

Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Wednesday, February 24, 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/457629661>
 - b. Or by telephone at:
United States: +1 (571) 317-3122
Access Code: 457-629-661
 - c. New to GoToMeeting? Get the app now and be ready when your first meeting starts: <https://global.gotomeeting.com/install/457629661>

 2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.
 - a. Email comments by 5:00 p.m. on Tuesday, February 23, 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.).
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1. **Call to Order by Chairperson Coonerty. 3:00 p.m.**
 - A. Roll call; establish quorum.
 - B. Supplements and deletions to the agenda.
 - C. Welcome new Board member Supervisor Wendy Root Askew, Monterey County and Supervisor Josh Pedrozo, Merced County.

2. **Oral Communications. 3:05 p.m.**
 - A. Members of the public may address the Commission on items not listed on today's agenda that are within the jurisdiction of the Commission. Presentations must not exceed five minutes in length, and any 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. – 10J.): 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 5-08

6. **Accept Alliance Dashboard for Q4 2020.**
 - Reference materials: Alliance Dashboard – Q4 2020.

Pages 6-01 to 6-02

7. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for twelve months ending December 31, 2020.**
 - Reference materials: Financial Statements as above.

Pages 7-01 to 7-08

Appointments: (8A – 8B.)

- 8A. **Approve appointment of Dr. Michael Yen to the Physicians Advisory Group.**
 - Reference materials: Staff report and recommendation on above topic.

Page 8A-01

- 8B. **Approve appointment of Dr. Cal Gordan to the Whole Child Model Clinical Advisory Committee.**
 - Reference materials: Staff report and recommendation on above topic.

Page 8B-01

Minutes: (9A. – 9H.)

- 9A. **Approve Commission meeting minutes of December 2, 2020.**
 - Reference materials: Minutes as above.

Pages 9A-01 to 9A-06

- 9B. Accept Compliance Committee meeting minutes of October 21, 2020 and December 2, 2020.**
 - Reference materials: Minutes as above.
 Pages 9B-01 to 9B-09
- 9C. Accept Continuous Quality Improvement Committee meeting minutes of October 22, 2020.**
 - Reference materials: Minutes as above.
 Pages 9C-01 to 9C-07
- 9D. Accept Finance Committee meeting minutes of September 23, 2020.**
 - Reference materials: Minutes as above.
 Pages 9D-01 to 9D-06
- 9E. Accept Member Services Advisory Group meeting minutes of November 12, 2020.**
 - Reference materials: Minutes as above.
 Pages 9E-01 to 9E-04
- 9F. Accept Physicians Advisory Group meeting minutes of September 3, 2020.**
 - Reference materials: Minutes as above.
 Pages 9F-01 to 9F-05
- 9G. Accept Whole Child Model Clinical Advisory Committee meeting minutes of September 17, 2020.**
 - Reference materials: Minutes as above.
 Pages 9G-01 to 9G-04
- 9H. Accept Whole Child Model Family Advisory Committee meeting minutes of November 9, 2020.**
 - Reference materials: Minutes as above.
 Pages 9H-01 to 9H-03

Reports: (10A. – 10J.)

- 10A. Accept report on Alliance 2021 Operating Plan.**
 - Reference materials: Staff report on above topic; and Alliance 2021 Operating Plan.
 Pages 10A-01 to 10A-02
- 10B. Accept report on Alliance Diversity, Equity and Inclusion Initiative Update.**
 - Reference materials: Staff report on above topic.
 Pages 10B-01 to 10B-02
- 10C. Accept report on Alliance Owned Properties: 2020 Annual Report.**
 - Reference materials: Staff report and recommendation on above topic
 Pages 10C-01 to 10C-02
- 10D. Accept report on Business Continuity and Disaster Recovery Planning: 2020 Annual Report.**
 - Reference materials: Staff report and recommendation on above topic.
 Pages 10D-01 to 10D-02
- 10E. Accept report on COVID-19 Update.**
 - Reference material: Staff report on above topic.
 Pages 10E-01 to 10E-03

- 10F. Accept report on Department of Health Care Services Behavioral Health Integration Incentive Program.**
 - Reference materials: Staff report on above topic.
 Pages 10F-01 to 10F-02
- 10G. Accept report on Medical-Cal Capacity Grant Program (MCGP) 2020 Impact Report.**
 - Reference materials: Staff report and recommendation on above topic; MCGP 2020 Impact Report (publication); MCGP Theory of Change and Medium-Term Outcomes; and MCGP Performance Dashboard.
 Page 10G-01 to 10G-17
- 10H. Accept report on Peer Review and Credentialing Committee Report of December 9, 2020.**
 - Reference materials: Staff report and recommendation on above topic.
 Page 10H-01
- 10I. Accept report on Quality and Performance Improvement Workplan – Q3 2020.**
 - Reference materials: Staff report and recommendation on above topic.
 Pages 10I-01 to 10I-03
- 10J. Accept report on Recuperative Care Pilot Application Process Update.**
 - Reference materials: Staff report on above topic.
 Pages 10J-01 to 10J-02

Regular Agenda Items: (11. – 14.): 3:15 p.m.

- 11. Discuss Healthcare Environment. (3:15 – 3:45 p.m.)**
 A. Mr. Larry Levitt, Executive Vice President for Health Policy, Kaiser Family Foundation, will review and Board will discuss above topic.
 - Reference materials: Mr. Larry Levitt biography.
 Page 11-01
- 12. Discuss California Budget Priorities in 2021. (3:45 – 4:00 p.m.)**
 A. Ms. Stephanie Sonnenshine, CEO, will review and Board will discuss above topic.
 - Reference materials: Staff report on above topic; 2021-22 Governor's Budget – DHCS Highlights; and Health and Human Services – 2021-22 Governor's Budget Summary.
 Pages 12-01 to 12-03
- 13. Consider approving report on Medi-Cal Managed Care Procurement Process. (4:00 – 4:15 p.m.)**
 A. Ms. Stephanie Sonnenshine, CEO, will review and Board will consider directing staff to explore interest in, and feasibility of, an expansion of Alliance service area and to report back to the board in March with a recommendation.
 - Reference materials: Staff report and recommendation on above topic; and County Managed Care Transition to Local Plan: Letter of Intent Instructions.
 Pages 13-01 to 13-07
- 14. Discuss Strategic Planning Preview. (4:15 – 4:25)**
 A. Ms. Stephanie Sonnenshine, CEO, will review and Board will discuss above topic.

Adjourn to Closed Session

- 15. Closed session pursuant to Government Code Section 54957.6 regarding the Agency's performance evaluation of the CEO. (4:25 – 4:45 p.m.)**
 - A. Closed session agenda item.
 - Reference materials: Evaluation of CEO Performance (Confidential).

- 16. Closed session pursuant to Government Code Section 54956.87 (c); Contract Negotiations. (4:45 – 4:55 p.m.)**
 - A. Closed session agenda item.

Return to Open Session

- 17. Open session regarding CEO's annual performance evaluation. (4:55 – 5:00 p.m.)**
 - A. Board will consider action regarding the CEO's annual performance evaluation.

Information Items: (18A. – 18J.)

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|----|--|-------------|
| A. | Alliance in the News | Page 18A-01 |
| B. | Alliance Fact Sheet – January 2021 | Page 18B-01 |
| C. | Annual Alliance Report to Board of Supervisors – 2020 | Page 18C-01 |
| D. | Letter to Governor Newsom – Vaccine Distribution | Page 18D-01 |
| E. | Letter of Support | Page 18E-01 |
| F. | Member Appeals and Grievance Report – Q4 2020 | Page 18F-01 |
| G. | Membership Enrollment Report | Page 18G-01 |
| H. | Member Newsletter (English) – December 2020
https://www.ccah-alliance.org/pdfs/member_newsletters/CAAH_Member_December_2020_EN-high-res.pdf | |
| I. | Member Newsletter (Spanish) – December 2020
https://www.ccah-alliance.org/pdfs/member_newsletters/CAAH_Member_December_2020_SP-high-res.pdf | |
| J. | Provider Bulletin – December 2020
https://www.ccah-alliance.org/pdfs/provider_bulletins/PSBulletin_202012.pdf | |

Announcements:

Meetings of Advisory Groups and Committees of the Commission

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

- Finance Committee
Wednesday, March 24, 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, March 4, 2021; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee
Thursday, March 18, 2021; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee
Monday, March 8, 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 February 24, 2021 meeting will be held via teleconference unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
Wednesday, March 24, 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: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Stephanie Sonnenshine, CEO
SUBJECT: Executive Summary from the Chief Executive Officer

Executive

Governor's January Budget Proposal: State Fiscal Year 2021-22. On January 8, 2021, Governor Newsom released his budget proposal for the 2021-22 State fiscal year, beginning July 1, 2021. The Governor's \$227B proposed budget focuses on funding for COVID-19 response, administration of the COVID-19 vaccine and investing in the relief for those most affected by the pandemic. The budget includes significant proposals for Medi-Cal and health care spending and system transformation. Staff will provide a report on the budget priorities at the February 24, 2021 meeting.

2021 Legislative Session. California's 2021 Legislative session is in full swing with the deadline to introduce new bills on February 19, 2021. The legislature has indicated interest in several areas for the 2021 session that could impact the health care environment and the work of the Alliance, including telehealth, health information exchange, healthcare affordability and equity and health disparities. Staff will work closely with the Local Health Plans of California and our representatives in Sacramento to monitor legislative activity and will provide reports to your board throughout 2021 as issues of board interest, importance or action arise.

Medi-Cal Managed Care Procurement. The Department of Health Care Services (DHCS) is beginning a statewide procurement process for its commercial Medi-Cal managed care plans (MCPs). This process provides an opportunity for commercial plans to submit bids to provide Medi-Cal managed care plan services in the Geographic Managed Care (GMC), Regional, Two-Plan, or San Benito model. In addition, DHCS has indicated that some counties that are currently GMC or Regional model counties are interested in transitioning to a managed care model that includes a local plan (i.e., COHS or Two-Plan model). For these counties, DHCS has established a March 31, 2021 deadline for the county(ies) and the corresponding MCP to indicate this intention via submission of a Letter of Intent (LOI). Contracts awarded through this process will be effective January 1, 2024. Staff will discuss the interest of San Benito and Mariposa counties in a partnership with the Alliance at the February meeting.

Medi-Cal Rx Uncertainty. Late in the day on February 17, 2021, DHCS announced that Medi-Cal Rx will be delayed without announcing a new implementation date. This announcement followed DHCS's February 10th e-mail to plans instructing plans to "temporarily hold sending out any notices...until further noticed by DHCS..." Staff have been working on necessary steps to assist with the transition including system configuration, contracting and member and provider communications. Staff are assessing the impacts to operations, staffing and budget from the delay in go-live and will keep the board apprised as relevant and reliable

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updates issue. Staff continue to urge DHCS to provide clarity and transparency regarding the implementation of this program, including a clear, consistent and feasible go-live date.

COVID-19 Vaccine Advocacy. California's distribution and administration of the COVID-19 vaccine has gotten off to a rocky start with complaints of confusing and hard to maneuver appointment systems, shifting rules on vaccine eligibility, inequitable distribution and allocation of vaccine supply and poor data collection. To address concerns with the roll-out of the vaccine, Governor Newsom announced a plan to move from a system run by county health departments to a centralized vaccine administration through an agreement with Blue Shield. Throughout, concerns regarding the equitable distribution of vaccine to individuals who receive services through the safety-net and to hard hit areas, including those in the Alliance service area have persisted. The Alliance has facilitated meetings with Senators Caballero and Laird and Assembly members Gray, Rivas and Stone to discuss vaccine distribution in our service area. Meetings include local health care leaders, board members and Alliance staff. Discussions in these meetings resulted in a joint letter to the Governor regarding local concerns and recommendations with regard to the equitable distribution of the COVID-19 vaccine in our service area. The letter is included as an attachment in the board packet.

Biden-Harris Administration. With the inauguration of Joe Biden as the 46th President of the United States on January 20, 2021, comes the anticipation of significant changes in health care policy and the Medicaid program. Immediately upon taking office, President Biden signed a number of Executive Orders related to COVID, health care and Medicaid, including mandating masks on federal property, strengthening Medicaid and the Affordable Care Act (ACA) and directing federal agencies to reexamine actions taken by the previous administration that may reduce coverage or undermine Medicaid and/or the ACA. Meanwhile, the President is working with Congress in an attempt to pass the American Rescue Package, a \$1.9T legislative relief package to address COVID-19.

Community Involvement. I attended the Southern California State of Reform Virtual Health Policy Conference on December 8, 2020. I attended the Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting on December 10, 2020 and the Santa Cruz Health Information Organization (SCHIO) Board of Directors Annual Meeting and Elections on December 14, 2020 by videoconference. On December 15, 2020 I attended the Department of Health Care Services (DHCS) Central Valley Long Term Collaborative meeting and on December 16, 2020 I attended the DHCS All-Plan CEO meeting by videoconference. I attended the HSA Team/HIPSCC Executive Committee meeting on January 5, 2021 and the Health Plan Council Meeting on January 14, 2021 by videoconference. On January 19, 2021 I attended the Local Health Plans of California Board Meeting and Strategic Retreat and the HIPSCC Executive Committee meeting on January 21, 2021 by videoconference. I attended the Medi-Cal Children's Health Advisory Panel on January 26, 2021 and the California Children's Services Advisory Group meeting on January 27, 2021 by teleconference. I attended the SCHIO Board of Directors meeting on January 28, 2021 by videoconference. On February 9, 2021 I attended the Recuperative Care Center Partner (Housing Matters) meeting and the Department of Health Care services Stakeholder Advisory Committee meeting on February 11, 2021 by videoconference. I plan to attend the SCHIO Board of Directors meeting on February 25, 2021 by videoconference.

Health Services

The Health Services Concurrent Review and Complex Case Management teams have prioritized care coordination with our hospital partners to minimize discharge delays during the recent COVID surge. The Prior Authorization team continues to prepare for the transition to a new version of the Essette authorization/case management system which is anticipated in mid-2021. With the delay in implementation of Medi-Cal Rx to April 1, efforts to ensure a smooth transition for the pharmacy carve-out continue. The Whole Child complex case management team is working to close any identified gaps in referrals to the California Children's Services (CCS) program.

Inpatient /Emergency Department Utilization. Inpatient volumes were decreased by 2% from the first month of the fourth quarter compared to 2019 but continued to increase to 2019 rates the following month. This was consistent with state averages seen across the state with the COVID surges resulting in increased ICU days. Emergency department volumes followed a similar pattern in the fourth quarter with an early decrease over 2019 followed by a surge increase mid-quarter.

The Complex Case Management team continues to contact all discharged members to facilitate discharge planning interventions and ensure that transitional care is appropriate to meet member needs. Following the January 1st implementation of the Post Discharge Meal Delivery Program as a new benefit, members were authorized to participate in the program. New work has begun utilizing an Alliance Registered Dietician to enhance education and training for members learning how to alter their shopping and meal preparation habits to enhance their preventative health measures.

Value Based Payments. QIPH has completed seven months of incentive payments totaling over \$2.82 million to network providers on behalf of the DHCS Proposition 56 Program to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. These risk-based incentive payments are targeted at physicians that meet specific achievement on metrics targeting areas such as behavioral health integration; chronic disease management; prenatal/post-partum care; and early childhood prevention services rendered on or after July 1, 2019.

The Healthier Living Program During COVID-19. The Alliance's Healthier Living Program (HLP) is an evidence-based self-management program originally developed at Stanford University. It is designed to help Alliance members diagnosed with chronic conditions gain self-confidence in their ability to control their symptoms and understand how their health problems affect their lives. The program focuses on problems that are common to individuals suffering from any chronic condition, such as pain management, nutrition, exercise, stress reduction, emotions and communicating with doctors.

Traditionally, the HLP workshops were held in-person at community locations for Alliance members in our tri-county servicing areas. Due to COVID-19, the Alliance modified this program to be offered over the phone. The telephonic HLP workshops are led by trained Alliance Health Education staff and the workshops consist of six 1-hour sessions.

What members are saying about the HLP and what they find most helpful:

- *"It gave me the courage to get my life back on track..."*
- *"What I enjoyed about this workshop is learning I'm not alone."*
- *"I felt accomplished with myself each week."*
- *"It helped me to learn how to take better care of myself."*
- *"The action planning and holding oneself accountable."*
- *"I liked having a place to come where others share the same questions."*
- *"I have always wanted to give myself time to meditate or do yoga and never made time. Thanks to this class, I was able to accomplish meditation and relaxation, and I am happy to say I will continue to incorporate this as part of my weekly routine."*

What members are saying about the new HLP telephonic workshops:

- *"During this pandemic time these 1hr calls were great."*
- *"I enjoyed great conversations and very relaxing. Got my mind off the daily struggles I was going through."*
- *"I frequently looked forward to my hour class. My family and friends were surprised I was taking a class over the phone."*
- *"These telephonic classes would be great for people who cannot leave their homes for whatever reason."*
- *"It could give [people] a sense of belonging and know they are not alone to deal with their condition."*

During the telephonic HLP workshops, Alliance members create weekly action plans that include goal setting around managing their chronic condition(s) and healthier living. Each week, the Alliance Health Educators work with members to review the weekly action plans and discuss successes and challenges. The HLP allows members to also receive support and share ideas with other members who are experiencing similar life challenges living with a chronic condition. Providers can refer members to any of the Alliance Health Education and Disease Management programs by utilizing the new Health Education and Disease Management Referral Form, located on the Alliance website.

Behavioral Health. The Alliance has begun internal efforts in preparation for the Managed Behavioral Health Organization's contract restatement with Beacon Health Options. An internal process has been developed to track the core components for successfully executing the contract prior to the July 1, 2021 implementation date. Work has also begun with Beacon to assure that they provide the necessary deliverables to the Alliance for these efforts. The contract period will be for two years, as approved by the Alliance's Board. Internal work is underway to identify priority areas to be further emphasized in this contract restatement.

In response to the State's Department of Managed Health Care Services All Plan Letter 21-002 - Implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage, the Alliance has been working collaboratively with Beacon to assure compliance of this new legislation enacted on January 1, 2021 for Alliance Care IHSS members in Monterey County. This new legislation was enacted to satisfy the requirements that all medically necessary treatment of mental health and substance use disorders (MH/SUD) listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of

Mental Disorders (DSM) be provided, and not limited to short-term or acute treatment. The legislation also prohibits Plans from limiting benefits or coverage for medically necessary services on the basis that those services may be covered by a public entitlement program. There are additional components of the Bill that require additional Beacon staff training. This legislation is not applicable to the Medi-Cal line of business.

Lastly, in response to Governor Newsom's declaration of a state of emergency in late January due to the winter storms in Monterey County, Beacon activated the applicable disaster management policy and procedure to ensure access to medically necessary services for all Alliance members in Monterey County.

Community Care Coordination. In support of the Alliance's Strategic Development (SD) Department efforts, Community Care Coordination staff have been involved in the pre-implementation work of the Recuperative Care Pilots (RCP) that were approved by the Board at the December 2, 2020 meeting. Staff have participated in the planning meetings with the identified County RCP partners and SD department, assisted with the pilot application and policy/procedure reviews, and are working internally to develop structures to support the implementation of this work and identify ways to facilitate learnings across the Alliance's service region in the future.

In early January, after the Governor released the preliminary State budget for 2021/2022, further information was provided by DHCS related to the implementation of CalAIM's Enhanced Care Management (ECM) and In Lieu of Services (ILOS) benefits to be implemented beginning on January 1, 2022. The benefits for specific ECM target populations identified will have a staggered implementation beginning in January 2022, with the transition of members receiving Whole Person Care Pilot services currently from the counties into the Plan's ECM. Ongoing meetings with the counties to discuss this transition continue. Further guidance from DHCS is expected in the near future, including an implementation timeline, DHCS deliverables, and additional details to support the development of internal structures to assure processes and operational development of these new benefits for Alliance members.

Employee Services and Communications

Alliance Workforce. As of February 1, 2021, the Alliance has 516 budgeted positions of which our active workforce number is 496 (active FTE and temporary workers). There are 11 positions in active recruitment, and 28.5 positions are vacant. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets.

Human Resources (HR) awaits further information from the Biden administration with regard to the anticipated extension of the Families First Coronavirus Response and The U.S. Coronavirus Aid, Relief, and Economic Security (CARES) Act. Upon final decisions, the Alliance will be ready to implement any required changes.

Facilities and Administrative Services. Construction contracts and lease amendments for the Capitola Manor SNF facility have been executed. The general contractor has developed a draft project schedule starting in February 2021 and finishing in early/mid 2022. Facilities is currently working with contracts to get the Inspector of Record (IOR) contract finalized. 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 OSHPD compliance officer is scheduled to visit the site in February.

HR, Facilities, and Health Services are currently working on finalizing a COVID 19 Prevention Program document that will replace the current COVID 19 Workplace Health and Safety Plan.

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. Staff are actively working to grow external messaging channels in order to reach our audiences with timely, engaging and accurate information. Since launching the [Alliance Facebook](#) page in September, the page has reached over 20,000 Facebook users in all three counties and organic page likes have grown to over 340. This corresponds to a 71% and 436% growth respectively, over the last month. Page engagement (likes, comments, shares) has also increased by 128% during that same time period. Looking ahead, we are continuing to test targeted content in order to grow overall engagement and reach. In addition, we are focusing on visually engaging content using infographics and short videos. Lastly, we are seeking to help grow the reach of our trusted health partners' content by re-sharing posts that our audience will find relevant, especially as it relates to important COVID-19 information. In addition to Facebook, we are working with the HR team on developing content on LinkedIn, with a focus on highlighting what makes the Alliance a great place to work. Content categories will include employee and department spotlights, sharing expertise from our medical team, work wellness tips and posts highlighting Alliance work benefits.

Operations

2019 Timely Access Survey. On December 31, 2020, the Department of Managed Health Care (DMHC) published their annual report of Provider Appointment and Availability Survey (PAAS) results for Measurement Year (MY) 2019. This document includes the DMHC's comparison of PAAS results for DMHC-licensed commercial and full-service health plans. As was reported previously, the Alliance brought the administration of the PAAS in-house in MY 2019. Through this new hybrid approach, the same vendor that administered the MY 2018 PAAS, Mazars, prepared the survey tool and completed associated reporting templates. Alliance staff completed survey outreach.

A comparison of the DMHC's annual PAAS reports for MY 2018 and MY 2019 shows significant improvement in Alliance performance in timely access to urgent and non-urgent appointments. During the 2019 survey year, 87% of survey providers offered a non-urgent visit within timely access standards, and 76% offered an urgent visit within timely access standards. The Alliance is pleased to partner with our providers in ensuring timely access for our members, and we look forward to reporting the outcomes of the MY 2020 PAAS in the coming months.

Engagement with Community Based Organizations. The Regional Operations Department began telephonic outreach to Community Based Organizations, local partners and key

stakeholders in Merced County in January of 2021. The goal of the telephonic outreach is to build and maintain relationships, share information to support members, and to gain community insight during the pandemic while face to face interaction is not possible. Topics for discussion and audience will change monthly and a summary will be created at the conclusion of each month. In January, outreach was conducted to 18 local organization with topics including the Nurse Advice Line and Behavioral Health Resources.

Member Committee Transition. Beginning January 2021, the Alliance transitioned staff facilitation and oversight supporting the Member Services Advisory Group and Whole Child Model Family Advisory Committee. To promote ongoing community collaboration and devote added leadership resources to Alliance member committees, meeting facilitation was transitioned from the Member Services Director to the Regional Operations Directors. Ronita Margain, Regional Operations Director, Merced County now facilitates the Member Services Advisory Group and Lilia Chagolla, Regional Operations Director, Santa Cruz and Monterey now facilitates the Whole Child Model Family Advisory Committee. Dana Marcos, Member Services Director continues to participate in committee meetings as a subject matter expert. Members of both committees have been informed of this change and agenda item discussions occurred with each committee to ensure members understand the transition and added Alliance facilitation support.

New Member Welcome Packets. As of January 1, 2021, Welcome Packets have been redesigned for new members joining the Alliance. The New Member Welcome Packet includes a step-by-step welcome letter which describes how to pick a doctor, use an Alliance ID card, and access benefits and services. Welcome Packets are provided in English, Spanish and Hmong according to each member's preferred written language. A notice is included to inform members about how to electronically access the Member Handbook, Formulary, and Provider Directory. Members of the Seniors and Persons with Disabilities (SPD) population will continue to receive a printed copy of the Provider Directory aligned with the Department of Health Care Services (DHCS) All Plan Letter 19-003, Providing Informing Materials to Medi-Cal Beneficiaries in Electronic Format. The redesign of the New Member Welcome Packet supports sustainability while also ensuring members are provided with clear and concise information. New Member Welcome Packets also include:

- A covered benefits matrix;
- Health and wellness information;
- Language assistance taglines and a non-discrimination notice;
- A Primary Care Provider (PCP) selection form;
- Member ID card; and,
- Business reply envelope.

Member Outreach. The Alliance Your Health Matters Outreach Program (YHM) has ended the 2020 year with positive outcomes during a time where adaptation was a necessity. With the various shelter in place orders the pandemic did not allow for the traditional face to face outreach efforts. As member needs were identified in collaboration with County Health Departments and community-based organizations the program adapted to reach members in different ways by responding to the many needs of our members via member outreach calls, participation in CBO lead drive-thru events, and staffing resources centers. 46 staff volunteered in the program where most made outreach calls to members. Staff participated in 17 events prior to the Pandemic and 5 virtual events later in the year. The total members

reached were 4,070. As of December of 2020, the YHM team has begun outreach calls to Alliance members to inform and educate them, avoiding group gatherings, stay home if they are sick, contact their doctor, and vaccine safety and availability.

Claims Related Projects. In December 2020, the Alliance outsourced check and electronic payment process for fee-for-service claims and monthly capitation payments to Change Healthcare to support administrative efficiencies. Staff have worked diligently with our vendor to mitigate any and all transition issues throughout the implementation to ensure the process is stabilized and transition is as seamless as possible for providers. Staff continue to conduct provider outreach to inform of the various payment options available including electronic funds transfer and intake questions that may arise.

Organizational Performance Update: Q4 2020 Alliance Dashboard. The Q4 2020 *Alliance Dashboard* indicates healthy organizational performance. Results for most processes met or exceeded 95% of target. The *Alliance Dashboard* is comprised of 155 metrics monitoring 62 health plan core, support and managerial processes. These 62 health plan processes are rolled-up to 12 top-level (Level 1) processes for Board monitoring using a composite methodology, meaning the performance of these core processes are averaged to produce top-level process performance results.

Exceptions to the 95% standard and other notable areas of performance are as follows:

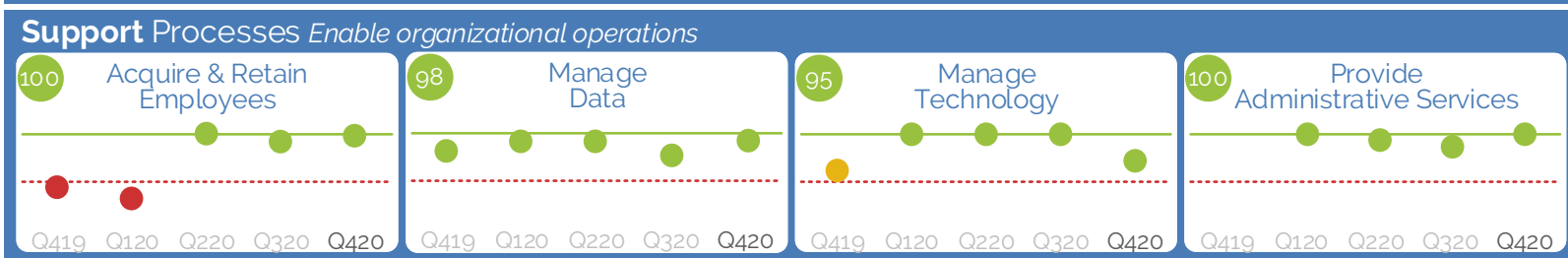
- *Manage and Improve Care.* Q4 2020 performance (94.4%) dropped 3.8 percentage points over Q3 2020 performance (98.2%). *Manage Care Use* indicators – inpatient, outpatient, pharmaceutical and behavioral health – experienced favorable performance (98.6%) during the period but *Improve Health* indicators dropped due to an increase in the rate of reported moderate and significant quality issues. Initial assessment indicates this increase is expected to stabilize in Q1 2021.
- *Pay Providers.* Q4 2020 performance dipped modestly (1.9%) at the top level but remained high performing at 98.1% of target. In December 2020 the Alliance outsourced its check and electronic payment process to a vendor and experienced some payment issues immediately after implementation (see *Claims Related Projects* below). A new metric has been added to the *Pay Providers* process to monitor quality and timeliness of payments moving forward and early insight in Q1 2021 indicates performance is stabilizing.
- *Manage Alliance Compliance Commitments.* Q4 2020 performance (96.7%) improved 7.4 percentage points over Q3 2020 performance (89.3%). *% of HIPAA incidents opened that are not repeat concerns* was the primary metric driving low performance in Q3 2020. Following the metric performance drop to 53.3% in Q3 2020, performance has returned to 100% in Q4 2020.

Alliance Dashboard - Quarter 4 2020

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

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

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



Alliance Dashboard

Board Metrics



No.	Metric	Period	Target	Performance
1	Calls to Member Services Answered Within 30 Seconds	Q420	80.0%	91.0%
2	New Member Welcome Call Completion Rate	Q320	30.0%	32.2%
3	Timely Resolution of Member Complaints	Q420	100.0%	100.0%
4	Members' Favorable Rating of Health Plan (CAHPS) (Medi-Cal)*	2019	Child: 86.0% Adult: 73.0%	Child: 86.5% Adult: 75.6%
5	Members' Favorable Rating of Health Care (CAHPS) (Medi-Cal)*	2019	Child: 84.5% Adult: 70.5%	Child: 82.0% Adult: 69.7%
6	% of Routine PCP Facility Site Reviews Completed Timely	Q420	100.0%	100.0%
7	% of Facility Sites Reviewed in Good Health	Q420	100.0%	100.0%
8	In Area PCP Market Share (all counties)	Q420	80.0%	86.3%
9	In Area Specialist Market Share (all counties)	Q420	80.0%	83.0%
10	Contracted PCP Open % (all counties)	Q420		61.8%
11	Overall Provider Satisfaction Rate	2019	95.0%	87.0%
12	Inpatient Bed Days/ 1,000 members/Year (Medi-Cal)	Q320	285.0	275.0
13	Admissions/1,000 Members/Year (Medi-Cal)	Q320	63.0	55.0
14	Total 30 Day All-Cause Readmissions %	Q320	11.0%	12.0%
15	Ambulatory Care Sensitive Admissions (Medi-Cal)	Q320	8.0%	5.6%
16	Average Length of Stay (Medi-Cal)	Q320	4.5	5.0
17	Emergency Department Visits/1,000 Members/Year (all LOBs)	Q320	513.0	348.0
18	Avoidable Emergency Department Visits (all LOBs)	Q320	18.0%	11.2%
19	Behavioral Health Utilization Rate by County (All Ages)	Q320	3.6%	SC: 9.4% Mont: 3.8% Merced: 3.9%
20	Routine Medical/Surgical Prior Authorizations Adjudicated Timely	Q420	100.0%	98.5%
21	Medical/Surgical Authorization Denial Rate	Q420		0.9%
22	Pharmacy Cost/Member/Month - Retail, Outpatient & Specialty	Q420	\$47.55	\$45.31
23	Generic Prescription %	Q420	88.0%	88.6%
24	Clean Claims Processed and Paid Within 30 Calendar Days	Q420	90.0%	99.8%
25	Employee Voluntary Turnover Rate	Q120 - Q420 Q420	Annual: 10.0% Quarterly: 2.5%	Annual: 5.1% Quarterly: 1.0%
26	Total Staffed Workforce	Q420	90.0%	94.9%
27	Board Designated Reserves Percentage	Q420	100.0%	83.2%
28	Net Income Percentage	Q420	0.5%	2.6%
29	Medical Loss Ratio	Q420	92.0%	90.5%
30	Administrative Loss Ratio	Q420	6.0%	6.2%

*Period previously reflected 'Report Year', now reflects 'Measurement Year'



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Lisa Ba, Chief Financial Officer
SUBJECT: Financial Highlights for the Twelve Months Ending December 31, 2020;
Unaudited as of 2/1/2021

The Alliance operated with a Medical Loss Ratio (MLR) of 95.5% and an Administrative Loss Ratio (ALR) of 6.4% of revenue, through December 31, 2020, resulting in an operating loss of \$24.7M. This loss is a result of the continued headwinds in medical costs and insufficient State revenue rates, despite the temporary positive financial impacts due to the pandemic.

December 2020 resulted in a positive operating income of \$0.4M (favorable to budget by \$6.4M) predominantly due to the lower utilization from the pandemic surge during the holiday season. The overall fourth quarter utilization decreased 20% from 2019 and as a result, lowered the expense accrued for the quarter.

The overall utilization for 2020 was down 15%, or an estimated \$24M cost deferral due to delay in care during the pandemic. This, coupled with the favorable enrollment mix and administrative expense, resulted in a reduced operating loss of \$24.7M, versus the budgeted loss of \$53.2M.

The fund balance was approximately \$418.8M, or 83% of the Board Designed Target.

Overall, the underlying revenue rate gap and hospital inpatient contractual rate outliers within the medical cost remain, hence the annual operating loss. The delayed utilization has alleviated the loss but may push the loss into future years due to a backlog of delayed elective procedures, surgeries and specialist referrals that are likely to be scheduled post-pandemic, when service levels return to normal.

The Alliance must maintain an adequate level of financial reserves to ensure financial sustainability. Staff has been working on the Cost Containment Plan to achieve breakeven no later than 2023.

Dec-20 MTD (In \$000s)				
<u>Key Indicators</u>	Current Actual	Current Budget	Current Variance	% Variance to Budget
<i>Membership</i>	364,602	326,727	37,875	11.6%
Revenue	115,409	101,720	13,689	13.5%
Medical Expenses	106,598	99,118	(7,480)	-7.5%
Administrative Expenses	7,619	7,822	203	2.6%
Operating Income/(Loss)	1,193	(5,220)	6,413	100.0%
Net Income/(Loss)	363	(5,836)	6,199	100.0%
<i>MLR %</i>	92.4%	97.4%	5.1%	
<i>ALR %</i>	6.6%	7.7%	1.1%	
<i>Operating Income %</i>	1.0%	-5.1%	6.2%	
<i>Net Income %</i>	0.3%	-5.7%	6.1%	

Dec-20 YTD (In \$000s)				
<u>Key Indicators</u>	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
<i>Membership</i>	4,198,784	3,952,099	246,685	6.2%
Revenue	1,312,891	1,231,242	81,649	6.6%
Medical Expenses	1,253,966	1,199,288	(54,678)	-4.6%
Administrative Expenses	83,622	85,130	1,508	1.8%
Operating Income/(Loss)	(24,696)	(53,176)	28,479	53.6%
Net Income/(Loss)	(31,999)	(60,265)	28,266	-46.9%
PMPM				
Revenue	312.68	311.54	1.14	0.4%
Medical Expenses	298.65	303.46	4.81	1.6%
Administrative Expenses	19.92	21.54	1.62	7.5%
Operating Income/(Loss)	(5.88)	(13.46)	7.57	56.3%
<i>MLR %</i>	95.5%	97.4%	1.9%	
<i>ALR %</i>	6.4%	6.9%	0.5%	
<i>Operating Income %</i>	-1.9%	-4.3%	2.4%	
<i>Net Income %</i>	-2.4%	-4.9%	2.5%	

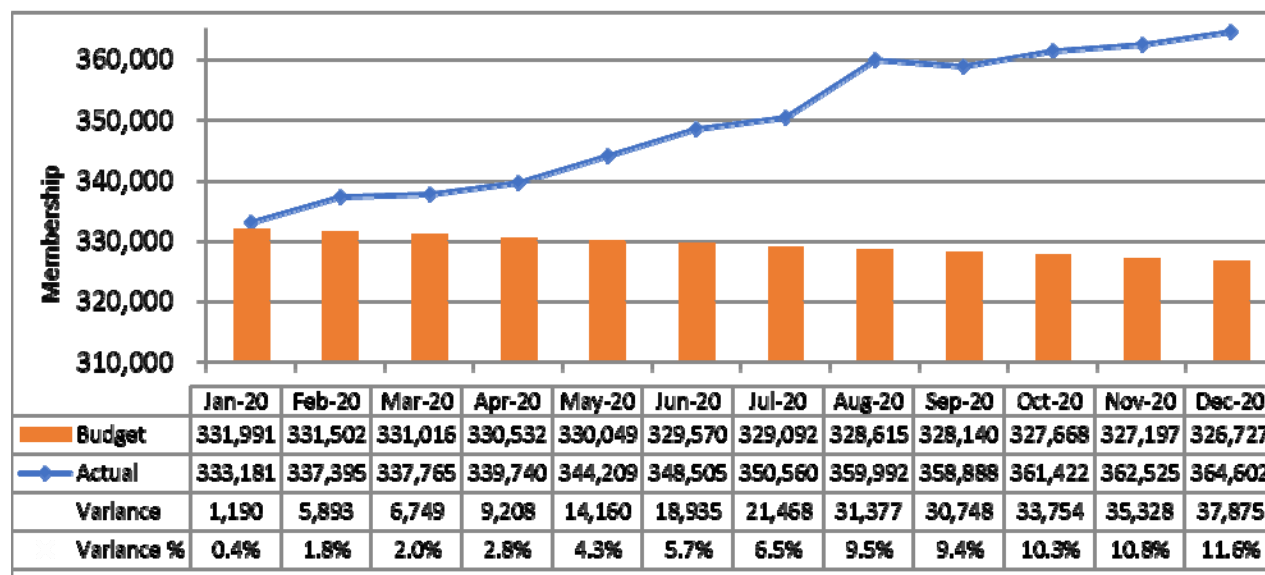
Per Member Per Month. Capitation revenue and medical expenses are variable based on enrollment fluctuations, therefore the per member per month (PMPM) view offers more clarity than the total dollar spend. The revenue and medical costs are closer to budget on a PMPM basis. Conversely, administrative expenses do not directly correspond with enrollment and are therefore viewed in terms of total dollar spend.

At a PMPM level, year-to-date (YTD) revenue is \$312.68, medical cost is \$298.65 and administrative cost is \$19.92, resulting in an operating loss of \$5.88 PMPM. PMPM actuals

across the board are close to budget, and revenue is 0.4% favorable despite the State's May budget revision and the resulting reduction to the Plan's bridge period rate. With costs exceeding revenue, we are experiencing an operating loss at the PMPM level, therefore higher membership results in higher losses.

Membership. December 2020 Member Months are favorable to budget by 11.6%. Favorability in Member Months is primarily driven by the "Family/Adult and Adult Expansion" Category of Aid, Whole Child Model which account for 77.4% of the increase. The increase is attributable largely to the suspension of the Medi-Cal redetermination process during the Public Health Emergency period. Member Months are partially offset by unfavorability in "LTC and LTC Full Dual" Category of Aid by 45.1%. By county, Santa Cruz is favorable to budget by 12.9%, followed by Merced at 12.4%, and Monterey at 10.5%.

Membership Actual vs. Budget (based on actual enrollment trend for Dec-20 YTD)



Revenue. December 2020 Medi-Cal capitation revenue of \$115.1M is favorable to budget by \$13.7M or 13.5%. This favorability is attributed to \$9.6M in enrollment and \$4.0M in rate true ups for the period July 2019 through July 2020. December 2020 YTD Medi-Cal capitation revenue of \$1,309.7M is favorable to budget by \$81.2M or 6.6%. Of this \$81.2M favorability, \$85.8M is attributed to enrollment favorability which is partially offset by a \$4.6M net rate variance. YTD Capitation Revenue includes a rate variance adjustment from the State's May Budget Revision, which proposed a 1.5% rate reduction for Adult, Child, ACA OE, and SPD population for the bridge period of July 2019 through December 2020. The financial impact for the full bridge period is \$19.9M.

Nov-20 YTD Capitation Revenue Summary (In \$000s)					
County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	295,052	280,764	14,287	18,603	(4,316)
Monterey	569,701	528,941	40,761	36,617	4,144
Merced	444,911	418,781	26,129	30,586	(4,457)
Total	1,309,664	1,228,487	81,178	85,806	(4,629)

Note: Excludes Dec-20 YTD In-Home Supportive Services premiums revenue of \$3.2M

Medical Expenses. December 2020 YTD Medical Expenses are \$1,254.0M, which is unfavorable to budget by \$54.7M or 4.6%, with an MLR of 95.5%. Inpatient Services (Hospital) are unfavorable by \$46.7M or 12.9%, Inpatient Services (LTC) are unfavorable by \$24.8M or 18.0%, and Pharmacy costs are unfavorable by \$3.5M or 1.9%. Medical Expenses include an additional \$6.1M IBNR reserve for COVID-19 pandemic under Inpatient Services (Hospital). Medical Expenses are partially offset by favorability in Other Medical of \$17.6M or 7.1%, Physician Services of \$1.4M or 0.7%, and Outpatient Facility of \$1.3M or 2.0%.

Administrative Expenses. December 2020 YTD Administrative Expenses are \$83.6M, which is favorable to budget by \$1.5M or 1.8%, with an ALR of 6.4%. Favorability is driven by Non-Salary Administrative Expenses of \$3.3M or 10.7%. Unfavorability in Salaries, Wages and Benefits (SWB) of \$1.8M or 3.3% was offset by savings in Non-Salary Administrative Expenses. SWB are unfavorable primarily due to accumulated staff paid time off resulting from the COVID-19 pandemic.

Non-Operating Revenue/Expenses. December 2020 YTD Total Non-Operating Revenue is unfavorable to budget by \$2.6M or 27.2% which is primarily driven by lower interest income and unrealized investment gain. December 2020 YTD Grants are favorable to budget by \$2.4M or 14.3% which is attributable to the delay of specific grant programs due to the Covid-19 pandemic. The current Grant Fund balance is \$146.0M. Overall, the Alliance experienced a Non-Operating Loss of \$0.2M.



CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Twelve Months Ending December 31, 2020
Unaudited as of 2/1/2021
(In \$000s)

Assets	
Cash	\$157,045
Restricted Cash	300
Short Term Investments	356,110
Receivables	247,729
Prepaid Expenses	2,822
Other Current Assets	10,394
Total Current Assets	<u>\$774,400</u>
Building, Land, Furniture & Equipment	
Capital Assets	\$83,694
Accumulated Depreciation	(36,246)
CIP	2,481
Total Non-Current Assets	<u>49,929</u>
Total Assets	<u><u>\$824,329</u></u>
Liabilities	
Accounts Payable	\$40,559
IBNR/Claims Payable	343,637
Accrued Expenses	1
Estimated Risk Share Payable	10,010
Other Current Liabilities	7,102
Due to State	4,244
Total Current Liabilities	<u>\$405,553</u>
Fund Balance	
Fund Balance - Prior	\$450,775
Retained Earnings - CY	(32,000)
Total Fund Balance	<u>418,776</u>
Total Liabilities & Fund Balance	<u><u>\$824,329</u></u>



CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Twelve Months Ending December 31, 2020
Unaudited as of 2/01/2021
(In \$000s)

	<u>MTD Actual</u>	<u>MTD Budget</u>	<u>Variance</u>	<u>%</u>	<u>YTD Actual</u>	<u>YTD Budget</u>	<u>Variance</u>	<u>%</u>
Member Months	364,602	326,727	37,875	11.6%	4,198,784	3,952,099	246,685	6.2%
Capitation Revenue								
Capitation Revenue Medi-Cal	\$115,136	\$101,485	\$13,651	13.5%	\$1,309,664	\$1,228,487	\$81,178	6.6%
Premiums Commercial	273	235	38	16.0%	3,227	2,755	472	17.1%
Total Operating Revenue	\$115,409	\$101,720	\$13,689	13.5%	\$1,312,891	\$1,231,242	\$81,649	6.6%
Medical Expenses								
Inpatient Services (Hospital)	\$35,314	\$30,285	(\$5,029)	-16.6%	\$409,469	\$362,727	(\$46,742)	-12.9%
Inpatient Services (LTC)	13,026	11,696	(1,331)	-11.4%	162,642	137,854	(24,788)	-18.0%
Physician Services	17,161	16,075	(1,087)	-6.8%	196,317	197,708	1,391	0.7%
Outpatient Facility	5,462	5,021	(441)	-8.8%	63,229	64,540	1,311	2.0%
Pharmacy	16,130	14,471	(1,659)	-11.5%	191,388	187,909	(3,479)	-1.9%
Other Medical	19,504	21,571	2,067	9.6%	230,920	248,549	17,629	7.1%
Total Medical Expenses	\$106,598	\$99,118	(\$7,480)	-7.5%	\$1,253,966	\$1,199,288	(\$54,678)	-4.6%
Gross Margin	\$8,812	\$2,602	\$6,209	100.0%	\$58,925	\$31,954	\$26,971	84.4%
Administrative Expenses								
Salaries	\$4,178	\$4,851	\$673	13.9%	\$56,170	\$54,385	(\$1,784)	-3.3%
Professional Fees	176	261	85	32.4%	1,788	2,715	927	34.1%
Purchased Services	1,169	896	(273)	-30.4%	9,820	10,170	350	3.4%
Supplies & Other	1,364	1,090	(275)	-25.2%	8,103	9,402	1,299	13.8%
Occupancy	154	134	(20)	-14.7%	1,241	1,614	373	23.1%
Depreciation/Amortization	578	590	13	2.1%	6,499	6,843	343	5.0%
Total Administrative Expenses	\$7,619	\$7,822	\$203	2.6%	\$83,622	\$85,130	\$1,508	1.8%
Operating Income	\$1,193	(\$5,220)	\$6,413	100.0%	(\$24,696)	(\$53,176)	\$28,479	53.6%
Non-Op Income/(Expense)								
Interest	\$249	\$717	(\$469)	-65.3%	\$4,894	\$9,066	(\$4,172)	-46.0%
Gain/(Loss) on Investments	(138)	(43)	(95)	-100.0%	933	(540)	1,472	100.0%
Other Revenues	98	84	14	16.7%	1,116	1,007	109	10.9%
Grants	(1,038)	(1,374)	336	24.5%	(14,245)	(16,622)	2,376	14.3%
Total Non-Op Income/(Expense)	(\$830)	(\$616)	(\$214)	-34.7%	(\$7,303)	(\$7,089)	-\$214	-3.0%
Net Income/(Loss)	\$363	(\$5,836)	\$6,199	100.0%	(\$31,999)	(\$60,265)	\$28,266	46.9%
<i>MLR</i>	92.4%	97.4%			95.5%	97.4%		
<i>ALR</i>	6.6%	7.7%			6.4%	6.9%		
<i>Operating Income</i>	1.0%	-5.1%			-1.9%	-4.3%		
<i>Net Income %</i>	0.3%	-5.7%			-2.4%	-4.9%		



CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Twelve Months Ending December 31, 2020
Unaudited as of 2/01/2021
(In PMPM)

	<u>MTD Actual</u>	<u>MTD Budget</u>	<u>Variance</u>	<u>%</u>	<u>YTD Actual</u>	<u>YTD Budget</u>	<u>Variance</u>	<u>%</u>
<i>Member Months</i>	364,602	326,727	37,875	11.6%	4,198,784	3,952,099	246,685	6.2%
Capitation Revenue								
Capitation Revenue Medi-Cal	\$315.79	\$310.61	\$5.17	1.7%	\$311.92	\$310.84	\$1.07	0.3%
Premiums Commercial	0.75	0.72	0.03	4.0%	0.77	0.70	0.07	10.2%
Total Operating Revenue	\$316.53	\$311.33	\$5.20	1.7%	\$312.68	\$311.54	\$1.14	0.4%
Medical Expenses								
Inpatient Services (Hospital)	\$96.86	\$92.69	(\$4.16)	-4.5%	\$97.52	\$91.78	(\$5.74)	-6.3%
Inpatient Services (LTC)	35.73	35.80	0.07	0.2%	38.74	34.88	(3.85)	-11.0%
Physician Services	47.07	49.20	2.13	4.3%	46.76	50.03	3.27	6.5%
Outpatient Facility	14.98	15.37	0.39	2.5%	15.06	16.33	1.27	7.8%
Pharmacy	44.24	44.29	0.05	0.1%	45.58	47.55	1.96	4.1%
Other Medical	53.49	66.02	12.53	19.0%	55.00	62.89	7.89	12.6%
Total Medical Expenses	\$292.37	\$303.37	\$11.00	3.6%	\$298.65	\$303.46	\$4.81	1.6%
Gross Margin	\$24.17	\$7.96	\$16.20	100.0%	\$14.03	\$8.09	\$5.95	73.6%
Administrative Expenses								
Salaries	\$11.46	\$14.85	\$3.39	22.8%	\$13.38	\$13.76	\$0.38	2.8%
Professional Fees	0.48	0.80	0.32	39.4%	0.43	0.69	0.26	38.0%
Purchased Services	3.21	2.74	(0.46)	-16.9%	2.34	2.57	0.23	9.1%
Supplies & Other	3.74	3.34	(0.41)	-12.2%	1.93	2.38	0.45	18.9%
Occupancy	0.42	0.41	(0.01)	-2.7%	0.30	0.41	0.11	27.6%
Depreciation/Amortization	1.58	1.81	0.22	12.3%	1.55	1.73	0.18	10.6%
Total Administrative Expenses	\$20.90	\$23.94	\$3.04	12.7%	\$19.92	\$21.54	\$1.62	7.5%
Operating Income	\$3.27	(\$15.98)	\$19.25	100.0%	(\$5.88)	(\$13.46)	\$7.57	56.3%



CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Twelve Months Ending December 31, 2020
Unaudited as of 2/01/2021
(In \$000s)

	MTD	YTD
Net Income	\$363	(\$31,999)
Items not requiring the use of cash: Depreciation	418	6,313
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	(108,792)	(73,369)
Prepaid Expenses	121	(823)
Current Assets	(3,019)	(2,957)
Net Changes to Assets	(\$111,690)	(\$77,149)
Changes to Payables:		
Accounts Payable	\$9,652	\$37,758
Accrued Expenses	(6)	(89)
Other Current Liabilities	335	2,125
Incurred But Not Reported Claims/Claims Payable	107,485	158,704
Estimated Risk Share Payable	827	(154)
Due to State	-	(19,706)
Net Changes to Payables	\$118,293	\$178,638
Net Cash Provided by (Used in) Operating Activities	\$7,383	\$75,803
Change in Investments	(\$104,942)	\$5,144
Other Equipment Acquisitions	127	(1,978)
Net Cash Provided by (Used in) Investing Activities	(\$104,815)	\$3,166
Net Increase (Decrease) in Cash & Cash Equivalents	(\$97,431)	\$78,969
Cash & Cash Equivalents at Beginning of Period	\$254,476	\$78,075
Cash & Cash Equivalents at December 31, 2020	\$157,045	\$157,045



DATE: February 24, 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
Dr. Michael Yen	Physician	Santa Cruz

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

Attachments. N/A



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Dr. Dale Bishop, Chief Medical Officer
SUBJECT: Whole Child Model Clinical Advisory Committee: Member Appointment

Recommendation. Staff recommend the Board approve the appointment of the individual listed below to the Whole Child Model Clinical Advisory Committee (WCMCAC).

Background. The Board established the WCMCAC 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 WCMCAC. This provider is replacing Dr. Elizabeth Falade on the Committee.

Name	Affiliation	County
Dr. Cal Gordan	Physician	Santa Cruz

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, December 2, 2020

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

Commissioners Present:

Ms. Dorothy Bizzini	Public Representative
Mr. Dan Brothman	Hospital Representative
Ms. Leslie Conner	Provider Representative
Supervisor Ryan Coonerty	County Board of Supervisors
Dr. Larry deGhetaldi	Provider Representative
Ms. Julie Edgcomb	Public Representative
Ms. Mimi Hall	County Health Services Agency Director
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Supervisor Lee Lor	County Board of Supervisors
Mr. Michael Molesky	Public Representative
Ms. Rebecca Nanyonjo	Director of Public Health
Supervisor Jane Parker	County Board of Supervisors
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
Dr. Gary Gray	Hospital Representative
Ms. Elsa Quezada	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

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Ms. Marina Owen
Ms. Van Wong
Ms. Kathleen McCarthy
Ms. Kathy Stagnaro

Chief Operating Officer
Chief Information Officer
Strategic Development Director
Clerk of the Board

1. Call to Order by Vice-Chair Conner.

Commission Vice-Chair Conner called the meeting to order at 3:05 p.m.

Vice-Chair Conner acknowledged the Board service of Commissioner Lor and Commissioner Parker. This was their last meeting.

[Chairperson Coonerty and Commissioner Schuller arrived at this time: 3:05 p.m.]

Roll call was taken and a quorum was present.

Chair Coonerty also acknowledged the Board service of Commissioner Lor and Commissioner Parker.

No changes to the agenda were made.

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.

Commissioner Lor thanked everyone on the Commission during her service on the board over the past four years. She informed the Board that she co-founded an interactive children's museum in Merced County which will further advance the quality of life for children and their families.

[Commissioner Weber arrived at this time: 3:09 p.m.]

4. Comments and announcements by Chief Executive Officer.

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

Ms. Sonnenshine expressed her appreciation to the Board for their commitment to the Alliance and for their time and attention this year. She also recognized Supervisor Parker and Supervisor Lor for their commitment and service on the Alliance's board.

Consent Agenda Items: (5. – 10G.): 3:13 p.m.

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

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

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Brothman, Conner, Coonerty, Edgcomb, Hall, Jimenez, Kalantari-Johnson, Lor, Molesky, Nanyonjo, Parker, Rabago, Radner, Schuller, Smith and Weber.

Noes: None.

Absent: Commissioners Cuevas, deGhetaldi, Gray and Quezada.

Abstain: None.

Regular Agenda Item: (11. - 15.): 3:16 p.m.**11. Consider approving: 1) Medical Budget and 2) Administrative Budget for Alliance Calendar Year (CY) 2021. (3:16 – 3:47 p.m.)**

Ms. Lisa Ba, Chief Financial Officer (CFO), reviewed the overall budget results and the Medical budget and Administrative budget. The priorities for budget development include ensuring sustainable financial performance, proactively bringing medical costs in line with revenue rate and utilization trends, improving administrative efficiency and maintaining access to and quality of care for members.

MOTION: Commissioner Parker moved to approve the CY 2021 Medical Budget at \$1,234,479,313, seconded by Commissioner Conner.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Brothman, Conner, Coonerty, deGhetaldi, Edgcomb, Hall, Jimenez, Kalantari-Johnson, Lor, Molesky, Nanyonjo, Parker, Rabago, Radner, Schuller, Smith, and Weber.

Noes: None.

Absent: Commissioner Cuevas, Gray and Quezada.

Abstain: None

[Commissioner deGhetaldi arrived at this time: 3:33 p.m.]

Ms. Ba reviewed the Administrative budget considerations which included improving overall cost structure while delivering on core responsibilities, improving administrative efficiency by optimizing low maturity and high cost processes, and continued focus on operational efficiencies and financial stewardship.

MOTION: Commissioner Weber moved to approve the CY 2021 Administrative Budget at \$82,065,452, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Brothman, Conner, Coonerty, deGhetaldi, Edgcomb, Hall, Jimenez, Kalantari-Johnson, Lor, Molesky, Nanyonjo, Parker, Rabago, Radner, Schuller, Smith, and Weber.

Noes: None.

Absent: Commissioner Cuevas, Gray and Quezada.

Abstain: None

12. Consider approving Alliance Medi-Cal Program Provider Incentive Program Funding for Calendar Year (CY) 2020. (3:47 – 3:58 p.m.)

Chair Coonerty reminded the Board that this item carried potential conflicts of interest. Those who perceived that they are at risk for conflicts of interest were advised to refrain from influencing the discussion and abstain from voting on item 12.

Ms. Lisa Ba, CFO, informed the Board that each year in December, the Board approves the budget for the following year's provider incentive programs, with actual payment amounts decided upon in December of that following year. Historically, the Alliance has considered financial performance when approving the funding for the incentive programs. In CY 2019, due to financial losses, the Board approved the funding for Care Based Incentives (CBI) but declined the funding for Specialty Care Incentives (SCI).

Staff recommended the Board approve a total incentive budget of \$10M to be distributed to Alliance contracted primary care providers for their performance in CBI for CY 2020 and to fund SCI at \$0.0M for CY 2020.

MOTION: Commissioner Parker moved to approve Alliance Medi-Cal provider incentive program funding for CY 2020, seconded by Chair Coonerty.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Coonerty, Edgcomb, Kalantari-Johnson, Lor, Molesky, Parker.

Noes: Commissioner Smith.

Absent: Commissioners Cuevas, Gray and Quezada.

Abstain: Commissioners Brothman, Conner, deGhetaldi, Hall, Jimenez, Nanyonjo, Rabago, Radner, Schuller and Weber.

13. Consider approving proposed Hospital Shared Savings Plan. (3:58 – 4:17 p.m.)

Chair Coonerty reminded the Board that this item carried potential conflicts of interest. Those who perceived that they are at risk for conflicts of interest were advised to refrain from influencing the discussion and abstain from voting on item 13.

Ms. Lisa Ba, CFO, discussed the proposed Hospital Shared Savings Plan. In 2019, the Board affirmed cost containment as a priority and continued emphasis among payers, providers, and the community on moving toward a value-based system, including continued emphasis on demonstrating outcomes, reducing the cost of care and exploring innovative reimbursement and contracting arrangements. In June 2020, the Board approved the Alliance cost containment plan to bring medical cost in line with revenue. An area of focus was inpatient hospital costs.

The Alliance continues to make progress in redesigning provider reimbursement strategies and re-negotiating all in-area hospital contracts to benchmark Medi-Cal APR-DRG payment structure. In preparing for plan implementation, staff assessed a shared savings model to be included as a component of hospital contracts addressing medical costs. A shared savings plan would be an added payment strategy to align earning potential for hospital partners and would contain the Plan's MLR at an optimal level in relation to revenue. The shared savings plan would be optional but is an opportunity to engage differently with providers to improve outcomes.

MOTION: Commissioner Bizzini moved to approve the concept of a shared savings plan for use in hospital contracts, seconded by Commissioner Edgcomb.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Conner, Coonerty, Edgcomb, Hall, Jimenez, Kalantari-Johnson, Lor, Molesky, Nanyonjo, Parker, Smith and Weber.

Noes: None.

Absent: Commissioners Cuevas, Gray and Quezada.

Abstain: Commissioners Brothman, deGhetaldi, Rabago, Radner and Schuller.

14. Consider approving recommendation on Recuperative Care Pilot. (4:17 – 4:55 p.m.)

Ms. Kathleen McCarthy, Strategic Development Director, provided background on the development of the proposed recuperative care and bridge housing pilot program. This pilot presents an opportunity to test and evaluate the effectiveness of services intended to improve outcomes for members with complex medical conditions and the cost of care.

[Commissioner Schuller departed at this time: 4:51 p.m.]

Commissioner Molesky suggested staff provide remaining grant fund balances for Merced, Monterey and Santa Cruz County in future reports and presentations. He further recommended spreading grant funds throughout various county organizations.

MOTION: Commissioner Bizzini moved to approve \$5,857,020 of unallocated Medi-Cal Capacity Grant Program funds to establish the Recuperative Care Pilot (RCP); and RCP program criteria, budget allocations and timeline, and direct staff to report back on the status of the pilot before the end of the two-year term, seconded by Commissioner Conner.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Brothman, Conner, Coonerty, deGhetaldi, Edgcomb, Hall, Jimenez, Kalantari-Johnson, Lor, Molesky, Nanyonjo, Parker, Rabago, Radner, Smith and Weber.

Noes: None.

Absent: Commissioners Cuevas, Gray, Quezada and Schuller.

Abstain: None.

15. Discuss Key Factors and Activities in 2021. (4:55 – 5:02 p.m.)

Ms. Stephanie Sonnenshine, CEO, reviewed key influential factors and efforts that staff are engaged in for 2021. There will be a change in federal administration as of January 2021 and a decision on the fate of the ACA is expected by June. COVID-19 will be both a significant national and California issue and significant progress is being made on the development and distribution of a vaccine. She discussed the California state budget and the Alliance bridge priorities for 2021.

Strategic planning efforts were paused due to the pandemic and will proceed with a long-term strategic plan. Staff will kick off the strategic planning process for 2022 and beyond early next year and hope to bring the planning work to the June board retreat. The Department of Health Care Services (DHCS) has delayed the Pharmacy Carve-out to April 1, 2021, citing impacts of the pandemic.

Another significant impact from DHCS for board awareness is the request for proposal for commercial managed care plans serving Medi-Cal beneficiaries in geographic managed care counties. The Alliance has had inquiry from two counties about a potential partnership. The local initiative and regional model counties kick off in January 2021 with implementation expected in January 2024. All indications from DHSC is the intent to proceed with Cal-AIM for 2022 implementation.

Discussion item only; no action was taken by the Board.

The Commission adjourned its meeting of December 2, 2020 at 5:02 p.m. to February 24, 2021 at 3:00 p.m. via teleconference unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE



Meeting Minutes
Wednesday, October 21, 2020
8:30 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Bob Trinh	Information Technology Director
Chris Morris	Operational Excellence Director
Dale Bishop	Chief Medical Officer
Dana Marcos	Member Services Director
Danita Carlson	Government Relations Director
Dianna Diallo	Medical Director
Frank Song	Analytics Director
Frank Souza	Claims Director
Gordon Arakawa	Medical Director, Merced County
Jay Sen	Budgeting and Reporting Director
Jenifer Mandella	Compliance Officer (Chair)
Jennifer Mockus	Community Care Coordination Director
Jordan Turetsky	Provider Services Director
Joy Cubbin	Accounting Director
Kathleen McCarthy	Strategic Development Director
Lilia Chagolla	Regional Operations Director, Monterey County
Linda Gorman	Communications Director
Lisa Ba	Chief Financial Officer
Lisa Hauck	Human Resources Director
Luis Somoza	Compliance Manager
Marina Owen	Chief Operating Officer
Mary Brusuelas	UM and Complex Case Management Director
Michelle Stott	Quality Improvement Director
Navneet Sachdeva	Pharmacy Director
Rick Dabir	Technology Development Director
Ronita Margain	Regional Operations Director, Merced County
Scott Fortner	Chief Administrative Officer
Stephanie Sonnenshine	Chief Executive officer
Van Wong	Chief Information Officer

Committee Members Absent:

Maya Heinert	Medical Director, Monterey County
Ryan Inlow	Facilities & Administrative Services Director

Committee Members Excused:

Kay Lor Provider Payment Director

Ad-Hoc Attendees:

Kat Reddell Compliance Specialist
Kate Knuston Compliance Supervisor
Paige Harris Compliance Specialist

1. Call to Order by Chairperson Mandella.

Chairperson Jenifer Mandella called the meeting to order at 8:34 a.m.

2. Review and Approval of September 16, 2020 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of September 16, 2020 meeting.

3. Consent Agenda.

- 1. Policy Hub Approvals**
- 2. Regulatory and All Plan Letter Updates**

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda**1. Delegate Oversight Quarterly Report**

Somoza, Compliance Manager, presented the Delegate Oversight Quarterly Activity Report which included updates to the 2020 Annual Review; Continuous Oversight Activities for Q2 2020, Q1 2020, and Q4 2019; and Additional Oversight Activities.

2020 Annual Review

Somoza provided an update to the 2020 Annual Review, stating the review of 6 of 9 delegates is complete and 3 delegates remain under review.

Staff recommended approval of the following activities:

- Beacon/CHIPA: Quality Improvement and Utilization Management
- SCVMC: Credentialing
- VSP: Finance

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

- MedImpact: Provider Disputes
- PAMF: Credentialing
- UCSF: Credentialing

COMMITTEE ACTION: Committee reviewed and approved the 2020 Annual Review and assigned the following action items:

- Alvarez to review MedImpact Provider Disputes documentation upon receipt and complete annual review.
- Dybdahl to review PAMF, and UCSF Credentialing documentation upon receipt and complete annual review.

Q2 2020 Continuous Oversight Activity

Staff recommended approval of the following Q2 2020 reports received from delegates:

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

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

- Beacon/CHIPA: Claims, Credentialing, Quality Improvement and Utilization Management
- MedImpact: Credentialing
- VSP: Credentialing

COMMITTEE ACTION: Committee reviewed and approved staff recommendations related to the Q2 2020 Continuous Oversight Activities and assigned the following action items:

- Dybdahl to review Beacon/CHIPA, MedImpact and VSP Credentialing documents and complete quarterly review.
- Gianopoulos to review Beacon/CHIPA Claims documents and complete quarterly review.
- Gillette-Walch to review Beacon/CHIPA Quality Improvement documents and complete quarterly review.
- Brusuelas to review Utilization Management documents and complete quarterly review.

Follow-Up on Q1 2020 Continuous Oversight Activity

Staff recommended approval of the following Q4 2019 quarterly reports received from the following delegates:

- Beacon/CHIPA: Credentialing, Member Connections and Provider Disputes
- LHPC: Credentialing
- MedImpact: Credentialing
- PAMF: Credentialing
- VSP: Member Connections

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

- VSP: Provider Disputes

COMMITTEE ACTION: Committee reviewed and approved staff recommendations related to the follow up to Q1 2020 Continuous Oversight Activities and assigned the following action items:

- Alvarez to review VSP Provider Disputes documents upon receipt and complete quarterly review.

Follow-Up on Q4 2019 Continuous Oversight Activity

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

- MedImpact: Credentialing

COMMITTEE ACTION: Committee reviewed and approved staff recommendations related to the follow up to Q4 2019 Continuous Oversight Activities and assigned the following action items:

- Dybdahl to review MedImpact Credentialing documents upon receipt and complete quarterly review.

2. HIPAA Quarterly Report

Mandella, Compliance Officer, presented the Q3 2020 HIPAA Quarterly Report. Mandella reviewed HIPAA disclosure notifications received in Q3 2020 and trends, noting that half of all reported events were due to mis-selections and entries while processing authorizations. Mandella informed the committee that Compliance staff had assessed all HIPAA events that were determined to be repeat concerns and ensured that actions have been taken in response to all incidents.

Wong, Chief Information Officer, presented security updates for Q3 2020 and provided an overview of email rejection rates for malicious emails sent to Alliance staff. Wong reported that the following security related activities took place in Q3 2020:

- Shut down of connectivity to suite in 1800 removing exposure to Alliance Network
- Quarterly review of Alliance-owned domains
- Implementation of security patches to Alliance Domain Controller servers
- Review of Alliance staff with access to Iron Mountain for retrieval of backup tapes
- Configuration of secure encrypted TLS email channel for email delivery from the Alliance to DHCS
- Communication to Alliance staff of the dangers of phishing related emails

COMMITTEE ACTION: Committee reviewed and approved the Q3 2020 HIPAA Quarterly Report.

3. APL Process Improvement

Knutson, Compliance Supervisor, presented a summary of All Plan Letter (APL) timeliness review and the results of the process improvement survey conducted in September, 2020 noting that that 26 Directors and Managers were prompted to complete a 10

question survey, 16 of which responded (54%). Knutson highlighted the following key takeaways of the survey:

- Desire for additional analysis / crosswalking to department operations
- Concerns that tasks have been assigned to incorrect responsible party(ies) and/or is missing additional applicable party(ies)
- Desire for APL summaries to be sent to department SMEs (Subject Matter Experts), rather than directors
- Desire to be able to see other department's responses to APLs
- Desire for additional clarity on expectations for department responses
- Desire for clarity on who is coordinating interdepartmental efforts to implement APLs
- Desire for high impact items and/or known gaps to be highlighted in analysis

Committee members provided additional feedback on the APL implementation process, including an acknowledgement that Compliance staff are providing a service to the organization, an acknowledgement of the variation in level of effort needed to implement APLs, and a request to align processes for implementing all new requirements, including APLs, legislation, and contractual obligations.

Knutson reviewed Compliance next steps and future plans for process improvement and asked requesting departments for commitment to continued support in responding to APLs completely and timely.

The meeting adjourned at 9:39 a.m.

Respectfully submitted,

Robin Sihler
Administrative Assistant - Compliance

COMPLIANCE COMMITTEE



Meeting Minutes
Wednesday, December 2, 2020
8:30 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Bob Trinh	Technology Services Director
Chris Morris	Operational Excellence Director
Dale Bishop	Chief Medical Officer
Dana Marcos	Member Services Director
Danita Carlson	Government Relations Director
Dianna Diallo	Medical Director
Frank Song	Analytics Director
Frank Souza	Claims Director
Gordon Arakawa	Medical Director, Merced County
Jay Sen	Budgeting and Reporting Director
Jenifer Mandella	Compliance Officer (Chair)
Jennifer Mockus	Community Care Coordination Director
Jordan Turetsky	Provider Services Director
Joy Cubbin	Accounting Director
Kay Lor	Provider Payment Director
Lilia Chagolla	Regional Operations Director, Monterey County
Linda Gorman	Communications Director
Lisa Ba	Chief Financial Officer
Lisa Hauck	Human Resources Director
Luis Somoza	Compliance Manager
Marina Owen	Chief Operating Officer
Mary Brusuelas	UM and Complex Case Management Director
Maya Heinert	Medical Director, Monterey County
Michelle Stott	Quality Improvement Director
Navneet Sachdeva	Pharmacy Director
Rick Dabir	Technology Development Director
Ronita Margain	Regional Operations Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Scott Fortner	Chief Administrative Officer
Stephanie Sonnenshine	Chief Executive officer
Van Wong	Chief Information Officer

Committee Members Absent:

Committee Members Excused:

Kathleen McCarthy Strategic Development Director

Ad-Hoc Attendees:

Aaron McMurray Information Security Analyst
Kat Reddell Compliance Specialist
Kate Knutson Compliance Supervisor
Nicole Krupp Government Relations Specialist
Sara Halward Compliance Specialist

1. Call to Order by Chairperson Mandella.

Chairperson Jenifer Mandella called the meeting to order at 8:34 a.m.

2. Review and Approval of October 21, 2020 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of October 21, 2020 meeting.

3. Consent Agenda.

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

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda**1. Program Integrity Quarterly Report**

Knutson, Compliance Supervisor, presented the Q3 2020 Program Integrity Activity Report and reviewed select Matters Under Investigation (MUIs). Knutson reported that 21 concerns were referred to Program Integrity in Q3 2020, 11 of which resulted in the opening of an MUI. There were 51 active MUIs in Q3 2020. Knutson noted that Program Integrity and Information Technology Services (ITS) staff continue to work to more accurately capture Recoveries on the Special Investigations Unit (SIU) Dashboard.

Knutson reviewed referral trends for the period noting that, of the 11 referrals resulting in MUI, 4 related to the providers potentially upcoding evaluation and management (E&M) services, 4 were member/other related, 1 was waste related, and 2 were state requests for provider data.

Knutson reviewed 4 exemplar cases, highlighting collaboration between SIU and Advanced Analytics to identify providers whose billing behavior characterizes higher than typical use of E&M Services specific to CPT 99215. The Committee discussed incorporating

feedback from Provider Services and Health Services staff when outlier providers are identified.

Knutson reviewed performance of the Program Integrity metrics from the Q3 Alliance Dashboard, noting that performance was above threshold for all metrics.

Knutson informed the Committee that DHCS has begun noticing the plan of effective Denial of Payment for New Admissions (DOPNAs) and PI has commenced implementation of noticing these providers with additional efforts being made to ensure that new admissions do not occur and that payment for new admissions are prevented.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2020 Program Integrity Report.

2. Internal Audit & Monitoring Report

Halward, Compliance Specialist, presented the Q3 2020 Internal Audit and Monitoring Activity Report noting that 9 reviews were conducted, all of which received a passing score.

Halward reviewed one internal audit focused on ensuring that terminated staff had their system access removed immediately upon departure. The audit received a passing score, with system access removed immediately in 90% of cases; Compliance staff provided further recommendations to streamline the process and address some inconsistencies.

Halward presented the 2021 Internal Audit & Monitoring workplan, which incorporates existing risks from the 2020 workplan and inclusion of potential new risks, including newly implemented requirements and audit findings. The 2021 Internal Audit & Monitoring workplan includes 33 planned focused reviews, of which 16 are high risk areas, 14 are medium risk areas and 3 are low risk areas. Additionally, the workplan includes a quarterly review of compliance-related metrics on the Alliance Dashboard.

Halward reported that the Alliance has not yet received preliminary findings from DMHC in regards to the 2020 Medical Survey.

COMMITTEE ACTION: Committee reviewed and approved the Q3 2020 Internal Audit & Monitoring Report.

3. HIPAA Security Assessment Update

Wong, Chief Information Officer, presented an update on work to remediate the findings of the 2020 AT&T security assessment, noting that there were 81 total findings and that the focus for the remainder of the year is to remediate the 33 Fail and High critical findings. Overall, the assessment found the Alliance to be secure and in a good position. Recommendations were made to further strengthen the Alliance's security posture in the following areas:

- Device hardening
- Improve user awareness to detect/avoid user-target attacks to the Alliance's internal network
- Practice defense-in-depth (multi-layered protection)

Wong reviewed next steps for 2020 and plan revisions for 2021 and introduced Aaron McMurray in the new role of Information Security Analyst.

4. 2020 Legislation Update

Krupp, Government Relations Specialist, presented a summary of 2020 Legislation that impacts Alliance operations, including their effective dates and next steps for implementation, as follows:

- AB 2276 – Childhood Lead Poisoning: Screening and Prevention
- SB 855 – Health Coverage: Mental Health of Substance Use Disorder

5. Medicaid Managed Care Regulation

Carlson, Government Relations Director, presented a background of Medicaid Managed Care Regulations and reviewed revisions made in November 2020 Final Rule. Key changes were made in the following areas:

- Network Adequacy
- Beneficiary Protections
- Appeals
- Quality Oversight
- Encounter Date
- Quality Strategy
- External Quality Review
- Rate Setting and Payment

Carlson reviewed next steps in implementation of revisions noting expected guidance from DHCS and collaboration with Compliance to distribute implementation guidelines and workplans.

The meeting adjourned at 9:48 a.m.

Respectfully submitted,

Robin Sihler
Administrative Assistant - Compliance

CONTINUOUS QUALITY IMPROVEMENT COMMITTEE



Meeting Minutes
Thursday, October 22, 2020
12:00 – 1:30 p.m.

Web Conference

Committee Members Present

Dr. Caroline Kennedy	Provider Representative
Dr. Casey KirkHart	Provider Representative
Dr. Eric Sanford	Provider Representative
Dr. Oguchi Nkwocha	Provider Representative
Ms. Susan Harris	Hospital Representative

Committee Members Absent:

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

Staff Present:

Mr. Amit Karkhanis	Quality and Performance Improvement Mgr.
Mr. Chris Morris	Operational Excellence Director
Dr. Dale Bishop	Chief Medical Officer
Ms. Dana Marcos	Member Services Director
Ms. Deborah Pineda	Quality and Health Programs Manager
Dr. Dianna Diallo	Medical Director
Ms. Hilary Gillette-Walch	Clinical Decision Quality Manager
Dr. Gordon Arakawa	Medical Director
Ms. Jacqueline Van Voerkens	Administrative Specialist
Ms. Jennifer Mockus	Community Care Coordination Director
Ms. Jordan Turetsky	Provider Services Director
Ms. Lilia Chagolla	Regional Operations Director / Monterey
Ms. Linda Gorman	Communications Director
Ms. Mary Brusuelas	UM/Complex Case Management Director
Ms. Mary Peddy	Administrative Assistant
Dr. Maya Heinert	Medical Director
Ms. Michelle Stott	QI/ Population Health Director
Ms. Navneet Sachdeva	Pharmacy Director
Mr. Pen Ho	Advanced Analytics Manager
Ms. Ronita Margain	Regional Operations Director / Merced
Ms. Tammy Brass	UM/Complex Case Management Manager
Ms. Viki Doolittle	UM/Complex Case Management Manager

1. Call to Order by Dr. Maya Heinert, Medical Director

2. Announcements

Quality and Health Programs Manager, Deborah Pineda, announced that the Alliance is exploring new services to support interpreting in video conferencing platforms. In order to ensure all members have equal access to Alliance covered services in their preferred language, the Alliance currently provides onsite interpreting services, as well as access to our telephonic interpreting line. The Alliance is now exploring other services that can support providers via their Telehealth visits during a video platform. One of those areas of service is audio interpreting, which could be used during GTM or Zoom meetings. We are in the very early stages of exploration and will be working with our Provider Services Team, in future, to share information once decisions are made.

3. Consent Agenda

Dr. Maya Heinert introduced the consent agenda, which included:

Meeting Minutes

- July 23, 2020 CQIC Minutes:
 - Action Item: Inviting Pharmacist to the CQIC. Outreach and recruitment are in process, and we hope to have a Pharmacist join the committee in 2021.

Subcommittee/Workgroup Meeting Minutes

- Pharmacy and Therapeutic (P&T) Committee Minutes
- Q3-20 Continuous Quality Improvement Workgroup (CQIW) Minutes
- Q3-20 Utilization Management Workgroup (UMWG) Minutes

Work plans:

- Q2 2020 Utilization Management Workplan

Policies Requiring Approval:

Policy Number	Title	Significant Changes
401-1510	Medical Record Review and Requirements	<ul style="list-style-type: none"> ▪ Verbiage added to the policy regarding providers are required to maintain and have medical records readily available, including sharing of all pertinent information relating to the health care of each enrollee. This includes QPIP monitoring activities for all covered services, including but not limited to assistance in facilitating a medical record review audit, evaluating continuity of care, potential quality issues, etc.
401-2001	Member Surveys	<ul style="list-style-type: none"> • Update header, changed "approved by to CQIC". • Added procedure on CAHPS Clinician and Group Survey (CG-CAHPS) under "procedures". • Updated procedures for " DHCS Consumer Satisfaction Survey" and "DMHC Enrollee Experience Survey". • Added Provider Services and Member Services to Impacted Departments in the References section.

401-4101	Cultural and Linguistic Services Program NEW	<ul style="list-style-type: none"> Health Programs unit transitioned under the Quality Improvement and Population Health Department (QI/PH) (<i>new title</i>) Department. Our unit name has also changed to Quality and Health Programs (QHP). Due to these changes we will be retiring our 405-account number and aligning our policies number with QI/PH 401.
401-4103	Interpreter Services (New)	<ul style="list-style-type: none"> Health Programs unit transitioned under the Quality Improvement and Population Health Department (QI/PH) (<i>new title</i>) Department. Our unit name has also changed to Quality and Health Programs (QHP). Due to these changes we will be retiring our 405-account number and aligning our policies number with QI/PH 401.

Committee Decision: Meeting minutes and all Consent Agenda items were approved by members present.

4. Delegate Oversight: CCC Director, Jennifer Mockus, provided presentation on the Alliance clinical oversight of MBHO, Beacon. Presentation included:

Background: Beacon has been our MBHO since 2014: Services include:

- Mild-moderate mental health services for individuals & groups;
- Mental health evaluations and treatment, or psychotherapy;
- Psychological testing as medically needed;
- Outpatient services for monitoring drug therapy;
- Outpatient labs;
- Supplying supplements,
- Psychiatric consults;
- BHT services and EPSDT services and treatment

Role of CQIC: To provide delegate oversight of quality performance and improvement plans (QPIP), excluding credentialing and re-credentialing.

Beacon Compliance with Alliance Standards: Areas of non-compliance

- Coordination of Care: Beacon was having difficulty getting their contracted behavioral health providers to send clinical notes for review, and charts received show that coordination of care between BH and school districts do not meet Alliance standards. It was also found that less than 80% of the charts contain a signed release of information for the BH Provider to work with PCP. Beacon has implemented several performance improvements and instituted auditing to correct these issues.
- Annual Member Satisfaction Survey Related to Timely Access: Members scores were lower than the required 80% in some areas. Two of these were related to access to care. In response to these findings, Beacon has increased access with Telehealth expansion, and providing the Alliance with monthly utilization reports. Beacon has also worked to improve communication with providers both directly, and in their newsletters.

- Internal Quality Committee Meeting Minutes: Minutes were incomplete and did not reflect any of the identified corrective action items or improvement work. These topics, and updates, have now been added to the Beacon internal meetings, as well as to the agendas of the monthly meetings with the Alliance.

Next steps: The Alliance will continue meeting with Beacon and community partners, and reimplement treatment team meetings with Beacon and Alliance staff to better collaborate on member needs. We will also continue to monitor the quality of beacon reports.

Action Item: Jennifer Mockus to email the Beacon PCP Referral Form to Dr. Kennedy. Note that this action was completed on October 26, 2020.

4. Pharmacy Carve Out: Presented by Navneet Sachdeva, Pharm, D, Pharmacy Director

Effective January 1, 2021, Medi-Cal will be transferring pharmacy benefits from Managed Care Plans to a fee for service delivery system, and contracting with Magellan Medicaid Administration. The Alliance has several contingency plans to assure, as much as possible, for a smooth transition. Our Pharmacy Department staff are here to assist you, please reach out as needed. Main points to keep in mind are:

What's changing:

- Responsibility of Medi-Cal: All pharmacy services to billed on pharmacy claims, including but not limited to:
 - Outpatient drugs (prescription and over-the-counter)
 - Enteral nutrition products
 - Physician Administered Drugs
 - Some Medical Supplies / DME
- Responsibility of Plans: Clinical Oversight
 - Medication and disease management
 - Medication adherence program
 - Medication reconciliation program
 - Beneficiary care coordination to assure our members get the medication they need even though we are not processing these claims.

What stays the same:

- All pharmacy services billed on medical claims, including but not limited to:
 - Physician administered drugs using HCPCS/CPT/J-Codes
 - Medical supplies (CGM, insulin pumps)
 - Already carved out medications (hemophilia treatment drugs and HIV drugs)
- For members in our IHSS line of business
 - Both pharmacy and medical claims remain with CCAH
 - Formulary Management
 - All other core and regulatory requirements

Member impact:

- Member pharmacy
 - Members can keep their PAVE enrolled local pharmacy or mail order pharmacy
 - If not enrolled in PAVE, they will need to change their provider. List of pharmacies not registered with PAVE has been shared with DHCS. Both CCAH and DHCS has reached out to these pharmacies to ask them to register.

- Formulary
 - 180 days transition plan policy
 - Up to 5 years PA for certain disease conditions (asthma, COPD, anti-hypertensives, diabetes management)
- Contact information for Magellan
 - Member Portal
 - Medi-Cal Rx Pharmacy Locator
 - Formulary Locator
 - Refills
 - Medi-Cal Rx Call Center Line (1-800-977-2273) twenty-four hours a day, seven days a week, or 711 for TTY Monday through Friday, 8 a.m. to 5 p.m.
 - Members are being encouraged to sign-up on the member portal
- Appeals and Grievance Process
 - No independent medical review (IMR) option after transition
 - Members will still have State Fair Hearing option. This can take up to 90 days, and we are in communication with DHCS for a possible expedited option, and what we can do while member is waiting for their hearing.

Provider impact:

- Largest impact will be to the prior authorization submission process
 - Authorizations for IHSS members, and medical claims will be through the CCAH portal
 - Provider portal includes easy look-up tool to see what is on the formulary and CDL
 - Authorizations for pharmacy claims for Medi-Cal members will be through the Magellan portal.
 - If you need assistance signing up for the Magellan portal, please reach out to our CCAH pharmacists. We are here to help!
 - Magellan is not registered with Surescripts. In order to send electronic prescriptions to the pharmacy, clinics will have to assure that their EMR system meets the Magellan criteria, and will otherwise need to fax prescriptions.
 - We have asked DHCS for additional clarity on this and will share our findings.
- Formulary
 - Contract Drug List (CDL) www.Medi-CalRx.dhcs.ca.gov
 - 180-day transition plan policy
- Magellan Resources
 - Provider portal <https://medi-calrx.dhcs.ca.gov/home/>
 - Medi-Cal Rx via Medi-Cal Rx Subscription Service
 - Medi-Cal Rx Call Center Line (1-800-977-2273) twenty-four hours a day, seven days a week or 711 for TTY, Monday through Friday, 8 a.m. to 5 p.m.
 - For general questions relating to Medi-Cal Rx, please direct your comments and questions to RxCarveOut@dhcs.ca.gov

Communication Plan:

- DHCS has training and educational material at Medi-Cal Rx Website.
- CCAH has developed Provider Manual updates, Provider Newsletters, flyers, a landing page on our website, and social media announcements, as well as similar member focused communications. The CCAH staff are here to support you in any way we can!

Collaboration between DHCS, Magellan & CCAH

- We are sharing claims data exchange now to facilitate preparation for the 180-days transition policy.
- A clinical liaison is available to assist with beneficiary care coordination and clinical oversight.
- We will continue to advocate that medications are added to CDL for crucial medical needs.

Action Item: Navneet Sachdeva to contact DHCS to request inclusion of formulary information (drugs on DCL) in Epocrates after the RX carve out. Note that this action was completed on October 22, 2020. CQIC Provider Representatives have been copied on the communication to DHCS.

5. BI-Tool / Readmissions: Presented by Pen Ho, Advanced Analytics Manager & Viki Doolittle, RN, Um/CCM Manager

- Goal developing this tool was to build a predictive model to flag high risk unplanned readmission right after the patient is admitted to the hospital and before the patient is discharged, so that we can begin interventions while they are still inpatient.
- Predictors include: chief complaint at admission, medical claims prior to admission and utilization for last 3-12 months, and incorporates BI-Tool predictive score and demographic variables.
- With this information, we are able to predict the likelihood of a 30-day readmission so we can identify high or very-high risk members and focus our efforts appropriately.
- We are working on reports that we hope to be able to share with PCPs and specialists in future and to assist with preventative care.
- Our **Reducing Readmission (RRAD)** Team began this work in mid-March and began initially with Mercy, Dominican, and SVMH, where highest amount of utilization was occurring. Due to COVID this has been remote only, and we still seeing positive effects. Team includes CR RNs, CCM RNS, MSWs and Pharmacy staff.
- This team employs the BI risk scoring reports to focus on high risk members. Complex case management cases were opened while members were still inpatient. Over 1679 cases were opened by Case Managers in Quarter 3, and another 833 by the MSWs. Team is also touching low risk cases and we have expanded now to all of our networked facilities.
- Some of the programs helping significantly include the Post Discharge Meal Delivery Plan, and Palliative Care, as well as assistance with transportation and pharmacy reconciliation.
- We continue to expand our work and outreach to facilities and members to reach our goal of a 10% reduction of readmissions.

6. WCM Update: Presented by Dianna Diallo, MD, Medical Director

- Title V Needs Assessment: As a condition of the Title V MCH Block Grant Program, the Federal MCH Bureau requires each state MCH agency to complete a needs assessment every five years. DHCS has partnered with the University of California, San Francisco Family Health Outcomes Project (FHOP) to conduct the Title V Needs Assessment. Findings released in March from the 2018-2020 assessment include:

- Based on the Alliance's WCM demographic data, compared to the state of CA, our members are: more medically complex; predominately Hispanic; families have less educational attainment; and require interpreting services more often.
 - The Alliance generally scored on par with State averages, though we were higher than average in the following assessment topics:
 - Interpretation provided
 - Helping to find a provider (adult services)
 - Members know that case management services are available at the plan
 - Members were satisfied with CM help received
 - Items were also identified as needing improvement related to communication and resource education. The Alliance is actively working on the following:
 - Considering a single point of contact for CM
 - Enhanced orientation/welcome materials
 - WCM page added to plan website with resources
 - Exploring workshops to target larger topics
 - 2019 WCM Corrective Action Plan: The CAPs assigned for Risk Stratification and ICP, the Age Out Process, and Member Eligibility have received priority attention and teams have worked hard to improve efficiencies in all areas. We expect to close out these CAPs by the end of the year.
 - CCS Referrals to County CCS Agencies: Across California, WCM counties have identified a decrease in overall referrals and caseloads when compared to pre-WCM implementation. The Alliance is working with the Counties to receive and review historical, and identify any root causes. Drop in referrals may be due to some of the following reasons:
 - Providers may not be aware they still need to refer to CCS
 - Due to process changes, there are now much less referral duplications received
 - Counties are declining diagnostic referrals
 - The Alliance has put the following methods in place to increase referrals:
 - Educating providers to resume CCS referrals at JOCs – clinic and hospital (including ED)
 - Development of a "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
7. **Future Topics:** No new topics were suggested at the meeting. Committee members are encouraged to submit items for discussion, at any time, to Michelle Stott or Mary Brusuelas.

The meeting adjourned at 1:28 p.m.

Next Meeting: Thursday, January 28, 2021 12:00 p.m. – 1:30 p.m.



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

Meeting Minutes
Wednesday, September 23, 2020
1:30 – 2:45 p.m.

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

Commissioners Present:

Ms. Mimi Hall	County Health Services Agency Director
Ms. Elsa Jiménez	County Health Director
Supervisor Lee Lor	County Board of Supervisors
Mr. Michael Molesky	Public Representative
Allen Radner, MD	Provider Representative
Mr. Tony Weber	Provider Representative

Commissioners Absent:

Ms. Leslie Conner	Provider Representative
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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. (1:34 p.m.)

Chairperson Molesky called the meeting to order at 1:34 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:35 – 1:36 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.

3. Approve minutes of May 27, 2020 meeting of the Finance Committee. (1:36 – 1:37 p.m.)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the May 27, 2020 meeting. Commissioner Weber moved to approve the minutes, seconded by Commissioner Radner. Motion carried with 6 votes affirmative, 1 absent and was so ordered.

4. Year-to-date July 2020 Financials. (1:38 – 1:48 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioners on the Alliance's most recent financials. As of July 2020, the net operating loss stands at \$35.7M, which is \$5.7M unfavorable to budget. Enrollment is 3.4% favorable to budget, which is equivalent to over 11K members monthly. Revenue is \$23.6M or 3.3% favorable. Medical Expenses are unfavorable to budget by \$28.3M or 4.0%. The Medical Loss Ratio (MLR) is 98.2%, compared to the budget of 97.5%.

Capitation revenue and medical expenses are variable based on enrollment fluctuations, therefore the per member per month (PMPM) view offers more clarity than the total dollar spend. The revenue and medical costs are closer to budget on a PMPM basis. Conversely, administrative expenses do not directly correspond with enrollment and are therefore viewed in terms of total dollar spend.

The Administrative Loss Ratio (ALR) is slightly below budget at 6.6% versus 6.7%. Administrative Expenses are unfavorable to budget by \$1.1M or 2.2% primarily due to accumulated staff paid time off (PTO) due to the pandemic. Staff have been asked to eliminate overtime and encouraged to take time off before the end of the year. This is expected to reduce or possibly eliminate the unfavorable administrative variance.

[Commissioner Elsa Jimenez arrived at this time: 1:43 p.m.]

Year-to-date PMPM revenue is \$311, medical cost is \$306 and administrative cost is \$21, resulting in an operating loss of \$15 PMPM. PMPM actuals across the board are very close to budget; revenue is only 0.1% unfavorable despite the State's May budget revision, which reduced the Plan's bridge period rate by 1.5% retroactive to July 2019. The overall 2020 revenue reduction is \$23M or \$16.6M year-to-date as of July. Barring the revenue cuts, the plan would have been below budget in PMPM expenses. PMPM medical costs are 0.7% unfavorable to budget. L. Ba explained that the PMPM equivalent provides the true cost adjusted for the enrollment variance and helps us distinguish the root cause of our financial losses. Currently, since our costs exceed revenue and we are experiencing an operating loss at the PMPM level, higher membership results in higher losses.

Utilization dropped 25% from mid-March to May and a further 10-15% in June-July; the decline then slowed to 5-10% in August and September. Despite this, medical expenses have been consistent from January through July due to several factors. Firstly, due to the claims lags, since it normally takes up to 90

days for claims to be submitted: for example, quarter one claims are still paid in April and May. Secondly, the Alliance paid claims advancement to certain providers in need of meeting their short-term cash flows. Thirdly, DHCS increased the Long-Term Care (LTC) rate by 10% retroactive back to March 1, 2020 due to COVID-19, which has caused us to increase our claims liability. Lastly, we have been accruing medical costs for COVID-19 cases. So far, 400 Alliance member cases have been reported, accrued for at \$40K each, for a total of \$16M. DHCS considers COVID-19 a regular medical cost that is covered in the Plan's regular capitation revenue, therefore no additional reimbursement is expected.

All of these factors have kept our financial performance consistent and no reduction in medical expenses has been realized despite the pandemic's effect on regular utilization. As we recover the claims advances from providers, close COVID-19 cases and pay LTC claims through regular claims process, we expect to see some relief in medical costs in the next couples of months.

Staff will prepare a 2020 forecast and share it with the Board at the October Board meeting. A total operating loss of \$53M was budgeted in 2020, which is projected to be on budget or better.

The fund balance as of the end of July 2020 is \$411.4M – about seven times the State requirement. Excluding the grant funding, the Plan is \$56.8M below the Board Designated Reserve Target, which is the equivalent of three months of capitation.

Commissioner Radner inquired if the COVID case load is based on actual inpatient count. L. Ba confirmed this is the actual COVID inpatient count. The \$40K per patient cost is based on the industry average.

5. 2019 Rate Development Template (RDT). (1:48-2:09 p.m.)

L. Ba described to the commissioners the Plan's rate setting process. The Rate Development Template (RDT) timeline runs three years in arrears: for example, the Alliance's current 2020 revenue is based on the 2017 cost experience, 2021 revenue will be based on 2018 data and so forth. Staff has recently completed compiling 2019 date of service data, which will be used as the basis for the 2022 rate. RDT for our current calendar year data will be submitted next year and will determine our rate for 2023.

To explain the step-by-step RDT process, L. Ba used the 2018 data which set the rate for the Plan's 2021 revenue. As a starting point, Mercer, the State actuary, will use our historical 2018 claims data and adjust it for the trended annual increase. They will then incorporate any program changes: in 2021 we are expecting a change to maternity claims. Currently, maternity reimbursement for County Organized Health Systems (COHS) such as the Alliance is built into the capitation rate, while most other plans are reimbursed per birth. As part of the CalAIM initiative to standardize benefits across all Medi-Cal Managed Care Plans, the State will carve out maternity reimbursement from COHS rates and implement the claim based per-birth billing process.

Following the program changes, Mercer will apply managed care efficiency adjustments. For rates prior to 2021, DHCS applied only two efficiency adjustments: the Potentially Preventable Hospital Admission (PPA) adjustment and the Healthcare Common Procedure Coding System (HCPCS) Maximum Allowable Cost (MMA) adjustment intended for health plans to mitigate potential avoidable costs due to reimbursement inefficiencies for physician administered drugs billed via HCPCS codes. Effective 2021, pharmacy will be carved out from Medi-Cal managed care plans, however, two new efficiency adjustments will be implemented: the Lower Acuity Non-Emergent (LANE) service efficiency adjustment for ED and Physician Administered Drugs (PAD) adjustment. Therefore in 2021, there will be three efficiency adjustments applicable to our rates: PPA, LANE and PAD, which will all comprise the efficiency factor affecting the rate setting.

Next in the Mercer RDT process is the non-medical load component, which is related to the plans' administrative costs. This also includes underwriting gain (UWG), for which we anticipate a change in 2021 rates: the State will reduce the UWG from 2.0% to 1.5%. This concludes the rate development process for 2021.

Next, L. Ba presented the 2019 cost experience, which will determine our 2022 revenue. 2019 total medical cost increased by \$90.7M or 11.7% compared to the prior year. Of that, Whole Child Model (WCM) expenses accounted for \$78M and non-WCM Medi-Cal accounted for \$13M. Part of the reason WCM costs were so high is because the program was implemented mid-year in July 2018. Even with the 2018 WCM expense annualized, the program still accounts for \$17M or more than half of the total increase. The year-over-year WCM increase is 14%.

The top five categories of service accounted for 80% the total year-over-year increase. Most significantly, the upsurge in inpatient hospital cost accounted for one-third of the total \$90.7M increase. On a PMPM basis, inpatient cost increased by 12.0% PMPM, which is comprised of the unit cost increase of 15.6% and utilization decrease of 3.1%.

L. Ba emphasized that back in 2016 the Alliance significantly increased provider reimbursements, with most hospitals signing a three-year contract establishing their rates for 2017, 2018 and 2019. In 2020 the Alliance did not increase any rates for our in-area hospitals.

The Alliance's historical medical cost trend over three years is 12%, where Mercer usually allows no more than 8%, resulting in a 4% gap. After including various efficiency adjustments, there is a potential gap of \$85M between revenue and cost in 2022. This assessment shows that we need to reduce our contract rate to bend the financial loss curve and reach breakeven. This gap does not take into account our cost containment plan that has been approved by the Board in June.

Since the approval of the cost containment plan, staff has been diligently working on its deliverables. In-area hospitals have been prioritized for renegotiation, letters have been mailed to the hospital's CFOs and CEOs explaining the reasons for the Board decision, and new terms were sent to all hospitals. We are now in the negotiations phase, which is expected to last a few months. The targeted reduction in inpatient expense is \$15M in 2021; the cumulative reduction in medical costs is projected at \$35M by 2022 and \$70-80M by 2023, which is the year the Alliance plans to achieve breakeven. The cost containment plan is staged over three years, since a single year cut to achieve the necessary savings would be too extreme for the hospitals.

Commissioner Elsa Jimenez inquired if the hospital rates are still being negotiated. L. Ba confirmed negotiations are ongoing.

Commissioner Molesky asked if the Alliance can recuperate any of the COVID-19 expenses in the future years. L. Ba explained that the State's assumption is for the health plans to cover the pandemic costs with the funds saved from the decrease in elective procedures, therefore no additional reimbursement is anticipated.

Commissioner Radner made a comment on the utilization decrease in 2020. As a provider representative, he noted a backlog of elective surgeries and other non-urgent procedures and expressed that the Alliance might need to financially plan or accrue for a potential jump in utilization that could start materializing in 2021 and 2022. L. Ba confirmed staff is building this assumption into the 2021 medical budget using authorizations data for relevant insight. Per general accepted accounting principles, however, we cannot accrue for those future projected expenses, since accruals can only occur for the year in which the cost was incurred. She added that the budget assumptions will be provided to the Finance Committee in October.

6. Investment Summary YTD through June 2020. (2:09-2:29 p.m.)

As of June 30, 2020, the Alliance holds \$250.1M in investment funds. Union bank holds the biggest portion – \$68.1M or 27%, followed by Local Agency Investment Fund (LAIF) with \$63.5M or 25% and CalTRUST with \$48.0M or 19%. Wells Fargo currently comprises only \$36.6 or 15% of our portfolio. There is also an additional \$224M in a Comerica sweep account as operating cash.

By holding category, the majority of our funds – \$111.4M or 45% – is in the Pooled Money Investment Account (PMIA), which includes CalTRUST and LAIF. The second highest holding category is corporate bonds with \$63.2M or 25%, followed by government bonds with \$43.1M or 17%. PMIA is a State maintained fund that holds a total of about \$140B of taxpayer funds, with more than half of its portfolio – 54% – being allocated to treasury securities, 18% to agencies debt and 15% to CDs and bank deposits.

In terms of ratings, per the Alliance’s investment policy we only invest in A and above rated funds with no longer than a five-year maturity. However, due to the recent years’ financial losses, we have been favoring even shorter term investments of no more than three years maturity in order to meet the operating cash need. Therefore, the maturity of our current investments is spread from 2020 through 2023. Once we are able to achieve breakeven and regain the ability to accumulate income, we can return to five-year maturity investments.

Our total yield for the second quarter of 2020 is 2.02%, compared to 2.08% in the first quarter. Compared to 2019, the Alliance’s 2020 year-to-date yield has decreased slightly from 2.09% to 2.00% with the pooled account showing the biggest decrease – from 2.23% to 1.53%. This is due to the account being heavily invested in short-term treasury funds, which were particularly affected by the pandemic.

Ms. Ba summarized that the Alliance has been managing its investment portfolio per the company policy in place. Our investing goals in order of importance are: safety of principal, liquidity of funds, social responsibility and, lastly, yield.

Commissioner Molesky asked for a brief overview for the new commissioners of the investment limitations the Alliance must follow as a COHS. L. Ba explained that as a Medi-Cal health plan, the Alliance is subject to certain restrictions in investing as set by the State. Our primary investing goal is safety of capital, therefore we do not strive to follow highest market return or invest in high-risk ventures. With the same objective in mind, we are limited to investing no more than 10% in any specific fund. These regulations apply to the \$119.0M the Plan holds in corporate and government bonds. The investment policy has been shared with our fund managers at Comerica, Union Bank and Wells Fargo, who, in turn, do their due diligence. PMIA, however, as a State managed fund, is by design subject to the same investing principles governing the Alliance, hence the 10% allocation rule does not apply to LAIF or CalTRUST funds. Therefore, as a qualifying local health plan, the Alliance invests heavily in these funds. LAIF is a voluntary program that offers the opportunity for its participants to be able to use the State as an investing resource. The program is governed by Local Agency Advisors, which is comprised of five members who are elected via statute. CalTRUST is a joined powers authority created by public agencies to provide convenience and a consolidation method for multiple public agencies to pool assets for investment.

The Alliance also voluntarily added the element of social responsibility in order to be a dutiful steward of public funds. The CFO added that she will cover the Alliance’s investment policy in more detail in future meetings.

Commissioner Molesky asked about the possibility of investing in green bonds and pointed out that in relation to socially responsible investing objective, he had in depth discussions on the subject with the previous Finance director and will share the info with L. Ba.

Commissioner Molesky then inquired if any physical modifications are needed to the Alliance's office space as it relates to COVID-19 safety and return to work, as well as the anticipated cost of such a project. He also asked if the Plan would be able to get reimbursed by the State for these capital improvements or if there could be a grant available to cover the cost. L. Ba reported that staff had organized a committee tasked with evaluating employees' safe return to work. Among the committee members are employees from Facilities, Human Resources and Health Services, including a medical director who used to serve as a health services director for Merced County. We do not have clear projections as to when the reopening will be deemed safe, but we have communicated to staff the timeline of no earlier than February 2021. The winter season developments will help us navigate accordingly. With relation to grants, as a Medi-Cal Health Plan, we do not qualify for any, however, any additional safety improvements may qualify as part of our regular rate setting process. It is too soon to determine at this time. Our current spend will set our rates for 2023 and as of now, DHCS has not released the criteria as to rate setting for that year.

Commissioner Molesky opened the floor for any other questions about any information presented or any suggestions on the upcoming December 2, 2020 Finance Committee agenda. No feedback was received.

The Alliance's investing strategy will be discussed in depth in the first Finance Committee meeting of 2021 since the December 2, 2020 meeting will be dedicated to 2021 budget planning.

L. Ba commended the commissioners on their work, especially related to the passing of the cost containment plan. She invited any feedback or suggestions on any topics the commissioners would like covered in future meetings. Commissioner Molesky joined the CFO in thanking the committee members for their hard work during these difficult times.

The Commission adjourned its meeting of September 23, 2020 at 2:30 p.m. to December 2, 2020 at 1:30 p.m. via videoconference from the Alliance office in Scotts Valley, Salinas, and Merced.

Respectfully submitted,

Ms. Oksana Chabanenko
Finance Administrative Specialist



**SANTA CRUZ – MONTEREY – MERCED
MEMBER SERVICES ADVISORY GROUP**

Meeting Minutes
Thursday, November 12, 2020
10:00 – 11:30 a.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

Advisory Group Members Present:

Santa Cruz County:

John Beleutz	Health Projects Center
Alene Smith	Consumer
Candi Walker	Consumer

Monterey County:

Enid Donato	Natividad Medical Center
Humberto Carrillo	Consumer
Elsa Quezada	Commissioner
Julie Edgecomb	Commissioner

Merced County:

Rob Smith	Commissioner
Erika Peterson	Merced County Head Start

Members Absent:

Martha Rubbo	Consumer
Doris Drost	Consumer
Yona Adams	HSA/CareTEAM
Lupe Chavez	Consumer
Ashley Lynne Gregory	Consumer
Alexandra Heidelberg	Consumer
Linda Jenkins	Consumer
Myisha Reed	First 5 Merced County
Rex Resa	Consumer
Linda Villa	Consumer
Silvia Wilson	Monterey County-CalHeers
Vivian Pittman	Consumer
Rebekah Capron	Merced HAS
Michael Molesky	Commissioner

Celeste Armijo
Tamara McKee
Tracy Clark

Monterey Department Social Services
HICAP – Alliance on Ageing
Merced HAS

Support Staff Present:

Dana Marcos
Maura Middleton
Hillary Gillette-Walsh, RN
Deborah Pineda

Member Services Director
Member Services Administrative Assistant
Quality and Population Health Manager
Quality and Health Programs Manager

1. Call to Order by Chairperson Beleutz.

John Beleutz, Chairperson, called the meeting to order at 10:02am. Self-introductions were made.

2. Oral Communications.

John Beleutz, Chairperson, opened the floor for any members of the public to address the Committee on items listed in the agenda.

No members of the public addressed the committee.

3. Comments and announcements by Advisory Group members.

John Beleutz, Chairperson, opened the floor for Advisory Group members to make comments.

No comments from Advisory Group members.

4. Comments and Announcements by Plan Staff.

No comments from Plan Staff.

Consent Agenda Items:

Chairperson Beleutz opened the floor for approval of the Consent Agenda

Action: All consent items approved.

Regular Agenda Items:

Population Needs Assessment (PNA)

Informational: Deborah Pineda, Quality and Health Programs Manager provided an overview of the findings of the Alliance PNA. The purpose of the PNA is to improve health outcomes for members and to ensure the Alliance is meeting member needs. The PNA identifies unique needs of targeted populations, such as seniors and persons with disabilities, children and youth with special health care needs, members with limited English proficiency, and other member groups from diverse cultural and ethnic backgrounds. Based on member data, a member survey, and member committee feedback, key findings of the PNA include the following:

- 75-80% of members reported satisfaction with timely access to care.
- 98% of members were satisfied with the help they received from the Alliance in coordinating care within the last 12 months (PNA survey).
- Members are interested in receiving more information or help from the Alliance regarding afterhours care. Such as, who to call at night when sick?

- Spanish speaking members would like more information and help regarding how to access medical care and Alliance services.
- The use of behavioral health services in 2019 was higher in Santa Cruz County, over Merced and Monterey.
- California Children’s Services (CCS) members under the age of 10 access preventative services at a higher rate than non-CCS members.
- Asian and Hispanic members showed higher rates of accessing care and services over other ethnicity groups.
- Male adolescents, ages 12 – 19 were less likely to have a PCP visit than their female peers.
- Health literacy, or understanding, is a newly identified need. Members would like:
 - Information in a simple, understandable format (e.g. infographic).
 - Opportunities for Alliance benefits to be explained in-person.
 - To better understand terms commonly used, such as “Primary Care Provider; PCP” and “coordination”.

Member Outreach During a Natural Disaster

Hilary Gillette – Walsh, RN, Quality and Population Health Manager presented about the Alliance’s outreach response to recent public emergencies, such as the drinking water crisis in Merced County, wildfire events throughout all counties, and the ongoing COVID pandemic. The goals of Alliance outreach to members during such events is to educate and connect members to needed emergency resources, and inform members that they can safely return to provider visits and resume care. Since April, 2020 the Alliance has reached out to 77,518 members.

Pharmacy Benefit Transition

Dana Marcos, Member Services Director presented about the Medi-Cal Rx Pharmacy Carve-out. Medi-Cal Rx was initially planned to transition on January 1, 2021, but this date has now been extended to a new date of April 1, 2021. The Alliance continues to prepare for this transition of Medi-Cal pharmacy benefits to a single, state-wide Fee for Service (FFS) delivery system. Staff is currently executing a robust member outreach plan to ensure Alliance members understand this transition and know how to access services through a new DHCS Pharmacy Benefits Manager (PBM), Magellan. To educate and inform members about Medi-Cal Rx, the DHCS and the Alliance is conducting member outreach in a variety of ways. The DHCS distributed 90-day and 60-day notices to all Medi-Cal members state-wide and the Alliance will issue a 30-day notice to members. In addition, the following Alliance outreach efforts are underway:

- An educational flyer is in development to be shared with providers and community partners to distribute to members.
- A Medi-Cal Rx article will be included in the Alliance Member Newsletter.
- The Alliance member website will be updated with information about the transition to Medi-Cal Rx, including links to the DHCS website and Magellan PBM.
- The Alliance will post social media information on Facebook that directs members to visit a member-oriented information page.

Proposed Dates for 2021 were accepted as listed below:

- Thursday, February 11, 2021
- Thursday, May 13, 2021
- Thursday, August 12, 2021

- Thursday, November 4, 2021** (*Thursday, November 11 is Veterans Day and the Alliance will be closed. Therefore we will meet the 1st Thursday of the month instead of the 2nd Thursday of the month.*)

Meeting adjourned at 10:55 a.m.

Respectfully submitted,

Maura Middleton, Clerk of the Advisory Group/Member Services Administrative Assistant



Physicians Advisory Group

Meeting Minutes

Thursday, September 3, 2020

12:00 - 1:30 p.m.

In Santa Cruz County:

Central California Alliance for Health

1600 Green Hills Road, Suite 101, Scotts Valley, California

In Monterey County:

Central California Alliance for Health

950 East Blanco Road, Suite 101, Salinas, California

In Merced County:

Central California Alliance for Health

530 West 16th Street, Suite B, Merced, California

Group Members Present:

Dr. Jennifer Hastings	Provider Representative
Dr. Scott Prysi	Provider Representative
Dr. Misty Navarro	Provider Representative
Dr. Patrick Clyne	Provider Representative
Dr. Shirley Dickinson	Provider Representative
Dr. Caroline Kennedy	Provider Representative
Dr. Devon Francis	Provider Representative
Dr. Amy McEntee	Provider Representative

Group Members Absent:

Dr. James Rabago	Provider Representative
Dr. Casey Kirkhart	Provider Representative
Dr. Barry Norris	Provider Representative
Dr. Allen Radner	Provider Representative
Dr. Anjani Thakur	Provider Representative
Dr. Chuyen Trieu	Provider Representative
Dr. Kenneth Bird	Provider Representative

Staff Present:

Dr. Dale Bishop	Chief Medical Officer
Dr. Gordon Arakawa	Medical Director
Dr. Maya Heinert	Medical Director
Dr. Dianna Diallo	Medical Director
Ms. Jordan Turetsky	Provider Services Director
Ms. Hilary Gillette-Walch	Clinical Decision Quality Manager
Ms. Michelle Stott	Quality Improvement Director
Ms. Navneet Sachdeva	Pharmacy Director
Ms. Tammy Brass	Utilization Management/CCM Manager
Ms. Lila Chagolla	Regional Operations Director
Mr. Jim Lyons	Provider Relations Manager

Ms. Ronita Margain	Regional Operations Director
Ms. Kristen Presleigh	Quality Improvement Advisor
Ms. Tracy Neves	Clerk of the Advisory Group

Public Representatives Present:

Ms. Becky Shaw	Public Representative
Ms. Vanessa Chavez	Public Representative
Ms. Shelly Barker	HIP Representative

1. Call to Order by Chairperson Dr. Bishop.

Group Chairperson Dr. Dale Bishop called the meeting to order at 12:00 p.m.
Roll call was taken.

No supplements or deletions were made to the agenda.

2. Oral Communications.

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

No members of the public addressed the Group.

Consent Agenda

3. The group reviewed the June 4, 2020 Physicians Advisory Group (PAG) minutes.

Minutes approved as written.

4. **Old Business - Updates**

A. Cares Based Incentives (CBI) Updates

Dr. Bishop reviewed CBI 2020 and 2021 updates. For CBI 2020, due to the public health emergency, DHCS temporarily suspended the requirement for initial health assessments (IHA) to be completed within 120 days of member enrollment. The Alliance recommendation is provider's eligible for this measure (five eligible population members) in the population should receive full points instead of being scored and performance improvement measure for IHA will remain the same.

In May, the American Academy of Pediatrics (AAP) released Guidance on the Necessary Use of Telehealth during the COVID-19 pandemic. Pediatric provider noted that they conducted some telehealth well visits in clinic for ages 5 and under. Another provider noted they only conduct telehealth for those that live far away or for mental health issues. Noted was the difficulty the member population has with telehealth visits. Provider noted protocols for in-office visits include; sterilized rooms, limited family members and use of masks. Monterey County conducts visits on 2 days with 50 % telehealth and 50% in-person.

For Well Child Visits, DHCS encourages providers to:

- Follow the AAP guidance.
- Encourages pediatric providers to discuss with members/parent caregivers the benefits of attending a well-child visit in person, in addition, to services received via telehealth.
- For components of the well-child visit provided in-person that continue a virtual/telephonic service; the provider should only bill for one encounter/visit.

For CBI 2021, there is a pending legislative amendment impact to exploratory measure Lead Screening in Children. The measure includes:

- Case management monitoring system.
- Quarterly reminders to providers on periodic health assessments and oral and written anticipatory guidance.
- Quarterly monitoring on children without a blood lead screening test.
- Identify children under 6 years of age who have missed a required blood lead screening.

In summary, provider's eligible for IHA measure should receive full points instead of being scored, and performance improvement measure for IHA will still be calculated based upon performance. Telehealth visits will be incorporated into CBI well-child visits and a provider portal report will be added that tracks lead screening in children under 6 years of age.

5. **New Business**

A. Resuming Care & Evolving Environment

Dr. Heinert presented outreach efforts. COVID emergency outreach efforts began in April, and outreach occurred in waves with emerging issues. Resuming Care outreach began on July 1st and encouraged members to visit their PCP for well visits and immunizations. In June, there was outreach conducted to Merced members regarding a water shut-off. Additional outreach was conducted to Santa Cruz and Monterey regarding the wildfires and air quality hazards. There was targeted outreach based on risk, some of the criteria included: vulnerable age bands, chronic diseases, respiratory conditions, rural or isolated members, and polypharmacy or denied pharmacy claims.

Community resources depending on member needs included locations for emergency food and supplies and emergency shelter. Almost 13,000 members were contacted by several Alliance departments. The Alliance received positive feedback from members regarding the outreach efforts. Dr. Bishop noted that outreach efforts were conducted in conjunction with Provider Services outreach.

Provider noted the outreach was much appreciated and the Alliance did an outstanding job. Provider also noted she loves working with the Alliance, and the Alliance is a great organization.

B. Health Improvement Partnership Continuing Medical Education (HIP CME)

Shelly Barker gave a presentation on the proposed speakers and topic of the next CME Session. The proposed CME would be an early morning October session and the topic is equity. One proposed speaker is Dr. Marissa Raymond-Flesch, MD, MPH. Dr. Raymond-Flesch is an Assistant Professor in the Philip R. Lee Institute for Health Policy Studies (IHPS) and the Division of Adolescent and Young Adult Medicine within the Department of Pediatrics. Dr.

Raymond-Flesch’s research focuses on access to care for adolescents and young adults with a particular interest in improving reproductive health access for minority and border communities. She is especially interested in using community-based participatory research to bring health care and health education into these underserved communities. Dr. Raymond-Flesch presented at HIPC on “Racism and Xenophobia: Impacts on Youth and the Providers Who Serve Them.”

The proposed agenda below will be further developed to incorporate primary care examples of policies and programs:

- Shifting United States Demographics
- Minority Health Outcomes
- Defining Racism
- Experiences of Racism
- Case Study: Impact of Immigration Policy on Youth
- Racism in Medicine

Another proposed speaker is Dr. Tony Iton, MD, JD, MPH. Dr. Iton is the Senior Vice President for Healthy Communities at The California Endowment. He is also a Lecturer of Health Policy & Management at UC Berkeley’s School of Public Health. In the fall of 2009, Dr. Iton began to oversee the California Endowment’s 10-Year, multimillion-dollar statewide commitment to advance policies and forge partnerships to build healthy communities and a healthy California. Dr. Iton presented at HIP’s Community Forum: “Policy Violence: The Root Cause of Health Inequity.” Presentation argues: Health is political, health is not health care, and health is an investment in the U.S. that is subject to policy violence.

Additional considerations include; Social and Political Determinants of Health, Health Equity and Accountability Act, California Breastfeeding Coalition- Baby Friendly Hospitals Map, and CinnaMoms a breastfeeding support program.

Provider suggested it would be helpful if the CME is recorded for those that are not able to attend on the scheduled day and time. It was noted that all CMEs are recorded.

C. Telehealth Discussion

Dr. Bishop shared new guidance in telehealth services with the Group. The guidelines may remain in place for some time, if not, permanently. The Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) have issued new guidance regarding the provision of telehealth services during the COVID-19 pandemic. In order to support social distancing and ensure the safety of members and providers, Alliance providers must take steps to allow members to obtain health care via telehealth when medically appropriate to do so. Guidelines for telephonic and video visits and billing codes were shared with the Group.

Provider noted they appreciated telehealth is inclusive of telephone as well as video. There was a question regarding behavioral health inclusion of telephone visits with therapists. Jordon Turetsky noted the allowance does extend to behavioral health and information will be posted on the Alliance website. Also noted, there is legislation for changes to be instituted beyond the

state of emergency; and Provider Services is tracking legislative updates. Provider noted telehealth visits have been very important for their patients and conducting visits over the phone helpful. Dr. Bishop noted behavioral health access has improved with telehealth visits.

6. **Open Discussion**

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

No topics for open discussion.

Dr. Bishop thanked the Group for their input and participation.

The meeting adjourned at 1:30 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Group

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



Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, September 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

Robert Dimand, MD

Gary Gray, DO

John Mark, MD

Patrick Clyne, MD

Provider Representative

Provider Representative

Board Representative

Provider Representative

Provider Representative

Committee Members Absent:

Jennie Jet, MD

Amanda Jackson, MD

Karen Dahl, MD

Salem Magarian, MD

Provider Representative

Provider Representative

Provider Representative

Provider Representative

Staff Present:

Dale Bishop, MD

Maya Heinert, MD

Dianna Diallo, MD

Lilia Chagolla

Mary Brusuelas, RN

Michelle Stott, RN

Sarah Sanders

Tammy Brass, RN

Angelique Milhouse

Tracy Neves

Chief Medical Officer

Medical Director

Medical Director

Regional Operations Director

UM & Complex Case Management Director

Quality Improvement & Population Health Director

Grievance and Quality Manager

UM Manager - Prior Authorizations

Provider Relations Liaison

Clerk of the Committee

Hospital Representatives Present:

Sherrie Sager

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 June 18, 2020 meeting were reviewed.

B. Grievance Update

Grievance presentation reviewed.

M/S/A Consent agenda items approved.

4. Old Business

A. COVID-19

Dr. Bishop noted ongoing COVID provisions are continually changing and the Alliance is still adjusting. Dr. Bishop asked the Committee how they are doing and how the telehealth visits are progressing. Stanford provider noted they are conducting telehealth visits with some in-person visits. There are more telehealth visits as families are reluctant to come in for office visits and due to distance from the office. Many of the telehealth visits are from the Monterey and Salinas areas. Providers noted about 40 % of their visits are telehealth. Telehealth is making a big difference for families and saving families from repeat visits.

Another provider noted the majority of his visits are being provided in-office and his office is conducting COVID testing. Patients with fevers are being scheduled for appointments in the afternoon.

It was noted, there are technology issues with families in Monterey. Some families are having difficulty with Wi-Fi or computer technology and, therefore, will come into the office. Provider noted they are working on education and providing access to broadband, notebooks, iPads, and Wi-Fi access. It was also noted the assistance provided with transportation has helped families with in-person visits.

Dr. Bishop noted the county public health office has given direction on testing and calls are happening weekly; this may be helpful for providers. The county will answer questions and emails. Provider noted they are utilizing zoom through My Chart; their office is mostly using zoom and a staff member calls beforehand and follows-up with the member. Only half of telehealth meetings were working initially and now about 95% are successful.

5. New Business

A. CCS Eligibility & Case Management Program

Dr. Bishop noted the Alliance is working to improve identification of CCS eligibility, Tammy Brass, RN, noted her team has been working on identifying CCS eligibility and improving the Case Management program. The team is working to increase referral numbers across all counties and is proactively reaching out to members due to COVID, resuming care, and the wildfires. The outreach and telehealth have had positive results and made things easier and removed barriers for members. The Alliance has received positive feedback from its members. The team continues to work on reporting improvements to capture members early and increase referrals. Work is also being conducted with providers and outside facilities.

Dr. Dianna Diallo introduced herself to Committee members and noted the Alliance team is establishing monthly meetings with the counties to increase referrals, and identify gaps to better support our most fragile members. The Joint Operational Committee (JOC) meetings continue with promotion of referrals to CCS within the WCM. Tammy is working on resources for education, and work is being done in conjunction with Provider Services in obtaining additional paneled providers.

It was discussed that identification of all eligible members is important to ensure that members receive care from special care centers when appropriate. Bishop noted in some cases the county may not have all the information it needs to determine eligibility and the Alliance is working on gaps in communication with the Counties. The Alliance will share progress and data on referrals and eligibility in future WCMCAC meetings.

B. Wildfire Outreach

Dr. Maya Heinert introduced herself to Committee members. Dr. Heinert noted wildfire outreach to members began in August, and CCS families were an integral part of the Alliance’s outreach efforts. The following Health Services data was shared with the Committee regarding all recent outreach efforts:

Health Services Member Outreach Campaigns 2020			
Outreach Campaign Name	Start Date	End Date	Member Count
COVID-19	4/1/2020	On-going	8,866
Water Shut-off: Dos Palos	6/25/2020	6/26/2020	99
COVID-19 Resuming Care	7/1/2020	On-going	3,659
Wildfires: SC & Monterey Counties Tier 1-2	8/20/2020	On-going	508
Air Quality Hazards: Merced County Tier 3	8/28/2020		
			Total 13,132

Targeted outreach was conducted based on risk and to all CCS members particularly children with respiratory conditions. Some of the criteria for targeted outreach included: vulnerable age bands: > 65 years, 0-3 years, chronic diseases, respiratory conditions, cardiovascular conditions, evacuation warning or order, rural or isolated members, no care received within last 6 months, pregnant or post-partum and polypharmacy or denied pharmacy claims.

Many resources were offered to members including emergency information, assistance for prescription medications, mental health hotline, including abusive situation and suicide hotlines, community resources, basic information/education, housing alternatives, case management connection, public health assistance, testing locations, and closed provider alternatives. Much assistance was needed with prescription medications; pharmacies were unaware they could prescribe prescriptions for 5 days in emergency situations.

Tammy noted initial outreach calls began with families that had been evacuated due to the wildfires. Many families needed assistance with housing, one family of five was living in a car for several days and their child was on insulin, the Alliance was able to assist the family with hotel housing and medication.

Another family was going to be displaced due to shelter overcrowding and COVID exposure, and another family had a child with leukemia and that was preparing to evacuate. The care team was able to assist the families with needed resources and continuity of care. Most recently in Merced county, the care team was assisting members in areas with poor air quality, high risks members were identified which included CCS members. A younger member had a lung transplant and the Alliance was able to connect the member with resources. The member outreach was well received. Alliance employees were also affected by the wildfires but remained committed to assisting members. Mary Brusuelas, RN, noted case management has increased with the addition of the pediatric team and relationships were already established with members which made a big difference. WCMCAC members noted they appreciated the Alliance's outreach to CCS families.

6. Open Discussion

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

No further discussion.

The meeting adjourned at 1:00 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Committee

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



Whole Child Model Family Advisory Committee

Meeting Minutes

Monday, November 9, 2020 1:30pm – 3:00pm

Pursuant to Governor Newsom’s Executive Order N-29-20 to minimize the spread of COVID-19, this was a teleconference meeting.

Committee Attendance

Committee Members

Present

Kim Pierce	Monterey County Local Consumer Advocate
Elsa Quezada	Monterey County - Board Member
Cindy Guzman	Merced County – CCS WCM Family Member
Janna Espinoza	Chair and Monterey County - CCS WCM Family Member
Deadra Cline	Santa Cruz County - CCS WCM Family Member
Susan Skotzke	Santa Cruz County - CCS WCM Family Member

Committee Members

Absent

Ashley Gregory	Santa Cruz County - CCS WCM Family Member
Manuel Mejia	Monterey County - CCS WCM Family Member
Frances Wong	Monterey County - CCS WCM Family Member
Christine Betts	Monterey County - Local Consumer Advocate
Vicky Gomez	Merced County – CCS WCM Family Member
Irma Espinoza	Merced County – CCS WCM Family Member
Cristal Vera	Merced County – CCS WCM Family Member
Cynthia Rico	Merced County – CCS WCM Family Member

Support Staff Present

Dana Marcos	Member Services Director
Maura Middleton	Administrative Assistant/Clerk of the Committee
Hilary Gillette-Walsh, RN	Quality and Population Health Manager

Meeting Administration: 1:30pm

LEADER: Janna Espinoza, WCMFAC Chair | TIME: 10 minutes | MEMBER PREP: None

Agenda Topic	Meeting Process
<p>TITLE: Call to Order</p> <p>PURPOSE:</p> <ul style="list-style-type: none"> ● Committee introductions and roll call. ● Supplements and deletions to the agenda. ● WCMFAC Mission Statement: <ul style="list-style-type: none"> – Serve as an advocate for other families – Commit to improving care and services – Collaborate in problem solving – Contribute to the success of the program 	<p>Meeting called to order at 1:30 by Janna Espinoza.</p> <p>No supplements or deletions to the agenda.</p>
<p>TITLE: Oral Communications.</p> <p>PURPOSE:</p> <ul style="list-style-type: none"> ● Members of the public may address the Committee on items not listed on today’s agenda, which are within the jurisdiction of the Committee. Presentations must not exceed five minutes in length and individuals may speak only once during Oral Communications. ● If any member of the public wishes to address the Committee on any item that is listed on today’s agenda, they may do so after the item is reviewed or discussed by the committee. Comments regarding agenda items must not exceed five minutes. 	<p>Janna Espinoza and Elsa Quezada read the mission statement.</p>

Consent Agenda: 1:40pm

LEADER: Janna Espinoza | TIME: 5 minutes | MEMBER PREP: Review packet consent items

Agenda Topic		Meeting Process
TITLE:	Accept FAC meeting minutes of September 14, 2020	Minutes were approved
PURPOSE:	<ul style="list-style-type: none"> Reference materials: Minutes as above. 	

Regular Agenda: 1:45pm

TIME: 65 minutes | MEMBER PREP: Review packet for follow-up and action items

Agenda Topic		Meeting Process
TITLE:	Election of Chair and Vice Chair	-Elsa Quezada was nominated as Vice Chair.
TIME:	1:45 – 2:00pm	
PURPOSE:	Action: FAC to nominate and vote on a Vice Chairperson for the 2020-2021 calendar years.	
LEADER:	Janna Espinoza, Committee Chair opened the floor for nominations and volunteers for the position of Vice Chair for the 2020-2021 calendar years. Elsa Quezada volunteered to be Vice Chair. Cindy Guzman nominated Ms. Quezada and Deardra Cline seconded. The Committee voted and all were in favor. Elsa accepted the role of Vice Chairperson.	
TITLE:	Review WCMFAC 2020 Roadmap	– FAC discuss 2020 topics to continue in 2021.
TIME:	1:55 – 2:05pm	
PURPOSE:	<i>Information and Feedback:</i> Dana Marcos reviewed the 2020 FAC roadmap and asked the Committee to provide feedback for items to carry over into 2021. The topic of communication and outreach to members was raised as an item to focus on, including social media outreach. The Committee recommended that the Alliance continue to work with families and develop more patient centered, individual, care plans. The Committee also emphasized that focusing on the wellbeing of family and caregivers is essential. Dana Marcos, Member Services Director	
TITLE:	Population Needs Assessment (PNA)	– Informational.
TIME:	2:05 – 2:25pm	
PURPOSE:	<i>Informational:</i>	
LEADER:	Hilary Gillette – Walsh, RN, Quality and Population Health Manager, gave an overview of the findings of the recent PNA. The primary goal of the PNA is to improve the health outcomes for members and to ensure the health plan meets member needs. The PNA addresses the unique needs of populations such as Seniors and Persons with Disabilities (SPD), Children and Youth with special health care needs, members with limited English proficiency, and other member groups from diverse cultural and ethnic backgrounds. Key findings from the 2019 member data and survey, are as follows: <ul style="list-style-type: none"> – 75-80% of members reported satisfaction with timely access to care. – 98% of members were satisfied with the help they received from the Alliance in coordinating care within the last 12 months (PNA survey). – Members are interested in receiving more information or help from the Alliance regarding afterhours care. Such as, who to call at night when sick? – Spanish speaking members would like more information and help regarding how to access medical care and Alliance services. – The use of behavioral health services in 2019 was higher in Santa Cruz County, over Merced and Monterey. – California Children’s Services (CCS) members under the age of 10 access preventative services at a higher rate than non-CCS members. – Asian and Hispanic members showed higher rates of accessing care and services over other ethnicity groups. – Male adolescents, ages 12 – 19 were less likely to have a PCP visit than their female peers. – Health literacy, or understanding, is a newly identified need. Members would like: <ul style="list-style-type: none"> o Information in a simple, understandable format (e.g. infographic). o Opportunities for Alliance benefits to be explained in-person. o To better understand terms commonly used, such as “Primary Care Provider; PCP” and “coordination”. 	
TITLE:	Member Outreach During A Natural Disaster	– Informational.
TIME:	2:25 – 2:45pm	
PURPOSE:	<i>Informational:</i>	

LEADER:	Hilary Gillette – Walsh, RN, Quality and Population Health Manager presented about the Alliance’s outreach response to recent public emergencies, such as the drinking water crisis in Merced County, wildfire events throughout all counties, and the ongoing COVID pandemic. The goals of Alliance outreach to members during such events is to educate and connect members to needed emergency resources, and inform members that they can safely return to provider visits and resume care. Since April, 2020 the Alliance has reached out to 77,518 members.	
TITLE:	CCS Advisory Group Representative Update	
TIME:	2:30 – 2:45pm	
PURPOSE:	<i>Informational and Feedback:</i>	
LEADER:	Susan Skotzke shared that the State-wide CCS Advisory Group continues to focus discussions on the upcoming Medi-Cal Rx Pharmacy Carve-out. Medi-Cal Rx was initially planned to transition on January 1, 2021, but this date has now been extended to a new date of April 1, 2021. An online portal has been developed that will allow members to access their authorizations and prescriptions in real time. Ms. Skotzke provided the following website information should FAC members wish to view the portal. https://medi-calrx.dhcs.ca.gov/home/	

Review Future Agenda and Action Items: 2:55pm
LEADER: Dana Marcos | TIME: 5 minutes

What is Requested/Proposed?	Who Will Take Action?	When Will an Update be Provided?
Community Partner Feedback	FAC Community Partners	January, 2021
2021 FAC Roadmap	Dana Marcos, Member Services Director	January, 2021

Adjourn (End) Meeting
LEADER: Janna Espinoza

The next meeting of the FAC after this November 9th meeting:

- Whole Child Model Family Advisory Committee
Monday, January 11, 2021 from 1:30 to 3:00 p.m.

Meeting was adjourned at 3:03pm.



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Marina Owen, Chief Operating Officer
SUBJECT: 2021 Operating Plan

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

Summary. The 2021 Operating Plan organizes and focuses effort at the organizational level on tactics that advance Alliance strategy, adapt Alliance operations or achieve regulatory requirements. The 2021 Plan, published in November 2020 in advance of employee goal-setting, makes organizational objectives and supporting cross functional tactics visible for employees and allows for ongoing monitoring throughout the year. Last year, the Operating Plan proved to be an effective tool to focus action in an evolving year, resulting in 85% of tactics timely completed. This year, the 2021 Operating Plan will continue to serve as a dynamic tool as tactics are initiated, adapted, completed or abandoned. Relevant updates will be provided in the operations section of the monthly executive summary.

Background. The Operations Division leads the annual tactical governance discipline at the Alliance to deploy strategy and execute cross-functional tactics. The Operating Plan was first developed in February 2020 as an approach to coordinate and implement tactics to meet organizational objectives. The Operating Plan was envisioned to organize and consolidate multiple plans relied on by the Alliance (*e.g. strategic tactical plan, operational project portfolio, process improvement portfolio, technology tactics*) into one annual Operating Plan. It now empowers leaders to develop tactics aligned with the organizational direction, allows for monthly monitoring and makes these efforts visible for all Alliance employees.

Operating Plan. In 2021, the Alliance is focused on three priorities: to adapt operations in an evolving environment, improve financial performance, and meet member needs. Five objectives, including aligning medical cost with revenue and preparing for delivery system transformation, serve as a Bridge Plan between the 2018-2020 three-year strategic plan and the next multi-year strategy. The Alliance identified 38 tactics aligned with these organizational objectives. Among these efforts, 16 tactics (42%) improve or develop an operational capability (*e.g. Develop a Population Health Strategy*), 13 tactics (34%) achieve a regulatory, contractual or board requirement (*e.g. Implement Medi-Cal Rx Carve-out*) and 9 (24%) execute or maintain and operational capability (*e.g. Complete Telecom System Upgrade*). The Alliance is now executing these projects, process improvement efforts or department projects through the operational tactical governance process.

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

Attachments.

1. Alliance 2021 Operating Plan

Alliance 2021 Operating Plan
 Last Updated January 22, 2021 | Version 1.8 - Clean



Vision Healthy people. Healthy communities.

Mission Accessible, quality health care guided by local innovation

Values Improvement Integrity Collaboration Equity

Priorities

- Ensure Sustainable Financial Performance**
Proactively bring medical costs in line with revenue rate and utilization trends and improve administrative efficiency, while maintaining access to and quality of care for members
- Meet Member Health Needs**
Develop population health capabilities and prioritize efforts to advance transformation in the Medi-Cal delivery system
- Adapt Operations in an Evolving Environment**
Deliver on core responsibilities and ensure member access to essential care during the pandemic, other environmental disruptions and corresponding recovery efforts

Objectives

Breakthrough

- Align Medical Cost with Revenue
- Improve Administrative Efficiency
- Prepare for Delivery System Transformation

Ongoing

- Achieve regulatory, contractual and core program requirements
- Maintain health plan operations

Success Metrics

- MLR target (as identified in 2021 budget).
- \$15M reduction in hospital medical costs from '18-'19 baseline
- Optimized low maturity, high cost processes with admin costs in line with peer averages
- Admin expenses within admin budget approved by Board
- In development
- Expected Performance in Compliance-related Dashboard Metrics
- Passing results on internal audits conducted in 2021
- Organizational processes achieving expected performance targets as measured by organizational dashboard

Tactics

- Define End-to-End Revenue Capture Process
- Execute Authorization Process Redesign Roadmap
- Develop Population Health Strategy
- Assess Managed Care Efficiency Adjustments
- Enhance Administrative Expense Controls
- Develop a Community Care Coordination Framework
- Execute Year 1 Hospital Renegotiation Strategy
- Pilot Recuperative Care
- Develop a Comprehensive Equity Initiative

Engage & Support Members

- Develop Provider and Member Noticing Communications Repository
- Develop a Comprehensive Community Response Plan (BC&DRP)

Manage & Improve Care

- Operationalize Post-Discharge Meal Delivery
- Implement Rx Carve Out
- Develop and Execute PNA Education Campaigns
- Enhance the Quality Improvement System
- Facilitate Pandemic Care Task Force

Manage Compliance Programs

- Achieve Knox Keene Licensure
- Review DHCS Medi-Cal Managed Care Contract Language Revision

Pay Providers

- Execute Prop 56 Value Based True Up Payments
- Implement Specialist Payment Change
- Improve Change Provider Payment Process Maturity (ORA)
- Outsource Medical FFS and Capitation Payment Fulfillment
- Outsource Check Run for Supplemental Payments
- Complete APR-DRG Hospital Payment Readiness

Advance Operational Effectiveness

- Guide Execution of ORA Recommendations
- Establish an Organizational Development Function (ORA)

Provide Administrative Services, Acquire & Retain Employees

- Develop Post-Pandemic Workplace Design

Manage Technology

- Redesign Website
- Complete Telecom System Upgrade
- Conduct HIPAA Security Assessments and Remediations
- Upgrade HSP to Version 10.7.x
- Reimplement Essette to Version 4.x
- Ensure Technology Failover Capabilities (BC&DRP)
- Implement ClaimsXten

Manage Data

- Meet CMS Interoperability Rule Requirements
- Meet DHCS Data Improvement Requirements
- Implement Provider Data Repository & User Interface

Develop & Maintain the Provider Network

- Implement Open Access Policy Revisions

Organizational Tactics (Grouped By Organizational Process)

Legend

- Status Change
- Tactic related to improving or developing an operational capability
- Tactic related to a regulatory, contractual or Board requirement
- Tactic required to execute or maintain an operational capability

ORA = Operational Readiness Assessment | BC&DRP = Business Continuity & Disaster Recovery Plan | PNA = Population Needs Assessment



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Scott Fortner, Chief Administrative Officer
SUBJECT: Alliance Diversity, Equity and Inclusion Initiative Update

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

Summary. In 2020, America experienced several incidents that highlighted disparities in equity across the nation. The coronavirus pandemic demonstrated unequivocally that long-standing systemic health and social inequities have put many racial and ethnic minority groups at increased risk of getting sick and dying from the virus. At the same time, 2020 brought widespread protests and acknowledgment of violence towards and killings of people of color by law enforcement, elevating U.S. issues of racial inequality to the global stage.

Also, in 2020, the Alliance was in the process of engaging staff to re-envision our core values. One of our four new guiding principles committed to by Alliance staff is that of Equity. With this value, we will work to eliminate disparity through inclusion and justice. The Alliance is not alone in its commitment to act towards equity. The California Department of Health Care Services (DHCS) also articulated the elimination of health disparities in Medi-Cal as a key priority, committing to increase its efforts to reduce disparities within its organization and long-standing inequities in our health care systems. Many Alliance partners have also recommitted to equity and are acting to yield health equity.

To that end, we are engaging the assistance of external consultants to lead efforts in developing a comprehensive diversity, equity and inclusion (DEI) framework that seeks to eliminate disparities in outcomes for members and promote equity in the Alliance workforce. This work will include assessing current DEI policies, programs, and perceptions via a global assessment, and receiving recommendations from our consultants to further develop our programs, both internally and externally. Our ultimate goal: Achieve health equity and results for Alliance members through a diverse, inclusive and representative workforce.

Focus areas for this work includes:

- Further development of Alliance practices to contribute to the achievement of health equity in results for Alliance members.
- Engagement of affected populations and stakeholders, together with engaging internal leaders overseeing relevant core processes as well as external stakeholders who can provide guidance and insight into the root causes resulting in equity, and advice as to intervention.
- Utilization of data to achieve equity, together with ongoing progress monitoring.

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- Efforts toward continuous improvement and practices to support a system that seeks to yield equity.
- Further development of Alliance recruitment, leadership, and staff development and retention practices in order to yield a diverse, inclusive and representative workforce.

This multi-year project will consist of three phases, with phase one focusing on information gathering and assessment,

Phase two will consist of a series of DEI visioning and action planning guided by the data acquired in phase one. Phase three will consist of implementing the DEI action plan developed in phase two.

An internal steering committee consisting of leaders from across the organization has been formed to guide this work. All Alliance staff will be engaged. The agreement with the DEI consulting firm is expected to be finalized in February, with work on this project starting soon after. Periodic reports will be provided to the Board on key activities and results.

Fiscal Impact. This project was included as part of the 2021 Administrative Budget

Attachments. N/A



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Scott Fortner, Chief Administrative Officer
SUBJECT: 2020 Annual Report: Alliance Owned Properties

Recommendation. Staff recommend the Board accept the Alliance Owned Properties 2020 Annual Report.

Summary. This annual report is prepared pursuant to the Board's 2018 direction for such annual reporting and provides an overview of current real estate holdings, status and a summary of annual financial performance of Alliance properties and any key issues impacting Alliance owned properties.

Background. The Alliance Board approved the first purchase of Alliance owned real property in 2004; an office space for Alliance operations in Santa Cruz County. Since that time, the Board has approved additional office building purchases in Monterey and Merced Counties, as well as the 2016 purchase of Capitola Manor, a skilled nursing facility in Santa Cruz County. The Board reviews criteria for the purchase of property, including investment opportunity of an appreciable asset, the reliability of fixed office space costs, the retention of the investments made on leasehold improvements, the receipt of steady income from tenants and the potential, as needed, to support expanded Alliance operations. The CEO is authorized to execute, acknowledge and deliver leases and related documents relating to real property owned by the Alliance. The Board reviews and accepts a report regarding Alliance owned properties annually.

Summary of Property Holdings and Status.

Business Offices: The Alliance currently owns five buildings with a total of 280,859 square feet of office space, of which 68% is occupied by the Alliance. Eighteen percent of Alliance owned office space is currently leased to tenants, with an additional 14% of space currently listed for lease at fair market value. A summary by county is shared below. Leases with current tenants range from short-term 2-3 years to long-term through the year 2028.

The CEO signed three new agreements in 2020 to lease office space at 1800 Green Hills Road, all new tenants each with multi-year lease agreements. Two existing tenants of 1800 Green Hills Road vacated the building. As of December 41%, of office space in the 1800 building was leased, with the target occupancy being 85%, which excludes the 6,842 square feet of space reserved for Alliance storage and conference/meeting rooms.

Skilled Nursing Facility: Capitola Manor, the Alliance owned skilled nursing facility located in Capitola, CA, totals 26,004 square feet and is currently under renovation. A lease and a provider contract for a skilled nursing facility operator have been executed. At the May 2020 Board Meeting the Board approved a staff request for a revised budget of \$11.7M. A

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contract has been executed with a new general contractor to finish the construction. The project is anticipated to be complete in early 2022.

Summary of Property Occupancy by County

Santa Cruz County

Scotts Valley

- 1600 Green Hills Road: 100% Occupied by the Alliance
- 1700 Green Hills Road: 100% Occupied by the Alliance
- 1800 Green Hills Road: 41% Leased to Tenants, 59% Vacant with 10% currently reserved for Alliance operations.

Capitola

- 1098 38th Avenue (Capitola Manor): Under Renovation

Monterey County

Salinas

- 950 East Blanco Road, Salinas: 100% Occupied
 - 56% Occupied by the Alliance
 - 44% Leased to Tenants

Merced County

Merced

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

Fiscal Performance and Impact.

2020 Financial Performance:

Annual Gross Rental Income: \$1,080,362.90

Annual Rental Expenses: \$600,948.25

Annual Net Revenue: \$479,414.65

Alliance Office Reopening. Since the start of the pandemic, an internal taskforce has been responsible for managing Alliance offices while ensuring the health and safety of essential onsite workers, and also for making recommendations with regard to the safe reopening of Alliance offices. Presently, the Alliance is scheduled to reopen the physical office spaces no sooner than July 1, 2021. The taskforce will continue to monitor the situation and make an updated recommendation for reopening as indicated by the environment. Staff are also currently evaluating the appropriate use of Alliance-owned facilities in a post-pandemic environment and will return to the Board in late 2021 with any recommendations regarding utilization of Alliance properties.

Attachments. N/A



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Scott Fortner, Chief Administrative Officer
SUBJECT: 2020 Business Continuity and Disaster Recovery Program Update

Recommendation. Staff recommend the Board accept the 2020 Business Continuity and Disaster Recovery Program (BCDRP) report.

Background. The purpose of the program is to manage emergency incidents having potential to impact services, put the organization at risk, etc. When an incident occurs, the Emergency Management team (EMT) convene to engage, assess and manage the incident. The BC/DRP is designed to ensure ongoing operations and the Alliance's recovery of critical functions, minimize loss, maintain compliance with regulatory and contractual requirements, and support employee safety.

Summary of 2020 Activity

COVID-19 Pandemic. As a result of the onset of the Covid-19 virus and pandemic, the Alliance implemented an incident management team and transitioned Alliance staff to a full-time remote work model in compliance with public health officer guidelines. Staff have been in a temporary fulltime remote environment since March 16, 2020. Functions that required onsite presence remained at the Scotts Valley office with COVID-19 safety protocols in place.

Throughout the pandemic, Alliance staff, including the CEO, EMT Chief, CMO, COO, Medical Directors, Regional Operations Directors, Facilities Director, Government Relations Director, and the BC/DRP Program Manager, among others, have participated in various local community forums and meetings sponsored by the Santa Cruz County Health Coalition and the Departments of Public Health for Santa Cruz, Monterey and Merced Counties. Staff have also (virtually) attended meetings hosted by the State of California and the CDC,

Alliance measures implemented in response to the pandemic included:

- Developed and implemented daily performance metrics and surveys to assess and respond to any impacts to business operations
- Assessed critical functions and developed process modifications where needed
- Prioritized working with providers to implement telehealth services
- Ensured that displaced members had access to prescription medications and refills
- Implemented COVID-19 safety protocols to all facilities
- Developed a webpage for staff, members and providers with COVID-19 resources
- Implemented online tools for staff to stay engaged and connected while working remotely

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Local Wildfires. In August of 2020, Alliance service area counties were impacted by numerous area wildfires, resulting in a code red (highest level) emergency for the Alliance. BC/DRP teams assessed their areas of responsibility and operations, and implemented emergency protocols to assist members, providers, and staff. Twenty percent of the Alliance workforce was impacted by mandatory evacuations.

During the wildfires, in order to stay abreast of the situation EMT leadership (virtually) attended daily press briefings for all three Alliance service area counties, hosted by local authorities. Staff were also in daily contact with the State of California to provide updates and reports on access and services for members impacted by the emergency.

Alliance measures implemented in response to the wildfires included:

- Outreach to displaced members
- Ensuring displaced members had access to medications and early refills, and knowledge of local pharmacies that remained open
- Contacted pharmacies to ensure emergency override program were in place
- Contacted providers impacted or potentially impacted by evacuation warnings to identify site closures, alternate locations and access to care procedures
- Engaged counties for local emergency responses, provided and complied community resources for members and providers
- Contacted displaced employees to ensure safety and provide support
- Implemented measures to ensure providers were paid timely

Public Safety Power Shutoff (PSPS) Events. The Alliance was subject to various potential and actual PSPS events in 2020. While a small percentage of staff were impacted by area PSPS events, the Alliance onsite generator at the main office building in Scotts Valley ensured continuation of Alliance services due to losses of power.

Emergency Management Team Meetings and Exercises Conducted:

- Emergency Management Team meetings were held quarterly in 2020.
- All sections conducted assessments and "lessons learned" exercises for the purposes of updating existing BC/DRP policies and procedures with regard to documenting responses to events in 2020.

Focus Areas for 2021:

- The EMT will assess the 2021 Tactical Plan and operational impacts for resumption of business activities to support the accomplishment of current and future organizational priorities.
- All Departments will update BC/DRP policies and procedures to capture new processes implanted resulting from 2020 incidents.
- The technology team will continue work toward a updating the company's critical systems redundancy plan, coupled with developing a "warm site" in our Merced office location.

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

Attachments. N/A



DATE: February 24, 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. From mid-December until the last week of January, rates of new COVID-19 positive cases, hospitalization and deaths increased in all three Alliance counties. The Counties remained in the purple (COVID widespread) category from mid-December and Intensive Care Unit (ICU) capacity locally has been between 0 and 15%. Since the last week of January, the situation has improved with lower rates of new cases, decreases in hospitalizations and increases in ICU capacity. Starting in late December, vaccine became available, although in limited amounts, and new viral variants have threatened progress.

As of February 5, 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	27,018	359	10.7%
Monterey	40,463	288	19%
Santa Cruz	13,790	155	10%

As now represented in in the California Healthy Places equity index, low-income, Black, Latino, Pacific Islander, and essential workers continue to be disproportionately impacted by COVID-19 in terms of higher rates of infection, hospitalizations, and deaths. Localized disparities in infection rates continue among the Latino population since COVID activity has become more widespread. Alliance staff continue to engage in regular calls and collaborative work with county leaders and local organizations to reach out to Latino populations in high-risk areas with COVID safety messaging.

With vaccine availability and the initial rollout of vaccine phases and tiers by the California Department of Public Health in late December, most recent efforts have related to supporting local efforts to communicate with providers about receiving vaccine and with members to message COVID vaccine safety. As of mid-January, all three counties had completed vaccination of 1/3-1/2 of the healthcare workers and most members in Skilled Nursing and Long-Term Care facilities in Phase 1A. As counties begin to vaccinate the Phase 1B population, the Alliance role in vaccinations has been to facilitate communication with providers, act as a liaison to and support efforts of the public health departments including member and provider communications. In Merced County, the Alliance has assisted with setting up provider and pharmacy "hubs" where vaccines can be delivered and administered. In Santa Cruz County, the Alliance has facilitated member and provider

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communication as directed and has offered support for mass vaccination clinics. In Monterey County, efforts have included targeted member messaging and provider communication.

Community Coordination. The Alliance is collaborating with county leaders, community-based organizations, and providers to inform and educate members on the value of prevention efforts. Follow-up meetings have taken place after convenings between the Alliance and the County Public Health department's leadership December through February. The Public Health departments identified three priority areas where further collaboration was desired, health promotion activities, COVID-19 testing, and vaccine safety and availability. The Alliance has continued outreach calls to members and providers to reinforce these health promotion messages, including preventive health education, COVID-19 testing, and resuming health care services. Outreach to members over 75 years old in high-risk communities to assist with recognizing vaccine availability and navigation to vaccine sites began the first week of February. Alliance leadership has been promoting equitable distribution of vaccine through discussions with the County Public Health Departments and the Local Health Plans of California.

The Alliance is participating in current work within the local planning groups such as the Monterey County-CHWs and COVID Outreach Project. The intention is to include members of the community in the planning and delivery of the work. As the need and resources vary in each county, coordination is critical to assure members and community partners are provided accurate and valuable information available in their community.

On December 15, 2020 the Alliance held a follow-up Central Valley Home and Community Based Services convening in Merced County to discuss ways to leverage existing community resources to support older adults and people with disabilities at risk of COVID-19, as well as to discuss ways to provide care after hospitalization for COVID-19 infection safely in non-congregate living settings.

Pandemic Care Task Force. The Resuming Care Task Force transitioned in January 2021 to the Pandemic Care Task Force, focusing cross-functional work on meeting the objectives of supporting the public health goal of achieving herd immunity in the Alliance service areas and informing Alliance members and providers through clear and vetted communications as put forth by Public Health.

Pandemic Care Communications. In support of the Pandemic Care Task Force, the team delivered several broad communications tactics in late January with evergreen messages about the COVID-19 vaccine and reminders on the importance of masking and social distancing. The deliverables include tactics in three languages, including a vaccine [website landing page](#), a [short video](#), a [flyer](#) and [social media](#) posts. Staff will continue to develop communications as emerging messages are identified through the Pandemic Care Task Force committees.

Pandemic Care: Member Outreach Calls. The Alliance launched the COVID II Automated Health Notification campaign for pediatric members 7 to <18 years of age to provide information on available resources during the COVID-19 pandemic surge. Due to regulatory requirements, the campaign only included members with landlines. A total of 14,482

members with English, Spanish or Hmong as their preferred language were outreached between December 29, 2020 and January 8, 2021. The success rate of the campaign was 14% or 1,995 members received the message through a live voice or voicemail.

Workspace Reentry Taskforce. On November 3, 2020, the Workspace Reentry Taskforce made a revised recommendation to the Chiefs 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: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Kathleen McCarthy, Strategic Development Director
SUBJECT: DHCS Behavioral Health Integration Incentive Program

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

Summary. This report provides an update on the Alliance's implementation of the Department of Health Care Services (DHCS) Behavioral Health Integration (BHI) Incentive Program. The Alliance Board was first informed of the program in the February 2020 Board Meeting Packet.

Background. DHCS launched the BHI Incentive Program in November 2019 to provide funding to support behavioral health integration in Medi-Cal managed care plan (MCP) networks. The objectives of the BHI Incentive Program are to incentivize MCPs to improve physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in MCP networks. The BHI Incentive Program provides funding for providers to implement one or more of six BHI project types, which range in focus from basic behavioral health integration, screening and treatment for special populations, and follow up after emergency department visits or hospitalization.

MCPs are responsible for overseeing and administering the application process and project awards on behalf of DHCS for providers within their service area. MCPs are also responsible for monitoring project milestones and measures, and reporting to DHCS on the progress of approved projects. MCPs work directly with approved providers and DHCS to achieve the goals and objectives of the BHI Incentive Program.

Discussion. Applications for the BHI Incentive Program were due January 21, 2020. The Alliance received 14 BHI project applications from 11 organizations in Santa Cruz and Monterey counties. No applications were received from providers in Merced County. Alliance staff reviewed applications received according to the Project Selection Criteria published by DHCS and submitted approval recommendations to DHCS on February 18, 2020 for eight of the 14 applications.

The BHI Incentive Program was anticipated to begin in April 2020 but experienced a significant delay in implementation due to funding uncertainties during the 2020-21 State budget approval process and the impact of the COVID-19 public health emergency on DHCS resources. The original timeline for the program was a 33-month period from April 2020 through December 2022. The new timeline is 24 months from January 2021 through December 2022.

DHCS provided the Alliance with a determination letter on November 2, 2020 that approved the eight recommended projects and total amount of eligible funding for each project, in addition to the \$200,000 operational maintenance fee payable to the Alliance.

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Subsequently, one of the projects withdrew participation and the Alliance worked with DHCS to reallocate that project's funding among the seven active projects. DHCS reissued a determination letter on December 15, 2020 with the revised project funding amounts for the seven awarded projects, as follows:

County	Organization	Project Option	Eligible Funding
Monterey	Door to Hope	Maternal Access to Mental Health and Substance Use Disorder Screening and Treatment	\$519,481
Monterey	Monterey County Health Dept. - Clinic Services	Maternal Access to Mental Health and Substance Use Disorder Screening and Treatment	\$1,826,083
Monterey	Doctors on Duty Medical Group	Basic Behavioral Health Integration	\$584,013
Santa Cruz	Doctors on Duty Medical Group	Basic Behavioral Health Integration	\$389,342
Santa Cruz	Salud Para La Gente	Maternal Access to Mental Health and Substance Use Disorder Screening and Treatment	\$297,521
Santa Cruz	Salud Para La Gente	Improving Follow-Up after Emergency Department Visit for Behavioral Health Diagnosis	\$200,020
Santa Cruz	Santa Cruz Community Health Centers	Maternal Access to Mental Health and Substance Use Disorder Screening and Treatment	\$481,439
Total			\$4,297,899

Alliance staff notified project applicants of the approvals and, under the guidance of DHCS, worked with awarded providers to revise their project milestones and budgets according to the new two-year program timeline. The Alliance executed a Memorandum of Understanding with each awarded provider and issued the first payment by the DHCS deadline of December 31, 2020. Providers began their project implementation January 1, 2021.

Next Steps. The Alliance will be responsible for collecting performance measure data, monitoring awardee project milestones, and making payments. The Alliance will make payments to awardees based on quarterly reporting of completed milestones.

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

Attachments. N/A



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Kathleen McCarthy, Strategic Development Director
SUBJECT: Medi-Cal Capacity Grant Program 2020 Impact Report

Recommendation. Staff recommend the Board accept the report on Medi-Cal Capacity Grant Program (MCGP) impact in 2020.

Summary. This report highlights the MCGP's impact in 2020 and highlights strategic investments made to improve the health and wellbeing of the members we serve. Accompanying this Board report is the abbreviated *Medi-Cal Capacity Grant Program 2020 Impact Report* publication that will be shared with the community and posted on the Alliance's website. This report also includes an update on the Alliance's progress towards the MCGP outcomes of improved access and health outcomes, and the attached *MCGP Performance Dashboard* includes overall MCGP and program-specific metrics as of 12/31/20.

Background. The Alliance established the MCGP in July 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act (ACA). Through investment of a portion of the Alliance fund balance, the MCGP offers grants to local organizations to support efforts to increase the availability, quality and access of health care and supportive services for Medi-Cal members in Merced, Monterey, and Santa Cruz counties. The initial focus of the MCGP was on increasing capacity of the medical delivery system to achieve the Alliance's mission of accessible, quality health care. Starting in 2017, the focus of the MCGP expanded to include more upstream interventions to improve the health and quality of life of Alliance Medi-Cal members. Over the past five and a half years, the MCGP has developed a portfolio of 12 funding opportunities to address health care access and quality, social determinants of health, and to prepare the Alliance for system transformation under the Department of Health Care Services' CalAIM initiative. Since 2015, the Alliance Board has approved 548 grants for a total of \$114.2M.

Discussion. In 2020, the Alliance awarded 56 grants totaling \$13.4M to community partners to advance goals in four focus areas: 1) Provider Capacity; 2) Behavioral Health and Substance Use Disorder Services; 3) High Utilizer Support Resources; and 4) Promoting Healthy Eating and Active Living. Across all grant programs, Alliance grantee partners demonstrated resilience and flexibility, remaining committed to meeting grant outcomes and member needs in a year marked by uncertainty due to the coronavirus pandemic.

2020 Program Highlights.

- The COVID-19 Response Fund was created in April 2020 to meet the urgent challenges facing Alliance members during the pandemic. The Alliance awarded three grants to local food banks to provide immediate relief to residents facing pandemic-related hunger. In addition, the Alliance awarded 22 grants to other

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community organizations to meet members' evolving needs, including funding for diapers and formula, meal delivery for high-risk members, and personal protective equipment and sanitizing supplies for providers of food and homeless services.

- *The Provider Recruitment Program* now has limited funds in all three counties and is narrowing awards to recruitment of high need specialty providers. One example of this was the identified need for Rheumatology in Santa Cruz County and a resulting Provider Recruitment grant award in October 2020 for a mid-level Rheumatology provider. Through 2020 the Alliance has remained responsive to challenges rising from the COVID-19 pandemic. Providers in our network have faced hardships, including decreased patient volume and alterations in staffing and recruitment plans. The MCGP has remained flexible, working with providers to extend the recruitment periods of grants and allowing replacement of providers recruited under grants when necessary due to circumstances related to COVID-19.
- *The Capital Program* marked five projects complete in 2020. In early 2020, MidPen Housing opened Moon Gate Plaza's doors to residents in Salinas' Chinatown district and Community Housing Improvement Systems and Planning Association, Inc. (CHISPA) welcomed residents to Junsay Oaks in Marina. The two permanent supportive housing projects allocated a total of 40 units for medically complex Alliance Medi-Cal members who receive supportive services through Monterey County Health Department's Whole Person Care Program. Specialty access was increased in Monterey County with the expansion of the Taylor Farms Family Health & Wellness Center which will offer podiatry, general surgery, orthopedic surgery, OB/GYN, women's health, behavioral health and diabetes education. Soledad Community Health Care District also opened their new Women's Health Care Center in November 2020. The center will feature a full-time OB-GYN and ultrasound services, a state-of-the-art mammogram machine and classrooms for perinatal and nutritional education. Behavioral health access increased in Santa Cruz County with the opening of Pajaro Valley Prevention and Student Assistance's new Mayou Family Center where mental health and substance abuse treatment services are provided to students and their families. Some active Capital Program grants experienced timeline delays due to COVID-19, but all projects are moving forward. The Capital Program was retired in January 2020 with the last awards for new projects awarded in April 2020. Grantees with existing Capital Planning grants may still apply for Implementation grants.
- *The Infrastructure Program* had two projects reach completion in 2020, both of which had a positive impact on health-related service delivery in the COVID-19 environment. Hospice of Santa Cruz County's telehealth implementation proved to be even more beneficial than anticipated by supporting remote patient care during the pandemic. Although they did face delays in staff training due to the shelter in place orders, they reported that 47% of palliative care patients were enrolled in telehealth within three months of implementation. The Monterey County Public Health Laboratory completed their Apollo-MediTech Interface project with Natividad Medical Center which has contributed to greater efficiency in ordering COVID-19 tests and reduced the turnaround time in reporting results to typically under 48 hours. The Infrastructure Program was retired in January 2020 with the last awards for new projects awarded in April 2020.

- *The Post-Discharge Meal Delivery Pilot* was approved in September 2020 by the Alliance Board to transition from a two-year grant-funded pilot to an Alliance-only benefit, beginning January 2021. Following the same program criteria used in the pilot, the ongoing benefit will provide eligible Medi-Cal members who are identified as high-risk for readmission to the hospital with home delivery of 14 ready-made, medically tailored nutritious meals each week for 12 weeks post-hospital discharge. The pilot, launched in November 2018, proved to be an effective intervention to keep members healthy, thereby reducing hospital admissions and lowering health care costs. In 2020, there were 220 members enrolled and over 38,000 meals delivered.
- *The Partners for Healthy Food Access Program* grantees were challenged in 2020 to reconsider ways to continue safe food distribution to clients during the COVID-19 pandemic. Some continued services with new safety protocols, while others pivoted to contactless food delivery, online nutrition education classes and social media outreach. Two projects were started in 2020 and there were 11 other active projects that will continue in 2021 to improve food security in the Medi-Cal population. In November 2020, Food What?! in Santa Cruz County was the first Food Access grantee to complete their two-year project, in which 99 Medi-Cal youth, their families, and 40 patients at Salud Para La Gente obtained access to fresh produce and deepened their relationship with healthy food in ways that improved their diet. The COVID-19 crisis prevented both the farm stand at Salud Para La Gente and the farm-based, youth program to proceed successfully in 2020 as it had in 2019. However, the youth program was transformed to include online nutrition workshops, farm and culinary tutorials, individualized support sessions, connection to community resources, and direct distribution of fresh, healthy food to youth and their families. The farm stand partnership between Food What?! and Salud Para La Gente is anticipated to be resumed once operations can return to normal.
- *The Intensive Case Management (ICM) Program* reached its final year of the three-year pilot in 2020. Throughout the year, seven primary care clinics provided case management services to 128 members with complex health and social needs. The last year provided an opportunity to test programmatic refinements to the clinic-based case management model and provide clinics with one-on-one technical assistance. Due to the pandemic, the pilot pivoted from quarterly in-person professional development trainings for case management staff to monthly webinars. Clinic staff were faced with challenges in conducting case management and care coordination as most interactions became telephonic which made it difficult to build rapport with members. The pilot evaluation, completed in 2020, found that the ICM Program did not achieve the intended goals of reducing inpatient and emergency department utilization and lowering health care costs. As a result, the Alliance Board made the decision to retire the pilot effective December 31, 2020. There is an opportunity for the Alliance to implement a new case management model in the future through the implementation of Enhanced Care Management as part of the DHCS CalAIM Initiative.
- *The Technical Assistance Program* added one grant in 2020 with an award to California State University Monterey Bay to develop curriculum for nursing, physician assistant and social work students on maternal-infant mental health, and to build knowledge and skills of students in field placements and their supervisors to engage in maternal mental health diagnosis and treatment. The project includes a three-part

webinar series: *A Community-Based Response to Maternal Mental Health Needs and Family Well-Being in the time of COVID*. The December 4, 2020 webinar had 170 participants. The Technical Assistance Program was retired in January 2020 with the last awards for new projects awarded in April 2020.

Measuring Impact of the MCGP. The Alliance measures the impact of the MCGP using a theory of change model. The MCGP Theory of Change, developed in 2016 and attached to this report, shows how our strategies (i.e. funding opportunities) connect to the outcomes (short-term, medium-term and long-term) we seek to achieve through our grantmaking and other Alliance strategies. The Theory of Change is a useful model for evaluation, providing a framework that allows us to know what to evaluate and when.

Grant program staff regularly monitor the short-term outcomes of each program, such as members served, providers recruited and capital projects completed, and this data is reported on the *MCGP Performance Dashboard*. In addition, staff monitor several indicators to measure progress towards the medium-term outcomes. Medium-term outcomes are influenced by the short-term outcomes and indicate if we are moving the needle toward positive change. Medium-term outcomes are impacted by other internal and external influences and are not solely the result of the grant program.

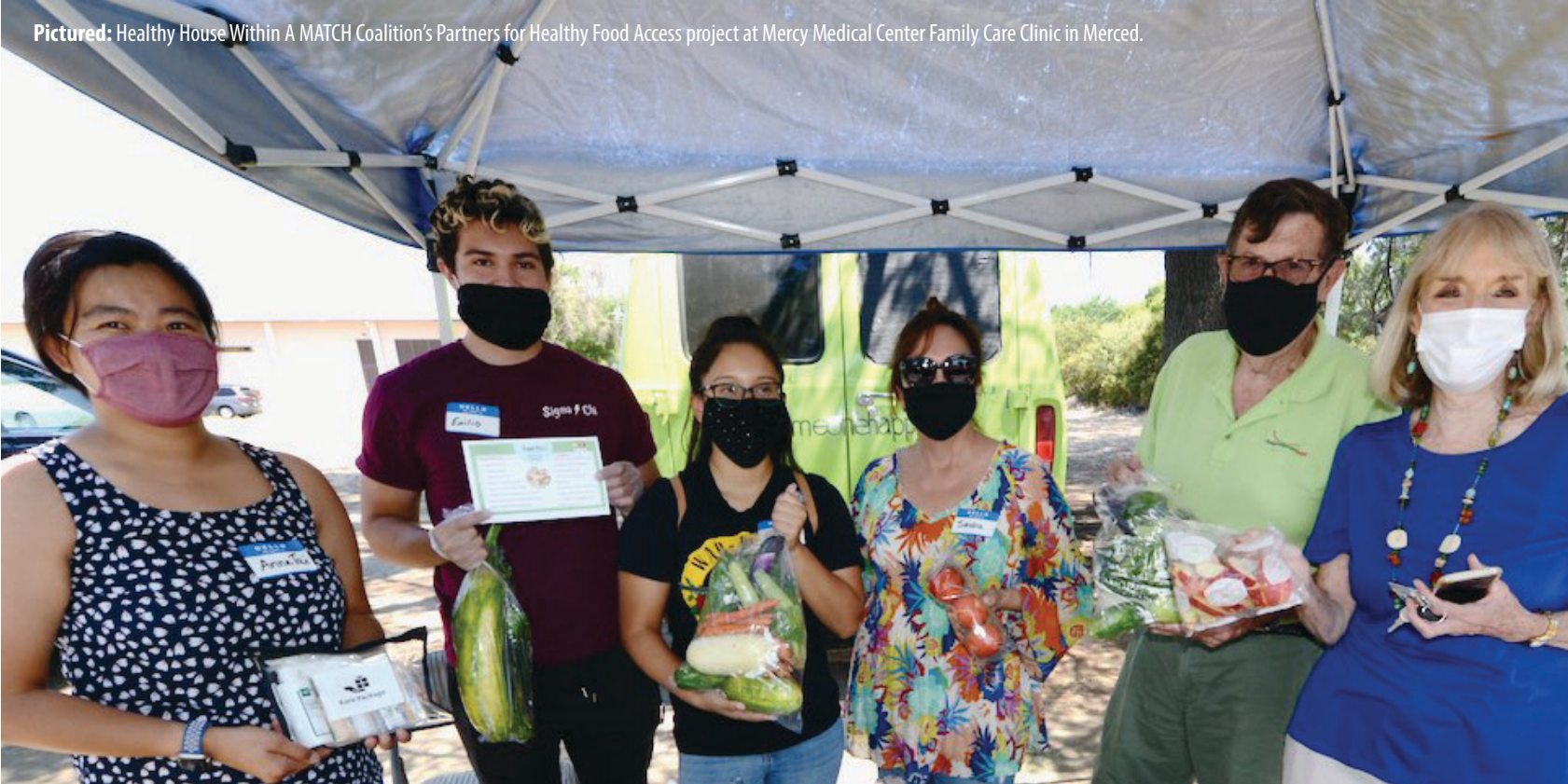
Since the launch of the MCGP in 2015, access-related indicators have improved. While there has been some improvement in indicators used to measure well-coordinated care and reduction in preventable illness, this is still an area for additional focus. Over the past five years, investments made through the MCGP have resulted in improved access and quality of care for Alliance Medi-Cal members. For additional detail, please find *Medium-Term Outcomes* attached to this report.

Evolving the MCGP. In 2020, the Alliance established a new vision: Healthy people. Healthy communities. The MCGP remains a valuable tool to support the advancement of the Alliance's vision and mission. The Alliance will continue to develop the grant program and strategically invest in local partnerships to improve the health and wellbeing of our members and the communities we serve. In 2021, staff will assess how the current MCGP framework and funding priorities are meeting the needs of providers and members. The information gathered during the Alliance's next strategic planning process, occurring in 2021, will provide the opportunity to better understand current unmet and emerging Medi-Cal needs. It will also provide insight on potential adjustments needed to the original MCGP framework (i.e., focus areas, one-time grants, spend down). Staff will return to the Board in 2021 with recommendations for how to evolve the program to increase the impact of the Alliance's funding and further improve the health of Alliance members.

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

Attachments

1. Medi-Cal Capacity Grant Program 2020 Impact Report (publication)
2. Medi-Cal Capacity Grant Program Theory of Change and Medium-Term Outcomes
3. Medi-Cal Capacity Grant Program Performance Dashboard



MEDI-CAL CAPACITY GRANT PROGRAM

2020 Impact Report

About the Medi-Cal Capacity Grant Program

Central California Alliance for Health's Medi-Cal Capacity Grant Program (MCGP) provides grants to health care and community-based organizations to increase the availability, quality and access of health care and supportive services for Medi-Cal members in Merced, Monterey and Santa Cruz counties. The Alliance invests to advance goals in four priority focus areas:

1. Provider Capacity
2. Behavioral Health and Substance Use Disorder Services
3. High Utilizer Support Resources
4. Healthy Eating and Active Living

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A MESSAGE

FROM OUR CEO



First 5 of Santa Cruz County and Santa Cruz Community Health Centers team up for diaper and formula distribution for families in need as a result of COVID-19.

The Central California Alliance for Health (the Alliance) established a new vision in 2020: Healthy people. Healthy communities. This challenging year underscored there was no better time to declare what the Alliance works to achieve for our members and communities. This report highlights the MCGP's significant impact areas in 2020.

In 2020, the MCGP provided immediate relief during the coronavirus pandemic by establishing the COVID-19 Response Fund, while continuing the Alliance's long-term investments in access to care and member wellness. The MCGP focuses on the critical impact of social determinants of health, including access to food and housing. The pandemic increased the urgency for funding in these areas. A large portion of the COVID-19 Response Fund was awarded to the three county food banks in our service area to provide immediate relief to the surge of residents facing pandemic-related hunger.



Alliance grantee partners showed incredible resilience and commitment to our shared vision of healthy people, healthy communities in a very challenging year. I am confident that the Alliance investments provide a critical foundation for achieving our vision and supporting accessible, quality health care and local innovation for years to come.

*Stephanie
Sonnenshine*

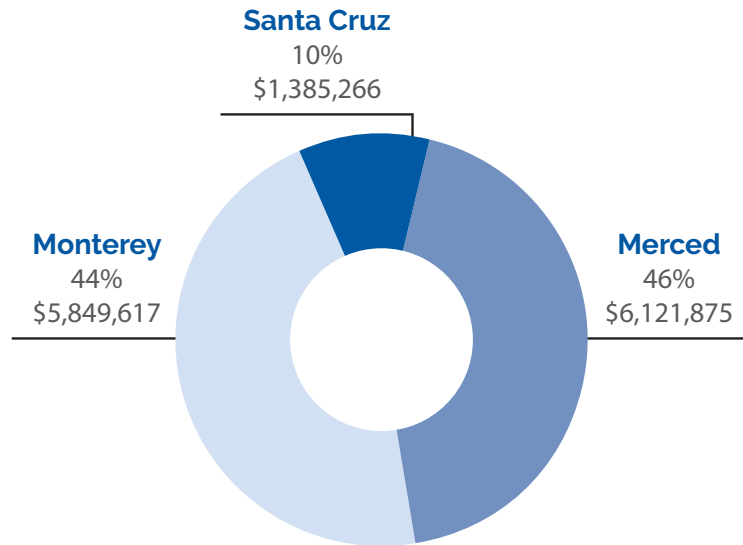


The Boys and Girls Clubs of Monterey County provided over 700 meal bags and 700 produce boxes weekly to families at low-income apartment complexes.

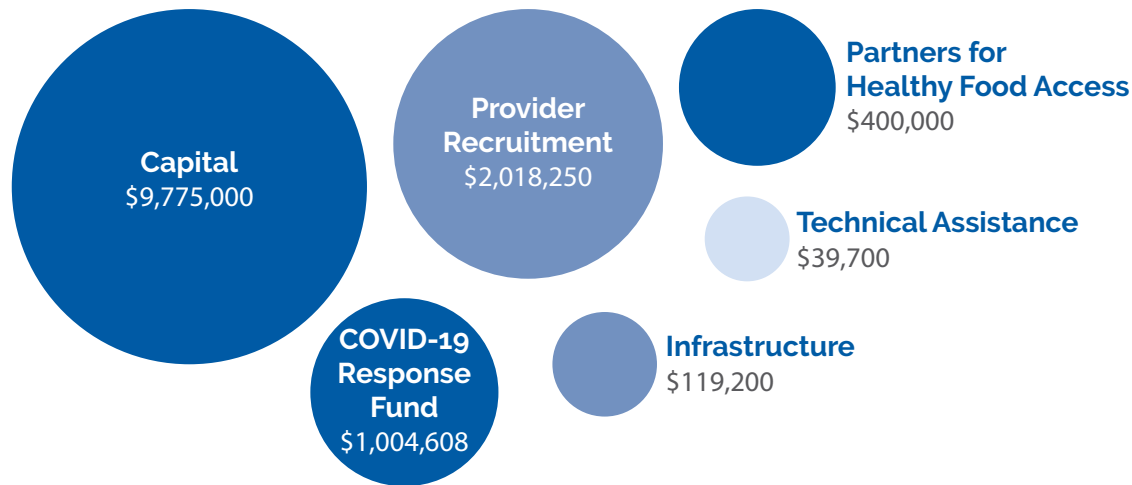
COVID-19 Response Fund

The COVID-19 Response Fund was created in April 2020 to meet the urgent challenges facing Alliance members during the pandemic. In addition to the \$600,000 awarded to local food banks, \$400,000 was awarded to local entities to meet members' evolving needs, including funding for diapers and formula, meal delivery for high-risk members, and personal protective equipment and sanitizing supplies for providers of food and homeless services.

2020 GRANT AWARDS



Total Awarded by County



Total Awarded by Program

\$13.4M
Awarded

56
Grants
Awarded

225,000
Alliance Members
Impacted

Since 2015, the Alliance has awarded **548** grants totaling **\$114,170,837** to **137** organizations in the Alliance's service area.

HOUSING

AND HEALTH



Junsay Oaks supportive housing complex in Marina.

Moon Gate Plaza in Salinas and **Junsay Oaks in Marina** were completed in 2020 and welcomed new residents. Both housing developments allocated 20 units each for medically complex Alliance members who receive supportive services through Monterey County Health Department's Whole Person Care Program. Residents receive on-site support from case managers with their health and personal goals, with the ultimate aim of improved health and a high quality of life. Meanwhile, construction of the County of Merced's Navigation Center is underway. The center will provide a variety of services to individuals experiencing homelessness, including low-barrier transitional housing and housing navigation services to assist participants in securing a permanent residence.

“I have suffered from depression for a long time. I would have probably taken drastic measures if I remained homeless; Junsay Oaks has saved my life and I have better health, too. I also suffer from chronic pain, but I can get a handle on it with housing and access to resources to manage the pain.”

– Alliance member and Junsay Oaks resident



Increasing local specialty care means Medi-Cal members **don't need to travel far to access critical services.**

Expanding Specialty Care Access

The MCGP supported expanded access to specialty care for Alliance members in 2020. Taylor Farms Family Health & Wellness Center in Gonzales opened its new specialty clinic, which provides services including podiatry, general surgery, OB/GYN, behavioral health and diabetes education in south Monterey County. Behavioral health access for youth also expanded with the new Pajaro Valley Prevention & Student Assistance's facility in Watsonville. Members receiving palliative care with Hospice of Santa Cruz County can now access services remotely through telehealth.

Reducing Food Insecurity

The COVID-19 pandemic amplified the urgency to respond to food insecurity across the Alliance's service area. MCGP grantees were able to provide fresh and healthy food to members through the Partners for Healthy Food Access and COVID-19 Response Fund grant programs. COVID-19 challenged these grantees to reconsider ways to continue safe food distribution to clients. Some continued services with new safety protocols, while others pivoted to contactless food delivery, online nutrition education classes and social media outreach.

In addition, the Post-Discharge Meal Delivery (PDMD) pilot proved to be an effective intervention to keep members healthy. The PDMD pilot provided eligible members with 14 ready-made, medically tailored nutritious meals each week for 12 weeks, post-hospital discharge, thereby reducing hospital admissions and lowering health care costs. The Alliance Board approved the transition of the PDMD pilot to an Alliance-only benefit starting 2021. Eligible members have a diagnosis of diabetes, congestive heart failure and/or chronic obstructive pulmonary disorder and are identified as high-risk for hospital readmission.



Clockwise from top left: Esperanza Farms CSA boxes; Food, What?! fresh produce delivery; Everyone's Harvest Alisal Farmers' Market; Teen Kitchen Project "Delivery Angel"



For more information about the Medi-Cal Capacity Grant Program, please visit <http://www.ccah-alliance.org/grantprogram.html>.



About the Alliance

Central California Alliance for Health (the Alliance) is a regional Medi-Cal managed care health plan, established in 1996 to improve access to health care for over 350,000 members in Santa Cruz, Monterey and Merced counties.

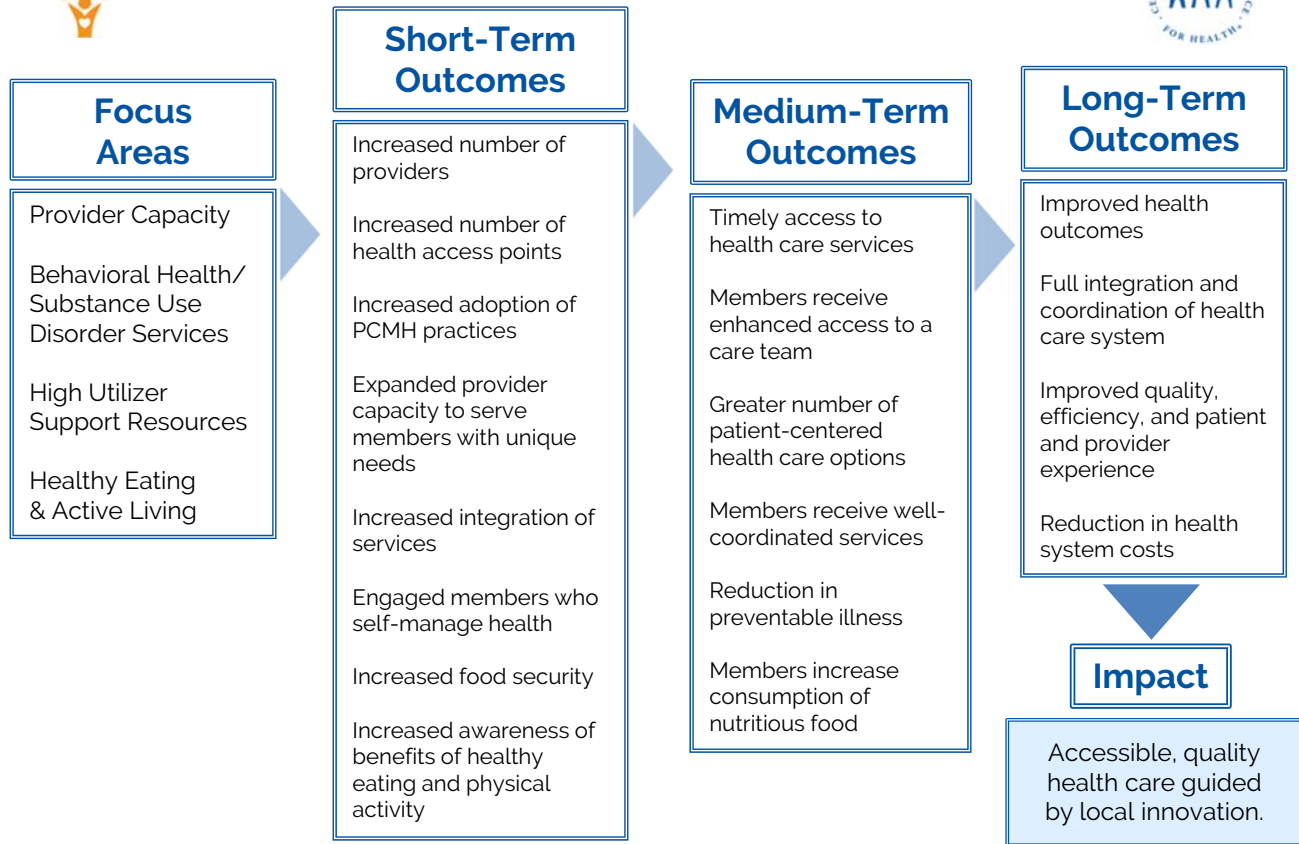


For more information about the **Medi-Cal Capacity Grant Program**, please visit

<http://www.ccah-alliance.org/grantprogram.html>.



MCGP THEORY OF CHANGE



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MCGP Medium-Term Outcomes



Medium-Term Indicators	2015	2016	2017	2018	2019	2020	Progress
Avoidable emergency department visits.	19.10%	17.92%	17.86%	16.19%	15.45%	Data not yet available	●
Availability of a third next available appointment within 10 business days for primary care.	40%	45%	32%	55%	11%*		---
Availability of a third next available appointment within 15 business days for specialty care providers.	38%	47%	45%	48%	19%*		---
Percentage of members (adults) that indicate they are usually or always able to get care quickly.	75.00%	No Survey Conducted	76.70%	73.70%	76.30%	80.30%	●
Percentage of members (child) that indicate they are usually or always able to get care quickly.	76.40%	No Survey Conducted	81.60%	82.4%	80.90%	86.80%	●
Percentage of 30-day readmissions.	13.96%	14.50%	13.49%	14.56%	14.53%	Data not yet available	●
Percentage of ambulatory care sensitive admissions.	11.05%	11.17%	10.09%	8.89%	11.21%		●
Behavioral health utilization rate (mild to moderate).	3.11%	3.70%	4.32%	4.68%	5.42%		●
Provider satisfaction with number of specialists in the Alliance's network.	28.4%	36.4%	36.90%	37.70%	41.80%		●

*2019 data showed a marked decline in contrast to other health plan measurements of access to care, all of which improved in 2019 compared to previous years. Indicator of progress will be updated when 2020 data is available.



Medi-Cal Capacity Grant Program

PERFORMANCE DASHBOARD

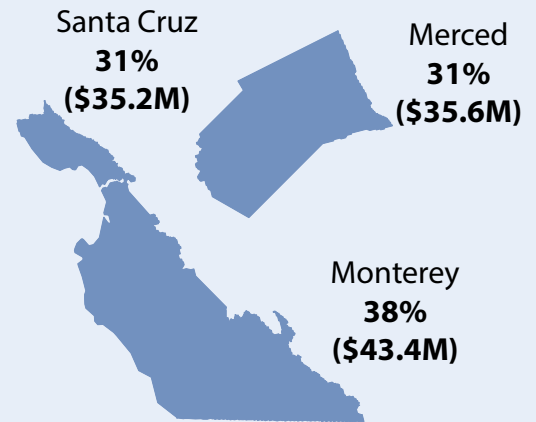
October 2015 through December 2020



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).

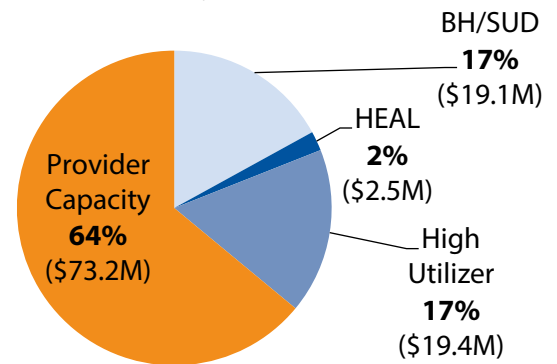
Total Awarded:
\$114.2M



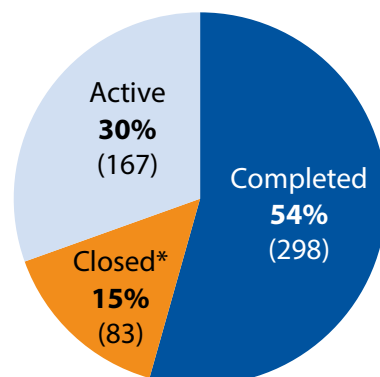
Number of Organizations Awarded:

137

Awards by Focus Area

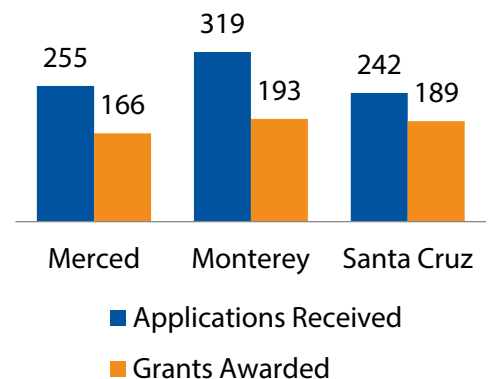


Award Status



* Withdrawn by grantee/terminated.

Total Grants Awarded: 548



HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Oct. 2015 through Dec. 2020 | Page 1

SCMMMMCC Meeting Packet | February 24, 2021 | Page 10G-12

Provider Recruitment Program

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

184 new providers hired to date.

81% retention of new recruits.

21 recruited primary care physicians specialize in Pediatrics.

59% increase in primary care sites open to accepting new members.

Type Recruited	Merced		Monterey		Santa Cruz		Total	% of Total
	Physician	Non-Physician	Physician	Non-Physician	Physician	Non-Physician		
Primary Care	25	18	16	17	12	6	94	51%
Specialty	5	3	25	2	10	3	48	26%
Allied		5				2	7	4%
Behavioral Health	1	1	3		9	9	23	13%
Dental	3				3		6	3%
Other				3		3	6	3%
Total Recruited	34	27	44	22	34	23	184	100%
	33% of total		36% of total		31% of total			

Specialties Recruited



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.

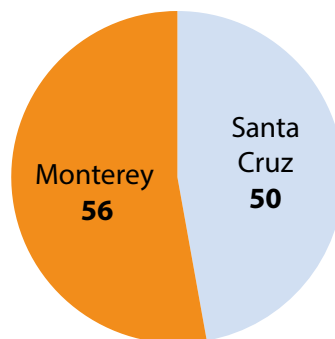
77% of Technical Assistance projects completed to date (10/12).

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

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 01/01/2018 and was retired on 12/31/20.

Members Enrolled: 106



7 of 10 sites participated in third and final year of the pilot.

6 FTE case managers provided ICM services at clinics.

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.



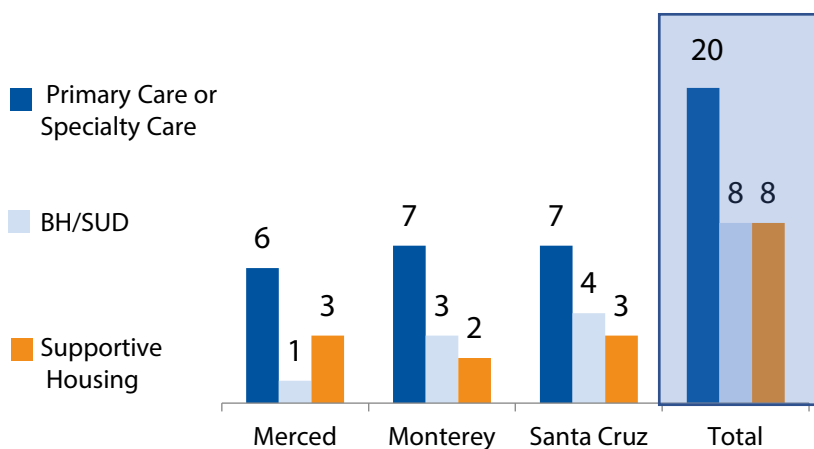
- **33** Physician Assistant graduates annually (starting 2020).
- Master of Science - Physician Assistant Program, CSU Monterey Bay.
- Serves Monterey and Santa Cruz counties.
- **30** Family Nurse Practitioner graduates annually (starting 2019).
- Master of Nursing - Family Nurse Practitioner Program, CSU Stanislaus.
- Serves Merced County.

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 areas. Capital grants are also available for projects that expand access to Medi-Cal services through transitional or permanent supportive housing for the Alliance’s most medically fragile Medi-Cal members.

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

36 Capital Projects



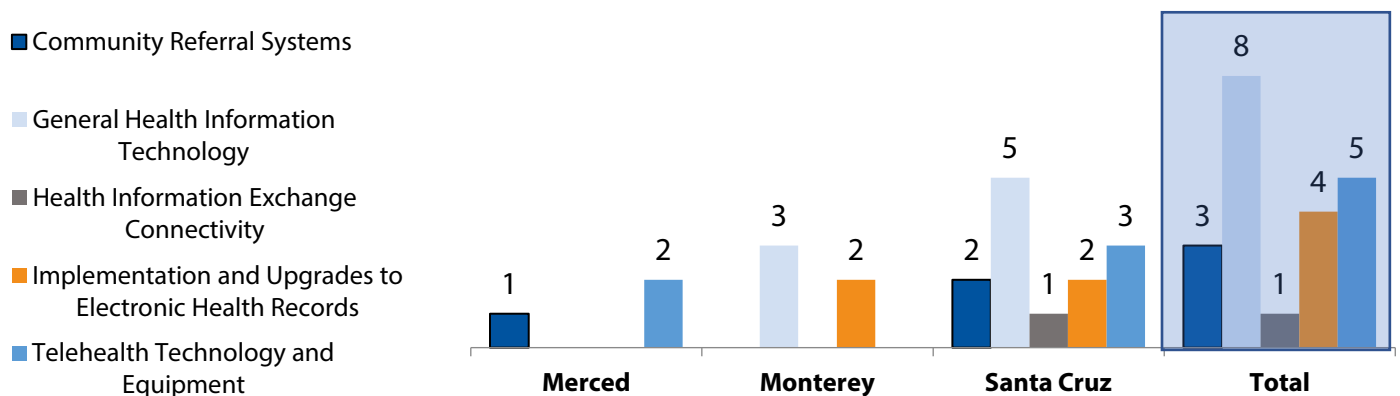
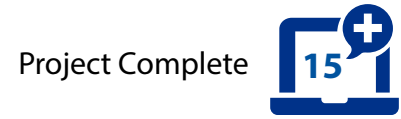
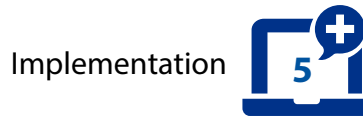
180K Medi-Cal members anticipated to be served by new and expanded facilities.

Infrastructure Program

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

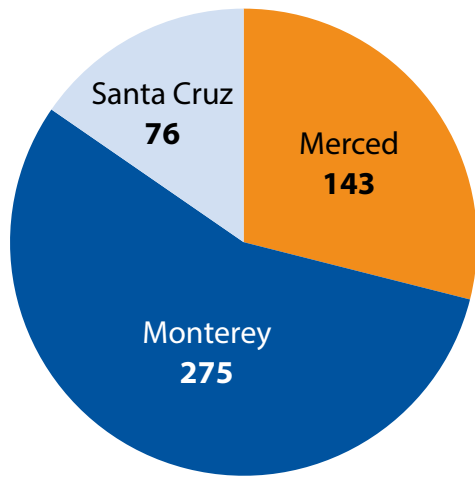
* Applicants may apply for both planning and implementation grants for one project.

21 Infrastructure Projects

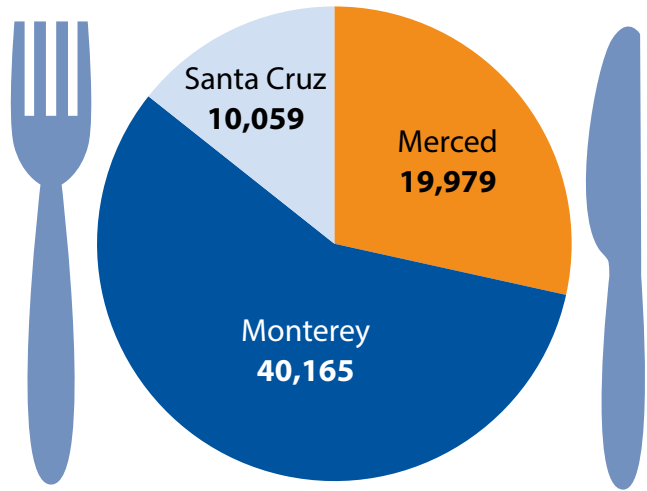


Post-Discharge Meal Delivery Pilot

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 11/01/2018. The Alliance Board approved the transition of the successful pilot to an Alliance-only Medi-Cal benefit, effective 1/1/21.



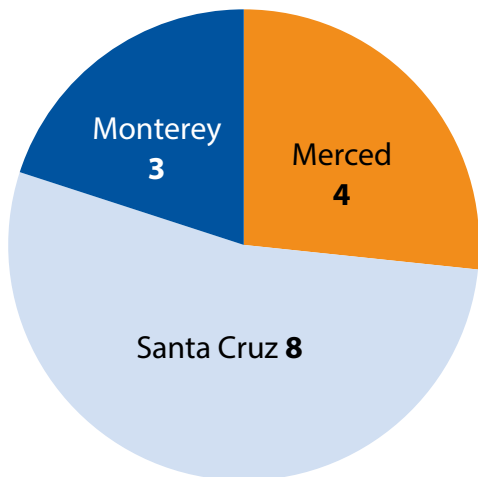
Members Enrolled: 494
55% completed 12-week program.



Meals Delivered: 70,203

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: 15

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

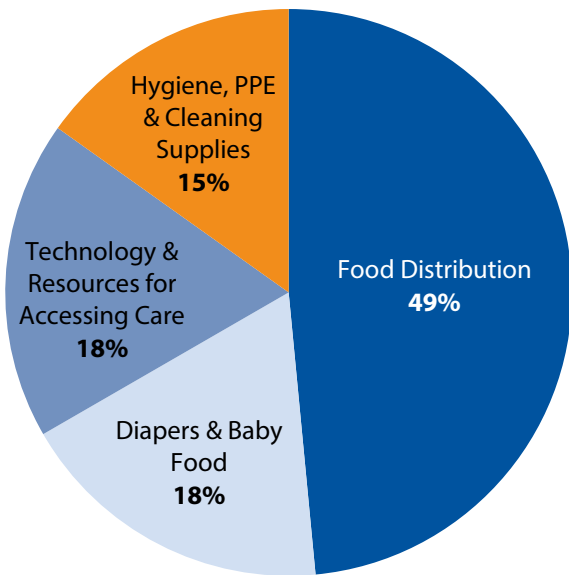
Knowledge & Skill Building

- Nutrition/Health Classes
- Community Gardening
- Cooking Classes

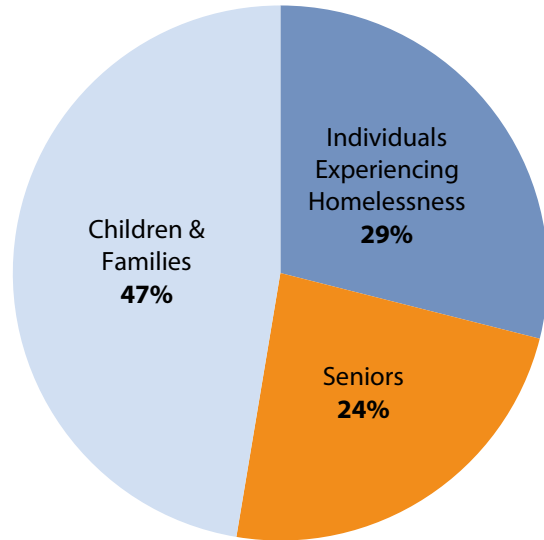
COVID-19 Response Fund

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

Funding Categories



Population Served



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



Retired Programs

Equipment Program

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

Practice Coaching Program

23 grants totaling \$619K awarded to practices committed to adoption of the Patient Centered Medical Home (PCMH) model of care. Program was retired as of October 2017.



DATE: February 24, 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 December 9, 2020

Recommendation. Staff recommend the Board accept the decisions from the December 9, 2020 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:
 - 27 Physician Providers (MD, DO, DPM)
 - 13 Non-Physician Medical Practitioners
 - 2 Allied Providers
 - 5 Organizations

- Recredentialed Providers:
 - 70 Physician Providers (MD, DO, DPM)
 - 31 Non-Physician Medical Practitioners
 - 6 Allied Providers
 - 11 Organizations

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

Attachments. N/A



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Michelle N. Stott, Quality Improvement and Population Health Director
SUBJECT: Quality and Performance Improvement Workplan – Q3 2020

Recommendation: Staff recommend the Board approve the Q3 2020 Quality Improvement (QI) Workplan.

Summary: This informational report provides pertinent highlights, trends, and activities from the Q3 2020 QI workplan.

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

The 2020 QI workplan was developed to align with the Alliance Strategic Plan of Member Wellness, Access to Care, and Promotion of Value. This is accomplished through the following initiatives: 1) Department of Healthcare Services (DHCS) required Performance Improvement Projects (PIPs): Childhood Immunizations and Adolescent Well Visits, 2) Member perception of access to care and utilization of healthcare services (i.e. Consumer Assessment of Healthcare Providers and Systems (CAHPS), Initial Health Assessment (IHA), 3) providing support to providers on clinical practices and care delivery through the *Kinetic QI Program*: learning collaboratives and practice transformation education/training, and 4) monitoring operational performance, including facility site review and potential quality issues.

QI Workplan Outcomes and Evaluation. DHCS PIPs: 1) Immunizations: The Alliance remains focused on increasing the HEDIS Childhood Immunization Status (CIS) rates in Merced County from 19.71% to 34.79% for children 2-years of age. At the beginning of 2020, the Alliance partnered with Castle Family Health Center (CFHC) on a PIP to increase their CIS rates from 7.28% to 14.76%. In response to the pandemic, DHCS closed out the PIP on 6/30/20. At the end of this quarter, the CIS rate in Merced county remained the same as baseline at 19.69%. Also, the CIS rate for CFHC remained stable at 12.23% in comparison to the previous quarter.

2) Adolescent Well Care Visits (AWC): The Alliance partnered with Livingston Community Health (LCH) on a PIP to increase the number of adolescent members 12-21 years of age who receive at least one adolescent well care visit with a PCP or OB/GYN practitioner from

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46.43% to 55.98%. In response to the pandemic, LCH could not continue to dedicate resources to the project and DHCS decided to close out on all PIPs on 6/30/20. At the end of this quarter, the AWC rate for LCH using a 12-month rolling methodology and 90-day claims lag was 41.98%, a six-percentage point decrease from the previous quarter.

Given the importance of preventive care services and to minimize further gaps in care from the pandemic, the Alliance will continue with the same topics for the DHCS 2020-2022 PIPs.

Access to Care: The goals for Access to Care are to achieve a 7.5% increase in Initial Health Assessment (IHA) compliance within 120 days of enrollment from 39.26% to 46.76%; achieve a five percentage point increase for the CAHPS member survey composite on "Getting Care Quickly" from 76.7% to 81.7% for adults and from 81.6% to 86.6% for child; achieve a five percentage point annual increase in availability of the third next available appointment within 10 business days for primary care and behavioral health providers from 42% to 47% and within 15 business days for specialty care providers from 55% to 60%; and achieve a 20% decrease in avoidable ED visits to 14.28%.

In response to the pandemic, DHCS temporarily suspended the requirement for the providers to complete the IHA, and the IHA rate decreased by 2.6 percentage points from the previous quarter to 35.93%. We received the 2020 CAHPS member survey results this quarter. There was a 4-percentage point increase to 80.3% for the adult members indicating they are usually or always able to get care quickly. There was a 5.9 percentage point increase to 86.8% for the child members, thus meeting the Alliance 2018-2020 Strategic Plan Outcome goal. There was a sharp decline in the Third Next Available Appointment rate which decreased to 11% compliance for primary care and 19% compliance for specialty care. There was no change in the avoidable ED visits and remained stable at 11.3% to still meet the goal. These are on-going topics at clinic Joint Operating Committee meetings.

Kinetic Quality Improvement: The goal for the Kinetic Quality Improvement program is to facilitate six Learning Collaboratives (two in each county), expand the Practice Coaching program to five additional providers and launch the Practice Transformation Academy in Monterey and Santa Cruz counties. Due to the pandemic, the goal for the Learning Collaboratives was revised to facilitate one virtual Learning Collaborative in 2020 which was conducted this quarter and focused on "Member Access and No-Shows." Although majority of the Practice Coaching projects were put on hold by the providers to focus on the pandemic, the team did meet their goal for the quarter to engage with at least one new provider site and was focused on improving the referral tracking process. Because of the pandemic, it was decided to conduct the Practice Transformation Academy through a virtual setting rather than in-person. The team continued to partner with Training and Development team this quarter to complete the first online training video in Q4.

Operational Performance. The QPIP includes surveillance to maintain and improve the clinical safety of services to members. Two key clinical safety operational functions: Facility Safety Review (FSR) and Potential Quality Improvement (PQI) programs are reported below. The FSR team monitors all network primary care providers to ensure that facilities are safe and accessible, care is evidence-based, and safe for our members. The FSR team's goals are for 100% compliance with operational metrics for 2020. During Q3 of 2020, 23 sites (92%) completed a full site review within 3 years of the last FSR. No Critical Elements were

identified and therefore not needing correction (N/A). Six of the eight clinics that were issued Corrective Action Plans (CAP) were (75%) able to submit a CAP plan within 45 calendar days. All six clinics (100%) requiring a CAP plan verification were completed on time (by 90-days). Issues encountered for site review include COVID-19 and fire evacuation staffing impact delayed a site's FSR and MRR, and ability to submit the CAP within 45 calendar days. Another site encountered a technological security issue prevented one site from being able to open the CAP via email in enough time to complete prior to 45 calendar days. The team continues to refine the remote review process and monitor All Plan Letter (APL) correspondence to ensure compliance with state requirements.

For the Potential Quality Issue (PQI) Program, the team reviewed 100% of the 115-member grievances and accepted additional reports of patient safety concerns from across the Alliance. Examples of a PQI include a member who falls while inpatient, clinics not following up on lab results, inappropriate opioid prescribing that results in injury to the member. Program's aim is to close cases within 60 calendar days of receipt; Q3 performance was 82% (N=98) of PQIs improved over the prior quarter's report of 69% closure on time. Alliance staff and network clinics continue to experience an impact from the pandemic resulting in reduced workforce impacting record retrieval, correspondence and timely resolution of cases.

Conclusion. There were impacts in Q3 2020 quality measure performance as providers continued to prioritize COVID-19 activities and emerging issues, such as wildfires and clinical resources. The QI team continues to engage the providers through virtual means as able, monitoring on-going performance, and coordinating activities to align with organizational and COVID-19 priorities.

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

Attachments. N/A



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Kathleen McCarthy, Strategic Development Director
SUBJECT: Recuperative Care Pilot Application Process Update

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

Summary. This report provides an update on the application review and approval process for the Alliance's Recuperative Care Pilot.

Background. On December 2, 2020, the Alliance Board approved \$5,857,020 of unallocated Medi-Cal Capacity Grant Program (MCGP) funds to establish a Recuperative Care Pilot. The Recuperative Care Pilot will provide funding for short-term housing with medical and social support services for Alliance Medi-Cal members who are experiencing homelessness and recovering from an acute illness or injury. The Recuperative Care Pilot will also fund 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.

On January 8, 2021, the Alliance invited the three organizations currently operating recuperative care facilities in the Alliance service area (one organization per respective county) to apply for Recuperative Care Pilot funding. These organizations include Housing Matters' Santa Cruz Recuperative Care Center in Santa Cruz County, Merced County Rescue Mission's Hope Medical Respite Care in Merced County and Community Homeless Solution's Central Coast Respite Center in Monterey County. Each organization accepted the invitation to apply and submitted grant applications by the due date of January 22, 2021. Each organization also completed a virtual site review between January 13 and 14, 2021, administered jointly by the Alliance Quality Improvement & Population Health Facility Site Review team, and the Strategic Development department.

Staff from the Strategic Development, Community Care Coordination and Utilization Management departments reviewed the grant applications submitted by each organization, as well as the site review findings and related documentation, for adherence to program criteria. Funding recommendations were submitted to Alliance Chief Executive Officer, Stephanie Sonnenshine, which Ms. Sonnenshine approved on January 29, 2021. On February 2, 2021, award notification letters were sent to each facility, notifying them of the Alliance's funding decision.

Discussion. Housing Matters (Santa Cruz County) was approved to receive a Recuperative Care Pilot grant. The Alliance is currently working with Housing Matters to execute a contract to participate in the pilot, with the aim of launching on March 1, 2021.

The Alliance notified Community Homeless Solutions (Monterey County) and Merced County Rescue Mission (Merced County) that the Alliance would like to award a

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Recuperative Care Pilot grant to each respective organization subject to their meeting all program requirements. Before issuing the grant agreements and contracting with these organizations for recuperative care and bridge housing services, there are several critical elements that were identified during the application and site review process that need to be addressed. The grant awards for Community Homeless Solutions (Monterey County) and Merced County Rescue Mission (Merced County) are contingent on these organizations meeting their pre-contract implementation requirements no later than June 1, 2021. Each organization will notify the Alliance when their pre-contract implementation requirements are resolved, and the Alliance will schedule a final virtual site review to verify that each organization is prepared to meet all pilot requirements. All participating organizations will be required to launch by July 1, 2021, and will conclude on the approved pilot end date of February 28, 2023.

The total budget for the two-year Recuperative Care Pilot, as previously approved by the Alliance Board, will not exceed \$5,857,020, with specific county allocations not to exceed \$3,301,380 for Merced County, \$1,001,880 for Monterey County and \$1,553,760 for Santa Cruz County. The total budget will be allocated for recuperative care services and bridge housing in Santa Cruz County. Depending on their pilot start dates, Merced and Monterey Counties will receive prorated grants for the second year of bridge housing. Details about the approved budget are below.

County	Number of Beds Available	Maximum Amount for Recuperative Care Over Two Years (\$140 per diem rate)	Fixed Amount for Bridge Housing Over Two Years (\$450,000 lump sum)	Total Maximum Amount for Recuperative Care & Bridge Housing Combined Over Two Years
Merced County	30-32	\$2,851,380	\$450,000	\$3,301,380
Monterey County	6	\$551,880	\$450,000	\$1,001,880
Santa Cruz County	12	\$1,103,760	\$450,000	\$1,553,760
Total	48-50	\$4,507,020	\$1,350,000	\$5,857,020

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

Attachments. N/A



Biography for Mr. Larry Levitt



Larry Levitt is Executive Vice President for Health Policy, overseeing KFF's policy work on Medicare, Medicaid, the health care marketplace, the Affordable Care Act, women's health, and global health. He previously was Editor-in-Chief of kaisernetwork.org, KFF's online health policy news and information service, and directed KFF's communications and online activities and its Changing Health Care Marketplace Project.

Prior to joining KFF, he served as a Senior Health Policy Advisor to the White House and Department of Health and Human Services, working on the development of President Clinton's Health Security Act and other health policy initiatives. Earlier, he was the Special Assistant for Health Policy with California Insurance Commissioner John Garamendi, a medical economist with Kaiser Permanente, and served in a number of positions in Massachusetts state government.

He holds a bachelors degree in economics from the University of California at Berkeley, and a masters degree in public policy from Harvard University's Kennedy School of Government.



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Stephanie Sonnenshine, Chief Executive Officer
SUBJECT: California Budget Priorities 2021

Recommendation. This report is informational only. There is no recommended action associated with this agenda item.

Summary. On January 8, 2021, Governor Newsom released his budget proposal for the 2021-22 State fiscal year, beginning July 1, 2021. The budget proposal reflects the Governor's priorities for California for the coming year, and beyond. Following includes a summary of key budget assumptions and Medi-Cal and health budget priorities.

Background. The California State Constitution establishes rules and deadlines for the State budget process. The Governor must propose a budget for the upcoming fiscal year on or before January 10th. This signifies the official start of the budget cycle, which culminates with the constitutional deadline of June 15th for the legislature to pass a budget bill to send to the Governor. The budget process plays out from January through June with legislative budget committee hearings, a revised budget proposal by the Governor in May accounting for April tax receipts and, ultimately a budget signed by the Governor for a July 1st effective date.

The January 2020 budget proposal reflected the then strong economy and included the Governor's goals of expanded eligibility and delivery system reform of the CalAIM proposals. However, impact of COVID-19, on both the economy and on the health care system, resulted in a retraction of many of those proposals in the finally adopted State fiscal year 2020-21 budget.

The Governor's \$227B proposed budget for the upcoming 2021-22 state fiscal year focuses funding for COVID-19 response, the administration of the COVID-19 vaccine and investing in the relief for those most affected by the pandemic. Key assumptions included in the proposed budget include the continuation of the federal public health emergency throughout 2021, Medi-Cal caseload will increase 11.7% to peak at 16.1M in January 2022, and a continued reduction in health care costs as result of ongoing suppressed utilization due to COVID-19. Finally, funding to the State from additional federal stimulus packages is not reflected in the proposed budget.

Discussion. The following includes a summary of key budget priorities for Medi-Cal and related health budget issues, including the *estimated cost or savings* for each item, in the Governor's budget proposals.

- Medi-Cal Rx – Accounts for the delayed implementation of the Medi-Cal Rx program until April 1, 2021. *Estimated Savings: \$612.7M (\$238.2M GF).*
- CalAIM – Proposes investments in CalAIM, including enhanced care management (ECM), in lieu of services (ILOS), infrastructure to expand whole person care approaches, and building upon existing dental initiatives. The proposed CalAIM funding amounts are consistent with what was

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proposed in the Governor's Budget in January 2020. *Total \$1.1B (\$531.9M GF); ECM estimate \$187.5M (\$93.7M GF); ILOS estimate \$47.9M (\$24.0M GF),*

- Medi-Cal Managed Care Incentive Program for Student Behavioral Health – Includes \$400M Incentive program in managed care, in coordination with county behavioral health and schools, to increase the number of students receiving preventive and early intervention behavioral health services. *\$400M (\$200M GF) over multiple years.*
- Behavioral Health Continuum – Proposes \$750M (GF) over three years for competitive grants to counties to invest in additional behavioral health service capacity. This includes at least 5,000 beds, units or rooms for short-term crisis stabilization, acute care, peer respite, and other clinical services. *\$750M GF over three years.*
- Telehealth – Proposes to make permanent and expand certain telehealth flexibilities currently in place due to COVID-19 and to cover remote patient monitoring as a Medi-Cal benefit. *No cost estimate provided.*
- Equity – Funds development of equity quality measures and benchmarks, an equity dashboard and COVID-19 equity analysis. States equity as a priority for Medi-Cal managed care and Covered CA procurement. *\$4.1M (\$3.7M GF) – Dashboard; \$1.7M GF – Analysis.*
- Medi-Cal Post-Partum Eligibility – Delays suspension of Medi-Cal post-partum eligibility by 12 months to December 31, 2022. *\$27.1M GF.*
- Medi-Cal Optional Benefits - Delays the suspension of Medi-Cal optional benefits to December 31, 2022. Specific benefits include: Audiology and speech therapy, Incontinence creams and washes, Optician and optical lab services, Podiatric services. *\$47M GF.*
- Prop 56 – Proposes delaying Proposition 56 suspensions for one year to July 1, 2022. *\$3.2B (\$275.3M GF, \$717.8M from Prop 56 fund, \$2.2B FFP).*

Other related health care priorities include:

- IHSS Service Hours Restoration – Delays the suspension of the 7 percent reduction to IHSS service hours to December 31, 2022. *\$449.8M GF.*
- Healthcare Affordability – Proposes to establish the Office of Health Care Affordability within CHHS. The office will be focused on increasing transparency on cost and quality, developing cost targets, enforcing compliance, and filling gaps in market oversight. *\$11.2M GF.*
- Homelessness – Continue competitive grants for local governments to purchase and rehabilitate housing. Of total proposed funding, the Governor is asking the Legislature to take early action to approve \$250 million GF in 2020-21 to continue funding Project Homekey projects. *\$750M GF.*
- Master Plan for Aging – Establishes an Office of Medicare Innovation and Integration within DHCS. DHCS to request a federal planning grant to develop a Medi-Cal Home and Community Based Services Roadmap. *No cost estimate provided.*

- Health Information Exchange (HIE) – No specified proposal. HIE is included as a general priority.
No cost estimate provided.

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

Link to Attachments.

1. 2021-22 Governor's Budget – DHCS Highlights
https://www.dhcs.ca.gov/Documents/Budget_Highlights/DHCS-FY-2021-22-Governors-Budget-Highlights.pdf
2. Health and Human Services – Governor's Budget Summary 2021-22
<http://www.ebudget.ca.gov/2021-22/pdf/BudgetSummary/HealthandHumanServices.pdf>



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Stephanie Sonnenshine, Chief Executive Officer
SUBJECT: Medi-Cal Managed Care Procurement Process

Recommendation. Staff recommend the Board direct staff to explore interest in, and feasibility of, San Benito and/or Mariposa counties changing Medi-Cal managed care models to join the Alliance's existing County Organized Health System (COHS) plan through an expansion of Alliance service area and to report back to the board in March with a recommendation.

Summary. The Department of Health Care Services (DHCS) is beginning a statewide procurement process for its commercial Medi-Cal managed care plans (MCPs). This process provides an opportunity for commercial plans to submit bids to provide Medi-Cal managed care plan services as a Geographic Managed Care (GMC), Regional, Two-Plan, or San Benito model commercial Medi-Cal managed care plan. In addition, DHCS has indicated that some counties that are currently GMC or Regional model counties are interested in transitioning to a managed care model that includes a local plan (i.e., COHS or Two-Plan model). For these counties, DHCS has established a March 31, 2021 deadline for the county(ies) and the corresponding MCP to indicate this intention via submission of a Letter of Intent (LOI). Contracts awarded through this process will be effective January 1, 2024.

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: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), Imperial, and San Benito.

Local plans operate in COHS and Two-Plan model counties. 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, who may choose between the two plans. COHS and Two-Plan models operate in thirty-six (36) counties across the state. The remaining counties are served by commercial plans that compete for Medi-Cal enrollees, who chose between the commercial plans operating in their county of residence. San Benito County is an exception. There is only one commercial Medi-Cal 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.

Representatives from San Benito County and Alliance staff have engaged in discussions several times over the past years regarding a potential partnership, including 2005-06, 2008-09 and 2012-13. For a variety of reasons, the timing and circumstances were such during each of these periods that a partnership did not commence. However, each of these

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occurrences has resulted in a better understanding by the Alliance of the health care delivery system in San Benito County. In 2013, DHCS announced its intention to contract with Anthem Blue Cross to serve as the Medi-Cal MCP in San Benito county. In 2017, San Benito County health care leaders reached out to the Alliance to revisit a possible partnership with the Alliance. At that time, it was determined that the next available opportunity for this discussion would be when DHCS initiated its Medi-Cal managed care plan procurement planned to begin in 2020.

In 2013, Mariposa County officials reached out to the Alliance to explore a possible partnership. At that time, it was determined that this partnership was not practical given the access pattern for Mariposa Medi-Cal beneficiaries. Mariposa County was subsequently included in the group of counties selected for the Regional Model with Anthem Blue Cross and California Health and Wellness (a subsidiary of Centene) contracting with DHCS to offer Medi-Cal managed care services in Mariposa County.

The San Benito and Regional Models of managed care have been in place now since 2013, and DHCS has announced its intention to recontract the commercial plans operating in those models as well as the commercial plans operating in GMC and Two-Plan model counties. A draft Request for Proposal (RFP) is scheduled for release in late Spring/early Summer with the final RFP to be released in October 2021. DHCS has stated that Counties that indicate an interest to transition to a COHS model may be removed from the RFP process.

Discussion. San Benito and Mariposa county have each now operated in a Medi-Cal managed care model with a commercial plan(s) providing Medi-Cal managed care services to Medi-Cal beneficiaries within their county since 2013. With managed care procurement process set to begin both counties are interested in exploring the option available to counties to transition to a COHS model county. To that end, county representatives have reached out to the Alliance to discuss this possibility and gauge the Alliance's interest in a potential partnership.

As mentioned above, DHCS' deadline for counties to state an intent to change managed care models is March 31, 2021. Submission of a Letter of Intent (LOI) does not guarantee that the transition 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.

Given the interest of San Benito and Mariposa Counties in a partnership with the Alliance and the impending March 31, 2021 deadline for submission of a LOI, staff recommends that the board direct staff to work with San Benito and Maricopa counties and return to the board at its March 24, 2021 meeting with a report of findings and recommendation regarding proceeding with the LOI.

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

Attachments.

1. County Managed Care Transition to Local Plan: Letter of Intent Instructions



County Managed Care Transition to Local Plan: Letter of Intent Instructions

March 31, 2021, is the deadline for counties, and the corresponding managed care plan, that intend to transition to a model that includes a local plan by January 2024, to indicate this intention to the California Department of Health Care Services (DHCS) via a *Letter of Intent*. This document provides instructions for the county *Letter of Intent*. Submission of a *Letter of Intent* does not guarantee that a county may shift to a local Medi-Cal contracted plan. However, failure to submit a complete *Letter of Intent* will preclude a county from shifting to a local plan model by January 2024.

Purpose

In 2021, DHCS is beginning a statewide procurement of commercial Medi-Cal managed care plans (MCPs). Some counties have expressed interest in transitioning to a model that includes a local plan. If a county transitions to a model that includes a local plan, DHCS may remove that county from the commercial plan procurement (for a single local plan model) or reduce the number of commercial plans procured in the county (for a Two-Plan Model). DHCS's timeline for finalization of the counties included in the procurement Request for Proposal (RFP) is **October 2021**. The purpose of the *Letter of Intent* is for the county to demonstrate 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 in 2021. The implementation date for commercial plans procured in the RFP, and any new local plans, is January 1, 2024.

State Statutory Authority

While State statutory authority may not be required for a county to transition to a model that includes a local plan, state statute can provide an important public review process. Counties should complete their own assessment of statute that may be needed to authorize specific aspects of the intended model or reverse any conflicting prior statute. DHCS is available to provide technical assistance as the county works with the Legislature on a bill.

Federal Authorization for a New Single Plan Model

Based on guidance from the Centers for Medicare and Medicaid Services (CMS), a plan that has not previously operated as a County Organized Health System (COHS) may act as the only Medi-

Cal plan (similar to a COHS model) in a county with federal authorization through either new federal statute or 1115 waiver expenditure authority. A single plan entity that is authorized only by 1115 waiver expenditure authority would not be a Health Insuring Organization (HIO), and so would be subject to all federal Managed Care Organization (MCO) requirements except plan choice. However, DHCS cannot guarantee CMS approval of the initial 1115 waiver expenditure authority for such a single-plan model, or the subsequent five-year renewals. Only new federal legislation can provide a guarantee of federal authorization.

DHCS Review

DHCS has state statutory authority to determine which, and how many, managed care plans the state contracts with for Medi-Cal services in counties. DHCS's review process will be based on the best interests of Medi-Cal beneficiaries and state goals for the Medi-Cal managed care delivery system, including plan experience, administrative and operational ability, adequate network, financial ability to take on risk, and the ability to meet future expectations of Medi-Cal program. For a county that intends to transition to a model that includes a local plan, DHCS will review information and approve, or deny, the county and plan to proceed at these four points in time:

- 1) After March 2021, DHCS will review the *Letter of Intent* submission. DHCS will also review current Medi-Cal quality performance data for a corresponding plan. This review is only applicable for a corresponding plan that is currently a Medi-Cal managed care plan. DHCS will not require any new information from the plan for the quality performance data review.
- 2) In October 2021, DHCS will verify completion of the county ordinance and any necessary state statute. At this time, DHCS will also request and review evidence of a viable network contracting strategy to support the new local plan responsibility.
- 3) In early 2022, DHCS will request and review information similar to the evaluation and qualification criteria outlined in the future commercial plan procurement RFP.
- 4) Later in 2022, the new local plan will begin the full readiness review process for implementation in January 2024.

Letter of Intent Contents

The *Letter of Intent* must include all of the following information:

County and managed care plan contact information:

1. County primary and secondary contact name, telephone number, mailing address, and email address.
2. Managed Care Plan primary and secondary contact name, telephone number, mailing address, and email address.

Indicate which local plan type the county is proposing:

1. Join an existing COHS plan.
2. Join an existing Local Initiative plan.
3. Develop a new Local Initiative plan.
4. Develop a new COHS plan that is an HIO and requires new federal legislation.
5. Develop a new single-MCP model plan that is not an HIO.

Description, contract model, and partners:

1. Include a short statement describing your county's interest in shifting to a local plan model.
2. List the potential participating entities that would work with your county as part of the formation and administration of the local plan. Address the following:
 - a. Will the new local plan be developed through arrangement with an existing managed care plan? Or, is the county forming a new local plan independent of an existing managed care plan? Please describe intended arrangements for the administration and operation of the new local plan.
 - b. Please explain any direct contract or subcontract/delegation arrangements that are planned. If contracting information is incomplete, please provide all information available at this time.

Attestations:

The county and corresponding plan will attest in the *Letter of Intent* that they have a reasonable expectation that they will meet the following requirements based on their knowledge and intent as of the date of the *Letter of Intent*. No supporting documentation is required at this time other than that noted in the "Required Attachments" section below. To complete items #1 and #2(a) below, please refer to the current [Medi-Cal Managed Care Two-Plan Boilerplate Contract Implementation Plan and Deliverables in Exhibit A, Attachment 18](#) starting on page 148 (hyperlinked). The readiness review process will begin in 2022. Though the 2022 readiness requirements will differ somewhat, the current Two-Plan requirements provide the best current example of the requirements that the local plan will have to meet prior to operation in 2024.

1. Financial:
 - a. The risk-bearing entity (county or corresponding plan) is 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.

- b. The county and/or the local plan will have the ability to self-fund all pre-implementation activities, including readiness requirements, and will not require funding from DHCS related to the cost of these activities.
 - c. The local plan will meet financial readiness requirements that are similar to the example requirements listed at the link above in Section 2 “Financial Information”, Section 8 “Provider Compensation Arrangements”, and Section 20 “Budget Detail and Payment Provisions”.
2. General Readiness Requirements:
- a. The local plan will meet non-financial readiness requirements and timelines that are similar to the example requirements listed at the link above.
 - b. If the local plan is a COHS (or equivalent single-MCP model plan), it will meet network capacity requirements for 100% of the Eligible Beneficiaries in the county. (This requirement differs from what is listed in the Two-Plan model contract.)
 - c. The local plan 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). The final proposal is available at the [DHCS CalAIM website](#).
3. Network Contracts:
- a. By September 2021, the county and corresponding managed care plan 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.
4. Regulatory Requirements:
- a. New state statute to authorize a shift to a local plan model will be enacted by October 2021.
 - i. Indicate if the county believes this requirement is not applicable.
 - b. New county ordinance to authorize the shift to a local plan model will be enacted by October 2021.

Required Attachments

The following supporting documentation must be included with the *Letter of Intent*:

- 1. A copy of the risk bearing entity’s (county or corresponding managed care plan), most recent annual financial statement and forecast; and

2. A description of any health related financial sanctions or corrective action plans currently in effect, and whether the county, and corresponding managed care plan if applicable, anticipate they will be lifted or completed by January 2024.

Readiness Planning

Included within the LOI, please submit a written response of not more than four pages total for the five following items to answer how the county and/or corresponding plan intend to meet the following readiness requirements (as outlined in W&I 14087.48 (b)), including any milestone dates and benchmarks:

1. Service utilization;
2. Network adequacy;
3. Quality and monitoring including utilization management protocols;
4. Accessibility standards; and
5. Any additional efforts undertaken by the MCP.

Signatures on the *Letter of Intent*:

These signatures indicate that both individuals attest to the accuracy of all information provided in the *Letter of Intent*:

1. County Board of Supervisors Chair(s) – with formal Board of Supervisors approval.
2. CEO of the corresponding managed care plan.

Submission Instructions

Counties that intend to shift to a local plan model by January 2024, shall submit a *Letter of Intent* to the Department of Health Care Services (DHCS) by close of business on **March 31, 2021**. If a group of counties is pursuing a shift to the same local plan, the counties may submit a joint *Letter of Intent* signed by the County Board of Supervisors Chairs, with formal Board of Supervisors approval, for all counties and the CEO of the corresponding managed care plan. The letter should be submitted by email to Brian.Hansen@dhcs.ca.gov and addressed to **Kirk Davis, Deputy Director, Health Care Delivery Systems, Department of Health Care Services**. The *Letter of Intent* should be no more than five pages long, including the Readiness Planning section information noted above.

Questions

Please email any questions to Brian.Hansen@dhcs.ca.gov.



Information Items: (18A. – 18J.)

A.	Alliance in the News	Page 18A-01
B.	Alliance Fact Sheet – January 2021	Page 18B-01
C.	Annual Alliance Report to Board of Supervisors – 2020	Page 18C-01
D.	Letter to Governor Newsom	Page 18D-01
E.	Letter of Support	Page 18E-01
F.	Member Appeals and Grievance Report – Q4 2020	Page 18F-01
G.	Membership Enrollment Report	Page 18G-01
H.	Member Newsletter (English) – December 2020 https://www.ccah-alliance.org/pdfs/member_newsletters/CAAH_Member_December_2020_EN-high-res.pdf	
I.	Member Newsletter (Spanish) – December 2020 https://www.ccah-alliance.org/pdfs/member_newsletters/CAAH_Member_December_2020_SP-high-res.pdf	
J.	Provider Bulletin – December 2020 https://www.ccah-alliance.org/pdfs/provider_bulletins/PSBulletin_202012.pdf	



DATE: February 24, 2021
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Scott Fortner, Chief Administrative Officer
SUBJECT: Alliance in the News

[Pediatric Home Health Org Seeks Donations](#)

Gilroy Dispatch (Gilroy, CA)
Alliance in the News via Press Release
January 15, 2021

COASTAL KIDS HOME CARE SERVES CHILDREN IN SAN BENITO, SANTA CLARA COUNTIES

Since the Covid-19 pandemic started, Coastal Kids Home Care—a regional nonprofit that provides specialized home healthcare for children living with illness and disability—has seen demand for its services skyrocket.

The organization is in the midst of its 15th Anniversary Capital Campaign to raise funds for operating expenses and to move into a spacious, permanent new office. [Coastal Kids Home Care](#) purchased an 8,000-square-foot building in Salinas, and is in need of about \$233,000 to complete renovations and for ongoing maintenance before the organization moves in, reads a press release.

Coastal Kids Home Care is the only nonprofit pediatric home health agency in California. It serves children in San Benito, Santa Clara, Monterey and Santa Cruz counties. The organization has continued providing services, uninterrupted by the Covid-19 pandemic, as visiting nurses have donned enhanced personal protection equipment to deliver vital care. Social workers have stepped in to help families access community food and financial resources, and masked counselors have been meeting with patients in backyards to maintain connections with vulnerable children.

Over the past year, respite nurses at Coastal Kids Home Care have provided 50,000 hours of in-home care for children with complex medical conditions—a fourfold increase over the previous two years. Since it was founded in 2005, the nonprofit has provided more than 70,000 in-home visits to more than 9,000 medically fragile children.

But the nonprofit needs help, and needs to raise \$233,000 to reach its \$2.2 million fundraising goal, according to the press release.

And the Covid-19 pandemic has only raised the need for Coastal Kids Home Care's services. The organization's demand for pediatric palliative care admissions has tripled because hospitals are a "scary place for families with medically fragile children" during the pandemic, the press release says.

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Furthermore, Coastal Kids has seen the number of children and teens accessing its mental health counseling services increase by 40 percent during the pandemic.

Coastal Kids' new home in Salinas—known as the Rodgers Center for Children's Health—was purchased with substantial donations from the Central California Alliance for Health (\$1.2 million); T.J. and Valeta Rodgers (\$300,000) and the Sally Hughes Church Foundation (\$200,000) among others.

"We are so grateful to our lead donors for their generous support," Coastal Kids Home Care Development Director Kelli Mullen Brown said. "The Rodgers Center for Children's Health will become a cornerstone of care for children living with illness and disability for many years to come."

The nonprofit still needs funding to add a new roof and air conditioning system, and for ongoing maintenance.

Coastal Kids Home Care was co-founded by Margy Mayfield in June 2005. After more than two decades as a pediatric nurse, Mayfield knew what children living with serious illness craved most—to simply be home.

"Children thrive when they can sleep in their own beds, eat their favorite foods and spend time with their friends," reads the press release. "Mayfield's idea was simple but revolutionary. With an exclusive focus on pediatrics, Coastal Kids is able to bring high-quality, compassionate home care to children with serious or life-limiting illness – all at a low cost to families and community healthcare dollars."

For more information or to make a donation, visit Coastal Kids Home Care's website at <https://coastalkidshomecare.org/>.

[Pediatric Home Health Org Seeks Donations](#)

San Benito.com (Hollister, CA)
Alliance in the News via Press Release
January 15, 2021

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For more information or to make a donation, visit Coastal Kids Home Care's website at <https://coastalkidshomecare.org/>.

[Coastal Kids Home Care Buys New Building to Expand Children's Health Care Practices](#)

My MOTHERLODE.com (Sacramento, CA)

via Press Release

January 14, 2021

NONPROFIT FOR SICK CHILDREN URGES FOR COMMUNITY SUPPORT

"The Rodgers Center for Children's Health will become a cornerstone of care for children living with illness and disability for many years to come"— Kelli Mullen Brown, Coastal Kids Home Care Development Director

SALINAS, CA, UNITED STATES,

January 14, 2021 /EINPresswire.com/ --

What do you do when an anxious mom of a medically fragile child has her fears compounded by COVID-related stresses? If you are Coastal Kids Home Care, California's only provider of specialized pediatric home health services for children living with illness and disability, you continue family-centered services uninterrupted. Visit nurses don enhanced PPE and continue vital care; social workers step in to help families access community food and financial resources; and masked counselors meet patients in the backyard to maintain connection with vulnerable children during this complex time. This year respite nurses at Coastal Kids Home Care provided 50,000 hours of in-home care for children with complex medical conditions last year – a fourfold increase over the last two years. Since it was founded in 2005, the non-profit has provided more than 70,000 in-home visits to more than 9,000 medically fragile children.

But the non-profit is bursting at the seams and needs help. Coastal Kids Home Care is close to the finish line of its 15th Anniversary Capital Campaign. The non-profit needs to raise \$233,000 to reach its \$2.2 million goal.

Due to COVID, the non-profit agency – which serves children in Monterey, San Benito, Santa Clara and Santa Cruz counties – saw its demand for pediatric palliative care admissions triple because in the current climate, hospitals were, and continue to be, a scary place for families with medically fragile children. Additionally, Coastal Kids has seen the number of children and teens accessing its mental health counseling services increase by 40% during the pandemic.

The agency is bursting at its physical seams as well. As its team of nurses, social workers and counselors continues to expand, the group has outgrown its 900-square-foot office. Thanks to [donations](#) from Central California Alliance for Health (\$1.2M); T.J. and Valeta Rodgers (\$300K) and the Sally Hughes Church Foundation (\$200k) among others, Coastal Kids Home Care has been able to purchase and renovate an 8,000 square-foot building in Salinas. The new Rodgers Center for Children's Health will house clinical and administrative management, and outpatient therapy.

Its current office is the organizations' ninth home in 15 years, so the Coastal Kids team is ecstatic to move into its permanent home in February, said Kelli Mullen Brown, Coastal Kids Home Care Development Director. "We are so grateful to our lead donors for their generous support. The Rodgers Center for Children's Health will become a cornerstone of care for children living with illness and disability for many years to come," she said.

An additional \$233K is needed to complete the project. Those monies will fund a new roof and air conditioning, and allow funds to be set aside for ongoing maintenance. The agency also welcomes in-kind donations.

Margy Mayfield co-founded Coastal Kids Home Care in June of 2005. After more than two decades as a pediatric nurse, Mayfield knew what children living with serious illness craved most – to simply be home. Children thrive when they can sleep in their own beds, eat their favorite foods and spend time with their friends. Mayfield's idea was simple but revolutionary. With an exclusive focus on pediatrics, Coastal Kids is able to bring high-quality, compassionate home care to children with serious or life-limiting illness – all at a low cost to families and community healthcare dollars.

WHO TO INTERVIEW:

Margy Mayfield, Executive Director, Coastal Kids Home Care
Cassie Jimenez, Marketing and Community Relations, Coastal Kids Home Care (Spanish speaker)

WHEN:

Interviews Available Upon Request

WHERE:

427 Pajaro Street
Salinas, CA 93901

Contact:

Terry Downing, PRxDigital
(408) 838-0962 | terry_downing@prxdigital.com
Cassie Waggy, Coastal Kids Home Care
(209) 923-2568 | cwaggy@coastalkidshomecare.org

About Coastal Kids Home Care

Coastal Kids Home Care is California's only nonprofit pediatric home health agency, improving the quality of life for children healing from injury or short-term illness, coping with chronic condition or developmental delays, and those facing the end-of-life.

Terry Downing

PRxDigital

+1 408-838-0962

[Monterey County Approves Pilot COVID-19 Outreach Program Aimed at Poor Latinos](#)

Monterey Herald
Jim Johnson
December 21, 2020

SALINAS — A pilot community outreach and education program using "trusted messengers" to target Monterey County's poorest communities hardest hit by the COVID-19 pandemic will go ahead as the virus continues to spread at an accelerated pace.

During a special meeting on Monday, the Board of Supervisors approved a six-month, \$5 million program that will hire and pay for 100 community health workers in collaboration with community-based organizations to encourage testing and provide access to services in poor, largely Latino neighborhoods dubbed "communities of color" where the vast majority of local COVID-19 cases, hospitalizations and deaths have occurred.

As of Monday morning, nearly 80% of all local COVID-19 cases were from Salinas and South County, including nearly 55% from just three ZIP codes, and Latinos represented more than 63.5% of all local cases. In all, the county had 23,582 cases as of Monday, 1,009 more than on Sunday, as well as 166 COVID-19 patients currently in the hospital and 178 people who have died with the virus.

The program, which is slated to start on Jan. 1, would spend most of its budget on administrative costs including paying the community health workers \$25 an hour with benefits to conduct the outreach efforts at COVID-19 testing sites and elsewhere. The program will also pay for seven program coordinators and seven data analysts, as well as administrative, operating and travel expenses.

Little funding would be devoted to the resulting demand for services such as temporary housing before and after testing for quarantine and isolation, cash assistance, food, and medical care, which would presumably rely on existing funding.

The program will include tracking of the number of contacts through the outreach and education efforts, the needs and challenges to addressing them, and actual access to resources, and is also expected to contribute to COVID-19 vaccination distribution. It would be funded by cannabis tax revenue, which will cover about \$3 million, as well as contingencies and reserves, which would cover about \$1 million each.

County staff recommended a three-month, \$2.3 million pilot program that they said would be quicker to implement, but county supervisors indicated they believed the program would need more time to be as effective as possible.

Overseen by the Community Foundation of Monterey County in collaboration with the county administrative office and health department, the program will work with nearly a dozen community organizations including COPA, Building Healthy Communities, Mujeres en Accion, Center for Community Advocacy, Centro Binacional para el Desarrollo Indigena Oaxaqueno, California Rural Legal Assistance, Bright Beginnings, Lideres Campesinas, the city of Gonzales, Central California Alliance for Health and Action Council.

Proposed at last week's county board meeting by COPA, the program is based on the Fresno County Equity Project and adapted to local needs, and is linked to county health's disparate impact report as a recommended strategy. It also follows collaborative efforts led by the Community Foundation involving a range of community organizations with the same goal that started last month.

There are 45 community health workers already trained and mobilized with another 55 to follow, according to a staff report.

County supervisors, staff and supporters of the program noted the program could provide a framework for providing services to "underserved" communities even after the pandemic is over.

[Help is Available for Merced County Residents Suffering from Wintertime, Holiday Blues](#)

Merced Sun-Star
Dr. Dale Bishop | Op-ed
December 11, 2020

The social isolation and lifestyle changes associated with COVID-19 have affected the mental health of many in our communities. We are the managed care health provider that serves over 350,000 Medi-Cal members in Merced, Monterey and Santa Cruz counties. Behavioral health providers in our service area have seen an over 700% increase in the use of telehealth services since the pandemic began, comparing pre-COVID numbers in December 2019 to our most recent numbers in September 2020.

Several factors that are making an already difficult situation worse: losing daylight savings and the holidays.

Turning the clock back an hour at the end of daylight savings may not seem like a big deal, but that time change, coupled with shorter winter days and cooler temperatures, can noticeably lower our spirits. Some may have mild "winter blues" while others may suffer from a form of major depression called seasonal affective disorder (SAD).

The holidays can be stressful in the best of times. But because of the ongoing pandemic, many are struggling to create new ways to celebrate in isolation or without the typical get-togethers. For some, the holidays can also bring about a sense of grief, due to the loss of a loved one or from the inability to take part in traditional celebrations. It can be a difficult holiday experience for anyone this year.

What can people do if they are suffering from feelings of sadness, depression or chronic low-energy? Talk to a health-care provider who can offer resources to help. This can be your primary care doctor, a therapist or a provider of behavioral health services.

While there are many behavioral health providers who can help, there are populations in Merced County who are less likely to access these services: seniors, adolescents and people of color. There are providers who are experienced in assisting people who identify as specific populations. You have a right to feel comfortable with your provider, so ask for

your preference when calling a behavioral health service or check your health plan's provider directory.

The important point to know for anyone struggling is that you're not alone. It's normal if you feel more anxious, depressed or are having trouble coping with the prolonged changes in our lives due to the events of 2020. There are resources to help. The first step is to reach out for support.

If you are a Medi-Cal member in Merced County, the Alliance and Beacon (our mental health services provider) can assist you. Visit our website for contact information and ways to get help at <https://www.ccah-alliance.org/behavioral-health.html>

If you aren't a Medi-Cal member, you can get support by contacting your health insurance provider, your company's Employee Assistance Program or Merced County Behavioral Health and Recovery Services (888-334-0163) to learn about local behavioral health resources. Or, call the National Alliance on Mental Illness (NAMI) Helpline at 800-950-NAMI. It's important to take care of yourself and your family, now more than ever. And that includes your mental health!

Dale Bishop, MD, is chief medical officer of Central California Alliance for Health (the Alliance), a Medi-Cal managed care health plan focused on improving access to health care for over 350,000 residents of Merced, Monterey and Santa Cruz counties. Dr. Bishop has more than 25 years of experience providing direct patient care to underserved populations in California's Central Valley.

[Mental health matters, now more than ever. There are resources to help in Monterey County](#)

Salinas Californian
Dr. Dale Bishop | Op-ed
December 7, 2020

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Behavioral health providers in our service area have seen an over 700% increase in the use of telehealth services since the pandemic began, comparing pre-COVID numbers in December 2019 to our most recent numbers in September 2020. Several factors are making an already difficult situation worse: daylight savings and the holidays.

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[Your Mental Health Matters, Now More than Ever. There are Resources to Help in Santa Cruz County](#)

Santa Cruz Sentinel
Dr. Dale Bishop | Op-ed
December 5, 2020

Your mental health matters, now more than ever. There are resources to help in Santa Cruz County.

The social isolation and lifestyle changes associated with COVID-19 have affected the mental health of many in our communities. We are the managed care health provider that serves over 350,000 Medi-Cal members in Santa Cruz, Monterey and Merced counties. Behavioral health providers in our service area have seen a more than 700% increase in the use of telehealth services since the pandemic began, comparing pre-COVID numbers in December 2019 to our most recent numbers in September 2020.

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If you aren't a Medi-Cal member, you can get support by contacting your health insurance provider, your employer's Employee Assistance Program or Santa Cruz County Behavioral Health Services (800-952-2335) to learn about local behavioral health resources. Or, call the National Alliance on Mental Illness (NAMI) Helpline at 800-950-NAMI.

It's important to take care of yourself and your family, now more than ever. And that includes your mental health!

Dr. Dale Bishop is Chief Medical Officer of Central California Alliance for Health (the Alliance), a Medi-Cal managed care health plan focused on improving access to health care for more than 350,000 residents of Merced, Monterey and Santa Cruz counties. Bishop has more than 25 years of experience providing direct patient care to underserved populations in California's Central Valley.

[Gonzales Healthcare Clinic Triples in Size, Offers New Services](#)

KION 5/46

Avery Johnson

November 6, 2020

GONZALES, Calif. (KION) The Taylor Farms Family Health & Wellness clinic has expanded, and it is now offering additional medical services in Gonzales.

The center first opened five years ago, according to the Salinas Valley Memorial Healthcare System, and has tripled in size as a result of a two-year long expansion project. The clinic was originally in a 6,400 square foot building, but it is now 20,000 square feet. In addition to growing in physical size, the services offered have expanded with it.

"We are proud to support the new specialty clinic at Taylor Farms Family Health & Wellness Center, which will increase access to crucial behavioral health and specialty services for our members in south Monterey County. This new center not only provides convenient access to important services for our members who live in Gonzales and the surrounding communities, but also provides health education and fitness programming that will improve our members' health and quality of life," said CEO of the Central California Alliance for Health Stephanie Sonnenshine.

The clinic will give residents access to podiatry, general surgery, orthopedic surgery, OB/GYN, behavioral health and diabetes education and more, according to SVMHS. It has started offering preventative care classes and workshops, including a diabetes prevention course, and when it is safe to do so, it will offer free fitness classes and community education programming.

"Since this center opened five years ago, it has been a model for delivering quality care in rural environments," says Pete Delgado, President/CEO of Salinas Valley Memorial Healthcare System. "The success of this expansion is due in large part to organizations who partnered with us and are equally dedicated to increasing access to care."

Taylor Farms helped with the project by providing a \$1.5 million grant, and the project received \$8 million in funding from philanthropic support from the Central California Alliance for Health, the Monterey Peninsula Foundation, Mike and Mary Orradre and contributions from Salinas Valley Memorial Hospital Foundation donors.

A small, socially distanced ribbon cutting ceremony is scheduled for Saturday at 2 p.m., but it will also be streamed live on Facebook [here](#).

[The Little Farm that Could](#)

Santa Cruz Waves
Elizabeth Limbach
October 13, 2020

How Common Roots Farm Fulfilled its Mission while Navigating 2020's Hardships
If you can stand the echo, I can paint while we talk."

As a farmer, Heidi Cartan does not have a moment to waste. On a hot day in mid-August, she is busy painting the walls of a freshly built housing unit at Common Roots Farm, a small organic farm tucked away just one mile from downtown Santa Cruz at the base of Pogonip Open Space preserve.

The farm was founded by a group of 10 families, including Cartan's, that have grown children with disabilities. In search of safe, permanent housing for their children, the parents came together with an ambitious plan to build a "pocket neighborhood" for disabled and non-disabled Santa Cruzans, alike, on a sustainable farm that is designed to be accessible for everyone- meaning farmers and volunteers with and without disabilities contribute and collaborate.

When we speak, Cartan and her crew are suffering through a scorching heat wave and are on day two of a power outage. A few days later, ash and smoldering leaves rain down on the farm's files, as the CZU Lightning Complex fire creeps nearer, never- thankfully- reaching its borders. As soon as it was safe to return, Common Roots volunteers harvested and donated many hundreds of pounds of cucumbers, tomatoes, peppers, lettuce, beans and melons to the Salvation Army and Santa Cruz Bible Church, both of which were feeding evacuees.

This wasn't the first time in 2020 that Common Roots stepped up during a crisis. Talking as she paints the new house, Cartan explains how the COVID-19 pandemic both shook the farm's foundation and presented an opportunity to live up to its guiding mission.

"My goal all along has been that people with disabilities would be providing something for their community...I never expected we'd have an opportunity during a pandemic to do it sooner and in a bigger way." - Heidi Cartan, Director of Common Roots Farm

"My goal all along has been that people with disabilities would be providing something for their community- and I assumed it would be normal farm produce through the normal outlets," she says. "I never expected we'd have an opportunity during a pandemic to do it sooner and in a bigger way."

Only in its fourth year of production, Common Roots Farm was still learning to navigate the rough and uncertain waters of farming when the pandemic abruptly capsized the markets and relationships Cartan had worked so hard to build over recent years. The Common Roots farm shuttered out of caution over food safety, and all of the restaurants and florists that buy its produce and flowers closed.

Cartan reconsidered the year's planting plan accordingly, ditching the greens in the wheelchair-accessible hydroponic greenhouse that would normally go to restaurants and forgoing the mint it was meant to grow for Santa Cruz Shakespeare to use in intermission mojitos. "Because," she explains, "the rule in farming is you shouldn't plant anything until you know where you'll sell it."

Elaborate harvesting schedules emerged to allow for new safety guidelines and eventually, once it was deemed safe, the farmers and volunteers with disabilities returned, social-distance style.

Amidst these changes, Common Roots was given the chance to support locals who were hit hardest by the pandemic's economic downturn. With assistance from a Central California Alliance for Health grant, the farm supplied produce to the Salvation Army, which passed it on to low-income Medi-Cal recipients in Santa Cruz County through grocery distribution and hot-meal programs. "It's been so gratifying for us to feel like our food is helping our community," Cartan says. The grant allowed Common Roots to keep its fields in production during the COVID slump.

Loath to compost the farm's surplus cut flower (it grows 25 varieties of these pollinator-friendly crops), Cartan donated bouquets to the Salvation Army recipients. "They are thrilled, because they never have money for flowers," she says. "Flowers are a luxury. A bouquet of fresh flowers is also a staple of the farm's community-supported agriculture (CSA) service, which has doubled in size this year. This increase has helped to keep the farm afloat through direct-to-consumer support.

Once the CSA season ends in mid-October, Common Roots will rely on the sales of its delectable jarred products sold through commonrootsfarm.org. Made by local food-waste fighting business Terrior in a Jar, Common Roots' products include a Bloody Mary mix featuring hot peppers and tomatoes; a strawberry margarita mix; hot sauces; strawberry jam; and a strawberry tarragon shrub that is delicious in cocktails or added to sparkling water.

Looking toward the horizon, Cartan is pleasantly surprised that 2020's challenges have not steered Common Roots off course. Its pocket neighborhood is on schedule to have occupants by spring, when 19 disabled individuals and renters from the wider community will move into its 10 houses and one studio. The farm is also on target to finish an accessible garden around them- a shady spot where visitors and volunteers can utilize wheelchair-friendly garden beds and a potting area. Another piece of the farm's inclusivity plan will wrap up come spring, as well: a wide, smooth pathway made from eco-conscious materials that will encircle the farm's four acres, giving folks in wheelchairs, kits on scooters and parents with strollers a scenic place to stroll. "The farm...has been from the start and will continue to be a community-wide resource," Cartan says.

For now, Common Roots must keep its fields healthy while patiently waiting for restaurants, florists and its own farm stand to open back up.

"We talk a lot about how nature keeps going," Cartan says. "The farm field, the insects [and] the soil don't care that there's a pandemic going on- and we need to continue caring for those resources. [We need to] continue to build our soil so we can grow the healthiest products possible, continue to take care of our land so it's productive and healthy for the long term, and try to figure out how to do things in a new way that really nobody could have ever prepared us for."

Learn more and shop products at commonrootsfarm.org. Find the farm on Instagram @common.roots.farm.

Alliance Fact Sheet

January 2021



ABOUT THE ALLIANCE

The Alliance is an award-winning regional non-profit health plan, established in 1996, with **over 25 years** of successful operation. Using the State's County Organized Health System (COHS) model, we currently serve **364,658 members** in Santa Cruz, Monterey and Merced counties. We work in partnership with our contracted providers to promote prevention, early detection and effective treatment, and improve access to quality health care for those we serve. This results in the delivery of innovative community-based health care services, better medical outcomes and cost savings. The Alliance is governed with local representation from each county on our Board of Commissioners.



Quick Facts²

1996

Year Established

501

Number of Employees

\$1.3B

YTD Revenue

6.4%

% Spent on Administration

Service Area:

Santa Cruz, Monterey and Merced counties

Membership by Program

Total Membership: **364,658³**

364,118

Medi-Cal

540

Alliance Care IHSS

OUR VISION

Healthy People,
Healthy Communities.

OUR MISSION

Accessible, quality health care guided by local innovation.

WHAT WE DO

The Alliance is a health plan that was developed to improve access to health care for lower income residents who often lacked a primary care "medical home" and so relied on emergency rooms for basic services. The Alliance has pursued this mission by linking members to primary care physicians (PCPs) and clinics that deliver timely services and preventive care, and arrange referrals to specialty care.

WHO WE SERVE

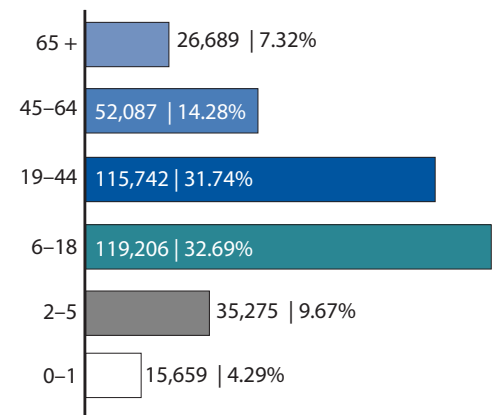
Our members represent 37 percent¹ of the population in Santa Cruz, Monterey and Merced counties. We serve seniors, persons and children with disabilities, low-income mothers and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled, and low-income, childless adults ages 19-64.

Our programs currently include Medi-Cal Managed Care serving Santa Cruz, Monterey and Merced counties, and Alliance Care In-Home Supportive Services (IHSS) in Monterey County.

PROVIDER PARTNERSHIPS

The Alliance partners with more than 9,700 providers to form our provider network, with 86.3 percent of primary care physicians and 83.0 percent of specialists within our service area contracted to provide services to our members.

Membership by Age Group



EXECUTIVE LEADERSHIP



Stephanie Sonnenshine,
Chief Executive Officer



Lisa Ba,
Chief Financial Officer



Dale Bishop, MD,
Chief Medical Officer



Scott Fortner,
Chief Administrative Officer



Marina Owen,
Chief Operating Officer



Van Wong,
Chief Information Officer

GOVERNING BOARD

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

- **Supervisor Wendy Root Askew,** County of Monterey
- **Dorothy Bizzini,** Public Representative
- **Dan Brothman,** Chairman & CEO, Halsen Healthcare; Board Chairman, Watsonville Community Hospital
- **Leslie Conner,** Executive Director, Santa Cruz Community Health Centers – Alliance Board Vice Chairperson
- **Supervisor Ryan Coonerty,** County of Santa Cruz – Alliance Board Chairperson
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas
- **Larry deGhetaldi, MD,** President, Santa Cruz Division, Palo Alto Medical Foundation (Sutter Health)
- **Julie Edgcomb,** Public Representative
- **Gary Gray, DO,** Chief Executive Officer, Natividad
- **Mimi Hall,** Director, Santa Cruz County Health Services Agency
- **Elsa Jimenez,** Director of Health, Monterey County Health Department
- **Shebreh Kalantari-Johnson,** Public Representative
- **Michael Molesky,** Public Representative
- **Rebecca Nanyonjo,** Director of Public Health, Merced County, Department of Public Health
- **Supervisor Josh Pedrozo,** County of Merced
- **Elsa Quezada,** Public Representative
- **James Rabago, MD,** Merced Faculty Associates Medical Group
- **Allen Radner, MD,** Salinas Valley Memorial Healthcare System
- **Joerg Schuller, MD,** Vice President Medical Affairs, Mercy Medical Center
- **Rob Smith,** Public Representative
- **Tony Weber,** Chief Executive Officer, Golden Valley Health Centers



AWARDS

The Alliance is a multi-award winning organization for outstanding health plan performance, quality and leadership in health care.

State Quality Awards:

Over the years, the Alliance has received numerous awards including the Department of Health Care Services (DHCS) Quality Awards for performance in the state's annual Healthcare Effectiveness Data Information Set (HEDIS®) measures for Medi-Cal managed care plans. The recent awards include:

2019

- Outstanding Performance for Medium-sized Plan

2018

- Most Improved Runner Up for Santa Cruz/Monterey Counties
- Innovation Award for Academic Detailing

¹County population data source: U.S. Census Bureau 2019 population estimate (as of Jul. 1, 2019).

Membership percentage by county: Santa Cruz (26 percent); Monterey (38 percent); Merced (47 percent).

²Fact sheet data as of Jan. 1, 2021.

³Fact sheet data as of Jan. 1, 2021.

Customer Service Honors:

- DHCS 2011 Gold Quality Award for Outstanding Service and Support

Employer Workplace Distinctions:

- American Heart Association 2016 Workplace Health Achievement Gold Level Award as a "Fit and Friendly Workplace"
- Second Harvest Food Bank, Santa Cruz County – CEO Cup 2018, 2017; Titanium Award 2015, 2014, 2013
- United Way of Santa Cruz County 2018, 2013 Corporate Campaign Gold Award
- 2020 Certified California Green Business - Program Participant since 2008.



**2020
ANNUAL REPORT
TO THE SANTA CRUZ, MONTEREY, AND MERCED COUNTY
BOARD OF SUPERVISORS
FROM
THE SANTA CRUZ-MONTEREY-MERCED
MANAGED MEDICAL CARE COMMISSION**

Central California Alliance for Health (the Alliance) is a locally governed and operated public agency established by Ordinances adopted by the counties of Santa Cruz, Monterey, and Merced. The Alliance is governed by the Santa Cruz – Monterey – Merced Managed Medical Care Commission (the Commission), whose members are appointed by the Boards of Supervisors in each county.

- The Alliance's Vision: Healthy people. Healthy communities.
- The Alliance's Mission: Accessible, quality health care guided by local innovation.
- The Alliance's Values: Improvement, Integrity, Collaboration, Equity

The Commission seeks to achieve the Alliance's mission through operation of a County Organized Health System (COHS) health plan, currently serving over 360,000 members in Santa Cruz, Monterey and Merced counties.

Commission Structure

The Alliance is governed by the Santa Cruz – Monterey – Merced Managed Medical Care Commission, a twenty-one member commission appointed by the counties' Boards of Supervisors, with seven members from each county representing interests of the public, providers and government. Additionally, the Commission has established advisory groups consisting of member and physician representatives, which advise the Commission on policy matters.

Typically, the Commission meets regularly in public meetings conducted via videoconferencing with sites in each county, as well as two face-to-face meetings each year, to discuss and decide upon policy issues for the Alliance and receive reports regarding on-going operations from Alliance staff. Meetings of the Commission, its Committees and its advisory groups are open to the public and are governed by the Brown Act. Beginning in April 2020, due to the COVID-19 pandemic, and based upon guidance from the California Department of Public Health and in compliance with the Governor's Executive Orders N-25-20 and N-29-20, Commission meetings were held via video and teleconferencing, accessible to all members of the public telephonically or otherwise electronically.



At the April 2020 Commission meeting, Santa Cruz County Supervisor, Ryan Coonerty was elected to continue to serve as the Commission Chairperson and Ms. Leslie Conner, Executive Director of Santa Cruz Community Health Centers was elected to continue to serve as the Vice Chairperson.

See Attachment A for a list of Commissioners who served during 2020, including each Commissioner's category of representation, and Attachment B for a report of Commissioners' meeting attendance during 2020.

Commission Activities and Accomplishments in 2020

The Alliance is proud of its accomplishments over the past year. 2020 was a year of challenges and unanticipated and unprecedented environmental factors and the Alliance was able to quickly adapt and meet those challenges. Early in 2020, the Alliance's priorities and activities quickly shifted to a COVID-19 response and included moving Alliance staff to 100% full-time work from home in response to the county and statewide shelter in place orders. With a focus on supporting Alliance members and its provider network to address healthcare needs within the community in this new remote work environment, activities and accomplishments of the Commission and the Alliance during 2020 included:

1. **COVID-19 Fund.** Allocated \$1M to establish a COVID-19 Response Fund to address immediate member need, which included \$600K in grant funding to local food banks in the Alliance tri-county service area and up to \$50K to community-based organizations that provide essential social and health services to Medi-Cal members most affected by the COVID-19 crisis. \$400K in community grants were funded through 25 grant awards.
2. **Medically Tailored Meals.** Approved funding to add Post-Discharge Meal Delivery as a benefit for members with a diagnosis of diabetes, congestive heart failure and/or chronic obstructive pulmonary disorder who are identified as high risk for hospital readmission. The program includes 14 ready-made medically tailored meals per week for 12 weeks post discharge with the goals of improving health outcomes and lowering health care costs by reducing hospital readmissions and emergency department utilization post discharge.
3. **Wildfire Response.** Implemented an Emergency Management Team response to the August wildfires throughout the Alliance service area, which included reporting daily to the State Department of Health Care Services regarding the local community impacts on access to care, establishing communications with county personnel engaged in the local emergency responses, staying connected with the provider network and ensuring access to care to medically necessary care including medications, medical supplies and equipment for members displaced by the evacuations.



4. **Federal fund availability.** With approval of the federal Centers for Medicare and Medicaid Services, using the Alliance's Medi-Cal managed care contract as a conduit, the Alliance facilitated the receipt and distribution of over \$41.1M in federal funds to county public health departments and public hospitals by leveraging local funds contributed by interested, qualified governmental agencies through intergovernmental transfers.
5. **Preventive Care.** The Alliance Care Based Incentives and Proposition 56 funded value-based payment program resulted in over \$12M in payments to providers for the provision of timely preventive to Alliance members.
6. **Access to Care.** The Alliance noted significant improvement in access to urgent and non-urgent appointments as reported by the Department of Managed Health Care in 2020.
7. **Recuperative Care Pilot.** Approved \$5.85M to develop a new two-year Recuperative Care Pilot program to be launched in March 2021 funded through the Alliance's Medi-Cal Capacity Grant program. The Recuperative Care Pilot will provide a temporary housing solution for Alliance Medi-Cal members who are currently homeless and recovering from an acute illness or injury. Recuperative care is an alternative to hospital and/or institutional care for individuals who no longer meet medical necessity criteria but have medical needs that would be exacerbated by living on the street or in a shelter.
8. **Quality of Care.** Achieved 10 high performance levels for Healthcare Effectiveness Data and Information Set (HEDIS)/Managed Care Accountability Set (MCAS) and noted statistically significant improvements in 11 measures in the domains for prevention and screening, access and availability, and utilization.
9. **Young Adult Coverage Expansion.** Transitioned nearly 3,000 young adults to full-scope Medi-Cal coverage effective January 1, 2020 when Medi-Cal eligibility was expanded to all income eligible young adults ages 19 through 25 regardless of immigration status.

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



Alliance Members

As of December 31, 2020, the Alliance served approximately 364,000 Medi-Cal beneficiaries and 540 Alliance Care IHSS members.

Membership by County

- In Santa Cruz County, the Alliance has approximately 71,000 Medi-Cal members.
- In Monterey County, the Alliance has approximately 163,000 Medi-Cal members and 540 Alliance Care IHSS members.
- In Merced County, the Alliance has approximately 130,000 Medi-Cal members.

Alliance Medi-Cal Members

Alliance Medi-Cal members are lower income persons in eligible aid categories (e.g. aged, disabled, single-parent, childless adult), and include nearly all Medi-Cal beneficiaries in the region. The Alliance's Medi-Cal members represent the following demographic composition:

- 67.60% are Latino, 15.77% Caucasian, 6.99% Filipino, 2.94% Asian/Pacific Islander, 2.32% African American, and 4.38% are other or not reported.
- 54.60% report primary language as English, 42.90% as Spanish, 0.70% as Hmong and 1.80% as other or not reported.
- 53.29% are female and 46.7% are male.
- 48.70% are 19 years old and younger, while 7.30% are 65 years or older

Alliance Care IHSS members

Alliance Care IHSS members are in-home caregivers that provide home care services for the recipients of IHSS program services in Monterey County.

Alliance Member Services

The Alliance Member Services Department engages and supports members through operation of a Call Center to respond to member requests, a Grievance System to resolve member issues, and an Operations Unit to maintain member data and execute member informing materials. Member Services staff reside in all three counties served by the Alliance and many staff are bilingual in English/Spanish or English/Hmong. Staff provide high quality service and support to Alliance members, providers, and community-based partners. Staff educate Alliance members about how to access Alliance health care benefits within the managed care environment. This includes providing new member orientations, helping members understand their benefits, answering questions, and resolving member concerns. Member Services develops and distributes written member informing materials, such as member identification cards, member handbooks, and a quarterly member newsletter.

1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
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209-381-5300



The Member Services Department facilitates two public committees that seek feedback from members to inform programs and procedures, including the quarterly Member Services Advisory Group (MSAG) and the bi-monthly Whole Child Model Family Advisory Committee (WCMFAC). Member Services staff are also responsible for reviewing and resolving plan enrollment data issues through collaboration with the local county Medi-Cal offices, the Social Security Administration, and the Department of Health Care Services (DHCS).

Member Outreach

In 2020, during the COVID-19 pandemic, to address emerging issues and provide resources, member outreach was coordinated and conducted by several Health Services teams for 80,659 members through both live and automated calls, 35,652 preventive care mailings, and completion of 444 translations and 1,117 face-to-face interpreting services. In addition, the Alliance received State recognition for innovation for developing a relative risk factor methodology for targeted member outreach

Alliance Health Services Division

The Alliance's Health Services (HS) Division is responsible for ensuring that members receive the right care in the right place at the right time and assures that the care provided is evidence-based. The Alliance works closely with its network of providers including physicians, hospitals, pharmacies and ancillary providers, to ensure members receive appropriate and timely access to care. Dale Bishop, MD serves as the Alliance's Chief Medical Officer. Drs. Maya Heinert, Gordon Arakawa and Dianna Diallo joined the HS team as Medical Directors in 2020. In addition, Dr. Robert Dimand continued to assist with the coverage of adult services and the Whole Child Model program throughout 2020. Physician clinical oversight responsibilities include Quality Improvement & Population Health (QI/PH), Utilization Management/Complex Case Management, Community Care Coordination and Behavioral Health. Under the supervision of Dr. Bishop, the Pharmacy Department oversees the Pharmacy and Therapeutics Committee (P&T).

The Alliance maintains a Quality Improvement (QI) System to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The QI/PH Department monitors the quality of health care services provided and is able to review quality of care at the individual member level, as well as for the Alliance's member population as a whole. 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

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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.

Alliance Providers

The Alliance recognizes the critical importance of its providers in furthering its mission to ensure access to quality health care for members. The Alliance's contracted network of providers includes Primary Care Providers (PCPs), federally qualified health centers and community clinics, specialists, hospitals, ancillary health services providers, pharmacies and long-term care facilities. The Alliance continues its efforts to strengthen its provider capacity to provide services, providing a robust network across all three counties in its service area. In 2020, the Alliance added 540 new providers to its provider networks including: 65 PCPs, 91 specialists, 95 non-physician medical practitioners, 20 allied providers, 26 provider organizations, and 243 facility-based providers.

In 2020, the Alliance once again conducted its annual provider satisfaction survey to learn more about its providers' experience with the Plan. The 2020 survey indicated that 84% of physicians surveyed rated the Alliance as completely or somewhat satisfactory, and 98% indicated that they would recommend the Alliance to other physicians' practices.

In April 2020, the Alliance launched a Provider Call Campaign to connect with, educate, and support the provider network in managing the COVID-19 pandemic. Outreach topics were tailored to the needs of the local healthcare system and Alliance staff assisted with helping providers understand evolving state and federal guidance and ensuring continued access to care for Alliance members.

Alliance Financial Performance

The Alliance's 2020 operating revenue was \$1.2B, through November 30, 2020.

The Alliance operated with a Medical Loss Ratio (MLR) of 95.8% and an Administrative Loss Ratio (ALR) of 6.3% of revenue, through November 30, 2020. As a result of continuing increased medical costs and State revenue less than those costs, the Alliance has reported a net income loss of \$32.4M through November 30, 2020. The Alliance must maintain an adequate level of financial reserves to ensure that the health plan has sufficient funds to cover incurred claims liabilities and the Commission has established a target reserve fund balance for this purpose. As of November 30, 2020, the Alliance is operating at 83% of its targeted reserve fund balance.

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Alliance Staff

The Alliance employs 501 people including staff in the following divisions: Administration, Employee Services and Communications, Finance, Health Services, Information Technology Services and Operations.

In a year of uncertainty and unforeseen challenges, Alliance staff rose to the occasion. The Alliance shifted to a fully remote workforce as of March 16, 2020, when the initial phase of the shelter-in-place order took effect in the state of California. The Alliance successfully transitioned the workforce to fulltime remote work capability in order to ensure staff safety. A very small group of essential workers come into the offices to manage facilities and perform duties that cannot be completed remotely. In addition, as many employees struggled with dependent care, home schooling, and other home responsibilities, the Alliance worked to ensure successful implementation of COVID-19 leave options and to provide support and flexibility as staff adjusted to a new way of working.

In addition to the pandemic, Alliance staff were also impacted by the wildfires in August and September, 2020. Approximately 20% of the Alliance workforce was evacuated from their homes during the wildfires that swept through our regions. The Alliance worked to support staff through this time, providing them guidance and resources where possible.

Alliance in the Community

In response to the COVID-19 pandemic, the Alliance engaged in efforts throughout 2020 to communicate and coordinate with public health and other county and local organizations across the tri-county service area. The purpose of this engagement was to ensure awareness of available resources that members might need during this time and to support the coordination of services for some of the Alliance's most vulnerable populations. Alliance staff supported the development of interagency preparation to provide supports and services for those experiencing homelessness who test positive for COVID-19 and need placement in an alternative care site or other forms of shelter and care. Staff also participated in teleconferencing with county health departments to inform the Alliance of public health guidance, to plan for surges in health care needs, and to monitor COVID-19 testing and supplies.

In late 2020, California began the implementation of the health equity metric that is being used to determine a county's tier regarding COVID-19 infections. Low-income, Black, Latino, Pacific Islander, and essential workers – have been disproportionately impacted by COVID-19 in terms of higher rates of infection, hospitalizations, and deaths. The Alliance staff have engaged in regular calls and collaborative work with



county leaders and local organizations to support improving county equity measures in our service area.

In addition, during 2020, the Alliance and its staff continued involvement in a number of regional and community coalitions and collaboratives that address public health issues, health care access, community networking and eligibility outreach in the tri-county service area. This includes Alliance involvement and participation in the following groups:

In Santa Cruz County

- Cabrillo College Community Health Workers – Program Advisory Committee
- Communications and Education for Farmworkers during COVID-19
- Disaster Recovery Collaborative
- Health and Wellness Santa Cruz
- Healthcare Leadership Briefing COVID-19
- OES Community Partner Update Meeting
- Whole Person Care Advisory Council
- Health Improvement Partnership of Santa Cruz Co. (HIPSC)
- Santa Cruz County Census 2020
- Santa Cruz County Operational Call COVID-19

In Monterey County

- Blue Zones Project – Wellness Champion Committee
- Disaster Recovery Collaborative
- Gonzales Unified School District Community Collaborative
- Community Alliance for Safety and Peace (CASP)
- CHWs and COVID Outreach Project
- Monterey County Caring Partners (MCCP)
- Monterey County Access and Functional Needs
- Monterey County Census 2020
- Monterey County Commission on Disabilities
- Monterey County COA Protecting Farmworkers from COVID-19
- Monterey County Operational Area Coordination Call
- Monterey Regional Health Development Group, Inc. (MoReHEALTH)
- Nutrition & Fitness Collaborative of the Central Coast
- Preventing Alcohol Related Trauma - South County & Monterey Peninsula
- Safety Net Integration Meeting
- Whole Person Care Social and Clinical Committee



In Merced County

- All in for Health
- Area Agency on Aging
- Behavioral Health and Recovery Services (BHRS)
- Binational Health Planning Committee
- Disaster Recovery Collaborative
- Health Services Advisory Committee
- Merced City and County CoC
- Merced County COVID-19 Updates for Healthcare Providers
- Merced County Health Care Leadership Council
- Merced County Local Complete Count Committee
- Merced County A Coalition Counteracting Tobacco (ACCT)
- Merced Mariposa County Asthma Coalition

Local Campaigns for Community Benefit

Alliance staff continued involvement with community food banks and United Way campaigns within Santa Cruz, Monterey and Merced counties during a full remote work environment due to the COVID-19 pandemic. Alliance staff raised over 7,040 pounds of food and donated \$37,271 as part of its holiday food drive efforts and contributed \$26,838 during the 2020 United Way campaign.

Looking Ahead

In 2021, the Alliance will continue its focus on the pandemic response and efforts to work collaboratively with local and state administrations towards effective vaccine distribution with emphasis on the three priorities established for 2021:

1. Adapt Operations in an Evolving Environment - Deliver on core responsibilities and ensure member access to essential care during the pandemic, other environmental disruptions and corresponding recovery efforts.
2. Ensure Sustainable Financial Performance - Proactively bring medical costs in line with revenue and utilization trends and improve administrative efficiency, while maintaining access to and quality of care for members.
3. Meet Member Health Needs - Develop population health capabilities and prioritize efforts to advance transformation in the Medi-Cal delivery system in order to identify and address member needs and disparities and improve health outcomes.

With an emphasis on these priorities the Alliance will be prepared to meet the challenges and opportunities presented with a change in federal administration.

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Further, the Alliance expects to focus attention and effort in 2021 towards the delivery system transformation envisioned through the state's CalAIM initiative which Governor Newsome has announced will be relaunched in 2021 towards a 2022 implementation.

In 2021, the Alliance board will begin its strategic planning process towards a new 3-year Strategic Plan which will likely focus largely on achieving the ambitious delivery system transformation goals of CalAIM with an emphasis on health equities and disparities.

The Commission and staff of the Central California Alliance for Health are pleased to provide this report on local efforts to improve access to health care for lower income residents of the tri-county service area and are appreciative of the continued support of the Boards of Supervisors.

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209-381-5300



Attachment A

Santa Cruz-Monterey-Merced Managed Medical Care Commission Roster for Year 2020

The Alliance has twenty-one board members (seven from Santa Cruz County, seven from Monterey County and seven from Merced County), in categories of representation including County government and health services, physicians, clinics, hospitals and the public. Board members during 2020 included:

From Santa Cruz County:

Leslie Conner, Vice Chair	Provider Representative
Ryan Coonerty, Chair	Board of Supervisors
Larry deGhetaldi, MD	Provider Representative
Dan Brothman (<i>effective on 8/18/20</i>)	Hospital Representative
Mimi Hall	Health Services Agency Director
Shebreh Kalantari-Johnson	Public Representative
Nanette Mickiewicz (<i>effective through 2/20/20</i>)	Hospital Representative
Michael Molesky	Public Representative

From Monterey County:

Maximiliano Cuevas, MD	Provider Representative
Julie Edgcomb	Public Representative
Gary Gray, DO	Hospital Representative
Elsa Jimenez	Director of Health
Jane Parker (<i>effective through 12/31/20</i>)	Board of Supervisors
Elsa Quezada	Public Representative
Allen Radner, MD (<i>effective on 1/1/20</i>)	Provider Representative

From Merced County:

Dorothy Bizzini	Public Representative
Lee Lor (<i>effective through 12/31/20</i>)	Board of Supervisors
Rebecca Nanyonjo	Public Health Director
James Rabago, MD	Provider Representative
Joerg Schuller, MD	Hospital Representative
Rob Smith	Public Representative
Tony Weber	Provider Representative

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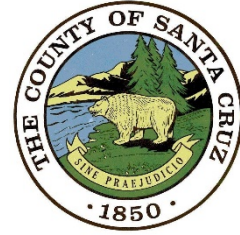
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Attachment B

Santa Cruz-Monterey-Merced Managed Medical Care Commission - 2020 Meeting Attendance Log

Commissioner	Total Absences	Attendance Rate	2.26.20	3.25.20 Cancelled	4.22.20	5.27.20	6.24.20	9.23.20	10.28.20	12.2.20
Bizzini, Dorothy	0	100%	Present		Present	Present	Present	Present	Present	Present
Brothman, Dan	0	100%	N/A		N/A	N/A	N/A	Present	Present	Present
Conner, Leslie	0	100%	Present		Present	Present	Present	Present	Present	Present
Coonerty, Ryan	1	86%	Present		Present	Present	EX	Present	Present	Present
Cuevas, Maximilliano	1	86%	Present		Present	Present	Present	Present	Present	EX
deGhetaldi, Larry	0	100%	Present		Present	Present	Present	Present	Present	Present
Edgcomb, Julie	0	100%	Present		Present	Present	Present	Present	Present	Present
Gray, Gary	2	71%	Present		Present	Present	Present	EX	Present	EX
Hall, Mimi	1	86%	Present		EX	Present	Present	Present	Present	Present
Jimenez, Elsa	0	100%	Present		Present	Present	Present	Present	Present	Present
Kalantari-Johnson, Shebreh	1	86%	EX		Present	Present	Present	Present	Present	Present
Lor, Lee	0	100%	Present		Present	Present	Present	Present	Present	Present
Molesky, Michael	0	100%	Present		Present	Present	Present	Present	Present	Present
Nanyonjo, Rebecca	1	86%	Present		EX	Present	Present	Present	Present	Present
Parker, Jane	0	100%	Present		Present	Present	Present	Present	Present	Present
Quezada, Elsa	1	86%	Present		Present	Present	Present	Present	Present	EX
Rabago, James	0	100%	Present		Present	Present	Present	Present	Present	Present
Radner, Allen	0	100%	Present		Present	Present	Present	Present	Present	Present
Schuller, Joerg	1	86%	Present		Present	Present	Present	Present	EX	Present
Smith, Rob	2	71%	Present		Present	X	X	Present	Present	Present
Weber, Tony	2	71%	EX		Present	Present	Present	Present	X	Present



February 3, 2021

The Honorable Gavin Newsom
Governor, State of California
State Capitol Building, 1st Floor
Sacramento, CA 95814

RE: Equitable Distribution of COVID-19 Vaccinations

Dear Governor Newsom:

On behalf of the Central California Alliance for Health (the Alliance), the Medi-Cal managed care plan serving over 360,000 Medi-Cal beneficiaries in Santa Cruz, Monterey and Merced counties, the local health departments of these counties and leaders of safety-net clinics in these counties, we write to share our concerns and provide recommendations regarding the equitable supply and distribution of the COVID-19 vaccine to Medi-Cal beneficiaries and those who otherwise use the safety-net to receive health care services.

Safety-net providers, including local health departments, federally qualified health centers (FQHCs) and community clinics, are the backbone of the health care delivery system for individuals who are most at risk for getting COVID-19, being hospitalized with COVID-19 and dying of COVID-19. These individuals are Medi-Cal beneficiaries, low-income workers and the uninsured. They are our seniors and persons with disabilities, our agriculture workers, homeless individuals, and low-income people with chronic health conditions. These local providers also serve a significant portion of the Latinx population,

which is also at an increased risk of contracting COVID, being hospitalized, and even dying from the disease.

We are aware that the Administration is shifting its vaccine strategy in an attempt to more quickly vaccinate more people and intends to use Blue Shield as its third-party administrator to do so. We are ready to partner with the Administration and its delegates toward this goal. **To ensure that this happens in an equitable manner and does not disparately harm the most vulnerable and at-risk individuals, we make the following recommendations.**

Multi-County Entities (MCEs) – MCEs, which are entities that operate in multiple counties within the state, receive vaccine allocations from the state for distribution. However, in some counties, there are no MCEs operating. In other counties, MCEs serve only a segment of the population which may leave care providers of at-risk populations without equitable access to vaccine.

Among the Medi-Cal population in Santa Cruz, Monterey and Merced counties, 65%, or approximately 190,000 Medi-Cal beneficiaries, receive health care services through an FQHC, not an MCE. In Monterey county, there are no MCEs present. FQHCs serve the most marginalized, the uninsured, and those with language, transportation and education barriers. FQHCs serve a significant proportion of low-income, and uninsured people of color. In our region particularly, the Latinx population is disproportionately impacted by COVID.¹ Our local FQHCs have played a major role in serving these communities since the very beginning of COVID, providing important testing and treatment services. They are poised to play a significant role in vaccinating the community.

Recommendation: Reserve and allocate vaccine supplies for Local Health Jurisdictions (LHJ) proportionate to Medi-Cal and FQHC populations so that the LHJ can work with the Administration to ensure distribution to the Medi-Cal delivery system within its jurisdiction and reduce disparate impact on vulnerable populations.

Redistribution of unused vaccine supply – The Administration has proposed that unused vaccine supply be returned for reallocation if the supply use has not met a specified threshold and a plan for administering the remaining supply is not submitted.

Medi-Cal and safety net systems serve the hardest to reach populations. Smaller and more rural counties do not have the same resources as larger urban areas and may need more time given less resources so that they may provide vaccines to their patients who see them as trusted providers. Applying a “one size fits all” metric systematically disadvantages hard to reach, high-risk populations, which may require more staff, more enabling resources, more use of traditional analog versus digital communication, and more time to serve effectively. LHJs and Medi-Cal plans have the local expertise and local relationships to address these issues effectively within county limits. Timeframes for vaccine distribution

¹ In Santa Cruz County, the Latinx population makes up 33% of the County’s population, yet they comprise 54% of known cases of COVID-19 cases.

should not solely be based on MCE resources and infrastructure, most typically geared towards the commercially insured.

Recommendation: Include equity, including projections of disparate impact on vulnerable demographics, in redistribution plans. Any vaccine allocation that is unused in the specified timeframe, should be reallocated to the same jurisdiction and should not be reallocated to a different jurisdiction without approval of the LHJ.

Reduction of Disparate Impact. County demographics including ethnicity, age, health conditions and occupation are contributing factors to the prevalence and severity of COVID-19 infections within a county. According to a UCSF study, food and agricultural workers, and particularly Latinx, have a 59% increase in chance of death from COVID-19.² LHJs have local knowledge, relationships with regional service providers, and specialized experience to reduce disparate harm to vulnerable populations within counties.

Recommendation: Vaccine supply allocation must consider the demographics of each county. Counties with higher proportions of essential workers at risk for severe COVID-19 infection and death should receive allocations proportionate to their at-risk population. LHJs and Medi-Cal plans should be included in the allocation methodology to provide input and data to ensure equitable distribution. Concrete vaccine equity metrics should be developed to ensure allocation and distribution to Medi-Cal beneficiaries and the lowest HPI quartiles.

We understand the Administration's interest in getting vaccines to as many people as quickly as possible. We are concerned this leads to reliance on large health systems in large counties. Yet, the highest rates of COVID-19 exposure and deaths are not necessarily in those areas.

The vaccination of lower-risk people (those who can work from home, live in uncrowded conditions, are in jobs that do not put them at risk, or do not have comorbidities placing them a greater risk) will not end the pandemic. **Vaccination of those most at risk is critical to ending the pandemic.** To do so, the state **must ensure equitable distribution of the vaccine.** Due to the disproportionate impact of COVID-19 among the Latinx population and agriculture workers, this may mean a greater initial distribution to certain area and populations. **Equity means taking different actions in order to ensure the same result for everyone.**

Together, we are committed to working with the Administration towards improving the rate of vaccination while ensuring equitable vaccine distribution that considers the relative risk within our communities and protects our essential workers and most vulnerable residents.

² <https://www.medrxiv.org/content/10.1101/2021.01.21.21250266v1.full>

Sincerely,



Stephanie Sonnenshine
Chief Executive Officer
Central California Alliance for Health



Elsa Jimenez
Director of Health Services
Monterey County Health Department



Dori Rose Inda
Chief Executive Officer
Salud Para La Gente



Leslie Conner
Chief Executive Officer
Santa Cruz Community Health Centers



Mimi Hall
Director
Santa Cruz County Health Services Agency



Rebecca Nanyonjo-Kemp
Director of Public Health
Department of Public Health



Maximiliano Cuevas, MD
Executive Director
Clinica de Salud del Valle de Salinas



Tony Weber
Chief Executive Officer
Golden Valley Health Centers

cc: Senator Anna Caballero
Senator John Laird
Assemblymember Adam Gray
Assemblymember Robert Rivas
Assemblymember Mark Stone
Yolanda Richardson, Secretary, Government Operations Agency
Ana Matosantos, Cabinet Secretary, Office of Governor Newsom
Mark Ghaly, MD, MPH, Secretary, Health and Human Services Agency
Will Lightbourne, Director, Department of Health Care Services
Tomás Aragón, MD, DrPH, Director and State Public Health Officer,
Department of Public Health
Central California Alliance for Health Board Members

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December 18, 2020

To Whom it May Concern:

I am writing to express my agency's support for the County of Santa Cruz Public Health Network of Care grant application to ACEs Aware, and also to commit to the work of the Santa Cruz County Aces Network in the planning and development of a Trauma-Informed Network of Care, including ACE screening and referral process, clinical protocols for interrupting the toxic stress response, and facilitating access to "buffering" resources and supports that will help to prevent, treat, and heal the harmful consequences of toxic stress.

Improving equity, health and wellbeing in our community is a shared responsibility and we are committed to this work.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephanie Sonnenshine". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Stephanie Sonnenshine
Chief Executive Officer



Q4 2020 Appeals and Grievances: 445

Appeals: 14% [52% in favor of Plan; 48% in favor of Member]
Exempt Grievances: 4%
Grievances : 77%
Other: 5% [Inquiries, Duplicates, Withdrawn]

Category Figures

- Referrals: 4%
- Access Issues: 6%
- Benefits and Coverage: 3%
- Quality of Care Issues: 15%
- Other: 69%
 - ❖ Transportation: 56% of "Other" Category
 - ❖ Provider Billing Issues: 28% of "Other" Category
 - ❖ Medication Issues: 9% of "Other" Category
 - ❖ Communication Issues: 3% of "Other" Category

Analysis and Trends

- ❖ A high percentage of "Other" grievances involved transportation issues for late, missed rides to appointments and quality of service issues.
- ❖ Grievances stable with a dip in volume toward the end of the year.
- ❖ No significant trends noted for grievances in Q4 2020.

Highest Grievances Filed by County

1. Monterey: 39%
2. Merced: 31%
3. Santa Cruz: 30%

Behavioral Health Beacon Grievances:

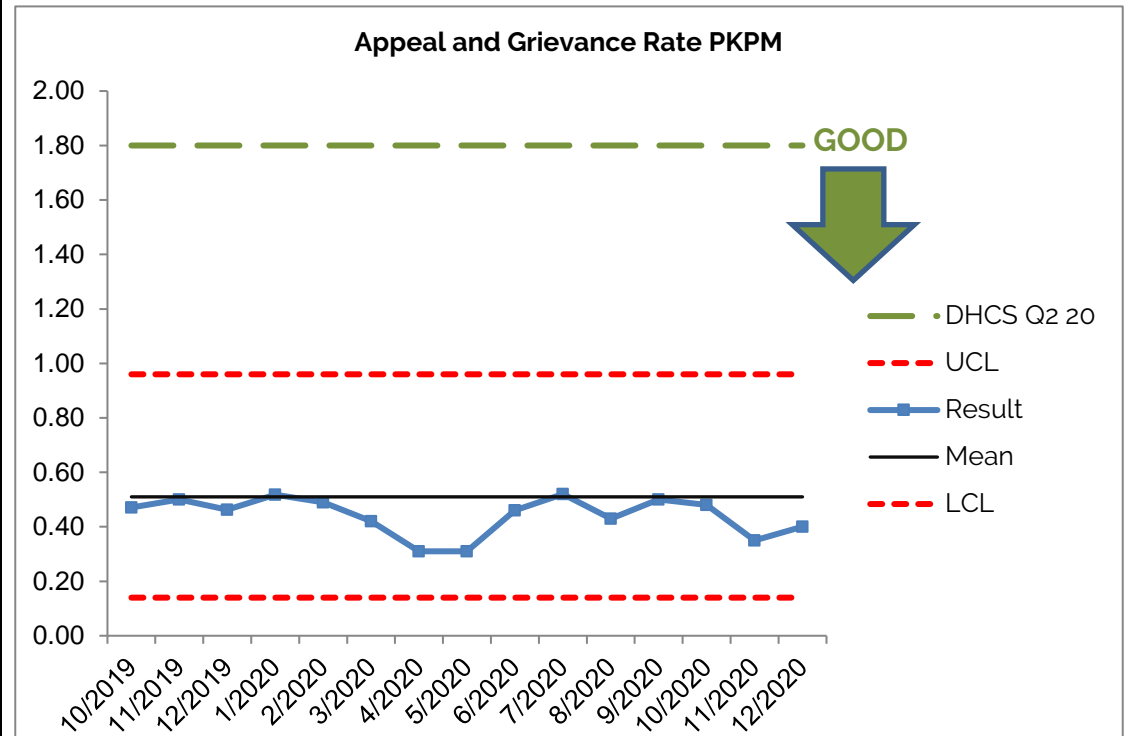
- ❖ Member Grievances: 12

IHSS Summary:

- ❖ Member Grievances: 4

- In Control
- Not in Control

A lower rate demonstrates a good or positive result when compared to Upper Control Limits (UCL) and Lower Control Limits (LCL) which represent three (3) standard deviations from mean or average performance.



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
2019 Enrollment	343,495	343,060	342,453	343,500	343,242	341,899	338,929	338,408	338,144	337,494	336,610	335,289
A & G Issues	190	200	287	225	214	150	191	223	216	158	168	155
Rate PKPM*	0.55	0.58	0.84	0.66	0.62	0.44	0.56	0.66	0.64	0.47	0.50	0.46
2020 Enrollment	334,394	337,640	337,484	341,823	346,219	350,086	352,936	355,506	358,519	360,304	362,465	365,001
A&G Issues	173	167	141	107	108	162	187	157	183	173	126	146
Rate PKPM*	0.52	0.49	0.42	0.31	0.31	0.46	0.52	0.43	0.50	0.48	0.35	0.40

*Grievances Per 1,000 Member Month

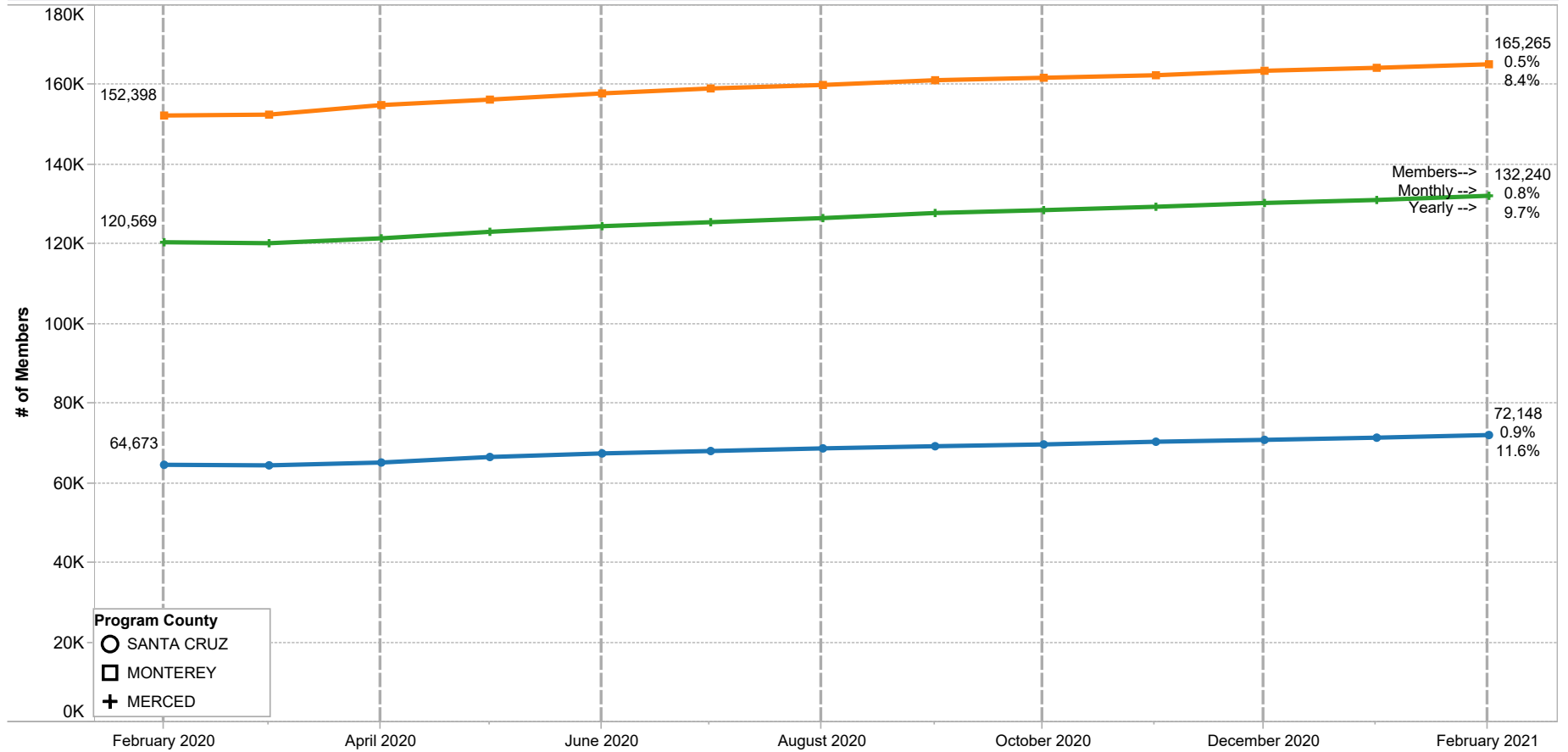
Enrollment Report

Year: 2017 & 2018 County: All Program: IHSS & Medi-Cal
 Aid Cat Roll Up: All Data Refresh Date: 2/4/2021



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



Program..	ProgramCo..	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021
Medi-Cal	SANTA CRUZ	64,673	64,534	65,246	66,635	67,533	68,134	68,799	69,339	69,790	70,468	70,935	71,488	72,148
	MONTEREY	151,818	152,046	154,451	155,814	157,373	158,616	159,503	160,705	161,325	161,968	163,094	163,841	164,736
	MERCED	120,569	120,329	121,554	123,191	124,601	125,606	126,634	127,915	128,635	129,483	130,432	131,185	132,240
IHSS	MONTEREY	580	575	572	579	579	580	570	560	554	546	540	537	529
Total Members		337,640	337,484	341,823	346,219	350,086	352,936	355,506	358,519	360,304	362,465	365,001	367,051	369,653