Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Wednesday, April 28, 2021

3:00 p.m. – 5:00 p.m.

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

Teleconference Meeting

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

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, Alliance offices will be closed for this meeting. The following alternatives are available to members of the public to view this meeting and to provide comment to the Board.

1. Members of the public wishing to join the meeting may do so as follows:
    a. Via computer, tablet or smartphone at:
    https://global.gotomeeting.com/join/521731693
    b. Or by telephone at:
    United States: +1 (872) 240-3311
    Access Code: 521-731-693
    c. New to GoToMeeting? Get the app now and be ready when your first meeting starts: https://global.gotomeeting.com/install/521731693

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, April 27, 2021 to the Clerk of the Board at kstagnaro@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to five minutes.
    b. Public comment during the meeting, when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

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

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

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

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

A. Members of the public may address the Commission on items not listed on today's agenda that are within the jurisdiction of the Commission. Presentations must not exceed five minutes in length, and any 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. – 9H.): 3:10 p.m.

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

- Reference materials: Executive Summary from the CEO.

Pages 5-01 to 5-06

6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for second month ending February 28, 2021.**

- Reference materials: Financial Statements as above.

Pages 6-01 to 6-09

Appointments: (7A.)

7A. **Approve appointment of Salvador Sandoval, MD to the Physicians Advisory Group.**

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

Page 7A-01

Minutes: (8A. – 8C.)

8A. **Approve Commission meeting minutes of March 24, 2021.**

- Reference materials: Minutes as above.

Pages 8A-01 to 8A-04

8B. **Accept Finance Committee meeting minutes of December 2, 2020.**

- Reference materials: Minutes as above.

Pages 8B-01 to 8B-06

8C. **Accept Whole Child Model Clinical Advisory Committee meeting minutes of December 17, 2020.**

- Reference materials: Minutes as above.

Pages 8C-01 to 8C-04

Reports: (9A. – 9H.)

9A. **Approve report on 2021 Legislative Session Update.**
- Reference materials: Staff report and recommendation on above topic; and 2021 Legislation Bill List.

Pages 9A-01 to 9A-19

9B. **Accept report on COVID-19 Update.**
- Reference materials: Staff report on above topic.

Pages 9B-01 to 9B-04

9C. **Approve report on COVID-19 Response Fund Grants.**
- Reference materials: Staff report and recommendation on above topic; and list of all COVID-19 Response Fund Grant Awards awarded between April 22. 2020 and April 1, 2021.

Pages 9C-01 to 9C-05

9D. **Approve Peer Review and Credentialing Committee Report of March 10, 2021.**
- Reference materials: Staff report and recommendation on above topic.

Page 9D-01

9E. **Approve Recuperative Care Pilot: Funding Recommendation for Bridge Housing Renovations for Community Homeless Solutions.**
- Reference materials: Staff report and recommendation on above topic.

Pages 9E-01 to 9E-02

9F. **Accept Medi-Cal Capacity Grant Program (MCGP) Performance Dashboard – October 2015 through March 2021.**
- Reference materials: MCGP Performance Dashboard.

Pages 9F-01 to 9F-07

9G. **Approve Medi-Cal Capacity Grants: Funding Recommendations. (Group A)**

A. Action on grants with no Board member affiliation.
- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; and Recommendation Summaries by Organization.

Pages 9G-01 to 9G-06

9H. **Approve Medi-Cal Capacity Grants: Funding Recommendations. (Group B)**

A. Action on grants with Board member affiliation.
- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; and Recommendation Summaries by Organization.

Pages 9H-01 to 9H-04

Regular Agenda Items: (10. – 13.): 3:15 p.m.

10. **Annual Election of Officers of the Commission. (3:15 p.m. – 3:30 p.m.)**

A. Board will nominate and elect Chairperson and Vice Chairperson.
- Reference materials: Staff report and recommendation on above topic.

Page 10-01

11. **Discuss Alliance's Care-Based Incentives (CBI) program outcomes for 2020. (3:30 p.m. – 3:50 p.m.)**

A. Ms. Michelle Stott, Quality Improvement and Population Health Director, will review and Board will discuss 2020 CBI program outcomes.

- Reference materials: Staff report on above topic.

Pages 11-01 to 11-02

12. **Consider approving proposed changes to Care-Based Incentives (CBI) for 2022. (3:50 p.m. – 4:10 p.m.)**

A. Dr. Dianna Diallo, Medical Director, will review and Board will consider approving proposed changes to CBI for 2022.

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

Pages 12-01 to 12-03

13. **Consider approving report on Medi-Cal Managed Care Procurement Process. (4:10 – 4:30 p.m.)**

A. Ms. Stephanie Sonnenshine, CEO, will review and Board will consider authorizing the CEO to sign a non-binding letter of intent to expand the Alliance service area to include its COHS model of Medi-Cal managed care to eligible Medi-Cal beneficiaries in San Benito and Mariposa County.

- Reference materials: Staff report and recommendation on above topic; and County Managed Care Transition to Local Plan: Letter of Intent.

Pages 13-01 to 13-14

Adjourn to Closed Session

14. **Closed session pursuant to Government Code Section 54956.9, subdivision (d)(1) – Conference with Legal Counsel – Pending Litigation (Doe. v. Santa Cruz-Monterey- Merced Managed Medical Care Commission, dba Central California Alliance for Health). (4:30 – 4:45 p.m.)**

A. Closed session agenda item.

15. **Closed session pursuant to Government Code Section 54956.9(d)(2) – Conference with Legal Counsel - Related to litigation. (4:45 – 4:55 p.m.)**

A. Closed session agenda item.

Return to Open Session

16. **Open session pursuant to Government Code Section 54956.9, subdivision (d)(1) – Conference with Legal Counsel – Pending Litigation (Doe. v. Santa Cruz-Monterey- Merced Managed Medical Care Commission, dba Central California Alliance for Health). (4:55 – 5:00 p.m.)**

A. Board will report on action taken in closed session.

17. **Open session pursuant to Government Code Section 54956.9(d)(2) – Conference with Legal Counsel - Related to litigation.**

A. Board will report on action taken in closed session.

Information Items: (18A. – 18B.)

Announcements:

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

- Finance Committee
  Wednesday, May 26, 2021; 1:30 – 2:45 p.m.

- Member Services Advisory Group
  Thursday, May 13, 2021; 10:00 – 11:30 a.m.

- Physicians Advisory Group
  Thursday, June 3, 2021; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee
  Thursday, June 17, 2021; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee
  Monday, May 10, 2021; 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 April 28, 2021 meeting will be held via teleconference unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, May 26, 2021, 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: April 28, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

2021 State Legislative Session. The Legislature is in full swing with new bills being heard in budget and policy committees. Staff is tracking over 70 bills in the board's area of legislative focus including items such as eligibility expansion and flexibilities for federally qualified health centers (FQHCs). A full bill list with recommended positions of support is included in the agenda packet as consent agenda item 9A.

FY 2021-22 State Budget. On April 15, 2021, the Senate Democrats released their Budget Priorities for 2021-22 and beyond, called the plan to Build Back Boldly. This includes ambitious proposals called a "strong first step in building a post-pandemic economy". Details and context for the plan are limited. However, the plan calls for lowering out of pocket costs for Covered CA, expanding access to Medi-Cal to all income eligible Californians regardless of immigration status, reforming the asset test for Medi-Cal eligibility and a commitment to addressing health inequities. All eyes will turn to the mid-May 2021 release of the May Revision to the Governor's proposed budget to determine how these priorities and proposals may be incorporated.

Medi-Cal Managed Care Procurement. Staff have continued conversations with both San Benito and Mariposa counties and relevant stakeholders regarding their respective interests in transitioning from their current managed care plan model to a County Organized Health System model through a partnership with the Alliance. Staff have worked with each of the counties to prepare a Letter of Intent (LOI) which requires County Board of Supervisor approval as well as Alliance board approval. At the April 28, 2021 meeting, your board will discuss and consider action to approve execution of the LOI for submission to the Department of Health Care Services (DHCS).

Federally Qualified Health Center Payment Modernization. DHCS has restarted discussions with clinics, plans and their respective associations regarding Federally Qualified Health Center (FQHC) payment modernization or alternative payment methodology. In previous discussions, Alliance clinics were interested in exploring ways to modernize payment rules for FQHCs that support patient centered care, focus on value and outcomes and allow FQHCs to provide, and be reimbursed for, services to members in different settings and through a broader range of providers. Staff will participate in related discussions with DHCS and clinics and will report back on progress as it develops.

Community Involvement. I attended the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting on April 8, 2021. On April 12, 2021 I recorded a video for Housing Matters in support of their Permanent Supportive Housing Project. On April 15,

2021 I attended the virtual HIPSCC Executive Committee meeting and I attended the virtual Local Health Plans of California April Board meeting on April 19, 2021. I attended the virtual Santa Cruz Health Information Organization Board of Directors meeting on April 22, 2021 and virtual MoRe Health meeting on April 28, 2021. I plan to attend the virtual Department of Health Care Services Stakeholder Advisory Committee meeting on April 29, 2021.

Health Services

The Health Service Division's priority efforts in April include streamlining authorization processes by identifying services that will no longer require authorization following the Essette authorization software transition planned for late June, performing Primary Care Provider chart audits as part of analysis for the 2021 Healthcare Effectiveness Data and Information Set submission to DHCS, and preparing the Model of Care submission for the CalAIM Enhanced Case Management program which is due in July. The Health Services team has also been working to ensure member communication and closure of open continuity of care requests, as well as to evaluate opportunities to collaborate to improve processes with Dignity hospital providers following resolution of the Common Spirit contract negotiations.

Utilization Management/Complex Case Management. The Utilization Management/Complex Case Management team continues to pursue interventions for member contact using ongoing enhanced Analytics predictability tools. Members are rated as high risk for readmission in addition to those being identified as developing a utilization pattern that will elevate them to a higher risk level. The Post Discharge Meal Delivery Program has received 78 referrals since the beginning of the first quarter. Reporting on decreased readmissions for this group will be evaluated after the 2nd quarter.

The Santa Cruz Recuperative Care Center (RCC) has received two referrals in the first month of the pilot program. Members are screened by the Concurrent Review Team for appropriateness and will be medically authorized for admission. Alliance staff is meeting with the RCC staff every two weeks to assess progress towards advancement to a bridge housing program.

Inpatient/Emergency Department Utilization. Early data comparing Q1 2021 to Q1 2020 indicates a downward trend for admissions per thousand members in the months of January and February 2021. Inpatient utilization for the 1st quarter is trending downward but will not be reported officially until validated against claims received, which tend to lag in time behind authorizations. An atypical flu season likely due to COVID-19 precautions has not been as significant as in past years. COVID-19 positive members who were hospitalized with pre-existing conditions did account for longer lengths of stay due to the severity of their illness.

Whole Child Model Program. Efforts to educate providers to the Whole Child Model/ California Children Services (CCS) referral processes continue through the Clinic and Hospital collaborative meetings. Referrals are increasing with enhanced collaboration with CCS County leaderships in all three counties.

Prior Authorization. The Authorization Process Redesign Roadmap is on track. Services that meet criteria including near 100% historic approval, low cost member safety and peer Plan

criteria are being evaluated for configuration in the system as no treatment authorization required. Ongoing utilization monitoring of services is being set up to ensure that as authorization requirements are eliminated for select codes, any potential overutilization or underutilization will be identified quickly for evaluation. The primary goal remains to decrease barriers to care and to reduce provider and Alliance staff burden.

Medi-Cal Rx Update. DHCS has not provided any updates on Magellan's development of a Medi-Cal Rx conflict avoidance plan. The draft is due to DHCS by Magellan on May 1, 2021 with an anticipated final plan by June 1, 2021. For now, DHCS has cancelled all workgroup meetings with plans, and will notify plans of the next steps in May after review of the conflict avoidance plan.

2021 Medi-Cal CAHPS Member Experience Survey. The fielding for the 2021 Medi-Cal Consumer Assessment of Healthcare Providers and Systems survey will be done between April 20 through June 29 to allow the vendor to deliver the final report to the Alliance in a timely manner.

Breast Cancer Screening Plan Do Study Act. DHCS required all health plans to conduct a Performance Improvement Plan (Plan Do Study Act rapid cycle) project on a single performance measure that focused on a preventive care, chronic disease management or behavioral health MCAS measure impacted by COVID-19. The Alliance focused on improving the Breast Cancer Screening (BCS) rate to above the National Committee for Quality Assurance Medicaid 50th percentile benchmark in Merced county. The Alliance partnered with Gettysburg Medical Clinic and El Portal Imaging Center to increase Gettysburg's BCS rate of eligible, non-compliant members by 10%. The intervention included the application of a screening mammogram standing order, coupled with a retrospective referral process of eligible members for screening. The intervention proved extremely successful and increased the BCS rate from 27% to 40%, far exceeding the 10% improvement goal.

Practice Transformation Academy. The Alliance Practice Transformation Academy (PTA) was launched in 2019 to provide instruction to primary health care clinics and staff in quality improvement methodology. Due to the COVID-19 pandemic, and in partnership with the Training and Development team, the PTA transitioned from in-person workshops to a video learning series presenting the Basics of Quality Improvement. The first video on SMART Aim Statements was completed last year and two more videos on Project Charters and Process Maps were completed in Q1 2021. The first module consisting of these three videos will be formally introduced to our providers in May 2021.

Community Care Coordination. The Alliance continues to work in collaboration with Beacon Health Options on the contract restatement for mild-to-moderate behavioral health services. As way of background, the Alliance's Board approved ongoing service delivery of mild to moderate behavioral health benefits with Beacon at the October, 2020 meeting. We anticipate that this work will be completed shortly and will align with the timeline for submission to DHCS and other regulatory work required prior to implementation.

Beacon and Alliance staff met in early April to discuss and identify priority focus areas for our behavioral health work in 2021, which will include maternal mental health as well as children/adolescent behavioral health needs. These specific areas of focus will align with

ongoing community efforts to support synergy and to maximize impact in the communities that the Alliance serves.

The Health Services Division is sponsoring ongoing efforts to prepare for execution of Enhanced Care Management (ECM) and In-Lieu of Services (ILOS). Staff are engaged in internal work in preparation for the implementation of the new ECM benefit and ILOS, beginning in January of 2022. In preparation of transitioning existing County Whole Person Care Pilot members to ECM, the Community Care Coordination department has been conducting monthly meetings with each County to discuss transition activities to avoid adverse impacts to members in relation to the transition. There is also a monthly Community Care Coordination Stakeholder meeting between the Alliance and the Counties in our service area to discuss state and professional association updates, and to collaborate on Alliance deliverables that will be required to be provided to DHCS to demonstrate the Alliance's ability to implement the new benefit and services in 2022 and beyond.

Employee Services and Communications

Alliance Workforce. As of March 29, 2021, the Alliance has 516 budgeted positions of which our active workforce number is 478.2 (active FTE and temporary workers). There are 13.5 positions in active recruitment, and 27 positions are vacant. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets.

Human Resources has implemented appropriate guidelines under the new California Supplemental Paid Sick Leave under Senate Bill 95. This provides paid sick leave for employees with various COVID-related absences in addition to all paid time off benefits. This benefit is effective retroactive to January 1, 2021 through September 30, 2021.

At the Q1 2021 All Staff, we introduced our new Diversity, Equity and Inclusion (DEI) consultants, Dr. Carley Corrado and Lisa Dennen-Young from Enliven Leadership. The Alliance is committed to making a positive difference and is actively working to create additional channels to advance DEI in our work place. Organizational wide work has been kicked off and we are very excited about this project which will focus on diversity, equity and inclusion both internally and externally in our service areas.

The Alliance has completed its Q1 2021 Check-in as part of the updated Professional Development process. Leadership and staff participate in ongoing communication and feedback cycles and the quarterly check-ins support this model.

Facilities and Administrative Services. Capitola Manor: California's Office of Statewide Health Planning and Development (OSHPD) has indicated that the building has mold/moisture issues that need to be remediated before construction can begin. A change order has been submitted to contracts for approval. The Inspector of Record (IOR) contract has been executed. The IOR is primary liaison between the Alliance and OSHPD. Additional structural drawings and details are currently being addressed by a structural engineer as noted by the IOR to avoid any scheduling delays. The OSHPD Increment 1 permit has not yet been issued but is in process.

The Workspace Reentry Taskforce and Alliance Leadership has determined that staff will return to the office no sooner than July 2021 due to COVID-19 safety concerns. Core

essential staff continue to report into the building for specific tasks that require them to be onsite.

Facilities staff continue to provide support for Alliance staff by scheduling curbside pickups of business-critical items (chairs, mice, monitor risers, keyboards, etc.) to ensure a safe and comfortable work environment at home.

Communications. The team is working with Regional Operations to launch a digestible, digital email newsletter meant to engage community partners and raise awareness about key Alliance activities that positively impact the health of the communities we serve. This bi-monthly email newsletter, called "The Beat", will be launched in late April and will include three to five topics per issue. The audience will include a variety of external partners and community stakeholders within the Alliance's service area. The email newsletter will also be posted on the Alliance website.

The external website re-launch project is on track for an early July launch. The new website will provide a professional, branded, mobile-responsive, compliant user experience, with easily digestible, searchable content.

Operations

CommonSpirit Update. After seven months of ongoing negotiations, the Alliance and CommonSpirit (representing Dignity Health hospitals and providers in Santa Cruz and Merced Counties) reached agreement on renewal terms for a multi-year contract with the Alliance for Dominican Hospital and Mercy Medical Center Merced. Alliance members will maintain continued access to care at these hospitals. CommonSpirit also agreed to continue providing Primary Care, Specialty Care and Home Health services and providers remained in the Alliance provider network effective April 1, 2021. Staff finalized language for hospital amendments reflecting agreed upon terms on April 7, 2021, as anticipated.

Ensuring Alliance members have access to care remains our priority and the focus as the Alliance worked diligently to reach an agreement that supports our long-term financial health. Upon successful conclusion of the negotiation, Alliance staff began engaging members and providers as follows:

- Provider Services deployed a three-day provider engagement campaign. Staff contacted Dignity Health providers, community primary care providers to whom members previously assigned to Dignity Health were reassigned on April 1, 2021 and specialists anticipated to see additional members in the absence of Dignity Health providers. All providers were informed that Dignity Health remained in network and available to Alliance members. Providers expressed appreciation that the negotiations concluded successfully. Alliance staff continue to work with primary care providers to ensure that members are assigned to the provider of their choice on May 1, 2021.
- Approximately 15,000 Alliance members received revised communications from the Alliance. As required by DHCS, a written notice should be mailed to members impacted by PCP assignment changes which resulted from the prior CommonSpirit termination negotiations. The revised written notice informs members that CommonSpirit providers, including Dignity Health Medical and Mercy Medical

Foundations and Groups, will remain in-network and will continue seeing Alliance members.

- The Alliance's Your Health Matters member outreach program staff initiated an outbound call campaign to inform members who were previously assigned to Dignity Health primary care providers. Nearly 2,600 outreach calls will be placed to members previously approved for continuity of care services with Dignity and Mercy providers. In addition, members have contacted the Member Services Department to obtain updated information and to be reassigned to their Dignity Health provider effective May 1, 2021.
- In partnership with CommonSpirit, the Alliance held meetings with Dignity Health Dominican Hospital (Santa Cruz County) and Dignity Health Mercy Medical Center (Merced County) the week of March 22, 2021. The goals of the meetings were to discuss continuity of care arrangements each organization will be putting in place, support clinical and operational leaders in affirming a plan that supports members and providers and align on mutually agreeable next steps. With a successful conclusion of the negotiation and completion of the amendments, the Alliance and Dignity Health will initiate strategically oriented joint operations committee meetings to support development and implementation of initiatives planned between our organizations to improve utilization and member health outcomes.

As always, the Alliance remains committed to our mission of providing accessible, quality health care guided by local innovation and are pleased that CommonSpirit remains an important Alliance partner towards the vision of healthy people, healthy communities.

Claims Director Transition. On April 9, 2021, Frank Souza, the Alliance's Claims Director retired after nearly 18 years of service and having an immeasurable impact. Frank was instrumental in his support of the Healthy Kids Program and through his support of the Claims Department over the past decade. The Alliance began recruitment for our next Claims Director in early 2021 and Bryan Smith joined the Operations Division on March 29, 2021. Bryan comes to us with nearly 20 years of claims management experience including operational expertise in Medicaid and Medicare programs. He served at Humana as Manager and then Director of Claims Operations. During that time, he oversaw Grievance and Appeals. Bryan also served as Executive Director of Claims at Community First Health Plan and Vice President at Health First with operational oversight of claims operations, quality, training and enrollment. Bryan holds a Bachelor of Business Administration from McKendree University in Louisville, Kentucky. Through our discussions with Bryan, his commitment to the mission and alignment with Alliance values came through. He is committed to recognizing and honoring the history of our organization while also leading towards the future.

DATE: April 28, 2021

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Second Month Ending February 28, 2021

For the month ending February 28, 2021, the Alliance reported a Medical Loss Ratio (MLR) of 89.6%, an Administrative Loss Ratio (ALR) of 5.3% and Operating Income Ratio of 5.1%. The Year-to-Date (YTD) MLR is 89.9%, ALR is 5.4% and the Operating Income is 4.7%. Please note that the YTD medical cost reflected services for November through February. This income is primarily due to lower outpatient utilization during the pandemic and stay at home orders between November 2020 and January 2021. Overall utilization for Q4 2020 was down 19% from the same period in 2019. As a result, YTD medical expenses are favorable to budget by $10.1M or 4.3%.

Notably however, YTD Inpatient Services (Hospital), which is roughly a third of total medical cost, is unfavorable by $3.5M or 4.7%. This is due to an increased number of inpatient stays from COVID-19 cases and is further explained in the Medical Expenses section of this report. The inpatient budget for this period assumes cost and utilization trends based on historical experience and does not assume impact from cost containment efforts. The Inpatient unfavorable variance is offset by favorability across all other categories of service. This results in a net favorability of $11.70 per member per month (PMPM), or 3.7% favorable to budget.

As stay at home orders and public health guidance continued to encourage people to limit activities early in the year, it is expected that utilization in the outpatient setting may remain suppressed through Q1 2021. As restrictions are loosened and vaccine becomes more widely available, it is expected (and desired) that outpatient utilization will resume in Q2 2021 and beyond, with costs expected to align to the 2021 budget. Staff assume a resumption of the delayed elective procedures, surgeries, and specialist referrals to be scheduled as restrictions on activities loosen and COVID-19 rates continue to decrease, and service levels return to normal.

The Alliance must maintain an adequate level of financial reserves to ensure financial sustainability. The fund balance was approximately $457.9M or 92.3% of the Board Designated Target. Staff continue executing the Board Approved Cost Containment Plan to meet this target.

Feb-21 MTD (In $000s)

Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*369,355*	*371,753*	*(2,398)*	*-0.6%*
Revenue	124,073	123,021	1,052	0.9%
Medical Expenses	111,124	116,526	5,401	4.6%
Administrative Expenses	6,586	6,525	(61)	-0.9%
Operating Income/(Loss)	6,363	(30)	6,393	100.0%
Net Income/(Loss)	6,378	(679)	7,056	100.0%
MLR %	*89.6%*	*94.7%*	*5.2%*	
ALR %	*5.3%*	*5.3%*	*0.0%*	
Operating Income %	*5.1%*	*0.0%*	*5.2%*	
Net Income %	*5.1%*	*-0.6%*	*5.7%*	

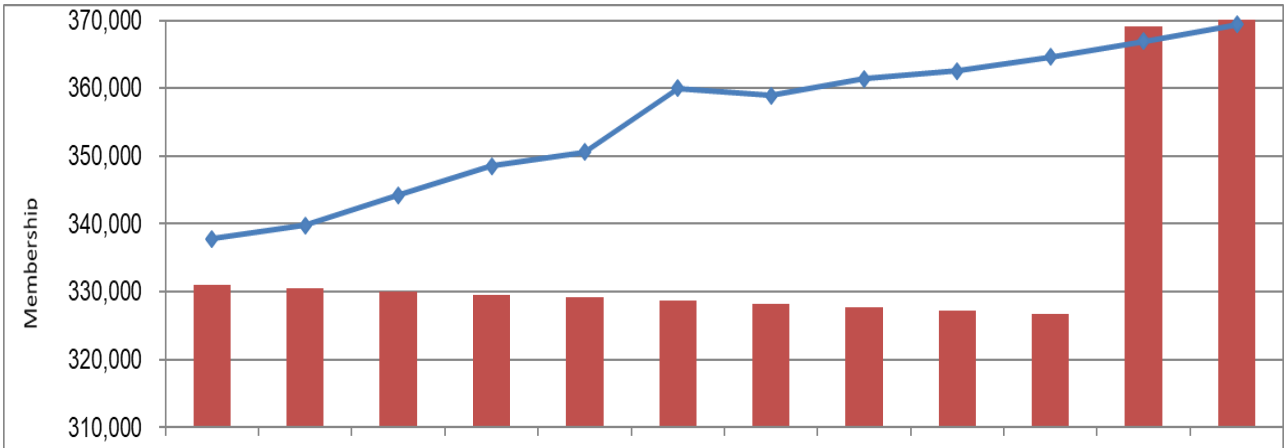
Feb-21 YTD (In $000s)

Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Membership	*736,293*	*740,899*	*(4,606)*	*-0.6%*
Revenue	247,390	245,372	2,018	0.8%
Medical Expenses	222,290	232,348	10,058	4.3%
Administrative Expenses	13,482	13,423	(59)	-0.4%
Operating Income/(Loss)	11,618	(399)	12,017	100.0%
Net Income/(Loss)	9,846	(1,684)	11,530	100.0%
PMPM				
Revenue	335.99	331.18	4.81	1.5%
Medical Expenses	301.90	313.60	11.70	3.7%
Administrative Expenses	18.31	18.12	(0.19)	-1.1%
Operating Income/(Loss)	15.78	(0.54)	16.32	100.0%
MLR %	89.9%	*94.7%*	*4.8%*	
ALR %	*5.4%*	*5.5%*	*0.0%*	
Operating Income %	*4.7%*	*-0.2%*	*4.9%*	
Net Income %	*4.0%*	*-0.7%*	*4.7%*	

Per Member Per Month. Capitation revenue and medical expenses are variable based on enrollment fluctuations, therefore the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not directly correspond with enrollment and are therefore viewed in terms of total dollar amount. At a PMPM level, year-to-date (YTD) revenue is $335.99, medical cost is $301.90 and administrative cost is $18.31, resulting in an operating income of $15.78 PMPM.

Membership. February 2021 Member Months are unfavorable to budget by 0.6%. In CY2020, the Member Months increased by 7% due to the suspension of the Medi-Cal redetermination process during the Public Health Emergency (PHE) period. The 2021 Budget assumes the PHE will end in June 2021.

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



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Budget	331,016	330,532	330,049	329,570	329,092	328,615	328,140	327,668	327,197	326,727	369,146	371,753
Actual	337,765	339,740	344,209	348,505	350,560	359,992	358,888	361,422	362,525	364,602	366,938	369,355
Variance	6,749	9,208	14,160	18,935	21,468	31,377	30,748	33,754	35,328	37,875	(2,208)	(2,398)
Variance %	2.0%	2.8%	4.3%	5.7%	6.5%	9.5%	9.4%	10.3%	10.8%	11.6%	-0.6%	-0.6%

Revenue. February 2021 Medi-Cal revenue of $123.8M is favorable to budget by $1.1M or 0.9%. This favorability is attributed to $1.9M in rate variances and offset by $0.8M due to enrollment unfavorability. February 2021 YTD revenue of $246.9M is favorable to budget by $2.1M or 0.8%. Of this $2.1M favorability, $0.6M is attributed to enrollment and $1.5M to rate variance.

Feb-21 YTD Medi-Cal Capitation Revenue Summary (In $000s)

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	55,436	54,937	499	472	27
Monterey	107,518	106,342	1,176	9	1,167
Merced	83,897	83,501	396	113	283
Total	**246,852**	**244,780**	**2,072**	**594**	**1,478**

Medical Expenses. February 2021 Medical Expenses of $111.1M is favorable to budget by $5.4M or 4.6%. February 2021 YTD Medical Expenses are $222.3M, which is favorable to budget by $10.1M or 4.3%, with an MLR of 89.9%. Of this $10.1M favorability, $1.4M is attributed to enrollment and $8.6M to rate variance. Please note that rate (PMPM) is the unit cost for a service times the utilization for the service. The suppressed utilization contributed to the favorable rate variance. YTD Medical Expenses include an additional $2.0M IBNR reserve for the COVID-19 pandemic under Inpatient Services (Hospital).

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

Category	Actual	Budget	Total Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	76,407	72,946	(3,461)	453	(3,914)
Inpatient Services (LTC)	27,154	29,923	2,769	186	2,583
Physician Services	34,467	38,082	3,614	237	3,378
Outpatient Facility	11,799	13,696	1,897	85	1,812
Pharmacy	30,388	34,537	4,149	215	3,934
Other Medical	42,074	43,163	1,089	268	821
Total	**222,290**	**232,348**	**10,058**	**1,444**	**8,614**

At a PMPM level, YTD Medical Expenses are $301.90, which is favorable by $11.70 or 3.7% as compared to budget. YTD Inpatient Services are unfavorable to budget by 5.4%, this is driven by the increase in active COVID-19 cases. From March 2020 through October 2020, we had an average of 68 monthly cases. For the four-month period between November 2020 and February 2021, we had an average of 295 monthly cases.

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

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	103.77	98.46	(5.32)	-5.4%
Inpatient Services (LTC)	36.88	40.39	3.51	8.7%
Physician Services	46.81	51.40	4.59	8.9%
Outpatient Facility	16.02	18.49	2.46	13.3%
Pharmacy	41.27	46.61	5.34	11.5%
Other Medical	57.14	58.26	1.12	1.9%
Total	**301.90**	**313.60**	**11.70**	**3.7%**

Administrative Expenses. February 2021 YTD Administrative Expenses are unfavorable to budget by $0.1M or 0.4% resulting in a 5.4% ALR. Salaries, Wages and Benefits (SWB) are unfavorable to budget by $0.7M or 7.5%. SWB are offset by favorability in Non-Salary Administrative Expenses of $0.6M or 12.9%.

Non-Operating Revenue/Expenses. February 2021 YTD Total Non-Operating Revenue is unfavorable to budget by $1.1M or 80.8% which is primarily driven by lower interest income and unrealized investment gain. February 2021 YTD Grants are favorable to budget by $0.6M or 22.2%.

Overall, the Alliance generated a YTD Net Income of $9.8M.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Second Month Ending February 28, 2021
(In $000s)

Assets	
Cash	$154,646
Restricted Cash	300
Short Term Investments	356,166
Receivables	169,429
Prepaid Expenses	2,253
Other Current Assets	19,069
Total Current Assets	**$701,864**
Building, Land, Furniture & Equipment	
Capital Assets	$83,694
Accumulated Depreciation	(37,351)
CIP	2,601
Total Non-Current Assets	**48,944**
Total Assets	**$750,808**
Liabilities	
Accounts Payable	$27,017
IBNR/Claims Payable	246,109
Accrued Expenses	1
Estimated Risk Share Payable	11,660
Other Current Liabilities	8,153
Due to State	0
Total Current Liabilities	**$292,941**
Fund Balance	
Fund Balance - Prior	$448,021
Retained Earnings - CY	9,846
Total Fund Balance	**457,867**
Total Liabilities & Fund Balance	**$750,808**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Second Month Ending February 28, 2021
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*369,355*	*371,753*	*(2,398)*	*-0.6%*	*736,293*	*740,899*	*(4,606)*	*-0.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$123,807	$122,726	$1,081	0.9%	$246,852	$244,780	$2,072	0.8%
Premiums Commercial	267	296	(29)	-9.9%	538	592	(54)	-9.1%
Total Operating Revenue	**$124,073**	**$123,021**	**$1,052**	**0.9%**	**$247,390**	**$245,372**	**$2,018**	**0.8%**
Medical Expenses								
Inpatient Services (Hospital)	$36,078	$36,799	$721	2.0%	$76,407	$72,946	($3,461)	-4.7%
Inpatient Services (LTC)	13,752	14,470	718	5.0%	27,154	29,923	2,769	9.3%
Physician Services	17,924	19,224	1,299	6.8%	34,467	38,082	3,614	9.5%
Outpatient Facility	6,052	6,914	863	12.5%	11,799	13,696	1,897	13.9%
Pharmacy	14,717	17,300	2,583	14.9%	30,388	34,537	4,149	12.0%
Other Medical	22,601	21,819	(782)	-3.6%	42,074	43,163	1,089	2.5%
Total Medical Expenses	**$111,124**	**$116,526**	**$5,401**	**4.6%**	**$222,290**	**$232,348**	**$10,058**	**4.3%**
Gross Margin	**$12,949**	**$6,496**	**$6,453**	**99.3%**	**$25,100**	**$13,024**	**$12,076**	**92.7%**
Administrative Expenses								
Salaries	$4,626	$4,276	($350)	-8.2%	$9,426	$8,765	($661)	-7.5%
Professional Fees	65	161	95	59.4%	138	327	189	57.9%
Purchased Services	807	787	(20)	-2.5%	1,618	1,627	9	0.6%
Supplies & Other	494	591	97	16.4%	1,050	1,279	229	17.9%
Occupancy	43	108	65	60.3%	146	217	72	33.0%
Depreciation/Amortization	551	602	52	8.6%	1,105	1,208	103	8.5%
Total Administrative Expenses	**$6,586**	**$6,525**	**($61)**	**-0.9%**	**$13,482**	**$13,423**	**($59)**	**-0.4%**
Operating Income	**$6,363**	**($30)**	**$6,393**	**100.0%**	**$11,618**	**($399)**	**$12,017**	**100.0%**
Non-Op Income/(Expense)								
Interest	$203	$582	($379)	-65.1%	$457	$1,168	($710)	-60.8%
Gain/(Loss) on Investments	(156)	(23)	(133)	-100.0%	(453)	(47)	(406)	-100.0%
Other Revenues	151	97	54	55.6%	248	194	54	27.7%
Grants	(183)	(1,305)	1,122	86.0%	(2,024)	(2,601)	576	22.2%
Total Non-Op Income/(Expense)	**$15**	**($649)**	**$664**	**100.0%**	**($1,772)**	**($1,286)**	**($486)**	**-37.8%**
Net Income/(Loss)	**$6,378**	**($679)**	**$7,056**	**100.0%**	**$9,846**	**($1,684)**	**$11,530**	**100.0%**
MLR	*89.6%*	*94.7%*			*89.9%*	*94.7%*		
ALR	*5.3%*	*5.3%*			*5.4%*	*5.5%*		
Operating Income	*5.1%*	*0.0%*			*4.7%*	*-0.2%*		
Net Income %	*5.1%*	*-0.6%*			*4.0%*	*-0.7%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Second Month Ending February 28, 2021
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*369,355*	*371,753*	*(2,398)*	*-0.6%*	*736,293*	*740,899*	*(4,606)*	*-0.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$335.20	$330.13	$5.07	1.5%	$335.26	$330.38	$4.88	1.5%
Premiums Commercial	0.72	0.80	(0.07)	-9.3%	0.73	0.80	(0.07)	-8.5%
Total Operating Revenue	**$335.92**	**$330.92**	**$5.00**	**1.5%**	**$335.99**	**$331.18**	**$4.81**	**1.5%**
Medical Expenses								
Inpatient Services (Hospital)	$97.68	$98.99	$1.31	1.3%	$103.77	$98.46	($5.32)	-5.4%
Inpatient Services (LTC)	37.23	38.92	1.69	4.3%	36.88	40.39	3.51	8.7%
Physician Services	48.53	51.71	3.18	6.2%	46.81	51.40	4.59	8.9%
Outpatient Facility	16.38	18.60	2.21	11.9%	16.02	18.49	2.46	13.3%
Pharmacy	39.84	46.54	6.69	14.4%	41.27	46.61	5.34	11.5%
Other Medical	61.19	58.69	(2.50)	-4.3%	57.14	58.26	1.12	1.9%
Total Medical Expenses	**$300.86**	**$313.45**	**$12.59**	**4.0%**	**$301.90**	**$313.60**	**$11.70**	**3.7%**
Gross Margin	**$35.06**	**$17.47**	**$17.59**	**100.0%**	**$34.09**	**$17.58**	**$16.51**	**93.9%**
Administrative Expenses								
Salaries	$12.53	$11.50	($1.02)	-8.9%	$12.80	$11.83	($0.97)	-8.2%
Professional Fees	0.18	0.43	0.26	59.1%	0.19	0.44	0.25	57.6%
Purchased Services	2.18	2.12	(0.07)	-3.2%	2.20	2.20	(0.00)	-0.1%
Supplies & Other	1.34	1.59	0.25	15.8%	1.43	1.73	0.30	17.4%
Occupancy	0.12	0.29	0.17	60.0%	0.20	0.29	0.10	32.5%
Depreciation/Amortization	1.49	1.62	0.13	8.0%	1.50	1.63	0.13	8.0%
Total Administrative Expenses	**$17.83**	**$17.55**	**($0.28)**	**-1.6%**	**$18.31**	**$18.12**	**($0.19)**	**-1.1%**
Operating Income	**$17.23**	**($0.08)**	**$17.31**	**100.0%**	**$15.78**	**($0.54)**	**$16.32**	**100.0%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Second Month Ending February 28, 2021
(In $000s)

	MTD	YTD
Net Income	$6,378	$9,846
Items not requiring the use of cash: Depreciation	551	1,105
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	85,721	78,300
Prepaid Expenses	(706)	568
Current Assets	(239)	436
Net Changes to Assets	**$84,777**	**$79,304**
Changes to Payables:		
Accounts Payable	11,522	(13,543)
Accrued Expenses	6	-
Other Current Liabilities	282	690
Incurred But Not Reported Claims/Claims Payable	(202,078)	(81,276)
Estimated Risk Share Payable	828	1,650
Due to State	-	-
Net Changes to Payables	**($189,440)**	**($92,478)**
Net Cash Provided by (Used in) Operating Activities	**($97,735)**	**($2,223)**
Change in Investments	(54)	(56)
Other Equipment Acquisitions	(1)	(121)
Net Cash Provided by (Used in) Investing Activities	**($55)**	**($177)**
Net Increase (Decrease) in Cash & Cash Equivalents	**($97,790)**	**($2,399)**
Cash & Cash Equivalents at Beginning of Period	**$252,436**	**$157,045**
Cash & Cash Equivalents at February 28, 2021	**$154,646**	**$154,646**

DATE: April 28, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Physicians Advisory Group: Member Appointment

Recommendation. Staff recommend the Board approve the appointment of the individual listed below to the Physicians Advisory Group (PAG).

Background. The Board established the PAG authorized in the Bylaws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission.

Discussion. The following individual has indicated interest in participating on the PAG.

Name	Affiliation	County
Salvador Sandoval, MD	Provider Representative	Merced

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

Attachments. N/A

SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, March 24, 2021

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

Commissioners Present:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Supervisor Ryan Coonerty	County Board of Supervisors
Dr. Larry deGhetaldi	Provider Representative
Dr. Gary Gray	Hospital Representative
Ms. Mimi Hall	County Health Services Agency Director
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Ms. Rebecca Nanyonjo	Director of Public Health
Supervisor Josh Pedrozo	County Board of Supervisors
Ms. Elsa Quezada	Public Representative
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Dr. Joerg Schuller	Hospital Representative
Mr. Rob Smith	Public Representative
Mr. Tony Weber	Provider Representative

Commissioners Absent:

Dr. Maximiliano Cuevas	Provider Representative
Ms. Julie Edgcomb	Public Representative

Staff Present:

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

Ms. Jenifer Mandella	Compliance Officer
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Coonerty.

Commission Chairperson Coonerty called the meeting to order at 3:04 p.m.

No changes to the agenda were made.

Roll call was taken and a quorum was present.

2. Oral Communications.

Chair Coonerty 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 Coonerty opened the floor for Commissioners to make comments.

No comments or announcements from Commissioners at this time.

4. Comments and announcements by Chief Executive Officer.

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

Ms. Sonnenshine, CEO, reminded the Board that they would adjourn to closed session following the regular agenda and to have necessary log in information at the ready. She added that staff's recommendation regarding Medi-Cal Procurement will be brought back to the April 28, 2021 board meeting as both Mariposa and San Benito County requested extensions to submit their letters of intent.

Consent Agenda Items: (5. – 8F.): 3:06 p.m.

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

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

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Coonerty, deGhetaldi, Gray, Hall, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada, Rabago, Radner, Schuller, Smith and Weber.

Noes: None.

Absent: Commissioners Cuevas and Edgcomb.

Abstain: None.

Regular Agenda Item: (9. - 10.): 3:09 p.m.

9. Consider approving the Alliance's legal and regulatory Compliance Program Report for 2020, consider approving a revised Alliance Code of Conduct for 2021 and receive required Board training in Compliance. (3:09 – 3:34 p.m.)

Ms. Jenifer Mandella, Compliance Officer, presented the Alliance Compliance Program Report for 2020 and provided required annual Board training in compliance. Key takeaways from the training included 1) a highly regulated and ever-changing environment; 2) the Compliance Program mitigates risk by preventing, identifying and correcting non-compliance; and 3) the Alliance Board is a key participant in the Compliance Program, providing oversight and ensuring an effective program.

MOTION: Commissioner Smith moved to approve the Alliance's legal and regulatory Compliance Program Report for 2020 and approve a revised Alliance Code of Conduct for 2021, seconded by Commissioner Askew.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Coonerty, deGhetaldi, Gray, Hall, Jimenez, Kalantari-Johnson, Molesky, Nanyonjo, Pedrozo, Quezada, Rabago, Radner, Schuller, Smith and Weber.

Noes: None.

Absent: Commissioners Cuevas and Edgcomb.

Abstain: None.

10. Discuss Alliance Strategic Plan. (3:34 – 4:18 p.m.)

Ms. Stephanie Sonnenshine, CEO, introduced Ms. Wendy Todd, Wendy Todd Consulting, who facilitated discussion around the Alliance strategic planning progress, themes identified from the Board survey responses and next steps.

Commissioners were provided feedback and input on the survey results to inform the design of the June Board retreat. Common themes related to the Alliance's strengths included adherence to the mission and providing access to health care, focus on and supporting members, and promoting quality through provider incentives. Areas of opportunity identified for improvement included fiscal health, alignment on scope of the organization, Board cohesion and representation, provider network, mental health and care coordination. Common themes related to opportunities to leverage included community engagement and partnerships, policy and financial opportunities, quality improvement and social determinants of health. Common themes related to potential threats included increased expectations of health plans and uncertain political and financial environment, provider capacity and poor health/socio-economic and environmental conditions of members. A majority of respondents agreed that the Alliance should consider creating a focus area/strategic priority and goals to impact community health more broadly. Other social determinants of health to potentially address comprised of continued investment in behavioral health, employment opportunities and policies, caregiving, broadband/internet access and small pharmacies that are not able to access equipment.

Additional discussion topics included fiscal sustainability, population health, member engagement and access, pediatrics and children, the role the Board can play to demonstrate commitment to equity, and what is most important for the Alliance to consider through the strategic planning process. Topics for June retreat planning were also discussed and considered.

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

Adjourn to Closed Session

Chair Coonerty moved the commission into Closed Session at 4:18 p.m.

11. Closed session pursuant to Government Code Section 54957.6 regarding the Agency's performance evaluation of the CEO.

Return to Open Session

Chair Coonerty reconvened the meeting to Open Session at 5:16 p.m.

12. Closed session pursuant to Government Code Section 54956.87(c); Contract Negotiations.

Chair Coonerty reported from Closed Session that the Board discussed and accepted staff's report.

The Commission adjourned its meeting of March 24, 2021 at 5:18 p.m. to April 28, 2021 at 3:00 p.m. via teleconference unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

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

Meeting Minutes

Wednesday, December 2, 2020

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

Members Present:

Ms. Leslie Conner	Provider Representative
Ms. Mimi Hall	County Health Services Agency Director
Supervisor Lee Lor	County Board of Supervisors
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. Oksana Chabanenko	Finance Administrative Specialist

1. Call to Order by Chairperson Molesky. (1:35 p.m.)

Chairperson Molesky called the meeting to order at 1:35 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:36 – 1:37 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.

Chairperson Molesky made note for the record that he had received an inquiry from a physician related to reimbursement for telecom visits. Chairperson Molesky indicated that details of the inquiry have been forwarded to Alliance staff.

Consent Agenda Items:

3. Approve minutes of September 23, 2020 meeting of the Finance Committee. (1:38 – 1:40 p.m.)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the September 23, 2020 meeting. Commissioner Weber moved to approve the minutes, seconded by Commissioner Lor. Motion carried with 5 votes affirmative, 2 absent and was so ordered.

4. Approve Finance Committee Meeting Schedule for 2021. (1:41 – 1:42 p.m.)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the 2021 Finance Committee meeting schedule. Commissioner Hall moved to approve the 2021 schedule, seconded by Commissioner Conner. Motion carried with 5 votes affirmative, 2 absent and was so ordered.

Regular Agenda Items:

5. Year-to-date September 2020 Financials. (1:43 – 1:51 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioners on the Alliance's most recent financials. As of September 30, 2020, the operating loss for all lines of business stands at $35.8M, which is $3M favorable to budget. Medical expenses are unfavorable to budget by $40.1M or 4.4%. Revenue is favorable to budget by $43.2M or 4.7%.

[Allen Radner, MD arrived at this time: 1:45 p.m.]

Ms. Ba explained that a detailed look at per member per month (PMPM) data provides a clearer view of the cost and revenue because much of the variance is due to enrollment.

Year-to-date PMPM revenue is $311 which is $0.11 unfavorable to budget. This includes the 1.5% rate reduction by the Department of Health Care Services (DHCS), Medical expenses are at $302 PMPM, or 0.2% favorable to budget. Administrative expenses are at $20 PMPM, or 4.7% favorable to budget, resulting in an operating loss of $11.52 PMPM. The Medical Loss Ratio (MLR) is 97.3% compared to the budget of 97.5% and with the goal being to maintain an MLR between 92% and 93%, at which point we can achieve break-even with staff being committed to maintaining the Administrative Loss Ratio (ALR) at less than 7%.

Next, Ms. Ba oriented the committee to the MLR by Category of Aid as broken down by county. Of note, for the Non-Whole Child Model we are over the target with an MLR of 95%, and for the Whole Child Model (WCM) the total MLR is significantly above target at 113%. In a more detailed view of the Non-Whole Child Model categories, Ms. Ba explained that for Long-Term Care (LTC) the MLR is 116%, The MLR for the Medi-Cal Expansion (MCE) is at 100%. Ms. Ba explained that, when the Affordable Care Act Optional Expansion (ACA OE) was implemented in 2014, the State overestimated the cost and the rate was set significantly high. As the State began reducing the rates, we are now losing money on the Medi-Cal Expansion. With regards to revenue mix, Medi-Cal Expansion accounts for one third of our revenue and represents 25% of our membership. Child accounts for 44% of our membership and has a healthy MLR, but only represents 12% of our revenue,

With regards to Tangible Net Equity (TNE), Ms. Ba reported that the fund balance as of the end of September 2020 is $411M which is about $60M below the Board Designated Reserve Target.

Ms. Ba outlined the key takeaways from the year-to-date September financials noting that, although the operating loss is favorable to budget, it is still a loss. On a PMPM basis, when the medical cost is higher than revenue it is staff's priority to bring our contracts in line with revenue, utilization trend and industry standard so that we can achieve break-even at a PMPM level. With regards to administrative costs, staff have implemented cost savings measures and expect to end the year within budget.

6. 2021 Budget and Medical Cost Assumption Detail. (1:51-2:12 p.m.)

Ms. Ba explained that staff developed the budget in October and November 2020 prior to receiving the notification that the Pharmacy Carve-Out that was to take effect on January 1, 2021 would be delayed until April 2021. Therefore, the proposed budget does not include pharmacy.

Ms. Ba reported that enrollment assumptions include a base period for the enrollment budget of January through October of 2020. Staff trended growth through June 2021. Ms. Ba explained that this projection is built on the assumption that the public health emergency (PHE) will end by June 30, 2021 and that redetermination will resume in July. The expectation then is that this would result in a decrease in the Plan's enrollment after July 2021. The Department of Health Care Services (DHCS) predicts that it will take a year to complete the redetermination process which would mean that by July 2022 the enrollment would fall back to the pre-pandemic level at about 340 to 350K enrolled.

Ms. Ba reviewed the revenue assumptions for the 2021 budget. The Plan has so far received two rate packages, one in September and one in October. The rate packages received had pharmacy revenue carved out and included the managed care efficiency adjustments for

Potentially Preventable Hospital Admission (PPA), the Healthcare Common Procedure Coding System (HCPCS) efficiency adjustment for Physician Administered Drugs (PAD), the Lower Acuity Non-Emergent (LANE) service efficiency adjustment for Emergency Department (ED) and the underwriting gain (UWG) reduction from 2.0% to 1.5%. Another rate package will be received in December and will include acuity adjustments for which the staff has built in an assumption of a 2% member acuity negative adjustment due to increased enrollment. The State has notified us that the pharmacy revenue will be included in the December package as the start date for the Pharmacy Carve-Out has been moved to April 1, 2021. Staff will need to reforecast in this area and amend the budget once this information is received.

Next, Ms. Ba spoke about the medical expense assumptions. She explained that the medical budget was developed based on historical claims data in the period from April 2019 to March 2020. More recent data was not used due to the timing of the COVID-19 pandemic leading to decreased utilization which is not representative of the normal course of business. The medical budget incorporates the cost containment initiative to align in-area hospital rates with revenue and industry standards.

With regards to utilization, Ms. Ba noted that the assumption has been made that in 2021 the utilization will increase by 4.5% compared to 2019. She shared with the committee some of the trending data that was used to develop this forecast including a view of pre-pandemic utilization in 2019 as well as the typical trends per quarter. She explained that much of the assumption is based on how the pandemic progresses and when the vaccine becomes available enough to allow for care to resume to more typical levels. It is expected that this will lead to a busier third and fourth quarter in 2021 in terms of utilization.

With regards to the administrative budget, staff continue to improve the overall cost structure and administrative efficiency and to focus on operational efficiencies and financial stewardship. In terms of the total administrative budget, a proposal of $82.1M which represents 6.4% of total budgeted revenue reflects a 3.5% decrease from the 2020 budget. The 2021 budget also reflects a net reduction in Full Time Equivalent (FTE) positions.

In summary, based on the assumptions presented, staff is submitting a medical cost budget of $1.2B and an administrative cost budget of $82.1M. A total operating loss of $40M is budgeted for 2021.

7. Cost Containment Plan Update. (2:13-2:30 p.m.)

Ms. Ba communicated that Alliance staff are executing the cost containment plan and are currently in the process of renegotiating the in-area hospital contracts using the Medi-Cal APR-DRG as the benchmark. The CFO noted that a proposed hospital shared savings plan will be presented to the Board today for consideration and approval.

Ms. Ba opened the floor for questions and discussion.

Commissioner Leslie Conner commended staff on their good work in making progress with discussions with the hospitals and in managing the administrative costs.

Commissioner Michael Molesky commented on the Tangible Net Equity (TNE) target reserve being below the Board Designated Reserve and asked about the possibility of looking at the

grants and whether this impacts the Plan's ability to make investments to generate any return on the remaining TNE dollars. Ms. Ba pointed out that, use of the grant funds to address operating losses would only provide a short-term fix. It is more important to have a financial performance target and plan for how to achieve that target we do now have. Additionally, Ms. Ba stated that the Alliance is fortunate to have the grant funds available for innovative uses for the community when needed.

Stephanie Sonnenshine, Chief Executive Officer expressed her agreement with Ms. Ba's explanation and further explained that, with regards to grant funding, the Board will be engaged in the strategic planning process for the Health Plan to ensure that how we utilize the grant program moving forward is aligned with the overall priorities for the Health Plan.

Commissioner Mimi Hall thanked Ms. Sonnenshine and Ms. Ba for their comments and work in planning for the Plan's future. She added that the budget development process and the plan to address structural problems is a statement of the values and principles of the Alliance as an organization and that the members and the reserve will benefit from this approach.

Commissioner Molesky asked if the hospital contracts should be in place prior to discussing a shared savings model. Ms. Ba shared that, as hospitals will be agreeing to align their current rates with industry benchmark, we want to engage the hospitals in cost savings ideas where the gain in savings can be shared with the hospitals. This is also aligned with our value-based payment strategic goal.

Commissioner Molesky expressed agreement with this philosophy and asked about the possibility of a provider choosing not to contract with the Alliance and how that might impact members and providers. Ms. Sonnenshine responded by explaining that, in the event that a provider refuses to contract with the Alliance, the Plan would pay non-contracted rate. Ms. Sonnenshine emphasized however, that it is our intent to work with our hospital partners to bring them into contract. She noted that the Alliance values the hospitals in our area and Ms. Ba and her team are working diligently with our hospital partners to conclude these negotiations.

In addition, Ms. Sonnenshine assured the committee that if staff had any concerns about access of services, or if there were any regulatory issues associated with access because of any contract termination, we would make the Board aware of those changes, and we do not have anything to report on that today.

Commissioner Molesky stated that this information was encouraging to hear and noted that the shared savings model seems to send a message of collaborating for the betterment of our members and providers alike. He thanked Ms. Ba and staff for their continued work towards improving financial performance.

Ms. Ba thanked the commissioners for their support and dedication especially in representing this committee to the Board and for their help related to the passing of the cost containment plan. Commissioner Molesky joined the CFO in thanking the committee members for their hard work and also thanked the new commissioners who have helped to provide a well-rounded representation from all three counties.

Commissioner Molesky opened the floor for any other questions about any information presented or any suggestions on the upcoming March 24, 2021 Finance Committee agenda. No feedback was received.

Adjourn:

The Commission adjourned its meeting of December 2, 2020 at 2:30 p.m. to March 24, 2021 at 1:30 p.m. via teleconference from the Alliance office in Scotts Valley, Salinas, and Merced.

Respectfully submitted,

Ms. Dulcie San Paolo
Finance Administrative Specialist

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, December 17, 2020
12:00 p.m. 1:00 p.m.

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

Committee Members Present:

Liz Falade, MD	Provider Representative
Robert Dimand, MD	Provider Representative
Gary Gray, DO	Board Representative
John Mark, MD	Provider Representative

Committee Members Absent:

Jennie Jet, MD	Provider Representative
Amanda Jackson, MD	Provider Representative
Salem Magarian, MD	Provider Representative
Patrick Clyne, MD	Provider Representative

Staff Present:

Dale Bishop, MD	Chief Medical Officer
Maya Heinert, MD	Medical Director
Dianna Diallo, MD	Medical Director
Jennifer Mockus	Community Care Coordination Director
Lilia Chagolla	Regional Operations Director
Mary Brusuelas, RN	UM & Complex Case Management Director
Michelle Stott, RN	Quality Improvement & Population Health Director
Sarah Sanders	Grievance and Quality Manager
Tammy Brass, RN	UM Manager - Prior Authorizations
Dana Marcos	Member Services Director
Angelique Milhouse	Provider Relations Liaison
Ronita Margain	Regional Operations Director
Tracy Neves	Clerk of the Committee

Hospital Representatives Present:

Vinyon Jackson	Hospital Representative

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

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

2. Oral Communications.

Chairperson Dr. Dale 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 September 17, 2020 meeting were reviewed.

B. Grievance Update
Dr. Bishop reviewed the Grievance presentation with the Committee. There was a question regarding grievance turnaround time. Urgent grievance requests are completed within 48 hours and routine requests within 30 days.

M/S/A Consent agenda items approved.

4. Old Business

A. COVID-19
Dr. Bishop noted COVID has recently become more problematic for the hospitals, and asked the Committee about their experiences. Provider noted pediatric patients under 1 year of age and those with underlying conditions tend to have more issues. Packard has had some increase in admissions but most patients have come in and been released; overall only a slight increase but nothing critical. Dr. Bishop noted that members ages 24-54 served by the Alliance are at highest risk and experiencing exposures.

Provider noted their hospital has been full for a week with 3-4 patients remaining in the emergency room. Once beds are free, they are immediately filled with another patient. The hospital is at capacity. Some patients are coming in for surgical procedures, are asymptomatic, and testing positive for COVID. Dr. Bishop noted that the Alliance is setting-up coverage schedules to assist providers with discharge placement during this time.

5. New Business

A. Title V, CCS Evaluation & CCS Eligibility
Dr. Diallo noted there has been concerns expressed by the State CCS Advisory Group and DHCS about an observed decrease in Whole Child Model (WCM) referrals, when plan Whole Child programs are compared to County CCS programs. Meetings are taking place to address the issue and a root cause analysis was done by the Quality Improvement department. Dr. Diallo shared data received from DHCS with the Committee illustrating the percentage of decrease for each county.

Prior to WCM, the referrals included PCPs, subspecialists, hospitals and the Alliance.

Counties opened CCS cases for a 3-month diagnosis period, and there were duplications from referral sources. After WCM, some confusion existed around providers being aware that they still needed to refer patients to CCS. Also, as a result, there were minimal duplicate referrals, inconsistencies around opening for diagnostic work-ups and delineation of responsibilities on referral processes. Per the Tri-County Quarterly meeting, there was a decrease in trauma/neonatal intensive care unit (NICU) referrals. Dr. Diallo presented a timeline that included the number of caseloads by health plans from 2015 to 2019. Some important dates noted included provider fax blasts, go-live, and referral clarifications made by DHCS. The Alliance is doing the following to increase referrals:

- Education of providers to resume CCS referrals through Joint Operational Committees.
- Quick reference guide for diagnoses.
- Provider outreach to panel targeted providers.
- Monthly meetings with counties to facilitate the referral and enrollment processes.
- Claims data, authorization, and pharmacy report reviews to capture diagnoses.

The Alliance is working to identify gaps by working with the counties, conducting monthly meetings, evaluation of the referral process and the Alliance's role in supporting those referrals. Some improvements made include risk stratification and ICP process improvement, age-out transition plans and eligibility.

Dr. Diallo noted UCSF family health outcomes project released the findings of the Title V Needs Assessment in March 2020. Based on the Alliance's WCM demographic data, compared to the state of California, Alliance members are more medically complex; predominately Hispanic; have less educational attainment; and require interpreting services more often.

Some Key Findings from Title V Needs Assessment:

ASSESSMENT TOPIC	CCAH	STATE
Family Effort:		
20+ hours per week family coordinating care	**33%**	14%
20-30 hours per week family provides care for medical condition	**20%**	7%
70+ hours per week family provides care for medical condition	14%	19%
Family needs to decrease work hours or leave job because of child's health	**72%**	53%
Health care provider helps link with support:		
Yes	43%	36%
No	27%	33%
Not Sure	31%	32%
Type of social/emotional support would help:		
Online or Tele-Support Group	20%	19%
In Person Support Group	40%	23%
Parent Mentor or Partner	22%	11%

Some key takeaways from the Title V Needs Assessment include the need for improved communication and education around resources, enhanced orientation/welcome written information, WCM webpage on the Alliance website and workshops targeting larger topics.

Next steps include; continue focus on increasing paneled providers and provider education on CCS referral process, continue to work with DHCS and counties to identify the gaps and work to close those gaps and target identified responses to the need's assessment.

Provider noted it might be helpful to reach out to other providers to see what are the barriers and how we can assist with referrals. Another provider noted the variability with the diagnostic referrals and the variability county by county.

Dr. Bishop noted the Alliance received new data through June and there has been an increase in Alliance Whole Child case eligibility suggesting that referrals have been increasing, the work the Alliance is doing seems to be working and progress is being made. The data through June will be shared at the next WCMCAC meeting. Dr. Bishop encouraged the Committee to reach out to the Alliance with any suggestions regarding how we can improve and better serve providers.

6. Open Discussion

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

Dr. Mark noted patients that need transportation to appointments have encountered issues with Uber and Lyft. Once the driver arrives and is made aware the appointment is at Packard, they leave and the member is unable to make it to his/her appointment. Another situation is the patient is transported to the appointment and the driver leaves, causing the patient to wait several hours for a ride home. Assistance is needed with member transportation in Greenfield, Salinas, and South County. Dana Marcos, Member Services Director, noted she is currently looking at the vendors and has implemented new practices. **Action:** Dana will connect with Dr. Mark to receive more information regarding the situation.

No further discussion.

The meeting adjourned at 12:50 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Committee

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

DATE: April 28, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: 2021 Legislative Session Update

Recommendation. Staff recommend the Board accept staff's report on the 2021 Legislative session, including adopting a position of support and directing staff to send a letter of support on the following bills: AB 4 (Arambula), SB 56 (Durazo), SB 316 (Eggman), and SB 365 (Caballero).

Background. Each legislative session staff works with its health plan associations, including the Local Health Plans of California (LHPC) and California Association of Health Plans (CAHP) as well as the Alliance's representatives in Sacramento, Edelstein, Gilbert, Robson and Smith (EGRS) to identify, review and monitor newly introduced legislation in the following areas of focus.

- Health Care Coverage/Delivery System Reform
- Medi-Cal Eligibility
- Medi-Cal Benefits
- Medi-Cal Provider Payments
- Medi-Cal Health Plan Revenue
- Medi-Cal and/or Managed Care Policies and Initiatives

Newly introduced bills in these categories are compiled into a bill list that staff monitors throughout the legislative session providing legislative updates to the board at its regular board meetings in April and June, or as needed. This includes staff identifying bills on which the board may wish to consider an advocacy position.

The bill list is attached for the board's information. Bills are separated into Tier 1 and Tier 2 categories. Tier 1 bill include those bills on which staff recommends that the board take an advocacy position as well as additional bills of interest given the potential for direct or significant impact on members, providers, and/or plan operations. Staff will take a position of "Watch Closely" on the remaining Tier 1 bills and will monitor the bills in Tier 2 for potential amendments of significance.

Discussion. The 2021 Legislative Session convened on January 11, 2021 with the deadline to introduce new legislation on February 19, 2021 and legislative committee hearings currently underway. Staff has developed a bill list that includes approximately 70 bills in the aforementioned areas of focus.

Among this list of bills, staff have identified four bills which staff recommends that the board consider taking an advocacy position of "Support".

These bills include legislative proposals previously supported by the board including eligibility expansion (AB 4 and SB 56) and a bill to allow Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs) to bill for same-day visits when certain conditions are met (SB 316). Also, included is a bill authored by Senator Caballero that makes electronic consultation services reimbursable under Medi-Cal program for enrolled providers, including FQHCs and RHCs.

- **AB 4 (Arambula) – Medi-Cal Eligibility**. Expands Medi-Cal coverage to all individuals who are eligible, regardless of immigration status.

- **SB 56 (Durazo) – Medi-Cal Eligibility.** Expands Medi-Cal coverage to all individuals over the age of 65, regardless of immigration status.

- **SB 316 (Eggman). Medi-Cal FQHC's and RHC's**. Authorizes FQHC or RHC reimbursement for a maximum of two visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit for purposes of establishing the FQHC's or RHC's rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill.

- **SB 365 (Caballero). E-Consult Services**. Makes electronic consultation services reimbursable under the Medi-Cal program for enrolled providers, including FQHCs or RHCs, and would require the department to develop a reimbursement policy for those services that, at a minimum, and with respect to primary care providers, is consistent with the Medicare program coverage policy. The bill would require the department to seek federal waivers and approvals to implement this provision.

In addition, staff have identified additional priority bills of interest given the potential for the impact on members, providers, and/or plan operations. Staff will take a "Watch Closely" position on these remaining Tier 1 Priority bills and provide board updates or recommendations for action as indicated.

These include, among other things, bills listed below that make permanent certain telehealth flexibilities allowed during the Public Health Emergency, implement various components of CalAIM and State budget proposals, develop a structure for Health Information Exchange and govern managed care plan payments and authorization processes.

- AB 32 (Aguiar-Curry) – Telehealth
- AB 368 (Bonta) – Medically Supported Food
- AB 685 (Maienschein) – Health Care Service Plans: Reimbursement
- AB 703 (Blanca Rubio) – Open meetings: local agencies: teleconferences
- AB 822 (Rodriguez) – Observation Services
- AB 935 (Maienschein) – Telehealth Mental Health
- AB 1131 (Wood) – Health Information Exchange
- AB 1160 (Blanca Rubio) – Medically Supported Food

- AB 1355 (Levine) – Medi-Cal Independent Medical Review System
- SB 242 (Newman) – Healthcare Provider Reimbursement
- SB 256 (Pan) – Medi-Cal Covered Benefits
- SB 371 (Caballero) – Health Information Technology
- SB 773 (Roth) – Medi-Cal Managed Care: Behavioral Health Services

Furthermore, staff will "Watch" all remaining bills on the bill list for any amendments or changes of significance to the Alliance and will report back to the board with updates.

Fiscal Impact. Recommendation to support legislation does not present immediate fiscal impact to the health plan. Fiscal impact of new services to be assessed at the time of implementation and accounted for in future medical budget.

Attachments.

1. 2021 Legislation Bill List

1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

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

Central California Alliance for Health
2021 Legislation
April 2021

Tier 1

AB 4 **Arambula**	**Medi-Cal Eligibility** **Summary:** Would expand Medi-Cal coverage to all individuals who are eligible, regardless of immigration status.
AB 32 **Aguiar-Curry**	**Telehealth** **Summary:** Current law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to specify that coverage is provided for health care services appropriately delivered through telehealth on the same basis and to the same extent as in person diagnosis, consultation, or treatment. Current law exempts Medi-Cal managed care plans that contract with the State Department of Health Care Services under the Medi-Cal program from these provisions, and generally exempts county organized health systems that provide services under the Medi-Cal program from Knox-Keene. This bill would delete the above-described references to contracts issued, amended, or renewed on or after January 1, 2021, would require these provisions to apply to the plan or insurer's contracted entity, as specified, and would delete the exemption for Medi-Cal managed care plans. The bill would subject county organized health systems, and their subcontractors, that provide services under the Medi-Cal program to the above-described Knox-Keene requirements relative to telehealth. The bill would authorize a provider to enroll or recertify an individual in Medi-Cal programs through telehealth and other forms of virtual communication, as specified.
AB 368 **Bonta**	**Medically Supported Food** **Summary:** Would require the State Department of Health Care Services to establish, no earlier than January 1, 2022, a pilot program for a 2-year period in 3 counties, including the County of Alameda, to provide food prescriptions for medically supportive food, such as healthy food vouchers or renewable food prescriptions, to eligible Medi-Cal beneficiaries, including individuals who have a specified chronic health condition, such as diabetes and hypertension, when utilizing evidence-based practices that demonstrate the prevention, reduction, or reversal of those specified diseases.
AB 685 **Maienschein**	**Health Care Service Plans: Reimbursement** Current law requires every insurer issuing group or individual policies of health insurance that cover hospital, medical, or surgical expenses to reimburse claims within specified timeframes and establishes the process for an insurer to contest or deny a claim for reimbursement. This bill would require health service plans and insurers to obtain an independent board-certified emergency physician review of the medical decision making related to a service before denying benefits, reimbursing for a lesser procedure, reducing reimbursement based on the absence of a medical emergency, or making a determination that medical necessity was not present for claims billed by a licensed physician and surgeon for emergency medical services, as specified.
AB 703 **Blanca Rubio**	**Open Meetings: Local Agencies Teleconferences** **Summary:** Current law, by Executive Order N-29-20, suspends the Ralph M. Brown Act's requirements for teleconferencing during the COVID-19 pandemic, provided that notice requirements are met, the ability of the public to observe and comment is preserved, as

	specified, and that a local agency permitting teleconferencing have a procedure for receiving and swiftly resolving requests for reasonable accommodation for individuals with disabilities, as specified. This bill would remove the requirements of the act particular to teleconferencing and allow for teleconferencing subject to existing provisions regarding the posting of notice of an agenda and the ability of the public to observe the meeting and provide public comment. The bill would require that, in each instance in which notice of the time of the teleconferenced meeting is otherwise given or the agenda for the meeting is otherwise posted, the local agency also give notice of the means by which members of the public may observe the meeting and offer public comment and that the legislative body have and implement a procedure for receiving and swiftly resolving requests for reasonable accommodation for individuals with disabilities, consistent with the federal Americans with Disabilities Act, as provided.
AB 822 **Rodriguez**	**Observation Services** **Summary:** Under current law, mental health plans provide specialty mental health services, and Medi-Cal managed health care plans and the fee-for-service Medi-Cal program provide non-specialty mental health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. To the extent funds are made available in the annual Budget Act, this bill would expand mental health services to include observation services, as defined, for emergency psychiatric treatment when provided in an observation unit, as defined, subject to utilization controls.
AB 935 **Maienschein**	**Telehealth Mental Health** **Summary:** Would require health care service plans and health insurers, by July 1, 2022, to provide access to a telehealth consultation program that meets specified criteria and provides providers who treat children and pregnant and certain postpartum persons with access to a mental health consultation program, as specified. The bill would require the consultation by a mental health clinician with expertise appropriate for pregnant, postpartum, and pediatric patients to be conducted by telephone or telehealth video, and to include guidance on the range of evidence-based treatment options, screening tools, and referrals. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing. The bill would require health care service plans and health insurers to monitor data pertaining to the utilization of the program to facilitate ongoing quality improvements, as necessary, and to provide a description of the program to the appropriate department.
AB 1131 **Wood**	**Health Information Exchange** **Summary:** Would require, by January 1, 2023, health plans, hospitals, medical groups, testing laboratories, and nursing facilities, at a minimum, contribute to, access, exchange, and make available data through the network of health information exchanges for every person, as a condition of participation in a state health program, including Medi-Cal, Covered California, and CalPERS. The bill would also state the intent of the Legislature to enact legislation that would expand the use of clinical and administrative data and further build on the promise of health information exchange, including specified strategies for achieving these goals.
AB 1160 **Blanca Rubio**	**Medically Supportive Food** **Summary:** Current law requires the State Department of Health Care Services to establish a Medically Tailored Meals Pilot Program to operate for a period of 4 years from the date the program is established, or until funding is no longer available, whichever date is earlier, in specified counties to provide medically tailored meal intervention services to Medi-Cal participants with prescribed health conditions, such as diabetes and

	renal disease. Effective for contract periods commencing on or after January 1, 2022, this bill would authorize Medi-Cal managed care plans to provide medically tailored meals to enrollees. The bill would authorize the department to implement this provision by various means, including plan or provider bulletins, and would require the department to seek federal approvals. The bill would condition the implementation of this provision on the department obtaining federal approval and the availability of federal financial participation.
AB 1355 **Levine**	**Medi-Cal Independent Medical Review System** **Summary:** Would require the Department of Health Care Services to establish the Independent Medical Review System (IMRS) for the Medi-Cal program, commencing on January 1, 2022, which generally models the specified described requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary grievance involving a disputed health care service is eligible for review under the IMRS, and would define "disputed health care service" as any service covered under the Medi-Cal program that has been denied, modified, or delayed by a decision of the department, or by one of its contractors that makes a final decision, in whole or in part, due to a finding that the service is not medically necessary. The bill would require information on the IMRS to be included in specified material, including the "myMedi-Cal: How to Get the Health Care You Need" publication and on the department's internet website.
SB 56 **Durazo**	**Medi-Cal Eligibility** **Summary:** Would expand Medi-Cal coverage to all individuals over the age of 65, regardless of immigration status.
SB 242 **Newman**	**Healthcare Provider Reimbursements** **Summary:** Requires that plans reimburse providers for business expenses that are necessary for service delivery, specifically PPE, equipment and testing supplies, transporting specimens, IT systems tracking, and others. This bill includes Medi-Cal and requires DHCS develop a reimbursement rate.
SB 256 **Pan**	**Medi-Cal Covered Benefits** **Summary:** This bill would require those mandatorily developed health-plan- and county-specific rates for specified Medi-Cal managed care plan contracts to include in lieu of services and settings provided by the Medi-Cal managed care plan. The bill would require each Medi-Cal managed care plan to disclose the availability of in lieu of services on its internet website and its beneficiary handbook, and to disclose to the department specified information on in lieu of services that are plan specific, including the number of people receiving those services. The bill would require the department to publish that information on its internet website.
SB 316 **Eggman**	**Medi-Cal FQHC's and RHC's** **Summary:** Current law provides that FQHC and RHC services are to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician and marriage and family therapist. Under existing law, "physician," for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a

	single location as a single visit for purposes of establishing the FQHC's or RHC's rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill.
SB 365 **Cabarello**	**E-Consult Services** **Summary:** Would make electronic consultation services reimbursable under the Medi-Cal program for enrolled providers, including FQHCs or RHCs, and would require the department to develop a reimbursement policy for those services that, at a minimum, and with respect to primary care providers, is consistent with the Medicare program coverage policy. The bill would require the department to seek federal waivers and approvals to implement this provision. The bill would make related findings and declarations.
SB 371 **Caballero**	**Health Information Technology** **Summary:** Would require any federal funds California Health and Human Services Agency (CHHSA) receives for health information technology and exchange to be deposited in the California Health Information Technology and Exchange Fund. The bill would authorize CHHSA to use the fund to provide grants to health care providers to implement or expand health information technology and to contract for direct data exchange technical assistance for safety net providers.
SB 773 **Roth**	Would require the Department of Health Care Services to make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics associated with targeted interventions, rendered by school-affiliated behavioral health providers, that increase access to preventive, early intervention and behavioral health services for children enrolled in kindergarten and grades 1-12, inclusive, at those schools. The bill would require the department to consult with certain stakeholders on the development of interventions, goals and metrics, to determine the amount of incentive payments, and to seek any necessary federal approvals.

Tier 2	
AB 77 **Petrie-Norris**	**SUD Treatment Services** **Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Current law provides for various benefits under the Medi-Cal program, including substance use disorder treatment and mental health services that are delivered through the Drug Medi-Cal Treatment Program, the Drug Medi-Cal organized delivery system, and the Medi-Cal Specialty Mental Health Services Program. This bill would declare the intent of the Legislature to enact Jarrod's Law, a licensure program for inpatient and outpatient programs providing substance use disorder treatment services, under the administration of the department.
AB 114 **Maienschein**	**Medi-Cal Benefits: Rapid Whole Genome Sequencing** **Summary:** Would expand the Medi-Cal schedule of benefits to include rapid Whole Genome Sequencing, including individual sequencing, trio sequencing, and ultra-rapid sequencing. The bill would authorize the department to implement this provision by various means without taking regulatory action.

AB 265 **Petrie-Norris**	**Medi-Cal Reimbursement** **Summary:** Current law requires the State Department of Health Care Services to develop, subject to federal approval, reimbursement rates for clinical or laboratory services according to specified standards, such as requiring that reimbursement to providers for those services not exceed the lowest of enumerated criteria, including 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services. This bill would delete provisions relating to the above-specified 80% standard and would make conforming changes.
AB 278 **Leyva**	**Medi-Cal Podiatric Services** **Summary:** Current law requires a health care provider applying for enrollment as a Medi-Cal services provider or a current Medi-Cal services provider applying for continuing enrollment, or a current Medi-Cal services provider applying for enrollment at a new location or a change in location, to submit a complete application package. Under current law, a licensed physician and surgeon practicing as an individual physician practice or a licensed dentist practicing as an individual dentist practice, who is in good standing and enrolled as a Medi-Cal services provider, and who is changing the location of that individual practice within the same county, is eligible to instead file a change of location form in lieu of submitting a complete application package. This bill would make conforming changes to the provisions that govern applying to be a provider in the Medi-Cal program, or for a change of location by an existing provider, to include a doctor of podiatric medicine licensed by the California Board of Podiatric Medicine.
AB 342 **Gipson**	**Health Care Coverage: Colorectal Cancer Screening and Testing** **Summary:** Would require a health care service plan contract or a health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2022, to provide coverage for colorectal cancer screening examinations and laboratory tests, as specified. The bill would require the coverage to include additional colorectal cancer screening examinations as listed by the United States Preventive Services Task Force as a recommended screening strategy and at least at the frequency established pursuant to regulations issued by the federal Centers for Medicare and Medicaid Services for the Medicare program if the individual is at high risk for colorectal cancer. The bill would prohibit a health care service plan contract or a health insurance policy from imposing cost sharing on an individual who is between 50 and 75 years of age for colonoscopies conducted for specified purposes.
AB 347 **Arambula**	**Healthcare Coverage: Step Therapy** **Summary:** Would clarify that a health care service plan may require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception if specified criteria are met. The bill would authorize an enrollee or insured or their designee, guardian, primary care physician, or health care provider to file an appeal of a prior authorization or the denial of a step therapy exception request, and would require a health care service plan or health insurer to designate a clinical peer to review those appeals. The bill would require a health care service plan, health insurer, or utilization review organization to annually report specified information about their step therapy exception requests and prior authorization requests to the Department of Managed Health Care or the Department of Insurance, as appropriate.
AB 361 **Robert-Rivas**	**Open Meetings: Local Agencies Teleconferences** **Summary:** Would authorize a local agency to use teleconferencing without complying with the teleconferencing requirements imposed by the Ralph M. Brown Act when a legislative body of a local agency holds a meeting for the purpose of declaring or

	ratifying a local emergency, during a declared state or local emergency, as those terms are defined, when state or local health officials have imposed or recommended measures to promote social distancing, and during a declared local emergency provided the legislative body makes certain determinations by majority vote.
AB 369 **Kamlager**	**Medi-Cal Street Medicine and Utilization Controls** **Summary:** Would, until January 1, 2026, prohibit the Director of the State Department of Health Care Services from imposing prior authorization or other utilization controls on an item, service, or immunization that is intended to test for, prevent, treat, or mitigate COVID-19.
AB 382 **Kamlager**	**Whole Child Model Program** **Summary:** Current law authorizes the State Department of Health Care Services to establish a Whole Child Model (WCM) program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties provide CCS services to Medi-Cal eligible CCS children and youth. Current law requires the department to establish a statewide WCM program stakeholder advisory group that includes specified persons, such as CCS case managers, to consult with that advisory group on the implementation of the WCM, and to consider the advisory group's recommendations on prescribed matters. Existing law terminates the advisory group on December 31, 2021. This bill would instead terminate the advisory group on December 31, 2023.
AB 383 **Salas**	**Mental Health: Older Adults** **Summary:** Would establish within the State Department of Health Care Services an Older Adult Mental Health Services Administrator to oversee mental health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and its responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of mental health services for older adults, monitoring the quality of programs for those adults, and guiding decision making on how to improve those services.
AB 454 **Rodriguez**	**Healthcare Provider Emergency Payments** **Summary:** Would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner to require a health care service plan or health insurer to provide specified payments and support to a provider during and at least 60 days after the end of a declared state of emergency, as specified. The bill would require a health care service plan or health insurer to provide all contracted capitation payments to its contracted network providers in the area of the declared emergency for the duration of the emergency and at least 60 days after its end.
AB 457 **Santiago**	**Telehealth Patients' Bill of Rights** **Summary:** Would create the Telehealth Patient Bill of Rights, which would, among other things, protect the rights of a patient using telehealth to been seen by a health care provider with a physical presence within a reasonable geographic distance from the patient's home, unless specified exceptions apply. The bill would require a health plan, as defined, to comply with the requirements in the Telehealth Patient Bill of Rights and to provide written notice to patients of all their rights under the Telehealth Bill of Rights. The bill would also exempt a health care service plan or a health insurer from the existing telehealth payment parity provisions for any interaction where the health care provider is not located within a reasonable geographic distance of the patient's home, unless that provider holds specialized knowledge not available in the patient's region.

AB 470 **Carrillo**	**Medi-Cal Eligibility** **Summary:** Would declare the intent of the Legislature to enact legislation to eliminate the consideration of assets for the purpose of determining Medi-Cal eligibility.
AB 507 **Kalra**	**Health Care Service Plans: Review of Rate Increase** **Summary:** The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Current law requires a health care service plan in the individual, small group, or large group markets to file rate information with the Department of Managed Health Care, as specified. Current law requires the information submitted to be made publicly available, except as specified, and requires the department and the health care service plan to make specified information, including justification for an unreasonable rate increase, readily available to the public on their internet websites in plain language. This bill would make technical, nonsubstantive changes to those provisions.
AB 510 **Wood**	**Out of Network Healthcare Benefits** **Summary:** Would authorize a noncontracting individual health professional, excluding specified professionals, to bill or collect the out-of-network cost-sharing amount directly from the enrollee or insured receiving services under a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, if the enrollee consents in writing or electronically at least 72 hours in advance of care. The bill would require the consent to include a list of contracted providers at the facility who are able to provide the services and to be provided in the 15 most commonly used languages in the facility's geographic region.
AB 521 **Mathis**	**Medi-Cal Unrecovered Payments: Interest Rates** **Summary:** Current law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the director to waive any or all of the interest or penalties owed as part of a repayment agreement entered into with the provider for up to 12 months, or 24 months for a large clinic, as defined, if the director determines that specified factors apply, including a demonstration that imposing the interest or penalties would have a high likelihood of creating a financial hardship for the provider or a significant danger of reducing the provision of needed health care services, a finding that the overpayment is due to a change in rate for a particular service that is not the fault of the provider, or for any situation in which the department recoups an overpayment pursuant to an audit or examination for specified reasons, and the first statement of account status or demand for repayment is issued on or after July, 1, 2020.
AB 540 **Petrie-Norris**	**Program for All Inclusive Care for Elderly** **Summary:** Current state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal State Plan, as specified. Current law authorizes the State Department of Health Care Services to enter into contracts with various entities for the purpose of implementing the PACE program and fully implementing the single-state agency responsibilities assumed by the

	department in those contracts, as specified. This bill would exempt a beneficiary who is enrolled in a PACE organization with a contract with the department from mandatory or passive enrollment in a Medi-Cal managed care plan.
AB 563 **Berman**	**School Based Health Programs** **Summary:** Would require the State Department of Education to, no later than July 1, 2022, establish an Office of School-Based Health Programs for the purpose of administering current health-related programs under the purview of the State Department of Education and advising it on issues related to the delivery of school-based Medi-Cal services in the state. The bill would require the office to, among other things, provide technical assistance, outreach, and informational materials to LEAs on allowable services and on the submission of claims.
AB 586 **O'Donnell**	**Pupil Health: Mental Health Services Funding** **Summary:** Would express the intent of the Legislature to enact legislation that would develop a two-year grant program to assist local educational agencies in building infrastructure and partnerships to secure ongoing federal Medi-Cal funding for mental health services, as provided. The bill would make various findings and declarations regarding pupil mental health.
AB 601 **Fong**	**Medi-Cal Reimbursement** **Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including clinical laboratory or laboratory services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Current law requires the department to develop, subject to federal approval, reimbursement rates for clinical or laboratory services according to specified standards, such as requiring that reimbursement to providers for those services not exceed the lowest of enumerated criteria, including 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services. This bill would make a technical, non-substantive change to these provisions.
AB 671 **Wood**	**Medi-Cal Pharmacy Benefits** **Summary:** Would require the Department of Health Care Services to provide a disease management or similar payment to a pharmacy that the department has contracted with to dispense a specialty drug to Medi-Cal beneficiaries in an amount necessary to ensure beneficiary access, as determined by the department based on the results of the survey completed during the 2020 calendar year.
AB 752 **Nazarian**	**Prescription Drug Coverage** **Summary:** Would require a health care service plan or health insurer, or an entity acting on its behalf, to furnish specified information about a prescription drug upon request by an enrollee or insured, their health care provider, or a third party acting on their behalf. The bill would set forth requirements for the request and response, including that they comply with established industry content and transport standards. The bill would prohibit a health care service plan or health insurer from restricting a health care provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost drug.
AB 797 **Wicks**	**Healthcare Coverage: Treatment for Infertility** **Summary:** Would require every health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2022, to provide coverage for the treatment of infertility. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would delete the exemption for religiously affiliated employers, health care service plans, and

	health insurance policies, from the requirements relating to coverage for the treatment of infertility, thereby imposing these requirements on these employers, plans, and policies.
AB 848 **Calderon**	**Medi-Cal: Monthly Maintenance Amount: Personal and Incidental Needs** **Summary:** Current law requires the State Department of Health Care Services to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Current law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80, and would require the department to annually adjust that amount by the same percentage as the Consumer Price Index.
AB 852 **Wood**	**Nurse Practitioners: Scope of Practice: Practice without Standardized Procedures** **Summary:** Current law authorizes a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including, but not limited to, conducting an advanced assessment; ordering, performing, and interpreting diagnostic procedures, as specified; and prescribing, administering, dispensing, and furnishing controlled substances. Current law, beginning January 1, 2023, authorizes a nurse practitioner to perform the functions described above without standardized procedures outside of the specified settings or organizations, in accordance with certain conditions and requirements, if the nurse practitioner holds an active certification issued by the board. This bill would refer to practice protocols instead of individual protocols and would delete the requirement to obtain physician consultation in the case of acute decompensation of patient situation. The bill would revise the requirement to establish a referral plan, as described above, and would require the referral plan to address the circumstance of a patient that has acute and unexpected decompensation or rare condition.
AB 862 **Chen**	**Medi-Cal: Emergency Medical Transportation Services** **Summary:** The Medi-Cal Emergency Medical Transportation Reimbursement Act, imposes a quality assurance fee for each emergency medical transport provided by an emergency medical transport provider subject to the fee in accordance with a prescribed methodology. Current law exempts an eligible provider from the quality assurance fee and add-on increase for the duration of any Medi-Cal managed care rating during which the program is implemented. Existing law requires each applicable Medi-Cal managed care health plan to satisfy a specified obligation for emergency medical transports and to provide payment to noncontract emergency medical transport providers, and provides that this provision does not apply to an eligible provider who provides noncontract emergency medical transports to an enrollee of a Medi-Cal managed care plan during any Medi-Cal managed care rating period that the program is implemented. The bill would provide that during the entirety of any Medi-Cal managed care rating period for which the program is implemented an eligible provider shall not be an emergency medical transport provider, as defined, who is subject to a quality

	assurance fee or eligible for the add-on increase, and would provide that the program's provisions do not affect the application of the specified add-on to any payment to a nonpublic emergency medical transport provider.
AB 875 **Wood**	**Medi-Cal Covered Benefits** **Summary:** Current law authorizes the State Department of Health Care Services to enter into various types of contracts for the provision of services to beneficiaries, including contracts with a Medi-Cal managed care plan. Current law requires the department to pay capitations rates to health plans participating in the Medi-Cal managed care program using actuarial methods, and authorizes the department to establish health-plan- and county-specific rates, as specified. Current law requires the department to utilize health-plan- and county-specific rates for specified Medi-Cal managed care plan contracts, and requires those developed rates to include identified specified information, such as health-plan-specific encounter and claims data. Current federal law authorizes specified managed care entities that participate in a state's Medicaid program to cover, for enrollees, services or settings that are in lieu of services and settings otherwise covered under a state plan. This bill would require those mandatorily developed health-plan- and county-specific rates for specified Medi-Cal managed care plan contracts to include in lieu of services and settings provided by the Medi-Cal managed care plan.
AB 882 **Gray**	**Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program** **Summary:** Current law, until January 1, 2026, establishes the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which requires the department to develop and administer the program to provide loan assistance payments to qualifying, recent graduate physicians and dentists that serve beneficiaries of the Medi-Cal program and other specified health care programs using moneys from the Healthcare Treatment Fund. Current law requires this program to be funded using moneys appropriated to the department for this purpose in the Budget Act of 2018, and requires the department to administer 2 separate payment pools for participating physicians and dentists, respectively, consistent with the allocations provided for in the Budget Act of 2018. For purposes of that program, and by January 1, 2022, this bill would require the department to exclusively provide loan assistance payments to Medi-Cal physicians and dentists who practice in federally designated health professional shortage areas, and to annually verify that these providers continue to practice in those designated areas.
AB 933 **Daly**	**Prescription Drug Cost Sharing** **Summary:** The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Current law provides for the regulation of health insurers by the Department of Insurance. Current law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug.
AB 942 **Wood**	**Specialty Mental Health Services and Substance Use Disorder Treatment** **Summary:** Under current law, for individuals 21 years of age and older, a service is "medically necessary" if it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Current law provides that for individuals under 21 years of age, "medically necessary" or "medical necessity" standards are governed by the definition in federal law. This bill would provide that the

	above-specified medical necessity standards do not preclude coverage for, and reimbursement of, a clinically appropriate and covered mental health or substance use disorder assessment, screening, or treatment service before a provider renders a diagnosis.
AB 1011 **Waldron**	**Health Care Coverage: Substance Use Disorder** **Summary:** Would require health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2022, that provide outpatient prescription drug benefits to cover all medically necessary prescription drugs approved by the United States Food and Drug Administration (FDA) for treating substance use disorders that are appropriate for the specific needs of an enrollee or insured, and would require those drugs to be placed on the lowest cost-sharing tier of the plan or insurer's prescription drug formulary, unless specified criteria are met. The bill would prohibit these contracts and policies from imposing prescribed requirements, including prior authorization or step therapy requirements on a prescription drug approved by the FDA for treating substance use disorders, unless specified criteria are met.
AB 1050 **Gray**	**Medi-Cal Application for Enrollment Prescription Drugs** **Summary:** The Telephone Consumer Protection Act, among other provisions, prohibits any person within the United States, or any person outside the United States if the recipient is within the United States, from making any call to any telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which the called party is charged for the call, without the prior express consent of the called party, using any automatic telephone dialing system or an artificial or prerecorded voice. Under current case law, a text message is considered a call for purposes of those provisions. This bill would require the application for enrollment to include a statement that if the applicant is approved for Medi-Cal benefits, the applicant agrees that the department, county welfare department, and a managed care organization or health care provider to which the applicant is assigned may communicate with them regarding their care or benefits through all standard forms of communication, including, but not limited to, Free to End User text messaging.
AB 1051 **Bennett**	**Medi-Cal: Specialty Mental Health Services Foster Youths** **Summary:** Current law requires the State Department of Health Care Services to issue policy guidance concerning the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. This bill would make those provisions for presumptive transfer inapplicable to a foster youth or probation-involved youth placed in a group home or a short-term residential therapeutic program (STRTP) outside of their county of original jurisdiction, as specified.
AB 1064 **Fong**	**Medi-Cal RX** **Summary:** Current law prohibits the reimbursement to Medi-Cal pharmacy providers for legend and non-legend drugs, as defined, from exceeding the lowest of drug ingredient cost plus a professional dispensing fee or the pharmacy's usual and customary charge, and requires the department to establish the drug ingredient cost of legend and non-legend drugs pursuant to specified standards, including that the average wholesale price cannot be used to establish the drug ingredient cost once the department has determined that the actual acquisition cost methodology has been implemented. This bill would prohibit subjecting a pharmacy to a prospective or retroactive reduction of claims for reimbursement as a result of the implementation of actual acquisition cost

	reimbursement methodology for dates of service from April 1, 2017, to February 22, 2019, inclusive, for a claim for reimbursement that was reimbursed under the reimbursement methodology in effect on March 31, 2017. The bill would exempt from this prohibition a situation where a claim was fraudulently submitted, reimbursement of a claim had previously been paid to the pharmacy or pharmacist under the methodology in effect on March 30, 2017, or services were improperly rendered by the pharmacy or pharmacist.
AB 1102 **Low**	**Telephone Medical Advice Services** **Summary:** Would specify that a telephone medical advice service is required to ensure that all health care professionals who provide telephone medical advice services from an out-of-state location are operating consistent with the laws governing their respective licenses. The bill would specify that a telephone medical advice service is required to comply with all directions and requests for information made by the respective healing arts licensing boards.
AB 1107 **Boerner**	**Emergency Ground Medical Transportation** **Summary:** Would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, that offers coverage for emergency ground medical transportation services to include those services as in-network services and would require the plan or insurer to pay those services at the contracted rate pursuant to the plan contract or policy. Because a willful violation of the bill's requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 1132 **Wood**	**Health Care Consolidation and Contracting Fairness Act of 2021** **Summary:** The Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Current law provides for the regulation of health insurers by the Department of Insurance. Current law regulates contracts between health care service plans or health insurers and health care providers or health facilities, including requirements for reimbursement and the cost-sharing amount collected from an enrollee or insured. This bill, the Health Care Consolidation and Contracting Fairness Act of 2021, would prohibit a contract issued, amended, or renewed on or after January 1, 2022, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities.
AB 1162 **Villapudua**	**Healthcare Coverage: Claims Payment** **Summary:** Would require a health care service plan or health insurer to provide access to medically necessary health care services to its enrollees or insureds that are displaced or otherwise affected by a state of emergency. The bill would allow the Department of Managed Health Care to also suspend requirements for prior authorization during a state of emergency.
AB 1178 **Irwin**	**Medi-Cal: Serious Mental Illness, Drug** **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, the provision of prescription drugs is a Medi-Cal benefit, subject to the list of contract drugs and utilization controls. After a determination of cost benefit, current law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs. This bill would delete

	the prior authorization requirement for any drug prescribed for the treatment of a serious mental illness, as defined, for a period of 365 days after the initial prescription has been dispensed for a person over 18 years of age who is not under the transition jurisdiction of the juvenile court.
AB 1204 **Wicks**	**Hospital Equity Reporting** **Summary:** Current law requires a private, not-for-profit hospital to adopt and update a community benefits plan that describes the activities the hospital has undertaken to address identified community needs within its mission and financial capacity, including health care services rendered to vulnerable populations. Current law defines "vulnerable populations" for these purposes to mean a population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs. Existing law requires a hospital to annually submit its community benefits plan to OSHPD not later than 150 days after the hospital's fiscal year ends. This bill would add minority racial and ethnic groups experiencing disparate health outcomes and socially disadvantaged groups to the definition of "vulnerable populations" for community benefits reporting purposes.
AB 1468 **Cunningham**	**Prior Authorization** **Summary:** Prior Auth – this bill establishes specific requirements for the PA process, and prohibits PA for certain services for new episodes of care. It does not exclude Medi-Cal.
SB 40 **Hurtado**	**Healthcare Workforce Development: California Medicine Scholars Program** **Summary:** Would create the California Medicine Scholars Program, a 5-year pilot program commencing January 1, 2023, and would require the Office of Statewide Health Planning and Development to establish and facilitate the pilot program. The bill would require the pilot program to establish a regional pipeline program for community college students to pursue premedical training and enter medical school, in an effort to address the shortage of primary care physicians in California and the widening disparities in access to care in vulnerable and underserved communities, including building a comprehensive statewide approach to increasing the number and representation of minority primary care physicians in the state.
SB 221 **Wiener**	**Timely Access for Follow-up Care** **Summary:** Has explicit language about applying timely access standards to follow-up mental health appointments, not just initial appointments. Includes language about coordinating interpreter services so that they are available at the time of the appointment. Specifies timely access standards for: urgent (w/ and w/o PA), non-urgent for primary care, non-urgent specialist, and non-urgent for appointments with nonphysician mental health or SUD providers. Requires that plans ensure telephone triage or screening services 24/7 with a waiting time not to exceed 30 minutes. Requires that plans ensure waiting time of no longer than 10 minutes to speak with a CSR. Does not exempt Medi-Cal.
SB 250 **Pan**	**Healthcare Coverage** **Summary:** This bill would authorize DMHC and the Insurance Commissioner, as appropriate, to review a plan's or insurer's clinical criteria, guidelines, and utilization management policies to ensure compliance with existing law. If the criteria and guidelines are not in compliance with existing law, the bill would require the Director of the Department of Managed Health Care or the commissioner to issue a corrective action and send the matter to enforcement, if necessary. The bill would require each department, on or before July 1, 2022, to develop a methodology for a plan or insurer to

	report the number of prospective utilization review requests it denied in the preceding 12 months. This bill would require a plan or insurer and its delegated entities, on or before January 1, 2023, and annually thereafter, to report, among other things, its average number of denied prospective utilization review requests, as specified. The bill would require, on and after January 1, 2023, a plan or insurer to examine a physician's record of prospective utilization review requests during the preceding 12 months and grant the physician "deemed approved" status for 2 years, meaning an exemption from the prospective utilization review process, if specified criteria are met. The bill would authorize a plan or insurer to request an audit of a physician's records after the initial 2 years of a physician's deemed approved status and every 2 years thereafter, and would specify the audit criteria by which a physician would keep or lose that status.
SB 274 **Wieckowski**	**Local Government Meetings: Agenda and Documents** **Summary:** The Ralph M. Brown Act, requires meetings of the legislative body of a local agency to be open and public and also requires regular and special meetings of the legislative body to be held within the boundaries of the territory over which the local agency exercises jurisdiction, with specified exceptions. Current law authorizes a person to request that a copy of an agenda, or a copy of all the documents constituting the agenda packet, of any meeting of a legislative body be mailed to that person. This bill would require a local agency with an internet website, or its designee, to email a copy of, or website link to, the agenda or a copy of all the documents constituting the agenda packet if the person requests that the items be delivered by email. If a local agency determines it to be technologically infeasible to send a copy of the documents or a link to a website that contains the documents by mail or by other electronic means, the bill would require the legislative body or its designee to send by mail a copy of the agenda or a website link to the agenda and to mail a copy of all other documents constituting the agenda packet, as specified.
SB 279 **Pan**	**Medi-Cal Medically Necessary Services** **Summary:** Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive medically necessary health care services, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for an individual under 21 years of age, subject to utilization controls and consistent with federal requirements. Under current state law, for individuals 21 years of age and older, a service is "medically necessary" if it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain and for individuals under 21 years of age, "medically necessary" or "medical necessity" standards are governed by the definition in federal law. This bill would make non-substantive changes to that provision of law.
SB 280 **Limon**	**Health Insurance: Large Group Health Insurance** **Summary:** Would require a large group health insurance policy issued, amended, or renewed on or after July 1, 2022, to cover medically necessary basic health care services, as defined. The bill would authorize the commissioner to adopt regulations to implement these provisions. The bill would require these provisions to apply to an individual, group, or blanket disability insurance policy if a specified condition is met.
SB 281 **Dodd**	**Medi-Cal: California Community Transitions Program** **Summary**: Existing law requires the State Department of Health Care Services to provide services consistent with the Money Follows the Person Rebalancing Demonstration for transitioning eligible individuals out of an inpatient facility who have not resided in the facility for at least 90 days, and to cease providing those services on January 1, 2024.

	Existing law repeals these provisions on January 1, 2025. This bill would instead require the department to provide those services for individuals who have not resided in the facility for at least 60 days, and would make conforming changes. The bill would require the department to use federal funds, which are made available through the Money Follows the Person Rebalancing Demonstration, to implement prescribed services, and to administer those services in a manner that attempts to maximize federal financial participation if those services are not reauthorized or if there are insufficient funds.
SB 293 **Limon**	**Medi-Cal: Specialty Mental Health Services** **Summary:** Current law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including specialty mental health services, and Early and Periodic Screening, Diagnostic, and Treatment services for an individual under 21 years of age. This bill would require, on or before January 1, 2023, the department, in consultation with specified groups, including representatives from the County Welfare Directors Association of California, to identify all forms currently used by each county mental health plan contractor for purposes of determining eligibility and reimbursement for specialty mental health services provided under the Early and Periodic Screening, Diagnostic, and Treatment Program, and to develop standard forms for the intake of, assessment of, and the treatment planning for, Medi-Cal beneficiaries who are eligible for those services to be used by all counties.
SB 368 **Limon**	**Healthcare Coverage: Deductibles and Out of Pocket Expenses** **Summary:** Would, for a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, in the individual or group market, require the health care service plan or health insurer to monitor an enrollee's or insured's accrual balance toward their annual deductible and out-of-pocket maximum, if any. The bill would require a health care service plan or health insurer to provide an enrollee or insured with their accrual balance toward their annual deductible and out-of-pocket maximum on a monthly basis during any month in which benefits were used, and would allow an enrollee or insured to request their most up-to-date accrual balances from their health care service plan or health insurer at any time.
SB 428 **Hurtado**	**Healthcare Coverage: Adverse Childhood Experiences** **Summary:** Would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage for adverse childhood experiences screenings. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
SB 508 **Stern**	**Mental Health Coverage: School Based Services** **Summary:** Current law provides that specified services, including targeted case management services for children with an individual education plan or an individualized family service plan, provided by local educational agencies (LEAs), are covered Medi-Cal benefits, and authorizes an LEA to bill for those services. Existing law requires the department to perform various activities with respect to the billing option for services provided by LEAs. Current law authorizes a school district to require the parent or legal guardian of a pupil to keep current at the pupil's school of attendance certain emergency information. This bill would authorize an LEA to have an appropriate mental health professional provide brief initial interventions at a school campus when necessary for all referred pupils, including pupils with a health care service plan, health insurance, or coverage through a Medi-Cal managed care plan, but not those covered by a county mental health plan."

SB 523 **Levya**	**Healthcare Coverage: Contraceptives** **Summary:** Current law establishes health care coverage requirements for contraceptives, including, but not limited to, requiring a health care service plan, including a Medi-Cal managed care plan, or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of federal Food and Drug Administration approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee or insured by a provider or pharmacist, or at a location licensed or authorized to dispense drugs or supplies. This bill, the Contraceptive Equity Act of 2021, would make various changes to expand coverage of contraceptives by a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on and after January 1, 2022, including requiring a health care service plan or health insurer to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical management restrictions and to reimburse enrollees and insureds for out-of-pocket costs for over-the-counter birth control methods purchased at any out-of-network pharmacy in California, without medical management restrictions.
SB 540 **Petrie-Norris**	**PACE** **Summary:** Exempts PACE enrollees from mandatory enrollment into a MCP. Requires that, in areas where PACE is available, it be provided as an enrollment option in the same manner as other MCP enrollment options. Requires MCP risk stratification to include identification of PACE-eligible members, and a subsequent referral process.
SB 562 **Portantino**	**Healthcare Coverage: Pervasive Developmental Disorders or Autism** **Summary:** Current law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism. Current law defines "behavioral health treatment" for these purposes to mean professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that meet specified criteria. This bill would modify that definition to mean professional services and treatment programs based on behavioral, developmental, relationship based, or other evidence-based models, including applied behavior analysis and other evidence-based behavior intervention programs that meet the specified criteria.

DATE: April 28, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: COVID-19 Update

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

Background. Throughout March, and into the first week of April, rates of new COVID-19 positive cases, hospitalizations and deaths decreased overall in all three Alliance counties, with Santa Cruz County moving from red (substantial) to orange (moderate) March 31, 2021, Monterey County moving from red (substantial) to orange (moderate) April 7, and Merced County moving to the red tier on April 14, 2021. ICU capacity has remained good throughout the Alliance region.

As of April 14, 2021, the total number of cases, deaths, and recent percent of positive tests reported in each county website was as follows:

County	Positive Cases	Deaths	Positive Case % in last 7 days
Merced	31,105	449	4.2%
Monterey	43,209	348	1.5%
Santa Cruz	15,432	202	1%

Alliance outreach continues to promote safe behavior and vaccine navigation while prioritizing members with higher risk for COVID infection and those living in areas identified as most in need from the California Healthy Places Equity Index,

Vaccine availability has improved in all Alliance counties in part due to progress with Blue Shield Third Party Administrator scheduling and vaccine distribution in early April. As of April 1,2021. members 50+ years of age were eligible to receive vaccine and as of April 15, 2021, members 16+ were eligible for vaccination in Santa Cruz and Monterey Counties. Merced County was able to offer vaccine to those 16+ by April 1, 2021. With the Janssen vaccine on hold starting April 13, 2021, there is concern that there may be some slowing of vaccine progress.

COVID-19 Vaccination Rates. Vaccination data is being collected from a variety of sources, immunization registries, the Department of Health Care Services (DHCS), Health Information Exchanges and pharmacy data. Note that the data currently underestimate the actual number of doses because any data exchange requires a perfect match of the member's name and date of birth for data to be shared. As of April 14, 2021, vaccine penetration from available Alliance data sources, including vaccine registries and DHCS encounter data, is as follows:

Number and Percent of Members Receiving at Least One Vaccine Dose by County and Age Group (December – April)

	Merced		Monterey		Santa Cruz	
Age Group	Vaccinated	% Alliance Population	Vaccinated	% Alliance Population	Vaccinated	% Alliance Population
Ages 10-19	549	2%	839	2%	401	3%
Ages 20-44	4,269	10%	7,797	16%	4,287	17%
Ages 45-64	3,417	19%	5,353	25%	3,233	23%
Ages 65-74	2,233	41%	2,590	39%	1,850	46%
Ages 75-84	1,285	46%	1,485	45%	884	51%
Ages 85+	527	46%	745	50%	392	56%

Number and Percent of Members Partially Vaccinated by County (December- April)

	Adult Population	Vaccinees	% Alliance Population
Merced	71,409	12,204	17%
Monterey	84,390	18,330	22%
Santa Cruz	45,698	10,976	24%
Total	201,497	21,104	10%

Number and Percent of Members Fully Vaccinated by County (December – April)

	Adult Population	Vaccinees	% Alliance Population
Merced	71,409	4,664	7%
Monterey	84,390	7,381	9%
Santa Cruz	45,698	5,552	12%
Total	201,497	17,597	9%

Number of Members by Race/Ethnicity Partially and Fully Vaccinated (December – April)

Racial Ethnic Groups	Partially Vaccinated	Fully Vaccinated
African American	444	706
All Others	1,392	2,376
Asian or Pacific Islander	3,016	5,744
Caucasian	4,702	8,437
Hispanic	14,568	19,730
Not Provided	23	117
Grand Total	24,145	37,110

Frequency of registry data downloads and data matching are anticipated to improve as DHCS has begun the process with CDPH to provide plans with member specific data from the CAIR immunization registry.

COVID-19 Quality Improvement Plan and Pandemic Care: Member Outreach Calls. Last Fall, DHCS mandated all health plans to submit a brief COVID-19 Quality Improvement Plan that includes interventions and/or strategies aimed at increasing the provision of preventive services, behavioral health services, and/or chronic disease care, for members amidst COVID-19.

Since January of this year staff have outreached though direct phone calls to 5,247 members who live in the highest risk communities. The staff provided essential information needed around COVID-19 safety precautions. Getting the Flu shot, stay home if you are sick, and no group gatherings are messages included in the outreach.

With the roll out of the COVID-19 vaccine staff identified over 2100 high risk, monolingual Spanish speaking members who live in the areas identified by county staff. Outreach calls began in mid-February to these members and were completed by the first week of March. The calls focused on vaccine distribution in their county, vaccines are free, vaccines safety, what to expect when vaccinated, reducing risk of getting sick, and cultural considerations.

Most members stated they have either received their vaccine or have scheduled an appointment to receive it. Few members are working with their PCP to schedule an appointment. Most members over age 65 are being taken by their children or family members to appointments. Resources were provided to members who had questions around where to get vaccine, transportation, and financial support. Guidance was also provided to members with "misinformation" they have received, such as; I've already had COVID-19, do I still need the vaccine; do I need to have both shots. Of the members that were recipients of the outreach efforts, 82 – 83% received a vaccine.

Community Coordination and Alliance Pandemic Care Task Force. Alliance staff engage in regular calls and collaborative work with county leaders and local organizations to support efforts to protect the community, to plan strategies to address local needs, and provide information to support members prioritizing the Alliance's most vulnerable populations. As the need and resources vary in each county coordination is critical to assure members and community partners are provided current information around resources available in their community. Current efforts led by the Alliance Pandemic Care Task Force include the coordination and education of vaccine distribution to the most vulnerable populations in our service area and coordination with our Provider Services department to inform providers around how to enroll in the vaccine distribution process.

Pandemic Care Communications. In support of this effort, the Alliance Communications team continued to provide community messaging about the COVID-19 vaccine and reminders on the importance of masking and social distancing. The deliverables included masking updates to the website landing page, as well as eight social media posts throughout the month. In addition, in partnership with Dr. Heinert, one of our Medical Directors, staff submitted an Opinion Editorial on COVID-19 Facts to three local papers, The OpEd was published in The Californian (Salinas), the Merced Sun Star and the Santa Cruz Sentinel. Staff will continue to develop communications as emerging messages are identified through the Pandemic Care Task Force committees.

Workspace Reentry Taskforce. On November 3, 2020, the Workspace Reentry Taskforce made a revised recommendation to leadership to reopen the Alliance offices no sooner than July 1, 2021.

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

Attachments. N/A

DATE: April 28, 2021

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

FROM: Kathleen McCarthy, Strategic Development Director

SUBJECT: Report on COVID-19 Response Fund Grants

Recommendation. Staff recommend the Board accept the report on COVID-19 Response Fund grants.

Summary. This report includes background on Alliance's COVID-19 Response Fund, details on the spend down, and a list of grants awarded between April 22. 2020 and April 1, 2021.

Background. The Alliance Board approved the creation of the COVID-19 Response Fund on April 22, 2020 to help Alliance members in Merced, Monterey and Santa Cruz counties most affected by the coronavirus pandemic. The fund supports local organizations that provide essential social and health services to meet the basic health-related needs of Alliance members. The Board allocated $1,000,000 from the Medi-Cal Capacity Grant Program (MCGP) to establish the COVID-19 Response Fund, with county-specific allocations.

Discussion. Over the last year, the Alliance awarded 27 COVID-19 Response Fund grants, totaling $1,029,400. When the $1M fund was established, the Alliance Board approved three grants totaling $600,000 to support the food banks in each of the three counties the Alliance serves. The remaining $400,000 would be awarded to support the provision of essential services and supplies to Medi-Cal members, including procurement and distribution of food, diapers and baby food, hygiene supplies, and masks and gloves. Funds transferred from a terminated Partners for Healthy Food Access grant to a COVID-19 Response Fund grant for the same grantee for food procurement and distribution increased the total fund budget to $1,029,400.

In order to deploy resources quickly, the Alliance did not accept unsolicited applications for COVID-19 Response Fund grants. Instead, the Alliance monitored where the COVID-19 Response Fund could support immediate needs and invited local organizations to apply for funds based on their ability to fill the needs identified in our service area. The Alliance awarded grants on an ongoing basis until all funds were spent down. All funds were awarded by June 5, 2020 in Santa Cruz County and by July 17, 2020 in Monterey County. The total spend down in Merced County was slower, with $29K remaining between July 2020 and April 2021 until a new grantee was identified in the county to award the remaining funds. At this point, the fund has been completely spent down and the program will be retired. The table below details the total awards by county and grant type.

County	Fund Budget	Food Bank Grants	Community Grants
Merced	$346,667	$208,000	$138,667
Monterey	$391,667	$235,000	$156,667
Santa Cruz	$291,066	$157,000	$134,066
Total	**$1,029,400**	**$600,000**	**$429,400**

The timelines of awarded projects ranged from one to 12 months, with an average of five months. The member populations served by the 27 awarded projects were comprised of three subgroups: 1) children and families (48% of projects); 2) individuals experiencing homelessness (26% of projects); and seniors (26% of projects). While some grants served more than one population, all focused on rapidly responding to meet the essential needs of our members.

The grant awards supported four main types of member needs, and some grants covered more than one type. The majority of projects had food distribution as a core component, and several included meal delivery. Other projects focused on the distribution of baby supplies (such as diapers, wipes, and formula/baby food), hygiene supplies for members, and cleaning supplies and personal protective equipment for members and staff of grantee organizations. A few projects focused on technology for clients to continue accessing care during the pandemic. These projects included providing temporary cell phones for recovery group participants and providing internet access to low-income seniors.

The COVID-19 Response Fund was a new type of funding opportunity for the MCGP. The relatively quick creation of this fund was made possible through the strong framework of the MCGP. The experience provided lessons for staff over the course of the fund distribution. The first lesson was that outreach to a wide range of local community-based organizations and other funders was critical to know exactly what was needed in our three counties in order to invite applicants to apply. Additionally, it was vital that outreach was conducted early, and in some cases checking back in with grantees, as the needs of our community during the pandemic have been evolving constantly.

Another important aspect of the COVID-19 Response Fund was the rapid response funding cycle. The CEO's authority to approve awards up to $50,000 each was foundational to a quick turnaround which allowed applicants to learn of award decisions and receive funds quickly. For comparison, a typical award round of MCGP grants takes about three months from the application deadline to the award date. As demonstrated by our community partners' response to COVID-19, flexibility and innovation were integral for staff to administer this new fund.

Fiscal Impact. Of the $1,029,400 allocated to the COVID-19 Response Fund, $1,029,400 has been awarded and $0 is remaining as of April 1, 2021.

Attachments.

1. List of all COVID-19 Response Fund Grant Awards awarded between April 22. 2020 and April 1, 2021.

Medi-Cal Capacity Grant Program
COVID-19 Response Fund
$1,029,400 Total Awarded

County	Organization	Award Date	Amount	Purpose
Merced	Merced County Food Bank	4/22/2020	$208,000	To increase food distribution countywide.
	Healthy House within a MATCH Coalition	5/8/2020	$10,000	To purchase and distribute diapers, baby wipes, formula, and baby food to low-income women with young children and to purchase and distribute water, masks, sanitizer, and soap to homeless clients in Merced County.
	Sierra Saving Grace	5/8/2020	$1,000	To purchase and distribute personal protective equipment and hygiene supplies for clients in ten permanent supportive housing units.
	LifeLine Community Development Corporation	5/15/2020	$20,500	To provide emergency food distribution and to prepare and distribute weekly resource and activity packets for children and adults with mental health, physical health and community resources.
	Merced County Rescue Mission	5/22/2020	$10,000	To purchase and distribute food and hygiene supplies to homeless individuals at Merced County Rescue Mission's 17 housing sites during the COVID-19 pandemic.
	Catholic Charities of Merced	6/19/2020	$20,000	To purchase and distribute food to individuals and families impacted by the COVID-19 pandemic.
	National Alliance on Mental Illness (NAMI) Merced County	6/26/2020	$12,375	To support communication technologies and technical assistance for culturally competent individual and group support for adults and youth in need of mental health services and resources during the COVID-19 pandemic.
	United Way Merced County	7/17/2020	$35,000	To support the procurement and distribution of food and supplies through the Merced County Help Hub to county residents impacted by the pandemic.
	Merced County Dept. of Public Health	7/24/2020	$5,000	To support the purchase and distribution of pulse oximeters by Family Medicine residents (MDs) during home visits with Medi-Cal members and other patients diagnosed with COVID-19.

Medi-Cal Capacity Grant Program
COVID-19 Response Fund
$1,029,400 Total Awarded

County	Organization	Award Date	Amount	Purpose
Merced	Provident Primary Care	2/26/2021	$2,000	To support the purchase of a vaccine refrigerator and medical supplies to administer COVID-19 patient vaccinations.
	Merced Lao Family Community, Inc.	4/1/2021	$22,792	To support distribution of culturally appropriate food and produce, diapers and hygiene supplies, personal protective equipment, and accurate and culturally competent education and resources regarding the COVID-19 public health crisis.
Monterey	Food Bank of Monterey County	4/22/2020	$235,000	To increase food distribution countywide.
	First 5 Monterey County	5/1/2020	$36,000	To purchase and distribute diapers, baby wipes, formula and baby food to low-income families with young children.
	Meals on Wheels of the Salinas Valley	5/8/2020	$25,000	To deliver meals prepared by local restaurants to low-income seniors through the Meals on Wheels of the Salinas Valley and Salinas Valley Community Partners in Action (MASA) program.
	Love Our Central Coast	5/22/2020	$15,000	To prepare and deliver grocery bags to homeless encampment sites in Salinas.
	Interim, Inc.	6/12/2020	$12,000	To provide cell phone service for clients to communicate with staff and participate in virtual programs during the COVID-19 pandemic.
	Sun Street Centers	6/12/2020	$24,000	To purchase and distribute food, diapers and hygiene supplies for clients in residential and non-residential treatment programs, and to purchase technology for telehealth programs.
	Boys and Girls Club of Monterey County	6/12/2020	$36,667	To distribute over 700 meal bags and 700 produce boxes weekly to families at low-income apartment complexes.
	The Marina Foundation	7/2/2020	$8,000	To support meal delivery four times per week for 12 weeks to formerly homeless seniors living in low-income housing in Marina during the COVID-19 pandemic.

Medi-Cal Capacity Grant Program
COVID-19 Response Fund
$1,029,400 Total Awarded

County	Organization	Award Date	Amount	Purpose
Santa Cruz	Second Harvest Food Bank	4/22/2020	$157,000	To increase food distribution countywide.
	Teen Kitchen Project	5/1/2020	$20,000	To deliver medically-tailored meals to Medi-Cal members with acute or chronic health conditions or who have been diagnosed with COVID-19.
	Food What?!	5/8/2020	$15,500	To prepare and deliver weekly produce boxes and "Grow Your Own" vegetable kits to low-income youth enrolled in the Food What?! Summer Program and their families.
	County of Santa Cruz, Health Services Agency, Public Health Division	5/8/2020	$9,000	To purchase and distribute diapers and baby wipes to Medi-Cal clients served by home visiting programs and other maternal and child health programs.
	First 5 Santa Cruz County	5/15/2020	$30,000	To purchase and distribute diapers, baby wipes, infant formula and baby food for children 0-5 and their families.
	Common Roots Farm	5/22/2020	$12,000	To support the farming and provision of produce for Salvation Army's Laurel Street Shelter's hot meal program and weekly food distribution program.
	Community Bridges	5/22/2020	$29,400	To expand food distribution at three Family Resource Centers.
	Community Action Board of Santa Cruz County, Inc.	6/5/2020	$18,166	To purchase and distribute food to low-income populations, provide personal protective equipment and hygiene/sanitation supplies for staff and clients during outreach, and implement communications technology for social support programs for seniors and youth.

DATE: April 28, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Peer Review and Credentialing Committee Report of March 10, 2021

Recommendation. Staff recommend the Board accept the decisions from the March 10, 2021 meeting 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 seven-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.

- New Providers:
  - 31 Physician Providers (MD, DO, DPM)
  - 16 Non-Physician Medical Practitioners
  - 17 Allied Providers
  - 5 Organizations

- Recredentialed Providers:
  - 51 Physician Providers (MD, DO, DPM)
  - 15 Non-Physician Medical Practitioners
  - 3 Allied Providers
  - 6 Organizations

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

Attachments. N/A

DATE: April 28, 2021

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

FROM: Kathleen McCarthy, Strategic Development Director

SUBJECT: Funding Recommendation for Bridge Housing Renovations

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Recommendation. Staff recommend the Board approve $26,600 of unallocated Medi-Cal Capacity Grant Program (MCGP) funds for bridge housing renovations to support Community Homeless Solutions' participation in the Recuperative Care Pilot (RCP) in Monterey County.

Summary. This report includes a brief background on the RCP, participation of Community Homeless Solutions in the pilot, and their request for funding to renovate a property which will serve as a bridge housing site for the pilot.

Background. On December 2, 2020, the Alliance Board approved $5,857,020 of unallocated Medi-Cal Capacity Grant Program (MCGP) funds to establish the two-year RCP. The RCP provides funding for recuperative care, which is short-term housing with medical and supportive services, for Alliance Medi-Cal members who are experiencing homelessness and recovering from an acute illness or injury. The RCP also funds bridge housing, which extends a stay in the recuperative care facility, or a separately approved bridge housing facility, after a member no longer meets the medical criteria for recuperative care and while awaiting a permanent housing placement.

Community Homeless Solutions was one of three organizations (one recuperative care provider in each county) invited to apply and approved for a grant to participate in the RCP. The grant award is contingent on Community Homeless Solutions meeting all pre-contract implementation requirements no later than June 1, 2021.

Discussion. In order to offer bridge housing through the RCP, Community Homeless Solutions requested funding from the Alliance to renovate one of their properties in Marina that would serve as a bridge housing site. The grant request is limited to the purchase and installation of furnishings, fixtures and equipment, and minor home improvements to bring the property up to code for occupancy. The unit to be renovated is located within an eight-unit apartment style complex which is owned and managed by Community Homeless Solutions. It is a three-bedroom unit with two beds per bedroom. The unit was previously occupied by a transitional housing program. It is now vacated and in need of renovations in preparation to provide RCP bridge housing.

The renovation work will likely be sole sourced to the contractor with whom Community Homeless Solutions has an established relationship. The renovation work is estimated at $22,760 plus $3,840 in materials, for a project total of $26,600. The time period estimated to compete the renovation is one month.

The RCP was under development as a pilot program when the Capital Program retired in January 2020, so Community Homeless Solutions was not able to apply to the Capital Program to support their participation in the RCP. The other two RCP participating providers were awarded Capital Implementation grants prior to January 2020 that support their recuperative care sites.

Should the Alliance Board approve this request for funding, the grant award for bridge housing renovations would be contingent on Community Homeless Solutions executing the RCP contract with the Alliance.

Fiscal Impact. The recommended grant award of $26,600 would be funded by the MCGP's unallocated budget and be added to the RCP budget for Monterey County, increasing it from $1,001,880 to $1,028,480 total.

Attachments. N/A

Medi-Cal Capacity Grant Program

PERFORMANCE DASHBOARD

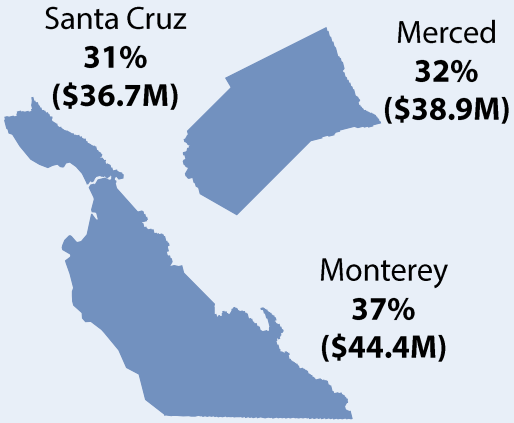
October 2015 through March 2021

About MCGP

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

Total Awarded:

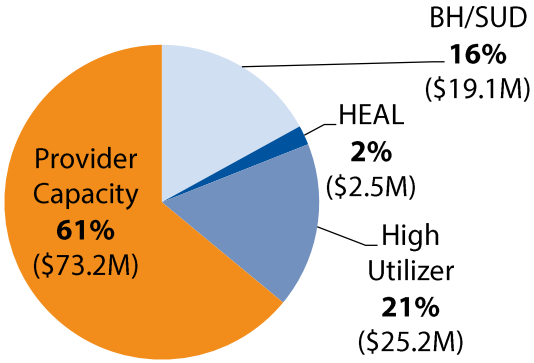
$120M



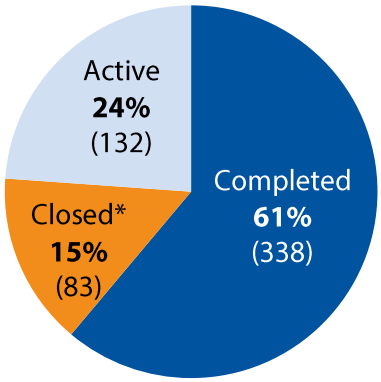
Number of Organizations Awarded:

137

Awards by Focus Area

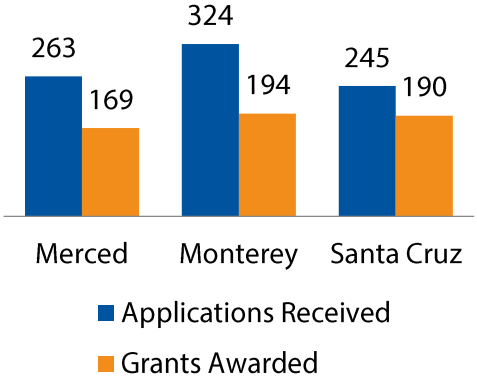


Award Status



* Withdrawn by grantee/terminated.

Total Grants Awarded: 553



Provider Recruitment Program

269 grants totaling $32.5M awarded to subsidize recruitment expenses for new health care professionals to serve the Medi-Cal population.

188 new providers hired to date.

81% retention of new recruits.

21 recruited primary care physicians specialize in Pediatrics.

69% increase in primary care sites open to accepting new members.

	Merced		Monterey		Santa Cruz		Total	% of Total
Type Recruited	Physician	Non-Physician	Physician	Non-Physician	Physician	Non-Physician		
Primary Care	25	19	16	17	12	6	95	51%
Specialty Care	5	3	24	2	10	3	47	25%
Allied		8				2	10	5%
Behavioral Health	1	1	3		9	9	23	12%
Dental	3				4		7	4%
Other				3		3	6	3%
Total Recruited	34	31	43	22	35	23	188	100%
	35% of total		35% of total		30% of total			

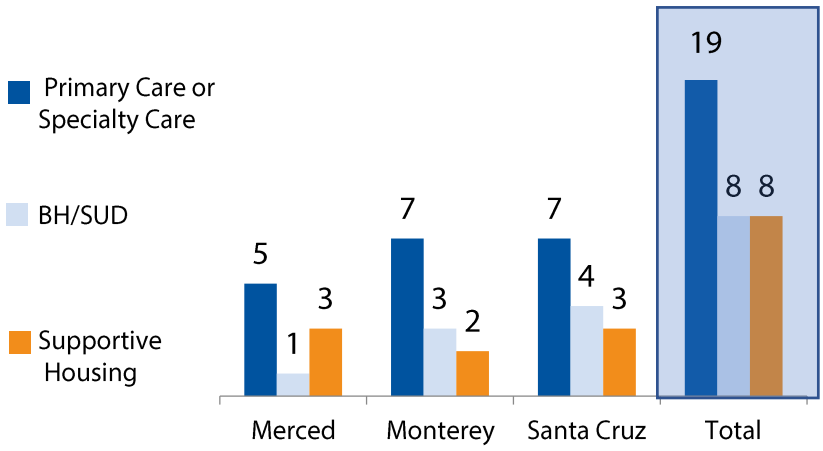
Specialties Recruited

Capital Program

55 grants* totaling $65.8M awarded for the expansion, construction, renovation, and/or acquisition of health care facilities that will serve the Medi-Cal population in the Alliance service area. Capital grants are also available for projects that expand access to Medi-Cal services through transitional or permanent supportive housing for the Alliance's most medically fragile Medi-Cal members.

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

35 Capital Projects



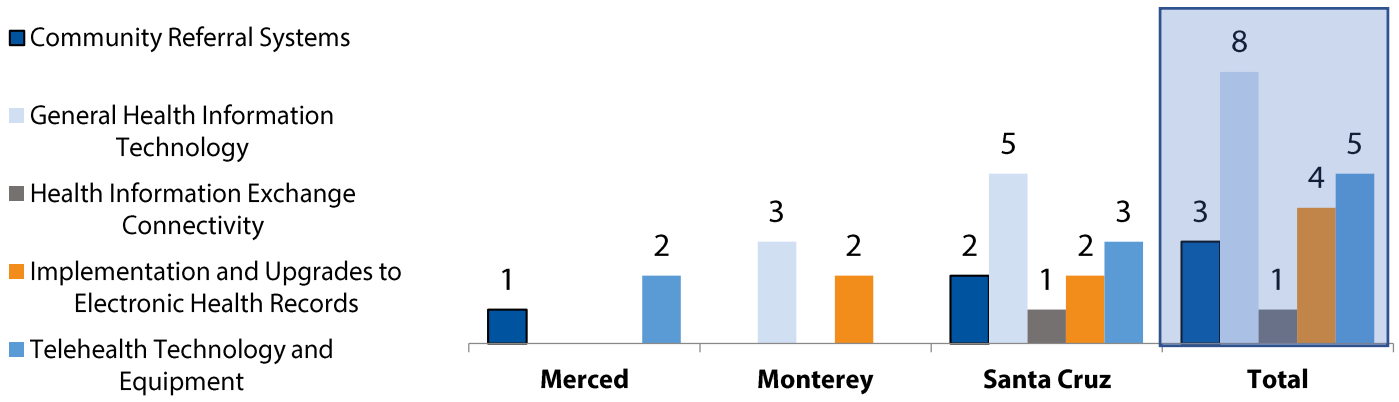
176K Medi-Cal members anticipated to be served by new and expanded facilities.

Infrastructure Program

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

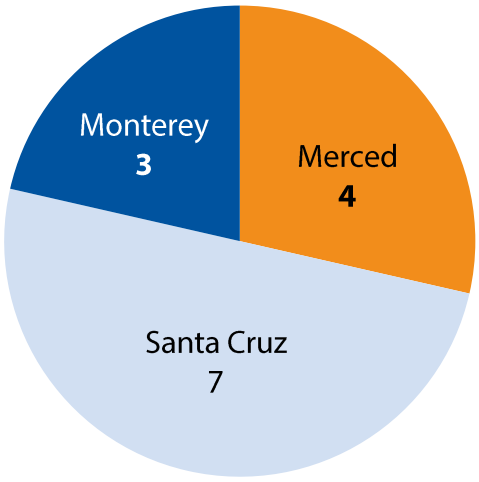
* Applicants may apply for both planning and implementation grants for one project.

21 Infrastructure Projects



Partners for Healthy Food Access Program

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



Projects by County: 14

Food Access Projects Focus On:

Food Insecurity Screening
Healthy Food Distribution

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

Referrals to Supportive Services

- Cal-Fresh Enrollment

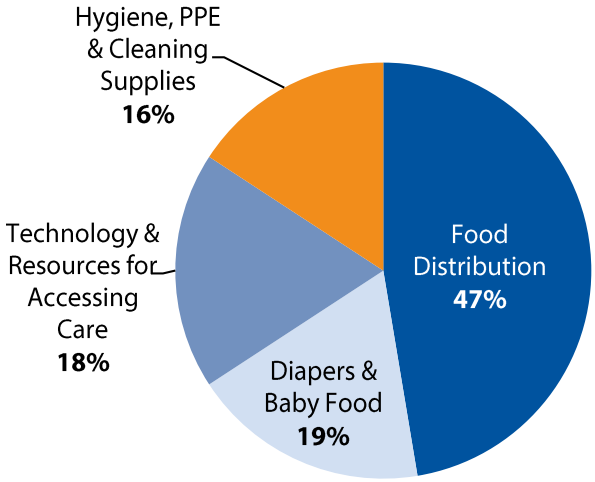
Knowledge & Skill Building

- Nutrition/Health Classes
- Community Gardening
- Cooking Classes

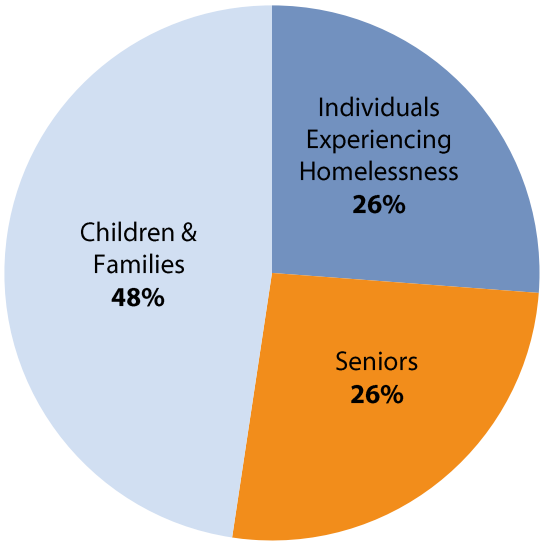
COVID-19 Response Fund

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

Funding Categories by Project



Populations Served by Project



While some grants covered more than one category and served more than one population, all focused on rapidly responding to meet the essential needs of our members.

Technical Assistance Program

13 grants totaling $470K awarded to provide support for training or consulting engagements that directly result in increased access, coordination of care and integration of services.

77% of Technical Assistance projects completed to date (10/13).

Project Categories	Number of Grants
Increased access to services	4
Integration of services and team-based care	1
Improved, patient-centered care	4
System optimization and service delivery	4

Workforce Development Investments

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

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

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

Retired Programs

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

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

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

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

Grants in the Community

Partners for Healthy Food Access

Volunteer Center of Santa Cruz County (Volunteer Center) was awarded a Partners for Healthy Food Access grant in October 2018 for a two-year project titled Healthy Connections that would transform and expand on their already successful Beat Back Diabetes program. Healthy Connections is a whole person approach to supporting mentally ill adults in achieving optimal health and wellness through access to fresh and healthy produce, CalFresh enrollment, physical activity, and self-management skill building. Prior to COVID-19, Healthy Connections provided group meals, site-based group services such as nutrition education and cooking classes, as well as community gardening groups. With the pandemic came increased food insecurity and mental health challenges for clients.

The Volunteer Center rose to the challenge to meet these increased needs while maintaining safety. They recruited volunteers to assist with grocery delivery, replacing in-person food pickup. Volunteers were trained to offer one-on-one lifestyle coaching. Community resources and health & wellness materials were included with each grocery delivery. Coaching was also modified to virtual and outdoor-based sessions. Healthy Connections was able to keep clients safely fed with nutritious food on a daily basis and connected to the community during uncertain times. Over the two-year grant, the program provided access to healthy food for 471 Medi-Cal members, 275 of whom also learned to plant, grow and harvest food from the community garden.

First 5 Monterey County was the recipient of a COVID-19 Response Fund grant in May 2020 to purchase and distribute diapers, baby wipes and formula to low-income families with children aged 0-5 most affected by the coronavirus pandemic. The two-month project served 2,076 unique individuals - over twice the number of individuals anticipated to be served. First 5 Monterey County purchased and distributed 84,690 diapers, 90,000 wipes and 500 cans of formula to families across Monterey County, but focused primarily in the East Salinas and South County regions.

A significant focus of the project involved coordinating pick-ups and deliveries of products for distribution with their numerous partner organizations. Some partners reached out to specific families that were known to need these supplies and coordinated direct delivery for them. These efforts strengthened partner relationships and helped to inform the community about other First 5 Monterey County services available to Medi-Cal members and their families.

COVID-19 Response Fund

Grants in the Community

Capital Implementation

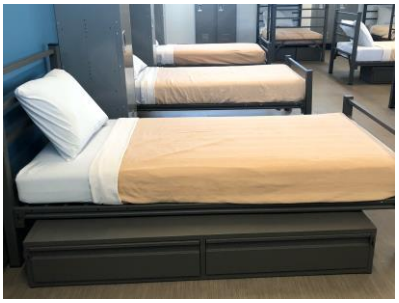
Merced County received a Capital Implementation grant to support construction of a low-barrier navigation center to provide transitional housing, case management and supportive services to 150 individuals experiencing homelessness annually. The Merced County Navigation Center opened in March 2021.

The 15,000 sq. ft. facility, constructed from repurposed shipping containers to reduce cost and construction time, has 75 beds separated into men's, women's and couples' dorms to temporarily house participants safely while they are linked to permanent supportive and affordable housing units. Due to COVID-19 safety requirements, the facility initially opened with a 66-bed capacity. The center also has kitchen and dining facilities, laundry, classroom, clinic, and office space for service providers such as Merced County Human Services Agency and Merced County Behavioral Health and Recovery Services. There is also space for clients to shelter their dogs during their stay.

All clients of the Merced County Navigation Center will be assigned to a case manager who will help them with goal-setting in areas like finding transitional or permanent housing, enrolling in public benefits and other income, and employment resources. Additionally, all participants will be enrolled in Medi-Cal, if eligible, and connected to a primary care physician.

The Merced County Rescue Mission will operate the facility 24 hours per day, 7 days per week. They established a Navigation Center Advisory Committee to work with partners, including businesses and organizations in the neighborhood, as a component of its "Good Neighbor Policy" to ensure community involvement and coordination to maximize the program's positive impact on the surrounding neighborhood.

Referrals to the Navigation Center are made in close coordination with homeless outreach workers, local law enforcement, and Navigation Center staff. The Navigation Center is a critical component in the collaborative effort in the Merced County region to address homelessness.



DATE: April 28, 2021

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

FROM: Kathleen McCarthy, Strategic Development Director

SUBJECT: Medi-Cal Capacity Grants: Funding Recommendations (Group A)

Recommendation. Staff recommend the Board approve grant recommendations that total $2,650,000 for Group A of funding recommendations under Consent Agenda Item 9G.

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

Background. Since the launch of the MCGP in July 2015, the Alliance Board has approved 553 grants for a total of $120M to expand Medi-Cal capacity in the Alliance service area in the MCGP's four priority focus areas: Provider Capacity, Behavioral Health and Substance Use Disorder Services (BH/SUD), High Utilizer Support Resources and Healthy Eating and Active Living (HEAL). Consent Agenda Item 9F includes the MCGP Performance Dashboard which provides details on grants awarded to date.

Discussion.

Grant Application Review and Recommendation Process. Grant applications in the current round of funding were due on January 19, 2021. This funding cycle, the Alliance received 15 applications from 8 organizations. Staff carefully reviewed each application to determine eligibility and is recommending approval of 6 out of the 12 eligible applications received.

An internal committee reviewed and selected applications to recommend to the Board for approval based on the eligibility and program criteria previously approved by the Board. The internal review committee included: Stephanie Sonnenshine, Chief Executive Officer; Dr. Dale Bishop, Chief Medical Officer; Lisa Ba, Chief Financial Officer; Jordan Turetsky, Provider Services Director; and Kathleen McCarthy, Strategic Development Director. All applicants received a letter notifying them whether or not their application was being recommended for approval in April 2021.

Of the 6 grant applications being recommended for approval, 67% (4) are from Merced County, and 33% (2) are from Santa Cruz County. No grant applications are being recommended from Monterey County due to the low amount of funding available for the Provider Recruitment Program under which all Monterey County applications were submitted. The majority of applications recommended for approval (83% or 5 applications) fall under the Provider Capacity focus area. There is one application recommendation under the High Utilizer Support Resources focus area. The 6 grant applications recommended for approval are distributed across programs as follows:

Grant Program	Number of Awards Recommended	Award Amount Recommended
Provider Recruitment	5	$685,856
Capital Implementation	1	$2,500,000
Total	**6**	**$3,185,856**

Grant Award Recommendations. Funding recommendations are grouped for two separate approval actions so that Board members with a conflict may abstain from voting where applicable. The two groups are included in the Consent Agenda as two separate items, as follows: Item 9G (Group A) includes applications not affiliated with Board members; and Item 9H (Group B) includes applications affiliated with Board members.

Grant award recommendations are listed in the table below with totals by county and grouped by Board member affiliation so that Board members with potential financial interests in grant awards may abstain from voting on Group B. Details for each grant award recommendation are included in the reference materials listed below.

County	Group A | Not Board Affiliated	Group B | Board Affiliated
Santa Cruz	$2,650,000	$0
Monterey	$0	$0
Merced	$0	$535,856
Total	$2,650,000	$535,856
Total Grant Award Recommendation: $3,185,856		

Fiscal Impact. Recommended grant awards totaling $3,185,856 would be funded by the MCGP budget which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan's reserves to create the MCGP.

Attachments.

1. Grant Recommendations by Program. (Group A)
   - List of grant award recommendations organized by county and grant type.
2. Recommendation Summaries by Organization. (Group A)
   - Detailed application summaries of grant award recommendations organized alphabetically by organization. All application summaries were prepared by Alliance staff based on information in the grant application.

Medi-Cal Capacity Grant Program
Grant Recommendations
GROUP A: Not Affiliated with Alliance Board Members

Provider Recruitment Program

County	Page*	Organization	Award**
Santa Cruz	3	Coastal Health Partners	$150,000
		Subtotal	**$150,000**

Capital Program

County	Page*	Organization	Award**
Santa Cruz	1	Housing Matters	$2,500,000
		Subtotal	**$2,500,000**

*Page number of Recommendation Summary is listed for each Group A grant recommendation on the following pages.

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Housing Matters**	
County:	Santa Cruz	
Grant Award History:	Capital Implementation (Paul Lee Loft)	$117,747
	Recuperative Care Pilot	$1,553,760

Capital Program - Implementation

Project Name:	180 Permanent Supportive Housing
Project Site Address:	119 Coral Street, Santa Cruz, CA 95060
Type of Capital Project:	New Construction
Proposed Start/End Dates:	10/1/21 - 4/1/23 *(18 months)*
Total Project Budget:	$23,124,000
Request Amount:	**$2,500,000**
***Recommended Award:**	**$2,500,000**

Proposal Summary: Housing Matters requested funding to support the construction of a new building on the Coral Street Campus that will include 120 units of permanent supportive housing for chronically homeless individuals. The new building will also include space for a County-operated behavioral health clinic and a new space for the Recuperative Care Center (RCC), a 12-bed medical respite program, funded in part by the Alliance. The project is designed to provide community and service space, both indoor and outdoor, for residents, building management, and case managers.

Currently, the lack of single-site supportive housing with embedded services perpetuates the homelessness of the most vulnerable, highest-complexity, and highest-cost individuals experiencing homelessness. There is a lack of housing available overall for those experiencing homelessness, and this subset of the population is rarely housed successfully because they have higher service needs. Individuals that do not have stable housing, utilize emergency services at a greater degree than those that are housed. To reduce the utilization of emergency services, appropriate and safe housing with the right services is a crucial element and a co-factor in achieving improved health outcomes. Housing Matters' solution is to create and operate high density, high quality affordable housing units as supportive housing with extensive services provided on site.

All residents of 180 Permanent Supportive Housing will be individuals who are experiencing chronic homelessness and are high utilizers of the health care system in need of on-site services. The site will serve 145 individuals, 100% of whom will likely be Medi-Cal members. Housing Matters will provide services to support the residents, including case management services, 24-hour staff in the building, and a social support network with activities to instill a sense of community among residents. Additonally, residents will have access to all other services on the campus, such as health care and dental services provided by Homeless Persons' Health Project and Dientes, and peer support meetings. The residents will also be assisted with housing navigation services if they are ready to live in a different location out in the community. The on-site Behavioral Health Clinic will be able to serve not only the residents and clients of the RCC, but also those individuals in the community in need of behavioral health services.

Objectives: By December 2021, Housing Matters will receive building permits for the 180 Permanent Supportive Housing Project. In May 2022, Housing Matters' plans to start construction. They plan to complete construction of the project and secure occupancy by July 1, 2023.

Impact: The 180 Permanent Supportive Housing project will include a 2,353 sq. ft. Behavioral Health Clinic, 2,019 sq. ft. Recuperative Care Center, and 45,589 sq. ft. of permanent supportive housing, which includes shared community space, case management offices and other amenities. A total of 145 individuals are anticipated to be housed in the 120 unit PSH building, nearly 100% of which will be Medi-Cal members. This project will greatly increase the capacity to serve chronically homeless individuals in need of housing and services. By locating the project on the Coral Street Campus, the linkages to community-based resources will reduce barriers to care and support successful long-term housing by co-locating residents with supportive services.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Coastal Health Partners**	
County:	Santa Cruz	
Medi-Cal Services:	Alliance – Specialty Care	
Grant Award History:	Equipment (1)	$20,000
	Provider Recruitment (4)	$600,000

Provider Recruitment Program

Services:	Specialty Care
Provider Type:	Physician
Provider Specialty:	Orthopedics and Minimally Invasive Spine Surgery
Provider Hours:	Full Time
Practice Name:	Coastal Health Partners
Practice Location:	1820 Main St., Watsonville, CA 95076
Amount Requested:	**$150,000**
***Recommended Award:**	**$150,000**

DATE: April 28, 2021

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

FROM: Kathleen McCarthy, Strategic Development Director

SUBJECT: Medi-Cal Capacity Grants: Funding Recommendations (Group B)

Recommendation. Staff recommend the Board approve grant recommendations that total $535,856 for Group B of funding recommendations under Consent Agenda Item 9H, voted upon separately due to potential conflicts of interest.

Summary. See report at Item 9G for content, background and process for this agenda item. This is the second of two recommendations to allow a separate vote on those items for which Board members may have a conflict.

Discussion.

Grant Award Recommendations. Grant award recommendations are listed in the table below with totals by county and grouped by Board member affiliation so that Board members with potential financial interests in grant awards may abstain from voting on Group B. Details for each grant award recommendation are included in the reference materials listed below.

County	Group A | Not Board Affiliated	Group B | Board Affiliated
Santa Cruz	$2,650,000	$0
Monterey	$0	$0
Merced	$0	$535,856
Total	$2,650,000	$535,856
Total Grant Award Recommendation: $3,185,856		

Fiscal Impact. Recommended grant awards totaling $3,185,856 would be funded by the MCGP budget which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan's reserves to create the MCGP.

Attachments.

1. Grant Recommendations by Program. (Group B)
   - List of grant award recommendations organized by county and grant type.
2. Recommendation Summaries by Organization. (Group B)
   - Detailed application summaries of grant award recommendations organized alphabetically by organization. All application summaries were prepared by Alliance staff based on information in the grant application.

Medi-Cal Capacity Grant Program
Grant Recommendations
GROUP B: Affiliated with Alliance Board Members

Provider Recruitment Program

County	Page*	Organization	Award**
Merced	1	Golden Valley Health Centers	$117,928
	1	Golden Valley Health Centers	$117,928
	2	Merced Faculty Associates Medical Group	$150,000
	2	Merced Faculty Associates Medical Group	$150,000
		Subtotal	**$535,856**

*Page number of Recommendation Summary is listed for each Group B grant recommendation on the following pages.

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Golden Valley Health Centers**	
County:	Merced	
Medi-Cal Services:	Alliance – Primary Care	
Grant Award History:	Capital Implementation (1)	$2,500,000
	Capital Planning (1)	$150,000
	Equipment (8)	$101,071
	Infrastructure Planning (1)	$40,000
	Intensive Case Management (1)	$300,000
	Practice Coaching (1)	$25,000
	Provider Recruitment (6)	$694,293

Provider Recruitment Program

Services:	Primary Care
Provider Type:	Physician
Provider Specialty:	Internal Medicine
Provider Hours:	Full Time
Practice Name:	Merced Suites Senior Health and Wellness Center Northview Health Center
Practice Location:	847 W. Childs Ave., Merced, CA 95341 857 W. Childs Ave. Merced, CA 95341 3940 Sandpiper Ave., Merced, CA 95340
Amount Requested:	**$150,000**
***Recommended Award:**	**$117,928***

Services:	Primary Care
Provider Type:	Physician
Provider Specialty:	Internal Medicine
Provider Hours:	Full Time
Practice Name:	Merced Suites Senior Health and Wellness Center Northview Health Center
Practice Location:	847 W. Childs Ave., Merced, CA 95341 857 W. Childs Ave. Merced, CA 95341 3940 Sandpiper Ave., Merced, CA 95340
Amount Requested:	**$150,000**
***Recommended Award:**	**$117,928***

*Recommended award is based on 50% of total recruitment-related expenses submitted on grant application.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**Merced Faculty Associates**	
County:	Merced	
Medi-Cal Services:	Alliance – Primary Care	
Grant Award History:	Equipment (1)	$20,000
	Provider Recruitment (14)	$1,645,985

Provider Recruitment Program

Services:	Primary Care
Provider Type:	Physician
Provider Specialty:	N/A
Provider Hours:	Full Time
Practice Name:	MFA G Street
Practice Location:	3393 G St., Ste. C, Merced, CA 95340
Amount Requested:	**$150,000**
***Recommended Award:**	**$150,000**

Services:	Primary Care
Provider Type:	Physician
Provider Specialty:	N/A
Provider Hours:	Full Time
Practice Name:	MFA North MFA Parkside
Practice Location:	127 W. El Portal Dr., Merced, CA 95348 535 W. 25th St., Merced, CA 95340
Amount Requested:	**$150,000**
***Recommended Award:**	**$150,000**

DATE: April 28, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Annual Election of Officers of the Commission

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

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

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

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

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

Attachments. N/A

DATE: April 28, 2020

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

FROM: Michelle N. Stott, RN, MSN, Quality Improvement Director

SUBJECT: Care-Based Incentive 2020 Program Outcomes

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

Summary. This report provides an overview of the CBI program performance during 2020 and includes background on the development of the existing CBI program.

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

Historically CBI has aligned with many DHCS mandated reported measures, but other state policies have also impacted measure selection including the California State Auditor's reports, DHCS All Plan Letters, California Governor Gavin Newsom's directives, and more recently directives during the Public Health Emergency. Measures selection for CBI has also taken into consideration those preventive service measure gaps and continues to include new measures or modifications to focus incentives for Medi-Cal's population.

In recognition of providers serving more complex patient panels, starting in 2020, a new business intelligence software is adding a scoring factor to provider programmatic payments to more accurately reflect the population our providers are serving.

Discussion. CBI 2020 Care Coordination - Hospital & Outpatient measures include 30-Day Readmissions, Ambulatory Care Sensitive Admissions (ACSA), and Preventable Emergency Visits. The Alliance Strategic Goal of 12.14% for 30-Day Readmissions was not met in 2020 in part due to readmissions related to COVID 19. Readmission rates have trended flat over the past couple of years at an average of 14% in 2019 and 2020. ACSAs have shown a decline in 2020, with a peak in late 2017, early 2018 continued with increased rates in the Q4/Q1 winter months. Average rates dropped 1.6% from 2019 to 2020. Heart Failure, COPD/Asthma in older adults, bacterial pneumonia and urinary tract infections continued to be among the top ACSA conditions in 2020.

Preventable Emergency Visit rates have fallen sharply in 2020 in part due to member avoidance of Emergency Department (ED) use overall due to COVID-19. The downward

trend started in Q2 2020 and met the strategic goal of 14.28%. The average rate decreased 4.6% from 2019 to 2020 and overall trends show a decreased rate in preventable emergency visits since 2017 by 6.4% (Source: UM Tableau Report). Common examples of 2020 preventable visits include acute upper respiratory infections, urinary system disorders, acute pharyngitis and otitis media. Overall there were 3,343 preventable urgent care visits and 14,053 preventable ED visits, a decrease of 457 preventable urgent visit and 12,314 preventable ED visits from 2019.

Care Coordination - Access measures are comprised of Alcohol Misuse Screening and Counseling (AMSC), Developmental Screening in the First 3 Years, Initial Health Assessments (IHA), and Post-Discharge Care. Despite the temporarily suspension of the IHA timeframe during the public health emergency, the 2020 rate ended above the strategic goal of 40%, first met in 2017. AMSC and Post-Discharge Care both made improvements from 2019 to 2020, and Developmental Screening improved from its initial start in Q1 2020 to Q4 2020 by almost 4%.

Quality of Care measures, assessed through early HEDIS data, has shown positive improvements in almost all pediatric measures in both Merced and Santa Cruz/Monterey reporting populations from 2019 to 2020. Almost all the administrative rates for Santa Cruz/Monterey pediatric measures were also above the DHCS benchmark of the 50th percentile in review in late January. Antidepressant Medication Management, Asthma Medication Ratio, HbA1c Poor Control, BMI: Child & Adolescent, Immunizations: Children (Combo 10), and Well Child Visit First 15 Months all showed improvements in both Santa Cruz/Monterey and Merced. Overall, 5/10 measures were above 50th percentile in Santa Cruz/Monterey, two in Merced.

Fee-For-Service measures are designed in the program to pay quarterly, and in 2020, 17 additional providers were paid for their Buprenorphine License to increase MAT services to members. One additional clinic obtained Patient-Centered Medical Home recognition through NCQA in 2020 as well. In summary, the greatest achievements for CBI in 2020 were seen through the continued decrease in preventable emergency visits and ambulatory care sensitive admissions and increased preventive service rates.

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

Attachments. N/A

DATE: April 28, 2020

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

FROM: Dr. Dianna Diallo, Medical Director

SUBJECT: Proposed Changes for Care-Based Incentives 2022

Recommendation. Staff recommend the Board approve proposed changes to programmatic, fee-for-service and exploratory measures to the Care-Based Incentives (CBI) payments as described in detail below for 2022.

Summary. This report provides an overview of the CBI program and makes a recommendation for structural program changes to CBI 2022.

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

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

In recognition of providers serving more complex patient panels, starting in 2020, a new business intelligence software is adding a scoring factor to provider programmatic payments to more accurately reflect the population our providers are serving.

Discussion. Proposed changes to 2021 programmatic measures are:

- Reallocate Plan All-Cause Readmission points
- Redistribute Preventable Emergency Visit and Ambulatory Care Sensitive Conditions points
- Add Breast Cancer Screening
- Change Antidepressant Medication Management to Depression Screening and Follow-up Plan
- Retire Maternity Care: Prenatal and Maternity Care: Postpartum

Proposed changes to Fee-For-Service measures are:

- Change Behavioral Health Integration to remove TJC PCMH as standalone qualification

Proposed changes to 2021 exploratory measures are:

- Add ACE Screening in Children and Adolescents
- Add Health Plan Health Disparity Measure

The proposed 2021 programmatic Care Coordination - Hospital & Outpatient measures will have the following redistribution of points from the Plan All-Cause Readmission measure to the Post-Discharge Care measure in order to equalize value of these two metrics. Consequently, 4.5 points will me moved from Plan All-Cause Readmission measure to the Post-Discharge care measure and each will be worth 10.5 points going forward in 2022. This keeps readmissions as a priority overall and allows for greater emphasis to be placed on the PCP for timely follow-up from hospitalization. Additionally, 5 points will be reallocated from the Preventive ED and Ambulatory Care Sensitive Admission measures to the Quality of Care Measures which will increase overall point allocation from 35 to 40 points. With this change, Preventive ED will have 9 points and Ambulatory Care Sensitive Admissions 8 points in 2022. The increase to the Quality of Care Measures is to support an overall improvement on performance for these important preventive care measures.

For Care Coordination - Access Measures and Performance Threshold measures, staff recommend no change beside the point reallocation from the Plan All-Cause Readmission to Post-Discharge Care.

In terms of 2021 programmatic Quality of Care measures, the following are recommended to remain unchanged: Asthma Medication Ratio; Body Mass Index Assessment: Children & Adolescent; Cervical Cancer Screening, Child and Adolescent Well-Care, Diabetic HbA1c Poor Control (>9%); Immunizations: Adolescents; Immunizations: Children (Combo 10); and Well-Child Visit First 15 Months. Maternity Care: Postpartum; Maternity Care: Prenatal are recommended for retirement following general high performance across all counties. Recommended additions include the transition of the Breast Cancer Screening measure from exploratory to programmatic status, and the change from the Antidepressant Medication Measure back to the Depression Screening and Follow Plan. Health Plan performance for the Breast Cancer Screening measure were below or near the 50th percentile for the 2019 measurement year, requiring a corrective Plan, Do Study Act (PDSA) project in Merced. For the Depression Screening and Follow-up Plan, the more actionable MCAS measure has now stabilized over the past couple of years and is a better fit for routine care compared to medication focused antidepressant medication management measure.

Fee-for-Service Measures are recommended to change the Behavioral Health Integration measure to remove the Joint Commission (TJC) Patient Center Medical Home (PCMH) certification as a standalone qualification. In recent years, both the NCQA PCMH recognition and the TJC PCMH certification have added elements of behavioral health into their PCMH programs. The additional qualifications to obtain the NCQA Distinction in Behavioral Health Integration are elements above and beyond the PCMH requirements.

Recommended additions to exploratory measures include Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents and a Health Plan Health Disparity Measure. Following DHCS, the Surgeon General of California's Report, and the ACEs AWARE campaigns to promote and educate both providers and patients on Adverse Childhood Experiences (ACEs), the ACE screening measure will review members 1-21 years of age who had an annual ACE screening. Resulting findings from the 2020 Medi-Cal Health Education and Cultural and Linguistic Population Needs Assessment (PNA), showed disparities between ethnic groups for some HEDIS measures amongst our member population, promoting continued review and education to serve those distinct member populations. The health plan health disparity measure would look globally at the overall Alliance rates among the Child and Adolescent Well-Care Visit to determine whether different ethnic groups had or did not have equal access to primary care, relative to our largest member population. These findings would be shared to all participating CBI groups with the goal for future paid implementation to allocate a certain point percentage to all CBI groups if no disparities are found.

Fiscal Impact. There is no fiscal impact associated with this agenda item. CBI has been budgeted and the design of the program will not have a negative fiscal impact.

Attachments. N/A

DATE: April 28, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Medi-Cal Managed Care Procurement Process

Recommendation.

1. Staff recommend the Board authorize the Chief Executive Officer (CEO) to execute a non-binding Letter of Intent (LOI) indicating shared intent to transition the County from the Regional model to join the Alliance's County Organized Health System (COHS) through an expansion of Alliance service area.
2. Staff recommend the Board authorize the CEO to execute the non-binding LOI indicating shared intent to transition the County from the San Benito model to join the Alliance's COHS through an expansion of Alliance service area.

Summary. The Department of Health Care Services (DHCS) is beginning a statewide procurement of commercial Medi-Cal managed care plans (MCPs) for contracts to be effective in January 2024. This process allows commercial plans to submit bids to provide MCP services in non-COHS counties. DHCS has indicated that it may remove a county from the commercial plan procurement if a county transitions to a COHS model. DHCS established an April 30, 2021 deadline for the county(ies) and the corresponding MCP to indicate this intention via submission of a LOI.

San Benito County and Mariposa County have requested the Alliance expand its COHS model to their counties. Each County's Board of Supervisors (BOS) has approved execution of the required LOI. Staff's work with each county and review of the LOI requirements support staff's recommendation that the Alliance execute the LOI for the Mariposa model change and the LOI for the San Benito model change.

Background. Nearly 11M Medi-Cal beneficiaries are currently enrolled in a Medi-Cal MCP across all fifty-eight (58) California counties. There are six main models of managed care including: COHS, Two-Plan, GMC, Regional Model (RM), Imperial, and San Benito.

Local plans operate in COHS and Two-Plan in thirty-six (36) counties across the state. In a COHS county, the COHS plan is the sole Medi-Cal MCP serving Medi-Cal enrollees residing in that county. In Two-Plan model counties, the Local Plan (or Local Initiative) is a locally governed plan, similar to a COHS plan, that operates in the county and competes with a commercial plan for Medi-Cal enrollees. Medi-Cal

enrollees in Two-Plan counties may choose between the Local Initiative and the commercial plan. Most remaining counties are served by the RM, consisting of commercial plans that compete for Medi-Cal enrollees. Medi-Cal enrollees in RM counties choose between the commercial plans operating in their county of residence. San Benito County is an exception. There is only one commercial MCP operating in San Benito County. Medi-Cal beneficiaries residing in San Benito County choose between enrolling in the commercial plan or remaining in fee-for-service Medi-Cal. The San Benito and Regional Models of managed care have been in place now since 2013.

In late 2020, DHCS announced its intention to recontract the commercial plans operating in the Regional, GMC and Two-Plan model counties. The Request for Proposal (RFP) is scheduled to be released in late 2021. DHCS has stated that Counties that indicate an interest to transition to a COHS model may be removed from the RFP process. DHCS' deadline for counties to state such an intent by submitting a LOI executed by the county's BOS and the corresponding MCP is April 30, 2021.

The purpose of the LOI is for the county to demonstrate an understanding of the MCP's obligations as a new local plan, describe county engagement underway, and outline the necessary steps in order to meet the preliminary requirements prior to the finalization of the commercial plan procurement RFP. Submission of the LOI does not guarantee that the transition to the COHS model will occur. However, failure to submit an LOI by the deadline will preclude a county from shifting to a local plan model in January 2024.

In prior expansions of Medi-Cal managed care, San Benito and Mariposa counties considered whether a COHS model would best meet the needs of their respective Medi-Cal beneficiaries. Each county engaged the Alliance in assessing potential partnerships to administer the Medi-Cal program. Each of those previous explorations did not result in the expansion of the Alliance's COHS, due to various factors including provider referral patterns and/or lack of in-county providers.

Discussion. In late 2020, San Benito and Mariposa counties each approached the Alliance regarding their respective interests in working with the Alliance towards an expansion of the Alliance's COHS Medi-Cal managed care plan services to eligible Medi-Cal beneficiaries within each county and entering into a joint letter of intent.

The Alliance's history of successful operations in the region and its emphasis on access, quality, member engagement and provider support are all factors in the counties' interests in working with the Alliance. All parties' interests are mutual and aligned in their appreciation of the opportunity to meet the health care needs of county residents through local governance.

At the February 2021 meeting, the Alliance's board directed staff to explore the feasibility of San Benito and/or Mariposa counties changing Medi-Cal managed care models to join

the Alliance's existing COHS plan through an expansion of Alliance service area and to report back to the board with a recommendation. Accordingly, staff have engaged in a series of meetings with stakeholders in each county, including county health and social services department leaders and key providers to discuss potential partnership opportunities including: access and network adequacy, primary care case management and the Patient Centered Medical Home, readiness for engagement in quality improvement and utilization management programs, and any potential factors or barriers to a successful COHS implementation.

Weighing in support of expansion, since the previous expansion assessment discussions, regulatory access requirements have been clarified that support network development that consider referral patterns and provider location and availability. That is, that county lines are no longer perceived barriers to network development as long as regulatory time and distance standards are met. In addition, staff's recent meetings with county staff and key provider partners indicate a shared commitment to the type of collaboration that is required to support a COHS.

In addition, weighing in support of expansion the proposed expansion of the COHS model to Mariposa and to San Benito counties would result in an increase of up to 23,000 additional Medi-Cal members for the Alliance. A table reflecting membership breakdown is displayed below.

County	Age 0-18	Age 19-64 (non-ACA expansion)	Age 65 & up	ACA expansion adults Age 19-64	Dual Eligible*	Total Enrollment
San Benito	7,907	4,248	1,293	5,096	1,617	18,544
Mariposa	1,709	1,315	452	1,917	746	5,393

** Source: CHHS Open Data; Citation: Month of Eligibility, Dual Status by county, Medi-Cal Certified Eligibility, February 2021.*
***Source: The California Department of Health Care Services, Medi-Cal eligibility data extracted from the Management Information System/Decision Support System (MIS/DSS data warehouse); Citation: State of California, Department of Health Care Services Medi-Cal Certified Eligible Data Table by County and Aid Code Group, February 2021 (Dates Represented: November 2020).*

Stakeholders have acknowledged benefits to the counties, Medi-Cal beneficiaries, and providers of joining with the Alliance, including opportunities for expanded network access and potential for better coordinated care and improved health outcomes. Stakeholders have also shared information about access and referral patterns within each county and an interest in working within the Alliance's COHS model plan and the opportunities available through local governance. Consequently, each county's Board of Supervisors has reviewed and approved of the county moving forward with submission of the LOI upon approval by the Alliance board.

In addition, staff see potential opportunities for the Alliance in such a partnership, including expanding the plan's geographic footprint with the addition of two counties which border our current service area and further solidifying the value of the COHS and local plan models within the State.

In light of the stakeholder engagement, membership increase, and provider commitment to collaboration weighing in favor of exploring expansion into each county, staff has reviewed the requirements for the LOI and is able to make the necessary attestations regarding financial status, general readiness, preliminary network planning time line requirements.

Staff have also identified conditions which must be satisfied prior to final approval of the agreements supporting expansion. These have been identified in the LOI and include: State and federal approval, adequate revenue approved by the Alliance board, receipt of sufficient pre-expansion utilization data to evaluate revenue and support provider network development, and confirmation of federal statutory authority and/or waiver requirements related to any existing COHS federal enrollment limits. Staff will return to the board with updates on these and other relevant issues and to seek board approval for the Chair's execution of the agreement regarding expansion at the appropriate time.

In addition to ensuring the above criteria are satisfied before moving forward, the Alliance's board must decide upon governance structure of a newly formed board, to include the addition of representation from both San Benito and Mariposa counties, and each county must adopt corresponding Ordinances codifying such. Staff anticipate returning to the board with a recommended approach for governance in the coming months.

Timeline and Next Steps

- Signed LOI to DHCS, upon board approval – *4/30/21*
- DHCS to release draft RFP – *Spring 2021*
- Governance structure determined and County Ordinances adopted – *9/30/21*
- Preliminary Provider Network Development Strategy to DHCS – *9/30/21*
- Executed County Ordinances to formalize the choice to change Medi-Cal managed care model to DHCS – *10/1/21*
- DHCS to release Request for Proposal with finalized list of counties included in the procurement – *Late 2021*

Fiscal Impact. N/A

Attachments.

1. LOI – Mariposa County/Central California Alliance for Health
2. LOI – San Benito County/Central California Alliance for Health

Mariposa County Health & Human Services Agency

Central California Alliance for Health

April 30, 2021

Ms. Bambi Cisneros
Acting Deputy Director
Health Care Delivery Systems
Department of Health Care Services
1501 Capitol Avenue, MS 4400
Sacramento, CA 95899-7413

RE: Letter of Intent – Mariposa County/Central California Alliance for Health

Dear Ms. Cisneros,

On behalf of the County of Mariposa (the County) and the Central California Alliance for Health (the Alliance), we are pleased to submit this non-binding Letter of Intent to express our mutual interest in a County/Health Plan partnership to expand the Alliance Service Area to include its County Organized Health System (COHS) model of Medi-Cal managed care to eligible Medi-Cal beneficiaries in Mariposa County.

The County and the Alliance first began discussions regarding the feasibility a partnership in 2012 and again most recently, the County contacted the Alliance in 2019 regarding its interest in exploring the possibility of working with the Alliance towards an expansion of the Alliance's COHS Medi-Cal managed care plan services. The Alliance's history of successful operations in the region and its emphasis on access, quality, member engagement and provider support are all factors in the County's interest in working with the Alliance.

The County will include key stakeholders, in the discussions regarding the change to a Medi-Cal managed care model and will ensure local buy-in and interest in pursuing the opportunity to bring the COHS model into the county health care delivery system. All parties' interests are mutual and aligned in their appreciation of the opportunity to meet the health care needs of Mariposa county Medi-Cal beneficiaries through local governance.

Based on current shared knowledge, available information, and mutual intent, the County and the Alliance attest to having a reasonable expectation that the following requirements will be met.

1. The Alliance remains in good financial standing, has a working capital ratio of at least 1:1, and is able to assume financial risk for Medi-Cal managed care plan services for Medi-Cal members in the county assuming revenue rates developed for the expansion area are determined to be adequate by the Alliance.

2. The County and the Alliance will work together to self-fund all pre-implementation activities, including readiness requirements, and will not require funding from DHCS related to the cost of these activities.
3. The Alliance will meet financial readiness requirements that are similar to those included in the Alliance current Medi-Cal contract in Section 2 “Financial Information”, Section 8 “Provider Compensation Arrangements”, and Section 20 “Budget Detail and Payment Provisions”.
4. The Alliance will meet non-financial readiness requirements and timelines that are similar to those included in the Alliance current Medi-Cal contract
5. The Alliance will meet network capacity requirements for 100% of the Eligible Beneficiaries in the county.
6. The Alliance will implement all applicable Medi-Cal managed care plan requirements that are added through new legislation or other guidance, including but not limited to, all elements of the final CalAIM proposal (California Advancing and Innovating Medi-Cal).
7. By September 2021, the Alliance will describe preliminary planning for a network contracting strategy and ongoing negotiations to support the increased capacity necessary for the new local plan responsibility for January 2024.
8. The County is not aware of any new state statute requirement necessary to implement this managed care model transition. If it were to be determined that such statutory authority was necessary, the County would work to develop and enact the requisite legislation.
9. The County Board of Supervisors will consider enacting local ordinances by October 2021 authorizing the shift to a County Organized Health System model through the Central California Alliance for Health.

Following are the County and Plan contacts for related to this discussion.

Mariposa County	Central California Alliance for Health
Primary: Shannon Gadd Director Health & Human Services Agency 5362 Lemee Lane, PO Box 99, Mariposa CA 95338 209-966-2000 sgadd@mariposacounty.org	**Primary: Stephanie Sonnenshine** Chief Executive Officer 1600 Green Hills Road, Suite 101 Scotts Valley, CA 95066 831-430-5530 ssonnenshine@ccah-alliance.org
Secondary: Eric Sergienko Mariposa County Health Officer 5362 Lemee Lane, PO Box 99, Mariposa CA 95338 209-966-2000 esergienko@mariposacounty.org	**Secondary: Danita Carlson** Government Relations Director 1600 Green Hills Road, Suite 101 Scotts Valley, CA 95066 831-212-1602 dcarlson@ccah-alliance.org

The County and the Alliance submit this non-binding Letter of Intent to expand the Alliance's COHS model of Medi-Cal managed care, to Medi-Cal beneficiaries in Mariposa County, contingent on state and federal approval and upon adequate revenue to support the expansion, as determined by the Alliance and approved by the Alliance governing board. To that end, the Alliance must receive sufficient pre-expansion utilization data to evaluate revenue rates and support provider network development. Further, final approval by the Alliance board is subject to confirmation of federal statutory authority and/or waiver requirements related to COHS enrollment limits, to ensure the long-term financial viability and sustainability of the Alliance's operations in its existing tri-county service area.

The County shares in the Alliance's mission to provide accessible, quality health care guided by local innovation and thanks the Department of Health Care Services for this opportunity to bring the Alliance mission, vision and values to its residents.

Sincerely,

Shannon Gadd
Director Health and Human Services
Mariposa County

Stephanie Sonnenshine
Chief Executive Officer
Central California Alliance for Health

Exhibit B: Readiness Planning

The Santa Cruz – Monterey – Merced Managed Medical Care Commission (dba: Central California Alliance for Health) or "the Alliance", operates a County Organized Health System (COHS) pursuant to State and federal statutes. (Welfare & Institutions Code §14087.54 and CFR § 42 U.S.C. § 1396u-2(a) (3) (c) serving over 370,000 eligible enrolled Medi-Cal beneficiaries in Santa Cruz county since 1996, Monterey county since 1999 and Merced county since 2009. As a COHS plan successfully operating for over 25 years and having twice previously successfully implemented county expansions the Alliance is well-positioned to expand its service area to encompass the Medi-Cal enrollees in Mariposa County, which borders all three of the Alliance current counties. *(Separately, the Alliance submits a parallel letter of intent to expand its service area to San Benito County.)*

The Alliance provides the following information to demonstrate its readiness planning and ability to meet all readiness requirements in each of the following areas.

Service Utilization

The Alliance has the demonstrated ability to provide reliable service utilization and cost data, including but not limited to, all required quarterly financial reports, audited annual reports, utilization reports of medical services, and encounter data.
The Alliance maintains an information system that collects and reports encounter and claims data in compliance with managed care plan contractual requirements regarding the provision of timely, accurate, reasonable and complete encounter and claims cost data.

The Alliance Finance Department complies with contractual requirements regarding periodic financial reporting, including quarterly and annual financial statements, rate development templates and all supplemental data requests.

Network Adequacy

The Alliance maintains a provider network adequate to provide all medically necessary Covered Services to 100% of the eligible enrollees in its service area. The Alliance's provider network includes primary care physicians, non-physician medical practitioners, specialists, pharmacies, hospitals and ancillary providers that are based on the population makeup and geographic needs within its service area. The Alliance contracts with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) as well as American Indian Health Programs and Freestanding Birthing Centers (FBCs) where available. In addition, the Alliance offers telehealth services to complement its provider network and address access to care.

The Alliance provider network complies with accessibility and availability requirements, including standards for time and distance as reflected in the plan's annual network certification submission.

Quality Monitoring

The Alliance administers robust quality improvement and utilization management programs which include prospective and retrospective review of services, patterns of practice review

and review of drug prescribing practices. In addition, the Alliance has mechanisms in place to review for and detect both over-utilization and under-utilization of services.

The Alliance maintains a Quality Improvement (QI) System to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The Quality Improvement and Population Health (QI/PH) Department monitors the quality of health care services provided and is able to review quality of care at the individual member level, as well as for the Alliance's member population as a whole. This includes leading the Alliance's effort to improve effectiveness and preventive care measures for members through the National Committee for Quality Assurance (NCQA) HEDIS/MCAS measures and the Alliance Care Based Incentives (CBI) program. The QI/PH Department manages the clinical safety program, including review of Potential Quality Issues, Facility Site Review audits, and on-going monitoring activities. To support providers with clinical improvement efforts, QI/PH provides technical assistance through quality practice coaching, learning collaboratives, practice transformation academy, CBI Forensic visits, and academic detailing. In addition, QI/PH provides health education and cultural and linguistic programs to support members with preventive care and chronic care management interventions.

Accessibility Standards

The Alliance has established accessibility standards in compliance with contractual and regulatory requirements including procedures for timely access to appointments within standards for timely appointments for urgent, non-urgent primary care, specialty and ancillary services as required.

The Alliance offers a 24/7 Nurse Advice Line service available to members with a registered nurse available to answer health care questions and assist members and connect them with services.

Additional Efforts

The Alliance is able to submit required deliverables to the Department, including but not limited to, quality improvement systems, utilization management, access and availability, member services and member grievance systems.

The Alliance will use its approved Member Handbook and member informing materials to provide information to new enrollees and will ensure that provider sites and facilities are reviewed in compliance with contractual requirements.

The Alliance has policies and procedures in place in compliance with standards and guidelines established by the Department which demonstrate its readiness to provide services to members and can provide additional information in any of the above areas upon request.

The County and the Alliance have no health-related financial sanctions or Corrective Action Plans in place.

April 31, 2021

Ms. Bambi Cisneros
Acting Deputy Director
Health Care Delivery Systems
Department of Health Care Services
1501 Capitol Avenue, MS 4400
Sacramento, CA 95899-7413

RE: Letter of Intent - San Benito County/Central California Alliance for Health

Dear Ms. Cisneros,

On behalf of the County of San Benito (the County) and the Central California Alliance for Health (the Alliance), we are pleased to submit this non-binding Letter of Intent to express our mutual interest in a County/Health Plan partnership to expand the Alliance Service Area to include its County Organized Health System (COHS) model of Medi-Cal managed care to eligible Medi-Cal beneficiaries in San Benito.

The County and the Alliance have had a series of discussions since 2005 regarding the feasibility of a partnership. Most recently, the County contacted the Alliance in 2017 regarding its interest in exploring the possibility of working with the Alliance towards an expansion of the Alliance's COHS Medi-Cal managed care plan services. The Alliance's history of successful operations in the region and its emphasis on access, quality, member engagement and provider support are all factors in the County's interest in working with the Alliance.

The County has included key local stakeholders, including the local district hospital and the sole federally qualified health center operating in the county, in the discussions regarding the change to a Medi-Cal managed care model and will ensure local buy-in and interest in pursuing the opportunity to bring the COHS model into the county health care delivery system. All parties' interests are mutual and aligned in their appreciation of the opportunity to meet the health care needs of San Benito county residents through local governance.

Based on current shared knowledge, available information, and mutual intent, the County and the Alliance attest to having a reasonable expectation that the following requirements will be met.

1. The Alliance remains in good financial standing, has a working capital ratio of at least 1:1, and is able to assume financial risk for Medi-Cal managed care plan services for Medi-Cal members in the county assuming revenue rates developed for the expansion area are determined to be adequate by the Alliance.

2. The County and the Alliance will work together to self-fund all pre-implementation activities, including readiness requirements, and will not require funding from DHCS related to the cost of these activities.
3. The Alliance will meet financial readiness requirements that are similar to those included in the Alliance current Medi-Cal contract in Section 2 "Financial Information", Section 8 "Provider Compensation Arrangements", and Section 20 "Budget Detail and Payment Provisions".
4. The Alliance will meet non-financial readiness requirements and timelines that are similar to those included in the Alliance current Medi-Cal contract
5. The Alliance will meet network capacity requirements for 100% of the Eligible Beneficiaries in the county.
6. The Alliance will implement all applicable Medi-Cal managed care plan requirements that are added through new legislation or other guidance, including but not limited to, all elements of the final CalAIM proposal (California Advancing and Innovating Medi-Cal).
7. By September 2021, the Alliance will describe preliminary planning for a network contracting strategy and ongoing negotiations to support the increased capacity necessary for the new local plan responsibility for January 2024.
8. The County is not aware of any new state statute requirement necessary to implement this managed care model transition. If it were to be determined that such statutory authority was necessary, the County would work to develop and enact the requisite legislation.
9. The County Board of Supervisors will consider enacting local ordinances by October 2021 authorizing the shift to a County Organized Health System model through the Central California Alliance for Health.

Following are the County and Plan contacts for related to this discussion.

San Benito County	Central California Alliance for Health
Primary: Tracey Belton Director, Health & Human Services 1111 San Felipe Rd #206 Hollister, CA 95023 831-636-4180 tbelton@cosb.us	**Primary: Stephanie Sonnenshine** Chief Executive Officer 1600 Green Hills Road, Suite 101 Scotts Valley, CA 95066 831-430-5530 ssonnenshine@ccah-alliance.org
Secondary: Casey Estorga Deputy Director, Health & Human Services 1111 San Felipe Road. #206 Hollister, CA 95023 831-630-5179 cestorga@cosb.us	**Secondary: Danita Carlson** Government Relations Director 1600 Green Hills Road, Suite 101 Scotts Valley, CA 95066 831-212-1602 dcarlson@ccah-alliance.org

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revenue rates and support provider network development. Further, final approval by the Alliance board is subject to confirmation of federal statutory authority and/or waiver requirements related to COHS enrollment limits, to ensure the long-term financial viability and sustainability of the Alliance's operations in its existing tri-county service area.

The County shares in the Alliance's mission to provide accessible, quality health care guided by local innovation and thanks the Department of Health Care Services for this opportunity to bring the Alliance mission, vision and values to its residents.

Sincerely,

Mark Medina
Chair, County Board of Supervisors
San Benito County

Stephanie Sonnenshine
Chief Executive Officer
Central California Alliance for Health

Exhibit B: Readiness Planning

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and review of drug prescribing practices. In addition, the Alliance has mechanisms in place to review for and detect both over-utilization and under-utilization of services.

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Additional Efforts

The Alliance is able to submit required deliverables to the Department, including but not limited to, quality improvement systems, utilization management, access and availability, member services and member grievance systems.

The Alliance will use its approved Member Handbook and member informing materials to provide information to new enrollees and will ensure that provider sites and facilities are reviewed in compliance with contractual requirements.

The Alliance has policies and procedures in place in compliance with standards and guidelines established by the Department which demonstrate its readiness to provide services to members and can provide additional information in any of the above areas upon request.

The County and the Alliance have no health-related financial sanctions or Corrective Action Plans in place.

Information Items: (18A. – 18B.)

DATE: April 28, 2021

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Alliance in the News

The truth about COVID-19 vaccines: 7 facts you should know
Alliance in the News via News Wire
The Californian Op-ed
March 29, 2021

The truth about COVID-19 vaccines: 7 facts you should know

Avoid falling for COVID-19 myths or scams by seeking information from experts only.

You might be hearing rumors about the COVID-19 vaccine, and you may have questions. At Central California Alliance for Health, we urge you to seek out the truth about the vaccines. Be ready to get the vaccine when it's your turn.

1. Getting a vaccine will not give you COVID-19. None of the vaccines contain the live virus. This means they cannot make you sick with COVID-19.
2. You should get vaccinated even if you've had COVID-19. Research shows that the consequences of COVID-19 can be severe. Even if you've recovered from having COVID-19, there is not enough information to know if you are protected from getting it again.
3. The COVID-19 vaccines do not have severe side effects in most people. It's common to experience mild to moderate signs that your body is building protection after getting a vaccine. These can include muscle aches, tiredness, headache, fever, chills, or soreness where you had the injection. Side effects often last for a day or two. However, any new medication can cause an allergic reaction in a small number of people. For this reason, you'll be asked to stay for observation for a short period after you've received the shot.
4. The COVID-19 vaccine will not change your DNA or make you infertile. The vaccines are designed to give your body instructions to fight the coronavirus. There is no way the vaccine can change the DNA of your cells. No evidence getting the vaccine can cause women to miscarry. If you are pregnant, talk to your doctor about the risks and benefits of getting the COVID-19 vaccine.
5. When you get the vaccine, you will not be asked for information about your immigration status. The vaccine is available to the public regardless of immigration status.
6. You will receive the COVID-19 vaccine at no cost. You will not have to pay for the vaccine. If you are asked to pay for it, it is a scam. Also, if you are asked to pay to receive the vaccine early or to be added to a list, you are being scammed.
7. After you've been vaccinated, you should still practice safety measures. The vaccine can prevent you from getting sick. However, there is not enough information to know whether you can still carry and give the virus to others. Continue to cover your

mouth and nose with a mask in public. Stay at least six feet away from people who don't live with you, avoid crowds and wash your hands often.

Avoid falling for COVID-19 myths or scams by seeking information from experts only. Some examples of reliable sources for vaccine information include the Centers for Disease Control and Prevention (CDC), your county's public health department, and your primary care provider (PCP). You can also check the Alliance website (www.ccah-alliance.org) for COVID-19 information for Medi-Cal members.

For up-to-date resources on COVID-19 vaccines, go to www.ccah-alliance.org.

Maya Heinert, MD is Medical Director of the Central California Alliance for Health, a Medi-Cal managed care health plan focused on improving access to health care for over 360,000 residents of Santa Cruz, Monterey, and Merced counties. Dr. Heinert has over 20 years of health care experience in Northern California.

In California: COVID-19 cases hold steady; state borrows $21B for jobless benefits
Alliance in the News via News Wire
Visalia Times Delta
March 29, 2021

The truth about COVID-19 vaccines

Are you on the fence about getting a COVID-19 vaccine? Or are you ready to get one but have reservations because of rumors you've heard? Dr. Maya Heinert, medical director of the Central California Alliance for Health, has written an informative article with seven facts you should know. "Avoid falling for COVID-19 myths or scams by seeking information from experts only," she writes. Read the full article here.

The truth about COVID-19 vaccines: 7 facts you should know
Alliance in the News via News Wire
Visalia Times Delta Op-ed
March 29, 2021

The truth about COVID-19 vaccines: 7 facts you should know

Avoid falling for COVID-19 myths or scams by seeking information from experts only.

You might be hearing rumors about the COVID-19 vaccine, and you may have questions. At Central California Alliance for Health, we urge you to seek out the truth about the vaccines. Be ready to get the vaccine when it's your turn.

1. Getting a vaccine will not give you COVID-19. None of the vaccines contain the live virus. This means they cannot make you sick with COVID-19.
2. You should get vaccinated even if you've had COVID-19. Research shows that the consequences of COVID-19 can be severe. Even if you've recovered from having COVID-19, there is not enough information to know if you are protected from getting it again.
3. The COVID-19 vaccines do not have severe side effects in most people. It's common to experience mild to moderate signs that your body is building protection after

getting a vaccine. These can include muscle aches, tiredness, headache, fever, chills, or soreness where you had the injection. Side effects often last for a day or two. However, any new medication can cause an allergic reaction in a small number of people. For this reason, you'll be asked to stay for observation for a short period after you've received the shot.

4. The COVID-19 vaccine will not change your DNA or make you infertile. The vaccines are designed to give your body instructions to fight the coronavirus. There is no way the vaccine can change the DNA of your cells. No evidence getting the vaccine can cause women to miscarry. If you are pregnant, talk to your doctor about the risks and benefits of getting the COVID-19 vaccine.
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New center for homeless ready to open in Merced

Alliance in the News via Press Release
Merced County Times
March 24, 2021

LOCAL NEWS

New center for homeless ready to open in Merced

'By having this center where county staff and nonprofit providers can interact with these folks on a daily basis, provide them with meals, and break bread, so to speak, I really feel like we are at a spot where we are going to increase our significance in helping the homeless."

Lloyd Pareira, Merced County Supervisor

Local leaders were poised this week to christen Merced County's new Navigation Center, expected to provide up to 75 beds and "wrap-around" services to help rescue homeless people living on the streets.

The opening of the facility comes less than a year from its groundbreaking along B Street, across from the cemetery, in south Merced.

"By having this center where county staff and nonprofit providers can interact with these folks on a daily basis, provide them with meals, and break bread, so to speak, I really feel like we are at a spot where we are going to increase our significance in helping the homeless," Merced County Supervisor Lloyd Pareira told his colleagues during a meeting Tuesday.

Pareira described the project as a "fast and furious" one that was accomplished in a surprisingly short amount of time after receiving county and city approvals, and despite the COVID-19 pandemic.

Supervisor Pareira, Assemblyman Adam Gray, Merced Mayor Matthew Serratto and others were expected to hold a ribbon-cutting ceremony on Wednesday, just after the Times press deadline this week.

After taking a tour of the Navigation Center, Pareira said he was most impressed by the "mindset" of staff members with the Human Services Agency and the Behavioral Health Department who will be working with the homeless.

"They talked about being effective and making a difference," Pareira said. "I say this often, and I want to say it again. I don't know who is listening, but people who are homeless, a majority of the time, have a behavioral health issue that keeps them from being housed. … Oftentimes it stems from a time earlier in their lives. People they trusted abused them, and then the drugs and alcohol came after that. So you have a population of people who don't trust people by virtue of the nature of where they are at in their lives."

The 15,000 square-foot facility was constructed from modified shipping containers to save money, cut down on construction time, and provide for a versatile and modern look. Construction was completed mid-March, and the Navigation Center will open for service on Monday, March 29. The county has contracted with the Merced County Rescue Mission to manage the new facility which will operate 24/7.

"The Rescue Mission considers it a great privilege to operate the Navigation Center as we collaborate with the County and City of Merced to provide services to people experiencing homelessness," said Bruce Metcalf, Executive Director of the Merced County Rescue Mission.

The Navigation Center will serve as a low-barrier emergency sheltering option for individuals currently residing in public spaces, and other places not suitable for human habitation. This initial step transitioning individuals out of homelessness includes providing a safe and service-rich temporary shelter with connections to onsite supportive services. Clients will be assigned a case manager. The goal is to link Navigation Center clients to permanent supportive and affordable housing units as quickly as possible, while simultaneously working on barriers to sustainability such as lack of income and behavioral health challenges.

The project is the result of many key partners, including Assemblyman Adam Gray, the county's Continuum of Care network, the Central California Alliance for Health, the City of Merced, and others.

"The opening of the Navigation Center is a vital part of our collective efforts to reduce homelessness in Merced County," said Assemblymember Gray. "It is not a silver bullet, but will go a long way in improving the quality of life for those experiencing homelessness in our community and all Merced residents. We remain committed to cleaning up our streets and ensuring that we not only provide a bed, but also the services needed to keep people in housing – the Navigation Center will help us accomplish those goals."

Said Stephanie Sonnenshine, the CEO of the Alliance for Health: "As the Medi-Cal managed care health plan serving approximately half of all Merced residents, the Alliance recognizes that having a stable home is a key factor in improving overall health outcomes for these individuals," "We are therefore pleased to support the new Merced Navigation Center as this facility will not only link its clients to secure housing, income, and job training resources, but will also ensure that all participants will be connected to Medi-Cal and a primary care physician. These proactive measures will ultimately reduce their need for more costly emergency medical services and hospitalizations, and more importantly, bring us closer to our shared vision of 'Healthy People, Healthy Communities'."

The Navigation Center design includes approximately 75 beds, kitchen and dining facilities, laundry, classroom, clinic, and office space for support service providers. Due to COVID-19 safety requirements, the center will initially open with a 66-bed capacity. The Merced County Rescue Mission has established a Navigation Center Advisory Committee to work with partners, including businesses and organizations in the neighborhood, as a component of its "Good Neighbor Policy" to ensure community involvement and coordination to maximize the program's positive impact on the surrounding neighborhood.

Serving as one of several emergency shelter options in Merced County, the Navigation Center will provide participants with 24/7 temporary living facilities, in addition to case management and connection to income, public benefits, health services, and transitional or permanent housing. The average anticipated length of stay is six months.

Referrals to the Navigation Center are made in close coordination with homeless outreach workers, local law enforcement, and Navigation Center staff.

To make a referral, contact the countywide New Direction Outreach and Engagement Center by calling (209) 726-2700. Once a referral is made, an assigned outreach worker will contact, screen, and refer individuals to the appropriate housing and community services based on a standard assessment tool.

"I am very excited for the county's Navigation Center to open," said Merced Mayor Matthew Serratto, who also serves as chairman of the Continuum of Care. "The achievement of the last few years has been in planning, funding, and now building this and other projects. Now it's time to get to work and hopefully start making gradual progress on this most challenging issue. We have a lot of tremendous people doing incredible work every day on addressing homelessness, and we will keep fighting to help our community."

The Navigation Center is one element of the proposed regional plan to address homelessness — a collaborative effort between Merced County, its six cities, and the Continuum of Care. Other elements include outreach and engagement, transitional housing, long-term supportive housing, and the system supports needed to coordinate these activities.

Earlier this year, the Board of Supervisors renewed an agreement with the Merced County Rescue Mission to provide other communities outside of the City of Merced with access to

similar services on an appropriate scale by renting homes distributed across Merced County that will be similarly used as low-barrier Navigation Centers.

Here is the truth about COVID-19 vaccines, as shown in seven facts you should know
Merced Sun-Star
Alliance in the News via Op-ed
March 19, 2021

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Here are the facts:

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2. You should get vaccinated even if you've had COVID-19. Research shows that the consequences of COVID-19 can be severe. Even if you've recovered from having COVID-19, there is not enough information to know if you are protected from getting it again.

3. The COVID-19 vaccines do not have severe side effects in most people. It's common to experience mild to moderate signs that your body is building protection after getting a vaccine. These can include muscle aches, tiredness, headache, fever, chills or soreness where you had the injection. Side effects often last for a day or two. However, any new medication can cause an allergic reaction in a small number of people. For this reason, you'll be asked to stay for observation for a short period after you've received the shot.

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Guest Commentary The truth about COVID-19 vaccines
Santa Cruz Sentinel
Alliance in the News via Op-ed
March 11, 2021
Dr. Maya Heinert, MD

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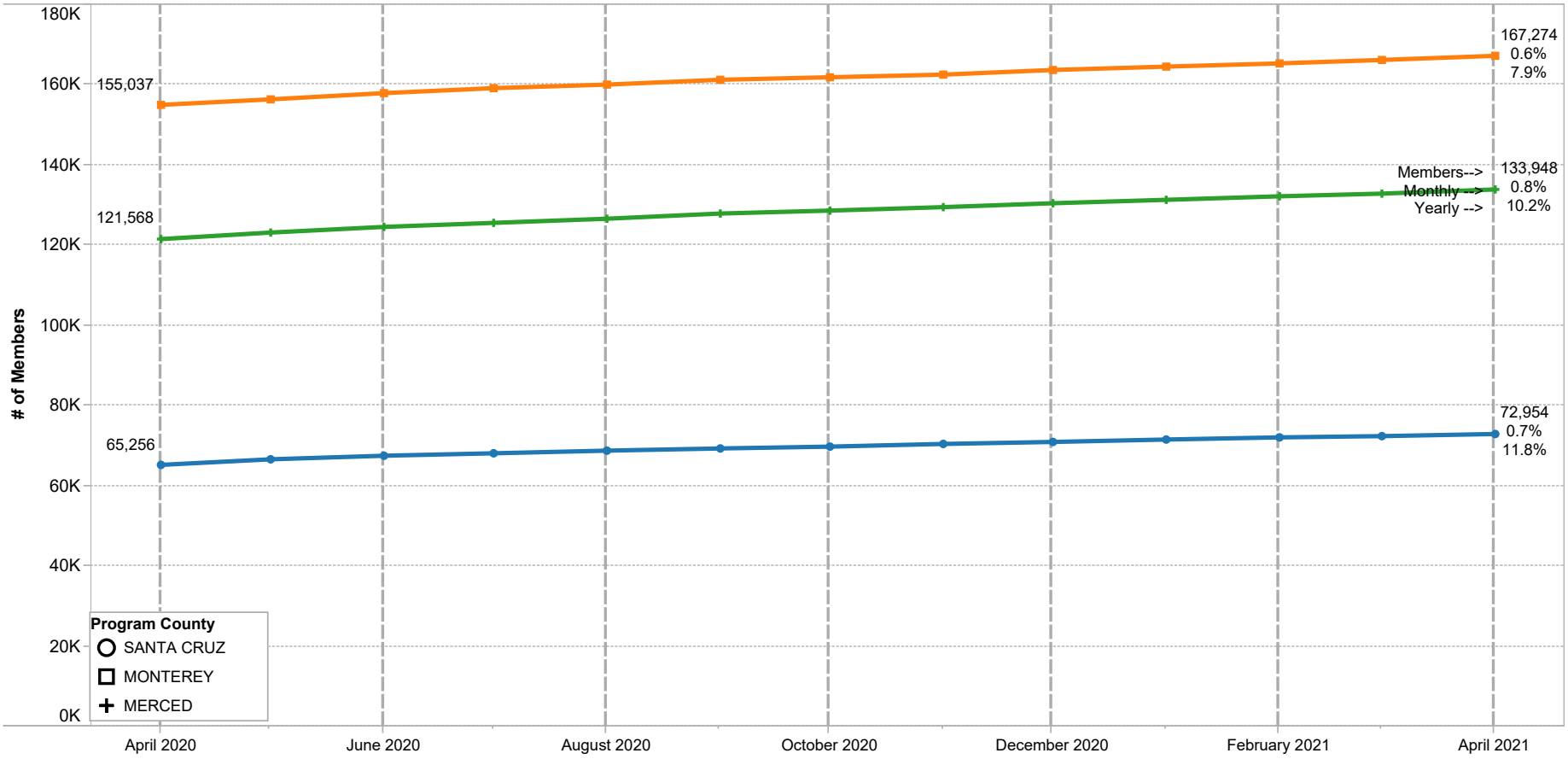
Enrollment Report

Year: *2017 & 2018* **County:** *All* **Program:** *IHSS & Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *4/5/2021*

StaticDate
4/1/2020 12:00:00 AM to 4/30/2021 11:59:59 PM

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



Program..	ProgramCo..	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021
Medi-Cal	SANTA CRUZ	65,256	66,647	67,537	68,147	68,805	69,353	69,809	70,480	70,976	71,576	72,113	72,426	72,954
	MONTEREY	154,465	155,842	157,391	158,633	159,530	160,740	161,371	162,040	163,203	164,043	164,856	165,727	166,763
	MERCED	121,568	123,199	124,608	125,611	126,649	127,940	128,673	129,536	130,509	131,359	132,241	132,904	133,948
IHSS	MONTEREY	572	579	579	580	570	560	554	546	540	537	529	516	511
Total Members		**341,861**	**346,267**	**350,115**	**352,971**	**355,554**	**358,593**	**360,407**	**362,602**	**365,228**	**367,515**	**369,739**	**371,573**	**374,176**

Back to Agenda