Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Wednesday, May 26, 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/255206629
    b. Or by telephone at:
    United States: +1 (646) 749-3122
    Access Code: 255-206-629
    c. New to GoToMeeting? Get the app now and be ready when your first meeting starts:
    https://global.gotomeeting.com/install/255206629

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, May 25, 2021 to the Clerk of the Board at kstagnaro@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to five minutes.
    b. Public comment during the meeting, when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

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

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

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.
C. Recognize Board service of Gary Gray, DO, Hospital Representative, Monterey 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. – 9H.): 3:10 p.m.

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

- Reference materials: Executive Summary from the CEO; and LHPC highlights from Governor's May Revision for 2021-22.

Pages 5-01 to 5-16

6. Accept Alliance Dashboard for Q1 2021.

- Reference materials: Alliance Dashboard – Q1 2021.

Pages 6-01 to 6-02

7. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for third month ending March 31, 2021.

- Reference materials: Financial Statements as above.

Pages 7-01 to 7-08

Minutes: (8A. – 8D.)

8A. Approve Commission meeting minutes of April 28, 2021.

- Reference materials: Minutes as above.

Pages 8A-01 to 8A-06

8B. Accept Continuous Quality Improvement Committee meeting minutes of January 28, 2021.

- Reference materials: Minutes as above.

Pages 8B-01 to 8B-06

8C. Accept Member Services Advisory Group meeting minutes of February 11, 2021.

- Reference materials: Minutes as above.

Pages 8C-01 to 8C-03

8D. Accept Whole Child Model Family Advisory Committee meeting minutes of March 8, 2021.

- Reference materials: Minutes as above.

Pages 8D-01 to 8D-06

Reports: (9A. – 9H.)

9A. Approve staff recommendation for Alliance Formulary Changes for Q2 2021 as recommended by the Pharmacy and Therapeutics Committee.
- Reference materials: Staff report and recommendation on above topic.

Pages 9A-01 to 9A-02

9B. Accept report on Alliance Office Reopening Update.
- Reference materials: Staff report on above topic.

Pages 9B-01 to 9B-02

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

Pages 9C-01 to 9C-04

9D. Approve staff recommendation to update Local Agency Investment Fund Authorization Resolution.
- Reference materials: Staff report and recommendation on above topic; and Resolution.

Pages 9D-01 to 9D-02

9E. Approve Quality Improvement Workplan Report for Q4 2020.
- Reference materials: Staff report and recommendation on above topic.

Pages 9E-01 to 9E-03

9F. Approve Quality and Performance Improvement Program Annual Report for 2020.
- Reference materials: Staff report and recommendation on above topic.

Pages 9F-01 to 9F-07

9G. Approve Quality Improvement and Population Health Workplan for 2021.
- Reference materials: Staff report and recommendation on above topic; and 2021 Quality Improvement and Population Health Workplan.

Pages 9G-01 to 9G-07

9H. Approve Utilization Management Quarterly Report for Q4 2020 and Utilization Management Workplan Template for 2021.
- Reference materials: Staff report and recommendation on above topic; and 2021 Utilization Management Workplan Template.

Pages 9H-01 to 9H-19

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

10. Consider accepting audited financial statements and management letters for Alliance's fiscal year ending December 31, 2020 from Moss Adams LLP, independent auditors. (3:15 p.m. – 3:45 p.m.)

A. Moss Adams staff will present and Board will consider accepting audited financial statements and findings of independent auditors for FY 2020.
- Reference materials: Audited Financial Statements: FY 2020.

Pages 10-01 to 10-52

11. **Consider approving recommendation regarding enabling ordinance in support of Medi-Cal Managed Care Procurement. (3:45 p.m. – 4:15 p.m.)**

Ms. Stephanie Sonnenshine, CEO, will review and Board will consider approving a model for Commission membership criteria for inclusion in enabling ordinances authorizing the San Benito County and Mariposa County shifts to the County Organized Health System (COHS) model through Central California Alliance for Health (the Alliance) in support of Medi-Cal Managed Care Procurement.

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

Pages 11-01 to 11-03

12. **Discuss Department of Health Care Services CalAIM Implementation. (4:15 p.m. – 4:30 p.m.)**

A. Ms. Stephanie Sonnenshine, CEO, will review and Board will discuss CalAIM implementation.

- Reference materials: Staff report on above topic; and CalAIM Executive Summary and Summary of Changes.

Pages 12-01 to 12-30

13. **Discuss 2018-2020 Strategic Planning Final Report. (4:30 – 4:45 p.m.)**

A. Ms. Stephanie Sonnenshine, CEO, will review and the Board will discuss the final report from the 2018-2020 Strategic Plan and the planned agenda for the Board's June 23, 2021 Strategic Planning Retreat.

- Reference materials: Staff report on 2018-2020 Strategic Planning Final Report; and staff report on Board Retreat.

Pages 13-01 to 13-06

Adjourn to Closed Session

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

- Closed session agenda item.

Return to Open Session

15. **Open session pursuant to Government Code Section 54956.9(d)(2) – Conference with Legal Counsel - Related to litigation. (4:55 – 5:00 p.m.)**

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

Information Items: (16A. – 16E.)

Announcements:

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

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

- Member Services Advisory Group
  Thursday, August 12, 2021; 10:00 – 11:30 a.m.

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

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

- Whole Child Model Family Advisory Committee
  Monday, July 12, 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 May 26, 2021 meeting:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, June 23, 2021, 9:00 a.m. – 4:00 p.m.
  Location: Alliance Office, 1600 Green Hills Road, Scotts Valley, CA 95066

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: May 26, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

2021-22 State Budget May Revise. Amidst rumors of an expected $75B budget surplus and a week of public appearances and announcements unveiling his "California Comeback Plan", Governor Gavin Newsom released the May Revision to the 2021-22 State Budget proposal on May 14, 2021. The May Revise includes Medi-Cal caseload assumptions of 14.5M Californians on average each month enrolled in Medi-Cal for FY 21-22, including an expansion of eligibility to for full-scope Medi-Cal for older adult ages 60 and older regardless of immigration status effective no sooner than May 1, 2022 and an expansion of eligibility for postpartum individuals from the current 60 days to 12 months. In addition, the May Revise proposes significant investments ($3.5B over five years) in youth behavioral health programs and services and funds other Administration priorities. See attached report from Local Health Plans of California that provides highlights and additional details from the Governor's May Revision for 2021-22.

Legislative Session 2021. At the April meeting, your board adopted positions of support on the following bills: AB 4 (Arambula), SB 56 (Durazo), SB 316 (Eggman), and SB 365 (Caballero). Letters of support for each of these bills were sent and are included as Item 16C in the board packet. The bills remain active in the legislative committee process with June 4, 2021 as the final day for bills to be passed out of their house of origin to be considered by the second house. Staff continues to monitor these, and other priority bills identified which may have an impact on the Alliance.

Medi-Cal Managed Care Procurement. As authorized by your Board at the April 28, 2021 meeting, the Alliance, in partnership with the counties of San Benito and Mariposa Boards of Supervisors submitted a non-binding Letter of Intent to express mutual interest to expand the Alliance service area to offer a County Organized Health System model of Medi-Cal Managed Care to eligible Medi-Cal beneficiaries in these counties. Accordingly, staff have met with representatives from both counties to begin planning and discussions on next steps. The most immediate next steps include adoption of County Ordinances to develop the structure for a new multi-county governing board and the development of a preliminary provider network development strategy due to the Department of Health Care Services (DHCS) in October. To that end, the Alliance board must decide upon governance structure for a newly formed board. Staff will present options for consideration at our May 26, 2021 meeting.

California Advancing and Innovating Medi-Cal (CalAIM). Planning for implementation of the CalAIM initiatives continues, with plans working in partnership with DHCS, counties and associations to prepare for the new Enhanced Case Management (ECM) benefit and

optional In Lieu of Services (ILOS) effective January 1, 2022. This is an ambitious timetable and significant efforts will be necessary to meet this deadline as many aspects of these programs remain under development. Staff will provide a report on CalAIM and these efforts at the May 26, 2021 board meeting.

Community Involvement. I attended the virtual CHCF Health Plan Council meeting on May 12, 2021 and the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting on May 13, 2021. On May 14, 2021 I participated virtually in the CHCF Medi-Cal/CBO Bootcamp Design focus group. I attended the virtual Local Health Plans of California May Board meeting on May 17, 2021. On May 22, 2021 I attended the Santa Cruz Community Health Centers/Dientes Community Dental Care/MidPen Housing groundbreaking at 1500 Capitola Road. I plan to attend the virtual HIPSCC Annual Community Forum on May 27, 2021.

Health Services

Health Services. The Health Service division's priority efforts in May include assessing and finalizing a list of codes to be removed from requiring prior authorization, COVID vaccine promotion outreach, pediatric care resumption outreach, completing Primary Care Provider (PCP) chart audits as part of analysis for the 2021 HEDIS submission to DHCS, and preparing the Model of Care submission for the CalAIM Enhanced Case Management program which is due July 1.

Inpatient / ED Utilization. ED volumes decreased in Q1 2021 compared to the COVID surges in the early months of the prior year. Non-mature Claims data for the second quarter indicates increased numbers, particularly in Santa Cruz County. Inpatient data reflects similar patterns with some increased length of stay as COVID-related illnesses extended usual disease patterns.

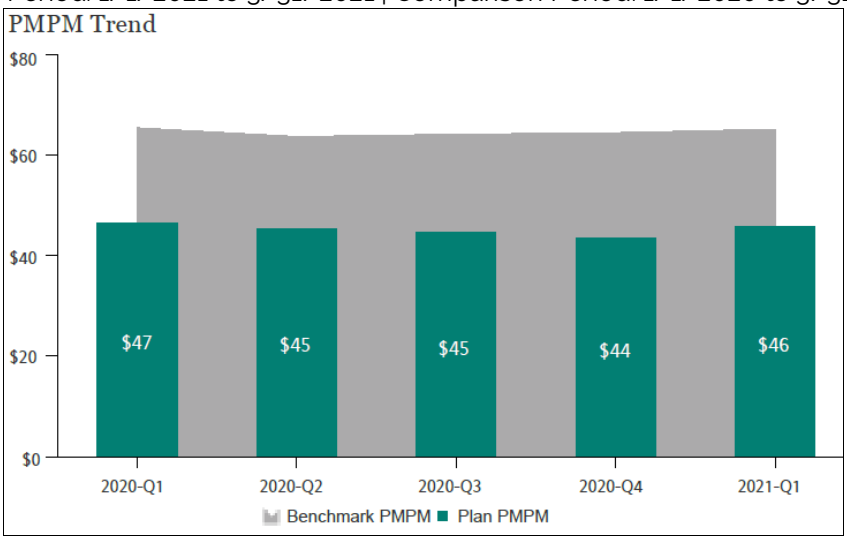
Inpatient care-coordination efforts continue with stratification of members identified as high risk for readmission per predictability reporting. Plans are in process for a return to member face-face interactions with Case Management prior to discharge. These interventions will resume when COVID restrictions are lifted. There continues to be increased enrollment in the Post Discharge Meal Delivery Program. Since becoming an Alliance benefit in January, 1st quarter enrollment totaled 78 members representing a 28% increase over 1st quarter of 2020.

Collaborative meetings have been initiated with the Alliance and Hope Respite teams for the Recuperative Care / Bridge Housing in Merced County scheduled to begin accepting members in the next two months.

Whole Child Model (WCM) Program. Efforts towards optimization of the WCM Program remains in process with increased automated reporting and auditing of key efforts. The DHCS dashboard continues to provide benchmarking comparisons to WCM plans that indicate positive trends in referrals and individualized care plans for high risk members. Optimization of the program has also advanced to enhanced reporting for the aging out process, the final area of focus for the internal CAP process completion.

Q1 2021 Pharmacy Trends. The Q1 2021 PMPM of $45.84 is decreased by 1.6% as compared to Q1 2020. This is due to both decrease in utilization and improved network discounts. This is lower than the Custom benchmark.

Report Period: 1/1/2021 to 3/31/2021 | Comparison Period: 1/1/2020 to 3/31/2020



The Alliance's membership has increased by 10.4% with an overall decrease in percentage and number of utilizing members. Prescription utilization (PMPM) decreased 20.7%. Although we saw the drug utilization among most drug classes is down, but there was a particularly large decrease in utilization for acute medication therapy.

- Allergy ↓ 27%
- Asthma/COPD ↓ 31% (including SABA, ICS, ICS/LABA, LRA, spacers)
- NSAIDs ↓ 26%
- Antibiotics ↓ 44%
- Antivirals for flu ↓ 99%
- Cough & Cold ↓ 68%
- Opioid Analgesics ↓ 27%.

The decrease in utilization is offset by drug mix (shift in therapy) for high cost drugs (Trulicity, Steglatro, Eliquis, Trikafta, Vyondys-53, Increlex, Taltz, Dupixent).
Overall cost per Rx increased 24.0% this period, with cost for branded prescriptions increasing 18.3% and generic prescriptions increasing 1.2%. In addition, our percentage of Specialty spend has increased from 42% in Q1 2020 to 47% in Q1 2021. That is leading to increase Specialty PMPM, which is an upward trend of 8.5% increase since Q1 2020.

We have improved network discounts, largely in part to improved rates on certain high-volume generic drugs (i.e. Albuterol inhaler, Gabapentin, Hydrocodone-APAP, Fluticasone-Salmeterol Diskus), as well as improved specialty drug network discounts through our Specialty vendor US Bio-services.

	Medi-Cal Non-CCS	Medi-Cal CCS	IHSS	Duals
Plan Paid PMPM	$42.77	$403.90	$155.03	$2.46
% Change since Q12020	↓ 3.8%	↑ 6.3%	↑ 23.3%	↓ 5.3%

When comparing PMPM for each member type (Medi-Cal Non-CCS, Medi-CCS, IHSS and Duals)

1. Medi-Cal Non-CCS PMPM has decreased by 3.8% since Q12020. It is due to decrease in utilization despite increase in membership.
2. Medi-Cal CCS PMPM had increased by 6.3% due to Specialty spend increase in CCS population. These Specialty medications are brand name high-cost drugs. For example, the medication to treat Duchenne muscular dystrophy Vyodys-53 costs about $124K/Rx. CCS Membership cost is the primary driver of upward trend in PMPM.
3. IHSS membership has decreased slightly, but utilization was steady (+1.2%). The addition of one high-cost therapy (Imbruvica - $14k/Rx) increased PMPM trend in IHSS PMPM.
4. Dual population has decrease in PMPM due to decrease in utilization.

Medi-Cal Rx Update. DHCS has not provided any updates on Magellan's development of a Medi-Cal Rx conflict avoidance plan. The draft was due to DHCS by Magellan on May 1, 2021 with an anticipated final plan by June 1, 2021. For now, DHCS has cancelled all workgroup meetings with plans, and will notify plans of the next steps in May after review of conflict avoidance plan. It is notable that in the May Revise, no savings are recognized from the carve-out for 2021.

Lead Screening. Assembly Bill (AB) 2276 (Chapter 216, Statutes of 2020) added blood lead screening requirements to state law. Plans as required by DHCS will ensure network providers are providing oral or written anticipatory guidance from the age of six months until 72 months of age. Additionally, blood lead screening is required for all child members at 12 and 24 months of age by state and federal law. If no testing has been completed after 24 months of age, screening should be completed once prior to 72 months of age. Should the parent refuse screening or the provider determines that risk of screening poses a greater risk to the child's health, than the risk of lead poisoning, providers must document reason(s) for not completing the blood lead screening test in the child's medical record. In cases where consent is withheld, the provider must ensure that this is documented in the child's record using a statement of voluntary refusal. Should the family refuse to sign it or is unable to do so, the provider must document the reason for not obtaining a signed statement of voluntary refusal in the child's chart. The Alliance has created a Provider Portal report indicating whether members have completed one or both blood lead screenings at 12 and 24 months, tracking children from ages six months to 72 months.

Health Education & Disease Management. The Quality and Health Programs (QHP) team continues to engage with members through various health education and disease management programs telephonically and are providing members with resources. In addition, QHP staff have supported the following outreach efforts:

CommonSpirit/Dignity Outreach. In response to the CommonSpirit/Dignity negotiations, QI/PH staff prioritized outreach efforts and engaged with Merced County members who were given Administrative status. Outreach calls were made to ensure members were informed of their options now that CommonSpirit/Dignity has continued to contract with the Alliance. A total of 1,103 members have been contacted by April 26, 2021.

Population Needs Assessment Survey. The primary purpose of the Population Needs Assessment (PNA) is to improve health outcomes for Medi-Cal members by identifying needs and gaps in health education and cultural and linguistic services. Multiple internal and external data sources will be used, including claims/encounter data, HEDIS, and state and county-level data. Findings from the PNA highlight areas of success, as well as areas of opportunities for improvement in the health plan. To continue supporting the annual PNA work, the QHP team has started to conduct outreach calls with Alliance members as of April 20, 2021 to gather input from members on how well the Alliance is addressing their needs. The PNA report is due to DHCS on June 30, 2021.

Cultural and Linguistic. The Cultural and Linguistic team continues to work with our language assistance services vendors to ensure continuity of access to telephonic and on-site face-to-face interpreting services for our Limited English Proficiency and Deaf and/or Hard of Hearing members during their medical visit with the provider. On-going provider communication regarding the availability of telephonic language assistance services are being provided.

Language Assistance Services Trends. The overall utilization of telephonic interpreting services has significantly increased among providers, Alliance staff, and contracted Alliance vendors. A total of 8,775 telephonic interpreting services calls were reported for measuring Q1 2021 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). This is a 92% increase when compared to the previous Q1 2020 (4,581). As for face-to-face interpreting services, we had a total of 337 provider requests that were coordinated in Q1 2021 across the Alliance's service areas. This is a 28% decrease when compared to the previous Q1 2020 (471). This could be due to the multiple efforts taken to ensure Alliance members and providers are supported during a telehealth visit. This has emerged as a need due to COVID-19 as many of our provider's transition to telehealth visits that may include phone and video options and may no longer be required to have a qualified interpreter to be present.

Recuperative Care Pilots. The Community Care Coordination (CCC) team continues to closely collaborate with the Strategic Development and UM/CCM departments in preparation for the go-live of the Recuperative Care Pilots (RCP) in Merced and Monterey Counties. Meetings are underway with the RCP teams to finalize facility site reviews and review of the facilities policies and procedures. The expected launch for both counties is July 2021. We anticipate initiating quarterly meetings with the three RCP sites in August, to share best practices of the pilot and to discuss any operational areas identified by the sites.

As reported previously, Santa Cruz County's RCP launched in April. Alliance staff are meeting regularly with the RCP, as well as local hospitals, to refine the RCP authorization process and to discuss care coordination for those members currently receiving RCP services.

Enhanced Care Management and In Lieu of Services. Work continues internally, as well as with our Whole Person Care (WPC) counties, in preparation for the implementation of ILOS and the new ECM Medi-Cal benefit in January 2022. Further direction from DHCS has narrowed the ECM populations of focus in 2022 to those populations currently receiving WPC services in Santa Cruz and Monterey Counties including people experiencing homelessness, high utilizers, and SMI/SUD populations. In addition, further guidance from DHCS is expected at the end of this month related to ECM/ILOS All Plan Letters, draft ECM rates, and the final ECM/ILOS requirements document. Staff are working towards the required DHCS submission of components of the Model of Care document, that is due the first of July. Lastly, internal staff are engaged in ongoing meetings with DHCS, as well as our professional associations, in preparation for this new benefit and services.

Behavioral Health. CCC staff have begun initial engagements within the Alliance service area to better understand the Adverse Childhood Experiences (ACE) work underway in the communities. As mentioned previously, ACE is a priority area of emphasis within the Alliance and Beacon, as a way of enhancing community care coordination in behavioral health services in 2021. Meetings are being held/scheduled to better understand the ongoing planning efforts being conducted by state ACE Aware grantees to increase awareness of the ACE screenings among health and social services providers, as well as to participate in the implementation of a comprehensive communication plan to increase visibility and awareness of the ACE Aware initiative. This work is complementary to other ongoing Alliance initiatives to promote ACE screenings within the provider network.

Employee Services and Communications

Alliance Workforce. As of April 26, 2021, the Alliance has 516 budgeted positions of which our active workforce number is 484.2 (active FTE and temporary workers). There are 9 positions in active recruitment, and 29 positions are vacant. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets.

Human Resources is partnering with Training & Development and Communications on an Employee Engagement initiative. Our new program, Alliance Connect, provides helpful information in three focus areas: Supervisor Connect is our way of supporting our supervisors, providing resources and information to support them in leading their teams; Parent Corner focuses on fun ideas Alliance parents can take home with them, as well as relevant guidance and support for working at home; Supervisor Connect focuses on resources and information designed specifically for our leadership team; and our last focus area, Health & Wellness, provides relevant benefit information, health-focused articles, and so much more for staff as a way to focus on taking care of themselves, both physically and mentally. These engagement forums have been well received by staff.

Human Resources is commencing work with Pearl Meyer, our outside compensation consultant, to ensure alignment between our compensation ranges, and the job market. This is an important evaluation process and best practice to ensure we are competitive in the market to attract and retain talent. This work provides an opportunity for us to review comp data, pay structures, evaluate benchmarked positions, and provide a summary report and recommendations, if any, at the conclusion of this work.

Facilities and Administrative Services. Capitola Manor: California's Office of Statewide Health Planning and Development (OSHPD) has indicated that the building has mold/moisture issues that need to be remediated before construction can begin. The remediation is currently underway and will be completed by the end of May. The OSHPD increment 1 permit has not yet been issued. The OSHPD permit is expected to be approved in late June 2021. The project is currently 2% complete and scheduled to be finished in Q2 2022.

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

Communications. The team collaborated with Operations and a small workgroup of internal stakeholders to launch a digestible, digital email newsletter meant to engage community partners and raise awareness about key Alliance activities that positively impact the health of the communities we serve. This bi-monthly email newsletter, called "The Beat," was launched on April 27, 2021 and will be sent on a bi-monthly basis to a variety of external partners and community stakeholders within the Alliance's service area. The Beat was seen by more than 1,500 community partners thus far and will continue to feature information valuable to our community partners. The email newsletter may also be found on the Alliance website.

The external website re-launch project is on track for a July 1, 2021 launch. The new website will provide a professional, branded, mobile-responsive, compliant user experience, with easily digestible, searchable content. Staff is working on a comprehensive communications plan to inform members, providers, community stakeholders and other interested parties about the website's features and benefits.

Operations

New Provider Data Repository Launched. The Provider Services and the ITS Division launched the Provider Data Repository (PDR) in April 2021, which was the culmination of a 3-year endeavor to enhance the accessibility and maintenance capabilities of provider data. PDR go-live preparation included hours of testing and data quality review and showcased the expertise and commitment of staff across Provider Services and ITS. The overarching goal of the Alliance's Provider Data Program is to significantly improve data accuracy and accessibility in support of regulatory deliverables and support the efficiency and effectiveness of ongoing operations.

2021 Annual Network Certification Completed. Our Provider Quality and Network Development team submitted the 2021 Annual Network Certification Filing and produced a summary of the 2020 Access Plan as well as solidified focus for the 2021 Access Plan. May 2021 priorities for Provider Services is also to complete and submit regulatory deliverables for DHCS and the Department of Managed Health Care, preparation of ECM and ILOS network documents, and provider education and outreach related to various areas of Alliance operations.

CommonSpirit Update on PCP Reassignment Progress. Another focus for Provider Services in collaboration with Member Services this past month was to assist in outreach to providers related to the positive resolution of the CommonSpirit negotiation. This provider outreach

included follow-up phone calls to inform providers of the outcome of the negotiation, and assistance with the reassignment of members to their local Dignity Health providers. Nearly 15,000 Alliance members were also notified that the Alliance remains in contract with CommonSpirit, including both Dignity Health Medical and Mercy Medical Foundations and Groups. The notice informed Alliance members that they may continue to access care with these in-network providers.

Our Regional Operations team coordinated an outbound call campaign to members who were previously assigned to Dignity Health primary care providers. Nearly 2,600 outreach calls have been made to members previously approved for continuity of care services. The intention of the calls was to inform members they can be reassigned to their Dignity Health Provider, effective May 1, 2021. Member Services received calls from members as well with general inquiries or requests for linkage to their prior Dignity or Mercy PCP and staff assisted by answering questions and fulfilling PCP linkage requests. Over 5,000 members were linked back to their prior PCP during the month, including over 2,000 members who had been approved for Continuity of Care. Over the next few months, staff will continue to ensure members are assigned to their PCP of choice and that questions are answered thoroughly.

Regional Operations Outreach and Engagement. The Alliance's focus for Regional Operations Department in May 2021 will be on COVID-19 outreach calls to members 16-64 years old with moderate health conditions to inform them of vaccine availability. Department staff will also focus on scheduling and initiating the Member Support and Engagement Committee. In addition, staff will also be actively engaging in several tactics to improve Joint Operations Committee and Clinic Joint Operations Committee meetings including: soliciting stakeholder feedback; redefining the objective; and implementing changes that drive action in collaboration with our key provider partners.

2020 Operating Plan Assessment and 2021 Progress Update. This past month, Operational Excellence completed various assessments to measure progress towards the execution of the Alliance's Operating Plan and measure organizational performance. Activities included the publication of a 2020 Operating Plan Assessment, which provided awareness that the Alliance's 2020 tactic execution was timely (81.5%) while also focusing on pandemic care needs, Measures of Performance of projects and tactics were achieved (100%) and lessons learned were identified for continuous improvement. These lessons included the need for an ongoing focus on measuring the right project outcome, standardizing sponsorship and enhancing Governance engagement.

In addition, Operational Excellence completed a 2021 Operating Plan Tactic Assessment, which reviewed tactics in process and concluded there is sufficient business rationale for tactics underway and execution is largely on track. To date, the Alliance completed and closed five (5) Operating Plan tactics (or 13% of the total). For organizational performance measurement, activities underway included supporting the Q1 2021 Alliance Bridge Plan success metric reporting and production of the Q1 2021 Alliance Dashboard.

Q1 2021 Operational Dashboard Results

Organizational Performance Update: Q1 2021 Alliance Dashboard. The Q1 2021 *Alliance Dashboard* is comprised of 149 metrics monitoring 60 health plan core, support and managerial processes. These 60 health plan processes are rolled-up to 13 top-level (Level 1) processes for Board monitoring using a composite methodology, meaning the performance of these core processes are averaged to produce top-level process performance results, as displayed in the *Alliance Dashboard*.

In addition to Level 1 process performance, page 2 of the *Alliance Dashboard* contains a subset of the 149 metrics that the Board has requested for quarterly monitoring. The Q1 2021 *Alliance Dashboard* indicates healthy performance. Results for 11 of 13 Level 1 processes met or exceeded 95% of target. Exceptions to the 95% standard and other notable performance are as follows:

- Engage and Support Members. Q1 2021 performance (96.9%) dropped 2.9 percentage points over Q4 2020. *Help Members Engage* (100.0%) and *Assess Member Experience* (98.1%) performed favorably during the quarter but *Help Members Navigate* (92.7%) declined 7 percentage points over Q4 2020, primarily a result of call center service levels impacted by high member response to communications regarding CommonSpirit contract negotiations during the quarter. Performance is expected to stabilize in Q2 2021.

- Manage and Improve Care. Q1 2021 performance (99.2%) improved 4.8 percentage points over Q4 2020. The rate of moderate and severe potential quality issues impacted performance in Q4 2020 and improved 33 percentage points (to 100% of target) in Q1 2021.

- Acquire and Retain Employees. Q1 2021 performance (93.5%) dropped 6.0 percentage points over Q4 2020, primarily the result of new employee turnover at 51.4 percent of target. Where applicable leadership is actively assessing opportunities to improve retention of newly onboarded employees in our full-time telecommuting environment.

- Manage Finances. Q1 2021 results (93.6%) improved 2 percentage points over Q4 2020 (91.6%) marking the third consecutive quarter of improved financial performance. Areas driving improved performance from Q4 2020 to Q1 2021 include *Board Designated Reserves* (83.2% to 98.7% respectively) and *Administrative Loss Ratio* (6.2% to 5.5% respectively), as reflected on page 2 of the *Alliance Dashboard*.

- Manage Communications and Organizational Branding. Q1 2021 marks the introduction of this process to the Alliance Dashboard. Performance (98.2%) reflects activity within the *Coordinate Organizational Messaging* and *Manage Branding* subprocesses.

The Q1 2021 Alliance Dashboard follows this report.

Attachment.
1. LHPC highlights from Governor's May Revision for 2021-22

To: Board of Directors & Staff

From: Linnea Koopmans, Interim CEO

Subject: Highlights from Governor's May Revision for 2021-22

Date: May 15, 2021

This memo includes highlights from Governor Newsom's May Revision for 2021-22, specifically health proposals of relevance to local plans. See the May Revision Budget Summary and the DHCS Budget Highlights for additional details. This memo only includes new projections and new or revised proposals and does not cover existing proposals in the Governor's January Budget. Please contact Linnea Koopmans at lkoopmans@lhpc.org with any questions.

STATE BUDGET OVERVIEW

Earlier this week, leading up to release of the May Revision, the Governor announced components of a historical Budget that includes a $100 billion "California Comeback Plan." The $100 billion includes $75.7 billion Budget surplus and $25 billion federal relief. Below is a brief summary of the overall Budget and major new investments.

The following highlights provide a snapshot of California's overall State Budget:

- *Total Budget*: $197 billion
- *Budget reserves:* $24.4 billion in budget reserves, an increase of over $2 billion compared to the January Budget, including:
    - $15.9 billion in the Rainy Day Fund
    - $450 million in the Safety Net Reserve
    - $4.6 billion in the Public School System Stabilization Account, and
    - $3.4 billion in the state's operating reserve

As a part of the Comeback Plan, the Governor is proposing $12 billion in immediate relief to low-income Californians, including the largest state tax rebate in American history, and funding to help renters pay back rent and past due utilities payments. The Governor is also proposing $12 billion for homelessness, including investments to get 65,000 people off the street through investments in Homekey, affordable housing, funding to support student homelessness, encampment strategies, and Project Roomkey. This includes $3.5 billion for behavioral health infrastructure to build 28,000 new housing or clinical beds. Another major investment includes youth behavioral health, which is discussed later in this memo.

DEPARTMENT OF HEALTH CARE SERVIECS

Overall Medi-Cal Budget

- *Revised 2020-21 Budget estimate*: $115.6 billion ($21.5 billion GF)
  - Caseload assumes 7.1 percent increase from 2019-20 to 2020-21
  - Assumes an average caseload of 13.6 million
- *Total 2021-22 Budget estimate*: $123.8 billion ($27.6 billion GF)
  - Assumes caseload will increase by 6.6 percent from 2020-21 to 2021-22 (January Budget assumed an increase of 11.7 percent)
- *Total projected enrollment*: 14.5 million Californians average monthly caseload in 2021-22 (January Budget estimated 15.6 million)

Youth Behavioral Health

As was announced earlier this week, the May Revision makes significant investments in youth behavioral health. The Budget proposes $3.5 billion of spending over five years, including ongoing spending, on the Children and Youth Behavioral Health Initiative. This Initiative includes several DHCS-specific components which are described below.

Overarching Design & Vision

Key features of services and programs operated under the initiative are:

- Accessible to all children and youth age 25 and younger
- Available statewide
- Payor agnostic, will be available to children in Medi-Cal and commercial health plans
- Evidence-based care
- Interactive tools via a virtual platform accessible 24/7

DHCS Virtual Care Platform

DHCS will develop a virtual platform to integrate BH services with screening, clinic-based care, and app-based support services. The platform will use a tiered model to deliver and monitor treatment and refer to Medi-Cal managed care plans or county mental health plans for clinical mental health services, when appropriate. The platform will also facilitate a statewide e-consult service for pediatricians and family practice providers. The funding for this component of the proposal is as follows:

- $83 million COVID Fiscal Recovery Fund (CFRF) for 2021-22
- $107 million CFRF for 2022-23
- $156 million ($125 million GF, $31 million FF) in 2023-24
- $180 million ($144 million GF, $36 million FF) in 2024-25
- $224 million ($179 million GF, $45 million FF) in 2025-26

Student BH Capacity and Infrastructure Grants

$100 million CFRF in 2021-22 and $450 million CFRF in 2022-23 for infrastructure, partnerships, and capacity to increase access to behavioral health services at schools, by:

- Expanding access to BH school counselors, peer supports, and BH coaches
- Building a statewide CBO network

- Connecting commercial plans and Medi-Cal plans, counties, CBOs, and schools via data sharing systems

This funding builds upon, but is distinct from, the Student Behavioral Health Incentive Program proposed in the January Budget.

Grants to Expand Evidence-Based BH Programs
$10 million CFRF in 2021-22 and $429 million CFRF in 2022-23 to fund grants to providers, behavioral health systems, Medi-Cal MCPs, CBOs, and others to support implementation of evidence-based BH treatment services for children and youth.

Dyadic Services as a Covered Benefit
$200 million ($100 million GF) ongoing for dyadic services as a covered Medi-Cal benefit to provide integrated physical and BH screening and services to the whole family.

Provider Training
$50 million one-time CFRF in 2022-23 for pediatric, primary care, and other health care provider training

Mental Health Student Services Act (MHSSA) Partnership Grants
$30 million GF done-time MHSA funding for MHSSA grants. These grants build on grants already awarded to counties to partners with schools.

Foster Youth
$39.2 million GF for counties to service foster youth with complex behavioral health needs and youth returning from out-of-state congregate placement.

ACEs
$12.4 million GF to fund seven demonstration projects focused on advancing research and building scalable approaches to treating and preventing ACEs.

Medi-Cal Eligibility Expansion
Full scope Medi-Cal for undocumented older adults
$1 billion ($859 million GF) annually to expand full-scope Medi-Cal to adults ages 60 and over, regardless of immigration status. This will be effective no sooner than May 1, 2022.

Postpartum eligibility
$90.5 million ($45.3 million GF) in 2021-22 and $362.2 million ($181.1 million GF) annually between 2022-23 and 2027-28 to implement the American Rescue Plan Act option to expand eligibility from 60 days to 12 months for postpartum individuals for up to five years. This will be effective April 1, 2022.

CalAIM
While the core CalAIM Budget proposals – including ECM, ILOS, and incentives – are not substantively different from the Governor's Budget in January, there are three new funding proposals related to CalAIM which are outlined below.

Population Health Management
$315 million GF for a population health management business solution to utilize administrative and clinical data and information for DHCS, MCPs, counties, providers, beneficiaries and others to use in in support of care delivery. DHCS will contract with vendor to provide this service which will include:

- Standardized, statewide risk stratification and risk tiers
- Support identification of gaps in care and gaps in beneficiary referrals
- Flag beneficiaries for potential case management
- Provide beneficiary specific care manager and contact information
- Support information-sharing among Medicare and Medi-Cal
- Contain all Medi-Cal standard assessments
- Provide information on SDOH
- Allow for population health analytics
- Provide health education to beneficiaries and allow beneficiaries to access their patient record
- Availability of longitudinal information about beneficiaries to providers, plans and DHCS

Providing Access and Transforming Health (PATH)
$200 million ($100 million GF) to support justice-involved initiatives within CalAIM, including capacity building, coordination, and planning for implementation of pre-release care and re-entry coordination. This builds upon the existing PATH proposal in the 1115 waiver.

Medically Tailored Meals (MTM) Pilot Program Augmentation
$1.7 million GF in 2020-21 and $10.6 million GF in 2021-22 to expand the MTM pilot to a broader population and adds five additional counties to the pilot program.

COVID Impacts
DHCS estimates several COVID-related Budget impacts in the May Revision, including reduced caseload estimates, COVID testing in schools, vaccine administration, funding for redeterminations, increased federal funding under the Families First Coronavirus Response Act (FFCRA), and support for public hospitals. These impacts and associated costs are briefly outlined below.

Reduced Caseload Estimates
DHCS assumes continued caseload growth but at a lower level than assumed in the January Budget. This reduced caseload assumption is reflected in a reduction of cost of $5.4 billion ($2.5 billion GF) across both years as compared to the Governor's Budget.

COVID Testing in Schools
$209.6 million ($96 million GF) in 2020-21 and $575.5 million ($265 GF) in 2021-22 to pay for COVID testing in schools.

Vaccine Administration
The federal government assumed full responsibility to cover vaccine administration costs as of April 1, 2021 through ARPA. The revised assumptions include $104 million ($24 million GF) in 2021 and $730 million ($12 million GF) in 2021-22 to cover vaccine administration costs. The costs budgeted in 2021-22 are due to claim lag and will be recovered in the following fiscal year.

Funding for Redeterminations
$73 million ($37 million GF) in 2021-22 and 2022-23 to support increased county workload to redetermine eligibility for Medi-Cal beneficiaries that remained enrolled due to the COVID continuous coverage requirement.

Increased Federal Funding
DHCS estimates a significant offset in state spending due to increased federal funding in the FFCRA that is projected to remain through December 2021 due to the ongoing public health emergency, specifically:

- $4.4 billion additional federal funding in 2020-21, offsetting $2.6 billion GF costs
- $3.6 billion additional federal funding in 2021-22, offsetting $2.3 billion GF costs

Support for Public Hospitals
$300 million in ARPA funding to pay direct grants to designated public hospitals in support of their health care expenditures that have occurred during the pandemic.

Telehealth
DHCS is revising its telehealth proposal in the Governor's January Budget as it relates to audio-only telehealth services. Specifically, DHCS proposes:

- Rates for audio-only telehealth services at 65% the Medi-Cal FFS rate
- Authorizing audio-only telehealth reimbursement for FQHCs at a rate comparable to DHCS' audio-only rate for other providers via an alternative PPS rate
- Establishing specific utilization management protocols for all telehealth services prior to implementation of post-pandemic telehealth services

Benefits and Allowable Provider Types
DHCS is proposing elimination of benefit suspensions, adding new Medi-Cal benefits, and a new Medi-Cal provider type. These proposals are briefly outlined below.

Eliminate Suspension of Optional Benefits
The May Revision permanently eliminates the suspension of optional benefits. The January Budget estimated the optional benefits – which include audiology and speech therapy, incontinence creams and washes, optician and optical lab services, podiatric services – will cost $47 million GF in 2021-22.

Doula Benefit
$403,000 ($152,000 GF) in 2021-22 and $4.4 million ($1.7 million GF) annually to add doula services as a Medi-Cal benefit effective January 1, 2022.

Community Health Workers (CHWs)
$16.3 million ($6.2 million GF) increasing to $201 million ($76 million GF) by 2026-27 to add CHWs as a Medi-Cal allowable provider type effective January 1, 2022.

Dyadic Care
$200 million ($100 million GF) ongoing. See "Youth Behavioral Health" section above for details.

Pharmacy
Medi-Cal Rx
The Budget indicates that there is still no implementation date identified for Medi-Cal Rx. However, the Budget assumes that the implementation will take place on January 1, 2022 "for budgeting purposes only." The Budget estimates $32 million ($14 million GF) in additional pharmacy-related costs due to the delay and $363 million ($134 million GF) additional costs in 2021-22. However, the estimated annual savings is estimated at $859 million ($309 million GF).

Medication Therapy Management (MTM) Program
$12 million ($4 million GF) to implement an MTM Program for specialty pharmacy services, effective July 1, 2021. This is a program proposed for FFS specialty pharmacy.

Proposition 56
The May Revision proposes permanent elimination of the Proposition 56 suspensions. These suspensions were passed in last year's Budget and were proposed to be delayed in the Governor's January Budget.

Accelerated Enrollment for Adults
$14.3 million ($7.2 million GF) in 2021-22 to expand accelerated enrollment for adults through CalHEERS to provide immediate benefits while income verification is pending.

OTHER HEALTH & HUMAN SERVICES PROPOSALS

Supporting Older Adults
The Budget includes several investments in support for older adults, consistent with the objectives of the Master Plan for Aging, including new funding proposals and elimination of funding suspensions. Some of these proposals are outlined below, with full details on p. 83 of the Budget Summary.

Recovery and Resiliency
$106 million GF over three years to enhance funding levels to existing programs, including senior nutrition, senior legal aid, home modifications and fall prevention, Behavioral Health Friendship Line, senior digital assistance, family caregiver support, senior employment opportunities, elder abuse prevention, and aging and disability resource connection.

Office of Medicare Innovation and Integration
$602,000 ($452,000 GF) ongoing to provide DHCS with expertise to lead innovative models for Medicare and dually eligible beneficiaries.

Office of Long-Term Care Patient Representative
$4 million GF ongoing to CDA to provide public patient representatives to nursing facility residents who lack capacity to make their own health care decisions and who do not have a family member or friend who can act as a patient representative.

Home Safe
$100 million GF in both 2021-22 and 2021-22 for the Home Safe program to provide housing supports to individuals involved or at risk of involvement in Adult Protective Services.

Housing and Disability Advocacy Program
$174 million GF annually through 2023-24 to assist disabled individuals who are homeless.

Community Care Expansion Program
$500 million in 2021-22 and 2022-23 for construction, acquisition, and/or rehabilitation of care facilities housing seniors who are homeless or at risk of becoming homeless.

Health Information Exchange
$2.5 million GF for Agency to lead efforts and stakeholder engagement in building out information exchange for health and social services programs.

Alliance Dashboard – *Quarter 1 2021*

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

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

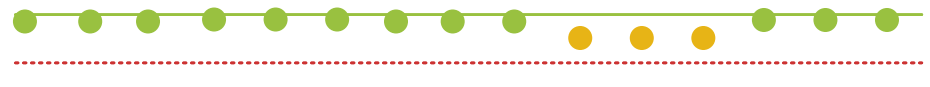
Legend | Target = desirable performance | Threshold = lowest acceptable performance | ≥ to 95% of *Target* | <95% of *Target* and >*Threshold* | <*Threshold*

Core Processes
Deliver value to our members, providers and community

Engage & Support Members
97% Of Target

SUBPROCESSES
- 100 Help Members Engage
- 93 Help Members Navigate
- 98 Member Experience

Manage & Improve Care
99% Of Target



SUBPROCESSES
- 98 Manage Care Use
- 100 Improve Care

Develop & Maintain the Provider Network
97% Of Target

SUBPROCESSES
- 99 Develop the Network
- 96 Maintain the Network

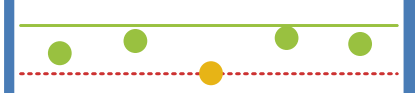
Pay Providers
99% Of Target

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

Managerial Processes
Guide the organization

97 Enhance Operational Effectiveness

95 Manage Compliance Commitments



94 Manage Finances

100 Manage Governmental & Community Relations

Support Processes *Enable organizational operations*

94 Acquire & Retain Employees

99 Manage Data

100 Manage Technology

97 Provide Administrative Services

98 Communications & Organizational Branding

Alliance Dashboard

Board Metrics

No.	Metric	Period	Target	Performance
1	% of days achieving member call answer time service level target	Q121	80.0%	65.6%
2	New Member Welcome Call Completion Rate	Q420	30.0%	32.6%
3	Timely Resolution of Member Complaints	Q121	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	Q121	100.0%	85.0%
7	% of Facility Sites Reviewed in Good Health	Q121	100.0%	100.0%
8	In Area PCP Market Share (all counties)	Q121	80.0%	87.0%
9	In Area Specialist Market Share (all counties)	Q121	80.0%	84.0%
10	Contracted PCP Open % (all counties)	Q121		60.7%
11	Overall Provider Satisfaction Rate	2020	88.0%	84.0%
12	Inpatient Bed Days/ 1,000 members/Year (Medi-Cal)	Q420	282.0	271.0
13	Admissions/1,000 Members/Year (Medi-Cal)	Q420	63.0	54.0
14	Total 30 Day All-Cause Readmissions %	Q420	11.0%	12.0%
15	Ambulatory Care Sensitive Admissions (Medi-Cal)	Q420	8.0%	5.7%
16	Average Length of Stay (Medi-Cal)	Q420	4.5	5.1
17	Emergency Department visits/1,000 members/year (all LOBs)	Q420	513.0	330.0
18	Avoidable Emergency Department visits (all LOBs)	Q420	18.0%	9.7%
19	Behavioral Health Utilization Rate by County (All Ages)	Q420	3.6%	SC: 9.4% | Mont: 4.2% | Merced: 4.2%
20	Routine Medical/Surgical Prior Authorizations Adjudicated Timely	Q121	100.0%	99.6%
21	Medical/surgical authorization denial rate	Q121		0.6%
22	Pharmacy Cost/Member/Month - Retail, Outpatient & Specialty	Q121	$47.55	$44.22
23	Generic Prescription %	Q121	88.0%	89.5%
24	Clean Claims Processed and Paid Within 30 Calendar Days	Q121	90.0%	98.7%
25	Employee Turnover Rate	Q220 - Q121	10.0%	7.1%
26	Total Staffed Workforce	Q121	90.0%	92.7%
27	Board Designated Reserves Percentage	Q121	100.0%	98.7%
28	Net Income Percentage	Q121	0.5%	5.5%
29	Medical Loss Ratio	Q121	92.0%	88.5%
30	Administrative Loss Ratio	Q121	6.0%	5.5%

**Period changed from 'Report Year' to 'Measurement Year'*

DATE: May 26, 2021

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Third Month Ending March 31, 2021

For the month ending March 31, 2021, the Alliance reported a Medical Loss Ratio (MLR) of 86.0%, an Administrative Loss Ratio (ALR) of 5.5% and an Operating Income Ratio of 8.4%. The Year-to-Date (YTD) MLR is 88.5%, ALR is 5.5% and the Operating Income is 6.0%. Please note that the YTD medical cost reflected services for December through March. This income is primarily due to lower utilization from outpatient, transportation, and specialist services during the pandemic and stay-at-home orders between December 2020 and February 2021. Overall, utilization for this period was down 19% from the same period a year ago. As a result, YTD medical expenses are favorable to budget by $18.8M or 5.3%.

Notably however, YTD Inpatient Services (Hospital), which is roughly a third of total medical cost, is unfavorable by $3.5M or 3.2%. This is due to an increased number of inpatient stays from COVID-19 cases and is further explained in the Medical Expenses section of this report. The inpatient budget for this period assumes cost and utilization trends based on historical experience and does not assume impact from cost containment efforts. The Inpatient unfavorable variance is offset by favorability across all other categories of service. This results in a net favorability of $14.84 per member per month (PMPM), or 4.7% favorable to budget.

It was expected that utilization in the outpatient setting may remain suppressed through Q1 2021. As restrictions are loosened and more people are vaccinated, it is expected (and desired) that outpatient utilization will resume in Q2 2021 and beyond. The 2021 financial performance is highly dependent on the timing and speed of resuming care. Staff is committed to inform the Board through quarterly forecasts.

Mar-21 MTD (In $000s)

Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*371,584*	*374,390*	*(2,806)*	*-0.7%*
Revenue	131,708	124,077	7,632	6.2%
Medical Expenses	113,315	120,378	7,063	5.9%
Administrative Expenses	7,301	7,390	90	1.2%
Operating Income/(Loss)	11,093	(3,692)	14,785	100.0%
Net Income/(Loss)	11,011	(4,354)	15,365	100.0%
MLR %	*86.0%*	*97.0%*	*11.0%*	
ALR %	*5.5%*	*6.0%*	*0.4%*	
Operating Income %	*8.4%*	*-3.0%*	*11.4%*	
Net Income %	*8.4%*	*-3.5%*	*11.9%*	

Mar-21 YTD (In $000s)

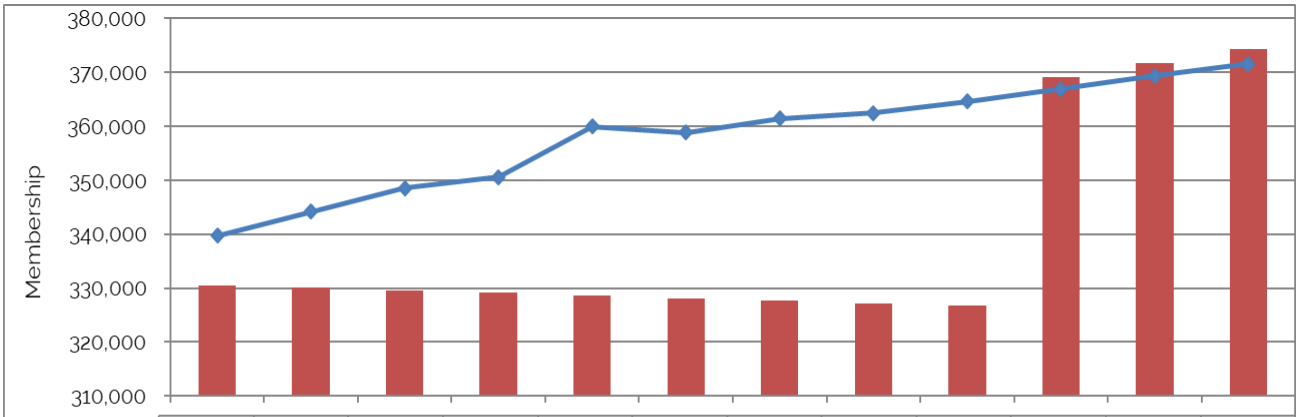
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Membership	*1,107,877*	*1,115,289*	*(7,412)*	*-0.7%*
Revenue	379,098	369,940	9,158	2.5%
Medical Expenses	335,605	354,402	18,797	5.3%
Administrative Expenses	20,783	20,813	30	0.1%
Operating Income/(Loss)	22,711	(5,275)	27,986	100.0%
Net Income/(Loss)	20,857	(7,223)	28,080	100.0%
PMPM				
Revenue	342.18	331.70	10.49	3.2%
Medical Expenses	302.93	317.77	14.84	4.7%
Administrative Expenses	18.76	18.66	(0.10)	-0.5%
Operating Income/(Loss)	20.50	(4.73)	25.23	100.0%
MLR %	88.5%	*95.8%*	*7.3%*	
ALR %	*5.5%*	*5.6%*	*0.1%*	
Operating Income %	*6.0%*	*-1.4%*	*7.4%*	
Net Income %	*5.5%*	*-2.0%*	*7.5%*	

Per Member Per Month. Capitation revenue and medical expenses are variable based on enrollment fluctuations, therefore the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not directly correspond with enrollment and are therefore viewed in terms of total dollar amount. At a PMPM level, YTD revenue is

$342.18, medical cost is $302.93 and administrative cost is $18.76, resulting in an operating income of $20.50 PMPM.

Membership. March 2021 Member Months are unfavorable to budget by 0.7%. In CY2020, the Member Months increased by 7% due to the suspension of the Medi-Cal edetermination process during the Public Health Emergency (PHE) period. The 2021 Budget assumes the PHE will end in June 2021.

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



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Budget	330,532	330,049	329,570	329,092	328,615	328,140	327,668	327,197	326,727	369,146	371,753	374,390
Actual	339,740	344,209	348,505	350,560	359,992	358,888	361,422	362,525	364,602	366,938	369,355	371,584
Variance	9,208	14,160	18,935	21,468	31,377	30,748	33,754	35,328	37,875	(2,208)	(2,398)	(2,806)
Variance %	2.8%	4.3%	5.7%	6.5%	9.5%	9.4%	10.3%	10.8%	11.6%	-0.6%	-0.6%	-0.7%

Revenue. March 2021 capitation revenue of $131.4M is favorable to budget by $7.7M or 6.2%. The month-to-date favorable variance is primarily driven by $8.6M in rate variance; this includes $2.2M in Maternity revenue for prior month adjustments, $1.2M Managed Care Organization (MCO) Tax true-up and $2.2M retroactive enrollment from 2014 thru 2017. This favorability is offset by lower than projected enrollment with a revenue impact of $0.9M. March 2021 YTD revenue of $378.3M is favorable to budget by $9.2M or 2.5%, of which $1.2M is attributed to enrollment and $8.1M to rate variance.

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

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	84,519	82,851	1,668	670	998
Monterey	164,804	160,520	4,283	235	4,048
Merced	128,977	125,681	3,296	281	3,015
Total	**378,300**	**369,052**	**9,248**	**1,186**	**8,062**

Note: Excludes Mar-21 In-Home Supportive Services premiums revenue of $0.8M

Medical Expenses. March 2021 Medical Expenses of $113.3M is favorable to budget by $7.1M or 5.9%. March 2021 YTD Medical Expenses are $335.6M, which is favorable to budget by $18.8M or 5.3%, with an MLR of 88.5%. Of this $18.8M favorability, $2.4M is attributed to enrollment and $16.4M to rate variance. Please note that rate (PMPM) is the unit cost for a service times the utilization for the service. The suppressed utilization contributed to the favorable rate variance.

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

Category	Actual	Budget	Total Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	113,669	110,175	(3,495)	732	(4,227)
Inpatient Services (LTC)	40,177	46,104	5,927	306	5,621
Physician Services	51,246	57,559	6,313	383	5,930
Outpatient Facility	18,772	20,698	1,926	138	1,789
Pharmacy	49,028	54,509	5,480	362	5,118
Other Medical	62,712	65,357	2,645	434	2,211
Total	**335,605**	**354,402**	**18,797**	**2,355**	**16,442**

At a PMPM level, YTD Medical Expenses are $302.93, which is favorable by $14.84 or 4.7% as compared to budget. YTD Inpatient Services are unfavorable to budget by 3.9%, this is driven by the increase in active COVID-19 cases. From March 2020 through October 2020, we had an average of 68 monthly cases. For the five-month period between November 2020 and March 2021, we had an average of 248 monthly cases.

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

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	102.60	98.79	(3.82)	-3.9%
Inpatient Services (LTC)	36.27	41.34	5.07	12.3%
Physician Services	46.26	51.61	5.35	10.4%
Outpatient Facility	16.94	18.56	1.61	8.7%
Pharmacy	44.25	48.87	4.62	9.5%
Other Medical	56.61	58.60	2.00	3.4%
Total	**302.93**	**317.77**	**14.84**	**4.7%**

Administrative Expenses. March 2021 YTD Administrative Expenses are on par with budget resulting in a 5.5% ALR.

Non-Operating Revenue/Expenses. March 2021 YTD Total Non-Operating Revenue is unfavorable to budget by $1.7M or 86.4% which is primarily driven by lower interest income and unrealized investment gain.

Overall, the Alliance generated a YTD Net Income of $20.9M.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Third Month Ending March 31, 2021
(In $000s)

Assets	
Cash	$225,670
Restricted Cash	300
Short Term Investments	377,033
Receivables	157,149
Prepaid Expenses	2,076
Other Current Assets	19,717
Total Current Assets	**$781,946**
Building, Land, Furniture & Equipment	
Capital Assets	$83,694
Accumulated Depreciation	(37,902)
CIP	2,780
Total Non-Current Assets	**48,572**
Total Assets	**$830,518**
Liabilities	
Accounts Payable	$39,585
IBNR/Claims Payable	286,301
Accrued Expenses	1
Estimated Risk Share Payable	12,494
Other Current Liabilities	6,690
Due to State	0
Total Current Liabilities	**$345,071**
Fund Balance	
Fund Balance - Prior	$464,590
Retained Earnings - CY	20,857
Total Fund Balance	**485,447**
Total Liabilities & Fund Balance	**$830,518**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2021
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*371,584*	*374,390*	*(2,806)*	*-0.7%*	*1,107,877*	*1,115,289*	*(7,412)*	*-0.7%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$131,448	$123,781	$7,668	6.2%	$378,300	$369,052	$9,248	2.5%
Premiums Commercial	260	296	(36)	-12.1%	798	888	(90)	-10.1%
Total Operating Revenue	**$131,708**	**$124,077**	**$7,632**	**6.2%**	**$379,098**	**$369,940**	**$9,158**	**2.5%**
Medical Expenses								
Inpatient Services (Hospital)	$37,262	$37,228	($34)	-0.1%	$113,669	$110,175	($3,495)	-3.2%
Inpatient Services (LTC)	13,023	16,181	3,158	19.5%	40,177	46,104	5,927	12.9%
Physician Services	16,779	19,477	2,698	13.9%	51,246	57,559	6,313	11.0%
Outpatient Facility	6,973	7,002	29	0.4%	18,772	20,698	1,926	9.3%
Pharmacy	18,640	18,296	(344)	-1.9%	49,028	54,509	5,480	10.1%
Other Medical	20,638	22,194	1,556	7.0%	62,712	65,357	2,645	4.0%
Total Medical Expenses	**$113,315**	**$120,378**	**$7,063**	**5.9%**	**$335,605**	**$354,402**	**$18,797**	**5.3%**
Gross Margin	**$18,393**	**$3,698**	**$14,695**	**100.0%**	**$43,494**	**$15,538**	**$27,955**	**100.0%**
Administrative Expenses								
Salaries	$5,022	$4,912	($110)	-2.2%	$14,457	$13,677	($780)	-5.7%
Professional Fees	229	161	(68)	-42.2%	366	487	121	24.9%
Purchased Services	923	858	(66)	-7.7%	2,534	2,485	(49)	-2.0%
Supplies & Other	508	739	232	31.3%	1,558	2,018	460	22.8%
Occupancy	68	108	40	37.2%	214	326	112	34.4%
Depreciation/Amortization	551	613	62	10.1%	1,656	1,821	165	9.1%
Total Administrative Expenses	**$7,301**	**$7,390**	**$90**	**1.2%**	**$20,783**	**$20,813**	**$30**	**0.1%**
Operating Income	**$11,093**	**($3,692)**	**$14,785**	**100.0%**	**$22,711**	**($5,275)**	**$27,986**	**100.0%**
Non-Op Income/(Expense)								
Interest	$281	$579	($298)	-51.4%	$738	$1,746	($1,008)	-57.7%
Gain/(Loss) on Investments	(397)	(23)	(374)	-100.0%	(850)	(70)	(780)	-100.0%
Other Revenues	131	97	34	35.1%	379	291	88	30.2%
Grants	(97)	(1,315)	1,218	92.7%	(2,121)	(3,915)	1,794	45.8%
Total Non-Op Income/(Expense)	**($82)**	**($662)**	**$580**	**87.7%**	**($1,854)**	**($1,948)**	**$94**	**4.8%**
Net Income/(Loss)	**$11,011**	**($4,354)**	**$15,365**	**100.0%**	**$20,857**	**($7,223)**	**$28,080**	**100.0%**
MLR	*86.0%*	*97.0%*			*88.5%*	*95.8%*		
ALR	*5.5%*	*6.0%*			*5.5%*	*5.6%*		
Operating Income	*8.4%*	*-3.0%*			*6.0%*	*-1.4%*		
Net Income %	*8.4%*	*-3.5%*			*5.5%*	*-2.0%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2021
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*371,584*	*374,390*	*(2,806)*	*-0.7%*	*1,107,877*	*1,115,289*	*(7,412)*	*-0.7%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$353.75	$330.62	$23.13	7.0%	$341.46	$330.90	$10.56	3.2%
Premiums Commercial	0.70	0.79	(0.09)	-11.4%	0.72	0.80	(0.08)	-9.5%
Total Operating Revenue	**$354.45**	**$331.41**	**$23.04**	**7.0%**	**$342.18**	**$331.70**	**$10.49**	**3.2%**
Medical Expenses								
Inpatient Services (Hospital)	$100.28	$99.44	($0.84)	-0.8%	$102.60	$98.79	($3.82)	-3.9%
Inpatient Services (LTC)	35.05	43.22	8.17	18.9%	36.27	41.34	5.07	12.3%
Physician Services	45.15	52.02	6.87	13.2%	46.26	51.61	5.35	10.4%
Outpatient Facility	18.77	18.70	(0.06)	-0.3%	16.94	18.56	1.61	8.7%
Pharmacy	50.16	48.87	(1.29)	-2.6%	44.25	48.87	4.62	9.5%
Other Medical	55.54	59.28	3.74	6.3%	56.61	58.60	2.00	3.4%
Total Medical Expenses	**$304.95**	**$321.53**	**$16.58**	**5.2%**	**$302.93**	**$317.77**	**$14.84**	**4.7%**
Gross Margin	**$49.50**	**$9.88**	**$39.62**	**100.0%**	**$39.26**	**$13.93**	**$25.33**	**100.0%**
Administrative Expenses								
Salaries	$13.52	$13.12	($0.40)	-3.0%	$13.05	$12.26	($0.79)	-6.4%
Professional Fees	0.62	0.43	(0.19)	-43.2%	0.33	0.44	0.11	24.4%
Purchased Services	2.49	2.29	(0.19)	-8.5%	2.29	2.23	(0.06)	-2.6%
Supplies & Other	1.37	1.97	0.61	30.8%	1.41	1.81	0.40	22.3%
Occupancy	0.18	0.29	0.11	36.8%	0.19	0.29	0.10	33.9%
Depreciation/Amortization	1.48	1.64	0.15	9.4%	1.49	1.63	0.14	8.5%
Total Administrative Expenses	**$19.65**	**$19.74**	**$0.09**	**0.5%**	**$18.76**	**$18.66**	**($0.10)**	**-0.5%**
Operating Income	**$29.85**	**($9.86)**	**$39.71**	**100.0%**	**$20.50**	**($4.73)**	**$25.23**	**100.0%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Third Month Ending March 31, 2021
(In $000s)

	MTD	YTD
Net Income	$11,011	$20,857
Items not requiring the use of cash: Depreciation	551	1,656
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	12,280	90,580
Prepaid Expenses	177	745
Current Assets	(648)	(212)
Net Changes to Assets	**$11,809**	**$91,113**
Changes to Payables:		
Accounts Payable	12,568	(975)
Accrued Expenses	-	-
Other Current Liabilities	(1,464)	(773)
Incurred But Not Reported Claims/Claims Payable	56,761	(24,515)
Estimated Risk Share Payable	834	2,484
Due to State	-	-
Net Changes to Payables	**$68,699**	**($23,779)**
Net Cash Provided by (Used in) Operating Activities	**$92,070**	**$89,847**
Change in Investments	(20,867)	(20,923)
Other Equipment Acquisitions	(179)	(299)
Net Cash Provided by (Used in) Investing Activities	**($21,046)**	**($21,222)**
Net Increase (Decrease) in Cash & Cash Equivalents	**$71,024**	**$68,625**
Cash & Cash Equivalents at Beginning of Period	**$154,646**	**$157,045**
Cash & Cash Equivalents at March 31, 2021	**$225,670**	**$225,670**

SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, April 28, 2021

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

Commissioners Present:

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

Commissioners Absent:

Ms. Dori Rose Inda	Hospital Representative
Ms. Rebecca Nanyonjo	Director of Public Health

Staff Present:

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

Ms. Marina Owen	Chief Operating Officer
Ms. Van Wong	Chief Information Officer
Ms. Jenifer Mandella	Compliance Officer
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Coonerty.

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

No changes to the agenda were made.

Chair Coonerty welcomed Dori Rose Inda, Santa Cruz County Hospital Representative, to the Board. Ms. Inda was unable to attend today's meeting and will join the Board at the May meeting.

Roll call was taken and a quorum was present.

2. Oral Communications.

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

No members of the public addressed the commission.

3. Comments and announcements by Commission members.

Chair Coonerty opened the floor for Commissioners to make comments.

Commissioner Conner stated that a groundbreaking for the opening of a new clinic in partnership with Santa Cruz Community Health, Dientes Community Dental Care and MidPen Housing, in the Live Oak area will be held on May 22, 2021. She acknowledged the Alliance for their contribution to the project.

Commissioner deGhetaldi acknowledged Commissioner Hall and Dr. Gail Newel for their brave work to save countless lives during the height of the pandemic and for sharing nationally their personal experience on This American Life. He additionally recognized the service of public health teams throughout the country for their front-line work during the pandemic.

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

[Commissioner Rabago arrived at this time: 3:11 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, CEO, recognized the passing of Mr. Wayne Johnson. Mr. Johnson was with the Deaf Hard of Hearing Service Center for nearly 30 years and served on the Alliance Member Services Advisory Group for more than five years.

Planning is under way for the June 23, 2021 Board retreat to take place in person at the Alliance offices in Scotts Valley. The agenda and logistics will be shared at the May meeting.

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

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

Chair Coonerty reminded the Board that in order to manage any risk of conflict, staff have separated the approval action for the Medi-Cal Capacity Grant Program: Funding Recommendation into two agenda items. Item 9G, Group A Grant applications that are not affiliated with Board members, which all Board members may discuss and vote on; and Item 9H Group B Grant applications that are affiliated with Board members which may have a conflict. Item 9H should be voted on separately from items 5-9G to facilitate two separate approval actions for Group A (applications not affiliated with Board members) and Group B (applications affiliated with Board members) so that the Board may have separate votes and Board members with a conflict may abstain from discussion and voting on item 9H.

MOTION: Commissioner Smith moved to approve Consent Agenda items 5-9G, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioners Inda and Nanyonjo.

Abstain: None.

Commissioner Smith moved to approve Consent Agenda item 9H, seconded by Chair Coonerty.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioner Inda and Nanyonjo.

Abstain: Commissioners Rabago and Weber.

Regular Agenda Item: (10. - 13.): 3:19 p.m.

10. Annual Election of Officers of the Commission. (3:19 – 3:23 p.m.)

The bylaws of the Santa Cruz – Monterey – Merced Managed Medical Care Commission require an annual election of the Chair and Vice Chair each year in April. Immediately following the election, the newly elected Chairperson facilitates the remainder of the April meeting.

Ms. Sonnenshine explained that historically, the Chairperson and Vice Chairperson have served three, one-year terms and have rotated across counties. She noted that there is value in supporting Chairperson development by following a more typical practice of having the Vice Chairperson succeed the Chairperson, allowing for representation across different counties.

Commissioner Coonerty moved to approve the nomination of Commissioner Conner as the Chairperson of the Commission and Commissioner Jimenez as the Vice Chairperson of the Commission, seconded by Commissioner Molesky.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioner Inda and Nanyonjo.

Abstain: None.

11. Discuss Alliance's Care-Based Incentives (CBI) program outcomes for 2020. (3:23 – 3:43 p.m.)

Ms. Michelle Stott, Quality Improvement and Population Health Director, provided an overview of CBI and a summary of the 2020 CBI results. The Board discussed A1C control measures and the potential development of a new approach with respect to capturing the data accurately.

[Commissioner Pedrozo departed at this time: 3:31 p.m.]

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

12. Consider approving proposed changes to Care-Based Incentives (CBI) for 2022. (3:43 – 4:06 p.m.)

Chair Conner advised the Board that this item presented potential conflicts of interest. Board members who perceived that they were at risk for a conflict of interest were advised to abstain from discussion and voting.

Dr. Dianna Diallo, Medical Director, summarized the proposed changes to CBI for 2022.

Proposed changes to programmatic measures: 1) reallocate Plan All-cause Readmission points; 2) redistribute Preventable Emergency Visit and Ambulatory Care Sensitive Conditions points; 3) add Breast Cancer Screening; 4) change Antidepressant Medication Management to Depression Screening and Follow-up Plan; and 5) retire Maternity Care Prenatal and Maternity Care Postpartum.

Proposed changes to Fee-For-Service measures: change Behavioral Health Integration to remove TJC PCMH as standalone qualification.

Proposed changes to exploratory measures: 1) add ACE Screening in Children and Adolescents; and 2) add Health Plan Health Disparity Measure.

MOTION: Commissioner Molesky moved to approve proposed changes to CBI for 2022, seconded by Commissioner Kalantari-Johnson.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioners Inda, Nanyonjo and Pedrozo.

Abstain: Commissioners Conner, Cuevas, deGhetaldi, Gray, Hall, Jimenez, Rabago, Radner, Schuller and Weber.

13. Consider approving report on Medi-Cal Managed Care Procurement Process. (4:06 – 4:27 p.m.)

Ms. Stephanie Sonnenshine, CEO, discussed with the Board the renewed engagement of San Benito County and Mariposa County with the Alliance to evaluate the possibility of the Alliance expanding its COHS model to their counties. Feasibility considerations, governance model considerations and immediate next steps were also discussed. Board discussion included whether a possible name change would be considered and concern was expressed with respect to the State's regional rate setting in Mariposa County and San Benito County.

MOTION: Commissioner Cuevas moved to authorize the Chief Executive Officer (CEO) to execute a non-binding Letter of Intent (LOI) indicating shared intent to transition the County from the Regional model to join the Alliance's County Organized Health System (COHS) through an expansion of Alliance service area and authorize the CEO to execute the non-binding LOI indicating shared intent to transition the County from the San Benito model to join the Alliance's COHS through an expansion of Alliance service area., seconded by Commissioner Edgcomb.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioners Inda, Nanyonjo and Pedrozo.

Abstain: None.

Adjourn to Closed Session

Chair Conner moved the Commission into Closed Session at 4:27 p.m.

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

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

Return to Open Session

Chair Conner reconvened the meeting to Open Session at 4:58 p.m.

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

Chair Conner reported from Closed Session that the Board discussed a claimant's matter concerning allegations related to data breach with legal counsel, and gave approval to proceed in accordance with legal Counsel's recommendations. The vote passed with 17 ayes and 4 absent.

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

Chair Conner reported from Closed Session that the Board discussed a claimant's matter concerning allegations related to litigation with legal counsel, and gave approval to proceed in accordance with legal Counsel's recommendations. The vote passed with 16 ayes and 5 absent.

The Commission adjourned its meeting of April 28, 2021 at 4:59 p.m. to May 26, 2021 at 3:00 p.m. via teleconference unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

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

Virtual Meeting / Web Conference

Committee Members Present

Dr. Caroline Kennedy	Provider Representative
Dr. Eric Sanford	Provider Representative
Ms. Susan Harris	Hospital Representative

Committee Members Absent:

Dr. Amy McEntee	Provider Representative
Dr. Casey KirkHart	Provider Representative
Dr. Eugene Santillano	Provider Representative
Dr. Madhu Raghavan	Provider Representative
Dr. Oguchi Nkwocha	Provider Representative
Ms. Allyse Gilles	Hospital Representative
Ms. Rohini Mehta	Hospital Representative

Guest Present:

Ms. Katilyn Mcintire	Hospital Representative

Staff Present:

Dr. Maya Heinert	Chairperson, CQIC and Medical Director
Mr. Amit Karkhanis	Quality & Performance Improvement Manager
Mr. Chris Morris	Operational Excellence Director
Dr. Dale Bishop	Chief Medical Officer
Ms. Dana Marcos	Member Services Director
Ms. DeAnna Leamon	Quality Improvement Nurse Supervisor
Ms. Deborah Pineda	Quality and Health Programs Manager
Dr. Dianna Diallo	Medical Director
Ms. Hilary Gillette-Walch	Quality and Population Health 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
Ms. Linda Gorman	Communications Director
Ms. Mary Brusuelas	UM/Complex Case Management Director
Ms. Michelle Stott	QI/ Population Health Director
Ms. Navneet Sachdeva	Pharmacy Director
Ms. Ronita Margain	Regional Operations Director

Ms. Tammy Brass	UM/Complex Case Management Manager
Ms. Yasuno Sato, PharmD	Clinical Pharmacy Manager

1. Call to Order by Dr. Maya Heinert, Chair

Dr. Maya Heinert called the meeting to order at 12:05 PM, and welcomed all members present.

Dr. Heinert Introduced Yasuno Sato, PharmD, to the committee as a new member. Dr. Heinert welcomed Katilyn Mcintire who is attending as an alternate for Allyse Gilles. Dr. Heinert announced that the committee is continuing to recruit a pharmacist representative.

2. Consent Agenda

Meeting Minutes

Dr. Maya Heinert presented the October 22, 2020CQIC Minutes. There were no edits requested to the minutes. No action items were pending from previous meeting.

Committee Decision: Minutes were approved as written

CQIC Charter
401-1201 Continuous Quality Improvement Committee.

Subcommittee/Workgroup Meeting Minutes

- Q3 2020 Pharmacy and Therapeutic Committee Formulary Changes
- 2/6/2020, 5/7/2020, and 8/6/2020 Continuous Quality Improvement Workgroup - Interdisciplinary Minutes
- Q3 2020 Continuous Quality Improvement Workgroup Minutes
- Q3 2020 Utilization Management Workgroup Meeting Minutes

Workplans:

- Q3 2020 Quality Improvement Workplan
- Q3 2020 Utilization Management Workplan

Policies Requiring CQIC Approval:

Policy Number	Title	Significant Changes
401-1505	Childhood Preventative Care	• Moderate revision to language specific to Lead Screening reflecting new law and APL requirements. • Updated Bright Futures attachment to reflect the March 2020 version.

401-1521	Physical Accessibility Review	• Annual Review of policy • Minor edits
401-3105	Diabetes Prevention and Diabetes Self-Management Education Benefit	• Updated department/unit names and staff tiles due to HS restructure (July-2020) • Added Medi-Cal Rx information (Nov-2020).
401-3108	Asthma Education Benefit	• Added CCC, Pharm, and UM/CCM as impacted department • Updated and added the new Healthy Literacy definition per Healthy People 2030
401-3109	Comprehensive Tobacco Cessation Services	• Updated department/unit names and staff tiles due to HS restructure (July-2020) • Added Medi-Cal Rx information (Nov-2020)

Informational	
Policy Number	**Title**
401-1515	Nurse Midwife: Scope of Practice and Supervision
401-1518	Medical Assistants: Scope of Practice and Supervision
401-1523	Non-Physician Medical Practitioner Scope of Practice and Supervision
401-3101	Health Education and Promotion Program
401-3102	Health Education Materials
401-3103	Health Promotion Incentives for Members
401-3106	Perinatal Services
401-3107	Breastfeeding Support Benefits Standards and Promotion Program

Delegate Oversight Report (BEACON): Q3-2020 delegate oversite summary included in consent agenda meeting packet.

Committee Decision: Consent Agenda was approved as written.

3. 2020 Alliance Member Outreach Campaigns (MOC)

An overview of the Alliance MOC Goals was presented to the committee. Emergent issues, lessons learned, Member Participation and Communications were reviewed. The committee was informed of the Alliance's COVID-19 Emergency Outreach and COVID-19 Resuming Care MOC's. Other MOC's are in place to provide high risk Alliance members a human connection over the phone while clarifying the resources available to them. Health Services collaborated with other Alliance departments and teams, such as the "Your Health Matters Team"

and the Provider Services team, which allowed for an increase in member and provider engagement. Interventions utilized included telephonic, mailings, and robocalls. A challenge to the campaigns was the Telephone Consumer Protection Act (TCPA), which stated any company must receive consent prior to calling cell phones. Campaigns allowed the Alliance to hear member concerns, including worries about being displaced and in temporary housing situations during the wildfires, fear of financial hardships, or needing PPE gear during the COVID-19 epidemic.

4. COVID-19 Update / Messaging

The Alliance's Communications team supports pandemic needs by creating timely, targeted, and engaging broad communications tactics to deploy across multiple communications channels. Present and future campaigns focus on encouraging preventative care, vaccine appointments and safety during the pandemic, encouraging receiving the flu shot, and providing information about behavioral health resources. The Alliance utilizes several communication channels such as Facebook, Instagram, broadcast media (radio/newspaper ads, radio interviews), earned media, fliers, and the Alliance website. Continued work is focused on a video, a landing page, and an info-graphic to respond to needs and emerging issues.

Committee member inquired on what messages are most evidence based around overcoming patient hesitancy regarding the COVID vaccine. The committee was informed that messaging is geared to guide and change behavior, reinforce that the vaccine is safe and effective, that it is being distributed in phases, and also stressing the importance of continuing to encourage protective behaviors.

Committee member suggested utilizing the "What's App" phone application. It was noted that Facebook is heavily used by the target demographics.

The committee was informed of the COVID-19 Monterey collaborative weekly meeting, Community Health Workers (CHW's) received 4.9 million dollars towards efforts to address COVID 19. Community members indicated messages received from trusted messengers are successful.

Dr. Sanford indicated the Natividad MD residents are willing to do outreach, and invites the Alliance to collaborate.

Action Items:

a. Recommendation for Alliance to explore evidence-based messaging regarding vaccine hesitancy by cultural or ethnic group – Michelle Stott, RN

b. Recommendation for Alliance to explore other Social media Apps that could be enlisted to reach specific cultural groups. – Linda Gorman

5. Readmission Reduction

The Alliance's Complex Case Management team, which includes eight registered nurses and 5 Social workers, successfully worked with Alliance members and dramatically reduced readmissions over all three counties in the fourth quarter of 2020. The team called members after discharge, identified members with clinical issues, chronic health conditions, and poor health illiteracy, and were able to engage and enroll the members in appropriate programs. High risk members were identified and 50 % of those members have not had a readmission.

6. Root Cause Analysis (RCA): Disparate performance in Merced County for 2-Year-Old Vaccinations

Merced County Immunization rates are lower than the NCQA 50th percentile, and lower than the Santa Cruz/Monterey county 2020 HEDIS rates. The Alliance conducted a root cause analysis to dig deeper into the source of the issue. Three vaccines with the lowest rates are influenza, Rotavirus, and DTaP. Considerations presented were to have Flu vaccinations the top priority across all providers, assume that English speaking members are less inclined to become compliant, target members classified as Black for intervention due to disparity to help to close the ethnic disparity gap, provide standing orders for appropriate vaccination schedules, highlighting Influenza, Rota, and DTaP vaccinations of all present Alliance members and those born under the standing order, and promote standing order policy adoption to providers.

7. Beacon's Areas of Non-Compliance

The Alliance implemented 3 Corrective Action Plans (CAPs) to guide Beacon on improving Coordination of Care measures, Member Satisfaction Survey Results, and their minutes. Beacon has implemented tactics to improve the two areas of metrics and the CAPs remain open. Beacon has successfully implemented changes to their minutes to reflect discussion and progress made on non-compliant areas and the third CAP regarding minutes is now closed.

8. Best Practices Sharing

The Committee shared some ideas/workflows/best practices implemented in response to the COVID-19 pandemic, and how to share the information with providers.

Committee discussed reaching out/collaborating with other organizations to share workflows and documentations, and condensing information to a couple pages. The committee discussed options for sharing the information once collected. Placing information, including contact information, in one virtual location was suggested.

Action:

a. Amit will reach out to providers and soliciting input on their best practices and challenges that COVID presents.

9. Future Topics

- Dr. Kennedy requested a future topic exploring COVID-19 vaccines for members, including hesitancy and barriers.
- Specialty care for members with long term COVID symptoms. Emerging evidence regarding care of COVID "long-haulers."
    - Provide brief clinical summary regarding what is known about this condition and the specialty types that are recommended for follow up care.
    - This information could be used to help educate providers regarding the condition, current Alliance specialists who could treat it, and a reminder about specialist referrals via telehealth.
- Exploring vaccines hesitancy in ethnic/cultural groups.

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

Next Meeting: Thursday, April 29, 2021 12:00 p.m. – 1:10 p.m.

The meeting adjourned at 1:10 p.m.

Minutes respectfully submitted by,

Jacqueline Van Voerkens
Administrative Specialist

SANTA CRUZ – MONTEREY – MERCED
MEMBER SERVICES ADVISORY GROUP

Meeting Minutes
Thursday, February 11, 2021
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

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Advisory Group Members Present:

Santa Cruz County:

John Beleutz	Health Projects Center
Alene Smith	Consumer
Margaret O'Shea	Consumer

Monterey County:

Enid Donato	Natividad Medical Center
Leo Demushkane	Consumer

Merced County:

Erika Peterson	Merced County Head Start

Members Absent:

Rob Smith	Commissioner
Elsa Quezada	Commissioner
Martha Rubbo	Consumer
Doris Drost	Consumer
Lupe Chavez	Consumer
Ashley Lynne Gregory	Consumer
Alexandra Heidelbach	Consumer
Linda Jenkins	Consumer
Myisha Reed	First 5 Merced County
Rex Resa	Consumer
Silvia Wilson	Monterey County-CalHeers
Vivian Pittman	Consumer
Rebekah Capron	Merced HAS
Michael Molesky	Commissioner
Celeste Armijo	Monterey Department Social Services
Tamara McKee	HICAP – Alliance on Ageing
Tracy Clark	Merced HAS

Candi Walker	Consumer
Humberto Carrillo	Consumer
Julie Edgecomb	Commissioner

Support Staff Present:

Dana Marcos	Member Services Director
Maura Middleton	Member Services Administrative Assistant
Hillary Gillette-Walsh, RN	Quality and Population Health Manager
Megan Simms	Member Services Operations Manager
Ronita Margain	Regional Operations Director, Merced

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:
Elect Advisory Group Chair
John Beleutz called for nominations for a new chair for 2021. John indicated his willingness to serve for another year. As no other nominations were made, it was unanimous to elect John as the Advisory Group Chair for 2021.

Meeting Facilitation Ownership Update
Dana Marcos, Member Services Director and Ronita Margain, Regional Operations Director provided an update regarding Alliance staff facilitation of the Member Services Advisory Group. Starting with the May MSAG meeting, Ronita Margain and Kayla Zoliniak, Administrative Specialist will serve as the Alliance staff assigned to facilitating this meeting, including preparing agenda topics, documenting meeting minutes, and maintaining meeting schedules. Dana Marcos will continue to participate as the Member Services Director and subject matter expert. Maura Middleton will support to ensure a seamless transition.

Pharmacy Benefit Transition
Dana Marcos, Member Services Director gave an update about the Medi-Cal Rx Carve-out. The implementation date was moved from January 1, 2021 to April 1, 2021. Medi-Cal and the Alliance will inform members of this change via letters, social media postings and notices on the Alliances website. Members will receive new ID cards.

New Member Packet Presentation
Megan Sims, MS Operations Manager presented on the updated New Member Welcome Packet. Members will now have access to certain member materials electronically. These include the Member Handbook, Formulary and the Provider Directory. Members within the Seniors and Persons will Disabilities (SPD) population will continue to receive hard copies of these materials. As a result of these changes the New Member Welcome packet has been redesigned, offering clear and concise step-by-step information to guide new members as they enroll with the Alliance. The redesigned packet promotes self-service and empowers members to use the Alliance Website which contains the most accurate and up-to-date information. The New Member Welcome Packet and process supports sustainability and assists with reduction in returned packets due to mail box sizes. One MSAG member suggested that a notecard or flyer be included in the New Member Packet to inform members who do not have access to the internet about how to request the full Handbook, Formulary or Directory materials in a print format.

Vaccinating Against COVID-19 in our Community
Hilary Gillette-Walch, RN, provided an update on COVID-19 vaccinations. Hilary described how the COVID vaccine protects individuals from becoming very ill from COVID-19. The vaccine is currently being distributed in phases by providers and county health departments. Once available, all members, aged 16 and older, with no severe allergic reactions to prior vaccines, should get vaccinated. The Alliance and providers will continue to share information with members about the vaccine as it becomes available. To get more information about the vaccine and the sign-up process, Hilary encouraged MSAG members to reach out to their local health department or visit www.cdc.gov.

Meeting adjourned at 11:00 a.m.
Respectfully submitted,
Maura Middleton, Clerk of the Advisory Group/Member Services Administrative Assistant

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 8, 2021

1:30p.m. – 3:00p.m.

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

Chairperson: Elsa Quezada, Vice-Chair and Monterey County Board Member

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

WCMFAC Committee Present: Deardra Cline, Santa Cruz County – CCS WCM Family Member; Irma Espinoza, Merced County – CCS WMC Family Member; Kim Pierce, Monterey County – Local Consumer Advocate; Lori Butterworth, Santa Cruz County – Local Consumer Advocate; Manuel López Mejia, Monterey County – CCS WCM Family Member; Susan Skotzke, Santa Cruz – CCS WCM Family Member; Vicky Gomez, Merced County – CCS WCM Family Member.

WCMFAC Committee Absent: Ashley Gregory, Santa Cruz County – CCS WCM Family Member; Christine Betts, Monterey County – Local Consumer Advocate; Cindy Guzman, Merced County – CCS WCM Family Member; Cristal Vera, Merced County – CCS WCM Family Member; Cynthia Rico, Merced County – CCS WCM Family Member; Frances Wong, Monterey County – CCS WCM Family Member; Janna Espinoza, Chair and Monterey County – CCS WCM Family Member.

CCAH Staff Present: Dana Marcos, Members Services Director; Dianna Diallo, Medical Director; Kelsey Riggs, RN, Pediatric Complex Case Management Supervisor; Jennifer Mockus, RN, Community Care Coordination Director; Ronita Margain, Merced County Regional Operations Director.

Guest: Patricia Potts, Jacobs Heart and Children's Hospice and Palliative Care Coalition; Blanca Sahagún, Public Health Program Coordinator for Merced County Department of Public Health – CCS Nursing & Therapy Division; Susan Paradise, Manager, Family Health Programs at County of Santa Cruz.

Agenda Topic	Minutes	Action Items
Meeting Administration Lilia Chagolla	• Lilia Chagolla, Regional Operations Director (ROD) welcomed the group and announced a last-minute change to the meeting Chair. Janna Espinoza, Committee Chair was not able to attend the meeting today and will keep the group posted on her status.	
Call to Order Elsa Quezada	• Elsa Quezada, Committee Vice-Chair called the meeting to order at 1:35p.m.	
Roll Call Maria Marquez / Lilia Chagolla	• Committee introductions and roll call was taken.	
Oral Communications Elsa Quezada	• Elsa Quezada, Committee Vice-Chair opened the floor for any members of the public to address the Committee on items not listed on the agenda.	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	No members of the public addressed the Committee. • Elsa Quezada, Committee Vice-Chair opened the floor for members/staff in attendance to make comments. • Lilia Chagolla. ROD shared that the Alliance and Common Spirit are engaged in negotiations to renew their provider contract, which is set to expire on April 1, 2021. For your awareness Common Spirit represents Dignity Health Medical Groups, auxiliary providers and hospitals including Mercy Medical Center in Merced County and Dominican Hospital in Santa Cruz County. While the continued discussions, the California Department of Health Services requires that health plans notify members at least 30 days in advance of the potential changes to their health plan. To comply with the requirements, the Alliance has sent letters to members who are assigned a Dignity Health provider informing them that they will be assigned to another provider effective April 1, 2021 if a new agreement is not reached by that date. • Lilia Chagolla, ROD raised awareness in the interest of transparency as the circumstances evolves. While we remain hopeful for a positive outcome with the negotiations the Alliance primary focus is to ensure that Alliance members have access of care including the continuum of care whenever possible. To sum, she shared the Alliance has always remained committed to their mission providing acceptable quality healthcare towards the vision of healthy people and healthy community. The Alliance teams continue to work directly with members and providers and are available to assist both providers and members.	
Consent Agenda Items: Accept WCMFAC Meeting Minutes from Previous Meeting Elsa Quezada	• Elsa Quezada, Committee Vice-Chair opened the floor for approval of the meeting minutes of the previous meeting on January 11, 2021.	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	Motion: Committee Member Kim Pierce move to approve the Consent Agenda. Abstain: Elsa Quezada. Action: The motion passed with the following vote: Committee Members Deardra Cline; Irma Espinoza; Kim Pierce; Lori Butterworth; Manuel Mejia; Susan Skotzke; and Vicky Gomez.	
Regular Agenda Item **ACEs Aware Initiative Parenting Education/Support by County** Jennifer Mockus	• Jennifer Mockus, Community Care Coordination Director presented on the Adverse Childhood Experiences Aware Initiative (ACE). The objective was to share information about ACE. Share ACEs resources in the Alliance's service area. Information about Parenting Programs and Parenting Program resources in the Alliance's service area were shared. • Elsa Quezada, Committee Vice-Chair inquired about who administers ACEs. Jennifer Mockus expanded on the ways for ACEs to be administered and how to obtain the ACEs score. Elsa Quezada asked if the resources for children with disabilities were integrated in the list of resources. Jennifer Mockus stated that the list of resources is not exhausted, these are similar resources across the Alliance's service area. She recommended using 211 as they will have great resources available. • Vicky Gomez, Merced County – CCS WCM Family Member. Inquired about resources in Merced County. Jennifer Mockus and Kelsey Riggs are available to connect with Vicky offline to determine if there are any specific needs and other ways to support. • Susan Skotzke, Santa Cruz – CCS WCM Family Member asked if the Alliance RN Case Managers could reach out to the CCS families conduct the ACEs. Kelsey Riggs weighed in and will connect with Susan offline.	Jennifer Mockus, to follow-up with Vicky Gomez on resources in Merced County. Kelsey Riggs to follow-up with Susan Skotzke to see if the Alliance Case Management can assist in doing ACEs.

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
WCMFAC Brochure Development Lilia Chagolla	• Lilia Chagolla, ROD provided a background on the request to create a FAC brochure. The objective was to provide a handout with resources to families with a newly diagnosed child. Lilia Chagolla provided an overview of the brochure, the resources to include and potential audience to share the brochure with. It was mentioned that the brochure wouldn't be condition specific and it would be general information for new parents to use as a tool. • Committee members selected the organizations that would be beneficial to list on the brochure as well as agreed on the organizations to removed. • Lori Butterworth shared that they are working on a google map for resources. Information is being pulled from a worksheet unto a map in which parents will be able to access information in their region. This resource is anticipated to be launch on a website by end of May 2021. Dialogs about adding this resource on the WCMFAC brochure. The need to have a hard copy vs. a digital document for all three regions was discussed and preferred. • Elsa Quezada Committee Vice-Chair suggested that the organizations listed on the brochure be notified of their listing to ensure they can assist Alliance members when contacted. • The first draft of the brochure will be presented to the Committee at the next meeting. Once approved by the Committee it will be translated to the Alliance's three threshold languages. • It was mentioned a digital format would be beneficial to have and break the digital divide. • It was suggested that lack of access to internet and technology as an access to care issue. This topic to be discussed on this Committee.	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
Community Partner Feedback | COVID-19 Impact on Members	• Open forum for Committee members to share COVID-19 impact. • Lor Butterworth, Committee member shared the success at Jacob's Heart in advocating for parents caring for seriously ill child to get vaccinated. She expressed her appreciation for Salud Para La Gente as they have been very helpful and understanding. She expressed the need to advocate and work together to get parents caring for children vaccinated. • Committee member Irma Espinoza shared a situation currently encountered with her child Primary Care Provider (PCP) office visit. Dana Marcos, Members services Director added that these types of situations are great to hear about and asked that Member Services be informed. Member Services can assist in documenting a grievance or a complaint. This is also an opportunity for Members Services to connect with the Providers office and help them understand the need as well as provide some education and/or work together for a resolution. • Susan Paradise raised her concern regarding CCS children and youth not doing in-person visits to see their PCP and/or Specialist. She mentioned the need for Alliance Case Management to assist families and ensure they are getting what they need during this challenging times.	Dana Marcos to have a Grievance Coordinator contact Irma Espinoza to assist with the PCP concern.
CCS Advisory Group Representative Report Susan Skotzke	• Susan Skotzke, Committee Member shared that the Department of Health Care Services (DHCS) is delaying the planned implementation date of April 1, 2021 for Medi-Cal Rx. More to come as a new implementation date is announced. • Susan Skotzke, Committee Member shared that there was a concern for the CCS referrals, but the referrals for Santa Cruz County are up and that was great to hear.	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 8, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	• Susan Skotzke, Committee Member raised her concern with CCS Children and Youth not having access to Medical Therapy Unit, in-person therapy during COVID. • Susan Skotzke, Committee Member encouraged members of the Committee to view the portal for other important data shared. • Lilia Chagolla ROD for the Alliance shared the CCS Advisory Group information for the Committee to have access to the information shared and could attend the quarterly meetings as chosen.	M. Marquez to share the website to the CCS Advisory Group with the WCMFAC Committee.
Future Agenda Items Lilia Chagolla	• Digital Connection for Families. How to Access Care • WCMFAC Brochure Draft – Lilia Chagolla	
Review Action Items Maria Marquez	• Maria Marquez reviewed the action items.	
Amendment Maria Marquez	Next WCMFAC Meeting is scheduled for Monday, May 10, 2021 at 1:30p.m. The June date noted on the meeting agenda is incorrect.	
Adjourn (end) Meeting Elsa Quezada	The meeting adjourned at 3:03p.m.	
Minutes Submission	The meeting minutes are respectfully submitted by Maria Marquez, Administrative Specialist	

Next Meeting: Monday, May 10, 2021 at 1:30p.m.

DATE: May 26, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Alliance Formulary Changes for Q2 2021

Recommendation. Staff recommend the Board approve the decision from the May 6, 2021 Pharmacy and Therapeutics (P&T) Committee on Alliance formulary changes for Q2 2021 listed below.

Background. The Alliance formulary is developed and maintained by the P&T Committee. The P&T Committee reports to the Continuous Quality Improvement Committee (CQIC). The CQIC is designated by, and accountable to, the Santa Cruz-Monterey-Merced Managed Medical Care Commission (Board). The activities, findings, recommendations and actions of the CQIC are reported to the Board on a scheduled basis.

Discussion. The P&T Committee accepted the following changes recommended by Alliance Pharmacists based on safety, efficacy, cost, scientific evidence and standards of practice.

Drug	Action
Trulicity	Added to formulary with step therapy, and modified step therapy criteria
Ozempic	Added to formulary with step therapy, and modified step therapy criteria
Victoza	Added to formulary with step therapy, and modified step therapy criteria
Byetta	Added to formulary with step therapy, and modified step therapy criteria
Bydureon	Added to formulary with step therapy, and modified step therapy criteria
Adlyxin	Added to formulary with step therapy, and modified step therapy criteria
Rybelsus	Added to formulary with step therapy, and modified step therapy criteria
Xultophy	Modified Prior Authorization Criteria
Soliqua	Modified Prior Authorization Criteria
Farxiga	Modified Prior Authorization Criteria
Invokana	Modified Prior Authorization Criteria
Jardiance	Modified Prior Authorization Criteria
Vancomycin 1.5-gram vial	Removed Prior Authorization Requirement
Moxifloxacin	New Prior Authorization Criteria

Baxdela	New Prior Authorization Criteria
Cortisporin-TC	New Prior Authorization Criteria
Klisyri	New Prior Authorization Criteria
Pimecrolimus	Modified Prior Authorization Criteria
Phentermine	Added to formulary with quantity restriction
Alli	Added to formulary with quantity restriction
Nicotine patches	Modified quantity restriction
Nicotine gum	Modified quantity restriction
Nicotine lozenges	Modified quantity restriction
Zerviate	New Prior Authorization Criteria
Vyzulta	New Prior Authorization Criteria

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

Attachments. N/A

DATE: May 26, 2021

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Alliance Office Reopening Update

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

Background. In response to the COVID-19 pandemic, Alliance office locations in all three counties have been closed since March 16, 2020. Alliance staff have been working in a temporary, fulltime telecommuting status since that date.

Discussion. As reported previously, the Alliance Workspace Reentry Taskforce recommended that the Alliance consider reopening our offices no sooner than July 1, 2021. Presently, we are seeing broad distribution of the coronavirus vaccine, along with the threat of the virus starting to subside across our services areas and activity restrictions being lifted. With that in mind, the Alliance is targeting Tuesday, September 7, 2021 as the date in which we will start to slowly, methodically, and safely reopen our offices. Details on plans for opening Alliance offices are provided below:

Alliance Facilities Reopening Plan **Projected Reopen Date:** Tuesday, September 7, 2021					
Category	**Phase 0**	**Phase 1**	**Phase 2**	**Phase 3**	**Phase 4**
			Dependent upon COVID data ratings and local guidance.		
Est. Staff Density by Office Location	0-10% of Workforce	10-15% of Workforce	15-40% of Workforce	40-75% of Workforce	75-100% of Workforce
Phase Summary	• Staff required to perform core work/duties onsite as determined by department leadership. • Staff required to physically prepare the office for reopening. • Staff allowed to voluntarily outreach and community events. Must follow Alliance guidelines.	• Staff required to perform core work/duties onsite as determined by department leadership. • Note: Vaccinated staff only.	• Staff required to perform core work/duties onsite as determined by department leadership, and those voluntarily wanting to return to the office to work.	• Staff required to perform core work/duties onsite as determined by department leadership, and those voluntarily wanting to return to the office to work.	• Business as usual, pre COVID-19.
Date & Duration	**Date:** Current thru Mon. Sept. 6.	**Date:** Tues, Sept. 7 **Duration:** TBD	**Date:** TBD **Duration:** TBD	**Date:** TBD **Duration:** TBD	**Date:** TBD **Duration:** TBD

In addition, starting May 1, 2021 the Alliance will resume outreach activities and community event attendance, where and when it is safe to do so, and in compliance with Alliance guidelines for staff safety.

We will continue to monitor the status and impact of the virus as part of ongoing planning for reopening Alliance facilities and make any adjustments to our plans as needed. As always, we will follow recommendations for the safe reopening of Alliance office locations based on State and Public Health Officer orders, the pandemic status, and the current environment.

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

Attachments. N/A

DATE: May 26, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: COVID-19 Update

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

Background. Throughout April, rates of new COVID-19 positive cases, hospitalizations and deaths continued to decrease in all three Alliance counties, with Santa Cruz County and Monterey Counites in the orange (moderate) tier and Merced County in the red tier through the first week of May.

As of May 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	31,682	454	3.30%
Monterey	43,506	381	.7%
Santa Cruz	16,029	205	.7%

Alliance outreach continues to promote safe behavior and vaccine navigation while prioritizing members with higher/moderate risk for COVID infection and those living in areas identified as most in need from the California Healthy Places Equity Index. Efforts to contact homebound members to arrange for home vaccination is underway. An additional population of high-risk members for outreach will be identified with expansion of age limits to include 12-15 year-olds. Promotion of provider testing for identification of infection and of potential COVID variants continues.

Vaccine availability continues to improve in all Alliance counties due to progress with Blue Shield Third Party Administrator scheduling and vaccine distribution. Pfizer vaccine was approved by the CDC for 12-15 year-olds on May 10, 2021.

COVID-19 Vaccination Rates. As of May 10, 2021, vaccine penetration from available Alliance data sources, including vaccine registries and the Department of Health Care Services encounter data is as follows:

Number and Percent of Members Partially Vaccinated by County and Age Group (December – May)

	Merced		Monterey		Santa Cruz	
Age Groups	N Vax	% Vax	N Vax	% Vax	N Vax	% Vax
AGES 10-19	1,065	7.97%	2,627	15%	1,189	20%
AGES 20-44	4,346	10.43%	8,178	17%	4,127	17%
AGES 45-64	2,827	15.20%	5,113	24%	2,927	21%
AGES 65-74	859	15.73%	1,029	15%	623	15%
AGES 75-84	418	14.77%	460	14%	215	12%
AGES 85+	142	12.58%	197	13%	85	12%

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

	Adult Population	Vaccinees	% Alliance Population
Merced	83,050	9,674	12%
Monterey	99,153	17,610	18%
Santa Cruz	51,324	9,168	18%
Total	233,527	36,452	16%

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

	Adult Population	Vaccinees	% Alliance Population
Merced	83,050	30,016	36%
Monterey	99,153	41,533	42%
Santa Cruz	51,324	24,062	47%
Total	233,527	95,611	41%

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

Race/Ethnicity	Partially Vaccinated	%Partially Vaccinated	Fully Vaccinated	% Fully Vaccinated
Alaskan Native or American Indian	59	8%	115	16%
Asian Indian	361	14%	726	29%
Asian or Pacific Islander	467	14%	814	24%
Black	663	8%	960	11%
Cambodian	32	18%	40	22%
Chinese	184	21%	264	30%
Filipino	2,528	9%	4,073	15%
Guamanian	12	10%	15	12%
Hawaiian	14	9%	26	16%
Hispanic	21,348	8%	29,881	12%
Japanese	76	29%	72	27%
Korean	78	18%	142	32%
Laotian	78	11%	167	24%
Not Provided	23	15%	61	41%
Other	2,121	12%	2,912	17%
Samoan	19	7%	14	5%
Vietnamese	255	24%	312	30%
White	6,989	12%	10,317	17%

COVID-19 Quality Improvement Plan and Pandemic Care: Member Outreach Calls. It is of note that available vaccine data continues to have gaps due to reporting lags and completeness but it is improving.

Community Coordination and Alliance Pandemic Care Task Force. The Alliance continues to regularly convene a cross-functional team of Alliance leaders to coordinate provider and member outreach and community engagement in support of vaccination efforts in our Service Area. With a shift from mass vaccination clinics to more targeted outreach to vulnerable populations, the Alliance is assisting with member calls and educational material distribution, as requested by our county Public Health partners. Our goals through this work remain to support the resumption of safe care and the equitable distribution and uptake of COVID-19 vaccinations for all Alliance members.

Pandemic Care Communications. The Alliance continues to communicate important messages about COVID-19 mask updates, social distancing recommendations, and other preventative messaging. In addition, staff continue to promote messages regarding the availability, safety and efficacy of the vaccines. These messages are posted on the Alliance's website, member-facing flyer and videos, which are available in all three languages. In addition, during the month of April, the Alliance published five COVID-19 related posts on Facebook, which reached over 2,800 Facebook users during that month.

Workspace Reentry. An Alliance office reopening update is included in the consent agenda.

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

Attachments. N/A

DATE: May 26, 2021

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Updated Local Agency Investment Fund Authorization Resolution

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Recommendation. Staff recommend that the Board approve the updated Local Agency Investment Fund (LAIF) Authorization Resolution to include the following Alliance Staff to be authorized users:

1. Stephanie Sonnenshine – Chief Executive Officer (CEO)
2. Lisa Ba – Chief Financial Officer (CFO)
3. Joy Cubbin – Accounting & Administrative Contracts Director
4. Jay Sen – Budgeting & Reporting Director
5. Jimmy Ho – Finance Manager

Background. LAIF was established in 1977 as an investment alternative for local agencies providing the opportunity to participate in a major investment portfolio through the California State Treasurer's Office. Local governmental agencies may participate in LAIF by filing a resolution adopted by the agency's governing board with the State Treasurer's Office.

Discussion. The Alliance's LAIF Resolution was approved by the Board on April 3, 1996, to grant the CEO and Finance Director authorization to manage the monies in the LAIF account and to add or remove authorized users. Staff seek approval from the Board to update the LAIF Authorization Resolution due to organizational growth and position title changes. The updated resolution allows for the CFO to oversee the treasury function and the addition of authorized users will ensure sufficient coverage to appropriately manage Alliance investments.

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

Attachment:

1. Resolution of Santa Cruz-Monterey-Merced Managed Medical Care Commission.

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

RESOLUTION OF SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISSIONS

AUTHORIZING INVESTMENT OF MONIES IN THE LOCAL AGENCY INVESTMENT FUND

WHEREAS, The Local Agency Investment Fund is established in the State Treasury under Government Code section 16429.1 et. seq. for the deposit of money of a local agency for purposes of investment by the State Treasurer; and

WHEREAS, the BOARD OF DIRECTORS hereby finds that the deposit and withdrawal of money in the Local Agency Investment Fund in accordance with Government Code section 16429.1 et. seq. for the purpose of investment as provided therein is in the best interests of the SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISIONS;

NOW THEREFORE, BE IT RESOLVED, that the BOARD OF DIRECTORS hereby authorizes the deposit and withdrawal of SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISIONS monies in the Local Agency Investment Fund in the State Treasury in accordance with Government Code section 16429.1 et. seq. for the purpose of investment as provided therein.

BE IT FURTHER RESOLVED, as follows:

Section 1. The following SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISIONS officers holding the title(s) specified hereinbelow **or their successors in office** are each hereby authorized to order the deposit or withdrawal of monies in the Local Agency Investment Fund and may execute and deliver any and all documents necessary or advisable in order to effectuate the purposes of this resolution and the transactions contemplated hereby:

STEPHANIE SONNENSHINE – CHIEF EXECUTIVE OFFICER

LISA BA – CHIEF FINANCIAL OFFICER

JOY CUBBIN – ACCOUNTING & ADMINISTRATIVE CONTRACTS DIRECTOR

JAY SEN – BUDGETING & REPORTING DIRECTOR

JIMMY HO – FINANCE MANAGER

Section 2. This resolution shall remain in full force and effect until rescinded by BOARD OF DIRECTORS by resolution and a copy of the resolution rescinding this resolution is filed with the State Treasurer's Office.

PASSED AND ADOPTED, by the BOARD OF DIRECTORS of SANTA CRUZ-MONTEREY-MERCED MANAGED MEDICAL CARE COMMISIONS of State of California on May 26,2021.

ATTEST:

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Kathy Stagnaro, Executive Assistant, Clerk of the Board

DATE: May 26, 2021

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

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

SUBJECT: Quality Improvement Workplan Report for Q4 2020

Recommendation: Staff recommend the Board approve the Quality Improvement (QI) Workplan report for Q4 2020.

Summary. This report provides pertinent highlights, trends, and activities from the Q4 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 priorities 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.

Discussion.

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 was at 17.85%. The CIS rate for CFHC remained stable at 12.5% 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 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. The AWC rate for LCH using a 12-month rolling methodology and 90-day claims lag decreased from the previous quarter to 34.38%.

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 Consumer Assessment of Healthcare Providers and Systems (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. However, the IHA rate increased by 5.3 percentage points from the previous quarter to 41.20%. The 2020 CAHPS member survey results showed 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. This quarter, the avoidable ED visits decreased by 1.6 percentage points to 9.68% in comparison the previous quarter to meet the goal. These are on-going topics at clinic Joint Operating Committee (cJOC) 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 in the previous quarter and focused on "Member Access and No-Shows." Because of the pandemic, it was decided to conduct the Practice Transformation Academy through a virtual setting rather than in-person. The team partnered with the Training and Development team to complete the first online training video in this quarter.

Operational Performance.

Metrics:

- FSR 100% complete, 100% CE resolved, 100% CAPs submitted, 100% CAPs completed.
- PQI timely resolved, QI grievances routed, Inter-rater reliability conducted quarterly.

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 here. The FSR team monitors all network primary care providers to ensure that facilities are safe and accessible, care is evidence-based, and timely for our members. The FSR team's goals are for 100% compliance with operational metrics for 2020. During Q4 of 2020, forty-five sites out of fifty-seven (79%) completed a full site review within 3 years of the last FSR. Four sites had Critical Element (CE) Corrective Action Plans (CAP) and 2 of 4 (50%) CE CAPs closed within 10 business days. Twenty-eight of thirty-three clinics (85%) that were issued Corrective Action Plans (CAP) were able to submit a CAP plan within forty-five calendar days. Twenty-three of the twenty-six clinics (88%) requiring a CAP plan verification were completed on time (by ninety-days). Issues encountered for site review include COVID-19 and staffing impact delayed a site's FSR and MRR, and ability to submit the CAP within forty-five calendar days. The team continues to refine the remote review process and monitor All Plan Letter (APL) correspondence to ensure compliance with state requirements.

Alliance staff and network clinics continue to experience an impact from the pandemic and fires resulting in reduced workforce impacting record retrieval, correspondence and timely resolution of cases. Additional temporary nursing staff was contracted with in Q3 and Q4 to alleviate reduction in staff resources.

The COVID-19 pandemic and the regional fires during 2020 had a significant impact upon operations and the ability for the FSR and PQI teams to meet their goals due to impact on these events' impacts on staff resources and typical operating procedures.

Conclusion. There were impacts in Q4 2020 quality measure performance as providers continued to prioritize COVID-19 activities and emerging issues. The QI team monitored and attempted to engage with providers as able on workplan activities. There was concerted effort to maintain routine operational processes and meet regulatory requirements. Many of the team members shifted to focusing on pandemic care planning, such as member outreach efforts and providing clinical expertise for communication efforts, risk stratification, and scenario planning. There will be continued efforts to maintain the QI activities throughout the pandemic while 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: May 26, 2021

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

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

SUBJECT: Quality and Performance Improvement Program Annual Report for 2020

Recommendation. Staff recommend the Board approve the Quality and Performance Improvement Program (QPIP) Annual Report for 2020.

Summary. This report provides the 2020 activities for the Alliance's QPIP and an evaluation of the Quality Improvement workplan. A written description of activities is reflected in the QI workplan, as evidenced by goals and objectives reviewed quarterly and evaluated on an annual basis. These activities are approved by the Continuous Quality Improvement Committee (CQIC), and ultimately, the Alliance Board.

Background. The Alliance is contractually required by the Department of Healthcare Services (DHCS) to maintain a QPIP to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. Each year, the Alliance's QPIP focuses upon areas with actionable challenges and significant clinical outcomes that relate to a large proportion of members. The intent is to evaluate the activities related to quality and develop future interventions for improvements in care delivery and ultimately, the health status of members. The 2020 QI workplan outcomes and evaluation are described in further detail in the report.

Discussion.

General 2020 QPIP activities.

Re-structure. In May 2020, the Quality Improvement Department was officially re-named as the Quality Improvement & Population Health Department to incorporate population health strategies and system transformation of care delivery as proposed through DHCS Cal AIM. To align efforts, the Health Programs Unit, which includes the scope of Health Education and Cultural & Linguistic programs, was integrated within the Quality Improvement Department to enhance the focus on both individual and population health outcomes.

Population Health. In preparation for the DHCS Cal AIM initiative on Population Health (PH), a gap assessment of the NCQA standards was conducted in 2020. For 2021, a strategy will be developed for remediating gaps for people, process, or systems, with the goal of Cal AIM readiness in 2023. As part of the PH requirements, a DHCS Health Education and Cultural and Linguistic Population Needs Assessment focusing on health disparities, gaps in services, and health status and behaviors of Alliance members in our tri-county reporting areas, was completed in July 2020. Based on the findings, an action plan was developed, and planned interventions are underway as a strategic tactic entitle "PNA Education Campaign".

Member Outreach. Quality improvement efforts for member outreach included support of live and robocalls for vulnerable members related to COVID-19, wildfires, power outage, and emerging issues. This included developing a member risk stratification methodology by assigning a relative risk score and additional variables to segment members from low to high risk for member rosters (recognized as a DHCS Innovation Award nominee). In addition, the team developed scripts, talking points, translations, significantly contributed to the content and review of communication materials, and an "emergency task" in Essette was developed to capture emerging events. In addition, the Nurse Advice Line was enhanced to include tele-visits through MD Live and incorporating COVID-19 prompts. Multiple teams across the organization conducted member outreach for the members:

Outreach Campaign Name	Intervention Type	Start Date	End Date	Member Count	% of Successful Calls *(includes live calls)*
COVID-19 Emergency	**Telephonic**	4/1/2020	8/31/2020	**8,866**	**N/A**
COVID-19 & Resources Robocalls	**Robocalls**	4/17/2020	5/10/2020	**63,639**	**49%***
Water Shut-off: Dos Palos	**Telephonic**	6/25/2020	6/26/2020	**99**	**30%**
COVID-19 Resuming Care	**Telephonic**	7/1/2020	1/10/2021	**5,415**	**65%**
Wildfires: SC & Monterey Counties Tier 1-2	**Telephonic**	8/20/2020	10/25/2020	**620**	**N/A**
Air Quality Hazards: Merced County Tier 3	**Telephonic**	8/28/2020			
Pediatric DHCS Campaigns EPDST Phase I Robocalls	**Robocalls**	10/9/2020	10/14/2020	**420**	**36%***
PSPS area with Powered DME: Santa Cruz County	**Telephonic**	10/14/2020	10/18/2020	**18**	**44%**
Pediatric DHCS Campaigns EPDST Phase II Robocalls	**Robocalls**	10/16/2020	10/21/2020	**1,673**	**27%***
PSPS area with Powered DME: Santa Cruz County	**Telephonic**	10/26/2020	10/26/2020	**2**	**0%**
Pharmacy Carve Out	**Telephonic**	11/2/2020	12/31/2020	**227**	**85%**
EPDST Pediatric DHCS Campaign Phase I (0-2.99 ages)	**Mailing**	11/3/2020	11/3/2020	**9,858**	**N/A**
EPDST Pediatric DHCS Campaign Phase II (3-6.99 ages)	**Mailing**	11/6/2020	11/6/2020	**25,794**	**N/A**
COVID-19 II & Resources Robocalls	**Robocalls**	12/29/2020	01/15/2021	**14,482**	**14%***
			Total	**131,113**	

****robocalls include live calls and voice messages***

2020 QI Workplan Outcomes and Evaluation.

DHCS Performance Improvement Projects (PIPs).

Immunizations. The Alliance focused on increasing the HEDIS Childhood Immunization Status (CIS) Combo 10 rates in Merced County from 19.71% to 34.79% for children 2-years of age and, continued to monitor the Immunizations for Adults (IMA) Combo 2 rates. At the beginning of 2020, the Alliance partnered with Castle Family Health Center (CFHC) on a Department of Health Care Services (DHCS) mandated Performance Improvement Project (PIP) to increase their CIS rates from 7.28% to 14.76%. However, in response to the pandemic, DHCS closed out the PIP on 6/30/20. At the end of the year, although the CIS Combo 10 rate for CFHC increased to 12.5%, the rate in Merced county decreased to 17.85%. The goal of monthly monitoring of IMA Combo 2 rate was met.

Guidance from DHCS specific to 2020-2022 PIPs was received in October and the Alliance decided to continue working with CFHC on the PIP to improve their CIS Combo 10 rate.

Adolescent Well Care Visits (AWC). The Alliance partnered with Livingston Community Health (LCH) on a DHCS Performance Improvement Project 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 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

all PIPs on 6/30/20. The 2020 AWC rate for LCH using a 12-month rolling methodology and 90-day claims lag was 34.38%.

Guidance from DHCS specific to 2020-2022 PIPs was received in October and a new health equity PIP proposal focused on increasing child and adolescent well care visits in Merced county was submitted to DHCS. The proposal was validated and approved by DHCS in December and the Alliance received confirmation from Golden Valley Health Center to partner on this PIP.

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.

Breast Cancer Screening (BCS) PDSA. DHCS required all health plans to conduct a PDSA rapid cycle project on a single performance measure that focuses on preventive care, chronic disease management or behavioral health MCAS measure impacted by COVID-19. The Alliance decided to focus on increasing the BCS rate as the measure needing most improvement and set the global aim to be above the NCQA Medicaid 50th percentile benchmark in Merced county. Data revealed that the screening compliance rates at Gettysburg Medical Clinic were lower than the other providers and the Alliance partnered with them and El Portal Imaging Center to improve their BCS rate by 10%. The eligible and non-compliant members were identified and as an intervention, a screening mammogram order was developed, and referrals were placed with El Portal by Gettysburg for these members. The El Portal staff completed up to three call attempts to these members requesting them to schedule their BCS. The compliance rate for these members was measured at 39.50% post-intervention in comparison to the 26.89% rate pre-intervention, exceeding the 10% improvement goal.

COVID-19 Quality Improvement Plan (QIP). In response to the COVID-19 pandemic, DHCS required all health plans to submit a brief COVID-19 QIP, aimed at interventions or strategies to increase the provision of preventive, behavioral health and/or chronic disease care services for members amidst the COVID-19 pandemic. The Alliance decided to focus on the member outreach efforts that were implemented in response to the COVID-19 pandemic for this QIP. For the initial submission, which was due in October, the Alliance included a description of the interventions which consisted of live phone calls, automated phone calls and letters to members in each of the three counties.

Access to Care (Appointment availability)**.** The Alliance 2018-2020 Strategic Plan 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 Consumer Assessment of Healthcare Providers and Systems (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 COVID-19 pandemic, DHCS temporarily suspended the requirement for the providers to complete the IHA and the 2020 rate was 41.20%. The 2020 CAHPS member

survey results showed 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 Strategic Plan goal. There was a sharp decline in the Third Next Available Appointment rate this year which decreased to 11% compliance for primary care and 19% compliance for specialty care. The 2020 avoidable ED visits were at 14.23% to meet the Strategic Plan goal.

We developed training to help providers improve their access scores on member surveys and provided training to the providers in addition to their CG-CAHPS member survey results. Also, we continued to promote the Nurse Advice Line and Urgent Visits and, launched MDLive virtual care platform so that members can benefit from receiving 24/7 access to certified physician.

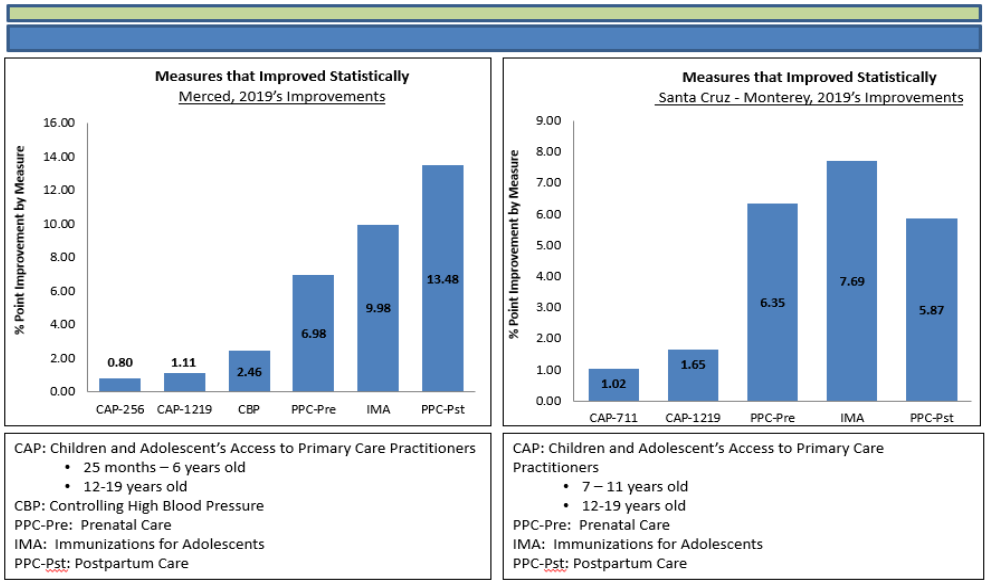
Operational Performance. The QPIP includes surveillance to maintain and improve the clinical safety of services to members. Two key clinical safety operational functions FSR and PQI programs are reported below.

Clinical Safety: Facility Site Review (FSR) and Potential Quality Issues (PQI). The FSR team monitors all primary care providers within the network to ensure that facilities are safe and accessible, care is evidence-based, prevention-focused and safe for our members. The FSR team set out to achieve all operational goals at 100% compliance for 2020. Forty-five sites or 79% (N=57) completed a full site review within 3 years of the last FSR. When Critical Element (CE) Corrective Action Plan (CAPs) were issued at a review, only 2 out of 4 sites (50%) had the CAP resolved within 10 business days. Critical Elements require near immediate resolution, including items like infection control practices. The clinics issued a CAP 85% (N=33) were able to submit a CAP plan within forty-five calendar days to the Alliance. Challenges in meeting these goals were driven by concerns reported from the providers; threat from wildfires, shelter in place orders, limited staff due to COVID-19, integrating a new Electronic Medical Record system, and other urgent personal matters causing the CE CAP or CAP to exceed the due dates. Although DHCS flexibility to extend site reviews was an option, staff worked diligently to support providers in communicating FSR requirements and completing reviews virtually. Despite these challenges, an educational video was developed to prepare providers for improved performance on FSR scores in collaboration with the Health Improvement Partnership (HIP).

For PQI, the team reviewed 100% of the 387 member grievances and accepted additional reports of patient safety concerns from across the Alliance. Examples include a member who falls while inpatient, failure to follow through on lab results, inappropriate opioid prescribing that result in injury to the member. The aim is to complete investigation of cases within ninety calendar days of receipt and the team was successful for 72% of PQIs (N=316). Challenges facing the program included staffing shortages due to leaves of absence, onboarding new staff and ongoing program development. As the program evolves, changes include reporting to the Medical Board of California, collaboration with Special Investigative Unit (SIU) for substantial cases, weekly RN case-study groups and updating the CAP policy. These changes have increased overall transparency to the PRCC and allowed additional follow-up for high risk providers.

HEDIS and Care-Based Incentive Programs. HEDIS 2020 (Measurement Year 2019) was a successful year for the Alliance. HEDIS measures, now known as MCAS also experienced a policy change to set the 50th percentile as the minimum performance level for plans and included proposed sanctions and CAPs for failure to meet these new requirements. The QIPH team reported a total of 10 high performance level measures (HPL) and 18 measures that were below the minimum performance level (MPL). Continuing from last year, both regions (Santa Cruz-Monterey and Merced) struggle with pediatric measure performance. Specifically, Well-Child Visits in the First Fifteen Months of Life, and in Merced with the Childhood Immunization measure, Combination 10. Fall of 2020 brought an opportunity to use Robocalls, phone calls and letters to reach out to families with young children. We observed a slight increase in services being delivered following this intervention.

HEDIS: Statistically Significant Improvement, by the Measure



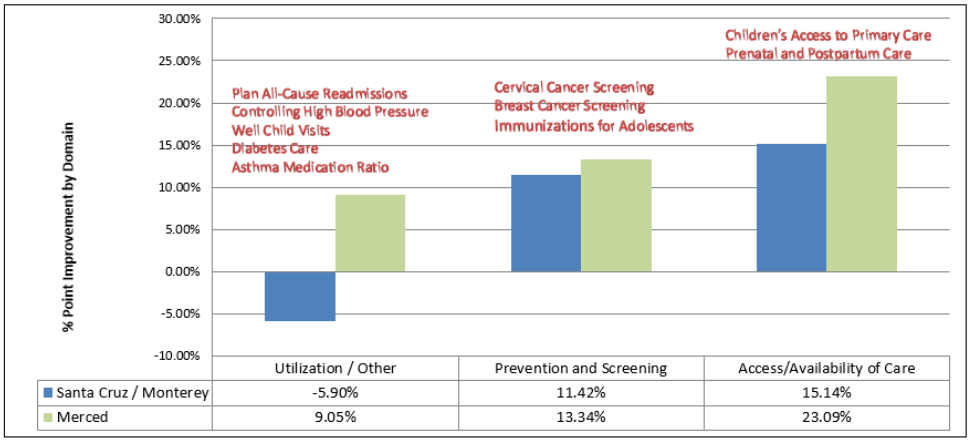
CAP: Children and Adolescent's Access to Primary Care Practitioners
- 25 months – 6 years old
- 12-19 years old

CBP: Controlling High Blood Pressure
PPC-Pre: Prenatal Care
IMA: Immunizations for Adolescents
PPC-Pst: Postpartum Care

CAP: Children and Adolescent's Access to Primary Care Practitioners
- 7 – 11 years old
- 12-19 years old

PPC-Pre: Prenatal Care
IMA: Immunizations for Adolescents
PPC-Pst: Postpartum Care

HEDIS: Improving Quality of Care, by Domain



	Utilization / Other	Prevention and Screening	Access/Availability of Care
Santa Cruz / Monterey	-5.90%	11.42%	15.14%
Merced	9.05%	13.34%	23.09%

The 2020 CBI evaluation is anticipated in April of 2021 following the completion of the 4th quarter build. In response to the decreased performance in the Well-Child Visits in the First Fifteen Months, the measure was added to the CBI Program along with a member incentive added to the program.

Kinetic QI Program. The Kinetic QI Program framework was developed based on a Quality Improvement Needs Assessment indicating receptiveness from providers for technical support by the Alliance Quality Improvement team. The program includes the following three key components: Practice Coaching, Learning Collaboratives and Practice Transformation Academy. As result of the COVID-19 pandemic, the Kinetic QI program had to be transformed to meet the needs of a virtual audience.

Although majority of the Practice Coaching projects were put on hold by the providers due to conflicting priorities because of the pandemic, we were still able to engage with five new providers in 2020. A virtual Learning Collaborative on "Member Access and No-Shows" was provided during the summer since the providers reported several challenges with access in the new COVID environment. There was also successful transition of the Practice Transformation Academy from an in-person setting to a virtual environment. In partnership with the Training and Development team, short online training videos were completed.

Quality Health Programs. The Health Education program provides services to members to enhance members' ability to self-manage chronic disease conditions. There was a successful launch and transition of the Healthier Living Program workshop from in-person to a telephonic intervention during the pandemic (2 workshops completed). In addition, the Healthy Moms and Healthy Babies Program underwent a new redesign which included a postpartum call in addition the parental call and topics related to oral health, well-child visits, immunization, and maternal mental health. A total of 6,745 member cases were created across all of the core programs, including Healthy Weight for Life, Live Better with Diabetes, Healthy Moms Healthy Babies, and Healthy Breathing for Life. There was full implementation of the DHCS Diabetes Prevention Program with the Provider Services team. As for the Cultural and Linguistics program, the Alliance Language Assistance Services were provided during the pandemic to ensure equal access to all services and included alterative processes to meet member/provider interpreting needs. There was a total of 1,117 face-to-face interpreter requests coordinated by the C&L team with the provider/vendor and 444 total translated documents (a 96% increase compared to last year). There were several efforts on member messaging in collaboration with the Communications Department. In addition, a Member Health and Wellness brochure was developed.

Medical Audits. A Department of Managed Healthcare (DMHC) Medical audit was conducted in July 2020, which included a review of the quality improvement system. A final report has not been issued. A DHCS Medical audit was not conducted in 2020.

Conclusion. The QPIP continued to maintain on-going activities despite the impacts due to COVID-19 and other emerging issues. The QPIP goals and objectives were challenging to meet and DHCS provided some flexibilities for regulatory requirements. For this year, the priorities were to meet member needs and support providers through population health strategies and targeted interventions for COVID-19 while engaging in QPIP activities as able. This was accomplished through creative means, such as virtual visits, telephonic outreach,

webinars/videos, and focusing on operational infrastructure to sustain the program. Overall, the QPIP remained stable with a continued focus to improve the quality care of Alliance members.

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

Attachments. N/A

DATE: May 26, 2021

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

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

SUBJECT: Quality Improvement and Population Health Workplan for 2021

Recommendation. Staff recommend the Board approve the Quality Improvement and Population Health (QI/PH) Workplan for 2021.

Summary. This report provides a summary of the activities planned for the 2021 QI/PH workplan. The workplan includes contractual required Performance Improvement Projects, operational performance metrics, health programs and cultural and linguistic services, and development of the population health management program. Refer to the QI/PH Workplan attachment for additional details.

Background. The Alliance is contractually required by the Department of Healthcare Services (DHCS) to maintain a quality improvement system to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. This is monitored through an annual QI/PH workplan with a written description of goals, objectives, and planned activities, reviewed quarterly and evaluated at the end of the year. The QI/PH workplan is approved by the Continuous Quality Improvement Committee, and ultimately, the Alliance Board. The Board can direct and provide modifications to the quality improvement system on an on-going basis to ensure that actions and improvements meet the overall Alliance mission.

Discussion. To improve health outcomes, the 2021 QI/PH Workplan incorporated a greater shift towards a population-based paradigm. This includes emphasis on preventive care services, provider and community engagement, members as active participants in their health, and optimizing the services and use of Alliance resources to ultimately minimize health disparities impacted by COVID and other factors/barriers.

The following describes the changes to the QI/PH Workplan:

- Performance Improvement Projects (PIPs). DHCS requires two PIPs with the topics of 1) Child and Adolescent Health, and 2) Health Equity for years 2020-2022. The Alliance had PIPs in Merced county for Childhood Immunizations-Combo 10 and Adolescent well visits during the 2019-2020 year, and this will be continued through 2022. These PIPs were chosen to address the geographic disparity in Merced county compared to Santa Cruz/Monterey and increase the rates for immunizations and preventive visits for children. Providers that were willing and prioritized these same initiatives were engaged to participate in the PIP.
- Quality Improvement Plans (QIPs). For any managed care accountability set (MCAS) quality measure below the 50th percentile, DHCS requires a QIP. Due to the pandemic, only one QIP was required, and the Alliance is working on improving rates for Breast Cancer Screening in Merced county using a workflow that includes

standing orders to obtain a mammogram. DHCS also requires a COVID-19 QIP focused on resuming preventive care during the pandemic. The activities include member outreach efforts to promote preventive care visits.

- Healthier Living Program (HLP). To assist members in self-efficacy towards better health, the Alliance provides workshops for chronic disease self-management through the Healthier Living Program. Evaluation of the workshops will be done through pre/post member surveys to assess "Overall Health" and "Quality of Life" and an increase in referrals to the program. In addition, in an effort to have greater presence in the community, the Alliance will promote quality initiatives related to wellness and health promotion through participation in health care collaboratives and other opportunities in partnership with the Regional Operations team.
- Cultural and Linguistic Services (C&L). As a core program for the Alliance, activities for C&L services will be monitored to ensure high quality, health equity, and appropriate language and culturally competent services are provided to reduce health disparities related to language/cultural barriers.
- Population Health Management (PHM). As required by CalAIM, a PHM program will need to be developed by January 1, 2023. The Alliance is developing a population health management program based on requirements by DHCS, NCQA and evidence-based literature. A strategy will be developed to remediate any gaps identified from the NCQA gap analysis, including those in people, process or systems.

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

Attachment.

1. 2021 Quality Improvement and Population Health Workplan

2021 Quality Improvement and Population Health Workplan

I. Projects and Initiatives

A. Immunizations

Project Description and Goals:

Purpose. To improve health outcomes for pediatric members by ensuring all appropriate immunizations are given per current Centers for Disease Control and Prevention (CDC) schedule and Advisory Committee of Immunization Practices (ACIP) guidelines. To increase the Childhood Immunization Status (CIS) Combination (Combo) 10 rate of immunization for children above the minimum performance level (MPL) in Merced county.

Priority. Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP) implemented at Castle Family Health Center.

Goals for 2021.

- In the context of COVID-19 pandemic, QI will collaborate with internal and external stakeholders to increase CIS Combo 10 rate of immunization for children from 19.71% (HEDIS 2020) to 24.71% [stretch: 34.79% (Exceed the NCQA 50th percentile)] in Merced County in 2021. Combo 10 is defined as the percentage of children 2 years of age who had four diphtheria, tetanus and a cellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one varicella (VZV); four pneumococcal conjugate (PCV) doses; 2 doses of hepatitis A (HepA); 2-3 rotavirus (RV) and 2 influenza doses (Flu) by their second birthday; and
- By December 31, 2022, Castle Family Health Center's will increase their percentage of children compliant with the HEDIS measure Childhood Immunization Status (Combination 10) among the three targeted sites from a baseline of 12.22% to 19.51%.

Activities (Secondary Drivers).

- Educate PCPs on EBP recommendations in the context of COVID-19 pandemic to improve Immunizations rates;
- Analysis of flu vaccination rates, where are children receiving no flu vaccine versus one flu vaccine dose. [parent is accepting of flu vaccine but did not get fully vaccinated]
- Model excellent provider communication strategies specific to immunizations;
- Refine and test interventions to increase rate for childhood immunizations including a tracking system;
- Through Practice Coaching, empower clinic staff to recall children behind on immunizations and create systems for COVID-19 vaccinations;
- Leverage required DHCS calls and written correspondence in addition to Alliance outreach to promote vaccinations directly to members;
- Increase routine local data submission and routine clinic use of the immunization registries;
- Emphasize health equity and increase outreach to member groups with lower rates of coverage (resuming care) with an emphasis on provider and community engagement.

B. Child and Adolescent Well Care Visits

Project Description and Goals:

Purpose. Using Associates in Process Improvement (API) Model for Improvement, effectively increase and enhance child and adolescent well-care visits in Merced County by testing changes on a small-scale using Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning and evaluation.

Strategic priority. Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP).

Goal/SMART Aim. By December 31, 2022, CCAH aims to increase the percentage of child and adolescent members 3-17 years of age, linked to Golden Valley Health Center - Los Banos clinic, who receive at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the intervention period, from 32.65% to 48.56% (rate of peer benchmark [Taylor Farms Family Health and Wellness Center - Gonzales, CA] in Monterey/reference county).

Activities. In collaboration with partnering clinical site (Golden Valley Health Center), complete the following DHCS/HSAG deliverables:

- Build internal and external PIP Teams and establish SMART Aim.
- Complete a process map, analyze failure modes and effects, identify interventions, and develop a key driver diagram.
- Plan intervention(s), effectiveness measure(s) and data collection process(es), test intervention(s), measure, monitor and analyze results, and evaluate intervention effectiveness (PDSA).
- Interpret overall results, assess successes, challenges and lessons learned, and evaluate potential for sustainability and spread."

C. PDSA, Breast Cancer Screening

Project Description and Goals:

Purpose. To complete: (1) two DHCS imposed PDSA cycles for a single underperforming MCAS measure in Merced county by 6/02/2021, and (2) three interventions/strategies aimed at increasing the provision of preventive services, behavioral health services, and/or chronic disease care, for members amidst COVID-19.

Strategic priorities. By 12/31/2020, complete first cycle PDSA intervention of one provider site, Gettysburg Medical Clinic. By 6/02/2021, perform second PDSA cycle intervention based on outcomes of first cycle results. Satisfy DHCS's requirements of submitting a brief COVID-19 Quality Improvement Plan (COVID-19 QIP).

Goals. PDSA - Increase breast cancer screening rate by 5% of targeted provider site, Gettysburg. QIP - By 3/1/2021, submit a 6-month progress update to DHCS on the COVID-19 strategies implemented.

Activities.

- PDSA - Standing order provided to Gettysburg Medical Clinic, establishing the clinical protocol for staging and completing screening events for Alliance members. Roster provided to Gettysburg of 56 eligible members to be screened. Gettysburg to perform chart review for eligibility based on most recent PCP visit and details captured in tracking spreadsheet. Referrals to be sent to El Portal Imaging Center, an Alliance partnered service provider, and bi-monthly meetings to be held with EL Portal to capture, track, and assess metrics on rate of screening completion of members confirmed for screening.

- COVID QIP: Resuming preventive care during COVID-19 pandemic: Pull various MCAS measure data to analyze intervention impact. Aggregate information and submit to DHCS.

D. Healthier Living Program

Project Description and Goals:

Purpose. To increase member self-efficacy in performing self-management behaviors by having member participate in the Alliance Healthier Living Program. (Chronic Disease Self-Management Program)

Strategic priorities: By 12/31/2021 at least 50% of participants will have scored "Good/Very Good/Excellent" for their "Overall Health" and "Quality of Life."

Goals.

- To increase member reporting favorable "Overall Health" and "Quality of Life"
  -Roll-up % of members who participate in the Healthier Living Program who report "Good/Very Good/Excellent" for their "Overall Health" and "Quality of Life"
  -Members' self-reported pre and post surveys.
- To increase referrals to HLP
- To expand the quality improvement system in the community by having greater presence and promoting Alliance quality initiatives related to wellness and health promotion.

Activities.

- Increase program participation to the Healthier Living Program workshop by prompting the member incentive and by offering different format options. (telephonic and virtual)
- Promote member incentives
- Align, engage, and track participation of QI/PH staff in Health Care Collaboratives (HCC) and actively promote Alliance quality initiatives in the community.

II. Operational Performance

A. Facility Site Review (FSR) Management

Project Description and Goals:

- 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date.
- 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days
- 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. (MMCD Policy Letter 14-004 pages 8-9).
- 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by the FSR team. (MMCD Policy Letter 14-004 pages 8-9).

Activities.

- Promote FSR video
- Monitor and comply with DHCS FSR/MRR flexibilities or requirements as communicated during the pandemic.

B. Grievance and PQI Management
Project Description and Goals:

- 100% of Potential Quality Issues (PQI) completed within 90 calendar days of receipt.
- Quality Improvement (QI) nurse to route 100% of grievances related to medical quality of care issues to the Medical Director. Conduct an inter-rater reliability audit on a quarterly basis.

Activities.

- Facilitate continuous quality improvement practices for grievances and PQI trends through cross-collaborative discussion and actions for improvement.
- Enhance Quality CAP process (i.e. high-risk provider issues/trends, involved departments, escalation)

C. Cultural and Linguistic (C&L) Services

Project Goal. To measure the performance of the Alliance C & L Services program and to make improvements accordingly.

Project Description.

- Effective communication is critical for our members to ensuring understanding, empowering, and to provide high quality care. The Alliance Language Assistance Services program ensures that Alliance members receive high quality and appropriate language services by reducing health dipartites related to language/cultural barriers.
- Explore the effectiveness of cultural competency services provided by the Alliance in ensuring that member's receive high-quality, person-centered care, and identifying opportunities for improvement where necessary.

Monitoring effectiveness of the program:

Data Collection and Reports.

- Monitor telephonic interpreting utilization
- Monitor face-to-face interpreting utilization
- Monitor translations and readability requests

Complaint Process.

- Monitor member and provider complaints
- Monitor PQIs

Direct Communication and Feedback.

- Development of a Health Literacy Tool kit for the organization
- Provider trainings

Increase Provider Utilization by 5%.

-Measure Utilization per County

Activities.

- Develop Health Literacy Toolkit for the organization (PNA Education Campaign)
- C & L Provider trainings

D. Population Health Management (PHM)
Project Description and Goals:
Purpose. Develop a population-based framework for the Alliance.
Project Goal.

- Based on the outcomes from the 2020 Population Health Gap Analysis, develop objectives and a strategy for population health to be implemented no sooner than 2022. Strategy will contemplate remediating any gaps identified in analysis, including those in people, process or systems. By the end of 2022, will have developed and implemented an enterprise-wide framework.

Project Description.

- Develop a PHM program based upon the NCQA gap analysis and the literature. Definitions of terms supporting the Population Health Initiative are finalized. List of critical elements to close gap-people, process and systems (leverage activities from Enhanced Care Management (ECM) efforts.
- Complete 2021 Population Health Needs Assessment. (June 2021)
- Shared definitions of terms supporting the Population Health Initiative are finalized. (Socialize)
- Complete at least one cycle of the S.P.I.A.A. cycle will be complete and have its evaluation documented.
- Program scope has been finalized and any necessary supporting policy documents are drafted and sent out to internal stakeholders for review. Completion of gap closure analysis and listed prioritization disseminated to internal stakeholders.
- Stakeholder engagement has occurred, discussion regarding shared measurement of health outcomes and equity have begun. Final population health strategy including gap closure sequencing plan presented to internal stakeholders.

DATE: May 26, 2021

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

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

SUBJECT: Q4 2020 UM Workplan Quarterly Report and 2021 UM Workplan Template

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Recommendation. Staff recommend the Board approve the Q4 2020 Utilization Management Workplan, and 2021 Utilization Management (UM) Workplan Template.

Summary. This document provides an overall summary of the 2020 UM Workplan activities, highlights and outcomes, in addition to the UM Workplan developed for 2021.

Background. The Utilization Management Program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and actively pursues identified opportunities for improvement. The program serves to accomplish the following:

1. Ensure that members receive the appropriate quantity and quality of health care services.
2. Ensure that the service is delivered at the appropriate time.
3. Ensure that the setting the service is delivered in is consistent with the medical care needs of the individual.
4. Ensure that medical management decisions will not be influenced by fiscal and administrative management.
5. Ensure compensation of staff or Subcontractors that conduct utilization management activities shall not be structured to provide incentives to deny, limit, or discontinue Medically Necessary services.

The Alliance recognizes the potential for over-and underutilization and takes appropriate steps and actions to monitor for this. The processes utilized for decision-making are based solely on the clinical appropriateness of care and services.

The Program provides a reliable mechanism to review, monitor, evaluate, and address utilization-related concerns as well as recommend and implement interventions to improve appropriate utilization and resource allocation This mechanism is established through the Utilization Management Work Group (UMWG)

- The UMWG provides guidance and direction to the Program and operates under the authority of the Continuous Quality Improvement Committee (CQIC).

UMWG activities include, but are not limited to:

- Reviewing and making recommendations to the Program Policy annually.
- Reviewing and approving the UM Workplan and Evaluation quarterly.
- Approving and ensuring implementation of utilization management criteria and UM/CCM policies.

- Analyzing summary data and making recommendations for action.
- Recommending medical policy, protocol, and clinical practice guidelines.
- Monitoring delegated utilization management activities through regular report.

UMWG is co-chaired by an Alliance Medical Director and the UM/CCM Director. UMWG membership includes representatives from all major areas of HS, including the CMO, Medical Directors, UM/CCM Managers, and Supervisors, Quality Improvement & Population Health Director, Pharmacy Director, and Community Care Coordinator Director, and other staff or delegates as needed. The UMWG meets, at a minimum, 12 times a year and once a quarter, and as needed. UMWG activities and recommendations are reported to the CQIC quarterly.

Q4 2020 Workplan Outcomes and Evaluation. Goals of the Committee are established by the UMWG and monitored quarterly for progress towards goals.

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

Challenges for the committee in 2020 included adapting work to COVID-related influences in utilization. Analysis of interventions for reducing readmissions was limited by pandemic influences on normal inpatient bed-days, ED utilization and the shifting provider network availability to see members.

Project and Initiative Outcomes

Complex Case Management. The Complex Case Management Team joined the UM team in the Q2 2020. Goals for team were focused on decreasing readmissions through discharge planning coordination with inpatient facilities, telephonic contact with members post-discharge, referrals to the Post Discharge Meal Delivery Program and utilization of evolving predictability tools for early intervention in those members likely to be admitted within the next six months. Pandemic influences affected face-to-face encounters but increased telephonic contact volumes increased.

Palliative Care. The Palliative Care benefit was not evaluated for impact to ED / Inpatient readmissions but evaluation did reflect an increase in referrals in the adult population. Efforts were made throughout the year to recruit more Palliative Care access in Merced and Monterey Counties and will continue into 2021. To increase access, providers were recruited in adjacent counties.

Pediatric Case Management. Highlights of the Pediatric Case Management team include completion of a 2019 corrective action plan (CAP) beginning in Q1 2020 for the Whole Child Model (WCM) Program. Deficiencies identified in November of 2019 have been sufficiently resolved and existing processes are now aligned with WCM Program requirements. The five areas of focus identified as opportunities for improvement have moved into a monitoring phase, with the review of key metrics carried over into 2021. In comparison to other COHS WCM programs, the Alliance performed better for referrals to CCS, Individualized Care Plans and facilitating the Age-Out process. Additionally, automated reports were developed for continual analysis of the program in all areas of the original CAP. This development has

increased progress towards goals by screening and identifying CCS eligible conditions outside of the UM processes.

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

Authorization Turn Around Times. Goal of 100%, Year End average of 99.4%

Prior Authorization Required Determination Metrics. Prior Authorization volumes decreased from the prior year by 22%. Decreases in authorization requests were consistent with the surges in COVID that influenced members avoiding preventative care visits. Increased approval rates were attributed to decreased in-area provider sites of care with limited capacity related to pandemic restrictions.

Top 10 Prior Authorization Requests Resulting in Medical Necessity Denials. The top 10 Authorization Medical Necessity Denials are reported out on the UMWP and reviewed for patterns of over-utilization as well as trending in technology advancing ahead of medical necessity criteria. These drive review of new technology and potential development of new policies and procedures.

Inter-Rater Reliability (IRR). IRR consists of formal testing of all staff involved in prior authorization decisions for consistency and accuracy. IRR results exceeded annual goal of 90% with 100% compliance in 2020

Utilization Performance Outcomes**:**

Inpatient Utilization. The overall admissions per 1000 members / month met or exceeded goals in most aid code categories. Admissions began to increase in the 1st and peaked in the 2nd qtr. These trends followed the pandemic surge and were greater than a 5% variance above goals in the SPD population. This would be consistent with the vulnerability of this group. Average Length of Stay increased in the SPD population by a day over the other aid code populations. Third and fourth quarter reflected a decrease in variance towards goals.

Ambulatory Care Sensitive Admission. Ambulatory Care Sensitive Admissions (ACSAs) met goals for the year but were above the state average in the 1st quarter. This is consistent with the prior year. Over the remainder of the year, the averages decreased across all three counties.

Readmissions. Year End Readmission averages were 12.4% for 2020 as compared to 12.8% in the prior year. Readmission rates were noted to increase in third and fourth quarters as the average medical severity of members presenting for admission and more serious COVID admissions were observed. Outcomes of readmission prevention interventions were difficult to analyze in this setting but will be a focus for 2021.

Long Term Care. Members residing in long term care (LTC)were evaluated annually for appropriateness to that level of care. In the Q1 2020, over 257 members were discharged to lower levels of care in an effort to move appropriate members back to community placement and support. Ongoing assessments have moved members out of LTC and

significantly increased the number of members appropriate to the LTC setting. The addition of contracted facilities in and out of the three counties has resulted in less delays in hospital discharges.

Emergency Department Utilization Metric. ED Utilization met goals as members avoided ED for routine problems due to the pandemic. Members were informed of the Nurse Advice Line and Urgent Care availability though multiple communication avenues. ED volumes dropped significantly in the second quarter and remained below the stated goal. This is attributed to the COVID exposure issues that began in the first quarter. Overall ED rates for 2020 remained well below goal but will be monitored for changes as care resumes and the effects of COVID vaccinations decrease impact to the ED settings.

Pharmacy Utilization. Pharmacy Costs increased by 2% but remained in the target goals range for 2020. Goal was to keep costs below 10% increase for the year. Pharmacy monitoring will continue as is with the unknown date of Pharmacy carve-out to FFS Medi-cal. Continue to monitor until transition to Medi-Cal Rx.

Out of Network (OON) Specialist Utilization Metric. OON utilization met goals for 2020. Prior Authorization staff continued to monitor and assess for redirection to in-network providers when appropriate. OON requests generally were approved during the COVID pandemic to decrease member/provider obstacles to care. Continue referrals to Case Management (CM) for redirection in network where appropriate. Continued work with Provider Services for any network access issues or patterns as gaps in services. are identified through ongoing reporting. Hospital and practice providers were added to the Alliance provider panel in 2020 in counties adjacent to those with limited resources.

Under/Over Utilization. Under Utilization typically comes from HEDIS measures that are below performance levels. Over Utilization was focused on specific codes and procedures that may lead to review for potential for fraud, waste and abuse. Through the use of advanced analytics, methodology was adapted to benchmark providers, services against national standards.

Behavioral Health. Monitoring for utilization associated with mild to moderate behavioral health continued to meet goals penetration for all of 2020. This was largely due to the increase of telehealth utilization in the face of the pandemic. Random file audits were performed quarterly with no recommendations for improvement. Goal for compliance with all requirements is 90% and the 2020 outcome was 100%. Files that do not meet the 90% threshold are subject to a corrective action plan.

Delegated Oversight. Utilization Reports reviewed quarterly are reflective of the parity between behavioral health and medical care utilization. All reporting is consistent with UM's operational performance metrics. There were no recommendations to the reports filed for the delegation of UM activities in 2020.

Summary of changes to the 2021 UMWP:

Projects and Initiatives.

- System Transformation Development/Community Care Coordination: added.
- Reducing Readmission Initiative: replaced previous Complex Case Management Initiative to incorporate all interventions for decreasing readmissions: Post Meal Delivery Pilot Program, Recuperative Care, Utilization of predictive Modeling Tool
- Palliative Care: removed as no longer a project/fully operational

Operational Performance. No changes

Utilization Performance.

- Alternatives to Acute Inpatient Days: added column for readmissions from Short Term Rehab facilities
- Under/Over Utilization Analysis: added Emerging Over Utilization Analysis as new metric to include auth reduction benefits and services. Additions to oversight were developed for 2021 monitoring by the UMWG in conjunction with decreased authorization requirements

UM Delegated Oversight.

- Combined Mental Health Utilization Rates and Beacon UM File Audits into one area as Beacon represents sole entity for which CCAH delegates utilization.

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

Attachments.

1. 2021 Utilization Management Workplan Template

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Summary of Changes for 2021 UM Work Plan Template

Projects and Initiatives

A. Pediatric Case Management: Updated data elements to align with DHCS WCM Tableau Report and add value to section
B. System Transformation Development / Community Care Coordination: Add this new section added
C. Reducing Readmissions Initiative: Added this new metric to replace earlier Adult Complex Case Management reporting grid

Other: Removed reporting on palliative care as this is no longer reported as a project in the work plan.

Operational Performance

A. Routine Prior Authorization Turn Around Time: No changes at the time
B. Prior Authorization Request Determination Metrics: No changes to table, will comment in narrative regarding auth reductions.
C. Top 10 Prior Authorization Medical Necessity Denials: No changes.
D. Inter-Rater Reliability - Nurses/MDs/Rx: Also no changes

Utilization Performance

A. Inpatient Utilization: Only update was to the weighted average, inpatient bedday goal for all MC LOB
B. Ambulatory Care Sensitive Admissions (ACSA): No changes
C. Readmissions: No changes
D. Alternatives to Acute Inpatient Days: Added column for short term rehab readmissions
E. Long-term Care: Updated data columns
F. Emergency Department Utilization: No changes
G. Pharmacy Utilization: No changes
H. Out-of-Network Specialist Utilization Metric: Added top 5 specialty types by county.
I. Under / Over Utilization Tracking and Reporting: Updated to reflect monitoring after investigation shows over/under utilization.
J. Emerging Under / Over Utilization Analysis: New metric to show services/benefits identified as needing review for over/under utilization.

UM Delegate Oversight

A. UM Delegate Oversight Quarterly Report Summary: no changes
B. Medi-Cal Mental Health Utilization Rates: Moved from separate BH Section so that all delegate reporting on this page
C. Beacon UM File Audit: Moved from separate BH Section so that all delegate reporting on this page

Central California Alliance for Health
2021 Utilization Management Work Plan and Evaluation

I. Projects and Initiatives
- A. Pediatric Case Management
- B. System Transformation Development / Community Care Coordination
- C. Reducing Readmissions Initiative

II. Operational Performance
- A. Routine Prior Authorization Turn Around Time
- B. Prior Authorization Request Determination Metrics
- C. Top 10 Prior Authorization Medical Necessity Denials
- D. Inter-Rater Reliability - Nurses/MDs/Rx

III. Utilization Performance
- A. Inpatient Utilization (Dr. A - review is complete)
- B Ambulatory Care Sensitive Admissions (ACSA)
- C Readmissions
- D Alternatives to Acute Inpatient Days
- E Long-term Care
- F Emergency Department Utilization
- G Pharmacy Utilization
- H Out-of-Network Specialist Utilization Metric
- I Under / Over Utilization Tracking and Reporting
- J. Emerging Under / Over Utilization Analysis

IV. UM Delegate Oversight
- A. UM Delegate Oversight Quarterly Report Summary-complete
- B. Medi-Cal Mental Health Utilization Rates
- C. Beacon UM File Audit

INITIAL WORK PLAN AND EVALUATION APPROVAL:

Submitted and approved by UMWG — Date: 3/16/2021

Submitted and approved by CQIC — Date: 4/29/2021

Submitted and approved by Board — Date:

Gordon Arakawa, MD, Medical Director — Date: 5/6/2021

Dale Bishop, MD, Chief Medical Officer — Date: 5/6/2021

Mary Brusuelas, RN, Utilization Management Director — Date: 5/6/2021

FINAL EVALUATION APPROVAL:

Submitted and approved by UMWG — Date:

Submitted and approved by CQIC — Date:

Submitted and approved by Board — Date:

Gordon Arakawa, MD, Medical Director — Date:

Dale Bishop, MD, Chief Medical Officer — Date:

Mary Brusuelas, RN, Utilization Management Director — Date:

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I. Projects and Initiatives

A. Pediatric Case Management

Assigned to UM/CCM Manager - Peds CCM

The Pediatric Case Management Program serves to optimize care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions. The goal of the program is to support comprehensive treatment of the whole child, including the child's full range of needs through early identification and referral for CCS eligibility and appropriate risk stratification. Data derived from DHCS WCM Tableau Report.

2021 Evaluation								
Time Period	Total # of Eligible members by County	# Newly Eligible by County	# Aged Out by County	# Approved NICU/PICU by County	# High Risk Members	# Low Risk Members	# ICPs	Comments/Recommendations
1st Quarter								
2nd Quarter								
3rd Quarter								
4th Quarter								
Year End								

B. System Transformation Development / Community Care Coordination

Assigned to CCC Director

Prepare for Execution of Enhanced Case Management (ECM) and In-Lieu of Services (ILOS)

2021 Evaluation			
Time Period	Objective	Status	Comments/Recommendations
1st Quarter	Develop necessary documentation for project launch, identify project team, and initiate project meetings.		
2nd Quarter	Identify information needed to complete Model of Care document and submit to DHCS by 7/1/21		
3rd Quarter	Incorporate further state guidance to identify ECM/ILOS provider network development requirements and rates. Begin contracting activities with potential ECM/ILOS providers		
4th Quarter	Implement necessary operational requirements to implement ECM/ILOS by 1/1/22.		
Year End			

C. Reducing Readmissions Initiative

Assigned to Concurrent Review Supervisor

To support reducing hospital readmissions, UM/CCM will track and evaluate the impact of the Post Discharge Meal Delivery Program (PDMDP) and the Recuperative Care Pilot (RCP) as it relates to reductions in readmissions for members participating in these services.

2021 Evaluation								
Time Period	PDMDP # Enrolled	PDMDP # Completed in 12 Weeks	PDMDP # Not Competed in 12 Weeks	PDMDP # Readmits During 12 Week Period	RCP # Enrolled	RCP # Enrolled	RCP Length of Stay	Comments/Recommendations
1st Quarter								
2nd Quarter								
3rd Quarter								
4th Quarter								
Year End								

II. Operational Performance

Assigned to UM/CCM Manger (PA)

A. Routine Prior Authorization Turn Around Time

Percent of routine prior authorizations completed within 5 business days (excludes extended or deferred authorizations).

2021 Evaluation				
Time Period	**Goal**	**Results**	**Assessment & Interventions**	**Recommendation for Future**
1st Quarter	**100%**			
2nd Quarter	**100%**			
3rd Quarter	**100%**			
4th Quarter	**100%**			

B. Prior Authorization Request Determination Metrics

Monitoring of prior authorization volume, volume and % of electronic submissions, and appeals.–TAT goal for Knox Keene LOB NOA's: denial letters sent within 2 business days. Auth reduction impact to be monitored through PA volume review.

2021 Evaluation							
Time Period	**#PA Volume**	**# Voided Auths**	**# Medical Necessity Denials**	**# Appeals**	**#Appeals Upheld**	**# Overturned**	**Assessment & Interventions**
1st Quarter							
2nd Quarter							
3rd Quarter							
4th Quarter							
YTD/Year End							

C. Top 10 Prior Authorization Requests that result in Medical Necessity Denials

List of the top 10 prior authorization medical necessity denials, by volume.

2021 Evaluation		
Time Period	**List Denials**	**Assessment & Interventions**
1st Quarter		
2nd Quarter		
3rd Quarter		
4th Quarter		

E. Inter-rater Reliability Review – Nurses

100% of nurses (RN and LVN) staff who review authorization requests for medical necessity, will score 90% or higher on the MCG care guidelines Inter-rater Reliability Case Studies to ensure proper understanding and application of MCG care guidelines.

2021 Evaluation				
Time Period	**Goal**	**Results**	**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**		Annual measure - Q4 Results	Annual measure - Q4 Results

F. Inter-rater Reliability Review – Physicians

100% of physicians will score 90% or higher on the MCG care guidelines inter-rater Reliability Case Studies to ensure proper understanding and application of Milliman Care Guidelines.

2021 Evaluation				
Time Period	**Goal**	**Results**	**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**		Annual measure - Q4 Results	Annual measure - Q4 Results

G. Inter-rater Reliability Review – Pharmacists

100% of pharmacists will score 90% or higher on the MCG care guidelines inter-rater Reliability Case Studies to ensure proper understanding and application of MCG care guidelines.

2021 Evaluation				
Time Period	**Goal**	**Results**	**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**		Annual measure - Q4 Results	Annual measure - Q4 Results

III. Utilization Performance

A. Inpatient Utilization

Assigned to UM Medical Director

The goals per line of business and by Medi-Cal aid category groupings were developed using Alliance historical performance, and DHCS state benchmarks. Of note; the state benchmarks reflect admissions per thousand per year (K/Y), while the Alliance uses bed-days per K/Y. The bed-days per K/Y goal was established by utilizing the historic average length of stay as a multiplier. The Alliance Bed Ambulatory Care Sensitive Admissions (ACSA) and 30-day Readmissions tracked per line of business and region.

IHSS							Goal						
Time Period	2020 Admit/K/Y Reported	2021 Admit/K/Y	Admit/K/Y State Average	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance		ACSA %	Readmits %	Assessment	Interventions
1st Quarter	98		N/A				200						
2nd Quarter	56		N/A				200						
3rd Quarter	57		N/A				200						
4th Quarter	75		N/A				200						
YTD/Year End	71		N/A				200						

Medi-Cal Child and Family Aid Codes							Goal						
Time Period	2020 Admit/K/Y Reported	2021 Admit/K/Y	Admit/K/Y State Average 12/2019	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	40		8				160						
2nd Quarter	31		8				160						
3rd Quarter	33		8				160						
4th Quarter	31		8				160						
YTD/Year End	33		8				160						

Medi-Cal Seniors and Persons with Disabilities Aid Codes							Goal						
Time Period	2020 Admit/K/Y Reported	2021 Admit/K/Y	Admit/K/Y State Average 12/2019	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	260		45				1350						
2nd Quarter	196		43				1350						
3rd Quarter	238		41				1350						
4th Quarter	243		40				1350						
YTD/Year End	234		42				1350						

New Medicaid Expansion Members (i.e. former LIHP, as well as new M aid code and 7U/7W aid code members)							Goal						
Time Period	2020 Admit/K/Y Reported	2021 Admit/K/Y	Admit/K/Y State Average 12/2019	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	77		12				400						
2nd Quarter	70		12				400						
3rd Quarter	78		12				400						
4th Quarter	74		11				400						
YTD/Year End	72		12				400						

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A. Inpatient Utilization (Continued)

Total Medi-Cal Inpatient Utilization: Total Medi-Cal Inpatient Utilization goal was calculated using a weighted average of the individual bed days/thousand/year goal for each aid code/population subset (SPD, Child and Family, and Medicaid Expansion members).

							Goal					
Time Period	2020 Admit/K/Y Reported	2021 Admit/K/Y	Admit/K/Y State Average 12/2019	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	61		65				282					
2nd Quarter	50		62				282					
3rd Quarter	55		61				282					
4th Quarter	53		59				282					
YTD/Year End	54		62				282					

B. Ambulatory Care Sensitive Admissions (ACSA) (%)

Assigned to UM Medical Director

Ambulatory Care Sensitive Admissions (ACSA) per region.

Time Period	Santa Cruz ACSA %	Monterey ACSA %	Merced ACSA %	Assessment	Interventions
1st Quarter					
2nd Quarter					
3rd Quarter					
4th Quarter					
YTD/Year End					

C. Readmissions (%)

Assigned to UM Medical Director

*30-day Readmissions per region

	Santa Cruz %					Monterey %					Merced %					
Time Period	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	Assessment & Interventions
1st Quarter																
2nd Quarter																
3rd Quarter																
4th Quarter																
YTD/Year End																

D. Alternatives to Acute Inpatient Days - Skilled Nursing Facility

Assigned to UM/CCM Manager CR

Appropriate inpatient utilization involves identification of hospitalized patients that do not require an acute inpatient level of care but cannot be discharged home safely. These patients should be transferred/discharged to a facility where they can receive a lower, more appropriate level of care or determined to be at an "admin" level in the hospital as appropriate discharge is secured. STR readmissions are tracked to evaluate trends in hospital readmissions occurring after placement at the LOC.

Time Period	#SNF Beddays (Updated #)	PKPY SNF SPD (Updated #)	PKPY IPT Beddays SPD (Updated #)	Total # STR	STR Readmits After Discharge	Assessment	Interventions
1st Quarter							
2nd Quarter							
3rd Quarter							
4th Quarter							
YTD/Year End							

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E. Long-term Care

Assigned to UM/CCM Manager - CR

New admissions are monitored for continued appropriateness of placement. Appropriate long-term care utilization involves identification of members who continue to meet Title 22 as well as members that no longer require long-term level of care.

Time Period	# of New Admissions	# of LTC	Total # of Members in LTC	Total # of Medi/Medi	Assessment	Interventions
1st Quarter						
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End						

F. Emergency Department

Assigned to UM Medical Director

The ED utilization goals by Medi-Cal aid category groupings were developed using Alliance historical performance, industry benchmarks (including MCG actuarial projects) and comparison to other County Organized Health Systems (COHS) data. Performance is assessed against goals and State benchmark of DHCS reporting on ED visits/K/Y. Total ED visits and Avoidable ED visits tracked per line of business and region.

IHSS				Goal				
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average	Assessment	Interventions
1st Quarter				N/A		N/A		
2nd Quarter				N/A		N/A		
3rd Quarter				N/A		N/A		
4th Quarter				N/A		N/A		
YTD/Year End				N/A		N/A		

Medi-Cal Child and Family				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 12/2019	% CCS Visits	Assessment	Interventions
1st Quarter				475		53			
2nd Quarter				475		47			
3rd Quarter				475		45			
4th Quarter				475		49			
YTD/Year End				475		49			

Medi-Cal Seniors and Persons with Disabilities				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 6/2019	% CCS Visits	Assessment	Interventions
1st Quarter				925		106			
2nd Quarter				925		104			
3rd Quarter				925		105			
4th Quarter				925		101			
YTD/Year End				925		104			

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F. Emergency Department (Continued)

Medicaid Expansion (i.e. former LIHP, as well as new M aid code and 7U/W aid code members)				**Goal**					
Time Period	**Avoidable Visits %**	**Total Visits/K/Y Reported**	**Total Visits/K/Y Updated**	**Total Visits K/Y**	**Total visits: Variance**	**Total Visits K/Y State Average 12/2019**	**% CCS Visits**	**Assessment**	**Interventions**
1st Quarter				555	100%	53			
2nd Quarter				555		53			
3rd Quarter				555		55			
4th Quarter				555		52			
YTD/Year End				555		53			

ED Visits per County								
Time Period	**Santa Cruz Avoidable Visits %**	**Santa Cruz Total Visits/K/Y**	**Monterey Avoidable Visits %**	**Monterey Total Visits K/Y**	**Merced Avoidable Visits %**	**Merced Total Visits K/Y**	**Assessment**	**Interventions**
1st Quarter								
2nd Quarter								
3rd Quarter								
4th Quarter								
YTD/Year End								

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G. Pharmacy

Assigned to Clinical Pharmacy Manager

The performance goal is to limit the increase of the Per Member Per Month (PMPM) cost by 10.0%. This goal was developed using projections from industry analysis for 2021. Note that the data from 2020 includes retail and specialty costs paid through the Pharmacy Benefit Manager.

Line of Business	Per Month (PMPM) Cost						Change from 2020
	2020	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2021 YTD	
Medi-Cal- SPD aid codes							#DIV/0!
Medi-Cal Child/Family aid codes							#DIV/0!
IHSS							#DIV/0!
Medicaid Expansion							#DIV/0!
Overall							#DIV/0!

Overall Pharmacy Performance				
Time Period	Goal	Results	Comments	Recommendation for Future
1st Quarter	10.0% Increase			
2nd Quarter	10.0% Increase			
3rd Quarter	10.0% Increase			
4th Quarter	10.0% Increase			
Year End	10.0% Increase			

Medical Necessity Pharmacy Denials Per Quarter

Monitoring of Pharmacy prior authorization volume, appeals, and State Fair Hearings (SFH). Outcomes of the SFH included in the narrative.

Time Period	# Auth Volume	# Denials	# Appeals	# Appeals Upheld	# Overturned	#SFH	Assessment	Interventions
1st Quarter								
2nd Quarter								
3rd Quarter								
4th Quarter								
Year End								

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G. Pharmacy (Continued)

Top 10 Drugs that Result in Medical Necessity Denial

List top 10 Pharmacy prior authorization medical necessity denials, by volume.

Time Period	List of drugs	Comments	Interventions
1st Quarter			
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

Narcotic Utilization Program

The Narcotic Utilization Program is focused on optimizing the management of narcotic utilization by informing and engaging providers and offering member specific information and resources regarding narcotic utilization. This program's goals include identifying high utilization members to improve patient safety by decreasing excessive use of narcotic medications.

Time Period	Status	Comments	Recommendation for Future
1st Quarter			
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

Prescription Emergency Access

Pharmacy staff review ED census and PBM reports to verify in-area contracted hospitals compliance with member access to medically necessary medications in emergency situations. Report is reviewed by an Alliance Medical Director and Pharmacy staff quarterly.

Time Period	# of Claims Reviews Completed (x of x)	Recommendation for Future
1st Quarter		
2nd Quarter		
3rd Quarter		
4th Quarter		
Year End		

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H. Out of Area / Out of Network Specialist Utilization Metric

Assigned to UM/CCM Manager - PA

Appropriate use of network specialist and out-of-network specialist is monitored for provider and member access. Review of referral practice by county provides opportunity for improved network development. Data derived from DHCS Out Of Network Tableau Report.

Time Period	Total Auths	Approvals	Denials	Voided / Canceled	Top 5 Specialty Types by County	Assessment & Interventions
1st Quarter					Merced: Monterey: Santa Cruz:	
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End	0	0	0	0		

I. Under / Over Utilization Tracking and Reporting

Assigned to the UM/CCM Director and Medical Director

Under-over utilization is closely monitored and UM investigates identified cases, develops interventions and works closely with other departments such as Program Integrity, QI and Provider Services. As authorization codes are waived as part of the Auth Reduction Project, we will monitor to assure there is no resulting inappropriate over utilization.

2020 Evaluation				
Time Period	Monitored Category	Over or Under	Assessment	Interventions
1st Quarter	1. Epidermal Nerve Fiber Density 2. EMG 3. Auth Redesign Codes Added 4. HEDIS	1. Over 2. Over 3. Over 4. Under		
2nd Quarter				
3rd Quarter				
4th Quarter				

J. Emerging Under / Over Utilization Analysis

Assigned to UM Medical Director

Provision of services that were not clearly indicated or provision of services that were indicated in either excessive amounts or in a higher-level setting than appropriate. True over and under results may be reported in Section I of this work plan for formal monitoring.

Time Period	Top 5 Over	Top 5 Under	Service / Benefit Type	Monitoring Assessment	Interventions
1st Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.		
2nd Quarter					
3rd Quarter					
4th Quarter					

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IV. UM Delegate Oversight

A. UM Delegate Oversight Quarterly Report (Analysis Summary)

Time Period	Delegate	Report Due Date	Reports Received	Reports Required	Follow-up Plan
Q4-20: Reported - Q1-21	Beacon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q1-21: Reported - Q2-21	Beacon				
Q2-21: Reported - Q3-21	Beacon				
Q3-21: Reported - Q4-21	Beacon				

B. Medi-Cal Mental Health Utilization Rates

Beacon Health Options (Beacon) is contracted with CCAH to provide mild to moderate mental health services. Beacon supplies this data in a quarterly report that is presented in quarterly meetings with each County Behavioral Health Department. Utilization percentage rates for children and adolescents and for adults are reported by for each county managed by CCAH. Utilization rates reflect a rolling 12 month measurement ending at the Quarter. Utilization percentage is calculated by dividing the number of unique members in each age cohort within each County into the number of members that have received Beacon services from that same County and age cohort within each quarter. Utilization percentage goals were developed by Beacon Health Options and are based on best reviewing data from other states, national benchmark data, historical data on county mental health utilization, and the structure of the California delivery system. The goals are in a mature market of 3 years of operation (market maturity: lower rates are expected in new markets and higher ranges are typical for mature markets with 3-5 years of Beacon presence).

Time Period	Santa Cruz	Monterey	Merced	GOAL	Assessment	Interventions
1st Quarter						
0-12				2.5% - 4%		
13-18				2.5% - 4%		
19+				4.5% - 6.5%		
2nd Quarter						
0-12				2.5% - 4%		
13-18				2.5% - 4%		
19+				4.5% - 6.5%		
3rd Quarter						
0-12				2.5% - 4%		
13-18				2.5% - 4%		
19+				4.5% - 6.5%		
4th Quarter						
0-12				2.5% - 4%		
13-18				2.5% - 4%		
19+				4.5% - 6.5%		

C. Beacon UM File Audit

Review occurring every quarter that looks at previous quarter UM work. For review, 15 files are randomly selected. If the first 8 files pass, no further review is conducted. If any of the first 8 fail. All 15 files are reviewed. While 100% is expected, 90% is the juncture at which a corrective action plan would be apprised if needed. Non-compliance with any of the elements require follow up analysis and correction by the vendor. Categories for review include: timeliness of decisions and notifications, appropriate practitioner review of denials, relevant information used for decisions, appeal rights communications to member, evidence of transitional care planning.

Time Period	% Compliance	Summary of Non-Compliance	Follow-up Actions
1st Quarter			
2nd Quarter			
3rd Quarter			
4th Quarter			

Communication with
Those Charged with Governance

Santa Cruz-Monterey-Merced Managed Medical Care Commission (d.b.a. Central California Alliance for Health)

December 31, 2020

MOSSADAMS

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Communication with Those Charged with Governance

To the Board of Directors
Santa Cruz-Monterey-Merced Managed Medical Care Commission
d.b.a Central California Alliance for Health

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health (the "Alliance"), as of and for the year ended December 31, 2020, and have issued our report thereon dated April 29, 2021. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated October 2, 2017, our responsibility, as described by professional standards, is to form and express an opinion about whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

Our responsibility is to plan and perform the audit in accordance with auditing standards generally accepted in the United States of America and to design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Alliance's internal control over financial reporting. Accordingly, we considered the Alliance's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Alliance are described in Note 2 to the financial statements. There were no changes in the application of existing policies during 2020. We noted no transactions entered into by the Alliance during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the Alliance's financial statements were:

- Management's estimate of the liability for incurred but unreported claims expense (medical claims liability) is based on historical claims experience and known activity subsequent to year end. We evaluated the key factors and assumptions used to develop the incurred but unreported claims expense in determining that they are reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the capitation receivable and revenue for eligible program beneficiaries is based upon a historical experience methodology using contracted rates and member counts. We evaluated the key factors and assumptions used to develop the capitation receivable in determining that they are reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the fair market values of 401a plan investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to the financial statement users. The most sensitive disclosures affecting the Alliance's financial statements were medical claims liability and capitation revenue.

Significant Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected and uncorrected misstatements, whose effects, as determined by management, both individually or in the aggregate, to the financial statements taken as a whole.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated April 29, 2021.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Alliance's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Independence

We are required to disclose to those charged with governance, in writing, all relationships between the auditors and the Alliance that in the auditor's professional judgment, may reasonably be thought to bear on our independence. We know of no such relationships and confirm that, in our professional judgment, we are independent of the Alliance within the meaning of professional standards.

Other Significant Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as the Alliance's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

This information is intended solely for the use of the Board of Directors and management of the Alliance and is not intended to be, and should not be, used by anyone other than these specified parties.

Moss Adams LLP

San Francisco, California
April 29, 2021

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

April 29, 2021

Moss Adams LLP

101 2nd Street, Suite 900

San Francisco, California, 94105

We are providing this letter in connection with your audits of the financial statements of Central California Alliance for Health (the "Alliance"), which comprise the statements of net position, statements of revenues, expenses, and changes in net position, and cash flows as of December 31, 2020 and 2019 and for the years then ended, and the related notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $2,200,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of April 29, 2021,

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated October 2, 2017, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
3. We acknowledge our responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.
4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
5. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.
6. All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.
7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.

Information Provided

8. We have provided you with:
    a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation and other matters;
    b. Minutes of the meetings of commissioners, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared;
    c. Additional information that you have requested from us for the purpose of the audit;
    d. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.
9. All transactions have been properly recorded in the accounting records and are reflected in the financial statements.
10. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
11. We have no knowledge of any fraud or suspected fraud that affects the entity and involves—
    a. Management,
    b. Employees who have significant roles in internal control, or
    c. Others when the fraud could have a material effect on the financial statements.
12. We have no knowledge of any allegations of fraud or suspected fraud, affecting the entity's financial statements communicated by employees, former employees, analysts, regulators or others.
13. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.
14. We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the financial statements
15. We have disclosed to you the identity of the entity's related parties and all the related party relationships and transactions of which we are aware.
16. There are no—
    a. Violations or possible violations of laws or regulations, such as those related to the Medicare antifraud and abuse statutes, including but not limited to the Anti-Kickback Act, Limitations on Certain Physician Referrals (commonly referred to as the "Stark law"), and the False Claims Act, in any jurisdiction whose effects should be considered for disclosure in the financial statements or as basis for recording a loss contingency other than those disclosed or accrued in the financial statements.
    b. Possible illegal acts brought to the attention of management.
    c. Unasserted claims or assessments that our lawyer has advised us are probable of assertion and must be disclosed in accordance with GASB 62 section 1500, *Reporting Liabilities*, paragraph .114 and section C50, *Claims and Judgments*, paragraph .115.
    d. Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB 62 section 1500 paragraph .114 and section C50 paragraph .115.
17. The Alliance has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral, except as disclosed to you and reported in the financial statements.
18. The Alliance has complied with all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance.
19. The Alliance has been in compliance with the requirements of licensure under the Knox-Keene Health Care Service Plan act of 1975.

20. Capitation revenue as disclosed in Note 2 of the financial statements is fairly stated in accordance with GAAP.
21. We have complied with all restrictions on resources and all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance.
22. We have disclosed to you any change in the Alliance's internal control over financial reporting that occurred during the Alliance's most recent fiscal year that has materially affected, or is reasonably likely to materially affect, the Alliance's internal control over financial reporting.
23. We have responded fully and truthfully to all inquiries made to us by you during your audits.
24. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the financial statements or on the disclosure in the notes to the financial statements.
25. We have made available to Moss Adams all known reviews, surveys and inquiries from Federal, State and local regulatory authorities completed or ongoing. We confirm that we are not aware of any non-compliance with laws and regulations.
26. No violations or possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements. This is including, but not limited to, the anti-kickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law), and the False Claims Act.
27. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning the investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.
28. We have appropriately reconciled our books and records (e.g., general ledger accounts) underlying the financial statements to their related supporting information (e.g. sub ledger or third-party data). All related reconciling items considered to be material were identified and included on the reconciliations and were appropriately adjusted in the financial statements. There were no material un-reconciled differences or material general ledger suspense account items that should have been adjusted or reclassified to another account balance. There were no material general ledger suspense account items written off to a statement of net position account, which should have been written off to an income statement account and vice versa.
29. Medical claims liability, including amounts for incurred but not reported claims and estimated recoveries for salvage and subrogation have been determined using appropriate estimated ultimate costs of settling the claims (including the effects of inflation and other societal and economic factors), considering past experience adjusted for current trends and any other factors that would modify past experience. The estimated liability is to the best of our knowledge and belief, an accurate estimate of our incurred but unreported health claims liability as of December 31, 2020. The data used in projecting the ultimate unpaid claims and claims adjustment expense is complete and accurate, and is reconciled to the underlying accounting records.
30. Management has no knowledge of a large pool of impending claims outstanding at December 31, 2020 and 2019 that would materially affect the estimate for liability for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims.
31. All reinsurance transactions entered into by the Alliance are final and there are no side agreements with reinsurers, or other terms in effect, which allow for the modification of term under existing reinsurance arrangements. Furthermore, the Alliance's reinsurance arrangements meet the risk transfer provisions or are accounted for as deposits.

32. Pay for performance, provider incentive, withhold, capitation and other arrangements with providers wherein the Alliance is obligated to provide for a settlement of accounts with providers have been calculated in accordance with the existing arrangements and are included in the statement of net positions at net realizable value, giving consideration to all amounts due under arrangements. We believe provider incentives payable is fairly stated as of December 31, 2020 and 2019, respectively.

33. Board designated reserves have been approved by the Alliance's Board and is complete and accurate.

34. The Alliance has accepted the following responsibilities related to the non-attest services provided related to the drafting the financial statements and related footnotes as of December 31, 2020 and 2019:

    a. Make all management decisions and perform all management functions.

    b. Designate an individual with suitable skill, knowledge, and / or experience to oversee the non-attest services.

    c. Evaluate the adequacy and results of the non-attest services performed.

    d. Accept responsibility for the results of the non-attest services performed.

    e. Establish and maintain internal controls including monitoring ongoing activities.

35. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by third-party organizations or other regulatory agencies.

36. We have the intent and ability to commit the necessary resources to become compliant with the laws and regulations contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") by the required compliance deadlines. We have no information that indicated that a significant vendor may be unable to sell to the Alliance; a significant customer may be unable to purchase from the Alliance; or a significant service provider may be unable to provide services to the Alliance, in each case because of their respective inability to comply with HIPAA.

37. We have reviewed all recently released accounting pronouncements and have evaluated those that may have an effect on the Alliance in the current and subsequent periods and disclosed as appropriate in the financial statements.

38. We are not aware of any reason that Moss Adams LLP would not be considered to be independent for purposes of the Alliance's audit.

39. To our knowledge, there are no instances where any officer or employee of the Alliance has an interest in a company with which the Alliance does business that would be considered a "conflict of interest." Such an interest would be contrary to the Alliance's policy.

40. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the financial statements of the Alliance are properly disclosed.

41. We have performed an analysis of expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under our contracts. We have determined that expected costs do not exceed anticipated revenues. Based on our analysis, we believe no premium deficiency reserves are necessary at December 31, 2020 and 2019, respectively.

42. We acknowledge our responsibility for presenting the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position, in accordance with accounting principles generally

accepted in the United States of America and we believe the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position are measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.

43. To the best of our knowledge and belief, no events have occurred subsequent to the balance sheet date and through the date of this letter that would require adjustment to or disclosure in the aforementioned financial statements.
44. In March 2020, the World Health Organization declared the novel coronavirus outbreak a public health emergency. The Alliance's results of operations could be adversely affected to the extent that the coronavirus or any other epidemic harms the global economy. Although the Alliance does not expect the impact on its operations and financial results to be significant, the duration and intensity of the impact of the coronavirus and resulting disruption to the Alliance's operations is uncertain.

DocuSigned by:
Lisa Ba
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Lisa Ba, CFO

DocuSigned by:
Joy Cubbin
7EA56398C4D147E...

Joy Cubbin, Director of Accounting and Administrative Contracts


MOSSADAMS

Report of Independent Auditors and
Financial Statements with Supplementary Information

Santa Cruz-Monterey-Merced Managed Medical Care Commission (d.b.a. Central California Alliance for Health)

December 31, 2020 and 2019

MOSSADAMS

Table of Contents

Management's Discussion and Analysis

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Management's Discussion and Analysis
Years Ended December 31, 2020, 2019, and 2018

The intent of management's discussion and analysis of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health (the Alliance) is to provide readers with an overview of the Alliance's financial activities for the fiscal years ended December 31, 2020, 2019, and 2018. Readers should review this summation in conjunction with the Alliance's financial statements and accompanying notes to the financial statements to enhance their understanding of the Alliance's financial performance.

Key Operating Indicators – Proprietary Fund

The table below compares key operating indicators for the Alliance for the fiscal years 2020, 2019, and 2018:

Key operating indicators	Fiscal years ended December 31 2020	2019	2018	2020-2019 Change	2019-2018 Change
Members (at end of fiscal period):					
Medi-Cal program	364,613	333,603	341,846	31,010	(8,243)
IHSS program	540	586	637	(46)	(51)
Average member months:					
Medi-Cal program	349,674	339,406	349,209	10,268	(9,803)
IHSS program	568	619	574	(51)	45
Total revenues (in millions)	$ 1,474.6	$ 1,303.4	$ 1,285.1	$ 171.2	$ 18.3
Capitation revenue	$ 1,467.6	$ 1,285.5	$ 1,270.6	$ 182.1	$ 14.9
Investment and other income	$ 7.0	$ 17.9	$ 14.5	$ (10.9)	$ 3.4
Operating expenses (in millions):					
Medical expenses (in millions)	$ 1,222.0	$ 1,214.1	$ 1,146.5	$ 7.9	$ 67.6
Administrative expenses (in millions)	$ 224.5	$ 145.2	$ 213.3	$ 79.3	$ (68.1)
Increase (decrease) in net assets (in millions):	$ 13.8	$ (69.0)	$ (96.0)	$ 82.8	$ 27.0
Total revenues per member per month	$ 350.9	$ 319.4	$ 306.2	$ 31.4	$ 13.3
Operating expenses per member per month:					
Medical expenses per member per month	$ 290.8	$ 297.6	$ 273.1	$ (6.8)	$ 24.4
Administrative expenses per member per month	$ 53.4	$ 35.6	$ 50.8	$ 17.8	$ (15.2)
Increase (decrease) in net assets per member per month	$ 3.3	$ (16.9)	$ (22.9)	$ 20.2	$ 6.0
Medical loss ratio	83.3 %	94.4 %	90.2 %	(11.10) %	4.20 %
Administrative expense ratio	15.2 %	11.1 %	16.6 %	4.10 %	(5.50) %
Administrative expense ratio (excluding premium tax)	5.6 %	6.2 %	7.0 %	(0.60) %	1.00 %

Overview of the Financial Statements

This annual report consists of the basic financial statements of the business-type activities and the aggregate remaining fund information of the Alliance, and the related notes to those statements, which reflect the Alliance's financial position and results of its operations for the fiscal years ended December 31, 2020 and 2019. The basic financial statements of the Alliance, including the statements of net position, statements of revenues, expenses, and changes in net position; statements of cash flows, represent the combined accounts and transactions of the two programs – Medi-Cal and In Home Support Services (IHSS) program – operated by the Alliance.

- The statements of net position include all of the Alliance's assets and liabilities, using the accrual basis of accounting, as well as an indication about which assets are utilized to fund obligations to providers and which are restricted or designated as a matter of the Alliance's board of directors' policy.

- The statements of revenues, expenses, and changes in net position present the results of operating and nonoperating activities during the respective fiscal years and the resulting decrease or increase in net position.

- The statements of cash flows report the net cash provided by operating activities, as well as other sources and uses of cash from investing and capital and noncapital related financing activities.
- The statements of fiduciary net position include all of the Alliance's assets and liabilities for the 401(a) Money Purchase Plan and Trust, using the accrual basis of accounting.
- The statements of changes in fiduciary net position, present the results of activities during the respective fiscal years and the resulting decrease or increase in fiduciary net position.

The following discussion and analysis addresses the Alliance's overall program activities. The Medi-Cal program accounted for approximately 99.8% of the Alliance's annual revenues during fiscal years 2020, 2019, and 2018.

Financial Highlights Fiscal Year 2020

- Total assets at year-end were $833.4 million and exceeded liabilities by $464.6 million.
- Net position increased by $13.8 million or 3.1% during fiscal year 2020.

Financial Highlights Fiscal Year 2019

- Total assets at year-end were $677.7 million and exceeded liabilities by $450.8 million.
- Net position decreased by $69.0 million or 13.3% during fiscal year 2019.

Condensed Statements of Net Position as of December 31 (dollars in thousands) are as follows:

	As of December 31			2020-2019 Change		2019-2018 Change	
Financial position	2020	2019	2018	Amount	Percentage	Amount	Percentage
Assets:							
Current assets	$ 451,649	$ 317,781	$ 410,544	$ 133,868	42.1 %	$ (92,763)	(22.6) %
Capital assets, net	49,929	54,263	56,125	(4,334)	(8.0)	(1,862)	(3.3)
Board-designated investments and restricted deposit	331,862	305,645	286,772	26,217	8.6	18,873	6.6
Total assets	$ 833,440	$ 677,689	$ 753,441	$ 155,751	23.0 %	$ (75,752)	(10.1) %
Liabilities:							
Current liabilities	$ 368,850	$ 226,914	$ 233,620	141,936	62.6 %	$ (6,706)	(2.9) %
Total liabilities	368,850	226,914	233,620	141,936	62.6	(6,706)	(2.9) %
Net position:							
Invested in capital assets	49,929	54,263	56,125	(4,334)	(8.0) %	(1,862)	(3.3) %
Restricted	300	300	300	-	-	-	-
Unrestricted	414,361	396,212	463,396	18,149	4.6	(67,184)	(14.5)
Total net position	464,590	450,775	519,821	13,815	3.1 %	(69,046)	(13.3) %
Total liabilities and net position	$ 833,440	$ 677,689	$ 753,441	$ 155,751	23.0 %	$ (75,752)	(10.1) %

Capital Assets Fiscal Year 2020

Capital assets, net decreased from $54.3 million to $49.9 million, or by $4.3 million, in 2020 compared to the previous year. This decrease is mainly the net result of $2.2 million in capital additions, $6.5 million in depreciation expense. Capital additions included $1.8 million in construction in process which was subsequently transferred and reflected in building additions and in furniture and equipment.

Capital Assets Fiscal Year 2019

Capital assets, net decreased from $56.1 million to $54.3 million, or by $1.9 million, in 2019 compared to the previous year. This decrease is the net result of $4.5 million in capital additions, $6.4 million in depreciation expense and no losses recognized on asset disposals. Capital additions included $4.5 million in construction in process which was subsequently transferred and reflected in building additions and in furniture and equipment.

Liquidity Fiscal Year 2020

At December 31, 2020, the Alliance maintained a working capital ratio, including board-designated investments, of 2.12. The increase of $18.1 million in working capital in 2020 compared to the prior year is primarily due to the change in net position.

During 2020, board-designated investments increased by $26.2 million from the prior year. The increase is due to improved revenues in 2020.

Liquidity Fiscal Year 2019

At December 31, 2019, the Alliance maintained a working capital ratio, including board-designated investments, of 2.75. The decrease of $67.2 million in working capital in 2019 compared to the prior year is primarily due to the change in net position.

During 2019, board-designated investments increased by $18.9 million from the prior year. The increase is due to a change to the calculation to three times average monthly capitation revenue as approved by the Board of Commissioners.

Results of Operations

The Alliance's fiscal year 2020 operations resulted in a $13.8 million increase in net position compared to a $69.0 million decrease in net position in fiscal year 2019. The Alliance's fiscal year 2018 operations resulted in a $96.0 million decrease in net position.

The following table shows revenues, expenses, and changes in net position for the three most recent years:

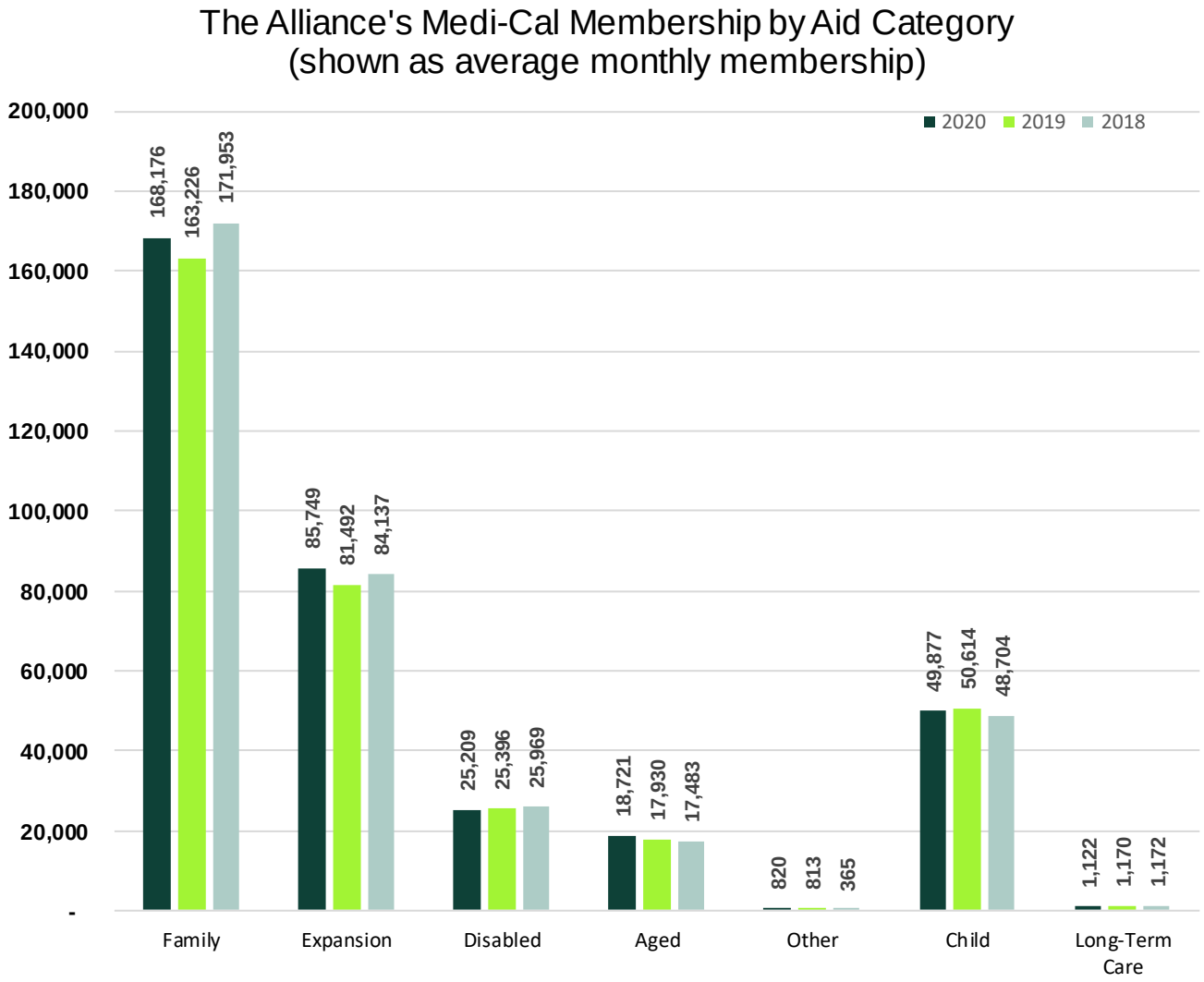
Table 1: Condensed revenues, expenses, and changes in net position for the years ended (in thousands):

Results of operations	2020	2019	2018	2020-2019 Change Amount	2020-2019 Change Percentage	2019-2018 Change Amount	2019-2018 Change Percentage
Revenues	$ 1,474,585	$ 1,303,376	$ 1,285,057	$ 171,209	13.1 %	$ 18,319	1.4 %
Expenses:							
Total medical expenses	1,222,017	1,214,097	1,146,499	7,920	0.7	67,598	5.9
Total administrative expenses	224,508	145,163	213,261	79,345	54.7	(68,098)	(31.9)
Grants	14,245	13,162	21,258	1,083	8.2	(8,096)	(38.1)
Total expenses	1,460,770	1,372,422	1,381,018	88,348	6.4	(8,596)	(0.6)
Increase (decrease) in net position	13,815	(69,046)	(95,961)	82,861	(120.0)	26,915	(28.0)
Total net position, beginning of year	450,775	519,821	615,782	(69,046)	(13.3)	(95,961)	(15.6)
Total net position, end of year	$ 464,590	$ 450,775	$ 519,821	$ 13,815	3.1 %	$ (69,046)	(13.3) %

Enrollment

During fiscal 2020, the Alliance served an average of 350,242 members per month compared to an average of 340,025 members per month in 2019. This increase in membership is primarily due to the Public Health Emergency (PHE) declaration which temporarily freezes the eligibility redetermination process. Under the Governor's orders, Counties cannot reduce or terminate Medi-Cal benefits during PHE. During fiscal 2019, the Alliance served an average of 340,025 members per month compared to an average of 349,783 members per month in 2018. This decrease in membership is mainly due to decreased enrollment of members in the family category.

The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2020, 2019, and 2018:



Operating Revenues Fiscal Year 2020

Revenues in 2020 increased over 2019 mostly due to increased Medi-Cal capitation rates from the Department of Health Care Services (DHCS). Membership also increased in 2020 over 2019.

Operating Revenues Fiscal Year 2019

Revenues in 2019 increased over 2018 due to a full twelve months of Whole Child Model revenues in 2019 compared to six months in 2018. The DHCS also increased the Medi-Cal per member per month rates paid to the Alliance, which was partially offset by decreased membership in 2019.

Medical Expenses Fiscal Year 2020

Overall, medical expenses increased by 0.7% in 2020, totaling $1,222.0 million compared to $1,214.1 million in 2019. The Alliance's medical expenses, as a percentage of capitation revenues, was 83.3% in fiscal year 2020, compared to 94.4% in 2019. The Alliance's average medical costs per member per month decreased by 2.3% in 2020. Medical expenses include the following:

- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $35.0 million in 2020 compared to $33.9 million in 2019. The increased cost is attributable to a small increase in membership.

- Hospital inpatient and long-term care expenses increased by $18.3 million, or 3.4%, in 2020. The increased cost of care is due to increased membership.

- Expenses related to physicians, outpatient facilities, and allied health providers decreased by $18.6 million, or 4.4%, in 2020. The primary reason for the decrease is decreased utilization due to the COVID 19 pandemic.

- Other medical decreased by $1.6 million or 6% in 2020 primarily due to decreased provider incentives in 2020.

- Prescription drugs expenses increased by $12.8 million or 6.5% during 2020. The increase was due to increased prescription drug pricing.

- Alliance Care IHSS program expenses increased by $274 thousand. The increase was due to favorable utilization.

- Net reinsurance recoveries decreased by $7.4 million compared to 2019 due to a large decrease in recoveries.

Medical Expenses Fiscal Year 2019

Overall, medical expenses increased by 5.9% in 2019, totaling $1,214.1 million compared to $1,146.5 million in 2018. The Alliance's medical expenses, as a percentage of capitation revenues, was 94.4% in fiscal year 2019, compared to 90.2% in 2018. The Alliance's average medical costs per member per month increased by 8.9% in 2019. Medical expenses include the following:

- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $33.9 million in 2019 compared to $35.1 million in 2018. The decreased cost is attributable to a small decrease in membership.

- Hospital inpatient and long-term care expenses increased by $52.3 million, or 10.7% in 2019. The increased cost of care is due to increased rates.

- Expenses related to physicians, outpatient facilities, and allied health providers increased by $23.4 million, or 5.9% in 2019. The primary reason for the increase is due to increased rates.

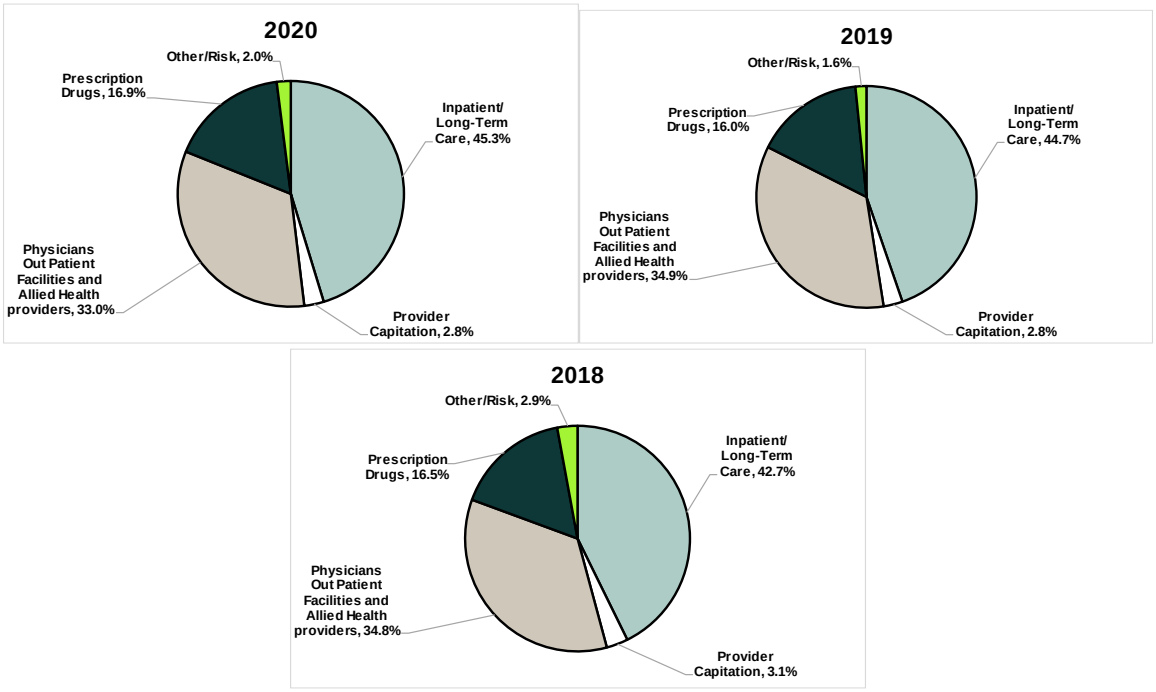
- Other medical decreased by $2.9 million or 10.0% in 2019 primarily due to decreased provider incentives in 2019.

- Prescription drugs expenses increased by $7.2 million or 3.8% during 2019. The increase was due to increased prescription drug pricing.

- Alliance Care IHSS program expenses decreased by $199 thousand. The decrease was due to favorable utilization.

- Net reinsurance expenses decreased by $11.0 million compared to 2018 due to a large increase in recoveries.

Below is a side-by-side comparison of medical expenses by major category and their respective percentages of the overall medical expenses in fiscal years 2020, 2019, and 2018:



Administrative Expenses Fiscal Year 2020

Total administrative expenses were $224.5 million in 2020 compared to $145.2 million in 2019, for a net increase of $79.3 million or 54.7%. This increase is primarily due to an increase of $77.2 million in premium taxes in 2020. Premium taxes were $141.3 million in 2020, compared to $64.1 million in 2019. In 2019, premium taxes were only effective for the first six months compared to twelve months in 2020. Salaries and benefits expenses were $55.6 million, an increase of $4.3 million compared to 2019. Salary expense increased in 2020 due to increased head count and annual merit increases.

Overall, professional fees, purchased services and supplies, occupancy, and insurance decreased $2.3 million or 9.7% in 2020. Reduced expenses for temporary employee services, travel, bank fees and penalties were the largest drivers of the decrease.

Administrative Expenses Fiscal Year 2019

Total administrative expenses were $145.2 million in 2019 compared to $213.3 million in 2018, for a net decrease of $68.1 million or 31.9%. This decrease is primarily due to the termination of premium taxes as of June 30, 2019. Premium taxes were $64.1 million in 2019, compared to $124.7 million in 2018. In 2019, premium taxes were only effective for the first six months compared to twelve months in 2018. Salaries and benefits expense were $51.3 million, a decrease of $4.9 million compared to 2018. Salary expense decreased in 2019 due to a decrease in head count.

Overall, professional fees, purchased services and supplies, occupancy, and insurance decreased $3.3 million or 12.3% in 2019. Reduced expenses for temporary employee services, software, and hardware were the largest driver of the decrease.

Economic Factors

On January 31, 2020, Health and Human Services declared a Public Health Emergency as a result of confirmed COVID-19 cases. The COVID-19 pandemic has had a major impact on California's economy. Governor Newsom proclaimed a State of Emergency in California on March 4th, 2020 due to the serious and ongoing threat of COVID-19. A subsequent Executive Order was issued on March 17th, 2020, citing the widespread economic impact to nearly every business sector due to social distancing recommendations. Under these orders, Counties cannot reduce or terminate Medi-Cal benefits during the public health emergency. As a result, the Alliance experienced moderate membership growth. When the public health emergency ends and Medi-Cal eligibility redetermination resumes, membership is expected to decrease. As stay at home orders and public health guidance continued to encourage people to limit activities, the Alliance experienced significant utilization decrease throughout. As restrictions are loosened and vaccine becomes more widely available, it is expected that medical services will return to normal and back to the pre-pandemic level.

FINANCIAL HIGHLIGHTS – FIDUCIARY FUND

The table below is a summarized comparison of the assets, liabilities and fiduciary net position of Central California Alliance for Health 401a Qualified Retirement Plan as of December 31, and the changes in fiduciary net position for the years ended December 31 (in thousands):

	2020	2019	2018
TOTAL ASSETS	$ 43,156	$ 36,117	$ 27,952
TOTAL LIABILITIES	-	-	-
TOTAL FIDUCIARY NET POSITION	$ 43,156	$ 36,117	$ 27,952
TOTAL ADDITIONS	$ 8,649	$ 9,953	$ 2,925
TOTAL DEDUCTIONS	1,610	1,788	2,552
INCREASE IN FIDUCIARY NET POSITION	7,039	8,165	373
FIDUCIARY NET POSITION - BEGINNING OF YEAR	36,117	27,952	27,579
FIDUCIARY NET POSITION - END OF YEAR	$ 43,156	$ 36,117	$ 27,952

Total fiduciary fund net position as of December 31, 2020, increased by $7.0 million from December 31, 2019 due to an increase in fair value of investments and contributions. Total fiduciary fund net position as of December 31, 2019, increased by $8.2 million from December 31, 2018 due to an increase in fair value of investments and contributions.

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Report of Independent Auditors

To the Commissioners
Santa Cruz-Monterey-Merced Managed Medical Care Commission
d.b.a. Central California Alliance for Health

Report on the Financial Statements

We have audited the accompanying financial statements of the business-type activities and the aggregate remaining fund information of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health, collectively known as Central California Alliance for Health (the "Alliance") as of and for the years ended December 31, 2020 and 2019, and the related notes to the financial statements, which collectively comprise the Alliance's financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and aggregate remaining fund information of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health as of December 31, 2020 and 2019, and the respective changes in net position and cash flows for the years ended December 31, 2020 and 2019, in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that the Management's discussion and analysis on pages 1 to 9 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. This supplementary information is the responsibility of the Alliance's management. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements that comprise the Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health's basic financial statements. The supplementary schedules of revenues and expenses by program and changes in net position for the years ended December 2020 and 2019, on pages 36 and 37 are presented for purposes of additional analysis and are not a required part of the basic financial statements.

The supplementary information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary schedules of revenues and expenses by program and changes in net position for the years ended December 2020 and 2019, are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Moss Adams LLP

San Francisco, California
April 29, 2021

Financial Statements

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Net Position
December 31, 2020 and 2019
(in thousands)

	2020	2019
Assets		
Current assets		
Cash and cash equivalents	$ 11,172	$ 7,127
Short-term investments	170,421	126,857
Capitation receivable from the Department of Health Care Services (DHCS)	244,359	171,721
Prepaid expenses and other assets	25,697	12,076
Total current assets	451,649	317,781
Capital assets, net		
Nondepreciable	10,044	11,148
Depreciable, net of accumulated depreciation	39,885	43,115
Capital assets, net	49,929	54,263
Board-designated investments	331,562	305,345
Restricted deposits	300	300
Total assets	$ 833,440	$ 677,689
Liabilities and Net Position		
Current liabilities		
Medical claims liability	$ 200,716	$ 184,933
Directed payments payable	110,100	-
Provider incentives payable	10,010	10,164
Medical loss ratio liability	-	23,950
Accounts payable	3,121	2,783
Accrued liabilities	44,903	5,084
Total current liabilities	368,850	226,914
Net position		
Invested in capital assets	49,929	54,263
Restricted	300	300
Unrestricted	414,361	396,212
Total net position	464,590	450,775
Total liabilities and net position	$ 833,440	$ 677,689

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2020 and 2019
(in thousands)

	2020	2019
Operating revenues		
Capitation revenue	$ 1,467,559	$ 1,285,524
Operating expenses		
Medical expenses		
Medi-Cal		
Provider capitation	34,999	33,892
Claim payments to providers	953,263	965,339
Prescription drugs	208,701	195,928
Other medical	24,627	26,188
Alliance Care: In Home Support Services (IHSS) program	2,952	2,678
Reinsurance and other, net of (recoveries) expense	(2,525)	(9,928)
Total medical expenses	1,222,017	1,214,097
Administrative expenses		
Premium tax expense	141,313	64,146
Salaries, wages, and employee benefits	55,636	51,318
Supplies, occupancy, insurance, and other	9,230	10,649
Professional fees	8,689	8,373
Depreciation and amortization	6,499	6,369
Purchased services	3,141	4,308
Total administrative expenses	224,508	145,163
Total operating expenses	1,446,525	1,359,260
Operating income (loss)	21,034	(73,736)
Investment income, including net realized and unrealized gains and losses	5,909	16,820
Other income	1,117	1,032
Grants	(14,245)	(13,162)
Increase (decrease) in net position	13,815	(69,046)
Net position, beginning of year	450,775	519,821
Net position, end of year	$ 464,590	$ 450,775

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Cash Flows
Years Ended December 31, 2020 and 2019
(in thousands)

	2020	2019
Cash flows from operating activities:		
Capitation and other revenue	$ 1,813,118	$ 1,569,046
Payments to providers	(1,530,507)	(1,489,767)
Payments to vendors	(145,664)	(128,918)
Payments to employees	(53,336)	(51,504)
Net cash provided by (used in) operating activities	83,611	(101,143)
Cash flows from capital and related financing activities:		
Purchases of capital assets	(2,164)	(4,507)
Net cash used in capital and related financing activities	(2,164)	(4,507)
Cash flows from noncapital financing activities:		
Grants	(14,245)	(13,162)
Net cash used in noncapital financing activities	(14,245)	(13,162)
Cash flows from investing activities:		
Purchases of investments	(304,226)	(264,455)
Sales of investments	234,444	241,927
Cash received from investment income	6,625	17,455
Net cash used in investing activities	(63,157)	(5,073)
Net change in cash and cash equivalents	4,045	(123,885)
Cash and cash equivalents, beginning of year	7,127	131,012
Cash and cash equivalents, end of year	$ 11,172	$ 7,127
Reconciliation of increase (decrease) in net position to net cash provided by (used in) operating activities:		
Increase (decrease) in net position	$ 13,815	$ (69,046)
Adjustments to reconcile decrease in net position to net cash provided by (used in) operating activities:		
Depreciation and amortization	6,499	6,369
Investment income	(5,909)	(16,820)
Grants	14,245	13,162
Changes in assets and liabilities:		
Capitation receivable from the DHCS	(72,638)	(19,606)
Prepaid expenses and other assets	(14,338)	(6,446)
Medical claims liability	15,783	30,769
Directed payments payable	110,100	-
Provider incentives payable	(154)	(5,002)
Medical loss ratio liability	(23,950)	(1,593)
Accounts payable	338	(1,154)
Accrued liabilities	39,820	(31,776)
Net cash provided by (used in) operating activities	$ 83,611	$ (101,143)

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Fiduciary Net Position
December 31, 2020 and 2019
(in thousands)

	2020	2019
ASSETS		
Investments, at fair value		
Stable value/cash management	$ 6,542	$ 4,712
Bond	1,809	1,770
Guaranteed lifetime income	346	486
Balanced/asset allocation	24,096	20,189
U.S. stock	6,590	5,856
International/global stock	1,455	1,706
Specialty	1,319	297
Total investments, at fair value	42,157	35,016
Receivables		
Notes receivable from participants	999	1,101
Total receivables	999	1,101
NET POSITION AVAILABLE FOR BENEFITS	$ 43,156	$ 36,117

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2020 and 2019
(in thousands)

	2020	2019
Additions to net position attributed to Investment income		
Net appreciation in fair value of investments	$ 4,347	$ 5,376
Total investment income	4,347	5,376
Interest income on notes receivable from participants	47	50
Contributions		
Employer and employee contributions	4,252	4,283
Rollover contributions	3	244
Total contributions	4,255	4,527
Total additions	8,649	9,953
Deductions from net position attributed to		
Benefits paid to participants	1,493	1,781
Miscellaneous debits	117	7
Total deductions	1,610	1,788
Increase in net position	7,039	8,165
Net position available for benefits		
Beginning of year	36,117	27,952
End of year	$ 43,156	$ 36,117

See accompanying notes.

NOTE 1 – ORGANIZATION

The Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health (the Alliance) is a Regional County Organized Health System serving Medi-Cal eligible persons in Santa Cruz, Monterey, and Merced Counties, California (the Counties). The Alliance is a local public agency separate and distinct from the respective county governments. The Alliance began serving enrollees in Santa Cruz County, expanded the Alliance's services into Monterey County, and expanded again into Merced County.

The Alliance has contracted with the California Department of Health Care Services (DHCS) to provide healthcare benefits to eligible County residents. In turn, the Alliance has contracted with various healthcare providers to provide or arrange hospital and medical services for its members. The Alliance's contract with DHCS extends through December 31, 2021.

The Alliance, in partnership with Monterey County In Home Supportive Services (IHSS) Public Authority, operates the Alliance Care: IHSS program. Alliance Care: IHSS provides comprehensive healthcare to IHSS caregivers in Monterey County.

The Medi-Cal program accounted for approximately 99.8% of the Alliance's revenues for the years ended December 31, 2020 and 2019.

The Alliance sponsors a 401(a) Money Purchase Plan and Trust (the Plan), which is a defined-contribution plan covering all of its employees. The Alliance also sponsors a voluntary 457 deferred compensation plan. See Note 7.

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of presentation – The Alliance is a locally governed and operated public health plan governed by the 21-member Santa Cruz-Monterey-Merced-Managed Medical Care Commission Board. The Alliance has no component units and is not reported as a component unit of any governmental entity.

Accounting standards – The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB). The activities of the Alliance are reported using the economic resources measurement focus and the accrual basis of accounting. Under this method, revenues are recorded when earned and expenses are recorded when the related liability is incurred. As permitted by GASB Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, the Alliance has elected to apply all Financial Accounting Standards Board Statements and Interpretations, Accounting Principles Board Opinions, and Accounting Research Bulletins issued after November 30, 1989, which have been codified under Accounting Standards Codification (ASC), except for those that conflict with or contradict GASB pronouncements.

Statements of net position – Net position is required to be classified for accounting and reporting purposes in the following categories:

Invested in capital assets – This component of net position consists of capital assets including capital assets, net of accumulated depreciation and amortization and reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of external constraints placed on net position by law. It also pertains to constraints imposed by constitutional provisions or enabling legislation.

Unrestricted – This component of net position consists of net position that do not meet the definition of "restricted" or "invested in capital assets." A portion of the unrestricted net position is board-designated.

Use of estimates – The preparation of financial statements in accordance with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Significant items subject to estimates include claims incurred but not reported, which is reported in medical claims liability. Another significant estimate is the return of capitation payments for shortfalls in the medical loss ratio related to adult expansion members, which is reported as medical loss ratio liability. Overpayments to be recouped by DHCS are reported as accrued liabilities. Actual results could differ from those estimates.

Cash and cash equivalents – The Alliance considers all highly liquid instruments purchased with an original maturity of three months or less to be cash equivalents.

Investments – The Alliance adopted GASB Statement No. 72, *Fair Value Measurement and Application* (GASB Statement No. 72), effective January 1, 2016. GASB Statement No. 72 requires the Alliance to use valuation techniques which are appropriate under the circumstances and are consistent with the market approach, the cost approach or the income approach. GASB Statement No. 72 establishes a hierarchy of inputs used to measure fair value consisting of three levels. Level 1 inputs are quoted prices in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. Level 3 inputs are unobservable inputs.

The Alliance adheres to the disclosure requirements of GASB Statement No. 40, *Deposits and Investment Risk Disclosures – An Amendment of GASB Statement No. 3 Deposits with Financial Institutions, Investments (including Repurchase Agreements and Reverse Repurchase Agreements)*.

Investments are stated at fair value in accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*. The fair value of investments is estimated based on quoted market prices for these or similar investments.

Capital assets – Capital assets are stated at cost. Significant additions, replacements, major repairs, and renovations to infrastructure and buildings and furniture, software, and equipment are capitalized if the cost exceeds $10,000 and a useful life of at least three years. The expenses of normal maintenance, repairs, and minor replacements are charged to operations when incurred. Depreciation is calculated on a straight-line basis over the estimated lives of the assets, which are summarized as follows:

Building	39 years
Building equipment	5 to 15 years
Furniture and equipment	3 to 5 years
Software	3 to 5 years

The Alliance evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Board-designated investments – The Board designated the establishment of certain reserve funds for contingencies. The desired balance for this fund is three times the average of monthly premium capitation revenue. As of December 31, 2020 and 2019, the Alliance had accumulated board-designated investments of $331.6 million and $305.3 million, respectively.

Medical claims liability – The Alliance establishes a medical claims liability based on estimates of the ultimate cost of claims in process and provision for claims incurred but not yet reported, which is determined based on historical claims payment experience and other statistics. Such reserves are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known; such adjustments are included in operations. Although considerable variability is inherent in such estimates, management believes that the medical claims liability is adequate and fairly stated; however, this liability is based on estimates and the ultimate liability may differ from the amount provided.

Provider incentives – Under the terms of its provider agreements, the Alliance has agreed to incentive arrangements in the Medi-Cal line of business. All Primary Care Providers (PCP) incentive budgets are paid through the Care Based Incentives (CBI) program. For 2020, the Board allocated $10.0 million to the PCP Medi-Cal Program CBI incentive budget. For 2019, the Board allocated $10.0 million to the PCP Medi-Cal Program CBI incentive budget. During the years ended December 31, 2020 and 2019, respectively, $10.0 million and $15.0 million were paid out. Accrued annual incentive program as of December 31, 2020 and 2019 is $10.0 million and $10.2 million, respectively, as included in provider incentives payable in the statements of net position.

Medical loss ratio – For months of service beginning January 1, 2014, the DHCS requires the Alliance to expend at least 85% of net capitation payments received for adult expansion members on allowable medical expenses. If the minimum 85% medical loss ratio threshold is not met, the Alliance is required to return the difference between the actual medical loss ratio and 85% to DHCS. The Alliance records a liability for the amount estimated to be returned to DHCS based upon the direct claims incurred, estimated indirect allowable medical expenses and estimated incurred but not yet reported claims for adult expansion members at reporting periods which is recorded in medical loss ratio liability in the statements of net position. In 2020, the Alliance made payments to the State of $20.7 million related to the July 1, 2016 – June 30, 2017 period. Based on final determination letters received from the State in 2020, as of December 31, 2020, the Alliance is owed approximately $9.1 million by the State, relating to reporting period July 1, 2017 – June 30, 2018, as included in prepaid expenses and other assets in the statements of net position. There are no estimated liabilities for DHCS between the minimum threshold and the actual allowed medical expenses for the reporting period July 2018 to December 31, 2020.

Premium deficiencies – The Alliance performs periodic analyses of its expected future medical expenses and maintenance expenses to determine whether such expenses will exceed anticipated future revenues under its contracts. Should expected expenses exceed anticipated revenues, a premium deficiency reserve is recorded. No premium deficiency reserve was needed at December 31, 2020 or 2019.

Statements of revenues, expenses, and changes in net position – For purposes of display, transactions deemed by management to be ongoing, major, or central to the serving of their members in Santa Cruz, Monterey, and Merced Counties are reported as operating revenues and expenses. Peripheral or incidental transactions are reported as nonoperating revenues and expenses. These peripheral activities include investment income, changes in unrealized gains and losses on investments, and grant expenditures.

Revenue recognition – Revenue is recognized in the month in which the members are entitled to healthcare services. Capitation revenue is received from DHCS each month following the month of service based on estimated enrollment and capitation rates as provided for in DHCS contract. Eligibility of beneficiaries are determined by the Counties of Merced, Monterey, and Santa Cruz and validated by the State. The State provides the Alliance the validated monthly eligibility file in support of capitation revenue for the month. Further, the Alliance receives monthly reconciliations reflecting retrospective enrollment amounts from DHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to DHCS for these retrospective adjustments. These estimates are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known; such adjustments are included in operations.

Eligibility for the IHSS program is determined by Monterey County In Home Supportive Services Public Agency. A list of covered members is provided to the Alliance each month by the County of Monterey. Premiums are paid by the County to the Alliance in the month coverage is provided. Retroactive additions or deletions are not allowed under the agreement.

Premium tax – Effective July 1, 2013 until June 30, 2016, Senate Bill 78 added Revenue and Taxation Code Article 5 to impose a 3.9375% sales tax on sellers of Medi-Cal health care services subject to DHCS providing capitation payments that make the Alliance actuarially sound. In 2016, California's Senate Bill X2.2 enacted a new Managed Care Organization tax, effective for a taxing period of July 1, 2016 through June 30, 2019. The approved tax structure is based upon enrollment between specified tiers that are assessed different tax rates. On April 3, 2020, the Centers for Medicare & Medicaid Services (CMS) approved a waiver for the broad-based and uniformity requirements related to the State of California's Managed Care Organization (MCO) tax, effectively renewing the program effective January 1, 2020. Total premium tax liability recorded in accrued liabilities as of December 31, 2020 and 2019 was $37.4 million and $0.0 million, respectively. The premium tax expense totaled $141.3 million and $64.1 million for the years ended December 31, 2020 and 2019, respectively.

Grants – In December 2014, the Alliance Board approved $116.7 million in grant funding. An additional $106.3 million was approved in October 2016. The purpose of the grant program is to further the Alliance's mission by increasing member access to quality health-care through strategic planning, program development, and responsive Medi-Cal capacity investments. In 2016, the grant program became fully operational. Grant expenditures are classified as nonoperating. For the years ended December 31, 2020 and 2019, a total of $14.2 million and $13.2 million, respectively, had been expended by the Alliance under this program.

Risk management – The Alliance is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Alliance carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Alliance's commercial coverage.

Medical reinsurance (stop-loss insurance) – The Alliance has entered into a reinsurance (stop-loss) agreement with a third party to limit its losses. Under the terms of the agreement, the third party will reimburse the Alliance certain proportions of claims in excess of specified deductibles (for 2020 and 2019, $250,000 for all lines of business for inpatient claims, which include hospital, sub-acute, skilled nursing, long term care, and durable medical equipment, implants, orthopedics and prosthesis, limited to $1,000,000 in aggregate over all contract years per member. Stop-loss insurance premiums of $7.6 million and $6.3 million are included in reinsurance and other expense in 2020 and 2019, respectively. In 2020 and 2019, there is a total of $10.1 million and $16.2 million, respectively, in recoveries.

Professional liability insurance –The Alliance maintains insurance coverage for professional liability and errors and omissions insurance. The policy is an occurrence-based policy and designed to provide comprehensive professional liability insurance and errors and omissions insurance for Alliance employees. There have been no reductions in coverage or any claims that have exceeded coverage in any of the past three years.

Income taxes – The Alliance operates as a government unit under the purview of Internal Revenue Code Section 501(a) whose income is excluded from taxation under Internal Revenue Code Section 115 and corresponding provisions of the California Revenue and Taxation Code. As such, the Alliance is not subject to federal or state taxes on income.

New accounting pronouncements – In June 2017, the GASB issued Statement No. 87, *Leases* (GASB 87), which is effective for financial statements for periods beginning after December 15, 2019. GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance* ("GASB No. 95"), which extended the effective date for GASB 87. The Alliance is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2022.

In June 2020, the GASB issued Statement No. 97, Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32 ('GASB 97'). GASB 97 amends the criteria for reporting governmental fiduciary component units – separate legal entities included in a government's financial statements. GASB 97 clarifies rules related to reporting of fiduciary activities under Statements No. 14 and No. 84 for defined contribution plans and to enhance the relevance, consistency, and comparability of the accounting and financial reporting of IRC Code section 457 plans that meet the definition of a pension plan. The Alliance is reviewing the impact of the adoption of GASB No. 97 for the fiscal year ending 2022.

NOTE 3 – CASH AND CASH EQUIVALENTS, SHORT-TERM INVESTMENTS, AND BOARD-DESIGNATED INVESTMENTS

Cash and cash equivalents and investments as of December 31, 2020 and 2019 consist of the following (in thousands):

	2020	2019
Cash deposits and equivalents	$ 11,172	$ 7,127
Short-term investments	170,421	126,857
Restricted deposits	300	300
Board-designated investments, at fair value	331,562	305,345
Total cash, cash equivalents, and investments	$ 513,455	$ 439,629

Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure, the Alliance may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code (the Code) requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the State law. At year-end, deposits were collateralized with securities held by the pledging financial institution's trust department or agent in the Alliance's name.

	2020		2019	
	Carrying Amount	Bank Balance	Carrying Amount	Bank Balance
Insured	$ 450	$ 450	$ 451	$ 451
Collateralized	11,022	14,767	6,976	13,284
Total cash and restricted deposits (in thousands)	$ 11,472	$ 15,217	$ 7,427	$ 13,735

Investments – The Alliance invests in obligations of U.S. government agencies, corporate notes, and instrumentalities. The Alliance's investment policy allows only high-quality investments as permitted by the Code and subject to the limitations of the Alliance's Annual Investment Policy (investment policy).

The Alliance also invests in the State of California Local Agency Investment Fund (LAIF). The Local Investment Advisory Board provides oversight for LAIF. The Board consists of five members as designated by statute. The chairman is the state treasurer or his designated representative.

Two members qualified by training and experience in the field of investment or finance, and the state treasurer appoints two members who are treasurers, finance or fiscal officers, or business managers employed by any county, city, or local district or municipal corporation of this state. The term of each appointment is two years or at the pleasure of the appointing authority. The recorded value of the Alliance's investments in LAIF is equal to the Alliance's share of the estimated fair value of the underlying assets.

In 2016, the Alliance invested in the Investment Trust of California (CalTrust) as one of its discretionary advisory partners. Blackrock Financial Management, a registered investment advisor, provides oversight for CalTrust pursuant to Joint Exercise of Powers Agreement. The Board of Trustees consists of ten Trustees, at least seventy-five percent are members of the governing body, officers, or personnel of the Members which are appointed by the initial Members and the Board. The Trustees and Officers currently serve without compensation but are reimbursed for reasonable expenses in connection with their duties. The Board is responsible for setting overall policies and procedures and for the retention and monitoring of all agents acting on behalf of CalTrust. The recorded value of the Alliance's investments in CalTrust is equal to the Alliance's share of the estimated fair value of the underlying assets.

LAIF and CalTrust are external investment pools. Per GASB 72, fair value hierarchy disclosure is not required for these external pooled investments.

Government money market funds are required to invest at least 99.5% of their total assets in (i) cash; (ii) securities issued or guaranteed by the United States or certain U.S. government agencies or instrumentalities; and/or (iii) repurchase agreements that are collateralized fully. The Fund is exempt from requirements that permit money market funds to impose a liquidity fee and/or temporary redemption gates. Shares are not restricted as to when they may be redeemed.

The following is a summary of the fair value hierarchy of the Alliance's short-term investments and board-designated investments, as of December 31 (in thousands):

	2020				
Investment type	**Total**	**Investment Exempt from Fair Value**	**Level 1**	**Level 2**	**Level 3**
Corporate bonds	$ 47,886	$ -	$ 47,886	$ -	$ -
State & local agency bonds	5,396	-	5,396	-	-
U.S. agency bonds	19,938	-	19,938	-	-
U.S. treasury notes	18,145	-	18,145	-	-
Money market funds	193,698	193,698	-	-	-
	285,063	$ 193,698	$ 91,365	$ -	$ -
External Investment Pool					
LAIF	63,819				
CalTrust	153,101				
	$ 501,983				

	2019				
Investment type	**Total**	**Investment Exempt from Fair Value**	**Level 1**	**Level 2**	**Level 3**
Corporate bonds	$ 75,236	$ -	$ 75,236	$ -	$ -
State & local agency bonds	17,585	-	17,585	-	-
U.S. agency bonds	82,132	-	82,132	-	-
U.S. treasury notes	23,060	-	23,060	-	-
Money market funds	74,006	74,006	-	-	-
	272,019	$ 74,006	$ 198,013	$ -	$ -
External Investment Pool					
LAIF	62,774				
CalTrust	97,409				
	$ 432,202				

Interest rate risk – In accordance with its investment policy, the Alliance manages its exposure to declines in fair value from increasing interest rates by matching maturity dates to the extent possible with the Alliance's expected cash flow draws. The policy of the Alliance limits maturities to five years. As of December 31, 2020, the Alliance's short-term and board designated investments have the following related maturity schedule (in thousands):

Investment type	Fair value	Less Than 1 Years	1-5 Years
Corporate bonds	$ 47,886	$ -	$ 47,886
State and local agency bonds	5,396	-	5,396
U.S. agency bonds	19,938	-	19,938
U.S. treasury notes	18,145	-	18,145
Money market funds	193,698	193,698	-
CalTrust	153,101	153,101	-
LAIF	63,819	63,819	-
	$ 501,983	$ 410,618	$ 91,365

As of December 31, 2019, the Alliance's short-term and board designated investments have the related maturity schedule (in thousands):

Investment type	Fair value	Less Than 1 Years	1-5 Years
Corporate bonds	$ 75,236	$ -	$ 75,236
State and local agency bonds	17,584	-	17,584
U.S. agency bonds	82,132	-	82,132
U.S. treasury notes	23,061	-	23,061
Money market funds	74,006	74,006	-
CalTrust	97,409	97,409	-
LAIF	62,774	62,774	-
	$ 432,202	$ 234,189	$ 198,013

Credit risk – The Alliance's investment policy is intended to conform to the Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments and by diversifying the investment portfolio in accordance with the investment policy. The investment policy sets minimum acceptable credit ratings for investments from two nationally recognized rating services: Standard and Poor's Corporation (S&P) and Moody's Investor Service (Moody's). For an issuer of short-term debt, the rating must be no less than A-1 (S&P) or P-1 (Moody's), while an issuer of long-term debt shall be rated no less than an A (S&P or Moody's).

As of December 31, 2020, the following are the credit ratings of short-term and board designated investments (in thousands):

Investment Type	Fair Value	Unrated	Rating as of Year-End						
			AAA	AA+	AA	AA-	A+	A	A-
Money market fund	$ 193,698	$ 193,698	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	47,884	-	13,778	7,708	7,581	1,082	2,104	12,551	3,080
F.N.MA	16,358	-	-	16,358	-	-	-	-	-
Federal Home Loan Mortgage	3,581	-	-	3,581	-	-	-	-	-
State and local bonds	5,396	-	-	-	3,509	1,887	-	-	-
United States Treasury Notes	18,146	18,146	-	-	-	-	-	-	-
LAIF	63,819	63,819	-	-	-	-	-	-	-
CalTrust	153,101	153,101	-	-	-	-	-	-	-
Total	$ 501,983	$ 428,764	$ 13,778	$ 27,647	$ 11,090	$ 2,969	$ 2,104	$ 12,551	$ 3,080

As of December 31, 2019, the following are the credit ratings of short-term and board designated investments (in thousands):

Investment Type	Fair Value	Unrated	Rating as of Year-End						
			AAA	AA+	AA	AA-	A+	A	A-
Money market fund	$ 74,006	$ 74,006	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	75,236	-	17,379	5,947	6,161	8,062	14,133	18,452	5,102
F.F.C.B.	27,450	-	-	27,450	-	-	-	-	-
F.N.MA	28,955	-	-	28,955	-	-	-	-	-
F.H.L.B	13,488	-	-	13,488	-	-	-	-	-
Federal Home Loan Mortgage	12,239	-	-	12,239	-	-	-	-	-
State and local bonds	17,584	1,000	-	447	8,179	7,958	-	-	-
United States Treasury Notes	23,061	23,061	-	-	-	-	-	-	-
LAIF	62,774	62,774	-	-	-	-	-	-	-
CalTrust	97,409	97,409	-	-	-	-	-	-	-
Total	$ 432,202	$ 258,250	$ 17,379	$ 88,526	$ 14,340	$ 16,020	$ 14,133	$ 18,452	$ 5,102

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. The Alliance's investment policy limits to no more than 5% of the total market value investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises; no more than 20% may be invested in one money market fund. The investment policy places a diversification limit of 5% for all issuers other than anyone U.S. government agency, for which the policy allows 100%, and only one repurchase agreement counterparty, for which the policy allows 25% to 50% depending on the maturity. Medium Term Maturity Corporate Securities are limited to 30% and State and Local Obligations are limited to 25%. The dollar limit of investments in LAIF is $75.0 million.

Investment	Issuer	Percentage of Portfolio 2020	Percentage of Portfolio 2019
Money market funds		38.6 %	17.1 %
U.S. government securities	Federal Farm Credit Bond	-	6.4
	Federal Home Loan Bank Bonds	-	3.1
	Federal Home Loan Mortgage	0.7	1.7
	United States Treasury Notes	3.6	5.3
F.N.M.A.	Federal National Mortgage Association	3.3	7.8
Corporate bonds	Various	9.5	17.4
State and local bonds	Various	1.1	4.2
LAIF	State of California	12.7	14.5
CalTrust	CalTrust JPA	30.5	22.5
		100 %	100 %

NOTE 4 – CAPITAL ASSETS

Capital assets – Capital assets activity in 2020 consists of the following (in thousands):

	December 31, 2019	Increases	Decreases/ Transfers	December 31, 2020
Capital assets not being depreciated:				
Land	$ 7,564	$ -	$ -	$ 7,564
Construction in process	3,584	1,794	(2,897)	2,481
Total capital assets not being depreciated	11,148	1,794	(2,897)	10,045
Capital assets being depreciated:				
Buildings and building equipment	44,594	-	583	45,177
Furniture and equipment	11,973	371	2,128	14,472
Software	16,657	-	-	16,657
	73,224	371	2,711	76,306
Less accumulated depreciation for:				
Buildings and building equipment	9,563	1,516	-	11,079
Furniture, equipment, and software	20,546	4,983	(186)	25,343
	30,109	6,499	(186)	36,422
Total capital assets being depreciated, net	43,115	(6,128)	2,897	39,884
Total capital assets, net	$ 54,263	$ (4,334)	$ -	$ 49,929

Capital assets activity in 2019 consists of the following (in thousands):

	December 31, 2018	Increases	Decreases/ Transfers	December 31, 2019
Capital assets not being depreciated:				
Land	$ 7,564	$ -	$ -	$ 7,564
Construction in process	4,686	4,507	(5,609)	3,584
Total capital assets not being depreciated	12,250	4,507	(5,609)	11,148
Capital assets being depreciated:				
Buildings and building equipment	39,807	-	4,787	44,594
Furniture and equipment	11,151	-	822	11,973
Software	16,657	-	-	16,657
	67,615	-	5,609	73,224
Less accumulated depreciation for:				
Buildings and building equipment	8,176	1,387	-	9,563
Furniture, equipment, and software	15,564	4,982	-	20,546
	23,740	6,369	-	30,109
Total capital assets being depreciated, net	43,875	(6,369)	5,609	43,115
Total capital assets, net	$ 56,125	$ (1,862)	$ -	$ 54,263

NOTE 5 – MEDICAL CLAIMS LIABILITY

The following is a reconciliation of the medical claims liability, including loss adjustment expenses for the years ended December 31, 2020 and 2019 (in thousands):

	2020	2019
Beginning balance	$ 184,933	$ 154,163
Incurred:		
Current year	1,219,345	1,210,620
Prior years	(18,033)	(16,010)
Total	1,201,312	1,194,610
Paid:		
Current year	1,032,870	1,027,276
Prior years	152,659	136,564
Total	1,185,529	1,163,840
Ending balance	$ 200,716	$ 184,933

Amounts incurred related to prior years represent changes from previously estimated liabilities. Liabilities at any year-end are continuously reviewed and reestimated as information regarding actual claims payments and expected payment trends become known. Negative amounts reported for incurred related to prior years result from claims being adjudicated and paid for amounts less than originally estimated.

Medical expenses in the statements of revenues, expenses, and changes in net position also include capitation payments to providers, reinsurance premiums, and other direct payments to providers, which do not flow through the claims payable.

NOTE 6 – RESTRICTED NET ASSETS AND TANGIBLE NET EQUITY

As a limited license plan under Knox-Keene Health Care Service Plan Act of 1975 (the Act), the Alliance is required to maintain a minimum level of tangible net equity, as determined by the State of California. The required tangible net equity level was approximately $55.5 million and $54.6 million at December 31, 2020 and 2019, respectively. The Act also requires the Alliance to maintain $300,000 restricted deposits, which is displayed as a restricted deposit in the accompanying statements of net position. As of December 31, 2020 and 2019, total net position was $464.6 million and $450.8 million, respectively, which exceeded the minimum tangible net equity level for both years.

NOTE 7 – CENTRAL CALIFORNIA ALLIANCE FOR HEALTH 401(A) QUALIFIED RETIREMENT PLAN

The Alliance sponsors a 401(a) Money Purchase Plan and Trust (the Plan), which is a defined-contribution plan covering all its employees. Under the terms of the plan agreement after one year of service, the Alliance will contribute 10% of salaries and wages on behalf of each participant for the plan year. The Alliance has the authority to amend the Plan's provisions.

The Alliance also sponsors a deferred compensation plan created in accordance with Internal Revenue Service Code Section 457. This is an elective defined contribution plan in which employees with work schedules of at least 30 hours per week may participate. The Alliance does not make any contributions to this plan.

The Alliance incurred $4.4 million and $4.3 million of retirement plan expense during 2020 and 2019, respectively, included in salaries, wages, and employee benefits in the statements of revenues, expenses, and changes in net position.

Summary of Significant Accounting Policies

Basis of accounting – The Plan fiduciary financial statements are prepared using the accrual basis of accounting. The Plan's contributions are recognized in the period in which contributions are made. Benefits are recognized when due and payable in accordance with the terms of the Plan.

Investments – The Plan's investments are reported at fair value, including certain investments held in collective investment trusts. The funds invested in the VantageTrusts collective trusts are discretionary accounts managed by ICMA Retirement Corporation. Investments held in each trust are maintained on a unit basis. The units represent a proportional ownership interest in each of the funds in which a participant is invested (net asset value or NAV). The NAV of a unit is determined by adding the market value of each respective fund's investments, plus receivables and other assets, and then deducting liabilities. The balance, called net assets, is divided by the number of units outstanding. The value of a unit at any given time will depend on the investment performance of the particular fund's portfolio of investments. All earnings (interest, dividends, realized gains, unrealized gains), losses (realized and unrealized), and expenses are recorded and reflected in changes in the NAV. The NAV is calculated daily.

Investments by fair value level include the following as of December 31 (in thousands):

Description	2020	Level 1	Level 2	Level 3
Investments by fair value level	$ -	$ -	$ -	$ -
	-	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
Collective investment trusts - at NAV	42,157			
Total investments	$ 42,157			

Description	2019	Level 1	Level 2	Level 3
Investments by fair value level	$ -	$ -	$ -	$ -
	-	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
Collective investment trusts - at NAV	35,016			
Total investments	$ 35,016			

Plan description – Participant data for the Plan, as of the measurement date for the year indicated, is as follows:

- All full-time, part-time, and per-diem employees of the Organization are eligible to participate in the Plan. Employees are eligible to receive employer contributions upon completion of one year of service, defined as working 12 months for a minimum of 1,000 hours.

- Participants will receive an employer contribution of 10% of compensation. Employees who wish to make elective contributions may do so through the agency's 457 plan.

- Participants are fully vested in employer contributions.

Employer contribution – The Alliance makes contributions based on the established funding practice.

Notes receivable from participants – Participants may borrow from their accounts a minimum of $1,000 up to a maximum equal to the lesser of $50,000 or 50% of their vested account balance. The maximum loan term is five years unless the loan term qualifies as a home loan, in which case the term of the loan is not to exceed thirty years.

Loans are secured by the balance of the participant's account and bear fixed, reasonable rates of interest, as determined by the custodians. Principal and interest are paid directly by the participant to the custodians through monthly ACH transactions. As of December 31, 2020 and 2019, the rates of interest on outstanding loans with ICMA-RC was 3.75% and 5.25%, respectively, with maturities extending up to five years. The interest rate is locked in for the term of the loan and established at the onset of the loan. The loan totals as of December 31, 2020 and December 31, 2019 were $999,070 and $1,100,556, respectively.

Rate of return – The Plan is a defined contribution plan with investment returns varying per participant based on investment elections. On a cumulative basis for the years ended December 31, 2020 and 2019, the cumulative rate of return for the 401(a) plan was 11.3% and 18.7%, respectively.

NOTE 8 – RISKS AND UNCERTAINTIES

The Alliance primarily serves Medi-Cal eligible persons. Laws and regulations governing the Medi-Cal program are complex and subject to interpretation. The Alliance believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medi-Cal programs.

NOTE 9 – CONTINGENCIES

The Alliance is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on the Alliance's financial position or results of operations.

In March 2020, the World Health Organization declared COVID-19 a global pandemic and recommended containment and mitigation measures worldwide. The related adverse public health developments, including orders to shelter-in-place, travel restrictions, and mandated business closures, have adversely affected workforces, organizations, economies, and financial markets globally, leading to increased market volatility and disruptions in normal business operations, including the Alliance's operations. The Alliance will continue to monitor the situation closely, but the continuing situation surrounding COVID-19 is uncertain.

NOTE 10 – HEALTH CARE REFORM

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates or benefits. The ultimate outcome of these proposals, including the potential effects of or changes to health care reform that will be enacted cannot presently be determined.

NOTE 11 – SUBSEQUENT EVENTS

The Alliance held investments at December 31, 2020, that may experience a significant decline in market value in 2021 as a result of market reaction to the coronavirus outbreak. The Alliance will continue to monitor the situation closely, but the market volatility and the continuing situation surrounding the coronavirus is uncertain. At this time, management believes any potential decline in fair value for these securities is temporary.

Supplementary Information

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Schedule of Revenues and Expenses by Program and Changes in Net Position
Year Ended December 31, 2020
(in thousands)

	Medi-Cal					
	Santa Cruz County	Monterey County	Merced County	IHSS Program	Administrative	Total
Operating revenues						
Capitation revenue	$ 326,597	$ 635,405	$ 502,330	$ 3,227	$ -	$ 1,467,559
Operating expenses						
Medical expenses						
Medi-Cal						
Provider capitation	4,789	15,660	14,550	-	-	34,999
Claim payments to providers	207,693	412,953	332,617	-	-	953,263
Prescription drugs	51,936	89,582	67,183	-	-	208,701
Other medical	4,612	10,978	9,037	-	-	24,627
Alliance Care: IHSS program	-	-	-	2,952	-	2,952
Reinsurance and other, net of (recoveries) expense	(1,823)	43	(745)	-	-	(2,525)
Total medical expenses	267,207	529,216	422,642	2,952	-	1,222,017
Administrative expenses						
Premium tax expense	-	-	-	-	141,313	141,313
Salaries, wages, and employee benefits	-	-	-	-	55,636	55,636
Supplies, occupancy, insurance, and other	-	-	-	-	9,230	9,230
Professional fees	-	-	-	-	8,689	8,689
Depreciation and amortization	-	-	-	-	6,499	6,499
Purchased services	-	-	-	-	3,141	3,141
Total administrative expenses	-	-	-	-	224,508	224,508
Total operating expenses	267,207	529,216	422,642	2,952	224,508	1,446,525
Operating income (loss)	59,390	106,189	79,688	275	(224,508)	21,034
Investment income, including net realized and unrealized gains and losses	-	-	-	-	5,909	5,909
Other income	-	-	-	-	1,117	1,117
Grants	-	-	-	-	(14,245)	(14,245)
Increase (decrease) in net position	$ 59,390	$ 106,189	$ 79,688	$ 275	$ (231,727)	13,815
Net position, beginning of year						450,775
Net position, end of year						$ 464,590

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Schedule of Revenue and Expenses by Program and Changes in Net Position
Year Ended December 31, 2019
(in thousands)

	Medi-Cal					
	Santa Cruz County	Monterey County	Merced County	IHSS Program	Administrative	Total
Operating revenues						
Capitation revenue	$ 281,860	$ 561,402	$ 439,325	$ 2,937	$ -	$ 1,285,524
Operating expenses						
Medical expenses						
Medi-Cal						
Provider capitation	4,618	15,088	14,186	-	-	33,892
Claim payments to providers	218,556	408,366	338,417	-	-	965,339
Prescription drugs	48,712	82,956	64,260	-	-	195,928
Other medical	5,126	11,775	9,287	-	-	26,188
Alliance Care: IHSS program	-	-	-	2,678	-	2,678
Reinsurance and other, net of recoveries	(1,236)	(4,688)	(4,004)	-	-	(9,928)
Total medical expenses	275,776	513,497	422,146	2,678	-	1,214,097
Administrative expenses						
Premium tax expense	-	-	-	-	64,146	64,146
Salaries, wages, and employee benefits	-	-	-	-	51,318	51,318
Supplies, occupancy, insurance, and other	-	-	-	-	10,650	10,650
Professional fees	-	-	-	-	8,373	8,373
Depreciation and amortization	-	-	-	-	6,368	6,368
Purchased services	-	-	-	-	4,308	4,308
Total administrative expenses	-	-	-	-	145,163	145,163
Total operating expenses	275,776	513,497	422,146	2,678	145,163	1,359,260
Operating income (loss)	6,084	47,905	17,179	259	(145,163)	(73,736)
Investment income, including net realized and unrealized gains and losses	-	-	-	-	-	16,820
Other income	-	-	-	-	-	1,032
Grants	-	-	-	-	-	(13,162)
Increase (decrease) in net position	$ 6,084	$ 47,905	$ 17,179	$ 259	$ (145,163)	(69,046)
Net position, beginning of year						519,821
Net position, end of year						$ 450,775


MOSSADAMS

DATE: May 26, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Medi-Cal Managed Care Procurement Process: Enabling Ordinance

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Recommendation. Staff recommend the Board adopt membership criteria for inclusion in enabling ordinances authorizing the San Benito County and Mariposa County shifts to the County Organized Health System (COHS) model through Central California Alliance for Health (the Alliance).

Summary. A key deliverable in support of the geographic expansion of the Alliance into San Benito and Mariposa counties is each county enacting an ordinance authorizing the shift from the county's current model to the COHS model through the Alliance. The DHCS procurement process requires that the relevant Board of Supervisors (BOS) consider and submit an executed ordinance by October 1, 2021. Among other things, the enabling ordinance specifies Alliance Commission membership, including number of members, representation of stakeholder constituencies, and term. This report provides relevant background and a recommended approach to board membership for the Alliance board consideration and action.

Background. The Department of Health Care Services (DHCS) has initiated its statewide procurement of commercial Medi-Cal managed care plans (MCPs) to provide MCP services in non-COHS counties for contract year 2024. DHCS provided a process for counties who wanted to change to a COHS model and thereby not be available for the commercial plan procurement.

San Benito County and Mariposa County requested the Alliance's partnership to change models in each county. By April 30, 2021, counties were required to submit a letter of intent (LOI) executed by both the County Board of Supervisors and the CEO of a partnering managed care plan indicating the intent to change models. Submission of the LOI does not guarantee that the transition to the COHS model will occur. However, failure to submit an LOI by the deadline would preclude a county from shifting to a local plan model. In April 2020, each BOS and the Alliance's board approved execution of the LOI, and the counties timely submitted the LOI to DHCS.

In its April report to the Alliance board, Staff identified that a key deliverable required for DHCS approval of the model change is each county enacting an ordinance authorizing the shift to the COHS model through the Alliance. To enable Alliance staff to work with each county to ensure consideration of the ordinance by the October 1, 2021 deadline, the Alliance's board must decide upon governance structure of a newly formed board, including representation from both San Benito and Mariposa counties. The ordinances would go into effect as of the date of the first meeting of the new commission, which would occur in mid-to late 2023. No change to the Alliance board would be made until the model change is confirmed by DHCS, and the newly form board met in 2023 to support implementation.

The Alliance's board currently has 21 members, 7 representatives per county. Since 2008, each county BOS appoints a County Supervisor, the County Health Director (or designee), a hospital representative, two at large public representatives of the population of beneficiaries to be served representatives ("member" representatives), and two at large provider representatives. Board members serve 4-year terms and are eligible for reappointment at the end of their term. This current composition was established during the Alliance's geographic expansion into Merced County and was guided by the following factors: balanced and diverse representation across the COHS stakeholders, flexibility for BOS to determine appropriate representation from their county and maintaining an efficiently sized board to enable effective governance for the plan.

Each county's ordinance reflects the composition described above and also requires that at large members be legal residents of the county and have a commitment to a health care system which seeks to improve access to high quality health care for all persons, regardless of their economic circumstances, and which in fact delivers high quality care, and which in fact is financially viable. Members of the Commission shall likewise have an abiding commitment to, and interest in, a quality publicly assisted health care delivery system.

In addition to those precedent considerations, for this current recommendation, staff also considered each county's current Medi-Cal membership and the potential for increases in membership due to any future Medi-Cal program expansions. Staff also met with the county to discuss the preparation of the ordinance and to describe the proposed approach to membership.

Discussion. Staff assessed various approaches to board composition and recommend the board consider approval of a "*Member Threshold Approach*" to determine board members as this approach meets the goals of producing an efficiently sized board to enable effective governance, ensuring a balanced and diverse representation for a regional health plan board, and providing the BOS with flexibility to determine appropriate representation on the Alliance's board. Key aspects of the recommended approach include:

- Allocate board members based on member volume for a particular county.
- Cap county allocation at a maximum of five (5) members (no more than 25 total board members).
- Identify representation for constituencies based on total number of seats, always including the County Health Director or their designee, and providing the BOS with the flexibility to appoint at-large members from the member and provider community.

The recommended allocation per threshold is shown in the table below:

Number of Members	Number of Board Members	Proposed Constituency Allocation
0-15K	1	County Health Director or designee
15-30K	2	County Health Director or designee At Large member (member or provider representative)

30-45K	3	County Health Director or designee (2) At Large members (1 member, 1 provider)
45-60K	4	County Health Director or designee County Supervisor (2) At Large members (1 member, 1 provider)
60K+	5	County Health Director or designee County Supervisor (3) At Large members (1 member, 1 provider, 1 general at large (provider or member)

The result of application of this model to the post-expansion Alliance board in 2023 would be as follows, based on current Medi-Cal member enrollment.

County	Santa Cruz	Monterey	Merced	San Benito	Mariposa	Total Board
Current Members	74,000	166,000	132,000	18,000	5,300	18
# of Board Seats	5	5	5	2	1	
Representation	Health Dir or designee, Supervisor (3) At Large	Health Dir or designee. Supervisor (3) At Large	Health Dir or designee. Supervisor (3) At Large	Health Dir or designee. (1) At Large	Health Dir or designee.	25 possible if membership growth

In developing this proposal, staff have also identified for potential future consideration the number and types of advisory groups to the board. This issue is not necessary for discussion or consideration during the May meeting as it need not be addressed by the ordinance, and, instead, can be addressed at the point in time in which the new board would adopt Bylaws. However, an evaluation of the opportunity to expand advisory groups to the board may support key constituency engagement in the Alliance and is an opportunity for further exploration. This issue is relevant as the board considers the allocation of fewer seats per county to ensure broader regional representation as the Alliance's geography expands. Staff will be prepared to preview this concept and obtain board feedback as to potential next steps.

Upon approval by the board of the recommended governance structure for the newly constituted board, staff will work with each County Health Director and County Counsel to ensure adoption and execution of a new or revised County Ordinance in support of this decision.

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

Attachments. N/A

DATE: May 26, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Department of Health Care Services CalAIM Implementation

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Recommendation. This is a discussion item only. No action is recommended.

Summary. This report provides an overview of the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) initiative. Medi-Cal Managed Care Plans (MCPs) begin implementation of CalAIM on January 1, 2022 and will continue to implement relevant programs through 2026. Staff will refresh the Board's awareness of the CalAIM initiative and will identify those aspects of CalAIM that will be influential on the Alliance over the coming years.

Background. On October 29, 2019, the Department of Health Care Services (DHCS) announced California Advancing and Innovating Medi-Cal (CalAIM), a multi-year set of proposals to improve the quality of life and health outcomes for Medi-Cal beneficiaries. The major components of CalAIM build upon the successful outcomes of various pilots (including, but not limited to, the Whole Person Care Pilots, Health Homes, and the Coordinated Care Initiative) from the previous federal waivers. CalAIM sets forward the State's vision for the Medi-Cal program, and so naturally serves as an important input as to the future for Alliance members and the Medi-Cal Managed Care plans (MCPs). CalAIM includes over 20 different proposals, to be implemented over a period of 5 years and which impact the MCPs, County and FFS delivery systems and the Medi-Cal beneficiaries these systems serve.

CalAIM has three primary goals: (1) Identify and manage member risk and need through Whole Person Care approaches and addressing Social Determinants of Health, (2) Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility, and (3) Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform. DHCS notes that the proposed reforms touch on every aspect of the Medi-Cal delivery system and seek to improve the continuum of care from birth to the end of life.

DHCS efforts to develop the final CalAIM proposals were slowed due to the COVID-19 pandemic and implementation was delayed through 2021. On January 8, 2021, DHCS released its revised CalAIM proposal, signaling its intent to implement the CalAIM proposals beginning in January of 2022. DHCS has been engaging county and plan stakeholders over the course of the past five months to refine the proposals and begin planning for implementation. DHCS has also developed the 1115 and 1915(b) waiver proposals to CMS that will support implementation of many aspects of CalAIM. The waiver is expected to be submitted soon with a goal of finalizing and obtaining CMS approval on or before December 31, 2021.

Discussion. CalAIM includes significant changes for MCPs. Those proposals which are most impactful to the Alliance are identified below, including the proposed date for implementation. During the May Board meeting, staff provide an overview of these key proposals to ensure the Board's awareness and to obtain feedback to inform future reporting to the Board.

There are additional proposals that staff are monitoring as they do not present a current opportunity for the Alliance but may be influential in the future. These include full integration plans and long-term plan for foster care. In addition, there are numerous proposals impacting County partners which are relevant to the Alliance and its members. These include significant behavioral health reforms, and enhanced county oversight regarding county eligibility, CCS and CHDP programs. In addition, DHCS has a proposal relating to increased dental benefits and access.

2022

Phase 1 implementation of Regional Rates. DHCS will shift MCP rate development from a county-based approach to a regional rate model, in 2-phases. Phase 1 will be the implementation of a regional rate to MCPs operating in multiple counties for all counties the MCP serves. Phase 2 will be implementation of regions which encompass many counties and the plans operating in those counties. In this second phase, MCP rates will be influenced by all counties within their designated region, not just those counties the MCP serves. The intent is to simplify DHCS rate development and to average costs across plans.

Enhanced Case Management (ECM). A new statewide enhanced case management benefit providing a whole person care approach to address clinical and non-clinical circumstances of high need Medi-Cal beneficiaries in defined populations. Implementation beginning in 2022 is focused on populations served by the Whole Person Care pilots (high utilizers, people experiencing homelessness, receiving SMI/SUD services.) Implementation for these populations will occur on January 1, 2022 in Santa Cruz and Monterey Counties due to their existing WPC pilots which expire as of December 31, 2021, and on July 1, 2022 in Merced county.

Work is underway to prepare for the ECM implementation, including collaboration with the Santa Cruz and Monterey County Whole Person Care pilot programs to plan for the transition of WPC members to the new MCP ECM benefit, development of mandated deliverables to DHCS including the ECM Model of Care and a transition and coordination plan, and planning for ECM network development and contracting. Key considerations include revenue available from the state, available workforce to provide the ECM benefit, member engagement and communication, and data sharing to support care coordination and service referral.

In Lieu of Services (ILOS). Plans may offer flexible wrap around services as a substitute to, or to avoid, other covered services. DHCS has identified 14 possible ILOS, which may be voluntarily offered by MCPs. The initial emphasis is on building the infrastructure for ILOS that would allow such services to be included as benefits in the Medi-Cal program. Plans may implement ILOS and build increased and county-wide capacity over time.

Staff are assessing an initial implementation of housing transition navigation, housing deposits, and housing tenancy and sustaining services, sobering centers which are currently offered by the WPC pilots, in addition to the existing recuperative care and bridge housing pilots and meal benefits. Plans may add ILOS over time as a component of its Population Health Strategies and in support of expanded ECM populations. Staff will continue to evaluate the financial feasibility and delivery system capacity to offer such services over time.

2023

Population Health Strategy. MCPs are to develop and maintain a patient centered population health strategy based on data driven risk stratification, predictive analytics and standardized assessments. The PHS will serve as a plan of action to address member needs.

Enhanced Case Management. Expansion of the ECM benefit to additional populations as defined by DHCS (long-term care, individuals exiting incarceration, children and youth)

2024

Geographic Expansion of the County Organized Health System Model. Geographic expansion is not a component of CalAIM. However, should DHCS approve the model change for San Benito and Mariposa counties, the Alliance's expansion of its service area to include those two counties would go live in January 2024. Each county has identified the opportunity to implement the system transformation contemplated by CalAIM with the Alliance pursuant to the COHS model as a key influence on their decision to pursue a model change. Significant effort would be required beginning in late 2022 and through 2023 to prepare for the January 2024 go-live, and successful implementation would be a focus for the plan through 2024. The Alliance would be required to offer ECM in both counties for all populations at go live, and to include members in all counties in its PHS.

2025

Medicare Dual-Special Needs Plan. By January 2025, MCPs in non-CCI counties will be required to operate Medicare D-SNPs for dually eligible Medicare and Medi-Cal beneficiaries. D-SNP implementation supports DHCS's goal of implementing statewide MLTSS in 2027, which would allow Medi-Cal beneficiaries statewide to obtain MLTSS and home and community-based services statewide through managed care instead of the currently limited availability through waiver programs today.

The Alliance has conducted previous preliminary assessments relating to Medicare with an emphasis on understanding member enrollment and utilization and cost assumptions that would support a high quality, financially viable program. The Alliance's feasibility assessment and implementation planning will commence in late 2021/early 2022 towards the 2025 implementation date.

2026

NCQA Accreditation. By 2026, MCPs will be required to achieve National Committee for Quality Assurance (NCQA). Efforts towards NCQA would commence no sooner than 2022 for the 2026 accreditation goal.

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

Reference Materials.

1. CalAIM Executive Summary and Summary of Changes

California Advancing and Innovating Medi-Cal (CalAIM)
Executive Summary and Summary of Changes

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that target social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services and puts the focus on improving outcomes for all Californians. Attaining such goals will have significant impact on individuals' health and quality of life, and through iterative system transformation, will ultimately reduce per-capita costs over time. DHCS intends to work with the Administration, Legislature and other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals. The "Summary of Changes" table at the end of this document summarizes major changes to the CalAIM proposal since its original release in October 2019.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations as well as state-level statutory and policy changes. During this time, the DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on their needs, some beneficiaries may access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental, developmental, In Home Supportive Services, etc.) in order to get their needs addressed. As one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate Medi-Cal our delivery systems and align funding, data reporting, quality, and infrastructure to mobilize and incentivize towards common goals.

Together these CalAIM proposals offer solutions designed to ensure the stability of Medi-Cal program and allows the critical successes of waiver demonstrations such as the Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and public hospital system delivery transformation, that advance the coordination and delivery of high-quality care for all Medi-Cal enrollees.

Our vision is that people served by our programs should have longer, healthier and happier lives. There will be a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It will be an integrated “wellness” system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

The whole system, person centered approach will be equitable. Services and supports will deliver the same high quality of care, and achieve more equal health outcomes across the entire continuum of care, for all. It will improve the physical, behavioral, developmental, oral and long term services and supports, throughout their lives, from birth to a dignified end of life.

When people need support, care or treatment they will be able to access a range of services which are made seamless, and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique need and what matters to them, as well as quality and safety outcomes.

To do this, we must change expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and systemic racism. We must make system changes necessary to close the gap in transitions between delivery systems, create opportunities for appropriate step-down care, and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles of the CalAIM initiative:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

Key Goals

To achieve such principles, CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Identify and Manage Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the state's health care delivery system aimed at achieving better care and better health. In line with these objectives, DHCS is proposing reforms would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care, as well as chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve such goals, DHCS proposes the following whole system, person centered approach

that focuses on addressing the needs of beneficiaries across the system with the overarching goal of improving quality of life and health.

- Development of a statewide **population health management strategy** and require plans to submit local population health management plans.
- Implement a new statewide **enhanced care management benefit**.
- Implement **in lieu of services** (e.g., housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement **incentive payments** to drive plans and providers to invest in the necessary infrastructure, build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness (SMI) /Serious Emotional Disturbance (SED) demonstration opportunity**.
- Require screening and enrollment for Medi-Cal **prior to release from county jail.**
- **Pilot full integration** of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for **foster care children and youth**.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a patient-centered population health strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall include, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care Pilots, and transitions those pilots to this new statewide managed care benefit to provide a broader platform to build on positive outcomes from those programs.

Proposed target populations include:

- Children or youth with complex physical, behavioral, developmental and oral health needs (e.g., California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under California's Whole Person Care Pilots, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with care management for members at high levels of risk and may fill gaps in state plan benefits to address medical or social determinants of health. The current list of in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services

- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for plans and optional for beneficiaries, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building incremental change to achieve integrated managed long-term services and supports (MLTSS) in the managed care program by 2027 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the state must use its ability to provide Medi-Cal managed care plans with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

SMI/SED Demonstration Opportunity

With some exceptions, federal Medicaid funding cannot be used to pay for services provided to a Medicaid beneficiary while the beneficiary is residing in an Institutional for Mental Disease (IMD). This is referred to as the IMD exclusion. Generally, an IMD is a hospital, nursing home or other institution with more than 16 beds that is primarily engaged in treating persons with mental diseases. However, the federal government has developed an opportunity for states to seek the ability to receive federal funding for institutional services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the flexibility the state has secured for the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. DHCS proposes to assess county interest in pursuing the SMI/SED demonstration opportunity, as long as our systems are positioned to achieve the required goals and outcomes, including building out a full continuum of care to offer beneficiaries community-based care in the least restrictive setting. Counties would voluntarily "opt-in" to participate. The main elements of the proposed SMI/SED demonstration opportunity would include:

- Ensuring quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community-based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this waiver opportunity, counties that "opt in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail or county juvenile facilities, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs, such as housing, transportation and overall integration back into the community are met. Studies have shown these types of coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate the county inmate pre-release Medi-Cal application process by January 2023. Additionally, DHCS proposes mandating that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal managed care plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected plans would not go live no sooner than 2027.

Develop a Long-Term Plan for Foster Care

In June 2020, DHCS launched the Foster Care Model of Care Workgroup to provide an opportunity for stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. The workgroup will complete its work in June 2021. Based on input from the workgroup, DHCS and the California Department of Social Services (CDSS) will develop a plan of action, which may involve budget recommendations, waiver amendments, state plan changes or other activities.

Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services vary depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and aligning delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental, and other county-based services.

To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long-term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance (NCQA) accredited
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Medical necessity criteria
- Administrative behavioral health integration statewide
- Regional contracting
- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle for young children (0 to 6 years of age) and Silver Diamine Fluoride for young children (0 to 6 years of age) and specified high-risk and institutional populations, as described in detail below.
- Pay for Performance for two adult and 11 children preventive services codes and continuity of care through a Dental Home

County-Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contact and demographic information

Managed Care

Managed Care Enrollment

DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and requiring all full- and partial-benefit dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. The one exception is for those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

Standardize Managed Care Benefit

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

Transition to Statewide Managed Long-Term Services and Supports

To achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative (CCI) to standardized mandatory enrollment of dual eligibles into managed care. The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs). This will be done in phases:

January 2022: The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care. DHCS will also implement voluntary in lieu of services at this time.

January 2023: Full transition to mandatory enrollment of dual eligibles into managed care. Further, all dual and non-dual fee-for-service Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023. In addition, Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.

January 2025: Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.

The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and

are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps to continue to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS. We recognize that we need to improve quality of and access to care for children and other vulnerable populations. In order to achieve true system transformation, DHCS is committed to first achieving behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation efforts and engage in value-based payment arrangements with their health plan partners to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to advance a high-quality continuum of care for mental health and SUD services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and SUD services. DHCS is proposing to update behavioral health medical necessity criteria to more clearly delineate and standardize requirements and to improve access for beneficiaries to appropriate services statewide.

Administrative Behavioral Health Integration

Approximately half of individuals with a serious mental illness (SMI) have co-occurring substance use and those individuals would benefit from integrated treatment. The state covers Medi-Cal SUD and specialty mental health services through separate county contracts, which makes it difficult for counties and contracted providers to offer integrated treatment to individuals with co-occurring disorders. For example, counties are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, providers offering integrated treatment to a Medi-Cal beneficiary must document SUD treatment services separately from specialty mental health services. The purpose of this proposal is to streamline the administrative functions for SUD and specialty mental health services.

Behavioral Health Regional Contracting

Small counties could optimize resources through regional administration and delivery of specialty mental health and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to provide services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the local Medi-Cal managed care plan or County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS encourages counties to join the Drug Medi-Cal Organized Delivery System (DMC-ODS) or provide DMC services through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

DMC-ODS Program Renewal and Policy Improvements

DHCS proposes to update the DMC-ODS program based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.

Dental

The Department set an initial goal to achieve at least a 60 percent dental utilization rate for

eligible Medi-Cal children. To continue progress toward achieving this goal, and based on lessons learned from the Dental Transformation Initiative (DTI), DHCS proposes the following statewide reforms for Medi-Cal dental coverage:

- Add new dental benefits based on the outcomes and successes from the DTI that will provide better care and align with national oral health standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high-risk and institutional populations; and

- Continue and expand Pay for Performance Initiatives initiated under the DTI that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult Medi-Cal enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS remains compliant with federal and state eligibility and enrollment requirements. These enhancements will be developed and implemented in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 children in Medi-Cal. The state delegates certain responsibilities for these high-risk children to California's 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach). The state needs to enhance the oversight of counties to ensure they comply with applicable state and federal requirements. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the state and counties, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which beneficiary contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

Advancing Key Priorities

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other -- without one, the others are neither possible nor powerful.

These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value-based and integrated delivery of care are significantly harder and potentially impossible to achieve.

These fundamental financing changes would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots) is critically dependent on the success of others.

The Medi-Cal program has evolved over the multiple decades since inception with ever-increasing system and fiscal complexities. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be more effective and efficient with the finite funding available for the program.

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medi-Cal can easily integrate, complement and catalyze the Administration’s plan to respond to the state’s homelessness crisis, support reforms of our justice systems for youth and adults who have significant health issues, build a platform for vastly more integrated systems of care, and move toward a level of standardization and streamlined administration required as we explores single payer principles through the Healthy California for All Commission.

Furthermore, CalAIM will translate a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for children, proliferating the use of value-based payments across our system, including in behavioral health and long-term care into the future of the program. CalAIM will also

support the ongoing need to increase oversight and monitoring of all county-based services, including specialty mental health and substance use disorder services, Medi-Cal eligibility administration, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if approved and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal. This will ensure the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal and in Medicaid nationally. CalAIM proposes enhanced care management and in lieu of services (such as housing-related services, transitions, respite and sobering centers) that address the clinical and non-clinical needs of these high-cost Medi-Cal beneficiaries. The initiative envisions a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services. It aligns the financing of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, and access to, integrated behavioral health care.

Vulnerable Children: CalAIM is designed to improve and streamline care for medically complex children to ensure they get their physical, behavioral, developmental and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children, including identifying the complex impacts of trauma, toxic stress and adverse childhood experiences by, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to the clinically-linked housing continuum for our homeless population, and would include housing transitions/navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.

Justice-Involved: The proposed Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health and non-clinical social services for justice-involved individuals prior to and upon release from county jails and county juvenile facilities. These efforts will support scaling of diversion and re-entry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for those who are incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services, carving in long-term care statewide, mandatory Medi-Cal managed care enrollment, and aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans would allow the state to build infrastructure over time to provide MLTSS statewide by 2027. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of California's Master Plan for Aging.

From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package in an attempt to achieve better alignment across the system. While Medicaid Section 1115 authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating the required budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

In addition, given that California has significant learnings from our past Section 1115 demonstrations, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for delivery system authorities in the Medi-Cal program.

This proposal outlines all elements of the Medi-Cal 2020 waiver and how they will, or will not, be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or ability to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of managed care delivery system.

In March 2020, as COVID-19 community spread accelerated, the State of California moved quickly to stem the spread by enacting one the nation's earliest stay-at-home orders. This stay-at-home order was accompanied by suspension of non-essential medical procedures, transition to telehealth for many services, transition to telework for administrative staff, and reprioritization of health care resources and training, including infection control measures, to address COVID. While the stay-at-home order and related delivery system changes slowed the spread of the virus, these changes caused significant disruption to the overall health care delivery system, and the economy, in California

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g., counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers and other partners are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 Section 1115 waiver.

In recognition, the Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. This confluence of events prevented the state from moving ahead with the negotiation and implementation of CalAIM with a January 1, 2021 start. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost-effectiveness, of the Medi-Cal/Medicaid program.

CalAIM Stakeholder Engagement

DHCS' released the original CalAIM proposal in October 2019 ahead of an intensive four-month stakeholder engagement process. Between November 2019 and February 2020, five topic-specific workgroups comprised of stakeholders across the state participated in a series of robust in-person meetings. During these discussions, Workgroup members provided real-time feedback on the proposals as they evolved and offered helpful considerations with respect to implementation and operations. The public also had the opportunity to provide feedback on the proposals, both during the workgroup sessions and in writing. This iteration of the CalAIM

proposal incorporates the broad range of feedback received during the stakeholder engagement process. It should be noted that this resulting proposal is dependent on the funding availability through the state budget process, and federal approvals.

Conclusion

CalAIM is an ambitious but necessary proposal to positively affect Medi-Cal beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, and ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.
- Creates a fundamental shift in how California organizes and administers specialty mental health and SUD services, and aligns the financing of behavioral health with physical health, providing financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care.
- Ensures medically complex children and adults get their physical, behavioral, developmental, and oral health needs met.
- Builds capacity in a clinically -linked housing continuum via in lieu of services for California's homeless population, including housing transitions navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions and day habilitation programs.
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail and county juvenile facilities.
- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the State's Master Plan for Aging.

Summary of Changes from Original Release in October 2019

	Proposal	Key Changes
Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health		

2.1	Population Health Management	• Implementation delayed until 1/1/23
		• Adds requirements and clarifications:
		  ○ Managed care plans must partner with community-based providers to address members' needs.
		  ○ Clarification that population health management strategies should be developed in coordination with both county behavioral health and public health departments.
		• Assessment of Risk and Need
		  ○ This section underwent substantial edits based on stakeholder feedback. Detail was added on data collection expectations, risk stratification and segmentation, risk tiering, and development of the IRA tool. Predictive algorithms will incorporate the population needs assessment and the NCQA requirements to identify rising risks and communities.
		• Adds planned learning collaborative topics and continuing areas of policy development.
		• Review main document for additional changes, including an update to population health management strategy requirements based on workgroup feedback.

2.2	Enhanced Care Management	• Enhanced care management will be implemented using a phased-in approach.
		  ○ 1/1/22: Medi-Cal managed care plans in counties with Whole Person Care pilots and/or and Health Homes Programs (HHP) will transition aligning target populations on 1/1/22;
		  ○ 7/1/22:
		  ▪ Medi-Cal managed care plans in counties with WPC and/or HHP will implement additional mandatory target populations
		  ▪ Medi-Cal managed care plans in counties without WPC or

	Proposal	Key Changes
		HHP will begin implementation of mandatory target populations ○ 1/1/23: Full implementation of all target populations in all counties. • Appendix I, describing the enhanced care management benefit, its core concepts, and each target population in detail was developed and finalized based on workgroup feedback and added to the document. The descriptions include the target population descriptions and the services included in the benefit specific to each population. • Clarifies that Local Government Agency Targeted Case Management (TCM) will continue (pending CMS approval). It will be the responsibility of managed care plans to ensure services are not being duplicated. • Clarifies that managed care plans will be required to contract with Health Homes community-based care management entities and Whole Person Care providers. • Changes name of Transition Plan to "Transition and Coordination Plan" and added details around timeline and requirements for the plan and the required Model of Care.
2.3	In Lieu of Services	• Implementation delayed until January 1, 2022. • The ILOS menu was revised extensively based on workgroup feedback. Most notably, a 14th service, Asthma Remediation, was added. The menu is Appendix J of the CalAIM proposal and includes the following for each service: 1) description, 2) eligibility, 3) restrictions and limitations, 4) allowable providers, and 5) state plan services to be avoided.
2.4	Shared Risks, Savings and Incentive Payments	• Updated timeline: ○ 2021: Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input. ○ 1/1/22: Begin implementation of managed care plan incentives. ○ No sooner than 1/1/23: Begin implementation of a seniors and persons with disabilities/long-term care blended rate. • Clarifies that the tiered model would be available for three calendar years -- 2023, 2024 and 2025. • Clarifies that a prospective model of shared savings/risk incorporated

	Proposal	Key Changes
		via capitation rate development would be implemented beginning in calendar year 2026 once historical cost and utilization experience is available that would reflect the implementation of in lieu of services, long-term care services, and enhanced care management benefits statewide in managed care.
2.5	SMI/SED Demonstration Opportunity	• Clarifies the implementation timeline and confirms that DHCS will pursue this demonstration opportunity. The waiver proposal would be developed no sooner than 7/1/22, and if approved by CMS, DHCS would work with counties for an expected launch in 2023. • Updates the list of states that have submitted or have an approved 1115 waiver application to CMS. • Updates to the summary of key requirements for the Section 1115 demonstration opportunity.
2.5	Mandatory Medi-Cal Application Process Upon Release from Jail	• Implementation date change to 1/1/23.
2.6	Full Integration Pilots	• Implementation delayed to no sooner than January 2027 to allow sufficient time for planning & preparation, in partnership with counties, plans, and other key stakeholders.
2.7	Develop a Long-term Plan for Foster Care	• Adds details on the workgroup, which launched in June 2020 & will continue to meet until June 2021. DHCS & CDSS will then develop a comprehensive set of recommendations and plan of action based on input from the workgroup. • More information on the workgroup can be found here: https://www.dhcs.ca.gov/provgovpart/Pages/Foster-Care-Model-Workgroup.aspx
Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility		

3.1	Managed Care Benefit Standardization	• Clarifies and revises timeline for carved-out and carved-in benefits
		  ○ Benefits to be carved out:
		  ▪ 4/1/21: Pharmacy benefits or services by a pharmacy billed on a pharmacy claim
		  ▪ 1/1/22:
		  • Specialty mental health services for Kaiser Medi-Cal members in Solano and Sacramento

	Proposal	Key Changes
		Counties • Multipurpose Senior Services Program (MSSP) in the seven Coordinated Care Initiative (CCI) counties o Benefits to be carved-in ▪ 1/1/22: All major organ transplants ▪ 1/1/23: Institutional long-term care services o 1/1/23 ▪ All Medi-Cal managed care plans provide the same benefit package. • See Appendix F for more details
3.2	Mandatory Managed Care Enrollment	• Implementation date moved to 1/1/22. o Transition to mandatory enrollment of all non-dual eligible beneficiaries that are not currently required to enroll in managed care. • 1/1/23:Transition to mandatory enrollment of dual eligibles into managed care
3.3	Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans	• Implementation moved to 1/1/27 to align with demonstration renewal periods. • Clarifies the definition of a non-dual, partial dual, and full-dual eligible population. • Clarifies that all dual and non-dual eligible individuals eligible for long-term care services, including long-term care share of cost populations, will transition to Medi-Cal managed care in 2023 (except those already in managed care in COHS and CCI counties). • Per new federal regulations, updated section around limiting Medicare Advantage D-SNP "look-alikes." CMS will not enter into new contracts with look-alikes starting in 2022 and will not renew contracts with look-alikes starting in 2023. DHCS will allow plans in CCI counties with MCP contracts, existing D-SNPs, and existing Medicare Advantage D-SNP look-alikes to transition their dual population enrolled in the look-alike into an existing D-SNP in 2022, prior to the end of CCI. • Clarifies that DHCS will require D-SNPs to use a model of care that supports coordinated care, high-quality care transitions, and information sharing.

	Proposal	Key Changes
		• Adds information on LTC carve-in and intersection with mandatory managed care for dual populations with LTC.
3.4	NCQA Accreditation of Medi-Cal Managed Care Plans	• Accreditation will be required by 2026. • Clarifies that DHCS will not accept accreditation from agencies besides NCQA. • DHCS will require a Long Term Services and Supports (LTSS) Distinction Survey by 2027 ○ The survey will only be required after all MCPs have achieved routine health plan accreditation. • DHCS will not yet require the Medicaid Module but may in the future. • DHCS will not require managed care plans to ensure their non-health plan sub-contractors are NCQA accredited, but may in the future. • Accreditation elements that are selected for potential deeming will be vetted with stakeholders before any final decisions are made.
3.5	Regional Managed Care Capitation Rates	• All implementation timelines moved back a year beginning on 1/1/22. See proposal for more details.
3.6	Behavioral Health Payment Reform	• Earliest start date moved to July 1, 2022. • Adds a proposal to transition from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code exists. If a suitable CPT code does not exist, DHCS would identify an appropriate HCPCS Level II code. • Clarifies transition from HCPCS Level II coding to CPT coding for specialty mental health services and SUD services. • Clarifies the rate setting methodology establishing reimbursement rates based on peer grouping. Rates would include a service component as well as an administrative component and a utilization management/quality assurance component, which would be percentages on top of the service component. • Added a bullet to rational "Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value"
3.7	Medical Necessity Criteria	• Implementation moved to 1/1/22. • Based on extensive stakeholder feedback, this proposal required a full

	Proposal	Key Changes
		re-write. • Proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met. • Proposes to clarify EPSDT protections for beneficiaries under age 21 and create criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness. • Proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed are or fee for service system. • Proposes to develop a standardized transition tool, for when a beneficiary's condition changes, and they would be better served in the other delivery system. • Proposes to implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. • Proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout. • Proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations.
3.8	Administrative Integration of Specialty Mental Health and SUD Services	• DHCS's goal is to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver, effective 2027. • Clarifies the distinction between behavioral health administrative integration and the Full Integration Plan. • Revises "cultural competence plan" to "culturally responsive care".
3.9	Behavioral Health Regional Contracting	• No substantial changes.

	Proposal	Key Changes
3.10	Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements	• Clarifies the timeline, delineating components included in the 12-month extension request (tentative effective date of 1/1/21, if approved) vs. remaining proposals that would go into effect 1/1/22. If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022-December 31, 2026. • Terminology changed from "Substance Use Disorder Managed Care" back to "DMC-ODS" throughout the document to reflect the reversion to the original program name. • Minor update to the background, noting that there are now 37 counties participating in the DMC-ODS. • Announces that DHCS intends to provide non-DMC-ODS counties another opportunity to opt-in. • Notes that the request to remove the number of residential treatment episodes that can be reimbursed in a one-year period was submitted with the 12-month extension request. • Notes that proposed clarifications to recovery services, additional MAT, and tribal services were submitted with the 12-month extension request. • Changes "physician consultation services" to "clinician consultation services" and proposes clarifications related to billing. • Proposes new clarifications related to medical necessity for NTPs • Proposes adding ASAM 0.5 for beneficiaries under 21.
3.11	New Dental Benefits and Pay for Performance	• Implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration. • Clarifies that expanded initiatives would be available statewide for children and adult enrollees. • Adds preventative services codes for children and adults • Specifies coverage of Silver Diamine Fluoride for children ages 0-6 years and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include adults living in a Skilled Nursing Facility/Intermediate Care Facility. • Adds maximum of four treatments per tooth.

	Proposal	Key Changes
		• Proposes providing an annual flat rate performance payment to a dental service office location that maintains dental continuity of care by establishing a dental home for each patient and perform at least one annual dental exam/evaluation (D0120/D0150/D0145) for two or more years in a row. • Adds Appendix G: Dental in Proposition 56 vs. CalAIM
3.12	Enhancing County Eligibility Oversight and Monitoring	• Revised implementation timeline with initial work beginning 6/1/21 • Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected in this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.
3.13	Enhancing County Oversight and Monitoring: CCS and CHDP	• Minor changes to the implementation timeline. Phase I began in August 2020.
3.14	Improving Beneficiary Contact and Demographic Information	• DHCS will engage with partners in 2022-2023.

DATE: May 26, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: 2018-2020 Strategic Planning Final Report

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

Background. In 2017, three significant factors motivated Central California Alliance for Health (the Alliance) to take a new approach to strategic planning. These included a need for focus after the rapid growth and development required by the Affordable Care Act (ACA), the potential impacts of then pending challenges to the ACA Medicaid Expansion, and the retirement of the health plan's first CEO. The Board and staff sought to ensure organizational alignment and clarity through a period of great transition.

In response, staff and the Board developed a three-year strategic plan for 2018-2020, adopted by the Board in October 2017. The Board envisioned the strategic plan as a roadmap to improve member health outcomes, provide excellent core health plan services and position the organization as a leader in the health care environment.

The 2018-2020 Strategic Plan prioritized: 1) Access to Care; 2) Member Wellness; and 3) Promotion of Value. The strategic plan included nine strategies to advance the priorities. The plan also identified three "building blocks" intended to strengthen organizational capacity. See Exhibit A for details on the Strategic Plan priorities and strategies. The Board also approved a set of outcomes to be used to measure progress under the strategic plan. Each year, staff developed an annual plan of tactics to be executed to advance the strategic priorities and outcomes.

This memo summarizes final progress towards the Alliance's 2018-2020 strategic priorities and outcomes and highlights key tactics. This report also identifies staff's key learnings from executing the 2018-2020 strategic plan, which have informed the current 2022 and beyond strategic planning process. Final performance on the strategic plan outcomes is available as Exhibit B to this report. A list of key tactics influencing the strategic plan outcomes is available as Exhibit C to this report.

Summary of Final Result. Review of the final performance across the strategic plan outcomes demonstrates that execution of the strategic plan achieved the Board's vision of improving health outcomes, providing excellent core health plan services and demonstrating leadership. Measurable progress was made in the priorities of Access to Care, Member Wellness and Promotion of Value and the Alliance's organizational capacity was improved. Between 2018 and 2020, the Alliance accomplished significant operational improvements and executed a wide range of tactics in support of the strategies outlined in the strategic plan.

Access to Care was improved as indicated by an increase in members reporting that they always or usually get care quickly and a decrease in avoidable Emergency Department (ED) use. Key tactics influencing these results included the implementation of a nurse advise line, increased access to urgent care, use of an annual network access plan, and improved access to telehealth. Work remains in improving behavioral health access.

Member Wellness was improved as indicated by increased rates of preventative exams for children and improved performance in chronic disease management indicators. Key tactics influencing these results included improvements made to member onboarding and the development of grant programs increasing access to healthy food.

Value was promoted through a decrease in opioid prescriptions, and the operation and evaluation of pilot programs for Post-Discharge Meal Delivery (PDMDP), ED Navigation, and Intensive Case Management. Most notably, the PDMDP demonstrated value and was approved as an Alliance benefit starting in 2021. Some progress was made in improved care coordination for members transitioning out of an inpatient setting. However, improvement remains to reduce 30-day readmissions, which is an area of focus for both the hospital shared savings program and CBI.

A focus on Building Blocks strengthened Alliance workforce, data analytics and core processes. Key accomplishments in this area included the implementation of the Business Intelligence (BI) software, establishment of data governance, implementation of business process architecture, process management and process improvement, and development of a more robust Communications Department. In addition, enhanced financial reporting and forecasting was developed for the Alliance's Board and a Cost Containment Plan was developed to yield improved financial performance. The Alliance's operational strength was demonstrated by the pivot to a full-time remote work environment in response to the COVID-19 pandemic with continued success in meeting operational metrics. Opportunities remain to increase member engagement, data analytics and data sharing to support Medi-Cal delivery system transformation in the future.

Key Learnings. As noted above, the 2018-2020 Strategic Plan was key to ensuring organizational performance through the significant transitions that were underway in late 2017. The plan was intended to ensure alignment and clarity for the organization, and it served this purpose well. As noted above, this focus on organizational alignment and goals also served the organization well through the COVID-19 pandemic.

Between 2018 and 2020, staff identified opportunities to improve organizational strategy execution. These included a focus on fewer priorities to increase impact, outcome measures which can be reported more timely, increased staff engagement, and integrated execution planning. The focus of and measurement of the plan are key considerations through the current 2022+ planning process. Staff engagement in, and improved execution of the plan have been addressed through improved integrated organizational planning implemented in 2020. Staff will monitor efficacy of these improvements over the course of the execution of the 2022 plan.

Exhibit A: Details of 2018-2020 Strategic Plan

2018-2020 Strategic Plan

Vision

The 2018–2020 Strategic Plan serves as the Alliance's roadmap to improve member health outcomes, provide excellent core health plan services, and position the organization as a leader in the health care environment.

Strategic Priorities

The Alliance identified the following three strategic priorities and related strategies to focus on over the next three years.

Access to Care

Use innovation to expand member access to care and maximize provider networks.

STRATEGIES			
	Provider Workforce Investments Expand programs and partnerships to maintain and build the provider workforce.	**Technology-based Solutions** Utilize new technology-enabled tools to expand member access to care.	**Right Care, Right Place, Right Time** Increase access to timely and coordinated care in innovative ways that align with the medical home model.

Member Wellness

Support prevention and wellness by promoting member engagement and partnering to address the social determinants of health.

STRATEGIES			
	Member Activation Expand education resources and programs to support members in managing their health.	**Prevention and Wellness Programs** Collaborate with providers and community agencies to design interventions that promote positive health behaviors.	**Partnerships to Address Social Determinants of Health** Build partnerships and identify opportunities to address the social and environmental factors that impact wellness.

Promotion of Value

Improve health outcomes and reduce cost of care through creative contracts and programs.

STRATEGIES			
	Value-based Payment Develop and assess new contracting, risk and incentive arrangements that promote better health outcomes and expand access.	**Programs to Serve Members with Complex Needs** Implement programs and partnerships to serve members with complex needs, including adult high-users and children with special needs.	**Communication** Effectively communicate with stakeholders about strategic priorities, programs and investments.

Building Blocks

The Alliance will focus on three building blocks as the foundation to achieve the strategic priorities and position the organization to execute the strategic plan. They include the Alliance's workforce, technology systems, and core business processes.

Alliance Workforce	Data Analytics and Information Exchange	Core Business Processes
Attract and retain a skilled, mission-driven, and motivated workforce in a competitive and evolving marketplace.	Build Alliance data reporting, analytics, forecasting, and information exchange capabilities.	Deliberate and continuous quality improvement to optimize effectiveness in meeting core health plan operations, executing the strategic plan, and responding to changes in health care delivery, financing, and policy.

Exhibit B: Table of Strategic Outcomes and Final Result

Indicator (*= Final result available May 2021)	2020 Strategic Plan Goal	2017 CCAH Performance/Baseline	2020 Result
ACCESS TO CARE			
Avoidable emergency department visits.*	-20% in AED to 14.86%	17.86% (2017)	11%
Members indicating, they are usually or always able to get care quickly.	5% in member report care quickly to A: 81.7%, C: 86.6%.	Adult - 76.7% Child - 81.6%	Adult - 80.3% Child - 86.8% (CAHPS 2020)
MEMBER WELLNESS			
Percentage of new members receiving an Initial Health Assessment within 120 days of enrollment.*	Increase IHA compliance to 46.76%.	39.26% (2017) Aggregate of all counties	41.54%
Child members that have at least one well-child visit within the last 12 months. (W34)	5 point increase to 81.40%.	76.40% (HEDIS 2017)	81.84% (HEDIS 2020)
Adolescent members that have at least one well-adolescent visit within the last 12 months. (CAP 12-19)	5 point increase to 93.59%.	88.59% (HEDIS 2017)	92.43% (HEDIS 2020)
Diabetes Care – HbA1c <8.0% Good Control. (CDC-H8)	5 point increase in HEDIS result 52.08%.	47.08% (HEDIS 2017)	52.74% (HEDIS 2020)
Controlled Blood Pressure. (CBP)	5 point increase in HEDIS to 58.28.	53.28% (HEDIS 2017)	62.05% (HEDIS 2020)
Asthma Control. (AMR)	5 point increase in HEDIS to 72.04%.	67.04% (HEDIS 2017)	68.23% (HEDIS 2020)
PROMOTION OF VALUE			
Achieve break-even financial performance.	Medical Loss Ratio = 92.0-93.0% Administrative Loss Ratio = 6.0-6.5% Operating Income = 0.5-2.0%	N/A	96.70% 6.50% -3.20%
30-day re-admissions rate.*	-10% in readmits to 12.14 %	13.49% (2017)	14.60%
Number of opioid prescriptions per 1,000 members per year.*	- 50 % in opioid Rx PM/PY to 153.1.	306.2 (2017)	159.2
Program Implementations: HEAL (PDMDP PHFA), ICM, EDN, communications.	Complete activity.	None.	Complete.

Exhibit C: List of Key Organizational Tactics Influencing Strategic Plan Outcomes

Access to Care
- Implemented Nurse Advice Line
- Piloted ED Navigation and evaluated ROI.
- Evaluated telehealth and expanded offerings.
- Developed and deployed annual network access plan.
- Re-envisioned and improved clinical joint operating committee meetings with large volume primary care providers.

Member Wellness
- Piloted and evaluated post-discharge meal delivery.
- Expanded member onboarding and developed member pathways to inform member engagement activities.
- Awarded grants to support health care and community-based organizations partnering to address food insecurity.
- Awarded grants to support members immediate needs during the COVID-19 pandemic.

Promotion of Value
- Piloted and evaluated Intensive Case Management.
- Enhanced Alliance communications.

Building Blocks
- Implemented annual planning process that aligns strategic and operational planning and execution.
- Implemented business process development and operational improvement.
- Assessed and implemented flexible scheduling.
- Acquired and implemented Business Intelligence software (BI Tool) to support clinical initiatives.
- Implemented process architecture and revised organizational operational dashboard.
- Implemented quarterly Leadership Forum to improve management communication and develop leadership skills.
- Successfully transitioned staff to remote working at outset of pandemic while maintaining core operational performance.
- Implemented enterprise data governance.
- Developed Cost Containment Plan and initiated execution.

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

Attachments. N/A

DATE: May 26, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Santa Cruz-Monterey-Merced Managed Medical Care Commission Retreat

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Recommendation. Staff recommend the Board consider and discuss the proposed retreat agenda.

Background. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Board) holds its face-to-face retreat annually to strengthen relationships across the Commissioners, discuss Plan priorities and performance, and set the stage for strategic efforts.

Discussion. The all-day, in-person Board retreat is scheduled for June 23, 2021 in Scotts Valley, California. The retreat will be held at the Alliance's offices with limited in-person attendance to support social distancing and promote staff and attendee safety. Refreshments and a catered lunch will be provided.

Staff will discuss proposed topics and speakers for the June retreat to support finalizing the June retreat agenda. Note that the June agenda will include routine business as well as strategic priorities and goals.

In order to comply with pandemic precautions and to ensure public safety, members of the public are encouraged to not attend the meeting in person. Alternatives will be available in the June agenda packet for individuals to view the meeting and to provide comment to the Board. Attendees will take necessary precautions during the meeting by wearing face coverings and practicing social distancing. Should the pandemic preclude an in-person meeting, the retreat will be held by teleconference with an amended agenda.

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

Attachments. N/A

Information Items: (16A. – 16E.)

DATE: May 26, 2021

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Alliance in the News

Dientes Community Dental Care restarts outreach

Alliance in the News
The Pajaronian
May 3, 2021

In the first months of the pandemic, Dientes Community Dental Care was forced to close its clinics throughout Santa Cruz County. The nonprofit organization, which aims to give people access to high-quality, affordable oral healthcare, had initially not been considered essential.

For more than two months they had to work with a skeleton crew, and only for emergency care. They lost revenue and were forced to lay off and furlough employees.

Thankfully, Dientes was eventually allowed to reopen in Summer 2020. They were approved for the second round of the Paycheck Protection Program, and as of now are back to about 90% of services they had pre-Covid.

"We've seen an amazing outpouring of support from our community," said Sheree Storm, Chief Development Officer for Dientes. "It's been a tough year for everyone. But we are super happy to be back—serving patients all over the county."

Dientes has also been able to restart its Outreach Days, which would normally be held at more than 30 locations across the county, including schools, juvenile hall and homeless shelters. Pop-up clinics are set up at the different sites, offering dental exams, X-rays, fluoride varnish, cleanings and sealants.

In addition, staff refers patients to one of the main clinics if they need additional treatments, such as for cavities.

Dientes worked closely with the County Office of Education to host two Outreach Days at Sequoia High School in Watsonville earlier this month, serving low-income students grades K-5 through pre-scheduled appointments.

"Going out to schools is so important because the kids, for many reasons, are not making it into the dentist," Storm said. "Usually it's about transportation. Parents just can't get them there, or they're working, or live far away without a car."

Another reason is cost. Dental care is expensive, and not often covered by health insurance. For instance, seniors on Medicare don't receive dental coverage and are often burdened by costly procedures. This could be prevented, Storm said, if only they had a good foundation of oral health to start with.

"Prevention is not just about treatment," she said. "You need to get kids early, to teach them better oral health habits… so they're not looking back and having the same problems that seniors now face."

The next Outreach Day is scheduled for May 8 in Santa Cruz, at Branciforte Small Schools Campus, 840 North Branciforte Ave. To make an appointment call 716-5926.

Dientes continues to work with dentists, educational institutions, and various organizations and agencies across the county and state, including Cabrillo College, First 5 Santa Cruz County, Salud Para La Gente and the Central California Alliance For Health. Together, they focus on campaigns to educate parents on the importance of oral health for their children, and help families better access quality services.

And soon Dientes will be able to expand their own services further. A new health and housing campus at 1500 Capitola Road will include a clinic for Dientes, a facility for Santa Cruz Community Health, along with 57 affordable housing units built by MidPen Housing.

The health facilities are expected to be completed by sometime in 2022, and the housing by 2023. Storm said they hope to break ground very soon.

"It's really exciting," she said. "We were expecting it to get going a year ago, but we had to pause due to Covid. Now we're really ready."

To learn more about the new facility, visit 1500capitolaroad.org.

Dental care, Storm said, is a vital part of healthcare that should be accessible to everyone.

"Your mouth is an internal part of your body," she said. "There is a direct relationship between oral and heart health. Oral health is linked to better pregnancy outcomes, to the ability to speak clearly. And it is so much about confidence, relationships with other people… Everyone deserves to have a healthy smile."

For information about Dientes Community Dental Care and to donate to the organization visit dientes.org

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Who is feeding the farmworkers? Esperanza Farms teaches Pajaro Valley families about healthy eating & living

Alliance in the News
Lookout Santa Cruz
April 24, 2021

Esperanza's two acres of farmland have become a means to not only address food insecurity, but also nourish the souls of families in need — and help them through a pandemic that has hit them disproportionately hard.

Mireya Gomez-Contreras spent much of her early life with her parents, working in the fields of the San Joaquin Valley and the Central Coast. "We picked everything from cherries to asparagus to melons, and bell peppers and grapes was our thing for the most part," she says.

She remembers in the mornings, her mom would carry her and her siblings to the car, still asleep. They would wake wherever the harvest was that day, covered in blankets, to find a

little fire and some coffee she had prepared for them. Then, when they were ready, they'd run to find her. "We'd go around, pick up wet dirt and make a hole in it, stick a flower in and give it to her," Gomez-Contreras says. "It was really fun, really good memories of just getting dirty, [of] dirty not being a bad word."

It wasn't all happy memories, though. Her parents would often come home covered in pesticides, warning her not to hug them until they had showered. When they were out in the fields, Gomez-Contreras remembers noticing everyone would get quiet, and turn their radios down, when they heard the landowner's truck approaching. When the truck would pass, "then they would become themselves again," she says.

Gomez-Contreras now has two children of her own, and the longtime Watsonville resident is the co-leader of Esperanza Community Farms, a non-profit with a mission to localize the food system and address inequality. Its two acres of farmland have become a means to not only address food insecurity, but also nourish the souls of farmworker families like the one in which she was raised, and help them through a pandemic that has hit them disproportionately hard.

Esperanza leases its farmland in Watsonville from the Land Trust of Santa Cruz County, and uses it to grow organic produce that it distributes to about 100 member families — for free — for around five months out of the year, usually between June November. Around 80% of the families work in agriculture, and 70% have been referred to the farm through the Watsonville Health Clinic because family members, usually children, are suffering from diseases like diabetes and obesity.

The farm's advisory council is made up of parents, farmworkers and others, all deeply rooted in the Pajaro Valley. Their input guides much of the work at Esperanza.

Many of the people the farm helps are agricultural workers themselves. But the food that they pick is often sold far away and, even if it isn't, is still not accessible price-wise, Gomez-Contreras says. Farmworkers are usually allowed to bring some food home, but it's not year-round, and it's all leftovers; a completely separate food system that can be less reliable and less diverse than wealthier families are offered at the grocery store.

A shoestring budget with a big impact

Esperanza Farms, in its current incarnation, receives most of its funding through a two-year, $196,000 grant from the Central California Alliance for Health. The farm was previously run at a smaller scale on private land in Corralitos, but since early 2020 has been located in Watsonville on Land Trust property. Gomez-Contreras started as a volunteer then became the co-leader in 2020 after the grant was awarded.

Esperanza has four paid employees who manage the farm and community programs. All of the staff have deep roots in agriculture. Hermelinda Vazquez, a Watsonville resident, used to work on farms in Mexico, but since moving to the U.S., she was mostly cleaning houses and working as a caretaker. She was a member and a volunteer at the farm until last year, and now she is on staff as the member engagement specialist.

"I love to work in the farm," she says. "I enjoy when the kids come, oh my God, I love that. This is the reason I want to work in Esperanza Farms."

Vasquez helps organize family events and activities, and says it's very important to get kids out to the farm so they can learn about vegetables while they're young and still curious.

In addition to providing produce, Vasquez and the rest of the team involve the community in educational activities, like gathering and sharing family recipes (like the ones below), or asking children to draw a family portrait with each family member represented as a vegetable.

Dr. Michele Violich, a physician at the Watsonville Health Clinic, was part of the grant application. Now her clinic refers families to the farm. They haven't gathered quantitative data yet, but anecdotally Violich thinks it is having an important impact.

"Diet, early on, could have major effects on children's lifetime health," Violich says. "But at the same time, [if] one is just in the clinic saying 'you should eat a lot of fruits and vegetables' — you can't tell people what to do. You have to help them make it happen."

Yenci Puega, a mother of two, was referred by the Watsonville Health Clinic and now receives produce from Esperanza, and says it has been a great learning experience for her and her kids. "We like it, they give us different vegetables, in different colors we didn't know [about] before," Puega says.

They recently tried purple carrots for the first time, and loved them.

The produce grown at the farm is chosen based on member input, and this, in addition to home delivery of the food, is key to the program's success, Violich says.

"It's hard to incorporate into your life going to pick something up, and not everyone has resources to do that," she says, and because the crops are things the members have asked for, "they're growing healthy foods that are more likely to be adopted into the diet of their clients."

COVID challenges and heightened need

The COVID-19 pandemic was disproportionately hard on Watsonville and the Pajaro Valley. Over half of all COVID-19 cases in Santa Cruz County were among Watsonville residents, though the city accounts for less than 19% of the total county population. Economic loss and food insecurity were similarly concentrated in this area. Puega lost her job as a caretaker, and she needed to be home to take care of her children while schools were closed. Food insecurity has always been an issue in the Pajaro Valley — and parts of the area are officially classified as food deserts — but the pandemic brought it to the forefront. "COVID spotlighted how much food insecurity there is in low income communities, and we know that we can't work our way out of food insecurity through food pantries and food banks," Gomez-Contreras says. "While that's a necessary and important immediate level resource, the longer term vision is something like this."

Violich says that for some patients, especially during the pandemic, Esperanza is important not only because it's healthy food, but because it's food, period.

Gomez-Contreras says she and the rest of the Esperanza team were in close communication with all their member families throughout the pandemic, and grew increasingly concerned about the compounding impacts of economic and food insecurity, and social isolation.

In late summer 2020, they were finally able to open the farm to about 21 families, by appointment for a U-pick event. "There was such joy," Gomez-Contreras says. "I just remember kind of the feeling of abundance and joy from watching the kids just go running through the fields and the corn and discovering the new bugs. And they hadn't

done that for months." Several parents told her they hadn't been out as a family for so long, and hadn't been somewhere outdoors with such a feeling of spaciousness and freedom.

In previous years, they would only hold two U-Pick events, but this year, after seeing the impact, they've decided to host four, and to involve more of their members as volunteers for the harvest.

"It was really, really impactful," Gomez-Contreras says. "We realized that even without the pandemic, just given the fact that we're working with marginalized communities and communities that are just constantly in motion, trying to make ends meet, the farm itself is literal space, that really fulfills and motivates people to just ... be in the moment."

New seasonal farmers market opens at Ramsay Park
Alliance in the News
Good Times Santa Cruz
April 22, 2021

The Pajaro Valley is a thriving agricultural hub, surrounded by farms and fields growing food for people all over the world.

But according to the Community Health Trust (CHT) of Pajaro Valley, certain areas of the region are still considered "food deserts," where people have limited access to healthy and affordable food.

This is despite the fact many live within a few yards of a farm, or work at one.

"We live in a very abundant area, surrounded by fresh, healthy produce," said DeAndre James, executive director for CHT, "but the truth is, many residents and families do not have easy access to these."

This is why the CHT, along with numerous sponsors and partners, decided to open a new farmers market in Watsonville. Located in the front parking lot of Ramsay Park, adjacent to the Family Center and across from Sotomayor Soccer Field, the El Mercado Farmers Market offers fresh produce, healthy prepared food and drinks, community resources and more. It will be open every Tuesday, 2-6pm, through Oct. 26.

Program Manager for El Mercado Annie Puckett said that the idea for the market came from talks between CHT and Second Harvest Food Bank in 2018. A joint council of the two organizations, called the Food, Farming and Health Policy Council, were looking for ways to improve the local food system and more easily provide healthy food to the community.

Puckett said that they originally planned to open the market last year but things were halted due to the pandemic. However, the delay did allow them to prepare better and make the weekly event as accessible and health-conscious as possible.

"It gave us more time to think carefully, work things out," Puckett said. "We are super excited to finally be opening things up."

The market will not only provide produce, but also make available health screenings and resources, and act as a redemption site for CHT's prescription food program, Veggie Rx. The program offers residents $20 vouchers to redeem at the market.

Once more Covid-19 restrictions are lifted, organizers hope to also hold live cooking demonstrations, giving people recipes and a chance to buy ingredients at nearby booths.

"We are a health and wellness organization, so it's imperative that we make sure the market is a safe, positive space for people to enjoy," said Nelly B. Otsu, marketing and communication manager for CHT. "Not only are they getting healthy food here, it's also giving them a place to be social in a safe way."

Watsonville City Councilman Francisco Estrada, who is also part of the development department at CHT, said that trying to identify a location for the market had at first been a challenge. They initially were looking to hold it in a parking lot across from the Watsonville Community Hospital. Then the city suggested Ramsay Park.

"After a few discussions, we realized this would be a perfect place," Estrada said

To put the market together, CHT and the city worked with Jesus Madrigal, manager of the Watsonville Farmers Market (held downtown every Friday). They also received a two-year grant from the Central California Alliance for Health (CCAH) to help support basic operations. Live Earth Farm and the Farm Discovery Program came on board as sponsors to supply produce for Veggie Rx.

As the market came alive Tuesday, residents wandered over and began purchasing produce from Rodriguez Farms and lining up for a baked potato at Ivan's Potatoes. Vendors like Monterey Bay Murals opened for business. CCAH offered guests health information, and a handful of nonprofits were also present.

Watsonville Wetlands Watch was one such organization, selling small potted plants and also offering free fruit and shade trees, which executive director Jonathan Pilch says is part of a new phase of the city's Urban Forest Revitalization Project.

Additional sponsors of El Mercado Farmers Market include Kaiser Permanente, Granite Construction Company, Lakeside Organic Gardens, Salud Para La Gente, Santa Cruz County Bank, California Giant Berry Company, Driscoll's and 99.9FM KDUB.

Estrada said as the Covid-19 situation improves, he hopes more and more people will come check out the market.

"It's pretty exciting. We really hope the community enjoys it," Estrada said.

For more information visit pvhealthtrust.org/elmercado.

New seasonal farmers market opens at Ramsay Park
Alliance in the News
The Pajaronian
April 21, 2021

WATSONVILLE—The Pajaro Valley is a thriving agricultural hub, surrounded by farms and fields growing food for people all over the world.

But according to the Community Health Trust (CHT) of Pajaro Valley, certain areas of the region are still considered "food deserts," where people have limited access to healthy and affordable food.

This is despite the fact many live within a few yards of a farm, or work at one.

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"It's pretty exciting. We really hope the community enjoys it," Estrada said.

For information visit pvhealthtrust.org/elmercado.

Merced County opens 'Navigation Center' to address homelessness

Alliance in the News
Westside Connect.com
April 15, 2021

Less than a year from its groundbreaking, Merced County's "Navigation Center", a critical component of the region's collaborative effort to address homelessness, opened in late March.

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

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

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

District 4 Supervisor Lloyd Pareira, who also serves on the Board of the Merced City and County Continuum of Care (CoC), highlighted the significance of this project as part of the continuum of services to address homelessness.

"The Navigation Center will not only address its participants' need for a safe space, bed, and meals, it also provides the opportunity to build relationships. Through these relationships, our goal is to engage homeless individuals with the necessary services to prepare and

transition them into stable housing," Pareira said. "This project is the result of many key partners, including Assemblyman Adam Gray, the CoC, the Central California Alliance for Health, the City of Merced, and others."

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

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

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

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

Referrals to the Navigation Center are made in close coordination with homeless outreach workers, local law enforcement, and Navigation Center staff. To make a referral, contact the countywide New Direction Outreach and Engagement Center by calling (209) 726-2700. Once a referral is made, an assigned outreach worker will contact, screen, and refer individuals to the appropriate housing and community services based on a standard assessment tool.

Alliance Fact Sheet
April 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 **371,573 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 Facts[2]

1996
Year Established

496
Number of Employees

$379.1M
YTD Revenue

5.5%
% Spent on Administration

Service Area:
Santa Cruz, Monterey and Merced counties

Membership by Program

Total Membership: **371,573**[3]

371, 057	516
Medi-Cal	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

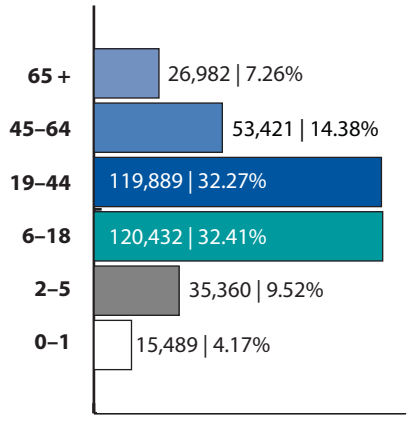
Our members represent 38 percent[1] of the population in Santa Cruz, Monterey and Merced counties. We serve seniors, persons and children with disabilities, low-income mothers and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly 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 11,576 providers to form our provider network, with 86.79 percent of primary care physicians and 84.17 percent of specialists within our service area contracted to provide services to our members.

Membership by Age Group



HEALTHY PEOPLE. HEALTHY COMMUNITIES.

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
- **Leslie Conner,** Executive Director, Santa Cruz Community Health Centers – Alliance Board Chairperson
- **Supervisor Ryan Coonerty,** County of Santa Cruz
- **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
- **Dori Rose Inda, CEO,** Salud Para La Gente
- **Elsa Jimenez,** Director of Health, Monterey County Health Department - Alliance Board Vice Chairperson
- **Shebreh Kalantari-Johnson,** Public Representative
- **Michael Molesky,** Public Representative
- **Rebecca Nanyonjo,** Director of Public Health, Merced County, Department of Public Health
- **Supervisor Josh Pedrozo,** County of Merced
- **Elsa Quezada,** Public Representative
- **James Rabago,** MD, Merced Faculty Associates Medical Group
- **Allen Radner,** MD, Salinas Valley Memorial Healthcare System
- **Joerg Schuller,** MD, Vice President Medical Affairs, Mercy Medical Center
- **Rob Smith,** Public Representative
- **Tony Weber,** Chief Executive Officer,

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

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.

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

Membership percentage by county: Santa Cruz (27 percent); Monterey (45 percent); Merced (48 percent).

[2]Fact sheet data as of April 1, 2021.

[3]Fact sheet data as of April 1, 2021.

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

April 28, 2021

The Honorable Joaquin Arambula
State Capitol
P.O. Box 942849
Sacramento, CA 94249-0031

RE: AB 4 - SUPPORT

Dear Assembly Member Arambula:

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 370,000 residents of Santa Cruz, Monterey and Merced counties, I am writing to express the Alliance's support for AB 4 which would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, regardless of immigration status.

AB 4 would ensure that all Californians have access to comprehensive, accessible, affordable health care coverage regardless of citizenship status allowing, individuals to live healthier lives. AB 4 will also provide opportunities for health care cost savings through access to medical care at the right time and in the right setting rather than forcing individuals to use costly emergency services as a last resort.

The Affordable Care Act (ACA) expanded coverage to millions of Californians through Covered California and expanded Medi-Cal coverage. Still, too many Californians remain uninsured and ineligible for coverage due to immigration status. Providing coverage for all ensures that individuals have access to preventive and primary care when needed. Early access to primary and preventive care reduces emergency room use and prevents serious illness, which leads to increased costs to the health care system.

The Alliance's tri-county population includes a high percentage of undocumented residents who are an important part of our regional economy. For these reasons, the Alliance is pleased to support AB 4.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

1600 Green Hills Road, Ste. 101
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950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

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

April 28, 2021

The Honorable Anna Caballero
State Capitol, Room 5052
Sacramento, CA 95814

RE: SB 365 – SUPPORT

Dear Senator Caballero:

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 370,000 residents of Santa Cruz, Monterey and Merced counties, I am writing to express the Alliance's support for SB 365 which would expand access to care through e-consult services, including e-consult services provided through federally qualified health centers (FQHCs) and rural health clinics (RHCs) .

The Department of Health Care Services' (DHCS) existing telehealth policy allows for reimbursement for e-consult services delivered by consultant providers, usually specialists. However, reimbursement is not authorized for e-consults provided by requesting or treating providers, usually primary care providers. In addition, FQHCs and RHCs are prohibited from receiving reimbursement for e-consult services rendered by their providers.

FQHCs and RHCs are essential network providers for Medi-Cal managed care plans, like the Alliance. The Alliance works together with our safety-net providers to increase access to care and improve Medi-Cal beneficiaries' overall care experience. SB 365 would ensure FQHCs and RHCs would receive reimbursement for e-consult services provided, thus increase access to care for members utilizing these critical safety-net providers.

SB 356 would ensure coverage of e-consults under Medi-Cal for primary care providers and would permit coverage of e-consult services provided by FQHCs/RHCs. For these reasons, the Alliance is pleased to support SB 365.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

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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

April 28, 2021

The Honorable María Elena Durazo
State Capitol, Room 5066
Sacramento, CA 95814

RE: SB 56 – SUPPORT

Dear Senator Durazo:

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 370,000 residents of Santa Cruz, Monterey and Merced counties, I am writing to express the Alliance's support for SB 56 which would expand full-scope Medi-Cal to older adults who are otherwise eligible but for their immigration status.

The Affordable Care Act (ACA) expanded coverage to millions of Californians through Covered California and expanded Medi-Cal coverage. Still, too many Californians remain uninsured and ineligible for coverage due to immigration status. Providing coverage for these older adults ensures that individuals have access to health care services when needed.

The Alliance's tri-county population includes a high percentage of undocumented residents. COVID-19 shone a light on the significant health disparities that are based on race, ethnicity and income status. SB 56 will ensure that older, low income undocumented individuals will have access to health care services. For these reasons, the Alliance is pleased to support SB 56.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

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Salinas, CA 93901-4487
831-755-6000

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

April 28, 2021

The Honorable Susan Talamantes Eggman
State Capitol, Room 4052
Sacramento, CA 95814

RE: SB 316 – SUPPORT

Dear Senator Talamantes Eggman:

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 370,000 residents of Santa Cruz, Monterey and Merced counties, I am writing to express the Alliance's support for SB 316, which would allow reimbursement of Federally Qualified Health Centers ("FQHCs") and Rural Health Clinics ("RHCs") for two visits by a Medi-Cal beneficiary taking place on the same day, under certain circumstances.

FQHCs and RHCs are essential network providers for Medi-Cal managed care plans, like the Alliance. The Alliance works with our safety-net providers to increase access to care and improve Medi-Cal beneficiaries' overall care experience. This effort includes reducing barriers to treatment for individuals with mental health conditions.

Under the current law, Medi-Cal patients receiving services at FQHCs or RHCs for a physical health problem who also require a mental health service must return to the clinic another day to be seen for the second visit – even if an appointment is available the same day and at the same place as their medical visit. This results in many Medi-Cal beneficiaries not receiving needed care. Individuals with untreated mental illness may have problems managing their physical health conditions, exacerbating physical health problems for individuals and increasing health care costs. This is inefficient, costly, and creates the risk that members with mental health needs will go without care because of the built-in delay. Allowing same day reimbursement for mental health services will result in better outcomes and lower overall health care costs.

SB 316 will improve access and help health plans and clinics ensure that patients receive timely, efficient, and better integrated mental health services. For these reasons, the Alliance is pleased to support SB 316.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

Member Appeals and Grievance Report
Q1, 2021

Q1 2021 Appeals and Grievances: 584

Appeals: 14% [63% in favor of Plan; 37% in favor of Member]
Exempt Grievances: 5%
Grievances: 76%
Other: 5% [Inquiries, Duplicates, Withdrawn]

Category Figures
Referrals: 2%
Access Issues: 11%
Benefits and Coverage 2%
Quality of Care Issues: 13%
Other: 68%
- Transportation: 44% of "Other" Category
- Provider Billing Issues: 19% of "Other" Category
- Medication Issues: 5% of "Other" Category
- Communication Issues: 2% 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 increased as members resumed care in the community
- Access grievances increased due to termination notifications sent to members
- No other significant trends noted for grievances in Q1 2021.

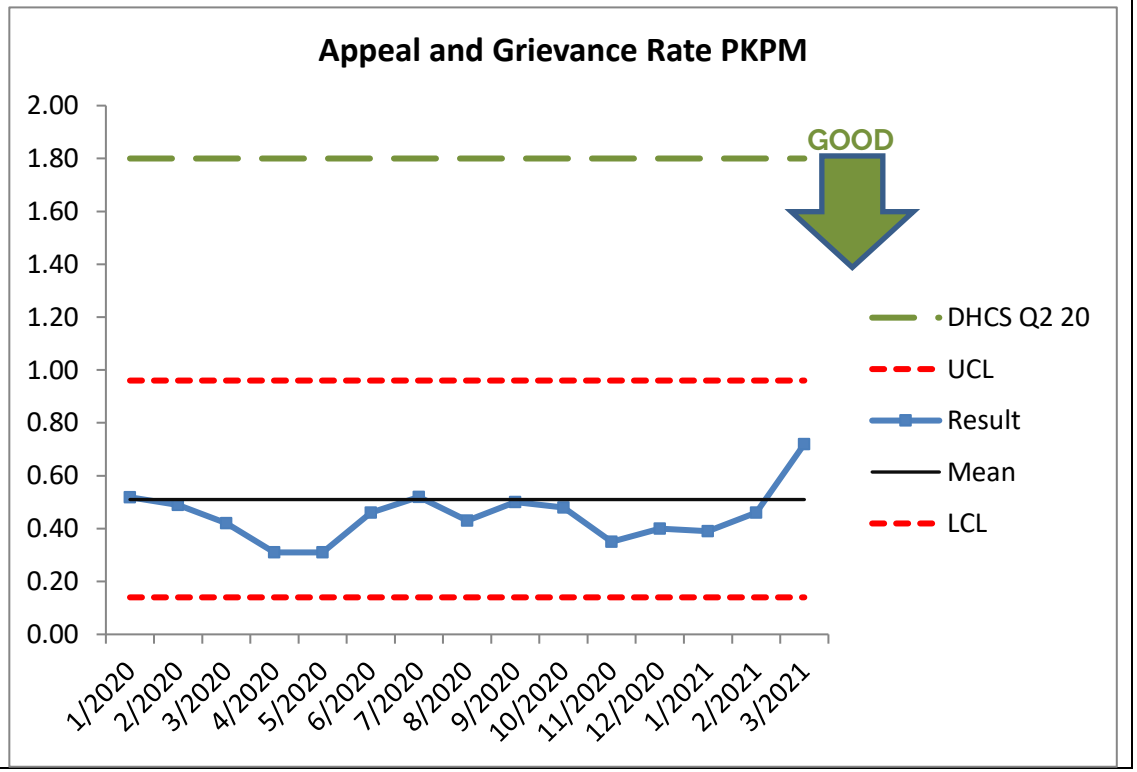
Highest Grievances Filed by County
1. Merced: 37%
2. Monterey: 36%
3. Santa Cruz: 27%

Behavioral Health Beacon Grievances:
- Member Grievances: 11

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
2020 Enrollment	334,394	337,611	337,444	341,861	346,268	350,131	352,983	355,570	358,607	360,426	362,625	365,250
A&G Issues	173	167	141	107	108	162	187	157	183	173	126	146
Rate PKPM*	0.52	0.49	0.42	0.31	0.31	0.46	0.53	0.44	0.51	0.48	0.35	0.40
2021 Enrollment	**367,575**	**369,855**	**371,828**									
A&G Issues	145	170	269									
Rate PKPM*	0.39	0.46	0.72									

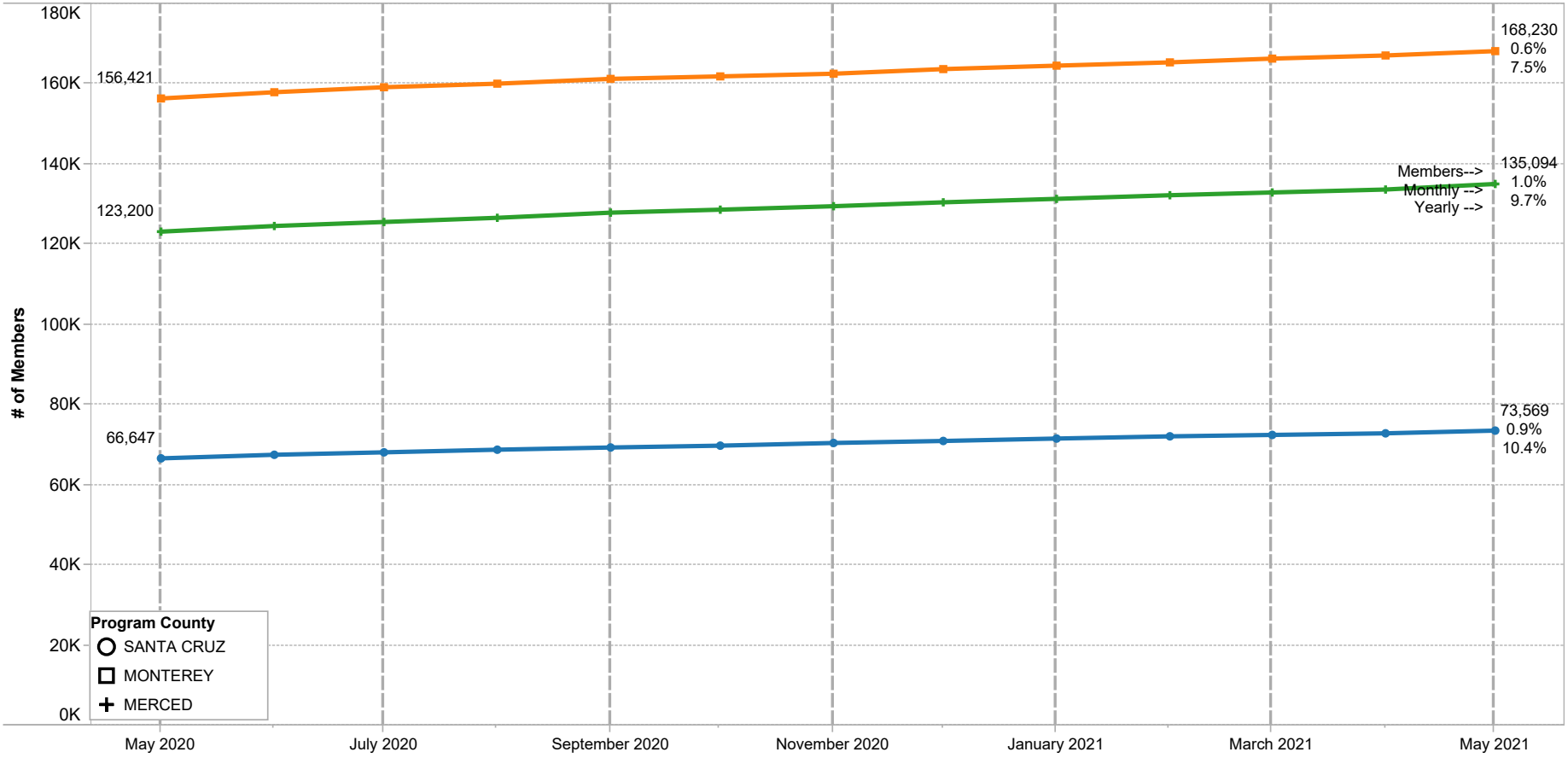
*Grievances Per 1,000 Member Month

Enrollment Report

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

StaticDate
5/1/2020 12:00:00 AM to 5/31/2021 11:59:59 PM

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



Program..	ProgramCo..	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021
Medi-Cal	SANTA CRUZ	66,647	67,542	68,152	68,809	69,358	69,815	70,486	70,986	71,588	72,142	72,492	72,891	73,569
	MONTEREY	155,842	157,401	158,642	159,539	160,749	161,376	162,048	163,207	164,070	164,898	165,847	166,634	167,725
	MERCED	123,200	124,609	125,609	126,652	127,940	128,681	129,545	130,517	131,380	132,286	132,973	133,708	135,094
IHSS	MONTEREY	579	579	580	570	560	554	546	540	537	529	516	512	505
Total Members		**346,268**	**350,131**	**352,983**	**355,570**	**358,607**	**360,426**	**362,625**	**365,250**	**367,575**	**369,855**	**371,828**	**373,745**	**376,893**