goals through the California Advancing Innovation in Medi-Cal (CalAIM) transformation. Our local COHS has spent decades cultivating strong and trusted relationships with our community-based organizations that serve our most vulnerable Medi-Cal members. Kaiser would not be able to do this quickly, so new Kaiser members would not have access to these critical services when they need it. T**he intention of the legislature has been to support a single model that can best meet member needs locally in a health plan that is publicly governed and directly accountable to the communities it serves.** We continue to support such a model and believe these networks are crucial to the success of CalAIM.

Further, this legislation contradicts the State's proclaimed commitment to equity. Equity requires removing obstacles to health and shifting practices and policies that have traditionally benefitted some and left out others. An action which primarily seeks to protect a commercial entity's interests over the interests of the public delivery system and the people it serves does not advance equity.

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Inspiring healthy lives

Additionally, as enrollment is diverted away from COHS plans, it will reduce the Medi-Cal supplemental payments that public providers receive – thereby impacting future funding for public hospitals, clinics, and public health departments necessary to sustain critical public health systems that responded so well to the pandemic. Currently, Medi-Cal supplemental payments are used to bolster low Medi-Cal rates for public providers and are based on enrollment in COHS plans. We anticipate that our county system could lose millions of dollars in supplemental funding if this proposal was to be implemented.

For the reasons described above, Natividad Medical Center must oppose the Alternative Health Care Service Plan proposal and uphold the integrity of the COHS model. We request the State's reconsideration of the proposal, based on our considerations of the harms it could cause to the safety net health systems in our county, and the Medi-Cal beneficiaries we serve. Thank you for your time and attention to this matter.

Hospital/County Description

Natividad Medical Center, located in Monterey County, operates a Level II Trauma Center with a 172-bed acute care hospital, including the only locked Mental Health Unit in the County. Natividad provided services for 10,546 admissions, 2,146 births, over 42,000 emergency department visits and over 64,000 outpatient visits in fiscal year 2021. The County operates 10 FQHCs, the D'Arrigo Family Specialty Clinic with over 15 specialties, and Natividad Medical Group. The Monterey County health system currently serves 40-45% of the County's Medi-Cal managed care enrollees and 100% of foster care youth.

Sincerely,

Charles R. Harris III, MD
Chief Executive Officer

cc: The Honorable Gavin Newsom, Governor of California
Richard Figueroa, Deputy Cabinet Secretary, Governor's Office
The Honorable Toni G. Atkins, Senate President Pro Tempore
The Honorable Anthony Rendon, Assembly Speaker
The Honorable Phil Ting, Assembly Budget Committee Chair
The Honorable Jim Wood, Assembly Health Committee Chair
The Honorable Nancy Skinner, Senate Budget Committee Chair
The Honorable Richard Pan, Senate Health Committee Chair
Secretary Mark Ghaly, MD, MPH, California Health and Human Services Agency
Director Michelle Baass, Department of Health Care Services

Natividad
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Chief Deputy Director, Jacey Cooper, Department of Health Care Services
Central California Alliance for Health Board

The Honorable Jim Wood
Chair, Assembly Committee on Health
1020 N St., Room 390
Sacramento, CA 95814

RE: **OPPOSE - AB 2724 (Arambula)**

Dear Chairman Wood,

We wanted to take this opportunity, as community health centers and frontline providers, to voice our strong opposition to AB 2724, and the recently proposed Alternative Health Care Service Plan model, which from our understanding would be implemented through the execution of a no-bid contract with the state.

As community health centers continue to work tirelessly to provide vital healthcare services to underserved communities throughout the state, we recognize the critical role our local health plan partners play in our efforts to promote health equity and ensure access to care.

Working either as a COHS or through a two-plan model, local health plans strive to make informed decisions through a process of open community engagement and with input from stakeholders about how to best meet the needs of our most vulnerable residents while ensuring the stability and viability of the Medi-Cal safety-net.

The Alternative Health Care Service Plan, as proposed in AB 2724, threatens the integrity of the COHS and two-plan models. We believe if implemented it would create a two-tiered system of Medi-Cal while exacerbating strains on the provider network for local health plans, and present unnecessary challenges to advancing the Medi-Cal delivery system transformation that the state has put forward as a key priority.

It is for these reasons that we stand in opposition to AB 2724.

Respectfully,

Paulo Soares
President, California Partnership for Health

Leslie Connor, MPH
CEO, Santa Cruz Community Health

Dori Rose Inda
CEO, Salud Para La Gente

Sharen Carey
Executive Director, Big Sur Health Center

Charanjit Birring
Manager, Newman Medical Clinic

Respectfully,
Charles Fenzi, MD
CEO, Santa Barbara Neighborhood Clinics

cc: Members of the Assembly Committee on Health
Committee Consultants for the Assembly Committee on Health

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530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

April 4, 2022

The Honorable Dr. Joaquin Arambula
State Capitol
PO. Box 942849
Sacramento, CA 94249-0031

Subject: AB 2724 – OPPOSE

Dear Assemblymember Arambula:

On behalf of the governing board of the Central California Alliance for Health (the Alliance), I write to express the Alliance Board's unanimous opposition to AB 2724.

The Alliance is a County Organized Health System (COHS) operating since 1996, and currently serves over 390,000 Medi-Cal beneficiaries in Santa Cruz, Monterey and Merced counties. The Alliance has received conditional approval to expand its COHS model to San Benito and Mariposa counties in 2024. A COHS is a publicly governed, Medi-Cal managed care plan specifically established under state statute to **meet the problems of the delivery of publicly assisted medical care and to demonstrate ways of promoting quality care and cost efficiency through an exclusive contract to arrange for the provision of health care services**. As a COHS plan, the Alliance places no limitations on Medi-Cal beneficiary enrollment into its plan, partners with all willing and qualified providers, including both traditional Medi-Cal safety net and private providers, and leverages cost efficiency and local innovation to expand member benefits, increase provider reimbursements and expand delivery system capacity. Since the 1980's and through the present day, counties across California have worked with the State and federal authorities to form COHS plans to improve the Medi-Cal delivery system through local transparent governance, partnership and collaboration.

AB 2724, as currently written, represents the de facto end of the COHS model. The bill language contradicts the COHS model exclusive contracting provided for in statute. This legislation, if enacted, authorizes DHCS to enter into a direct, no-bid contract with a private, commercial entity to provide statewide Medi-Cal managed care plan services, even in counties already served by a COHS (or by a local initiative health plan). This action stands in stark contrast to the COHS model, characterized by public governance, beneficiary and provider engagement, and reliance on the voice of the people most impacted by policy to guide its efforts.

The provisions included in AB 2724, prioritize private commercial entity interests over the interests of public entities and the people they serve. Through this legislation, a commercial entity is allowed to grow its business in areas in the State where the entity has historically prioritized commercial business and not service to Medi-Cal beneficiaries. This will create a two-tier Medi-Cal delivery system, one which prioritizes the desires of a commercial entity and the limited enrollees it chooses to serve over the needs of the public traditional, safety net delivery system and the members the safety net has, and always will, serve.

This commercial prioritization will exacerbate the negative impacts of market competition across commercial entities in the delivery system and will not encourage their engagement in a sustainable delivery system for the public good. This risks a return to the Medi-Cal member experience of the 1990s, where the delivery system limited access to people with Medi-Cal to what the organization perceived of as their "fair share" as opposed to looking towards what collectively the organization could provide to the community in partnership with their peer competitors. When the Alliance began operations 26 years ago, competition across private, commercial providers was a significant factor in the absence of a comprehensive,

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sustainable Medi-Cal delivery system. Fewer than 10 private physicians served people with Medi-Cal in Santa Cruz County. Advantaging one commercial entity over others can reasonably be expected to result in an entrenchment in private provider competitive position as opposed to maintaining a commitment to collective problem-solving and collaboration to ensure access to care.

The provider ecosystems in rural communities like those the Alliance serves are delicate. Disruption to the partnership that the Alliance's COHS model has been able to engender between public and private entities, wherein all entities work together to strengthen the delicate system, is not the kind of disruption that will advance the interests of the Medi-Cal beneficiary and, in fact, will result in loss of access to care to those who most need it.

Further, this legislation stands in contradiction to the State's proclaimed commitment to equity. Equity requires removing obstacles to health and shifting practices and policies that have traditionally benefitted some and left others out. An action which primarily seeks to codify a commercial entity's interests over the interests of the public delivery system and the people it serves does not advance equity.

In forming the Alliance, our communities made **informed decisions through a public process and with input from all stakeholders** about how to best meet the needs of our most vulnerable residents while ensuring the stability and viability of the Medi-Cal safety net. Ending the COHS model through AB 2724 threatens the stability of our safety net network, erodes the trust built over the past 26 years, unnecessarily exacerbates strains on the provider network, and presents unnecessary challenges to advancing the Medi-Cal delivery system transformation the State has put forward as a key priority.

For these reasons, the governing board of the Central California Alliance for Health is strongly opposed to AB 2724.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

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March 24, 2022

Senator Richard Pan
Capitol Office
1021 O Street, Suite 7320
Sacramento, CA 95814-4900

RE: SB 966 - SUPPORT

Dear Senator Pan,

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 390,000 residents of Santa Cruz, Monterey, and Merced counties, I am writing to express the Alliance's support for SB-966 which would allow federally qualified health centers (FQHC) and rural health clinics (RHC) continued flexibilities offered during the COVID-19 public health emergency regarding billing for the services of associate clinical social workers and/or associate marriage and family therapists, under licensed supervision.

Use of associate social workers and associate marriage and family therapists has greatly increased access to behavioral health services and helped meet the increased patient demand during COVID-19. FQHC/RHCs have decreased capacity to meet increased behavioral health needs given the extreme workforce shortage across the state and the impacts are disproportionately felt by low income and people of color. SB 966 will mitigate some of these issues by allowing clinics to continue to bill for services provided by these important providers beyond the public health emergency.

For these reasons, the Alliance is pleased to support SB-966.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

cc: Senator Monique Limon

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March 24, 2022

Assembly Member Jim Wood
Capitol Office, 1020 N Street, Room 390
P.O. Box 942849
Sacramento, CA 94249-0002

RE: AB 1900 - SUPPORT

Dear Assembly Member Wood,

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 390,000 residents of Santa Cruz, Monterey, and Merced counties, I am writing to express the Alliance's support for AB 1900 which would increase the standard income level for maintenance per month for seniors and persons with disabilities to be equal to the income limit for Medi-Cal without a share of cost.

AB 1900 would ensure that our Medi-Cal members over the age of 65 or who are disabled are able to afford their basic necessities such as food, clothing, and housing, while continuing to receive adequate levels of care through the Medi-Cal program.

Seniors and persons with disabilities often have more acute and ongoing medical needs, and an adjustment to the income level for maintenance proposed through AB 1900 may help to alleviate their financial burden particularly in light of record levels of inflation and increased housing costs in our service area.

The Alliance currently serves over 46,000 seniors and persons with disabilities across our current three county service area. AB 1900 provides financial protection to these members who may otherwise need to go without in order to continue to receive the care they need.

For these reasons, the Alliance is pleased to support AB 1900.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

cc: Assemblymember Dr. Joaquin Arambula

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March 24, 2022

Assembly Member Jim Wood
Capitol Office, 1020 N Street, Room 390
P.O. Box 942849
Sacramento, CA 94249-0002

RE: AB 1995 - SUPPORT

Dear Assembly Member Wood,

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 390,000 residents of Santa Cruz, Monterey, and Merced counties, I am writing to express the Alliance's support for AB 1995 which would eliminate the current cost sharing requirements certain Medi-Cal beneficiaries have, including low-income children, pregnant and postpartum women as well as their infants under the age of 2, and certain employed members with disabilities who are eligible based on income and other factors.

Individuals in these categories may require more regular and routine check-ups or are more medically needy and gaps in coverage can be extremely detrimental to their health and well-being. Cost sharing, including copayments, premiums, and subscriber contributions can be a barrier to care for low-income individuals and households and may disrupt access to vital services because of an inability to pay. AB 1995 would ensure these individuals and families will not lose their Medi-Cal coverage, giving them peace of mind that they will not have to choose between health coverage or paying for other basic needs.

For these reasons, the Alliance is pleased to support AB-1995.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

cc: Assemblymember Dr. Joaquin Arambula

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March 24, 2022

Assembly Member Jim Wood
Capitol Office, 1020 N Street, Room 390
P.O. Box 942849
Sacramento, CA 94249-0002

RE: AB 2402 - SUPPORT

Dear Assembly Member Wood,

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 390,000 residents of Santa Cruz, Monterey, and Merced counties, I am writing to express the Alliance's support for AB 2402 which would expand continuous eligibility for Medi-Cal, allowing for children under 5 years of age to be continuously eligible for Medi-Cal without regard to income, until such children reach the age of 5.

Children under 5 years of age need regular, routine checkups. Having uninterrupted healthcare coverage allows children to have consistent access to well-child visits, vaccinations, and specialty care which are critical to children's health and well-being. Gaps in both coverage and access to care can be detrimental to a child's development; even a short gap in coverage can harm a child by reducing their access to necessary care. This bill would alleviate these concerns by ensuring continuous Medi-Cal eligibility for children up to 5 years of age.

For these reasons, the Alliance is pleased to support AB-2402.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

cc: Assemblymember Blanca E. Rubio

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March 21, 2022

RE: Letter of Support for Family Empowerment Centers on Disability Grant Application

To Whom it May Concern:

On behalf of Central California Alliance for Health (the Alliance), I am writing to express support for Challenged Family Resource Center (CFRC) funding opportunity to establish a family engagement center.

This grant opportunity will allow CFRC to continue their current work serving Merced County families with Center for Children and Youth with Special Health Care Needs (CYSHCN) in their work with other agencies in the community to improve children's growth and development. A component of the work of the Family Engagement Center is to educate families about how to work with school systems, especially those families who have children with Individual Family Service Plans and Individual Education Programs. CFCR has been a partner for parents by providing parent-to-parent support for children with special needs and their families.

As the Medi-Cal managed care plan responsible for arranging for and coordinating the health care services for over 64,000 children and youth under age 19, including those children eligible for services through the California Children's Services program, the Alliance is keenly aware of the importance of the services provided by the CFRC. The Alliance is pleased to support this grant opportunity toward improving children's growth and development through the establishment of a family engagement center..

Sincerely,

Stephanie Shonnenshine
Chief Executive Officer

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

April 4, 2022

RE: Letter of Support – Breathe California

To Whom It May Concern:

I am writing to recommend that Breathe California of the Bay Area, Golden Gate and Central Coast (Breathe California) receive funding to conduct COPD patient education services under your Learn More Breathe Better program, and to express our wish to collaborate to make these services available to our low-income patients, especially those in the rural areas we serve.

Central California Alliance for Health (the Alliance) has offered Breathe California's asthma services to its members for sixteen years and has seen members benefit by receiving these services. We have a long-standing relationship with Breathe California to deliver these services under an agreement and have been impressed with the results. We would like to refer COPD patients and their families for education, especially those who need special language support that Breathe California provides.

Established in 1996, the Alliance ensures quality health care for over 386,980 members in Santa Cruz, Monterey and Merced counties. The Alliance's public, non-profit health plan partners with over 11,990 providers in the tri-county service area to create a system of care emphasizing prevention, care coordination and best medical practices in order to fulfill our vision of healthy people, healthy communities.

We urge you to fund our long-time partner, as they have proven their ability to serve our diverse patient base.

Sincerely,

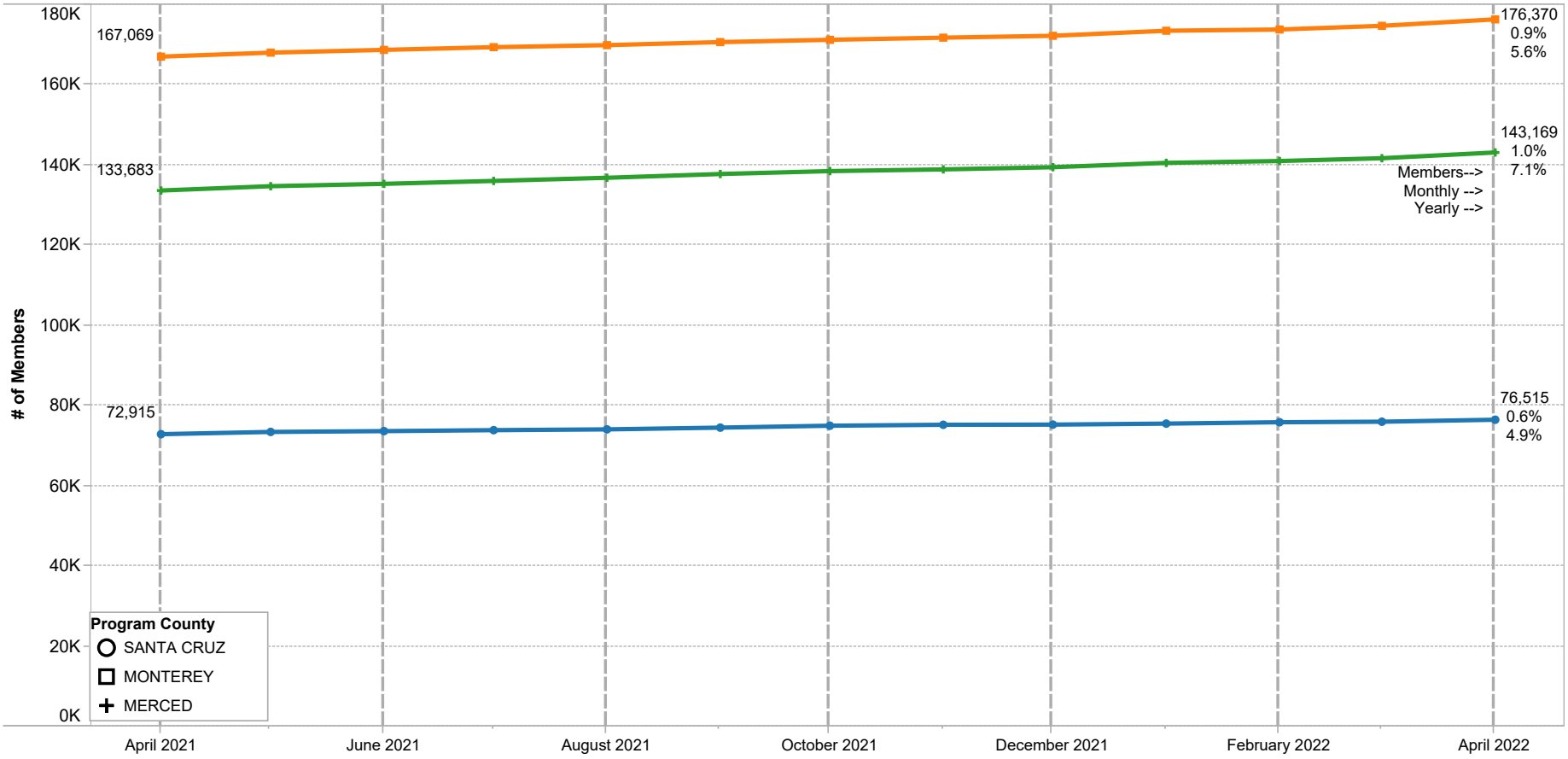
Stephanie Shonnenshine
Chief Executive Officer

Enrollment Report

Year: *2017 & 2018* **County:** *All* **Program:** *IHSS & Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *4/8/2022*

StaticDate
4/1/2021 12:00:00 AM to 4/30/2022 11:59:59 PM

Membership Totals by County and Program, % Change Month-over-Month and % Change Year-over-Year



Program..	ProgramCo..	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022
Medi-Cal	SANTA CRUZ	72,915	73,475	73,674	73,916	74,112	74,549	75,025	75,256	75,296	75,549	75,893	76,021	76,515
	MONTEREY	166,557	167,565	168,255	168,938	169,427	170,180	170,759	171,289	171,751	173,018	173,329	174,165	175,746
	MERCED	133,683	134,761	135,349	136,074	136,859	137,798	138,524	138,949	139,495	140,579	141,037	141,734	143,169
IHSS	MONTEREY	512	505	501	498	509	516	513	515	517	511	511	589	624
Total Members		**373,667**	**376,306**	**377,779**	**379,426**	**380,907**	**383,043**	**384,821**	**386,009**	**387,059**	**389,657**	**390,770**	**392,509**	**396,054**

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