Santa Cruz – Monterey – Merced Managed Medical Care Commission

Board Retreat 2022

(800) 700-3874
www.ccah-alliance.org

Date: Wednesday, September 28, 2022

Time:
Arrive and Refreshments..................8:30 a.m.
Call to Order..9:00 a.m.
Catered Lunch...12:15 p.m. – 12:45 p.m.
Adjourn...4:00 p.m.

Location: Central California Alliance for Health – Scotts Valley Auditorium
1700 Green Hills Road, Scotts Valley, CA 95066

Facilitator: Ms. Bobbie Wunsch, Pacific Health Consulting Group

A face covering is encouraged but not required to attend this meeting.

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, September 27, 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.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

1. Call to Order by Chairperson Jimenez. 9:00 a.m.

A. Roll call; establish quorum.

B. Supplements and deletions to the agenda.

2. Oral Communications. 9:05 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. – 9C.): 9:10 a.m.

5. 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.

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

Pages 5-01 to 5-02

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

- Reference materials: Executive Summary from the CEO.

Pages 6-01 to 6-09

7. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the seventh month ending July 31, 2022.

- Reference materials: Financial Statements as above.

Pages 7-01 to 7-09

Minutes: (8A. – 8E.)

8A. Approve Commission special meeting minutes of August 19, 2022 and regular meeting minutes of August 24, 2022.

- Reference materials: Minutes as above.

Pages 8A-01 to 8A-09

8B. Accept Compliance Committee meeting minutes of July 20, 2022.

- Reference materials: Minutes as above.

Pages 8B-01 to 8B-05

8C. Accept Finance Committee meeting minutes of March 23, 2022.

- Reference materials: Minutes as above.

Pages 8C-01 to 8C-03

8D. Accept Physicians Advisory Group meeting minutes of June 2, 2022.

- Reference materials: Minutes as above.

Pages 8D-01 to 8D-06

8E. Accept Whole Child Model Clinical Advisory Committee meeting minutes of June 16, 2022.

- Reference materials: Minutes as above.

Pages 8E-01 to 8E-04

Reports: (9A. – 9C.)

9A. Authorize the Chairperson to sign Amendments to the Alliance's primary Medi-Cal contract number 08-85216 and to the Alliance's secondary Medi-Cal contract number 08-85223 to extend the term of the contracts through December 31, 2023.

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

Page 9A-01

9B. Accept decisions from the June 8, 2022 and September 14, 2022 meetings of the Peer Review and Credentialing Committee.

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

Pages 9B-01 to 9B-02

9C. Accept report on Alliance 2022-2026 Strategic Plan Outcome Measures.

- Reference materials: Staff report on above topic.

Pages 9C-01 to 9C-03

Retreat Agenda Items: (10. – 17.): 9:15 a.m.

10. Introductions. (9:15– 9:20 a.m.)

A. Ms. Bobbie Wunsch, Pacific Health Consulting Group, will facilitate introductions and review the goals and outline of the retreat day.

- Reference materials: Ms. Bobbie Wunsch biography.

Page 10-01

11. Board Discussion: California Administration's Vision and Priorities for Healthcare. (9:20 – 9:50 a.m.)

A. Dr. Mark Ghaly, Secretary of the California Health & Human Services Agency, will review and Board will discuss the administration's priorities and vision for health care in California, as well as what role the administration sees for the County Organized Health System plans going forward.

- Reference materials: Dr. Mark Ghaly biography; and Cal HHS: Guiding Principles & Strategic Priorities.

Pages 11-01 to 11-07

12. Board Discussion: Federal Healthcare Policy Environment. (9:50 – 10:20 a.m.)

A. Rodney Whitlock, Ph.D., McDermott + Consulting, will review and the Board will discuss events in Washington DC, emerging areas of emphasis for the federal health care policy landscape, and address questions about implications of future elections.

- Reference materials: Rodney Whitlock, Ph.D. biography; and Fact Sheet: The President's Budget for Fiscal Year 2023.

Pages 12-01 to 12-12

13. Board Discussion: Federal and State Healthcare Policy Landscape. (10:20 – 10:35 a.m.)

A. Ms. Wunsch will facilitate discussion with the Board on federal and state healthcare policy landscape responsive to speakers.

Break (10:35 – 10:45 a.m.)

14. Board Discussion: Alliance Strengths, Weaknesses, Opportunities, and Threats (SWOT). (10:45 a.m. – 12:15 pm.)

A. The Alliance Executive Team will orient the Board to refreshed SWOT analysis and key opportunities and threats Alliance executives see as influencing the Alliance's future.
B. Ms. Wunsch will facilitate a panel discussion/presentation activity with Board and Alliance Executive Team.
- Reference materials: SWOT Snapshot

Page 14-01

Lunch (12:15 – 12:45 p.m.)

15. Board Discussion: Dual Special Needs Plan (D-SNP): Considerations Informed by Financial Feasibility Assumptions and Policy Proposal Details. (12:45 – 2:00 p.m.)

A. Ms. Van Wong, Chief Operating Officer and Ms. Lisa Ba, Chief Financial Officer, will introduce the Board to D-SNP and key considerations for the Alliance in evaluating feasibility.
- Reference materials: DHCS: Dual Eligible Special Needs Plans in California; and DHCS: Medi-Cal D-SNP Feasibility Study.

Pages 15-01 to 15-05

16. Board Discussion: Quality and Equity: Alliance's Approach to Equity Benchmarks and Implications. (2:00 – 3:30 p.m.)

A. Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality and Population Health Management, Department of Health Care Services, will discuss State's goals around equity.
B. Dr. Maurice Herbelin, Chief Medical Officer, will review and Board will discuss commitment to Alliance health equity outcomes.
C. Ms. Wunsch will facilitate workgroup discussions.
- Reference materials: Dr. Palav Babaria biography; and DHCS: Comprehensive Quality Strategy Executive Summary 2022.

Page 16-01 to 16-06

17. Wrap Up and Next Steps. (3:30 – 4:00 p.m.)

A. Ms. Wunsch will wrap up the day, identify key themes and next steps.

Information Items: (18A. – 18H.)

A. Alliance in the News — Page 18A-01
B. Letter: DHCS Proposed Waiver Amendments — Page 18B-01
C. Letters of Support — Page 18C-01
D. Local Health Plans of California: News Release — Page 18D-01
E. Membership Enrollment Report — Page 18E-01
F. Member Newsletter (English) – September 2022
https://thealliance.health/wp-content/uploads/CCAH-Member-Fall-2022-ENG.pdf
G. Member Newsletter (Spanish) – September 2022
https://thealliance.health/wp-content/uploads/CCAH-Member-Fall-2022-SPA.pdf
H. Provider Bulletin – September 2022
https://thealliance.health/wp-content/uploads/CCAH-Provider-September-2022-Hi-Res.pdf

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, October 26, 2022; 1:30 – 2:45 p.m.

- Member Services Advisory Group
  Thursday, November 10, 2022; 10:00 – 11:30 a.m.

- Physicians Advisory Group
  Thursday, December 1, 2022; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee
  Thursday, December 15, 2022; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee
  Monday, November 14, 2022; 1:30 – 3:00 p.m.

The above meetings will be held via teleconference unless otherwise noticed.

The next meeting of the Commission, after this September 28, 2022 meeting will be held via teleconference unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, October 26, 2022; 3:00 – 5:00 p.m.

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: September 28, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: AB 361 – Brown Act: Teleconferencing Meeting Procedures

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

(A) The Board has considered the circumstances of the current COVID-19 state of emergency; and,

(B) Any of the following exists:

- (i) The state of emergency continues to directly impact the ability of the members to meet safely in person.
- (ii) State or local officials continue to impose or recommend measures to promote social distancing.

Staff further recommend that the Board consider making these findings on behalf of its Committees and the Advisory Groups of the Board to allow for the conduct of business via teleconferencing compliant with Government Code § 54953.

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

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

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

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Discussion. The federal public health emergency remains in place and the spread of COVID-19 continues. The CDC Community Level ratings in Alliance service area counties are as follows: Merced County remains high on the CDC county ratings and Santa Cruz and Monterey Counties have moved to low.

In order to continue utilizing teleconferencing under the procedures outlined by AB 361, following this meeting of the Board, and if the state of emergency remains active or state or local officials continue to impose or recommend measures to promote social distancing, the Board must, no later than 30 days after this meeting and every 30 days thereafter, reconsider the circumstances of the state of emergency. To that end, the Board approved a meeting schedule for the remainder of 2022 to meet in compliance with AB 361 to consider the present state of emergency and determine if the above circumstances continue to exist in order to enable continued meeting via teleconferencing and will next consider this at the Board's October 26, 2022 meeting.

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

Attachments. N/A

DATE: September 28, 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

Medi-Cal Managed Care Procurement: Notice of Intent to Award Contracts. On August 25, 2022, the Department of Health Care Services (DHCS) released a notice of its intent to award contracts to commercial managed care plans (MCPs) to deliver Medi-Cal services to Californians across the state, beginning in 2024. This was DHCS' first-ever statewide procurement for commercial MCPs. Notably, Community Health Group, a Local Health Plans of California local health plan member, was not included in the contract award despite having the largest Medi-Cal enrollment in the area (330,000 members) and 40 years of experience delivering care to Medi-Cal and uninsured populations in San Diego County. Instead, DHCS intends to award contracts to Molina Healthcare and Healthnet to serve San Diego Medi-Cal beneficiaries, in addition to Kaiser, leaving only commercial insurers to provide Medi-Cal managed care services in San Diego County. This announcement is concerning and further suggests the current Administration's possible disregard for local plans.
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Federal Public Health Emergency. The federal public health emergency (PHE) is currently in effect until October 13, 2022. The Biden Administration has committed to providing 60 days' notice prior to allowing the PHE to terminate. Thus, in the absence of notice to terminate by mid-August, an additional 90-day extension is likely. Staff continue to monitor this closely, particularly as eligibility redetermination is on hold throughout the PHE.

2022 Legislative Session. The 2022 legislative session came to an end at midnight on August 31, 2022 with a legislative deadline to adopt bills to send to the Governor. The Governor has 30 days to sign or veto legislation sent to his desk. Staff continue to monitor legislation identified in the legislative areas of focus adopted by your Board and presented at the April meeting. Staff will review final legislation signed by the Governor and report back at a future meeting.

Community Involvement. On September 14, 2022 I attended the virtual DHCS All-Plan CEO meeting. I attended the virtual Medi-Cal Children's Health Advisory Panel meeting on September 15, 2022. On September 29, 2022 I plan to attend the virtual MoReHEALTH Executive Committee meeting.

Health Services

The Health Services Division has been focused upon 2023 budget planning and developing measurable 2023 performance goals that are tied directly to the strategic plan outcomes of Health Equity and Person-Centered Delivery System Transformation. Establishing these 2023 performance goals requires setting 2026 goals that are aligned with the five-year strategic plan vision and determining what incremental year-over-year improvements are needed to reach that vision. The recommended 2026 Strategic Plan Outcomes for Health Equity and Person-

Centered Delivery System Transformation are provided within the Board packet for this Board meeting. Feedback from the Board would be greatly appreciated on whether these 2026 goals are realistic, achievable, and align with the desires of the Board.

The Measurement Year 2021 Healthcare Effectiveness Data and Information Set Quality results were received along with the comparison to other Medicaid plans on a national basis. Some measures within pediatric preventive health were below the 50th percentile such as Well-Child Visits and Childhood Immunizations. Merced County generally showed lower Quality performance than Santa Cruz and Monterey counties. Health Services is in the process of revisiting the Quality strategy in order to drive significant year-over-year improvements that would align with the 2026 vision for Health Equity.

Monkeypox Vaccination. Member and provider facing materials are available on our website addressing Monkeypox. We continue to monitor the evolving situation and provide support to our local public health partners. Vaccination is free, but providers may be reimbursed for vaccine administration. On September 6, 2022 Monkeypox was added to the Title 17 section 2500 of the CCR requiring healthcare providers to report monkeypox or orthopox virus infections within one working day, suspect or confirmed cases. We recommend clinicians be alert to patients presenting with a new characteristic rash or who meet other criteria to be suspicious of Monkeypox. Testing for Monkeypox is widely available through commercial laboratories and covered by the Alliance. We recommend reviewing the Clinical Assist Tool for Monkeypox (MPX) Evaluation developed by California Department of Public Health.

COVID-19 Report

COVID-19 Disease Activity (Collected on September 9, 2022)

County	Cases per 100K (7-day average)	14-day Average of Hospitalized Patients	Rate of Positive Tests (7-day rate)	Confirmed Deaths (total)
Merced	15.9	10.8	11.1%	856
Monterey	9.5	28.3	8.0%	762
Santa Cruz	19.3	13.1	3.3%	274
California	15.8	2,998.9	7.8%	94,558

Source: https://covid19.ca.gov/state-dashboard/#location-california

Current COVID-19 Vaccination Status:

COVID-19 Vaccination Rates for Eligible Alliance Members as of 9/6/2022 – All Ages (6 months+)	
	% Alliance members with at least one dose
Merced	45.5%
Monterey	57.9%
Santa Cruz	65.4%
IHSS (18 yrs. +)	80.2%
CCAH	60.0%

Note: We are currently validating our data and recoding doses to ensure that we are accurately representing fully vaccinated members and identifying booster doses correctly.

Quality Improvement and Population Health

Population Health Management. Population Health Management Program (Pop Health) is under development. Risk scoring methodology using our CAVE BI Tool's Care Needs Index (CNI) and the MRx tools to score all members was completed. We are in the pilot phase of using the risk scores to segment our membership into levels of low, moderate, and high risk, excluding those targeted for Enhanced Case Management services or already engaged in those services. The Population Health team is collaborating with our Community Care Coordination (CCC) and Pediatric Case Management teams to pilot our scoring and risk levels in members with diabetes. Guidance from DHCS on the Program Readiness Assessment is due to DHCS on October 21, 2022. The Pop Health team is working with multiple departments including Analytics and CCC to complete the assessment as we continue to develop the program for a go-live date of January 1, 2023.

Utilization Management/Complex Case Management (UM/CCM)

Inpatient and Emergency Department (ED). As members are returning to care, overall and avoidable ED visits have increased through Q2 and are now approaching pre-pandemic rates. SPD and Medicaid Expansion populations have shown the largest increases in avoidable ED rates and when considering ED visits per county, Monterey had the largest increase with 16% of avoidable ED visits compared to a 14% noted in Merced and 12% in Santa Cruz, all of which reflect increases from prior quarters.

As seen with ED utilization, and again as a result of members returning to care and caring for conditions that were not consistently addressed during the pandemic, inpatient admissions are approaching pre-pandemic levels in all Alliance contracted hospitals. Readmission rates remain at the same levels as seen since 2021 at 11 and 12%. Length of stays have shown general decreases over prior quarters as access to long term care following hospitalization is improving likely due to the resolution of the COVID-19 surge activity that previously closed many facilities to new admissions in Q1.

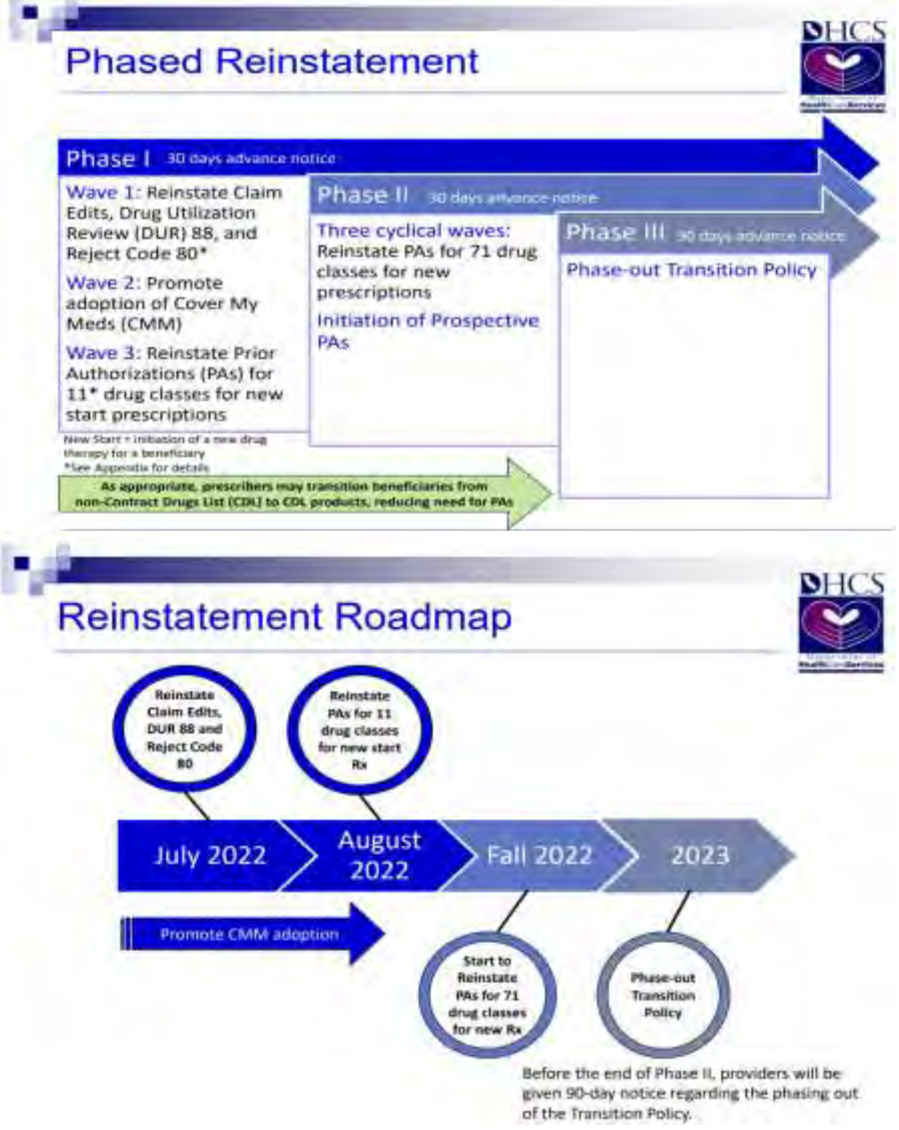
An interdisciplinary team process and readmission reduction/ED overutilization program partnering Alliance CCM and CR/UM teams directly with facility and community providers has been re-initiated and strategies employed include complex case review, utilizing the Recuperative Care Program, internal Enhanced Case Management and Community Support Services (ECM/CS) referrals and coordination of processes to support care transitions.

Prior Authorization. Heading into September, an approximately 5% overall increase in authorization activity was noted from Q1-Q2, with specific increases seen in primary care physician referrals and outpatient activity. Both increases are likely a reflection of normalizing member access patterns in this new phase of COVID-19 pandemic activity. Prior authorization distribution has been similar to Q1 with noted increases primarily in diagnostics and palliative care services, and a slight decrease in surgical authorization activity. September was also notable for additions to in the Alliance Non-Emergency Medical Transportation network and improved member access in this area. Continued efforts are underway to reduce prior authorization requirements and improve processes.

Whole Child. Overall California Children Services (CCS) member volumes continue to increase, with over 8,000 CCS members, an increase of approximately 1,000 members over Q1. Newly eligible Whole Child Model CCS member totals in Q2 2022 continue to increase with CCS eligibility for 318 new members noted in the quarter, a reflection of program development and provider and county collaborative efforts. The overall CCS referral approval rates increased, with an average 72% approval rate for CCS eligibility determinations by County CCS programs. Efforts to continue to improve referral rates continue especially with Monterey County. The Peds Complex Management team is beginning a new Population Heath directed outreach effort to effectively address preventive care, member education (disease management) and identify additional case management needs. Most members contacted have already been opened to care.

Pharmacy

Medi-Cal Rx. As previously shared, DHCS has planned a three-phased approach to reinstate the suspended claims edits and prior authorization requirements. They were turned off to support the challenges during the first months of the transition.



1. Beginning September 16, 2022, prior authorization requirement for new start Contract Drug List (CDL) drugs in the 11 drug classes (Phase I, Wave III) will be reinstated.
   - Diuretics.
   - Lipotropics, including statins and omega-3 fatty acids.
   - Hypoglycemics, including glucagon.
   - Coronary vasodilators (nitrates and pulmonary arterial hypertension agents).
   - Cardiovascular agents, including antiarrhythmics and inotropes.
   - Anticoagulants and antiplatelets
   - Niacin, Vitamin B, and Vitamin C products.
2. Wave III will only apply to adult beneficiaries and will exclude children and youth under the age of 21.
3. CDL drugs that did not have any prior authorization requirement were not affected. They continued to not require a PA.
4. If the member has been on the medication at least once in the past 15 months, they do not need a prior authorization for the same drug at this time.
5. List of impacted drugs are listed here: Medi-Cal_Rx_Approved_NDC_List.xlsx (live.com).
   - Prior authorization = Yes and PA Status = P1W3 to see specific medications in the 11 drug classes.
   - Prior authorization = No: never had a PA requirement

The Pharmacy team has created a provider bulletin to educate our providers on this incoming change. We will continue to monitor the impact of reinstatement on our members by monitoring the pharmacy claims data and initiating any beneficiary care coordination when indicated.

Ivermectin Misuse for COVID-19. During the COVID-19 pandemic, there has been a rapid and significant increase in Ivermectin use across the United States. Ivermectin is approved for human use to treat infections caused by parasitic worms, head lice and skin conditions like rosacea. Ivermectin is not approved by the FDA for the treatment of any viral infection and should not be used for treatment or prevention of COVID-19.

The Pharmacy Department noticed a spike in Ivermectin prescriptions in July and August 2021. To ensure our members received safe, effective, and medically appropriate therapy for treatment and prevention of COVID-19, it was important to take action in the following ways:

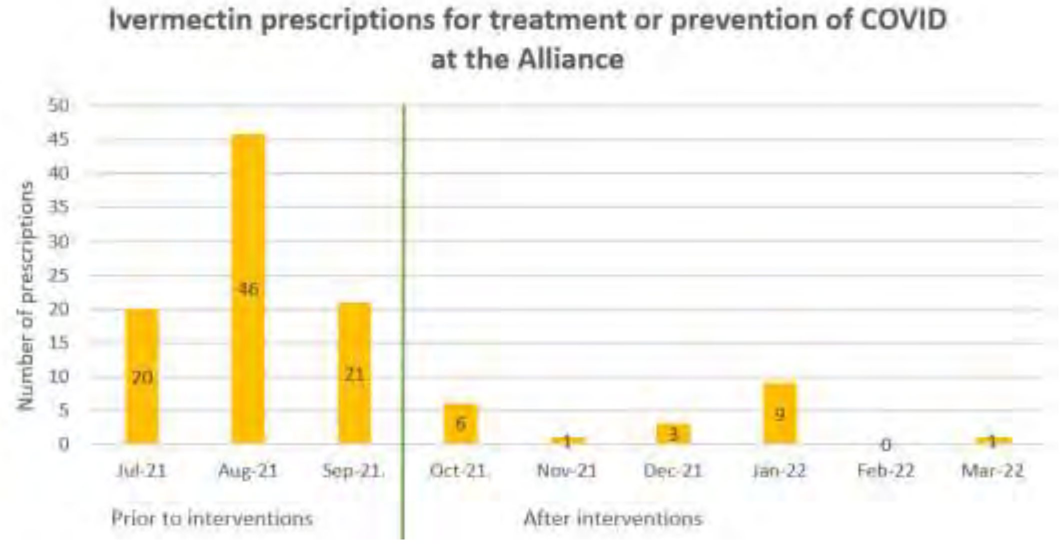
- Monitored Ivermectin prescribing and utilization and implemented restrictions on prescribers of concern.
- Outreach to prescribers and members, cautioning them against Ivermectin use for COVID-19.
- Reported doctors who inappropriately prescribed Ivermectin to DHCS.

As a result of these actions, inappropriate Ivermectin use by our members decreased significantly (see graph below). The majority of prescribers we identified and contacted or reported to DHCS stopped prescribing Ivermectin for COVID-19 to our members. Additionally, 80% of members identified as Ivermectin utilizers for prevention of COVID-19 stopped taking the drug after our outreach.

Collaboration among multiple departments within the Alliance was key to this success.

- Quality Improvement provided input to Pharmacy's plan.
- Provider Services sent educational fax blasts to providers.
- Health Services admins conducted provider outreach via fax to those flagged as Ivermectin prescribers for COVID-19.
- Program Integrity reported findings to DHCS.
- Care Management conducted outreach to members.

Eliminating Ivermectin use for COVID-19 and educating members and providers was essential to ensure our members received quality, safe, evidence-based care.



Community Care Coordination (CCC)

In collaboration with other Health Services departments, CCC staff have begun piloting strategies of care management that align with the intention of the PHM Program, as well as National Committee for Quality Assurance (NCQA) care management requirements. The pilot was initiated with members who have been identified as having high needs related to their diagnosis of diabetes. As part of the PHM Program, the Alliance will be required to understand each member's risk in a manner that is aligned with NCQA risk stratification PHM requirements for risk stratification and have a process for assessing and reassessing members needs at least annually by January 2023. The Alliance will need to ensure that members who may most benefit from additional or specialized care management services or other interventions are identified and stratified and offered those services. The intention of the pilot is to start with care management approaches for diabetes, and add additional diagnosis' over time, including at least high needs members with depression, cardiovascular disease, and asthma.

Enhanced Case Management and Community Support Services. Work is underway to prepare for the implementation of the new populations of focus for ECM in January 2023. The two new populations of focus are: Adults Living in the Community who Are at Risk for LTC Institutionalization, and Nursing Facility Residents Transitioning to the Community. Provider engagement sessions have started to inform community providers with culturally relevant experience serving members in these populations virtually. Attendees include home health

providers, CBAS center staff, Co. Adult and Aging staff, and other CBOs that serve seniors in the Alliance's service area. In the next few weeks, staff will be reviewing interested provider's Certification Tools and work towards contracting with these agencies to deliver ECM and/or CS for the go-live date.

Staff are also working towards building the provider network by adding additional ECM/CS providers for the existing populations of focus. New providers were contracted to provide these services in all three counties within the last month. Lastly, ongoing training and oversight have been provided by Alliance staff and the contracted vendor, Health Management Associates (HMA). Examples of support include chart reviews to assure all core services and activities are provided, training webinars on housing readiness, field safety/de-escalation, and complex case presentation/discussion. HMA is also providing practice coaching to all ECM/CS providers that express interest in receiving this support.

Behavioral Health. With the onboarding of the new Behavioral Health (BH) Director, an analysis of present state in relation to the BH continuum and the role of Beacon has begun. The process includes analysis of existing data, interviews and site visits with counties, and discussions with other health plans about their approach to non-specialty mental health services. This will lead into a future state proposal for how the Alliance can best leverage resources to meet strategic goals and operationalize CalAIM initiatives.

Recent BH work included the generation of a distinct BH Department analysis and evaluation of the workload anticipated in 2023, as well as participation in budget proposals. Continued efforts are being made towards improving stakeholder relationships with rigorous engagement, monitoring Beacon to improve member experience, and revising workflows to connect members struggling with eating disorders.

Employee Services and Communications

Alliance Workforce. As of August 29, 2022, the Alliance has 533.3 budgeted positions of which our active workforce number is 515.1 (active FTE and temporary workers). There are 25 positions in active recruitment and 49 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 Finance to ensure alignment in this area.

2022 Employee Engagement Survey. Human Resources completed the 2022 Employee Engagement Survey on August 29, 2022. Findings showed that 75% of Alliance staff show favorable ratings for engagement, with 87% of the workforce responding. We presented high-level organization results at the Q3 2022 All Staff assembly on September 8, 2022 and will then work with division and department leadership for respective results.

Competencies and Career Development. 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. This work is currently in the system implementation phase. Next steps will be to survey leadership on core competencies.

2023 FTE Request Process. Human Resources will work cross-functionally with Operational Excellence, and with support from Compliance, managing and executing the request process for 2023 new positions. Division Chiefs and Department Directors assess their core work to

determine appropriate and necessary justification for new position requests. This process aligns with our budget cycle, and based on priority factors, and budget allowance, will result in proposed 2023 FTE added positions. This process commenced in early September and will end in December with the Board-approved budget for 2023.

Communications. The annual flu media campaign is scheduled to launch September 6, 2022 and will run through mid-November. This year's theme, "You don't have time for the flu" aims to persuade busy members to get their annual flu vaccine to avoid becoming seriously ill or spreading illness to others. The campaign includes a mix of owned and paid media tactics. Bi-lingual paid tactics include mobile display ads, digital news publication ads, ads in buses in all counties, and Facebook paid posts. Owned tactics include a website landing page, home page website banner ad, articles in our member bulletin, provider bulletin and our community e-newsletter (The Beat), a member flyer and a press release to local media. The website messaging, flyer and member newsletter article are in all three languages.

Staff is working on a media campaign to support eligibility redetermination for members to coincide with the unwinding of the PHE. The campaign will consist of owned and paid media tactics. A definitive launch date will be dependent on when the PHE is scheduled to end but will likely run late 2022 or early 2023. Messaging must be approved by DHCS and once approved, a media campaign will be developed.

Staff is working with internal stakeholders and our newsletter vendor to conduct a redesign of the Member Bulletin, effective for the March 2023 issue. The redesign incorporates feedback from members seeking more digestible, visually engaging content. In addition, the content approach will provide greater alignment with strategic priorities and messaging across other communications platforms.

Facilities and Administrative Services.

1098 38th Avenue. The Alliance has begun the process of engaging with MidPen Housing for the purchase of the property, as per the Board's instruction at the August Board meeting. The demolition of the previous structure has been completed and the final gas shutoff was completed on September 9, 2022.

HVAC Replacement. The Facilities Department is working to replace several large heating and air conditioning units at 1600 and 1800 Green Hills Road, and 950 E Blanco Road as part of the capital project plan.

Operations

Member Services. Member Services continues to see a larger than expected volume of member calls. With that, we have seen an increase in member walk-ins, specifically in our Merced and Salinas offices. We are currently seeing an average of 40 walk-ins per month per site. In August, Merced had a total of 74 walk-ins which was a significant increase from 47 in July. Members walk-in for various reasons including billing issues, transportation questions, primary care physician changes, or to replace a lost ID card. We have also seen an increase in member walk-ins requesting services not directly offered by the Alliance such as, Medi-Cal Rx, dental and vision benefits, and contact information for the local Health Services Agency.

Due to the increase in calls and member walk-ins, Member Services leadership has been evaluating this trend to ensure we can continue to provide strong and efficient services to our members. Actions implemented to decrease member wait time to speak to a representative included onboarding additional staff to support the call volume and providing customer service training for staff to maximize efficiency. Further, the Alliance is engaging our current transportation vendor to take on the intake and scheduling of member requests for transportation services. As our transportation vendor currently supports this work for many large health plans in California, they have the capacity to provide high quality service to our members while meeting established call center service levels. The Alliance will transition transportation calls to our transportation vendor in October 2022.

Claims. We continue to make great progress with reducing our claims inventory and lowering our claims aging despite having an all-time high of claims receipt in the 450K range. From June to September, our average claims inventory has gone from 76,569 in June to 54,317 in September, a reduction of 29.06%. Our 26+ claims aging went from an average of 14,921 in June to an average of 2875 in September, a reduction of 80.73%. We have now achieved our 26+ target of having no more than 5% of our inventory that is 26+ days old. We are only 9,500 claims away from achieving our inventory claims target, which is a maximum of 10 days on hand. We expect to achieve that target by the end of September.

Provider Services. Provider Services continues to work with our Enhanced Care Management (ECM) and Community Supports (CS) providers to ensure capacity for our membership. Effective September 1, 2022, four new providers were added to the network. For ECM services, Santa Cruz Community Health Centers, Janus of Santa Cruz, and Merced County Community Action Agency were added. Mission Merced was also added September 1, 2022 as a new CS Sobering Center.

The team is diligently preparing for the January 1, 2023 new populations of focus for adults living in the community who are at risk for long term care institutionalization and nursing facility residents transitioning to the community. A new CS of environmental accessibility adaptations is going live on January 1, 2023 to support the new Populations of Focus.

Regional Operations Santa Cruz/Monterey/Merced. Alliance staff attended the HIP Annual Community Forum where the focus for this year was Health Workforce in Santa Cruz County. Discussions centered around how to alleviate the significant issues around hiring, retaining and educating health workers in our community. Issues around employing health workers became more apparent with the COVID-19 pandemic where retention and cost challenges impacted the workforce as well as reskilling of health workers whose jobs were replaced by technology. The solution framework discussed was a collaboration between employers, education, and workforce boards and CBOs. This partnership is key to assuring alignment around compensation, training, and demand. The Alliance is looking forward to continuing these discussions with community partners to improve the health workforce in our service area.

Additionally, in August, the Alliance partnered with Insure the Uninsured Project and the Health Improvement Partnership of Santa Cruz County to develop and present “Seizing Opportunity: Bringing Community into CalAIM”. The two-hour session offered information on the CalAIM initiative and how community-based organizations can participate. Over 100 individuals registered throughout our tri-county region. After the session, nearly all participants reported having a better understanding of Medi-Cal and CalAIM than prior. Several organizations also indicated that they would be interested in becoming a contracted provider.

DATE: September 28, 2022

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Seventh Month Ending July 31, 2022

For the month ending July 31, 2022, the Alliance reported an Operating Loss of $1.9M. The Year-to-Date (YTD) Operating Income is at $69.4M, with a Medical Loss Ratio (MLR) of 87.0% and an Administrative Loss Ratio (ALR) of 5.2%.

The budget expected a $40.7M Operating Income for YTD July. The actual result is favorable to budget by $28.7M or 70.4%, driven primarily by the boosted enrollment from the Public Health Emergency (PHE).

Jul-22 MTD (In $000s)				
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*406,414*	*362,379*	*44,035*	*12.2%*
Revenue	118,160	112,867	5,293	4.7%
Medical Expenses	113,659	106,287	(7,373)	-6.9%
Administrative Expenses	6,427	7,129	702	9.9%
Operating Income/(Loss)	(1,926)	(549)	(1,377)	-100.0%
Net Income/(Loss)	1,085	(1,793)	2,878	100.0%
MLR %	*96.2%*	*94.2%*	*-2.0%*	
ALR %	*5.4%*	*6.3%*	*0.9%*	
Operating Income %	*-1.6%*	*-0.5%*	*-1.1%*	
Net Income %	*0.9%*	*-1.6%*	*2.5%*	

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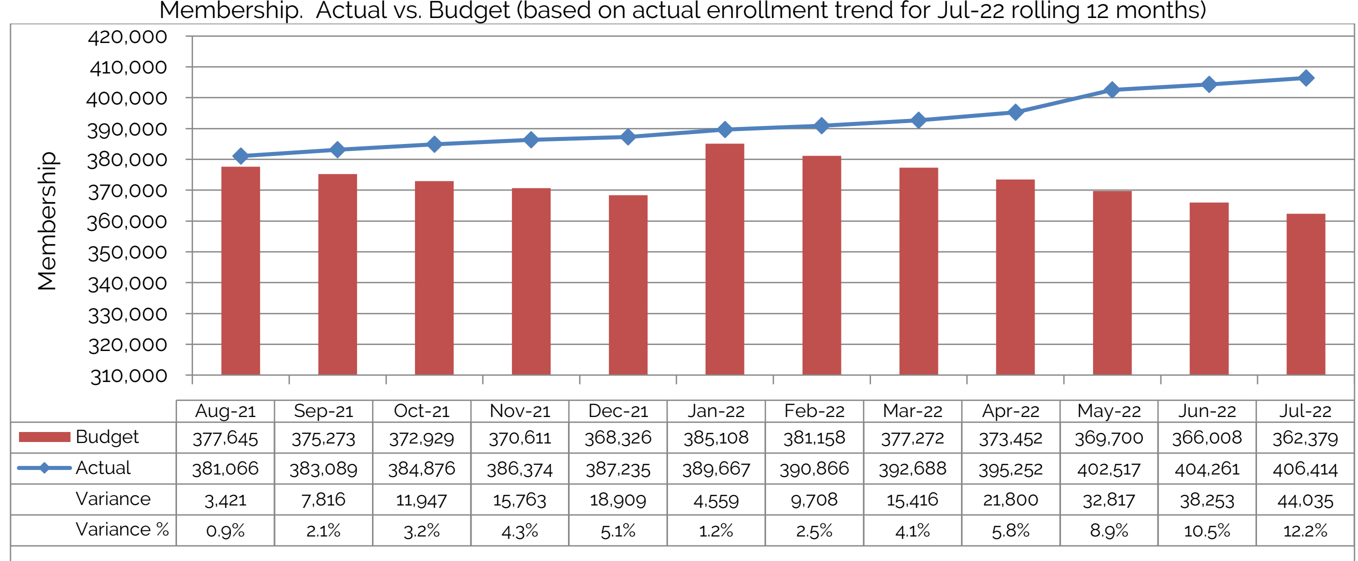
Jul-22 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*2,781,665*	*2,615,077*	*166,588*	*6.4%*
Revenue	881,635	814,528	67,106	8.2%
Medical Expenses	766,709	724,132	(42,577)	-5.9%
Administrative Expenses	45,555	49,682	4,127	8.3%
Operating Income/(Loss)	69,371	40,714	28,656	70.4%
Net Income/(Loss)	55,695	32,063	23,632	73.7%
PMPM				
Revenue	316.95	311.47	5.47	1.8%
Medical Expenses	275.63	276.91	1.28	0.5%
Administrative Expenses	16.38	19.00	2.62	13.8%
Operating Income/(Loss)	24.94	15.57	9.37	60.2%
MLR %	87.0%	*88.9%*	*1.9%*	
ALR %	*5.2%*	*6.1%*	*0.9%*	
Operating Income %	*7.9%*	*5.0%*	*2.9%*	
Net Income %	*6.3%*	*3.9%*	*2.4%*	

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 usually correspond with enrollment and should be evaluated at the dollar amount.

At a PMPM level, YTD revenue is $316.95, which is favorable to budget by $5.47 or 1.8%. Medical cost PMPM is $275.63, which is favorable by $1.28 or 0.5%. The resulting operating income PMPM is $24.94, which is favorable by $9.37 compared to the budget.

Membership. July 2022 membership is favorable to budget by 12.2%. Please note that the 2022 budget assumed the PHE would end in January 2022, and enrollment would decrease gradually to the pre-pandemic level by December 2022. The State anticipates the PHE will expire no sooner than October 13, 2022. Additionally, effective May 1, 2022, the State extended eligibility to Adults ages 50, regardless of immigration status. The Alliance has approximately 5,000 members in this category. Overall, the membership will remain favorable in 2022.



	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Budget	377,645	375,273	372,929	370,611	368,326	385,108	381,158	377,272	373,452	369,700	366,008	362,379
Actual	381,066	383,089	384,876	386,374	387,235	389,667	390,866	392,688	395,252	402,517	404,261	406,414
Variance	3,421	7,816	11,947	15,763	18,909	4,559	9,708	15,416	21,800	32,817	38,253	44,035
Variance %	0.9%	2.1%	3.2%	4.3%	5.1%	1.2%	2.5%	4.1%	5.8%	8.9%	10.5%	12.2%

Revenue. July 2022 capitation revenue of $117.8M is favorable to budget by $5.2M or 4.6%, mainly attributed to higher enrollment of $13.7M, reduced by rate variances of $8.5M. A favorable rate variance of $0.4M is offset by an $8.9M adjustment for MCO Tax from CY 2021. Gains from the prior period have been moved to liability in anticipation of the Department of Health Care Services' (DHCS') MCO Tax reassessment.

July 2022 YTD capitation revenue of $879.3M is favorable to budget by $66.6M or 8.2%. Of this amount, $49.9M is from boosted enrollment, and $16.7M is due to rate variance. The favorable rate variance includes funding for various programs not yet finalized when preparing the 2022 budget, including CalAIM Incentive Payment Programs, rapid genome sequencing, and the expansion of Medi-Cal benefits to undocumented Californians age 50 and older. Please note that DHCS plans to finalize the 2022 rates in March 2023.

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

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	193,030	183,631	9,399	10,571	(1,172)
Monterey	376,293	346,809	29,483	20,741	8,743
Merced	309,947	282,215	27,733	18,638	9,095
Total	**879,270**	**812,655**	**66,615**	**49,949**	**16,666**

Note: Excludes Jul-22 YTD In-Home Supportive Services (IHSS) premiums revenue of $2.4M.

Medical Expenses. July 2022 Medical Expenses of $113.7M are $7.4M or 6.9% unfavorable to budget. July 2022 YTD Medical Expenses of $766.7M are above budget by $42.6M or 5.9%. Of this amount, $46.1M is due to higher enrollment, which offsets $3.6M from increased PMPM cost variance. "Other Medical" expense is unfavorable to budget by $30.1M or 28.4% due to higher utilization in lab, behavioral health services, and increases in unit cost driven by a mix of services from the lab, DME, non-medical transportation, and behavioral health. This category also includes

CalAIM Incentive Payment Program expenses as the Alliance aims for budget-neutral and to distribute the payment to providers or cover its own cost of expanding capacity and building infrastructure.

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	297,666	274,940	(22,726)	(17,514)	(5,211)
Inpatient Services (LTC)	93,545	91,603	(1,943)	(5,835)	3,893
Physician Services	147,926	152,473	4,547	(9,713)	14,260
Outpatient Facility	91,805	98,443	6,638	(6,271)	12,910
Pharmacy	(541)	481	1,022	(31)	1,052
Other Medical	136,307	106,192	(30,116)	(6,765)	(23,351)
Total	**766,709**	**724,132**	**(42,577)**	**(46,129)**	**3,552**

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

At a PMPM level, YTD Medical Expenses are $275.63, which is favorable by $1.28 or 0.5% compared to the budget. Please note that the rate (PMPM) is the unit cost for a service multiplied by the utilization.

The 2022 budget assumed utilization would return to the 2019 level during Q1 2022 and increase 5% over 2019 by year-end. Actual YTD utilization has not achieved the 2019 level but indicates upward movement. Authorizations suggest that inpatient utilization continued to be below the 2019 level through early 2022, representing approximately 50% of medical expenses. However, there have been $8.9M inpatient payments for prior years that resulted in higher Inpatient PMPM cost and higher Incurred but Not Reported (IBNR) estimate.

The budget assumed that the Long-term Care (LTC) COVID-19 add-on would be discontinued in 2022. Due to the PHE extension, the COVID-19 add-on is still in place. Therefore, the LTC cost will be higher than the budget.

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

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	107.01	105.14	(1.87)	-1.8%
Inpatient Services (LTC)	33.63	35.03	1.40	4.0%
Physician Services	53.18	58.31	5.13	8.8%
Outpatient Facility	33.00	37.64	4.64	12.3%
Pharmacy	(0.19)	0.18	0.38	100.0%
Other Medical	49.00	40.61	(8.39)	-20.7%
Total	**275.63**	**276.91**	**1.28**	**0.5%**

Administrative Expenses. July YTD Administrative Expenses are favorable to budget by $4.1M or 8.3% with a 5.2% ALR. Salaries, Wages, & Benefits (SWB) are favorable by $2.6M or 7.5% due to employee benefits running lower than budget and savings from vacant positions. Non-Salary Administrative Expenses are favorable by $1.5M or 10.1% due to the actual spend versus budget timing.

Non-Operating Revenue/Expenses. July YTD Total Non-Operating Revenue is unfavorable to budget by $10.2M. There is a $12.7M unrealized loss on investments, reduced by $7.6M favorability in grants and interests.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $55.7M, with an MLR of 87.0% and an ALR of 5.2%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Seventh Month Ending July 31, 2022
(In $000s)

Assets	
Cash	$111,509
Restricted Cash	300
Short Term Investments	608,230
Receivables	166,301
Prepaid Expenses	4,292
Other Current Assets	16,721
Total Current Assets	**$907,354**
Building, Land, Furniture & Equipment	
Capital Assets	$83,392
Accumulated Depreciation	(43,200)
CIP	319
Total Non-Current Assets	**40,512**
Total Assets	**$947,866**
Liabilities	
Accounts Payable	$35,093
IBNR/Claims Payable	261,075
Accrued Expenses	-
Estimated Risk Share Payable	5,833
Other Current Liabilities	7,377
Due to State	-
Total Current Liabilities	**$309,378**
Fund Balance	
Fund Balance - Prior	$582,793
Retained Earnings - CY	55,695
Total Fund Balance	**638,488**
Total Liabilities & Fund Balance	**$947,866**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Seventh Month Ending July 31, 2022
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*406,414*	*362,379*	*44,035*	*12.2%*	*2,781,665*	*2,615,077*	*166,588*	*6.4%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$117,789	$112,599	$5,191	4.6%	$879,270	$812,655	$66,615	8.2%
Premiums Commercial	370	268	103	38.3%	2,365	1,874	491	26.2%
Total Operating Revenue	**$118,160**	**$112,867**	**$5,293**	**4.7%**	**$881,635**	**$814,528**	**$67,106**	**8.2%**
Medical Expenses								
Inpatient Services (Hospital)	$47,915	$40,187	($7,728)	-19.2%	$297,666	$274,940	($22,726)	-8.3%
Inpatient Services (LTC)	11,779	14,176	2,397	16.9%	93,545	91,603	(1,943)	-2.1%
Physician Services	21,427	22,482	1,054	4.7%	147,926	152,473	4,547	3.0%
Outpatient Facility	13,515	14,979	1,464	9.8%	91,805	98,443	6,638	6.7%
Pharmacy	(85)	71	157	100.0%	(541)	481	1,022	100.0%
Other Medical	19,108	14,392	(4,716)	-32.8%	136,307	106,192	(30,116)	-28.4%
Total Medical Expenses	**$113,659**	**$106,287**	**($7,373)**	**-6.9%**	**$766,709**	**$724,132**	**($42,577)**	**-5.9%**
Gross Margin	**$4,500**	**$6,580**	**($2,079)**	**-31.6%**	**$114,926**	**$90,397**	**$24,529**	**27.1%**
Administrative Expenses								
Salaries	$4,653	$4,853	$200	4.1%	$32,015	$34,622	$2,607	7.5%
Professional Fees	152	139	(12)	-8.7%	924	1,219	294	24.1%
Purchased Services	554	763	209	27.4%	4,904	4,853	(51)	-1.1%
Supplies & Other	703	978	275	28.2%	5,123	6,243	1,120	17.9%
Occupancy	89	102	13	12.4%	637	728	91	12.5%
Depreciation/Amortization	276	294	18	6.1%	1,951	2,017	66	3.3%
Total Administrative Expenses	**$6,427**	**$7,129**	**$702**	**9.9%**	**$45,555**	**$49,682**	**$4,127**	**8.3%**
Operating Income	**($1,926)**	**($549)**	**($1,377)**	**-100.0%**	**$69,371**	**$40,714**	**$28,656**	**70.4%**
Non-Op Income/(Expense)								
Interest	$1,021	$318	$703	100.0%	$4,399	$2,215	$2,183	98.5%
Gain/(Loss) on Investments	2,161	(240)	2,401	100.0%	(14,334)	(1,673)	(12,662)	-100.0%
Other Revenues	120	75	45	60.4%	867	584	283	48.5%
Grants	(291)	(1,397)	1,106	79.2%	(4,607)	(9,778)	5,171	52.9%
Total Non-Op Income/(Expense)	**$3,011**	**($1,244)**	**$4,255**	**100.0%**	**($13,676)**	**($8,651)**	**($5,025)**	**-100.0%**
Net Income/(Loss)	**$1,085**	**($1,793)**	**$2,878**	**100.0%**	**$55,695**	**$32,063**	**$23,632**	**73.7%**
MLR	*96.2%*	*94.2%*			*87.0%*	*88.9%*		
ALR	*5.4%*	*6.3%*			*5.2%*	*6.1%*		
Operating Income	*-1.6%*	*-0.5%*			*7.9%*	*5.0%*		
Net Income %	*0.9%*	*-1.6%*			*6.3%*	*3.9%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Seventh Month Ending July 31, 2022
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*406,414*	*362,379*	*44,035*	*12.2%*	*2,781,665*	*2,615,077*	*166,588*	*6.4%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$289.83	$310.72	($20.90)	-6.7%	$316.09	$310.76	$5.34	1.7%
Premiums Commercial	0.91	0.74	0.17	23.3%	0.85	0.72	0.13	18.6%
Total Operating Revenue	**$290.74**	**$311.46**	**($20.72)**	**-6.7%**	**$316.95**	**$311.47**	**$5.47**	**1.8%**
Medical Expenses								
Inpatient Services (Hospital)	$117.90	$110.90	($7.00)	-6.3%	$107.01	$105.14	($1.87)	-1.8%
Inpatient Services (LTC)	28.98	39.12	10.14	25.9%	33.63	35.03	1.40	4.0%
Physician Services	52.72	62.04	9.32	15.0%	53.18	58.31	5.13	8.8%
Outpatient Facility	33.25	41.33	8.08	19.5%	33.00	37.64	4.64	12.3%
Pharmacy	(0.21)	0.20	0.41	100.0%	(0.19)	0.18	0.38	100.0%
Other Medical	47.02	39.71	(7.30)	-18.4%	49.00	40.61	(8.39)	-20.7%
Total Medical Expenses	**$279.66**	**$293.30**	**$13.64**	**4.7%**	**$275.63**	**$276.91**	**$1.28**	**0.5%**
Gross Margin	**$11.07**	**$18.16**	**($7.08)**	**-39.0%**	**$41.32**	**$34.57**	**$6.75**	**19.5%**
Administrative Expenses								
Salaries	$11.45	$13.39	$1.94	14.5%	$11.51	$13.24	$1.73	13.1%
Professional Fees	0.37	0.38	0.01	3.0%	0.33	0.47	0.13	28.7%
Purchased Services	1.36	2.10	0.74	35.2%	1.76	1.86	0.09	5.0%
Supplies & Other	1.73	2.70	0.97	35.9%	1.84	2.39	0.55	22.9%
Occupancy	0.22	0.28	0.06	21.9%	0.23	0.28	0.05	17.7%
Depreciation/Amortization	0.68	0.81	0.13	16.3%	0.70	0.77	0.07	9.0%
Total Administrative Expenses	**$15.81**	**$19.67**	**$3.86**	**19.6%**	**$16.38**	**$19.00**	**$2.62**	**13.8%**
Operating Income	**($4.74)**	**($1.52)**	**($3.22)**	**-100.0%**	**$24.94**	**$15.57**	**$9.37**	**60.2%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Seventh Month Ending July 31, 2022
(In $000s)

	MTD	YTD
Net Income	$1,085	$55,695
Items not requiring the use of cash: Depreciation	276	1,951
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	2,436	79,248
Prepaid Expenses	1,297	(2,095)
Current Assets	958	(617)
Net Changes to Assets	**$4,691**	**$76,536**
Changes to Payables:		
Accounts Payable	(17,176)	(21,848)
Accrued Expenses	-	(1)
Other Current Liabilities	561	62
Incurred But Not Reported Claims/Claims Payable	13,551	(63,674)
Estimated Risk Share Payable	833	(4,167)
Due to State	-	-
Net Changes to Payables	**($2,231)**	**($89,628)**
Net Cash Provided by (Used in) Operating Activities	**$3,821**	**$44,555**
Change in Investments	(3,033)	(70,346)
Other Equipment Acquisitions	(72)	(227)
Net Cash Provided by (Used in) Investing Activities	**($3,105)**	**($70,573)**
Net Increase (Decrease) in Cash & Cash Equivalents	**$715**	**($26,019)**
Cash & Cash Equivalents at Beginning of Period	**$110,794**	**$137,528**
Cash & Cash Equivalents at July 31, 2022	**$111,509**	**$111,509**

SANTA CRUZ – MONTEREY – MERCED MANAGED MEDICAL CARE COMMISSION MEETING

Meeting Minutes
Special Meeting of the Board

Friday, August 19, 2022

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

Commissioners Present:

Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Dr. Larry deGhetaldi	Provider Representative
Supervisor Zach Friend	County Board of Supervisors
Dr. Charles Harris	Hospital Representative
Ms. Dori Rose Inda	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Ms. Mónica Morales	County Health Services Agency Director
Ms. Rebecca Nanyonjo	Director of Public Health
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. Joerg Schuller	Hospital Representative
Mr. Rob Smith	Public Representative

Commissioners Absent:

Supervisor Wendy Root Askew	County Board of Supervisors
Dr. Maximiliano Cuevas	Provider Representative
Ms. Julie Edgcomb	Public Representative
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Mr. Tony Weber	Provider Representative

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Kathy Stagnaro	Clerk of the Board

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1. Call to Order by Chair Jimenez.

Commission Chairperson Jimenez called the meeting to order at 7:34 a.m.

Roll call was taken and a quorum was present.

2. Approve findings that the state of emergency continues to impact the ability of members to meet safely in person and/or State or local officials continue to impose or recommend measures to promote social distancing. (7:36 – 7:41 a.m.)

Ms. Stephanie Sonnenshine, Chief Executive Officer, informed the Board that AB 361 permits the Board to meet by teleconference where state or local officials impose measures to promote social distancing and the Board determines that meeting in person would present imminent risk to the health and safety of attendees. To continue meeting via teleconference during the public health emergency, the Board must consider and make these findings every 30 days. The Board met to consider and make the finding that will enable holding the regularly scheduled August 24, 2022 meeting by teleconference. A recommendation will be included in the August 24, 2022 packet adopting a meeting schedule for the remainder of 2022 to meet in compliance with AB 361 to consider the present state of emergency and determine if circumstances continue to exist in order to enable continued meeting via teleconference.

MOTION: Commissioner Friend moved to approve to continue to meet via teleconferencing as permitted by the Brown Act, as amended in AB 361, during a proclaimed state of emergency and made the requisite findings supporting teleconferencing, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Conner, deGhetaldi, Friend, Harris, Inda, Jimenez, Morales, Nanyonjo, Pedrozo, Schuller and Smith.

Noes: None.

Absent: Commissioners Askew, Cuevas, Edgcomb, Kalantari-Johnson, Molesky, Rabago, Radner and Weber.

Abstain: None.

Abstain: None.

The Commission adjourned its special meeting of August 19, 2022 at 7:41 a.m. to the regular meeting of August 24, 2022 at 3:00 p.m. via teleconference unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

Meeting Minutes

Wednesday, August 24, 2022

Teleconference Meeting

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

Commissioners Present:

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

Commissioners Absent:

Ms. Leslie Conner	Provider Representative
Ms. Mónica Morales	County Health Services Agency Director
Dr. James Rabago	Provider Representative
Mr. Tony Weber	Provider Representative

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Mr. Scott Fortner	Chief Administrative Officer
Dr. Maurice Herbelin	Chief Medical Officer
Mr. Cecil Newton	Chief Information Officer

Ms. Van Wong	Chief Operating Officer
Ms. Jessica Finney	Grant Program Manager
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Jimenez.

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

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

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

No members of the public addressed the Commission.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

Commissioner Askew thanked Alliance staff and the CEO specifically for their research and clarification related to Beacon Health wishing to record behavioral health therapy appointments. She noted that this is not being proposed for California at this time and would recommend expressing opposition should this issue arise. She also mentioned the upcoming webinar on Seizing Opportunity: Bringing Community into CalAIM and inquired if there is opportunity to share details and the link for registration.

Commissioner Inda thanked Alliance staff, leadership and the Board for the grant support for Watsonville Community Hospital. Acquisition of the hospital is expected to close on August 31, 2022.

Vice Chair Pedrozo acknowledged Alliance staff and appreciated their responsiveness to a couple of matters. In addition, he noted that Dr. Salvador Sandoval was appointed to serve as the permanent Merced County Health Officer by the Merced County Board of Supervisors.

Commissioner Cuevas stated that Clinica de Salud del Valle de Salinas completed an audit by the Joint Commission on August 5, 2022 and continues to be accredited for quality. He added that through an initiative, 30 physicians have been brought into community health centers from Mexico as a short-term solution to the physician shortage to practice for three years on a California license. Eight out of ten of these physicians are participating in Monterey County and after three years will be returning to Mexico.

4. Comments and announcements by Chief Executive Officer.

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

Ms. Sonnenshine informed the Board that the final agenda for the September 28, 2022 retreat was included in the packet on consent. Staff are planning for in-person attendance in the Alliance Scotts Valley office and will ask Board members to rapid COVID-19 test the morning of

the retreat to ensure adequate precautions are being taken to protect against infection. She noted that additionally on consent was staff's update on the CEO recruitment.

She announced that the grant payment was released towards the acquisition of Watsonville Community Hospital. Staff anticipate providing a detailed status report in the September packet.

She reported that Shaina Zurlin, LCSW, PsyD., has been named the new Alliance Behavioral Health Director.

Ms. Sonnenshine recognized Ms. Kathleen McCarthy, Strategic Development Director, whose last full day with the Alliance will be Thursday, August 25, 2022. Ms. McCarthy led the development of the Medi-Cal Capacity Grant Program and all the programs and grant opportunities the Alliance has made available to the community over the past seven years. She took the Board's and the founding CEO's vision and made the grant program a reality, along with her exceptionally talented team.

Consent Agenda Items: (5. – 11l.): 3:13 p.m.

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

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

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioners Conner, Morales, Rabago and Weber.

Abstain: None.

Regular Agenda Item: (12. - 16.): 3:16 p.m.

12. Consider approving Non-Emergency Medical Transportation (NEMT) Policy. (3:16 – 3:20 p.m.)

Ms. Lisa Ba, Chief Financial Officer, provided background information on the challenges to expand the Non-Emergency Medical Transportation provider network due to non-contracted providers unwilling to accept 100% of Medi-Cal fee schedule and reviewed the current and proposed financial analysis. The current Medi-Cal fee schedule does not incorporate special "add-on" services and increased regulatory requirements, member grievances, and provider cost challenges are catalysts for enhanced medical transportation rates. Enhanced rates will ensure timely access for Alliance members and will expand the transportation provider network.

Staff recommended increasing NEMT to 160% of Medi-Cal and allow add-ons for special cases. The annual cost is estimated at $3M and the medical budget will cover the additional cost.

MOTION: Commissioner Cuevas moved to increase Non-Emergent Medical Transportation (NEMT) rates to 160% of Medi-Cal Fee Schedule and allow add-on payments retro effective July 1, 2022, seconded by Commissioner Askew.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioner Conner, Morales, Rabago and Weber.

Abstain: None.

13. Consider approving proposed Medi-Cal Capacity Grant Program (MCGP) Framework and Governance Evolution. (3:20 – 4:08 p.m.)

Ms. Sonnenshine, CEO, facilitated discussion about the Alliance's governance and administrative approach to grant making and approval of the grant program Framework and direction as to future governance and administration of the MCGP. The Board supported implementation of an annual spending plan, a change to MCGP governance to avoid conflict of interest, a change to MCGP governance to ensure the Board focuses on core health plan, a governance/administration which segregates grant funds from the fund balance and enables access to other grant funds and partnerships, and shared additional principles and criteria for MCGP grantmaking.

Two concepts were put forward in the Board's June discussion that weren't in the framework because they would require a different administrative structure: 1) an additional component to the investment strategy which would segregate the MCGP funds from the fund balance, and 2) a component relevant both to the investment strategy and generally as to administration which is to enable access to other grant funds. The Board considered prioritizing these as elements of the investment strategy and directed staff to return with a proposal evaluating the formation of a 501(c)3 non-profit foundation model to administer the grant program.

MOTION: Commissioner Cuevas moved to approve the proposed Medi-Cal Capacity Grant Program Framework and direct staff to return to the Board with a recommendation which addresses governance for the Medi-Cal Capacity Grant Program, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioner Conner, Morales, Rabago and Weber.

Abstain: None.

14. Consider approving Medi-Cal Capacity Grant Program (MCGP): Focus Area Goals and Funding Priorities. (4:08 – 4:31 p.m.)

Ms. Jessica Finney, Grant Program Manager, reviewed the new MCGP focus area goals and funding priorities. The purpose of evolving the grant program is to address unmet and emerging Medi-Cal needs and opportunities; align with organizational and State priorities; increase investments upstream towards root causes and prevention; and direct resources in areas outside of core health plan responsibility where other funds are not available. Over the past few months, staff have engaged the Board to inform goals and priorities towards which new grant programs and opportunities can be developed. In March, the Board approved three new focus areas responsive to changes in the environment: 1) Access to Care, 2) Healthy Beginnings, and 3) Healthy Communities. The next step in the MCGP evolution is establishing the focus area goals and funding priorities to direct grantmaking and a theory of change to guide the impact of grantmaking to advance the Alliance's vision of *Healthy People*. *Healthy Communities*.

Moving forward in the evolution of the MCGP, staff will begin to inform the community of new funding goals and priorities, explore opportunities for more equitable grantmaking and inclusion of member voice to inform investments, develop new funding opportunities that align with grantmaking strategy, and implement changes to the administrative structure of the MCGP.

MOTION: Commissioner Pedrozo moved to approve focus area goals, funding priorities and theory of change for the Medi-Cal Capacity Grant Program, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Cuevas, Edgcomb, Friend, Harris, Inda, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo and Pedrozo.

Noes: Commissioners deGhetaldi and Smith.

Absent: Commissioner Conner, Morales, Rabago and Weber.

Abstain: Commissioners Radner and Schuller.

15. Consider approving Annual Allocation to Strategic Use of Reserves. (4:31 – 4:45 p.m.)

Ms. Ba, CFO, informed the Board of the Alliance's financial plan to ensure the long-term financial viability of the organization: 1) uninterrupted serves to members, 2) timely and adequate reimbursement to providers, 3) compliance with regulatory requirements, and 4) to ensure the organization's capacity to respond to short and long-term capital needs and opportunities consistent with the Alliance's strategic plan. The health care expense reserve target is at three times the average monthly premium capitation. Reserves enable implementation of future program and to strengthen the local delivery system for the future. Reserves can be used to improve member benefits, expand network access and augment provider reimbursement.

The Board approved the reserve policy framework in June 2022. Staff submitted the formal policy for Board approval in August 2022 and the reserve target included a prudent balance for health care expenses. Staff recommended funds to offset the potential loss for Dual Eligible Special Needs Plans implementation and recommended allocation of the remaining surplus to the Medi-Cal Capacity Grant Program to enhance the local delivery system for the future.

MOTION: Commissioner Smith moved to strategically allocate $56.7M for the potential losses in Dual Eligible Special Needs Plans and $43.6M to the Medi-Cal Capacity Grant Program, seconded by Commissioner Jimenez.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioner Conner, Morales, Rabago and Weber.

Abstain: None.

16. Consider approving entering into Purchase and Sale Agreement with MidPen Housing for the 38th Avenue property. (4:45 – 5:09 p.m.)

Mr. Scott Fortner, Chief Administrative Officer, provided an update on the 38th Avenue (formerly Capitola Manor) property. At the January 2022 meeting, the Board authorized staff to engage with MidPen Housing towards a formal partnership agreement for the purpose of developing the 38th Avenue property. They further directed staff through that partnership to assess the feasibility of a proposed project and to return with a recommendation for final disposition of the property.

Ms. Joanna Carman, Director of Housing Development at MidPen Housing, presented on the potential partnership with the Alliance and their offer to purchase the property. Ms. Carman apprised the Board of MidPen Housing's vision and their proposal for the 38th Avenue property. The proposal includes a three-story building with 52-78 units of affordable housing with 20-25% of units preferenced for Alliance members. Included in the property proposal was potential for Alliance office space and community amenities.

The terms of the purchase and sale agreement includes a $3M purchase price, 90-day due diligence, $25K deposit applicable to the purchase price, 30 days to close with a 90-day extension at MidPen Housing's election, and title and escrow fees to be paid by MidPen Housing.

MOTION: Commissioner Pedrozo moved to approve entering into a Purchase and Sale Agreement with MidPen Housing, resulting in the sale of the 38th Avenue property, seconded by Commission Askew.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, deGhetaldi, Edgcomb, Friend, Harris, Inda, Jimenez, Kalantari-Johnson, Pedrozo, Schuller and Smith.

Noes: Commissioners Cuevas and Molesky.

Absent: Commissioner Conner, Morales, Rabago and Weber.

Abstain: Commissioners Nanyonjo and Radner.

The Commission adjourned its regular meeting of August 24, 2022 at 5:09 p.m. to the annual Board Retreat on September 28, 2022 at 9:00 a.m. in Scotts Valley.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, July 20, 2022
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Dale Bishop	Medical Director
Danita Carlson	Government Relations Director
Gordon Arakawa	Medical Director
Jenifer Mandella	Compliance Officer (Chair)
Jennifer Mockus	Community Care Coordination Director
Kate Knutson	Compliance Manager
Kathleen McCarthy	Strategic Development Director
Kay Lor	Financial Planning and Analysis Director
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Luis Somoza	Member Services Director
Maurice Herbelin	Chief Medical Officer
Michelle Stott	Quality Improvement and Population Health Director
Navneet Sachdeva	Pharmacy Director
Ronita Margain	Regional Operations Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Scott Fortner	Chief Administrative Officer
Van Wong	Chief Information Officer

Committee Members Absent:

Rick Dabir	Application Services Director
Dianna Diallo	Medical Director

Committee Members Excused:

Lilia Chagolla	Regional Operations Director, Monterey County
Stephanie Sonnenshine	Chief Executive Officer

Ad-Hoc Attendees:

Jessie Dybdahl	Credentialing and Provider Data Configuration Manager
Rebecca Seligman	Compliance Supervisor
Sara Halward	Compliance Specialist III

Kat Reddell	Compliance Specialist II
Margarita Orellana-Valle	Compliance Specialist II
Ka Vang	Compliance Specialist II
Sarina King	Process Architect

1. Call to Order by Chairperson Mandella.

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

2. Review and Approval of June 15, 2022 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of June 15, 2022 meeting.

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

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

Mandella, Compliance Officer, pulled the Quarterly Policy Monitoring report for discussion, noting that staff continue to complete policy review timely. Mandella reminded meeting attendees to review policy attachments, in addition to the policy. Mandella also reminded the group to ensure updated Policy Hub members are identified when staff transitions occur.

4. Regular Agenda

1. **Delegate Oversight Quarterly Activity Report**

Knutson, Compliance Manager, presented the Q1 2022 Delegate Oversight Quarterly Activity Report and 2022 Annual Review.

2022 Annual Review
Staff recommended approval of the following documents received from delegates:
- Beacon/CHIPA: Compliance
- LPCH: Credentialing
- MedImpact: Credentialing, Finance and Member Rights PHI
- UCSF: Credentialing
- VSP: Compliance and Member Rights PHI

Staff recommended holding approval of the following reports pending staff review of documentation as described below:
- Beacon/CHIPA: Provider Disputes, Quality Improvement and Utilization Management
- MedImpact: Provider Disputes and Utilization Management
- VSP: Finance, Member Grievance and Provider Disputes

COMMITTEE ACTION: Committee reviewed and approved the continued delegation of the identified functions as indicated for the 2022 Annual Review and assigned the following action items:

- Rimac to review Beacon/CHIPA, MedImpact and VSP Provider Disputes documentation and complete annual review
- Leamon to review Beacon/CHIPA Quality Improvement documentation and complete annual review
- Bishop to review Beacon/CHIPA and MedImpact Utilization Management documentation and complete annual review
- Ba to review VSP Finance documentation upon receipt and complete annual review
- Sanders to review VSP Member Grievance documentation and complete annual review

Q1 2022 Continuous Oversight Activities

Staff recommended approval of the following documents received from delegates:

- Beacon/CHIPA: Claims, Credentialing, Member Connections, Network Adequacy and Quality Improvement
- ChildNet: Credentialing
- LPCH: Credentialing
- MedImpact: Claims
- PAMF: Credentialing
- SCVMC: Credentialing
- UCSF: Credentialing
- VSP: Claims, Credentialing, Member Connections and Quality Improvement

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

- Beacon/CHIPA: Member Grievance, Provider Disputes and Utilization Management
- MedImpact: Network Adequacy and Utilization Management
- VSP: Member Grievance and Provider Disputes

COMMITTEE ACTION: Committee reviewed and approved the continued delegation of the identified functions as indicated for the Q1 2022 Review and assigned the following action items:

- Sanders to review Beacon/CHIPA and VSP Member Grievance documentation and complete quarterly review
- Rimac to review Beacon/CHIPA and VSP Provider Disputes documentation and complete quarterly review
- Bishop to review Beacon/CHIPA and MedImpact Utilization Management documentation and complete quarterly review
- Schultze to review MedImpact Network Adequacy documentation and complete quarterly review

Q4 2021 Continuous Oversight Activities

Staff recommended approval of the following documents received from delegates:

- Beacon/CHIPA: Member Grievance

COMMITTEE ACTION: Committee reviewed and approved the Q4 2021 Continuous Oversight Activities.

Additional Oversight Activities
Knutson reviewed the Q1 2022 Beacon Performance Guarantees noting that Beacon met all measurement requirements and that we no longer have performance guarantees from MedImpact due to the pharmacy carve-out and associated removal of performance guarantees from the MedImpact contract.

Knutson reported that the Beacon Credentialing Corrective Action Plan (CAP) is ongoing and 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 Additional Oversight Activities of the Q1 2022 Quarterly Report.

2. Delegate Oversight Process Current and Future State

Due to time limitations, this topic will be reviewed at the August 2022 Compliance Committee meeting.

3. Provider Payment Configuration CAP

Ba, Chief Financial Officer and Wong, Chief Operations Officer reported on actions taken in response to the CAP issued by Compliance staff on provider payments. Ba outlined the process used to assess the findings in the CAP and outlined root causes, as follows:

- Knowledge limitations
- Retro rates
- Documentation Standards
- Human/Process error
- Decision Making

Ba also reviewed planned interventions to address the root causes. The Committee reviewed and discussed recommendations and supported the implementation of the proposed interventions.

4. Record Retention and Instant Message

Mandella reviewed record retention requirements for instant messaging (IM), noting the importance of aligning with Alliance policy to use IM for brief, fast and efficient communications and not for topics of significance.

The Committee discussed appropriate use of IM and agreed to the following action items:

- Directors to confirm staff compliance with policy 600-0004, provide training as needed and report findings to August Compliance Committee.
- Compliance to revise policy 105-0008 – Record Retention to clarify that IMs are not considered Records.
- Compliance to conduct additional staff training via All Staff or other medium.

The meeting adjourned at 9:57 a.m.

Respectfully submitted,

Robin Sihler
Compliance Administrative and Data Reporting Assistant

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

Meeting Minutes

Wednesday, March 23, 2022

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

Members Present:

Mr. Michael Molesky	Public Representative
Allen Radner, MD	Provider Representative
Mr. Tony Weber	Provider Representative

Members Absent:

Ms. Elsa Jiménez	County Health 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. (1:31 p.m.)

Chairperson Molesky called the meeting to order at 1:31 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:32 – 1:33 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 minutes of the October 27, 2021 meeting of the Finance Committee. (1:33 – 1:34 p.m.)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the October 27, 2021 meeting.

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

ACTION: The motion passed with the following vote:

Ayes: Commissioners Molesky, Radner, Weber

Noes: None

Absent: Commissioner Jiménez

Abstain: None

Regular Agenda Items:

4. Preliminary 2021 financial results. (1:34 – 1:51 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), provided an update on the Alliance's 2021 financial performance and oriented the commissioners to a view of the Plan's trended financial performance since 2018.

The 2021 unaudited financial results include an operating income of $123.3M or 7.8%. Favorability was due in part to higher than budgeted revenue by $84.2M or 5.6%, which resulted from a higher enrollment and capitation rate as well as special add-ons during the pandemic. Utilization continued to be suppressed throughout 2021 due to the continuation of the Public Health Emergency (PHE). This in turn contributed to medical cost being favorable to budget by $76.8M or 5.3%. Administrative Expense was at budget at $85.6M. Ms. Ba noted that the 2021 financials are currently still open until the financial audit is finalized. The final report will be presented to the Board by our auditor, Moss Adams, at the May 2022 meeting.

Ms. Ba opened the floor for questions and discussion.

Commissioner Allen Radner inquired about the Administrative Loss Ratio (ALR) and asked why it has continued to decline since 2018. Ms. Ba explained that Staff have made a conscious effort to control the administrative expense since 2018 by looking closely at processes and technology to ensure that efficiencies are in place where possible. However, Ms. Ba noted that favorable enrollment is likely the biggest factor that has contributed to the ALR percentage remaining low over the past two years. The CFO advised that the expectation is that the ALR will likely be higher in the coming years due to increased

administrative costs associated with many new initiatives that the Department of Health Care Services (DHCS) has asked Health Plans to implement.

5. 2020-2021 RDT findings. (1:51 – 1:59 p.m.)

Ms. Ba provided an overview of the 2020-2021 Rate Determination Template (RDT) process and findings. She explained that DHCS and Mercer have indicated that the 2023 rates will be based on submitted costs from the 2020 and 2021 base period. Utilization was down approximately 9% in both periods, which could then result in 2023 rates being lowered by up to 9% if no additional trend is applied by DHCS. It is expected that the rate will be available in late August, and staff will analyze the rate in comparison to utilization for the first half of 2022 and provide an impact analysis for the Finance Committee's review.

6. Investment update through December 2021. (1:59 – 2:09)

Ms. Ba provided the commissioners with an update on the Alliance's investment portfolio as of December 31, 2021. She noted that, in accordance with the Board approved Investment Policy, Staff have utilized the Pooled Money Investment Account (PMIA), which includes CalTRUST and Local Agency Fund (LAIF), to manage the majority of the funds. These accounts are designed for public agencies and their investment objectives are aligned with those of the Alliance.

Ms. Ba explained that Staff manage less than 25% of the balance through Comerica and US Bank. The Wells Fargo account was closed in May of 2021. The internally managed accounts are focused on long term bonds (4-5 years) to diversify our portfolio. The PMIA reserves have been moved from short-term (less than 12 months) to mid-term (1-3 years) as we move from operating losses in 2018-2019 to operating gains in 2020 and 2021. Overall, the Alliance's investment performance through December 2021 was better than benchmark.

7. Guest speaker from CalTRUST. (2:09-2:38)

Ms. Ba introduced Laura Labanieh, CalTRUST Chief Executive Officer and Ludwig Marek, BlackRock Managing Director. Ms. Labanieh presented an overview of CalTRUST. Mr. Marek provided a market and economic update for the commissioners.

Adjourn:

The Commission adjourned its meeting of March 23, 2022 at 2:38 p.m.

Respectfully submitted,

Ms. Dulcie San Paolo
Finance Administrative Specialist

Physicians Advisory Group

Meeting Minutes

Thursday, June 2, 2022
12:00 - 1:30 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

Group Members Present:

Dr. Scott Prysi	Provider Representative
Dr. Shirley Dickinson	Provider Representative
Dr. Michael Yen	Provider Representative
Dr. Salvador Sandoval	Provider Representative
Dr. James Rabago	Provider Representative
Dr. Caroline Kennedy	Provider Representative
Dr. Cristina Mercado	Provider Representative

Group Members Absent:

Dr. Anjani Thakur	Provider Representative
Dr. Patrick Clyne	Provider Representative
Dr. Barry Norris	Provider Representative
Dr. Casey Kirkhart	Provider Representative
Dr. Jennifer Hastings	Provider Representative
Dr. Amy McEntee	Provider Representative
Dr. Devon Francis	Provider Representative
Dr. Misty Navarro	Provider Representative

Staff Present:

Dr. Dale Bishop	Medical Director
Dr. Gordon Arakawa	Medical Director
Ms. Jennifer Mockus, RN	Community Care Coordination Director
Ms. Jessica Hampton	ECM Manager
Ms. Jessie Dybdahl	Credentialing Manager
Ms. Hilary Gillette-Walch, RN, MPH	Quality & Population Health Manager
Ms. Mary Peddy	UM Administrative Assistant

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

Group Chairperson Bishop called the meeting to order at 12:10 p.m.
Roll call was taken.

No supplements or deletions were made to the agenda.

2. Oral Communications.

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

No members of the public addressed the Group.

Consent Agenda

A. The group reviewed the March 3, 2022 Physicians Advisory Group (PAG) minutes.

Action: Minutes approved as written.

3. **Old Business**

A. Pharmacy Carve-Out Update
Dr. Bishop provided a pharmacy carve-out update noting that on July 1st the Department of Health Care Services (DHCS) was going to require plans to submit prior authorizations (PAs) for medication that was previously approved. DHCS has decided to suspend PAs and health plans will be given 90 day notification prior to implementation of this process. DHCS recognized there were concerns and issues with this process. DHCS will have phase reinstatements and transitions and training will be provided with opportunities for feedback. As a follow-up from the last meeting, it was noted ICD-10 codes are not a requirement if the medication requires a PA. Although, it is helpful to have the ICD-10 code noted. A provider noted ICD-10 requirements can vary depending on NDC directory. Dr. Bishop noted that providers please bring forward any medications where this is an issue, and the Alliance will take the feedback to DHCS.

B. Care Based Incentives (CBI) 2023
Dr. Bishop presented on CBI 2023. It was noted the Board approved the following CBI changes:

Programmatic Measures:

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

Fee-For Service Measures:

- **Add:** $200 FFS measure for completion of the ACEs training and attestation.

Exploratory Measures:

- **Add**: Colorectal Cancer Screening.

- **Retire:** 90-Day Referral Completion, and Latent Tuberculosis Infection (LTBI) Screening.

Regarding ACEs, providers that are certified and have completed the attestation will receive the payment beginning in 2023. A provider inquired about ACEs training for staff. Training is available on the ACEs Aware website (2-hour online training) and there is an attestation that goes to DHCS. Providers will not be paid until the attestation is complete. The Alliance will be downloading the provider file from DHCS. Currently mid-level residents and doctors are eligible. The Alliance is hoping to increase ACEs screenings as utilization has been low. It was noted there are grants available through the public health institute.

The Health Plan Disparity measure is a new exploratory measure that reviews whether various ethnic groups had or did not have equal access to primary care, specific to the 3 - 21 year old members in the Child and Adolescent Well-Care Visit measure.

For 2023, the approved recommendation is to change from an exploratory measure to a programmatic measure that creates a plan-wide challenge, to set aside five points that will be distributed if we achieve the challenge to close each of the racial/ethnical gaps. The focus will be on closing gaps to the 50th and 75th percentile. This would distribute funds to all CBI groups if a 50% gap closure can be achieved for race/ethnic groups currently below the 50th percentile, and a 50% gap 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.

The 2021 Child and Adolescent Well-Care Visits for all counties by race and ethnicity data was shared with the Group. It was noted, 80% of Alliance members fall under the LatinX category, and LatinX, Asian Pacific Islander and all others meet the current 50th percentile, the White and Black populations did not. Baseline and targets for gap closure also shared with the Group.

The Alliance will be hosting CBI 2023 workshops beginning in September with the following proposed topics: population health, payment adjustments, activities for peer discussion of challenges, barriers, and opportunities for care, and communicating effectively with members.

The Alliance would also like to create a Population Health Portal Report that would provide consolidated gaps in care report. Dr. Bishop asked for the Group's input regarding what would be most beneficial for clinics? The intent is to put all linked members with care gaps in one place. Provider noted it would be helpful to sort data by various screenings. The delay on the data is 30 days after bill and claims data reports are run monthly. Current provider portal linked member reports include:

- Linked Member Roster
- Newly Linked Members and 120 IHA
- Linked Member Inpatient Admissions
- Linked Member ED Visits
- Linked Member High ED Utilizers

More information will be given to providers.

4. **New Business**

A. Managed Care Accountability (MCAS) Accountability Results
Hilary Gillette-Walch provided an overview of MCAS Accountability Results. MCAS for Measurement year 2021 for maternal child health measures were discussed. Data was collected using claims, lab data and provider information. The Alliance measures that are meeting or exceeding were reviewed. Any measures that fall below the MPL, the Alliance can receive sanctions from DHCS. Santa Cruz fell below the HPL (90th percentile) in prenatal care and HPL was met for post-partum care. Weight and Assessment Counseling for BMI Assessment exceeded HPL in Santa Cruz and Monterey while Merced struggled in this area. Other Well Child Visits fell below MPL, and the Alliance is working on increasing numbers in Child and Adolescent Well-Care. Immunization measures increased slightly. It was noted there were challenges with this measure during the pandemic. A provider noted they still struggle with not having enough providers and there is difficulty accommodating members for appointments. Another provider noted she is busy with well child visits. A provider suggested incentives for providers for catch-up clinics. It was noted there is an incentive for completing vaccinations on time ($100) with a monthly raffle for each county, additionally, incentives for second dose flu vaccine for children under age 2 is also offered. There are incentives for teens on a monthly basis in each county and CBI measure incentives. A provider noted that transportation to and from clinics is essential in getting members in for visits.
Action: The Alliance will explore incentives for catch-up clinics for well childcare.

B. CalAIM Updates
Enhanced Care Management (ECM) Populations of Focus
Jessica Hampton presented on ECM Populations of Focus which will be rolled out in three phases.
Phase I – January 2022

- Individuals and Families Experiencing Homelessness (one of the only populations that will include the pediatric population this year).
- High Utilizer Adults.
- Adults who have serious mental illness (SMI) and substance use disorder (SUD) conditions.

Phase II – January 2023

- Adults & Children/Youth Transitioning from incarceration.
- Eligible for long-term care (LTC) and at risk for institutionalization.

- Nursing Facility Residents who want to transition back to the community.

Phase III – July 2023

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

Merced Expansion Update

Jennifer Mockus provided an overview of the Merced Expansion of Enhanced Care Management. Community/Supports (ECM/CS) in Merced. Santa County and Monterey went live with the ECM/CS benefit in January, however, Merced County did not have a Whole Person Care or home health pilot so the Alliance will be implementing and going live next month on July 1st. The Alliance conducted four provider engagement sessions, these sessions were a way to expand knowledge of hospitals, large safety net clinics, community based organizations, non-profits and other organizations that serve the three populations of focus. The sessions were held in collaboration with our community partners. The Alliance provided engagement sessions at various community meetings such as mental health services ongoing planning council meeting and with Unite Us community partners. The Alliance is hoping to go live with six community supports and with our community partners on a sobering center. Housing services and supports, recuperative care, short term post hospitalization housing, and medically tailored meals services will be offered. Resources are available online on becoming an ECM provider. There is no wrong door to make a referral; there is an online referral form, providers can call 831 430-5512, sub a treatment authorization request, and members and ECM providers can also refer. **Action:** Provider requested Jennifer send her information regarding the training.

C. Behavioral Health Developments

Dr. Bishop presented on Behavioral Health (BH) Developments. This is a priority for the Alliance and part of the Strategic Plan. The vision is to transform the Behavioral Health System. The 2022 - 2023 Tactics include:

- Psych Collaborative Care - integrated behavioral health services billed through the primary care provider, using the new collaborative care codes. Codes would be used by counselors or clinicians in the clinics. More information will be forthcoming.
- No Wrong Door - provides for case management and concurrent coverage across spectrum mild-moderate-severe mental health. This requires the plan to work much more closely with our BH county partners, Beacon, and contracted providers through Beacon. The Alliance will be responsible for comprehensive case management even if services are outside or carved-out.
- Dyadic Care - serving children and their parents together rather than on their own. Community Health Workers could offer additional assistance in clinics. This benefit will become effective January 2023.
- Student Behavioral Health - incentive payments paid through Medi-Cal managed care plans to build infrastructure, partnerships, and capacity

for school behavioral health services. This is to ensure closer collaboration across multiple systems for families.

A provider inquired about school based clinics in Merced County. It was noted, the Alliance is working with the Office of Education and Atwater School District to collaborate to have providers in the school setting. The Alliance will keep provides posted on the progress.

D. Community Health Worker Benefit
The Department of Health Care Services (DHCS) is adding Community Health Worker (CHW) services effective July 1, 2022. The CHW will assist providers with services such as care plans, case management, outreach, and advocacy. CHW services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. CHWs must be supervised by a community-based organization, local health authority, licensed provider, clinic, or hospital. The CHW will assist with a variety of health issues. Additional assistance provided by CHWs will be to provide individual support or advocacy that assists a beneficiary in preventing a health condition, injury, or violence. A provider noted it is difficult to find training for her staff. Training is offered every 6 months and takes a long time to complete. Provider asked about online, in-person, or local training programs. **Action:** The Alliance will look into CHW training options.

Another provider noted the CHW should be from the community and bilingual, this would be helpful and more effective.

6. **Open Discussion**

Chairperson Bishop opened the floor for the Group to have an open discussion.

A provider asked how the Alliance is addressing the formula shortage. Information and resources are kept up-to-date on the Alliance member webpage. The Alliance is connected with WIC and CPS programs and others to make certain information is up-to-date. It was noted, WIC has expanded formula brands they will cover. If there is a member that is on specialty formula, the Alliance can assist. Provider noted food banks and hospitals have formula, but store shelves are empty.

The meeting adjourned at 1:30 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Group

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

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, June 16, 2022
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

Jennie Jet, MD	Provider Representative
Cal Gordon, MD	Provider Representative
Devon Francis, MD	Provider Representative
Sarah Smith, MD	Provider Representative

Committee Members Absent:

John Mark, MD	Provider Representative
Patrick Clyne, MD	Provider Representative
Salvador Sandoval, MD	Provider Representative

Staff Present:

Dale Bishop, MD	Medical Director
Maurice Herbelin, MD	Chief Medical Officer
Gordan Arakawa, MD	Medical Director
Jennifer Mockus, RN	Community Care Coordination Director
Ashley McEowen, RN	Complex Case Management Supervisor
Michelle Stott, RN	QI & Population Health Director
Kelsey Riggs, RN	Complex Case Management Supervisor
Jessie Newton, RN	Care Coordination Manager
Tammy Brass, RN	UM & Complex Case Management Manager
Sarah Sanders	Grievance and Quality Manager
Gisela Taboada	Member Services Call Center Manager
Tracy Neves	Clerk of the Committee

Other Representatives Present:

James Rabago, MD	Board Representative
Becky Shaw	Provider Representative
Laurie Soman	Provider Representative

1. **Call to Order by Chairperson Bishop.**
   Chairperson Dr. Dale Bishop called the meeting to order at 12:00 p.m.
   Roll call was taken.

   Dr. Maurice Herbelin, new CMO, introduced himself to the Committee.

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

No members of the public addressed the Committee.

3. Consent Agenda Items.
A. Approval of WCMCAC Minutes
Minutes from the March 17, 2022 meeting were reviewed.

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

M/S/A Consent agenda items approved.

4. Regular Business.
A. Pharmacy Carve-Out Update
Dr. Bishop noted that on July 1st the Department of Health Care Services (DHCS) was going to require plans to submit prior authorizations (PAs) for medication that was previously approved. DHCS has decided to suspend PAs and health plans will be given 90 day notification prior to implementation of this process. DHCS recognized there were concerns and issues with this process. A provider noted some edits to the implementation were suspended and there was significant push back from providers and patients to delay implementation. DHCS will have phase reinstatements and transitions and training will be provided with opportunities for feedback.

Also noted was the Medi-Cal Rx contract drug list tool is not working, Back-up mechanism not working either. Provider inquired about the need for a sterile compounding pharmacy, and concerns that families are having to pay out-of-pocket. Dr. Bishop noted the Alliance was not able to find a sterile compound pharmacy willing to contract with Medi-Cal Rx. The Alliance has reimbursed patients in the past for emergent needs a case-by-case basis. Providers will need to work with the Alliance Pharmacy department on these medications. Meetings with DHCS and Magellan are happening, and provider will take this information forward regarding sterile compounding issue. Magellan has created a special populations clinical liaison team available from 8:00 AM – 8:00 PM Monday thru Friday to address problematic issues.

B. Whole Child Model California Children's Services (CCS) Referral Updates
Tammy Brass shared referral data from 2021 to current day. Total referral by County for Q1 includes a total of 473 CCS referrals with Merced - 167, Monterey - 233 and Santa Cruz – 72.

CCS Referral Approval Rates by County for Q1:
Merced: 70.5%
Monterey: 59.5%
Santa Cruz: 74.5%
Average Approval Rate: 68.2% higher now that processes have been streamlined.

CCS Referral Denial Rates by County for Q1:
Merced: 20.6%
Monterey: 30.9%
Santa Cruz: 24.3%
Average Denial Rate: 25.3% (the Alliance working to lower this number).

Newly eligible CCS member totals increased in Quarter 1 and was higher than any prior quarter in 2021. There were 388 new members total and increases included Merced - 10%, Santa Cruz - 7% and Monterey - 4 % increase.
Many of the referrals are coming from prior authorization. The Alliance partners and meets with the Counties monthly. The prior authorization team looks for anything trending towards a CCS diagnosis, and the team works proactively monitoring and referring members to specialty care.

A provider asked about the gap in referral totals, Majority of new referrals are coming from Alliance activity identifying authorizations with CCS diagnoses. The gap has developed as a result of decreased referral activity coming from outside the Alliance. Provider inquired about how to make referrals. It was noted some providers send inpatient CCS referrals. Also noted, providers may need some training and communication around the CCS referral process.

C. Non-Emergency Medical Transportation (NEMT) & Non-Medical Transportation (NMT)
Tammy Brass provided an overview of NEMT. If a member is medically unable to utilize other forms of transportation such as a car, bus, train or taxi, the Alliance will arrange transportation for the member based on prescribed transportation service level. This type of transportation is considered NEMT. The NEMT service requires a PA and the level of service needed is based on the Physicians Certification Statement (PCS) form. The NEMT modalities available are:

- NEMT ambulance services
- Van services
- Wheelchair van services
- NEMT by air

All of these require a complete PCS form. The PCS indicates the level of transportation services for Medi-Cal members. The same PCS form can be utilized for 12 months of NEMT services and transportation is arranged by Alliance Transportation Coordinators.

Transportation is a growing need for Alliance members. There have been reports of NEMT provider and access issues such as no shows, late pick-ups, safety concerns and limited NEMT provider availability. The Alliance continues to strengthen communication with vendors. VIP status for all CCS members and tracking of members that require door-to-door service. The Alliance is also actively working on efforts to broaden the NEMT provider network.

Gisela Taboada provided an overview or Non-Medical Transportation (NMT).

NMT is private or public transportation provided to and from Medi-Cal services for eligible beneficiaries. A member calls the Member Services line and goes through an attestation process. The Alliance works with the vendor Call the Car to coordinate rides for Alliance members. Transportation trends from 2021 to 2022 was shared with the Committee. Calls have steadily increased in 2022.due to members getting out into the community more and more awareness about the benefit. Member Services has been doing outreach regarding the transportation benefit. Members will also call if they cannot afford gas.

NMT is a benefit for Medi-Cal members only. NMT is utilized when a member:

- Cannot get in and out of a vehicle without assistance.
- Is not in need of special medical equipment while traveling to or from an approved appointment.
- Can show no other forms of transportation are available.

If a member is eligible for the benefit, the Alliance will determine which transportation option to provide based on the need of the member and will assist with scheduling.

A provider asked about tracking of WCM members and NEMT and NMT as transportation is a concern. More specific information on this topic in the future would be helpful. There have been some NMT issues with drivers such as no shows, late pick-ups and safety concerns. The Alliance continues to strengthen communication with Call the Car and tracks members requiring door-to-door assistance. CCC members are flagged as VIPs in the system. Currently there are not enough drivers for the need statewide, other counties are experiencing similar issues. Providers and members can request VIP status. All CCS members are considered VIP.

5. Open Discussion.

Chairperson Bishop opened the floor for the Committee to have an open discussion.

Provider asked about occupational therapy (OT) as she was made aware that the Dominican center is closing. Provider is concerned that this leaves members without services due to reimbursement issues. This impacts NICU and other vulnerable members. **Action:** The Alliance will discuss reimbursement for OT with Provider Services.

Provider noted transportation services have made it possible for members to go up and down stairs and this has made a dramatic difference. Stair chair service is available for members utilizing NMT.

The meeting adjourned at 1:00 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Committee

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

DATE: September 28, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Department of Health Care Services Medi-Cal Contract Amendments: Term Extension

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Recommendation. Staff recommend the Board authorize the Chairperson to sign Amendments to the Alliance's primary Medi-Cal contract number 08-85216 and to the Alliance's secondary Medi-Cal contract number 08-85223 to extend the term of the contracts through December 31, 2023.

Summary. The Alliance Medi-Cal contracts with the Department of Health Care Services (DHCS) currently extend through December 31, 2022. DHCS is seeking to extend the term of the agreements an additional 12 months.

Background. The Alliance contracts with DHCS to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey and Merced counties. The Alliance entered into the primary Agreement 08-85216 and the secondary agreement 08-85223 with DHCS on January 1, 2009. Each have been amended periodically via written contract amendments to include required regulatory and statutory provisions, program changes, rate adjustments and term extensions.

Discussion. DHCS has offered to extend the term of the agreements through December 31, 2023, to obtain a continuation of the services identified in the original agreements. Board authorization for the Chairperson to sign the Amendments is required. It is expected that this will be the last 12-month extension offered as DHCS will implement an entirely new services agreement with the Alliance effective January 1, 2024.

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

Attachments. N/A

DATE: September 28, 2022

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

FROM: Dr. Dale Bishop, Medical Director

SUBJECT: Peer Review and Credentialing Committee Report of June 8, 2022 and September 14, 2022

Recommendation. Staff recommend the Board accept the decisions from the June 8, 2022 and September 14, 2022 meetings of the Peer Review and Credentialing Committee (PRCC).

Background. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Board) is accountable for all provider credentialing activities. The Board has delegated to the PRCC the authority to oversee the credentialing program for the Central California Alliance for Health (the Alliance).

Discussion. The PRCC is currently a six-member committee comprised of Alliance-contracted physicians who make recommendations to approve, defer, or deny network participation for new and existing providers based on established credentialing criteria. The committee meets quarterly. The PRCC also conducts peer review of network providers and offers advice and expertise when making credentialing decisions. Provider credential verification and review ensures that network providers possess the legal authority, relevant training and experience, and professional qualifications necessary to provide a level of care consistent with professionally recognized standards. The Alliance credentialing standards are aligned with applicable credentialing and certification requirements of the State of California, the Department of Health Care Services, the Department of Managed Health Care and, as appropriate, the National Committee for Quality Assurance.

June 8, 2022 Meeting

- New Providers:
  - 22 Physician Providers (MD, DO, DPM)
  - 27 Non-Physician Medical Practitioners
  - 4 Allied Providers
  - 6 Organizations
  - 13 ECM/CS

- Recredentialed Providers:
  - 61 Physician Providers (MD, DO, DPM)
  - 14 Non-Physician Medical Practitioners
  - 5 Allied Providers
  - 12 Organizations

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

September 14, 2022 Meeting

- New Providers:
    - 22 Physician Providers (MD, DO, DPM)
    - 21 Non-Physician Medical Practitioners
    - 1 Allied Providers
    - 4 Organizations
    - 12 ECM/CS

- Recredentialed Providers:
    - 87 Physician Providers (MD, DO, DPM)
    - 25 Non-Physician Medical Practitioners
    - 3 Allied Providers
    - 21 Organizations

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

Attachments. N/A

DATE: September 28, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Alliance 2022-2026 Strategic Plan Outcome Measures

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

Background. In September 2021, the Board approved the Alliance 2022-2026 Strategic Plan. The ambitious five-year plan focuses on two strategic priorities: Health Equity and Person-Centered Delivery System Transformation each with two goals. Staff have prepared outcome measures to assess organizational performance against the four strategic goals.

Discussion. The outcome measures that are tracked internally and by Beacon will be reported out quarterly in tandem with the publication of the Alliance Dashboard. The annual measures will be reported out in the Q2 Alliance Dashboard each year.

Health Equity

Health equity means that everyone has a fair and just opportunity to be as healthy as possible to fully address health inequities, the Alliance will seek to understand root causes of health disparities, particularly those experienced by members who identify as Black, Indigenous and people of color (BIPOC).

Goal 1 - Eliminate health disparities and achieve optimal health outcomes for children and youth.

The Strategic Plan Outcome Measures for this goal will focus on closing racial/ethnic disparities in well-child visits and immunizations. The measures will be detailed by race/ethnicity and rolled up in to the below contributing measures.

Contributing Measures	Goal	2021	Data Source
Close racial/ethnic disparities for children's well-child visits in Merced County.	NCQA 90th percentile by 2026	41%	Annual MCAS scores
Close racial/ethnic disparities well-child visits for children in the first 15 months in Santa Cruz, Monterey, and Merced.		Merced: 31% SCMON: 51%	
Close racial/ethnic disparities for well-child visits for age 15-30 month in Merced.		55%	
Close racial/ethnic disparities in childhood immunizations by age 2 in Merced.		17%	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Goal 2 – Increase member access to culturally and linguistically appropriate health care.

The Strategic Plan Outcome Measures for this goal will focus on members reporting culturally and linguistically appropriate care by their personal doctor.

Contributing Measures	Goal	2021	Data Source
Members reporting they were treated unfairly by their personal doctor because they did not speak English well.	Pending 2022 survey completion	Will receive baseline data for 2022	Annual CAHPS survey
Members reporting they were treated unfairly by their personal doctor because of race or ethnicity.			
Members reporting that their personal doctor (or office staff) did or said something that made them feel that they did not understand their culture or language.			

Person-Centered Delivery System Transformation

Throughout the planning process, the Alliance identified the need to center on the people it serves rather than the health care services it delivers. Such a shift requires a transformation to honor the dignity and self-determination of members and to focus on their health as the intended result, rather than the delivery of health care services alone. This idea represents an evolution towards a system that yields member health through shared decision making and action, rather than a system that simply delivers health care services.

Goal 1 – Improve behavioral health services and systems to be person-centered and equitable.

The Strategic Plan Outcome Measures for this goal will focus on members self-reporting on their mental or emotional health, timely access to behavioral health services, and follow up rates.

Contributing Measures	Goal	2021	Data Source
Members (adult and child) reporting very good, or excellent mental or emotional health.	SPH Book of Business 90th percentile by 2026	Adults: 34% Children: 66%	Annual CAHPS Survey scores
Timely Access to Behavioral Health Services	95%	65%	Beacon's Timely Access Survey
Follow up rate after emergency room visits for mental health	NCQA 90th percentile by 2026	Merced:30% SCMON: 27%	Annual MCAS scores
Follow up rate after emergency room visits for substance use disorder		Merced: 6% SCMON:10%	

Goal 2- Improve the system of care for members with complex medical social needs.

The Strategic Plan Outcome Measures for this goal will focus on access to and utilization of appropriate services for members with complex medical and social needs.

<table>
<tr><th>Contributing Measures</th><th>Goal</th><th>2021</th><th>Data Source</th></tr>
<tr><td>Access to Preventive/Ambulatory Care Services for members aged 20-44</td><td>NCQA 90th percentile by 2026</td><td>Merced: 68%
SCMON: 68%</td><td>Annual MCAS scores</td></tr>
<tr><td>30-Day All-Cause Readmissions</td><td>20% reduction in SPD readmissions by 2026</td><td rowspan="3">2022 baseline by line of business TBD</td><td>Annual MCAS Scores</td></tr>
<tr><td>Emergency Department visit/1,000 members/year</td><td>20% reduction in SPD utilization by 2026</td><td>Annual MCAS Scores</td></tr>
<tr><td>Timely follow-up care after discharge</td><td>50% of SPD members have post-discharge visits by 2026</td><td>Internal Reporting</td></tr>
</table>

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

Attachments. N/A

Biography for Bobbie Wunsch

Bobbie Wunsch, founder and partner of Pacific Health Consulting Group, has worked with the health care safety net to secure increased access for disadvantaged communities throughout California. Finding appropriate financing and sustaining high performing comprehensive health services for low-income individuals in a continually changing environment occupies most of Bobbie's time today. Bobbie has had the privilege of working closely with hundreds of safety net staff and observed first-hand their dedication to the communities they serve and their persistence and innovation in the face of constant challenges. Bobbie plays a unique role in California working at the nexus of community health centers and clinics, public hospitals and county health departments, Medi-Cal managed care plans, the State of California and the statewide health foundations to increase access to care and expand coverage to uninsured and low-income residents of the state.

Bobbie's consulting work with community health centers, California counties and local publicly operated health plans and their related associations stimulates new partnerships and supports the spread of innovations to improve quality, care and operations in the safety net. Her work has also included consultation on women's health and reproductive health programs as well as the creation of the FamilyPACT program and to many counties to expand coverage for uninsured children through the Healthy Kids Program and Children's Health Initiatives and to uninsured low-income adults as well as the development and implementation of many of California's local public Medi-Cal managed care plans. Bobbie continues to provide consultation on strategic planning, program development and cooperative business ventures.

Bobbie is well-known for organizing and facilitating high profile meetings for a wide variety of health organizations focused on issues impacting the safety net including her work with the California Department of Health Care Services on the last three 1115 stakeholder groups, her on-going work with the DHCS Stakeholder Advisory Committee and CPCA's Workforce Policy Coalition. Bobbie was the lead consultant to the Blue Shield of California Foundation in the development and on-going operations of the Clinic Leadership Institutes, designed for emerging leaders in community health centers, for 15 years.

In 2017, Bobbie was the recipient of the California Primary Care Association's Hero Award in recognition of her contributions.

Biography for Mark Ghaly, MD, MPH

Dr. Mark Ghaly was appointed Secretary of the California Health and Human Services Agency in early 2019 by Governor Gavin Newsom.

In serving California, Dr. Ghaly has the privilege of working with partners across sectors and disciplines to improve the lives and life chances of ALL Californians. This has been especially true during our response to the COVID-19 pandemic.

Dr. Ghaly is a primary care pediatrician who continues to use his clinical and community experiences, working in California's health care safety net system, to inform a whole person, whole community, approach to integrating services so they are equity-anchored and person-centered for ALL, but especially the most vulnerable Californians.

Dr. Ghaly holds the deep belief that together our collective efforts can not only serve Californians well today but set us on a path where ALL Californians have a brighter and healthier future.

Nothing he does can be done well without the support of his wife, Dr. Christina Ghaly, and his 4 young children.

GUIDING PRINCIPLES & STRATEGIC PRIORITIES

Person centered • Equity focused • Data driven

GUIDING PRINCIPLES

FOCUS ON EQUITY

We must be a leader in the fight for equity and strive to create programs that address persistent and systemic inequities. The COVID-19 pandemic showed us how so many people are far behind and that the distance to make up to achieve equity is driven by historical, deep seated structural factors of racism, sexism and other forms of discrimination. In order to create a state where all of us can have a chance to thrive based on our efforts and hard work, we cannot allow certain groups and individuals to be disadvantaged because of the color of their skin, gender identity, sexual orientation, age or disability. We will seek to lift all boats, but some boats need to be lifted more.

ACTIVELY LISTEN

We must be better and more active listeners. This will require us to take a step back and proactively listen to the individuals and communities we are serving to better understand their conditions and the things they yearn for. As a result, we will formulate better policies, programs and services that truly meet the needs of the individuals, families and communities we serve.

USE DATA TO DRIVE ACTION

We must better leverage our data to understand the current conditions in our communities, the impact of our existing programs and the opportunities to improve service delivery. While we have built good systems to amass data, we find ourselves data rich but information poor. Actionable and timely data will help us advance social and economic mobility and improve the health and well-being of children, families and individuals.

SEE THE WHOLE PERSON

We must always think about what each person needs to thrive, always considering the cultural, economic and social factors that impact people's lives. We will integrate shared opportunities to meet individual needs across departments–both within government and across our community partners. Our focus will be on the needs of the people we serve, not on the siloed structures of government and its programs.

PUT THE PERSON BACK IN PERSON-CENTERED

We must re-engage individuals and their communities so that programs are informed and structured to meet the diverse and unique needs of each community and person. Too often, "personcentered" programs stopped being about people and became focused on satisfying a specific funding source or administrative process. We will refocus our programs on the people being served.

CULTIVATE A CULTURE OF INNOVATION

We must courageously take new approaches to solve our most intractable problems. The relentless pursuit of innovation, applied thoughtfully, will catalyze our improvement efforts. We will also design programs and services across departments, including those outside CalHHS, in collaborative and partnership.

DELIVER ON OUTCOMES

We must ensure that the delivery of our programs and services yield concrete and meaningful results. We will focus our attention and energy on work which will directly improve the lives of all Californians. We will continuously evaluate and adapt our programs to better address our clients' unmet needs while furthering our goal of delivering positive outcomes.

OUR NORTHSTAR

HEALTHY CALIFORNIA FOR ALL

We envision a Healthy California for All where every individual belongs to a strong and thriving community.

Where all our children can play and learn, and where we are confident that we have done all we can to pass to them a state they can lead into the future.

Where older and disabled Californians can live with purpose and dignity, and where they are supported and valued.

Where equity is not just a word or concept but the core value.

Where we constantly pursue social and racial justice by not only lifting all boats but especially those boats that need to be lifted more.

Where health care is affordable, accessible, equitable and high-quality so it drives toward improved health.

Where we prioritize prevention and the upstream factors that impact an individual's health and well-being.

Where we are committed to tackling the economic inequalities that force many Californians to live on the street.

Where necessities like housing and childcare are complimented by access to physical and behavioral health services.

Where we see the whole person and where programs and services address the social, cultural and linguistic needs of the individuals they serve.

Where climate threats collide with forward leaning health practices and policies that visibly turn the tide toward community resilience.

And where we see our diversity as a strength, and where we embrace a joint responsibility to take care of one another.

STRATEGIC PRIORITIES

CREATE AN EQUITABLE PANDEMIC RECOVERY

- Strengthen California's safety net programs to disrupt the inequities and disparities that fueled the pandemic in order to lift families out of poverty and create economic selfsufficiency.
- Work to achieve a California where race, ethnicity, gender identity, sexual orientation and other forms of social categorization no longer predict a person's or community's health and life outcomes.
- Build new and innovative paths to train and hire culturally competent workers to meet the full diversity of California's health and human services needs.
- Develop a 21st century public health system that builds on a core set of functions that are disease agnostic and support the work of local public health department.

BUILD A HEALTHY CALIFORNIA FOR ALL

- Ensure all Californians have meaningful and timely access to care by enhancing technological infrastructure, developing new and innovative workforce models and expanding care delivery capacity.
- Promote a whole person orientation to care that is focused on prevention and is delivered in a culturally and linguistically appropriate manner.
- Reduce the rate of growth in health care costs and increase public transparency of the quality of care and equity of health care delivery.
- Build climate resilient communities in which every Californian, regardless of origin or income, has access to high-quality, affordable health care.

INTEGRATE HEALTH AND HUMAN SERVICES

- Build consensus on a common set of policies and procedures to govern the exchange of health and human services information among health and social services entities in order to improve health outcomes.
- Recognize and utilize Medi-Cal as a tool to help address many of the complex challenges facing California's most vulnerable residents, including the homeless, those with mental health conditions, children with complex medical conditions, those who are justice-involved and the growing aging population.
- Transform California's mental health and substance use disorder systems by increasing the availability of prevention and outpatient services and treatments, as well as stabilizing and expanding the overall number of community-based placements for individuals who require residential support on their path to greater self-reliance and independence.
- Address the upstream social determinants, including housing and food insecurity, which disproportionately impact communities of color, drive disease and worsen health and economic disparities.

IMPROVE THE LIVES OF THE MOST VULNERABLE

- Reduce homelessness, especially chronic homelessness, by focusing on a "housing first" strategy and building up permanent supportive housing and the support services needed by those we house, including employment support, substance abuse treatment, and mental health treatment as a path out of poverty.
- Provide opportunities for Californians with intellectual and developmental disabilities, regardless of the severity of their disability, to prepare for and participate in competitive integrated employment.
- Move toward paying for outcomes in the developmental services system by implementing rate reforms and developing the capability to adequately track and measure outcomes at the regional center, service provider and consumer level.
- Expand diversion, re-entry and reintegration services so that anyone released from an incarcerated setting can reintegrate into the community seamlessly with access to health and social services.
- Expand diversion, re-entry and reintegration services so that anyone released from an incarcerated setting can reintegrate into the community seamlessly with access to health and social services.

ADVANCE THE WELL-BEING OF CHILDREN AND YOUTH

- Transform California's behavioral health system into an innovative ecosystem where all children and youth age 25 and younger have access to a full continuum of services, in ways that are easily accessible and culturally appropriate for children, youth, and their families.
- Improve outcomes for children living in extreme poverty, in foster care and in juvenile justice system by addressing adverse childhood experiences, early childhood and education needs, and improving access to physical health, mental health and social services.
- Promote parental responsibility to enhance the well-being of children by providing child support services to establish parentage and collect child support.
- Ensure the health and well-being of children and youth with complex needs who receive services from multiple and at times fragmented public systems.
- Ensure fewer children encounter the juvenile justice system by building up the network of trauma informed, community-based, culturally appropriate interventions to support these young Californians before such encounters, and for those who have an encounter, to divert them early and often toward community-based interventions and away from institutional interventions.

BUILD AN AGE-FRIENDLY STATE FOR ALL

• Mobilize state government, local communities, private organization and philanthropy to harness the state's innovative spirit, channel resources where they are needed most, and open new opportunities for working together to create inclusive, equitable communities for all Californians of all ages.

• Create more choices for home and community living as we age, including expanded service options, affordable and accessible housing models, health care partnerships with Medi-Cal and Medicare, and support for family and paid caregivers – with easier navigation and care coordination for diverse adults and families.

• Support healthy aging for all, by reducing health inequities and disparities across the lifespan, preventing and addressing isolation as we age, and expanding dementia awareness and geriatric care.

• Protect older and disabled adults from abuse, neglect, and exploitation both at home and in congregate facilities, while ending older adult homelessness and prevent poverty and hunger as we age.

Biography for Rodney Whitlock, Ph.D.

Rodney is an accomplished health care advisor with more than two decades on the Hill in the House and Senate where he specialized in rural health, the health care safety net and disability policy. While working in Congress, Rodney served as former US Representative Charlie Norwood's (R-GA) health policy director, where he managed the Patients' Bill of Rights (S.1890), among other notable health policy matters. During his time in the Senate as health policy director to Senator Chuck Grassley (R-IA), Rodney helped staff Republicans in the Senate on such prominent and essential legislation as the Deficit Reduction Act of 2005, Tax Relief and Health Care Act of 2006, CHIP Reauthorization Act of 2007 and 2009 and Affordable Care Act of 2010. Rodney possesses and offers clients the kind of knowledge that is uniquely available to those who have drafted and advanced legislation. He strategically guides clients through dense Medicare and Medicaid issues that have significant business impact.

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HEALTHY PEOPLE. HEALTHY COMMUNITIES.

BRIEFING ROOM

FACT SHEET: The President's Budget for Fiscal Year 2023

MARCH 28, 2022 • PRESS RELEASES

Under the President's leadership, America is on the move again. We created more than 6.5 million jobs in 2021, the most our country has ever recorded in a single year. Our economy grew at 5.7 percent, the strongest growth in nearly 40 years. And the unemployment rate has fallen to 3.8 percent, the fastest decline in recorded history. At the same time, the deficit fell last year—by around $300 billion. This progress was a direct result of the President's strategy to grow the economy from the bottom up and the middle out and his effective management of the American Rescue Plan—a strategy that was built on smart, fiscally prudent investments that helped jumpstart our economy.

As our historic economic and labor market recovery continues, the President's Budget projects that the deficit in 2022 will be more than $1.3 trillion lower than last year's—the largest ever one-year decline in our country's history. The strongest economic growth in four decades, powered by the American Rescue Plan, has also contributed to a historic decline in the deficit—by fueling strong revenue growth and allowing the Administration to responsibly phase down emergency pandemic-related spending.

Today, the President released a Budget that details his vision to expand on our economic and fiscal progress—investing in our economy and our people while cutting deficits, improving our country's long-term fiscal outlook, and keeping the economic burden of debt low.

As he made clear in his State of the Union address, the President is committed to working with Congress to enact legislation that lowers costs for American families, expands the productive capacity of the American economy, and further reduces the deficit: by reducing prescription drug costs and fixing the tax code to ensure corporations and wealthy people pay the taxes they already owe and close loopholes they exploit.

The President's FY 2023 Budget also proposes additional smart, targeted investments designed to spur durable economic growth, create jobs, reduce cost pressures, and foster shared prosperity. These investments are more than fully paid-for through tax reforms that ensure corporations and the wealthiest Americans pay their fair share, while also fulfilling the

President's ironclad promise that no one earning less than $400,000 per year will pay an additional penny in new taxes. Overall, the Budget reduces deficits by more than $1 trillion over the next 10 years and deficits under the Budget policies would fall to less than one-third of the 2020 level the President inherited.

The Budget improves our country's long-term fiscal outlook while also delivering on the ambitious agenda the President laid out in his State of the Union address—to build a better America, reduce costs for families, advance equity, and grow our economy from the bottom up and the middle out. It proposes significant new investments in proven strategies to reduce gun crime and keep our communities safe. It makes additional investments in the American people that will help lay a stronger foundation for shared growth and prosperity. It advances a bipartisan unity agenda through proposals to take on the mental health crisis, combat the opioid epidemic, support our veterans, and accelerate progress against cancer. And during what will be a decisive decade, it strengthens our military and leverages America's renewed strength at home to meet pressing global challenges, deepen partnerships and alliances, and manage crises as they arise.

PUTTING THE NATION ON A SOUND FISCAL AND ECONOMIC COURSE

The Budget proposes smart, targeted, fully-offset investments while also cutting deficits, improving our country's long-term fiscal outlook, and keeping the economic burden of debt low. The Budget's investments are more than paid for with tax reforms focused on making sure the rich and the largest corporations pay their fair share, reducing deficits by over $1 trillion over the next 10 years.

- The tax code currently offers special treatment for the types of income that wealthy people enjoy. This special treatment, combined with sophisticated tax planning and giant loopholes, allows many of the very wealthiest people in the world to end up paying a lower tax rate on their full income than many middle-class households. To finally address this glaring problem, the Budget includes a minimum tax on multi-millionaires and billionaires who so often pay indefensibly low tax rates. This minimum tax would apply only to the wealthiest 0.01 percent of households—those with more than $100 million—and over half the revenue would come from billionaires alone. It would ensure that, in any given year, they pay at least 20 percent of their total income in Federal income taxes.

- **Ensures Corporations Pay Their Fair Share.** The Budget also includes an increase to the rate that corporations pay in taxes on their profits. Corporations received an enormous tax break in 2017. While their profits have soared, their investment in our economy did not: the tax breaks did not trickle down to workers or consumers. Instead of allowing some of the

most profitable corporations in the world to avoid paying their fair share, the Budget raises the corporate tax rate to 28 percent, still the lowest tax rate faced by corporations since World War II except in the years after the 2017 tax cut. This increase is complemented by other changes to the corporate tax code that incentivize job creation and investment in the United States and ensure that large corporations pay their fair share.

- **Prevents Multinational Corporations from Using Tax Havens to Game the System.** For decades, American workers and taxpayers have paid the price for a tax system that has rewarded multinational corporations for shipping jobs and profits overseas. Last year, the Administration rallied more than 130 countries to agree to a global minimum tax that will ensure that profitable corporations pay their fair share and will incentivize U.S. multinationals to create jobs and invest in the United States. The Budget contains additional measures to ensure that multinationals operating in the United States cannot use tax havens to undercut the global minimum tax.

Advancing Legislation to Lower Costs, Reduce the Deficit, and Expand Productive Capacity

The President is committed to working with Congress to sign legislation that lowers costs for American families, reduces the deficit, and expands the productive capacity of the American economy. That means cutting costs for prescription drugs, healthcare premiums, child care, long-term care, housing, and college; reducing energy costs by combatting climate change and accelerating the transition to a clean energy economy; supporting families by providing access to free, high-quality preschool, up to two years of free community college, nutritious food at school and resources to purchase food over the summer months, and paid family and medical leave and by continuing the enhanced Child Tax Credit and Earned Income Tax Credit; and providing health coverage to millions of uninsured Americans. The President believes these proposals must be paired with reforms that ensure corporations and the wealthiest Americans pay their fair share, including ensuring that they pay the taxes they already owe.

Because discussions with Congress continue, the President's Budget includes a deficit neutral reserve fund to account for a future agreement, preserving the revenue from tax and prescription drug reforms the President proposed last year for this legislation for the investments needed to bring down costs for American families and expand our productive capacity.

BUILDING A BETTER AMERICA

The Budget includes smart, targeted investments in the American people that will help build a better America. It will keep our communities safe and combat violent crime; promote job

creation and expand the productive capacity of our economy; improve our public health infrastructure; ensure America leads the world in combating the climate crisis; and advance equity and opportunity for all. It strengthens our military and leverages America's renewed strength at home to meet pressing global challenges, deepen partnerships and alliances, and manage crises as they arise.

Combating Crime to Keep Our Communities Safe

- The Budget provides $3.2 billion in discretionary resources for State and local grants, and $30 billion in mandatory resources to support law enforcement, crime prevention, and community violence intervention, including putting more officers for community policing on the beat across the Nation.

- The Budget provides $1.7 billion for the Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) to expand multijurisdictional gun trafficking strike forces with additional personnel, increase regulation of the firearms industry, enhance ATF's National Integrated Ballistic Information Network, and modernize the National Tracing Center.

- Under the President's Budget, key Federal law enforcement agencies like the FBI and U.S. Marshals Service will have the resources they need fight violent crime, including through fugitive apprehension and enforcement operations. The Budget also ensures U.S. Attorneys have the necessary support to prosecute violent crimes.

- The Budget makes important investments to support law enforcement while addressing longstanding inequities and strengthening civil rights protections. The Budget invests $367 million, an increase of $101 million over the 2021 enacted level, at the Department of Justice to support police reform, the prosecution of hate crimes, enforcement of voting rights, and efforts to provide equitable access to justice.

- The Budget includes $100 million for a historic multi-agency collaboration to provide comprehensive workforce development services to people in the Federal prison system and proposes $106 million to support the deployment of body-worn cameras to DOJ's law enforcement officers.

Promoting Job Creation, Reducing Cost Pressures, and Boosting Productive Capacity

- In communities throughout the country, rents are skyrocketing and homeownership is becoming increasingly out of reach. This strains family budgets and holds back our economy – making it harder for workers to afford to live near good jobs and good transportation options. To address the critical shortage of affordable housing in

communities throughout the Nation, the Budget proposes $50 billion for housing construction and supply – addressing existing market gaps and helping to stabilize housing prices over the long-term. This includes funding, via the Department of Housing and Urban Development, for state and local housing finance agencies and their partners to provide grants, revolving loan funds, and other streamlined financing tools to boost housing supply, with a particular focus on housing types that have traditionally been difficult to finance using existing Federal financing but have the potential to boost supply and density in supply-constrained communities. The Budget also includes grants to advance and reward state and local jurisdictions' efforts to remove barriers to affordable housing development. It also includes modifying Low-Income Housing Tax Credits to better incentivize new unit production, and funding for the Department of the Treasury's Community Development Financial Institutions Fund to support financing of new construction and substantial rehabilitation that creates net new units of affordable rental and for sale housing.

- **Accelerates Efforts to Move More Goods Faster through American Ports and Waterways.** The Budget continues support for the historic levels of Federal investment to modernize America's port and waterway infrastructure provided under the Bipartisan Infrastructure Law. It includes $230 million for the Port Infrastructure Development Program to strengthen maritime freight capacity, as well as $1.7 billion in spending for the Harbor Maintenance Trust Fund to facilitate safe, reliable, and environmentally sustainable navigation at coastal ports.

- **Strengthens the Nation's Supply Chains through Domestic Manufacturing.** To help ignite a resurgence of American manufacturing and strengthen domestic supply chains, the Budget provides $372 million, an increase of $206 million over the 2021 enacted level, for the National Institutes of Standards and Technology's (NIST) manufacturing programs to launch two additional Manufacturing Innovation Institutes in 2023 and continue support for the two institutes funded in 2022. The Budget includes a $125 million increase for the Manufacturing Extension Partnership to make America's small and medium manufacturers more competitive. The Budget also invests $200 million for a new Solar Manufacturing to build domestic capacity in solar energy supply chains while moving away from imported products.

- **Expands Access to Registered Apprenticeships and Equips Workers with Skills They Need to Obtain High-Quality Jobs.** The Budget invests $303 million, a $118 million increase above the 2021 enacted level, to expand Registered Apprenticeship opportunities in high growth fields, such as information technology, advanced manufacturing, health care, and transportation, while increasing access for historically underrepresented groups,

including people of color and women. In addition, the Budget invests $100 million to help community colleges work with the public workforce development system and employers to design and deliver high-quality workforce training programs. The Budget also provides $100 million for a new Sectoral Employment through Career Training for Occupational Readiness program, which will support training programs focused on growing industries, enabling disadvantaged workers to enter on-ramps to middle class jobs, and creating the skilled workforce the economy needs to thrive.

- **Fosters Competitive and Productive Markets and Targets Corporate Concentration.** The Budget reflects the Administration's commitment to vigorous marketplace competition through robust enforcement of antitrust law by including historic increases of $88 million for the Antitrust Division of the Department of Justice (ATR) and $139 million for the Federal Trade Commission (FTC).

Restoring American Leadership and Confronting Global Threats

- **Supports United States' European Allies and Partners**. The Budget includes $6.9 billion for the European Deterrence Initiative, the North Atlantic Treaty Organization (NATO), and countering Russian aggression to support Ukraine, the United States' strong partnerships with NATO allies, and other European partner states by bolstering funding to enhance the capabilities and readiness of U.S. Forces, NATO allies, and regional partners in the face of Russian aggression.

- **Defends Freedom Globally**. To support American leadership in defending democracy, freedom, and security worldwide, the Budget includes nearly $1.8 billion for the State Department and USAID to support a free and open, connected, secure, and resilient Indo-Pacific Region and the Indo-Pacific Strategy, and $400 million for the Countering the People's Republic of China Malign Influence Fund. In addition, the Budget provides nearly $1 billion in assistance to Ukraine for State Department, USAID, and Department of Defense to counter Russian malign influence and to meet emerging needs related to security, energy, cyber security issues, disinformation, macroeconomic stabilization, and civil society resilience.

- **Promotes Integrated Deterrence in the Indo-Pacific and Globally.** The Budget proposes $773 billion for the Department of Defense. To sustain and strengthen deterrence, the Budget prioritizes China as the Department's pacing challenge. DOD's 2023 Pacific Deterrence Initiative highlights some of the key investments the Department is making that are focused on strengthening deterrence in the Indo-Pacific region. DOD is building the concepts, capabilities, and posture necessary to meet these challenges, working in

concert with the interagency and our allies and partners to ensure our deterrence is integrated across domains, theaters, and the spectrum of conflict.

- **Renews America's Leadership in International Institutions**. The Budget continues the Administration's efforts to lead through international organizations by meeting the Nation's commitments to fully fund U.S. contributions and to pay United Nations peacekeeping dues on time and in full. The Budget also provides $1.4 billion for the World Bank's International Development Association (IDA). This investment restores the United States' historical role as the largest World Bank donor to support the development of low- and middle-income countries, which benefits the American people by increasing global stability, mitigating climate and health risks, and developing new markets for U.S exports.

- **Advances Equity and Equality Globally.** The Budget provides $2.6 billion to advance gender equity and equality across a broad range of sectors. This includes $200 million for the Gender Equity and Equality Action Fund to advance the economic security of women and girls. This total also includes funding to strengthen the participation of women in conflict prevention, resolution, and recovery through the implementation of the Women, Peace, and Security Act.

- **Advances American Leadership in Global Health, Including Global Health Security and Pandemic Preparedness.** The Budget includes $10.6 billion to bolster U.S. leadership in addressing global health and health security challenges. Within this total, the Budget supports a $2 billion contribution to the Global Fund's seventh replenishment, for an intended pledge of $6 billion over three years, to save lives and continue the fight against HIV/AIDS, tuberculosis, and malaria, and to support the Global Fund's expanding response to COVID-19 and global health strengthening. This total also includes $1 billion to prevent, prepare for, and respond to future infections disease outbreaks, including the continued expansion of Global Health Security Agenda capacity-building programs and a multilateral financial intermediary fund for health security and pandemic preparedness

Strengthening America's Public Health & Advancing Cures for Cancer and Other Diseases

- **Prepares for Future Pandemics and Other Biological Threats**. In addition to combatting the ongoing COVID-19 pandemic, the United States must catalyze advances in science, technology, and core capabilities to prepare for future biological threats. The Budget makes transformative investments in pandemic preparedness across the Department of Health and Human Services (HHS)—$81.7 billion available over five years—to enable an agile, coordinated, and comprehensive public health response to protect American lives, families, and the economy.

- **Builds Advanced Public Health Systems and Capacity.** The Budget includes $9.9 billion to build capacity at CDC and state and local levels to improve the core immunization program, expand public health infrastructure in States and Territories, strengthen the public health workforce, support efforts to modernize public health data collection, increase capacity for forecasting and analyzing future outbreaks, including at the Center for Forecasting and Outbreak Analytics, and conduct studies on Long COVID to inform diagnosis and treatment options.

- **Transforms Mental Health Care.** The United States faces a mental health crisis that has been exacerbated by the COVID-19 pandemic. The Budget proposes reforms to health coverage and invests in the behavioral health workforce. It provides sustained and increased funding for community-based centers and clinics, and mental health staff in schools, makes historic investments in youth mental health and suicide prevention programs, and strengthens access to crisis services by building out the National Suicide Prevention Lifeline and crisis services infrastructure. These resources will help build system capacity, connect more Americans to care, and create a system of support to improve mental health for all.

- **Advances Maternal Health and Health Equity.** The United States has the highest maternal mortality rate among developed nations, with an unacceptably high mortality rate for Black and American Indian and Alaska Native women. The Budget includes $470 million to reduce maternal mortality and morbidity rates, expand maternal health initiatives in rural communities, implement implicit bias training for healthcare providers, create pregnancy medical home projects, and address the highest rates of perinatal disparities. The Budget also expands maternal and other health initiatives in rural communities to improve access to high-quality care.

- **Accelerates Innovation through the Advanced Research Projects Agency for Health (ARPA-H).** The Budget proposes a major investment of $5 billion for ARPA-H, significantly increasing direct Federal research and development (R&D) spending in health to improve the health of all Americans. With an initial focus on cancer and other diseases such as diabetes and dementia, this major investment will drive transformational innovation in health technologies and speed the application and implementation of health breakthroughs.

Taking Historic Steps to Combat the Climate Crisis and Advance Environmental Justice

- **Invests in Clean Energy Infrastructure and Innovation.** The Budget invests $3.3 billion to support clean energy projects that will create good paying jobs, continue to cut to cost

of clean energy, and drive progress toward President Biden's climate goals. Investments include $502 million to weatherize and retrofit low-income homes, including $100 million for a new LIHEAP Advantage pilot to electrify and decarbonize low-income homes, and $260 million to support energy efficiency improvements to USDA-assisted multifamily homes. In addition, the Budget provides $150 million to electrify Tribal homes and transition Tribal colleges and universities to renewable energy, and $80 million for a new Grid Deployment Office to build the grid of the future.

- **Strengthens Climate Resilience.** The Budget provides more than $18 billion for climate resilience and adaptation programs across the Federal Government. These critical investments will reduce the risk of damages from floods and storms, restore the Nation's aquatic ecosystems, and make HUD-assisted multifamily homes more climate resilient. In line with President Biden's commitment to ensure the American's fighting wildfires earn $15 an hour, the Budget includes $1.8 billion in the Forest Service and Department of the Interior to strengthen the Federal firefighting workforce, increase capacity, and improve firefighter compensation.

- **Advances Equity and Environmental Justice.** The Budget provides historic support for underserved communities, and advances the President's Justice40 commitment to ensure 40 percent of the benefits of Federal investments in climate and clean energy reach disadvantaged communities. The Budget includes $1.45 billion to bolster the EPA's environment justice efforts that will help create good-paying jobs, clean up pollution, implement Justice40, advance racial equity, and secure environmental justice for communities that too often have been left behind

- **Achieves the President's Historic Climate Pledge.** The Budget includes over $11 billion in international climate finance, meeting the President's pledge to quadruple international climate finance a year early. This funding will accelerate the global energy transition to net zero emissions by 2050; help developing countries build resilience to the growing impacts of climate change, including through the President's Emergency Plan for Adaptation and Resilience and other programs; and support the implementation of the President's Plan to Conserve Global Forests. Among these critical investments are $1.6 billion for the Green Climate Fund, a critical multilateral tool for financing climate adaptation and mitigation projects in developing countries and support for a $3.2 billion loan to the Clean Technology Fund to finance clean energy projects in developing countries.

Expanding Economic Opportunity, Advancing Equity, and Strengthening our Democracy

- **Makes Historic Investments in K-12 Schools and Education Beyond High School.** The Budget more than doubles funding for Title I compared to the 2021 enacted level through a combination of discretionary and mandatory funding. This substantial funding, which serves 25 million students in nearly 90 percent of school districts across America, is a major step toward fulfilling the President's commitment to addressing long-standing funding disparities between under-resourced schools—which disproportionately serve students of color—and their wealthier counterparts. The Budget increases support for children with disabilities by providing a $3.3 billion increase for IDEA Grants to States – the largest two-year increase ever for the program. The budget also doubles funding for IDEA Grants for Infants and Families and proposes to reforms to increase equitable access to early intervention services with a proven record for improving academic and developmental outcomes. The Budget also provides $1 billion in sustainable funding to help schools increase the number of school counselors, psychologists, social workers and other health professionals. The Budget provides an additional $438 million for Full Service Community Schools, ramping up the mental health and wraparound supports in schools for students and their families. The Budget proposes to double the maximum Pell Grant by 2029, beginning with a historic $2,175 increase over the 2021-2022 school year, thereby expanding access and helping nearly 6.7 million students afford college.

- **Advances Child and Family Well-Being in the Child Welfare System.** The Budget proposes to expand and incentivize the use of evidence-based foster care prevention services to keep families safely together and to reduce the number of children entering foster care, while also targeting resources to reduce the overrepresentation of children and families of color in the child welfare system. For children who do need to be placed into foster care, the Budget provides States with support to place more children with relatives or other adults who have an existing emotional bond with the child and fewer children in group homes and institutions while also providing additional funding to improve the educational outcomes of foster youth and support youth who age out of care without a permanent caregiver.

- **Guarantees Adequate and Stable Funding for the Indian Health Service (IHS).** The Budget significantly increases IHS's funding over time, and shifts it from discretionary to mandatory funding. For the first year of the proposal, the Budget includes $9.1 billion in mandatory funding, an increase of $2.9 billion above 2021. After that, IHS funding would automatically grow to keep pace with healthcare costs and population growth and gradually close longstanding service and facility shortfalls. Providing IHS stable and predictable funding will improve access to high quality healthcare, rectify historical

underfunding of the Indian Health system, eliminate existing facilities backlogs, address health inequities, and modernize IHS' electronic health record system.

- **Protects Our Elections and the Right to Vote.** As our democracy faces threats across the country—and to provide state and local election officials with a predictable funding stream for critical capital investments and increased staffing and services—the Budget proposes $10 billion in new elections assistance funding to be allocated over ten years. The Budget also proposes to fund an expansion of U.S. Postal Service delivery capacity in underserved areas and support for vote-by-mail, including making ballots postage-free and reducing the cost of other election-related mail for jurisdictions and voters.

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SWOT SNAPSHOT

SWOT

STRENGTHS

1. Effective core health plan operations
2. Meeting and understanding members' needs
3. Partnering with community stakeholders
4. Engaged, mission-driven staff
5. Loyal and engaged provider network
6. Fiscally responsible

WEAKNESSES

1. Health disparities
2. Behavioral health services
3. Preventative care for children
4. Alignment on scope and organizational priorities
5. Technology and analytics
6. Commercial competitive business practices

OPPORTUNITIES

1. Expand community partnerships and services provided by CBOs
2. Provider network capacity + pipeline
3. Enhance network cultural competency
4. Increase data collection and sharing
5. Increase quality and lower cost
6. Strengthen competitive administrative ability
7. Financial strategy to improve benefits and capacity

THREATS

1. Determinants of health impacting members
2. Health care workforce shortages
3. Behavioral health access and capacity
4. Uncertain fiscal environment
5. Complicated policy environment
6. Increasingly competitive environment
7. Key SME retention/Competition for key SMEs

Dual Eligible Special Needs Plans in California

February 3, 2021

What is a Dual Eligible Special Needs Plan (D-SNPs)?

D-SNPs are Medicare Advantage (MA) health plans which provide specialized care for dual eligibles that must have a State Medicaid Agency Contract (SMAC) with the Department of Health Care Services (DHCS). DHCS can choose whether to contract with D-SNPs.

What is aligned enrollment?

Under aligned enrollment, beneficiaries can enroll in a Medi-Cal Managed Care Plan (MCP) and D-SNP that are operated by the same parent organization for better care coordination and integration. The aligned enrollment will take place at different times depending on the county. In the Coordinated Care Initiative (CCI) counties, aligned enrollment begins in 2023. In non-CCI counties, aligned enrollment will phase in as plans are ready and able, but not later than contract year 2025.

How is a D-SNP different from a Cal MediConnect (CMC) plan?

CMC is a demonstration project (part of the Coordinated Care Initiative) that combined both Medicare and Medi-Cal benefits (acute, primary, institutional, and home and community-based) services into a single benefit package for individuals who are fully eligible for Medicare and Medicaid. CMC plans coordinate dual eligible members Medicare and Medi-Cal benefits under a single health plan.

CMC Transition to D-SNP Structure under CalAIM

CMC members will transition to aligned MCPs and D-SNPs operated by the same parent organization as their CMC plan. The goal is to ensure that CMC members transition into a D-SNP operated by the same parent organization to ensure continuity of care from their current providers.

California decided to use this D-SNP model to expand the care coordination and integration that duals in CCI counties were receiving from CMC plans on a statewide scale. This model meets the statewide goals of improved care integration and person-centered care, under both CalAIM and the California Master Plan for Aging.

Government Human Services Consulting

Medi-Cal D-SNP Feasibility Study

State of California
Department of Health Care Services
June 2022

welcome to brighter

A business of Marsh McLennan

Section 1
Executive Summary

The California Advancing and Innovating Medi-Cal (CalAIM) Medi-Cal managed care plan (MCP) Dual Eligible Special Needs Plan (D-SNP) requirement is an important component of the State's overall health care strategy for Dual Eligible enrollees. The opportunity to improve access to, and quality of care across Medicare and Medi-Cal for Dual Eligible enrollees, through better care coordination and benefit coordination, is substantial.

The Department of Health Care Services (DHCS) is collaborating with the Centers for Medicare & Medicaid Services (CMS) as well as MCPs to establish an Exclusively Aligned Enrollment (EAE) D-SNP model to replace the current financial alignment demonstration known as Cal MediConnect. MCPs in the seven Coordinated Care Initiative (CCI) counties are establishing these EAE D-SNPs effective January 1, 2023. MCPs in non-CCI counties will be required to establish EAE D-SNPs no later than contract year 2026.

EAE is a state policy that limits a D-SNP's membership to only individuals with aligned enrollment. All beneficiaries enrolled in an EAE D-SNP are also enrolled in a matching Medi- Cal plan. D-SNPs will only be allowed to enroll members who are in their aligned MCP. EAE D-SNPs are a new type of Medicare Advantage (MA) plan that will begin in California on January 1, 2023, and will provide a similar type of integrated care as Cal MediConnect. In 2023, EAE D-SNPs will be managed by the same health plans that offered Cal MediConnect. These plans will meet integrated D-SNP care coordination requirements, will have integrated member materials, and will have membership limited to dually eligible individuals who are also enrolled in the Medi-Cal managed care plan affiliated with the D-SNP. This aligned enrollment provides more integrated and coordinated care than other D-SNPs, where members may not be in a Medi-Cal plan that aligns with their Medicare plan. When dual eligible beneficiaries choose a Medicare plan that is an EAE D-SNP, they are automatically enrolled in the Medi-Cal plan that aligns with their Medicare plan, so there is one organization coordinating care across both sets of benefits.

The purpose of this study is to examine the feasibility of Medi-Cal MCPs in non-CCI counties to establish and operate EAE D-SNPs. This study gives DHCS information and data considerations for program feasibility and satisfies the requirement within Welfare and Institutions Code (WIC) § 14184.208(c)(5) to conduct a feasibility study, to be completed no later than July 1, 2022, in specific counties as determined by the Department . This will help inform DHCS' review and consideration of individual plan requests for exemption from the requirement to establish a D-SNP, thereby ensuring the Department can make an appropriate decision regarding any D-SNP exemption requests made.

A key starting point in any feasibility study is what is meant by the term "feasible", and in particular the phrase, "financially feasible". Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, adopted the following definitions after consultation with DHCS:

1. Feasible[1]
   A. Capable of being done or carried out.
2. Financially Feasible (short term)
   A. Operating a D-SNP would not be unduly burdensome from a financial perspective.
3. Financially Feasible (long[er] term)
   A. In 3–5 years, D-SNP capitation revenues and claims are projected to achieve bid gain/margin under reasonable assumptions.

Therefore, this Medi-Cal D-SNP Feasibility Study seeks to determine if the Medi-Cal contracted MCPs operating a D-SNP in non-CCI counties will be able to achieve fiscal results consistent with these definitions. On a national level, with the rapid growth in D-SNP health plans and enrollment, as well as strong profitability results, the answers to those questions appears to be a resounding yes. In California, for CCI counties effective January 1, 2023, DHCS and partner health plans are similarly confident that the transition from Cal MediConnect to D-SNP will prove feasible, and financially feasible. But what of the non-CCI counties, and their January 1, 2026 D-SNP effective date? Given that date is three and one-half years in the future, the differing county characteristics, and in several cases differing health plans with more limited or no (recent) experience in the Medicare program, answers to the feasibility questions are naturally less certain. Mercer used both qualitative and quantitative approaches to assist DHCS with prospective evaluations related to financial feasibility for non-CCI health plans/counties.

Fundamental to D-SNP feasibility is health plan financial strength. Generally each of the Medi-Cal health plans are currently in strong financial condition. Other operational and financial challenges and concerns legitimately raised by various stakeholders around D-SNP implementation are not unique to California. With the exception of a health plan having insufficient initial financial strength, Mercer believes through appropriate diligence they typically can all be overcome. However, individual plan concerns on any of these issues should be weighed carefully by DHCS in considering a D-SNP exemption request, if any.

After review and discussion, for a variety of reasons addressed later in the report, the San Francisco and Santa Barbara/San Luis Obispo regions were selected for detailed actuarial modeling. The base scenario results project a positive margin (profit) will be achieved in 2029 for each of the San Francisco and Santa Barbara/San Luis Obispo regions. Similar to other D-SNPs nationwide, the revenue in Year 1 (i.e., 2026) is projected to be insufficient to cover costs which results in a negative profit margin in a bid. Based on a variety of factors (both known and unknown) to be discussed in great detail later in this report, it is reasonable to assume there will be a path towards long-term profitability.

While it was determined to be impractical and unnecessary to actuarially model all non-CCI health plans/regions/counties at this time, there was analysis more broadly across all applicable counties through analysis of enrollment projections, and via the interview and surveys, as mentioned in detail later in the report.

[1] https://www.merriam-webster.com/dictionary/feasible

Mercer believes there is a potential path to feasibility for all regions in California. However, each region and MCP will have unique challenges to overcome as they look to achieve feasibility. We have listed some of the key factors for MCPs to be successful below. In the absence of achieving enough of these factors in a given county/region, feasibility becomes increasingly more challenging.

- D-SNP Membership Growth
- Administrative Cost per D-SNP Member
- Provider Contracting
- Star Rating
- Risk Score Coding Accuracy
- Medical Cost Management

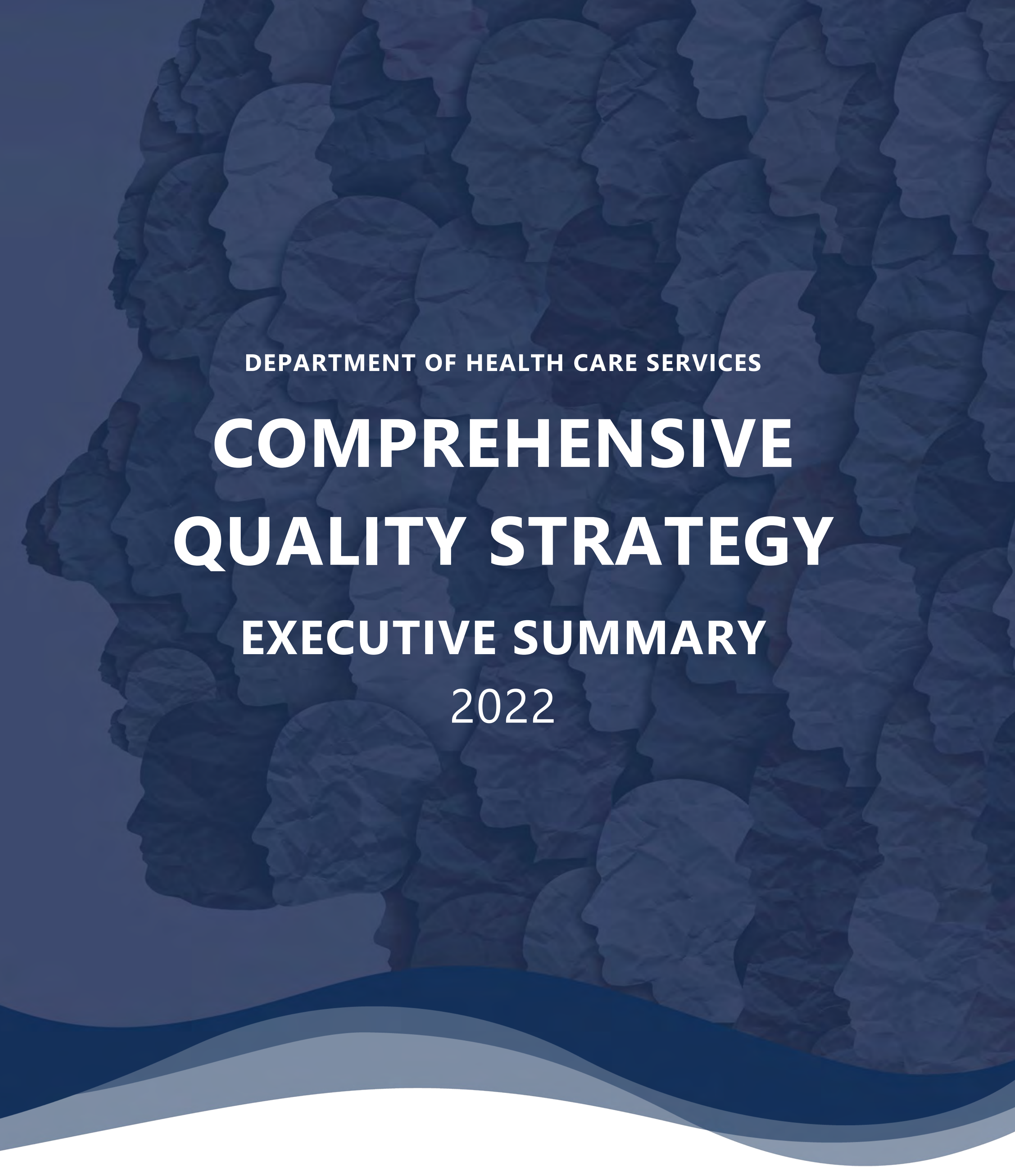
Achieving economies of scale through membership growth, therefore spreading the fixed administrative cost over a larger membership base, is a critical element towards achieving long term feasibility. However, we believe the MCPs in California will have an opportunity to achieve these economies of scale sooner than a non-Medi-Cal affiliated Medicare Advantage start-up due to the MCPs existing Medi-Cal line of business already having a significant number of members.

We recommend DHCS encourage aligned enrollment of dual eligibles into matching MCPs and D-SNPs to promote high-levels of integrated care. DHCS has implemented this in 12 Medi-Cal Matching Plan counties, which includes CCI counties, where the Medi-Cal plan is aligned to the Medicare plan choice, if a matching plan is available. DHCS will expand this policy in counties where EAE D-SNPs will be implemented in the future.

If there are concerns about feasibility, MCPs should work with DHCS to review the specific key factors above and their corresponding feasibility impact for the MCP. This will be reviewed on a case-by-case basis which may result in potential exemption of the D-SNP requirements in specific counties for a time-limited period.

Biography for Dr. Palav Babaria

Dr. Palav Babaria was appointed Chief Quality Officer and Deputy Director of Quality and Population Health Management of the California Department of Health Care Services beginning in March 2021. Prior to joining DHCS, she served as Chief Administrative Officer for Ambulatory Services at the Alameda Health System (AHS) where she was responsible for all outpatient clinical operations, quality of care, and strategy for primary care, specialty care, dental services, and integrated and specialty behavioral health, as well as executive sponsor for value-based programs including the Medi-Cal 1115 Waiver. She also previously served as Medical Director of K6 Adult Medicine Clinic, where she managed a large urban hospital-based clinic, overseeing all practitioners, improving quality of care, and patient safety programs. In addition, she served on the Clinical Advisory Committee with the California Association of Public Hospitals/Safety Net Institute. She also has over a decade of global health experience and her work has been published in the New England Journal of Medicine, Academic Medicine, Social Science & Medicine, L.A. Times, and New York Times. Dr. Babaria received her bachelor's degree from Harvard College, as well as her MD and Masters in Health Science from Yale University. She completed her residency training in internal medicine and global health fellowship at the University of California, San Francisco.


DEPARTMENT OF HEALTH CARE SERVICES
COMPREHENSIVE QUALITY STRATEGY
EXECUTIVE SUMMARY
2022

The Department of Health Care Services' (DHCS) ten-year vision for the Medi-Cal program is that the people served by Medi-Cal should have longer, healthier, and happier lives. In this whole-system, person-centered, and population health approach to care, health care services are only one element of supporting better health in the population. Partnerships with Medi-Cal members, communities, community-based organizations (CBO), schools, public health agencies, counties, and health care systems will be essential to preventing illness, supporting health care needs, addressing health disparities, and reducing the impact of poor health.

The COVID-19 public health emergency (PHE) has made DHCS' vision more relevant than ever. The pandemic's impacts, including a reduction by one and a half years in national life expectancy in 2020 (almost three years for Black and Latino communities), outbreaks in nursing homes and correctional facilities, schools shifting to virtual instruction, job losses, risks for essential workers, and enormous stresses on public health and health care delivery systems, have been devastating. And yet, the pandemic also fostered unprecedented collaborations across silos, demonstrating the power of partnerships, especially in implementing COVID-19 testing, vaccination, and community education and outreach efforts. These partnerships can serve as models to help achieve DHCS' ten-year vision for Medi-Cal.

The 2022 DHCS Comprehensive Quality Strategy (CQS) lays out DHCS' quality and health equity strategy to support this vision. Section 1 of the CQS, in accordance with the Managed Care Final Rule, provides an overview of the Medi-Cal program and the quality management structure at DHCS, including the process for developing and reviewing the CQS.

Section 2 outlines DHCS' quality and health equity strategy. The CQS takes a more expansive view of quality, beyond access and clinical outcomes, to address multiple drivers of health at the individual and system. To achieve this, the CQS incorporates and builds upon the policy framework outlined in CalAIM, and leverages the Home and Community-Based Services (HCBS) Spending Plan, upcoming Medi-Cal managed care procurement, and historic health investments in the fiscal year (FY) 2021-22 state budget to define a path for how we can ensure high-quality and equitable care for all Medi-Cal members. As mentioned in the CQS, given numerous forthcoming policy changes that will affect dual-eligibles, seniors and persons with disabilities (SPDs), those receiving long-term supports and services (LTSS), as well as numerous transformative CalAIM initiatives for the behavioral health delivery system, DHCS anticipates issuing an

addendum to this quality strategy for all of these domains next year.

The CQS goals and guiding principles (summarized below) are built upon the Population Health Management (PHM) framework that is the cornerstone of CalAIM, and they stress DHCS' commitment to health equity, member involvement, and accountability in all of our programs and initiatives, and for all populations.

Section 2.3 of the CQS outlines the implementation of PHM, which aims to help *all* members stay healthy via preventive and wellness services, identify and assess member risks to guide care management and care coordination needs, and identify and mitigate social drivers of health to reduce health care disparities. Coupled with PHM, the CQS outlines three clinical focus areas – children's preventive care, maternity care and birth equity, and behavioral health integration – that are designed to address the foundations of health (i.e., preventive efforts that have long-lasting impact from infants to seniors). Addressing child and maternal health and behavioral health for all populations will reduce chronic diseases and serious illnesses in the decades to come. These clinical focus areas are designed to complement the significant CalAIM and HCBS initiatives that are targeted at specific high-risk and vulnerable populations, especially foster children, justice-involved, dual-eligibles, SPDs, and those receiving LTSS.

Section 2.4 of the CQS outlines specific clinical goals across the Medi-Cal program. Centered on specific clinical focus areas, the CQS introduces DHCS' *Bold Goals: 50x2025*

initiative that, in partnership with stakeholders across the state, will help achieve significant improvements in Medi-Cal clinical and health equity outcomes by 2025. Additional high-priority goals with measurable targets are included for each managed care delivery system (Medi-Cal managed care, behavioral health, and dental). These goals were identified to ensure a comprehensive quality approach across multiple populations. A complete set of all measures reported and tracked across Medi-Cal programs are available in **Appendix D**.

In order to achieve DHCS' vision of eliminating health care disparities, DHCS has defined needed improvements in data collection and stratification, workforce diversity and cultural responsiveness, and disparity reduction efforts. The Health Equity Roadmap in Section 2.5 shows DHCS' existing initiatives in each of these domains, and outlines gaps and questions that should only be answered with the involvement of Medi-Cal members and communities most affected by health care disparities. DHCS will launch a Health Equity Roadmap co-design process in 2022 with individuals and communities to refine and build upon existing work, and to help DHCS complete a project plan for addressing key health disparities.

BOLD GOALS: 50x2025

STATE LEVEL

Close racial/ethnic disparities in well-child visits and immunizations by 50%

Close maternity care disparity for Black and Native American persons by 50%

Improve maternal and adolescent depression screening by 50%

Improve follow up for mental health and substance use disorder by 50%

Ensure all health plans exceed the 50th percentile for all children's preventive care measures

The CQS also introduces a set of priority clinical outcome metrics (a subset of its Medi-Cal managed care measures) that align with a population health approach for all ages

(colorectal cancer, high blood pressure, diabetes, prenatal and postpartum care, well-child visits, childhood and adolescent immunizations, and follow up for mental health and substance use disorder needs). These will also serve as health equity metrics, stratified by race and ethnicity, to inform disparity reduction efforts. Given that value-based payments (VBP) are an essential lever to support quality improvement and health equity efforts, these measures, along with member experience reviews and scores, will be incorporated into Medi-Cal managed care rates and member-assignment algorithms in 2023. Additional VBP efforts are outlined in section 2.6 of the CQS and the 2024 managed care procurement Request for Proposal.

Lastly, Section 3 of the CQS outlines significant changes at DHCS in terms of its quality management structure and managed care monitoring and oversight activities. Specifically, DHCS is centralizing and elevating core quality and health equity functions under its new Quality and Population Health Management (QPHM) Program. It will also align and standardize managed care policies, as possible, across delivery systems, and institute standard, proactive monitoring strategies (including user-friendly public dashboards) to support transparency and accountability.

DHCS is unwaveringly committed to addressing quality and health equity in Medi-Cal, as described in this strategy. However, as the COVID-19 pandemic and national awakening to racial injustice have demonstrated, incremental improvements are insufficient. The transformative investments in Medi-Cal through California Advancing and Innovating Medi-Cal (CalAIM) and the FY 2021-22 state budget, coupled with the disruption of COVID-19 and a society-wide desire for change, offer us a unique opportunity to transform Medi-Cal and achieve high-quality, equitable health care for all. This will not be an easy journey. It will require significant transformation and partnerships at all levels, and in different ways than have been attempted before, to achieve the ambitious goals we have outlined in this strategy. We invite you to join us.

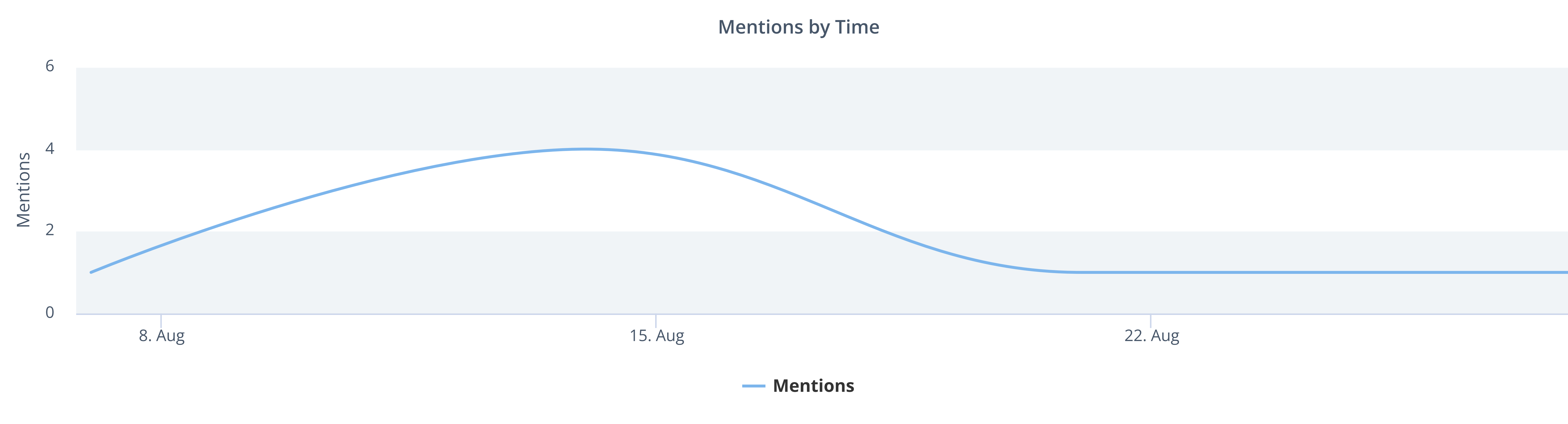
Information Items: (18A. – 18H.)

A. Alliance in the News Page 18A-01
B. Letter: DHCS Proposed Waiver Amendments Page 18B-01
C. Letters of Support Page 18C-01
D. Local Health Plans of California: News Release Page 18D-01
E. Membership Enrollment Report Page 18E-01
F. Member Newsletter (English) – September 2022
https://thealliance.health/wp-content/uploads/CCAH-Member-Fall-2022-ENG.pdf
G. Member Newsletter (Spanish) – September 2022
https://thealliance.health/wp-content/uploads/CCAH-Member-Fall-2022-SPA.pdf
H. Provider Bulletin – September 2022
https://thealliance.health/wp-content/uploads/CCAH-Provider-September-2022-Hi-Res.pdf

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

September 2022 Board Report

Mention Analytics



Total Online News Audience
26,014

Total Online News Publicity
USD $288

Total Number of Clips 7

1

Guest Commentary | Santa Cruz and Monterey county health providers: Watsonville hospital a vital community health-care resource

Date Collected Aug 29, 2022 10:49 PM EDT
Category Local
Source Santa Cruz Sentinel
Author Santa Cruz Sentinel

Est. Audience 17,094
Est. Publicity Value USD $186
Market Santa Cruz, CA
Language English

The authors represent the Medical Societies of Santa Cruz and Monterey counties, as well as the primary providers of safety net clinic services in Santa Cruz and North Monterey Counties – Salud Para La Gente and Santa Cruz Community Health. Together, they represent hundreds of physicians providing care to the majority of local residents.

In Santa Cruz County, keeping our communities healthy is a collaborative effort by many health care service providers, and Watsonville Community Hospital is an essential piece of that puzzle.
For several months now, Watsonville Community Hospital has been ...

2

Hospital fundraising nears the finish line

Date Collected Aug 26, 2022 8:06 PM EDT
Category Local
Source Register Pajaronian
Author Guest Columnists

Est. Audience 2,617
Est. Publicity Value USD $26
Market Watsonville, CA
Language English

... Valley Healthcare District Project (PVHDP) was formed to accomplish this.

Local and state leaders and interested groups have come together to help PVHDP meet the goal of purchasing the hospital. This includes a $25 million public investment through the state budget, a $3 million grant from the **Central California Alliance for Health**, and several other significant donations. We are 98% of the way to achieving the largest community fundraising effort in Santa Cruz County history.

The ongoing health of our region requires we all come together to save Watsonville Community Hospital—we need your help to push us over the ...

3

Homelessness Update Shows Mixed Results In Santa Cruz County

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Date Collected Aug 18, 2022 1:50 PM EDT
Category Local
Source Press Banner

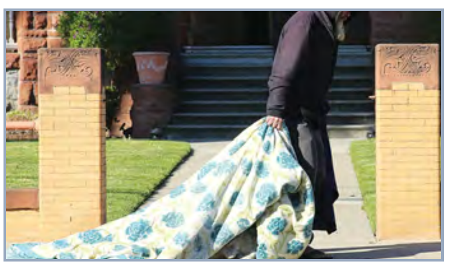
Est. Audience 267
Est. Publicity Value USD $2
Market Scotts Valley, CA
Language English

Santa Cruz County has reduced homelessness among families by 59% compared to 2019, even as overall homelessness in the county increased by 6%.

That's according to preliminary results of the county's biannual Point-In-Time (PIT) count released Aug. 5 by the Housing for Health Partnership.

Santa Cruz County's biannual PIT count, conducted on Feb. 28, provides an overview of homelessness over time in Santa Cruz County. The full 2022 report release is expected within two months.

The report also showed a 94% decrease in unsheltered homelessness and a 61% drop in the number of unsheltered ...



Homeless Census Shows Mixed Results in Santa Cruz County

4

Date Collected Aug 17, 2022 6:34 PM EDT
Category Local
Source Good Times Santa Cruz
Author Todd Guild

Est. Audience 3,205
Est. Publicity Value USD $39
Market Santa Cruz, CA
Language English

Santa Cruz County has reduced homelessness among families by 59% compared to 2019, even as overall homelessness in the county increased by 6%.

That's according to preliminary results of the county's biannual Point-In-Time (PIT) count released Aug. 5 by the Housing for Health Partnership.

Santa Cruz County's biannual PIT count, conducted on Feb. 28, provides an overview of homelessness over time in Santa Cruz County. The full 2022 report release is expected within two months.

The report also showed a 94% decrease in unsheltered homelessness and a 61% drop in the number of unsheltered ...

Hundreds show up for Back-to-School event at Castle

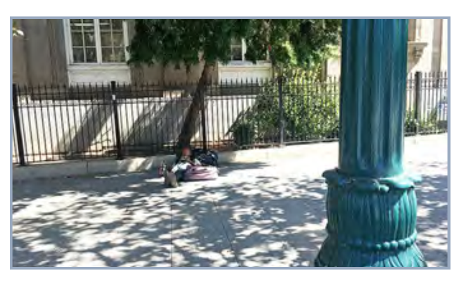
5

Date Collected Aug 15, 2022 4:41 PM EDT
Category Local
Source MercedCountyTimes.com
Author Yanira Ledezma

Est. Audience 214
Est. Publicity Value USD $3
Market Merced, CA
Language English

Free backpacks, diapers, food boxes, vaccines, physicals, and resource information were available to community members and their families at Castle Family Health Center in Atwater last Saturday morning as part of their annual Back-to-School event.

Even though the hot summer sun beat down on the pavement sidewalk right outside the health clinic, a long line of residents remained lined up right outside the cul-de-sac at the main entrance of the center. Helpers stood at the entrance, gesturing community members in one at a time to prevent overcrowding and to allow everyone a chance at picking ...



HOMELESS COUNT: 2,299, UP 6%

6

Date Collected Aug 15, 2022 1:04 PM EDT
Category Online News
Source Times Publishing Group
Author Jondi Gumz

Language English

Since 2019, Santa Cruz County made progress in finding homes for unsheltered families and young people age 18-24, but the number of homeless veterans and chronically homeless people with mental illness or drug addiction more than doubled, resulting in an 6% increase overall, from 2,167 to 2,299, according to the 2022 Point-In-Time Count.

Data:

128% increase in chronically homeless people with mental illness or drug addiction, from 403 to 921
120% increase in homeless veterans, from 151 to 332
59% decrease in homeless families – only five unsheltered
61% decrease in homeless young people age 18-24
1,073 people report substance use
818 people report serious mental illness
Santa Cruz County Board of Supervisors got a summary of the findings Tuesday from Robert Ratner, director of the County of Santa Cruz Housing for Health Division, and Randy Morris, director of the county Human Services Department.

...

Update on homelessness shows mixed results from county efforts

7

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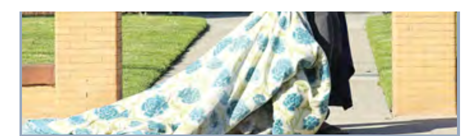

Date Collected Aug 10, 2022 3:06 PM EDT
Category Local
Source Register Pajaronian
Author Todd Guild

Est. Audience 2,617
Est. Publicity Value USD $32
Market Watsonville, CA
Language English

... children under age 18 were identified, which is a decrease of 51 from 2019.

The City of Santa Cruz plans to use some one-time state funds to create safe sleeping and shelter options for people living in the San Lorenzo Park "Benchlands" encampment.

Meanwhile, the county is working with the **Central California Alliance for Health** to increase shelter capacity by 80-100 beds, and to operate a 14-20 bed transitional housing program for young homeless people in unincorporated Watsonville.

The county's Rehousing Wave, an $8 million partnership with various agencies and nonprofits, has since its May 2021 inception served more ...

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530 West 16th Street, Ste. B
Merced, CA 95240-4710
209-381-5300

September 12, 2022

Michelle Baass, Director
Jacey Cooper, Chief Deputy Director & State Medicaid Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Via email: CalAIMWaiver@dhcs.ca.gov

Re: Comments on Proposed 1115 and 1915(b) Waiver Amendments

Dear Directors Baass and Cooper,

On behalf of the Central California Alliance for Health (the Alliance) which is the County Organized Health System (COHS) serving over 400,000 Medi-Cal beneficiaries in our region since 1996, I appreciate the opportunity to provide comments in response to the Department of Health Care Services (DHCS) draft amendments to California's 1115 and 1915(b) waivers.

The Alliance offers our strong support for DHCS' request to seek authority from the Centers for Medicare & Medicaid Services (CMS) for Medi-Cal managed care model change in counties that will join an existing COHS or which will transition to a Single Plan model (hereinafter "model change authority"). However, the Alliance continues to express our strong opposition to the component of the 1915(b) waiver that seeks federal authority to implement a statewide contract for an alternative health care service plan (the statewide contract) which contradicts the exclusive contracting authority of the COHS. The model change policy advances the strong public policy which relies on public entities to address the challenges of the Medi-Cal delivery system, while in contrast the statewide contract undermines that very same public policy.

First, with regards to our support for DHCS's request for model change authority, local plans have been a cornerstone of the Medi-Cal managed care delivery system in California for over 40 years. COHS and Local Initiative (LI) plans were created specifically to meet the health care needs of underserved populations in their communities through a public entity governed locally with input from local stakeholders. COHS and LIs are authorized under state and federal statute and formed through county ordinance. Since the early 1980s, 15 COHS and LIs were established across 35 counties in California for this purpose. The fact that so many counties have sought and implemented the local plan model speaks volumes about the value that local plans bring to their communities.

In 2020 and 2021, in anticipation of the statewide commercial plan procurement, DHCS offered counties the opportunity to select the model of Medi-Cal managed care which best meets the needs of their community and which would best set up the county for success in achieving the State's ambitious CalAIM goals. Fourteen additional counties chose to join an

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existing local plan and two counties with existing LIs chose to transition to a Single Plan model.

By seeking federal authority to implement these county model changes, DHCS is affirming the critical role that local communities play in determining how to design a local delivery system to meet their local needs while also advancing state and federal goals for the Medicaid program. CMS approval of DHCS's authority to implement the Medi-Cal managed care model change is critical to furthering important public policy.

Second, with regards to the statewide contract, the Alliance continues to express its strong opposition as DHCS seeks federal authority through the 1915(b) waiver amendment to implement this statewide contract. As you are aware, strong and voluminous opposition was expressed by county health departments, Boards of Supervisors, local providers and local health plans about the statewide contract offered by DHCS to Kaiser Foundation Health Plan (Kaiser) and subsequently authorized through AB 2724 (Arambula). DHCS' waiver request to expand COHS plans and the Single Plan model supports the role of local communities in self-determination. In stark contrast, the statewide contract undermines the locally driven public plan model and is, therefore, opposed by local stakeholders. In addition, this statewide contract creates an inequitable, two-tiered Medi-Cal delivery system: one tier for those individuals served by a private, commercial non-profit corporation that prioritizes the commercially covered population, and another for those people experiencing the deepest poverty who are served by the public and traditional safety net delivery system.

For these reasons the Alliance expresses its support for DHCS' request to seek authority from CMS for Medi-Cal managed care model change in counties that will join an existing COHS or transition to a Single Plan model. However, the Alliance is strongly opposed to the 1915(b) waiver request seeking federal authority to implement a statewide contract for an alternative health care service plan.

I appreciate the opportunity to provide these comments on the draft waivers which seek to shape the Medi-Cal managed care delivery system for years to come.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

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August 10, 2022

Golden Valley Health Centers
Mr. Tony Weber, CEO
737 West Childs Avenue
Merced, CA 95341

RE: Support for Golden Valley Health Centers' Service Area Competition Application

Dear Mr. Weber:

On behalf of Central California Alliance for Health (the Alliance), I am pleased to write this letter to express support for Golden Valley Health Centers' Service Area Competition (HRSA-22-021) application to the Bureau of Primary Health Care for continued operational support under the Consolidated Health Center Program, as a Community Health Center, Migrant Health Center and Homeless Health Center.

As an organization dedicated to ensuring access to affordable health care services, the Alliance recognizes that Golden Valley Health Centers is an integral part of the health care delivery system in Merced, serving low-income families, the uninsured, and many high-risk and vulnerable populations such as migrant and seasonal farm workers and poor women and children living in rural communities.

The health centers operated by Golden Valley Health Centers play a critical role in improving access to needed health care services for medically underserved and uninsured individuals most of whom live in families with incomes at or below the federal poverty level.

We share Golden Valley Health Centers' mission of providing quality health care to our community. The Alliance supports this application and looks forward to Golden Valley Health Centers' continued efforts to improve the health of the residents of our communities.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

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August 22, 2022

California Department of Health Care Services
Behavioral Health Continuum Infrastructure Program (BHCIP) Application Review Committee

Dear members of the BHCIP Application Review Committee:

We are writing to urge BHCIP to fund Encompass Community Services' application for Round 4 funding to support the development of its new Sí Se Puede Behavioral Health Transition-Age Youth (TAY) Expansion project in Watsonville, CA. Doing so will leverage the Central California Alliance for Health's (the Alliance) already significant investment in capacity expansion for healthcare and supportive services for Medi-Cal beneficiaries.

The Alliance has long been a supporter of this project, as Encompass's Sí Se Puede Behavioral Health expansion project will significantly increase Santa Cruz County's behavioral health treatment capacity for transition-age youth (TAY), especially in the south county region where access is limited. Recognizing the community benefit of an Encompass capacity expansion project, the Alliance granted this project a $2.5M Capital Program grant from our Medi-Cal Capacity Grant Program to support the development of a new center. As you may know, the Medi-Cal Capacity Grant Program invests in local organizations in the Alliance's service area for the specific purpose of increasing availability, quality and access to health care and supportive services for Medi-Cal members in Merced, Monterey and Santa Cruz counties.

We are aligned with Encompass in their conviction that this project matches the State's BHCIP Round 4 funding priority to expand the behavioral health continuum of treatment and service resources for Californians ages 25 and younger and is ready to launch. BHCIP support would allow Encompass to secure the remainder of the project funding needed to break ground as early as January 2023 and complete the project within the Alliance's approved timeline for disbursing funds.

Encompass must reach a critical fundraising threshold in order to leverage the Alliance's $2.5 grant award for this project. If Encompass is not awarded BHCIP funds, it will significantly delay the construction timeline and may result in the Alliance having to withdraw funding or reduce funding for a narrower project scope for behavioral health capacity building.

We urge BHCIP to fund Encompass's Round 4 application to support its new behavioral health expansion project in Watsonville. Funding this request will leverage the Alliance's already significant investment in capacity expansion for healthcare and supportive services for Medi-Cal beneficiaries.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

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FOR IMMEDIATE RELEASE
August 26, 2022

Contact: Nicole Evans
nevans@nkestrategies.com | (916) 502-2756

LHPC Responds to DHCS Announcement of Medi-Cal Managed Care Contract Awards

SACRAMENTO, CA -- On behalf of the Local Health Plans of California (LHPC), a group representing 16 of the not-for-profit local health plans that serve more than 70 percent of Californians enrolled in Medi-Cal managed care, CEO Linnea Koopmans offered comment following the Department of Health Care Services' announcement of its intent to award Medi-Cal contracts to three managed care plans. Community Health Group, an LHPC local health plan member, was not included in the contract award despite having the largest Medi-Cal enrollment in the area (330,000 members) and their 40 years of experience delivering care to Medi-Cal and uninsured populations in San Diego County.

> "It is disappointing to see that Community Health Group was not selected through Medi-Cal procurement given their track record for delivering excellent care with a community focus. As the only local plan choice in the region, this is a loss for San Diego.
>
> "This is the first time in Medi-Cal's history that a not-for-profit, local health plan, serving a small region with a community-focus, has not been selected through the contracting process. This leaves only commercial insurers to provide Medi-Cal coverage in San Diego County. Medi-Cal managed care began through local plans due to their ability to address the needs of their community while ensuring access to high quality health care.
>
> "Community Health Group, which is the largest Medi-Cal plan in the region, epitomizes the unique community focus of a local health plan in Medi-Cal. The not-for-profit grew from a small health clinic as demand for their person-focused care grew throughout San Diego. In fact, more Medi-Cal enrollees in San Diego choose Community Health Group over the other commercial options in the area.
>
> "Over the years, Community Health Group's quality scores and performance have been consistently higher than all other Medi-Cal plans with a non-staff model in San Diego County and statewide. They have served Medi-Cal and the community well for the past 40 years.

"LHPC stands with our local plan partner as Community Health Group pursues all options to continue to ensure San Diegans have a local plan option."

###

About LHPC

Local Health Plans of California (LHPC) is a statewide trade association that represents all 16 of the community-based, not-for-profit health plans that provide access to critical and comprehensive healthcare services for low-income populations enrolled in California's Medicaid program, "Medi-Cal," in 36 out of 58 counties in the state. With over 8.5 million enrollees, our plans serve approximately 70 percent of all Medi-Cal managed care beneficiaries. LHPC member plans cover more lives than 49 other states' entire Medicaid programs. More here.

Enrollment Report

Year: *2017 & 2018* **County:** *All* **Program:** *IHSS & Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *9/6/2022*

StaticDate
9/1/2021 12:00:00 AM to 9/30/2022 11:59:59 PM

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

180K
170,694
160K
148,592
1.3%
7.8%
137,830
140K
Members-->
Monthly -->
Yearly -->
120K
100K
# of Members
78,812
0.7%
5.7%
80K
74,562
60K
40K
Program County
SANTA CRUZ
MONTEREY
MERCED
20K
0K
September 2021
November 2021
January 2022
March 2022
May 2022
July 2022
September 2022

Program..	ProgramCo..	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022
Medi-Cal	SANTA CRUZ	74,562	75,046	75,277	75,313	75,572	75,906	76,053	76,366	77,606	77,680	77,872	78,270	78,812
	MONTEREY	170,178	170,761	171,296	171,760	173,035	173,357	174,207	175,316	179,353	180,414	181,534	182,152	183,941
	MERCED	137,830	138,542	138,969	139,530	140,617	141,075	141,800	142,725	144,815	145,403	146,197	146,751	148,592
IHSS	MONTEREY	516	513	515	517	511	511	589	624	650	657	654	660	658
Total Members		**383,086**	**384,862**	**386,057**	**387,120**	**389,735**	**390,849**	**392,649**	**395,031**	**402,424**	**404,154**	**406,257**	**407,833**	**412,003**