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/164478157
   b. Or by telephone at:
      United States:  +1 (646) 749-3122
      Access Code: 164-478-157
   c. New to GoToMeeting? Get the app now and be ready when your first meeting starts: https://global.gotomeeting.com/install/164478157

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, October 27, 2020 to the Clerk of the Board at kstagnaro@ccah-alliance.org.
      i. Indicate in the subject line “Public Comment”. Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
      ii. Comments will be read during the meeting and are limited to five minutes.
   b. Public comment during the meeting, when that item is announced.
      i. State your name and organization prior to providing comment.
      ii. Comments are limited to five minutes.

3. Mute your phone during presentations to eliminate background noise.
   a. State your name prior to speaking during comment periods.
   b. Limit background noise when unmuted (i.e. paper shuffling, cell phone calls, etc.).
1. **Call to Order by Chairperson Coonerty.** 3:00 p.m.
   A. Roll call; establish quorum.
   B. Supplements and deletions to the agenda.

2. **Oral Communications.** 3:05 p.m.
   A. Members of the public may address the Commission on items not listed on today’s agenda that are within the jurisdiction of the Commission. Presentations must not exceed five minutes in length, and any individuals may speak only once during Oral Communications.
   B. If any member of the public wishes to address the Commission on any item that is listed on today’s agenda, they may do so when that item is called. Speakers are limited to five minutes per item.

3. **Comments and announcements by Commission members.**
   A. Board members may provide comments and announcements.

4. **Comments and announcements by Chief Executive Officer.**
   A. The Chief Executive Officer (CEO) may provide comments and announcements.

**Consent Agenda Items:** (5. – 8H.): 3:10 p.m.

5. **Accept Executive Summary from the Chief Executive Officer (CEO).**
   - Reference materials: Executive Summary from the CEO.  
     Pages 5-01 to 5-08

6. **Accept Alliance Balance Sheet, Income Statement and Statement of Cash Flow for eight months ending August 31, 2020.**
   - Reference materials: Financial Statements as above.  
     Pages 6-01 to 6-03

**Minutes:** (7A. – 7D.)

7A. **Approve Commission meeting minutes of September 23, 2020.**
   - Reference materials: Minutes as above.  
     Pages 7A-01 to 7A-05

7B. **Accept Compliance Committee meeting minutes of July 15, 2020.**
   - Reference materials: Minutes as above.  
     Pages 7B-01 to 7B-05

7C. **Accept Finance Committee meeting minutes of May 27, 2020.**
   - Reference materials: Minutes as above.  
     Pages 7C-01 to 7C-04

7D. **Accept Whole Child Model Clinical Advisory Committee meeting minutes of June 18, 2020.**
   - Reference materials: Minutes as above.  
     Pages 7D-01 to 7D-04
Reports: (8A. – 8H.)

8A. Accept report Authorizing the Chairperson to sign Amendment #44 to the Alliance’s primary Medi-Cal contract number 08-85216 and Amendment #11 to the Alliance’s secondary Medi-Cal contract number 08-85223 to extend the term of the contracts to December 31, 2021.
- Reference materials: Staff report and recommendation on above topic. Page 8A-01

8B. Accept Alliance Compliance Dashboard Reports for Q2 2020.
- Reference materials: Compliance Delegate Oversight Dashboard, Compliance Health Insurance Portability and Accountability Act Dashboard, Compliance Internal Audit Dashboard, and Program Integrity Special Investigations Unit Dashboard – Q2 2020. Pages 8B-01 to 8B-04

8C. Accept report on COVID-19 Update.
- Reference materials: Staff report on above topic. Pages 8C-01 to 8C-04

8D. Accept report on 2020 Legislative Session Wrap-up.
- Reference material: Staff report on above topic. Pages 8D-01 to 8D-03

8E. Accept report on Quality Improvement Workplan – Q2 2020
- Reference materials: Staff report and recommendation on above topic. Pages 8E-01 to 8E-03

- Reference materials: MCGP Performance Dashboard. Pages 8F-01 to 8F-08

8G. Approve Medi-Cal Capacity Grants: Funding Recommendations. (Group A)
A. Action on grants with no Board member affiliation.
- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; and Recommendation Summaries by Organization. Pages 8G-01 to 8G-07

8H. Approve Medi-Cal Capacity Grants: Funding Recommendations. (Group B)
A. Action on grants with Board member affiliation.
- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; and Recommendation Summaries by Organization. Pages 8H-01 to 8H-05

Regular Agenda Items: (9. – 12.): 3:15 p.m.

9. Discuss revenue and expense factors influencing the Alliance’s CY 2020 Financial Forecast. (3:15 – 3:45 p.m.)
A. Ms. Lisa Ba, Chief Financial Officer, will review and Board will discuss above topic.
- Reference materials: Staff report on above topic. Pages 9-01 to 9-02
10. **Discuss Medi-Cal Rx Implementation. (3:45 – 4:10 p.m.)**
   A. Dr. Dale Bishop, Chief Medical Officer, will review and Board will discuss above topic.
   - Reference materials: Staff report on above topic; Member Notice; and Provider Notice.
     Pages 10-01 to 10-09

11. **Consider approving recommendation on selection of Managed Behavioral Health Organization (MBHO) vendor. (4:10 – 4:45 p.m.)**
   A. Dr. Dale Bishop, Chief Medical Officer and Ms. Jennifer Mockus, Community Care Coordination Director, will review and Board will consider entering into contract negotiations with Beacon Health Options/College Health Independent Physicians Association for an MBHO Agreement effective July 1, 2021 for a period of two years.
   - Reference materials: Staff report and recommendation on above topic.
     Pages 11-01 to 11-04

12. **Consider approving 2021 Board meeting schedule. (4:45 – 5:00 p.m.)**
   A. Ms. Stephanie Sonnenshine, CEO, will review and Board will consider approving the Board meeting schedule for 2021.
   - Reference materials: Staff report and recommendation on above topic.
     Pages 12-01 to 12-02

**Information Items: (13A. – 13B.)**
   A. Alliance in the News          Page 13A-01
   B. Membership Enrollment Report  Page 13B-01
Announcements:

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

- Whole Child Model Family Advisory Committee
  Monday, November 8, 2020; 1:30 – 3:00 p.m.

- Member Services Advisory Group
  Thursday, November 12, 2020; 10:00 – 11:30 a.m.

- Finance Committee
  Wednesday, December 2, 2020; 1:30 – 2:45 p.m.

- Physicians Advisory Group
  Thursday, December 3, 2020; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee
  Thursday, December 17, 2020; 12:00 – 1:00 p.m.

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

The next meeting of the Commission, after this October 28, 2020 meeting will be held via teleconference unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, December 2, 2020, 3:00 – 5:00 p.m.

Members of the public interested in attending should call the Alliance at (831) 430-5523 to verify meeting dates and locations prior to the meetings.

The complete agenda packet is available for review at Alliance offices, and on the Alliance website at [www.ccah-alliance.org/boardmeeting.html](http://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.
June 30, 2020 was a milestone date in the 2020 Legislative Session, with the deadline for Governor Newsom to sign or veto bills remaining on his desk. As previously reported, the 2020 Legislative session was unusual given the forced recesses due to COVID-19 and the significant change in the State economy and State budget outlook from the outset of the legislative session in January to its conclusion. Staff have been monitoring bills of interest and impact and a report on final bill outcomes is provided in the board packet.

Medi-Cal Managed Care RFI. The Department of Health Care Services (DHCS) began the process to re-procure commercial plan contracts in Two-Plan, Geographic Managed Care and Regional Model counties with the issuance of a Request for Information (RFI). The re-procurement process is for commercial plans operating in these managed care model counties and does not directly impact local plans, like the Alliance. However, DHCS has included in its RFI process, a request for stakeholder input regarding goals for the Medi-Cal managed care delivery system and is soliciting input on proposed updates and additions to Medi-Cal managed care plan contracts, which will ultimately become part of a restated Medi-Cal managed care plan contract template. Therefore, the Alliance will be closely monitoring these discussions and providing input regarding program goals and health plan requirements.

Public Health Emergency Extended. Effective October 23, 2020, Health and Human Services Secretary Alex Azar renewed the January 31, 2020 national Public Health Emergency (PHE) that was previously renewed twice, on April 21, 2020 and July 23, 2020. The extension of the PHE is effective for ninety days and subject to further renewal. The effects of the continuation of the PHE are the continued flexibilities granted by the Centers for Medicare and Medicaid to states via Blanket Waivers as well as those specific to California that have been approved through the State’s Waiver requests and State Plan amendments. This includes, among other things, continued flexibility in the use of telehealth.

Federal COVID Relief. After several stops and starts and conflicting messaging from the White House, Congress appears to remain at an impasse over Coronavirus relief funding. It is becoming increasingly likely that agreement on a stimulus bill will not be reached prior to the November 3, 2020 election. As previously reported, the implications of this on the State budget are of concern. The FY 2020-21 State budget assumed an additional $14B in federal aid for California by October 15, 2020 to stave off “trigger cuts”. With the delay and...
uncertainty in the availability and amount of federal funding it is likely that the Governor and lawmakers will once again be faced with budget decisions that may impact health care when they return to Sacramento in January.

Community Involvement. On October 7, 2020 I attended the DHCS California Children's Services Advisory Group teleconference meeting and Health Improvement Partnership of Santa Cruz County (HIPSCC) Council teleconference meeting on October 8, 2020. I attended the College of Health Sciences and Human Services Leadership Council teleconference meeting on October 12, 2020 and the HIPSCC Executive teleconference meeting on October 15, 2020. On October 22, 2020 I attended the Santa Cruz Health Information Exchange Board teleconference meeting. I plan to attend the DHCS Stakeholder Advisory Committee webinar meeting on October 28, 2020.

Health Services

Health Services continues efforts to ensure that authorizations, care management, pharmacy and quality improvement programs promote member care, and support providers during the pandemic. In September and October, Health Services is prioritizing member outreach to children ages 0-3 to resume care and receive preventive care including flu vaccinations. Health Services is finalizing preparations for the pharmacy carve-out, developing improved workflows for the Essette authorization system update planned in spring 2021, and developing plans for optimizing referrals to and care management in the Whole Child Model program. Other key activities are described below.

Utilization Management/Complex Case Management (UM/CCM). Complex Case Management continues outreach to all discharged members to identify opportunities to decrease readmissions. Members are being identified for follow-up through the utilization of a predictability scoring report in addition to those who have a history of high emergency department (ED) utilization and readmissions.

Prior Authorization. Staff are engaged in a Authorization Process Redesign to be completed in the summer of 2021. The effort will evaluate services requiring prior authorization, identify opportunities to streamline processes and reduce administrative burden to both providers and Alliance staff. The process will also seek to maintain process which mitigates the risk of potential harm to members from unnecessary care as well as areas prone to overutilization or potential fraud, waste, and abuse.

Department of Health Care Services (DHCS) Pediatric Campaign. The DHCS Pediatric Campaign included live calls that were initiated on July 1, 2020, and automated calls to landlines and mailers targeted for infants, early, and middle childhood (0-6 years old) initiated on October 7, 2020. The messaging for the pediatric campaign aligned with the Alliance promotion of "Check In, Check Up" to ensure that members connect with their primary care for well-visits, immunizations, and lead screening. The pediatric campaign will conclude by December 31, 2020.

Healthcare Effectiveness Data and Information Set (HEDIS)/Managed Care Accountability Set (MCAS). DHCS has outlined several quality improvement activities and submission requirements for 2020-21 related to MCAS measures focused on preventive care, chronic disease management, or behavioral health impacted by COVID-19. These include: 1) in lieu
of imposing sanctions or corrective action plans on minimum performance levels (MPL), a
PDSA rapid cycle project is required on a single performance measure. The Alliance is
working with one provider site on the Breast Cancer Screening measure and use of a
standing order, and 2) COVID-19 Quality Improvement Plan (COVID-19 QIP) on initial and 6-
month interventions and/or strategies aimed at increasing the provision of healthcare
services. The interventions for COVID-19 were primarily focused on member outreach
efforts to vulnerable members, and a description of these efforts was submitted to DHCS as
the COVID-19 QIP.

HEDIS/MCAS Rates. September also saw the public release of plan rates for the measures
where reporting to DHCS and National Committee for Quality Assurance (NCQA) was
required. Below are rates for a selection of maternal child health measures reported by
County Operated Health System (COHS) plans, including the Alliance. Performance below
the state required 50th percentile of the National Medicaid rates are shaded red, those
exceeding the 90th percentile are shaded green. The plans’ collective performance in these
areas such as Adolescent Well Care and Well Child Visits in the First 15 Months of Life (six or
more visits) underscores the ongoing need to focus on adequate access to high quality
pediatric care. Prenatal care for Medi-Cal women has made considerable gains towards
matching or meeting commercial plan rates in recent years (NCQA), of note, the minimum
allowable performance is now 90.21%.

<table>
<thead>
<tr>
<th>County Organized Health System</th>
<th>Reporting Unit</th>
<th>AWC</th>
<th>CIS-10</th>
<th>PPC–Pre</th>
<th>W15–6+ Visits</th>
<th>W34</th>
</tr>
</thead>
<tbody>
<tr>
<td>CalOptima</td>
<td>Orange County</td>
<td>56.97%</td>
<td>44.99%</td>
<td>95.13%</td>
<td>66.67%</td>
<td>79.21%</td>
</tr>
<tr>
<td>CenCal Health</td>
<td>Santa Barbara County</td>
<td>59.37%</td>
<td>50.61%</td>
<td>97.81%</td>
<td>68.13%</td>
<td>85.19%</td>
</tr>
<tr>
<td>CenCal Health</td>
<td>San Luis Obispo County</td>
<td>57.18%</td>
<td>50.61%</td>
<td>97.32%</td>
<td>63.02%</td>
<td>76.32%</td>
</tr>
<tr>
<td>Central California Alliance for Health</td>
<td>Monterey/Santa Cruz Counties</td>
<td>63.26%</td>
<td>52.07%</td>
<td>91.73%</td>
<td>63.99%</td>
<td>86.46%</td>
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<tr>
<td>Central California Alliance for Health</td>
<td>Merced County</td>
<td>55.23%</td>
<td>19.71%</td>
<td>90.27%</td>
<td>47.93%</td>
<td>73.28%</td>
</tr>
<tr>
<td>Gold Coast Health Plan</td>
<td>Ventura County</td>
<td>58.15%</td>
<td>42.09%</td>
<td>97.32%</td>
<td>54.99%</td>
<td>78.59%</td>
</tr>
<tr>
<td>Health Plan of San Mateo</td>
<td>San Mateo County</td>
<td>53.28%</td>
<td>51.68%</td>
<td>87.59%</td>
<td>48.18%</td>
<td>81.64%</td>
</tr>
<tr>
<td>Partnership Health Plan of California</td>
<td>Southeast</td>
<td>55.23%</td>
<td>43.31%</td>
<td>94.89%</td>
<td>51.34%</td>
<td>80.28%</td>
</tr>
<tr>
<td>Partnership Health Plan of California</td>
<td>Southwest</td>
<td>52.80%</td>
<td>43.07%</td>
<td>95.38%</td>
<td>62.53%</td>
<td>79.44%</td>
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<tr>
<td>Partnership Health Plan of California</td>
<td>Northeast</td>
<td>43.07%</td>
<td>16.33%</td>
<td>92.94%</td>
<td>47.69%</td>
<td>72.94%</td>
</tr>
<tr>
<td>Partnership Health Plan of California</td>
<td>Northwest</td>
<td>43.80%</td>
<td>20.19%</td>
<td>91.97%</td>
<td>38.83%</td>
<td>70.05%</td>
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<table>
<thead>
<tr>
<th>P90 HPL</th>
<th>P90 MPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.14%</td>
<td>49.27%</td>
</tr>
<tr>
<td>94.64%</td>
<td>81.64%</td>
</tr>
<tr>
<td>94.64%</td>
<td>73.28%</td>
</tr>
<tr>
<td>81.64%</td>
<td>78.59%</td>
</tr>
</tbody>
</table>

AWC: Adolescent Well Care, CIS-10: Childhood Immunization Status, PPC–Pre: Timely Prenatal Care, W15-6+ Visits: Well Child Visits (6 visits before 15 months of age), and W34: Well Child Visits 3-6 years of age.

Community Care Coordination The Alliance and community health care leaders providing
case management services to members in our service area are being asked to participate in
key informant interviews conducted by EM Consulting. The Alliance has contracted with
EM Consulting to provide recommendations on how staff can align our resources for a
can on complex case management model based upon NCQA’s Population Health standards.
Community Care Coordination leaders have participated in these interviews since the last
report from Health Services in the Executive Summary. Key informant interviews continue
with county behavioral health leaders, large safety net clinic providers, and others.

**Finance**

**Financial Highlights for the Eight Months Ending August 31, 2020**

- The August Operating Income for all lines of business stands at $3.8M
- Medical Expenses are unfavorable to budget by $2.5M or 2.5% with an MLR of 91.1%
- Administrative Expenses are favorable to budget by $0.9M or 12.6% with an ALR of 5.5%
- Fund Balance is $415.0M or 7.5 times the minimum Tangible Net Equity (TNE) required
  by the State

<table>
<thead>
<tr>
<th>Aug-20 MTD (In $000s)</th>
<th>Current</th>
<th>Current</th>
<th>9.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>359,992</td>
<td>328,615</td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>112,191</td>
<td>102,351</td>
<td>9.6%</td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>102,216</td>
<td>99,760</td>
<td>(2,455)</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>6,130</td>
<td>7,015</td>
<td>12.6%</td>
</tr>
<tr>
<td>Operating Income/(Loss)</td>
<td>3,845</td>
<td>(4,425)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>3,631</td>
<td>(5,022)</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>Current Actual</th>
<th>Current Budget</th>
<th>Current Variance</th>
<th>% Variance to Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>359,992</td>
<td>328,615</td>
<td>31,377</td>
<td>9.5%</td>
</tr>
<tr>
<td>Revenue</td>
<td>112,191</td>
<td>102,351</td>
<td>9,840</td>
<td>9.6%</td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>102,216</td>
<td>99,760</td>
<td>(2,455)</td>
<td>-2.5%</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>6,130</td>
<td>7,015</td>
<td>885</td>
<td>12.6%</td>
</tr>
<tr>
<td>Operating Income/(Loss)</td>
<td>3,845</td>
<td>(4,425)</td>
<td>8,270</td>
<td>100.0%</td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>3,631</td>
<td>(5,022)</td>
<td>8,654</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

| MLR %                                       | 91.1%           | 97.5%           | 6.4%              |
| ALR %                                       | 5.5%            | 6.9%            | 14%               |
| Operating Income %                          | 3.4%            | -4.3%           | 7.7%              |
| Net Income %                                | 3.2%            | -4.9%           | 8.1%              |
### Aug-20 YTD (In $000s)

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>YTD Variance</th>
<th>% Variance to Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership</td>
<td>2,751,347</td>
<td>2,642,367</td>
<td>108,980</td>
<td>4.1%</td>
</tr>
<tr>
<td>Revenue</td>
<td>856,902</td>
<td>823,418</td>
<td>33,485</td>
<td>4.1%</td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>833,381</td>
<td>802,610</td>
<td>(30,771)</td>
<td>-3.8%</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>55,417</td>
<td>55,234</td>
<td>(183)</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Operating Income/(Loss)</td>
<td>(31,895)</td>
<td>(34,427)</td>
<td>2,531</td>
<td>7.4%</td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>(35,775)</td>
<td>(39,080)</td>
<td>3,305</td>
<td>8.5%</td>
</tr>
</tbody>
</table>

**Membership:** August 2020 Member Months are favorable to budget by 9.5%. Favorability in Member Months is primarily driven by the “Family/Adult and Adult Expansion” Category of Aid, Whole Child Model (WCM), and IHSS, which account for 67.9% of the increase. The increase is attributable largely to the discontinuation of the Medi-Cal redetermination process during the pandemic emergency period. Member Months are partially offset by unfavorability in “LTC and LTC Full Dual” Category of Aid by 19.2%. By county, Merced is favorable to budget by 9.9%, followed by Santa Cruz at 9.6%, and Monterey at 9.2%.

Membership Actual vs. Budget (based on actual enrollment trend for Aug-20 YTD)
Revenue. August 2020 Medi-Cal capitation revenue is $111.9M, which is favorable to budget by $9.8M or 9.6%. August 2020 year-to-date (YTD) Medi-Cal capitation revenue of $854.8M is favorable to budget by $33.2M or 4.0%. Of this $33.2M favorability, $39.2M is attributed to enrollment favorability which is partially offset by a $6.1M net rate variance. YTD Capitation Revenue includes a rate variance adjustment from the State’s May Budget Revision, which proposed a 1% rate reduction for Adult, Child, ACA OE, and SPD population for the bridge period of July 2019 through December 2020. The financial impact for the full bridge period is approximately $19.7M.

<table>
<thead>
<tr>
<th>County</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>Variance Due to Enrollment</th>
<th>Variance Due to Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Cruz</td>
<td>192,567</td>
<td>187,784</td>
<td>4,782</td>
<td>7,570</td>
<td>(2,788)</td>
</tr>
<tr>
<td>Monterey</td>
<td>371,188</td>
<td>352,884</td>
<td>18,304</td>
<td>17,900</td>
<td>404</td>
</tr>
<tr>
<td>Merced</td>
<td>291,032</td>
<td>280,934</td>
<td>10,097</td>
<td>13,775</td>
<td>(3,677)</td>
</tr>
<tr>
<td>Total</td>
<td>854,786</td>
<td>821,603</td>
<td>33,183</td>
<td>39,244</td>
<td>(6,061)</td>
</tr>
</tbody>
</table>

Note: Excludes Aug-20 YTD In-Home Supportive Services premiums revenue of $2.1M

Medical Expenses. August 2020 YTD Medical Expenses are $833.4M, which is unfavorable to budget by $30.8M or 3.8%, with an MLR of 97.3%. Inpatient Services (Hospital) are unfavorable by $21.0M or 8.6%. Inpatient Services (LTC) are unfavorable by $18.2M or 19.8%. Pharmacy Costs are unfavorable by $2.6M or 2.1%, and Outpatient Facility is unfavorable by $0.03M or 0.1%. Medical Expenses include $3.9M Inpatient Services (Hospital) and $1.9M Inpatient Services (LTC) IBNR reserve for COVID-19 pandemic costs. Medical Expenses are partially offset by favorability in Other Medical of $6.3M or 3.8% and Physician Services of $4.7M or 3.5%.

Administrative Expenses. August 2020 YTD Administrative Expenses are $55.4M, which is unfavorable to budget by $0.2M or 0.3%, with an ALR of 6.5%. Unfavorability is driven by Salaries, Wages and Benefits of $1.9M or 5.2%. Administrative Expenses are partially offset by favorability in Professional Fees of $0.6M or 33.1%, Purchased Services of $0.4M or 5.6%, Supplies & Other by $0.3M or 6.4%, Occupancy of $0.3M or 23.6%, and Depreciation & Amortization of $0.2 or 3.4%.

Non-Operating Revenue. August 2020 YTD Total Non-Operating Revenue is unfavorable to budget by $0.3M or 4.3% and consists of $3.8M in interest income, $1.6M in unrealized investment gain and $0.7M in rental income for a total of $6.2M. Unrealized gains or losses will not be realized unless the bonds are sold prior to their maturity. The bonds have been bought with the intention of holding them to maturity. If held to maturity, unrealized gains or losses would be completely reversed.

Non-Operating Expenses. August 2020 YTD Total Non-Operating Expenses of $10.1M are favorable to budget by $1.1M or 9.5%. There is currently $150.2M in the Grant program, which is a non-operating expense.
Non-Operating Revenue/Expenses. August 2020 YTD Total Non-Operating Revenue of $6.2M was offset by $10.1M in grant distribution, resulting in a Net Non-Operating Loss of $3.9M.

Fund Balance. The Fund Balance is currently $415.0M, which is 7.5 times the minimum TNE requirement established by the State of $55.7M. The Alliance’s reserves without grants are $264.8M, which is $54.1M or 17.0% below the Designated Reserves Target established by the Board. Please note that the Alliance’s internal State Required TNE differs from DMHC’s due to a different calculation methodology.

Health Care Expense Reserve. The Plan’s Health Care Expense Reserve is $318.9M, an increase from the prior reporting period of $1.4M. This line on the Alliance’s Balance Sheet reflects three times capitation premiums and prior year adjustments.

Operations

Annual Access Plan. In early 2020 the Alliance shared an Access to Care framework which serves as a model for measuring and monitoring access to care across multiple areas of health plan operations. Following, the Provider Services Department launched an interdisciplinary Network Development Steering Committee (NDSC), whose primary objectives are to: monitor and evaluate member access to care and support improved member access to care through oversight of the development and execution of an annual provider network Access Plan.

The Annual Access Plan now serves as a focus for provider recruitment and network expansion efforts, informed by various data points utilized as inputs to the framework. Ultimately, the Access Plan supports the objective to continuously improve, develop and maintain a provider network that meets our member needs. The 2020 Access Plan recognizes the change in Alliance membership as a result of the COVID-19 pandemic, and contemplates the following areas of focus:

1. Ensure greater appointment availability and member choice by expanding private Primary Care Provider (PCP) access; and
2. Increase access to the specialty services of cardiology, endocrinology, pulmonology, and behavioral health to expand appointment availability and member choice within the network.

The Access Plan was finalized in September 2020 and work is underway to recruit and expand practice capacity, including increased use of telehealth for specialty services. Progress against the Access Plan is reported to the NDSC monthly, with improvement anticipated in the areas of market share, PCP capacity, referral acceptance rate, and utilization of telehealth services. Planning for the 2021 Annual Access Plan will begin in January of 2021.

Network Certification. DHCS requires the certification of health plan networks on an annual basis. The 2020/2021 certification year marks the third year that the Alliance completed the DHCS Network Certification filing. Through the work of an interdisciplinary team, the Alliance prepared accessibility analyses, recruitment updates, and supporting documentation necessary to accurately represent our provider network and the access
available to Alliance members. Importantly, this submission now included the requirement that providers meet time and distance requirements, as opposed to time or distance requirements. Our filing was submitted in July 2020, with subsequent clarifying questions from DHCS addressed in August and September. In previous years, DHCS has issued Network Certification findings (pass, corrective action, etc.) in quarter 3 to support the timeline put forward by CMS, which requires DHCS to file its health plan networks by July. Due to the COVID-19 pandemic, DHCS has secured an extension with CMS to file no later than January 1, 2021, and health plans are now beginning to receive their results from DHCS.

On October 13, 2020, staff received notification from DHCS that the Alliance’s provider network was certified with conditions pending the review of Alternate Access Standard requests outlined in a Corrective Action Plan. All regions in which time and distance are not met are those previously approved and were known at the time of Network Certification filing, largely concentrated in rural South Monterey County. Requests for Alternate Access Standards were submitted, as required, and are pending review by DHCS with a comprehensive update to your Board forthcoming.

**Employee Services and Communications**

**Alliance Workforce.** As of September 28, 2020, the Alliance has 528.1 positions of which our active workforce is 497.1 (active FTEs and temporary workers). There are nine positions in active recruitment, and 26 positions are vacant. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets.

As mentioned last month, the CZU Complex Wildfire impacted approximately 100 Alliance employees, forcing evacuations from their homes in Bonny Doon, Felton, Ben Lomond, Boulder Creek and Scotts Valley. Human Resources (HR) worked to ensure staff had up-to-date access to resources to support them through an Alliance Facebook page, and direct employee outreach. Although some staff continue to deal with the aftermath, we are fortunate that all employees are safe. HR continues to support those staff through guidance and resource sharing.

HR will be reviewing employee benefits to select a comprehensive and competitive benefits package for 2021. Open Enrollment will occur in November 2020 for a January 1, 2021 effective date.

**Facilities and Administrative Services.** For the purposes of business resiliency, the Facilities team has installed a standby generator in the Scotts Valley location to handle power outages as a result of rolling outages and Public Safety Power Shutdown events. The generator will be onsite through November 2020.

**Communications.** The Alliance officially launched a Facebook Page in September. The objective is to engage with target audiences and share health care information and resources to those in our communities in an accessible and timely way. Staff developed a content scheduling process and worked with Member Services to develop a comment response protocol that aligns with our Grievance process. Staff also implemented a Social Media Code of Conduct Policy, which clearly outlines community terms and conditions for users, as well as a Social Media Policy for staff.
<table>
<thead>
<tr>
<th>Assets</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$232,379</td>
</tr>
<tr>
<td>Restricted Cash</td>
<td>$301</td>
</tr>
<tr>
<td>Short Term Investments</td>
<td>$250,571</td>
</tr>
<tr>
<td>Receivables</td>
<td>$201,947</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>$2,801</td>
</tr>
<tr>
<td>Other Current Assets</td>
<td>$9,026</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>$697,024</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Building, Land, Furniture &amp; Equipment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Assets</td>
<td>$82,261</td>
</tr>
<tr>
<td>Accumulated Depreciation</td>
<td>(34,263)</td>
</tr>
<tr>
<td>CIP</td>
<td>$3,594</td>
</tr>
<tr>
<td><strong>Total Non-Current Assets</strong></td>
<td><strong>51,593</strong></td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$748,617</strong></td>
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</table>

<table>
<thead>
<tr>
<th>Liabilities</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts Payable</td>
<td>$94,099</td>
</tr>
<tr>
<td>IBNR/Claims Payable</td>
<td>$218,249</td>
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<td>Accrued Expenses</td>
<td>$31</td>
</tr>
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<td>Estimated Risk Share Payable</td>
<td>$10,017</td>
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<tr>
<td>Other Current Liabilities</td>
<td>$6,977</td>
</tr>
<tr>
<td>Due to State</td>
<td>$4,244</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>$333,617</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fund Balance</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fund Balance - Prior</td>
<td>$450,775</td>
</tr>
<tr>
<td>Retained Earnings - CY</td>
<td>(35,775)</td>
</tr>
<tr>
<td><strong>Total Fund Balance</strong></td>
<td><strong>415,000</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Fund Balance</strong></td>
<td><strong>$748,617</strong></td>
</tr>
</tbody>
</table>
# Income Statement - Actual vs. Budget

For The Eight Months Ending August 31, 2020  
(In S000s)

<table>
<thead>
<tr>
<th></th>
<th>MTD Actual</th>
<th>MTD Budget</th>
<th>Variance</th>
<th>%</th>
<th>YTD Actual</th>
<th>YTD Budget</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Months</strong></td>
<td>359,992</td>
<td>328,615</td>
<td>31,377</td>
<td>9.5%</td>
<td>2,751,347</td>
<td>2,642,367</td>
<td>108,980</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>Capitation Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation Revenue Medi-Cal</td>
<td>$111,908</td>
<td>$102,115</td>
<td>9,793</td>
<td>9.6%</td>
<td>$854,786</td>
<td>$821,603</td>
<td>33,183</td>
<td>4.0%</td>
</tr>
<tr>
<td>Premiums Commercial</td>
<td>283</td>
<td>235</td>
<td>48</td>
<td>20.4%</td>
<td>2,116</td>
<td>1,814</td>
<td>302</td>
<td>16.6%</td>
</tr>
<tr>
<td><strong>Total Operating Revenue</strong></td>
<td>$112,191</td>
<td>$102,351</td>
<td>9,840</td>
<td>9.6%</td>
<td>$856,902</td>
<td>$823,418</td>
<td>33,485</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>Medical Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services (Hospital)</td>
<td>$29,299</td>
<td>$30,544</td>
<td>1,244</td>
<td>4.1%</td>
<td>$264,639</td>
<td>$243,688</td>
<td>($20,951)</td>
<td>-8.6%</td>
</tr>
<tr>
<td>Inpatient Services (LTC)</td>
<td>15,509</td>
<td>11,676</td>
<td>(3,832)</td>
<td>-32.8%</td>
<td>110,493</td>
<td>92,260</td>
<td>(18,233)</td>
<td>-19.8%</td>
</tr>
<tr>
<td>Physician Services</td>
<td>16,341</td>
<td>16,192</td>
<td>(149)</td>
<td>-0.9%</td>
<td>129,764</td>
<td>134,498</td>
<td>4,734</td>
<td>3.5%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>6,901</td>
<td>5,058</td>
<td>(1,843)</td>
<td>-36.4%</td>
<td>44,870</td>
<td>44,843</td>
<td>(27)</td>
<td>-0.1%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>15,893</td>
<td>14,586</td>
<td>(1,307)</td>
<td>-9.0%</td>
<td>126,296</td>
<td>123,711</td>
<td>(2,585)</td>
<td>-2.1%</td>
</tr>
<tr>
<td>Other Medical</td>
<td>18,272</td>
<td>21,704</td>
<td>3,432</td>
<td>15.8%</td>
<td>157,319</td>
<td>163,610</td>
<td>6,291</td>
<td>3.8%</td>
</tr>
<tr>
<td><strong>Total Medical Expenses</strong></td>
<td>$102,216</td>
<td>$99,760</td>
<td>($2,455)</td>
<td>-2.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gross Margin</strong></td>
<td>$9,975</td>
<td>$2,590</td>
<td>$7,385</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Administrative Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries</td>
<td>$4,145</td>
<td>$4,402</td>
<td>$258</td>
<td>5.9%</td>
<td>$37,724</td>
<td>$35,843</td>
<td>($1,881)</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Professional Fees</td>
<td>160</td>
<td>235</td>
<td>75</td>
<td>31.9%</td>
<td>1,153</td>
<td>1,723</td>
<td>570</td>
<td>33.1%</td>
</tr>
<tr>
<td>Purchased Services</td>
<td>752</td>
<td>944</td>
<td>192</td>
<td>20.3%</td>
<td>6,261</td>
<td>6,632</td>
<td>370</td>
<td>5.6%</td>
</tr>
<tr>
<td>Supplies &amp; Other</td>
<td>460</td>
<td>727</td>
<td>267</td>
<td>36.8%</td>
<td>5,126</td>
<td>5,474</td>
<td>349</td>
<td>6.4%</td>
</tr>
<tr>
<td>Occupancy</td>
<td>81</td>
<td>134</td>
<td>53</td>
<td>39.4%</td>
<td>823</td>
<td>1,078</td>
<td>255</td>
<td>23.6%</td>
</tr>
<tr>
<td>Depreciation/Amortization</td>
<td>533</td>
<td>573</td>
<td>41</td>
<td>7.1%</td>
<td>4,329</td>
<td>4,484</td>
<td>154</td>
<td>3.4%</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>$6,130</td>
<td>$7,015</td>
<td>$885</td>
<td>12.6%</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Operating Income</strong></td>
<td>$3,845</td>
<td>($4,425)</td>
<td>$8,270</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-Op Income/(Expense)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest</td>
<td>$273</td>
<td>$745</td>
<td>($472)</td>
<td>-63.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gain/(Loss) on Investments</td>
<td>(171)</td>
<td>(44)</td>
<td>(127)</td>
<td>-100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Revenues</td>
<td>86</td>
<td>84</td>
<td>2</td>
<td>2.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants</td>
<td>(402)</td>
<td>(1,382)</td>
<td>981</td>
<td>70.9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Non-Op Income/(Expense)</strong></td>
<td>($214)</td>
<td>($598)</td>
<td>$384</td>
<td>64.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net Income/(Loss)</strong></td>
<td>$3,631</td>
<td>($5,022)</td>
<td>$8,654</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MLR</td>
<td>91.1%</td>
<td>97.5%</td>
<td>97.3%</td>
<td>97.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALR</td>
<td>5.5%</td>
<td>6.9%</td>
<td>6.5%</td>
<td>6.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Income</td>
<td>3.4%</td>
<td>-4.3%</td>
<td>-3.7%</td>
<td>-4.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Income %</td>
<td>3.2%</td>
<td>-4.9%</td>
<td>-4.2%</td>
<td>-4.7%</td>
<td></td>
<td></td>
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</tbody>
</table>
CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Eight Months Ending August 31, 2020
(In $000s)

<table>
<thead>
<tr>
<th></th>
<th>MTD</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Income</td>
<td>$3,631</td>
<td>($35,775)</td>
</tr>
<tr>
<td>Items not requiring the use of cash: Depreciation</td>
<td>533</td>
<td>4,329</td>
</tr>
<tr>
<td>Adjustments to reconcile Net Income to Net Cash provided by operating activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes to Assets:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receivables</td>
<td>(1,131)</td>
<td>(27,587)</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>188</td>
<td>(802)</td>
</tr>
<tr>
<td>Current Assets</td>
<td>(448)</td>
<td>(1,589)</td>
</tr>
<tr>
<td><strong>Net Changes to Assets</strong></td>
<td><strong>($1,390)</strong></td>
<td><strong>($29,977)</strong></td>
</tr>
<tr>
<td>Changes to Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>($2,671)</td>
<td>$91,298</td>
</tr>
<tr>
<td>Accrued Expenses</td>
<td>(8)</td>
<td>(59)</td>
</tr>
<tr>
<td>Other Current Liabilities</td>
<td>81</td>
<td>2,000</td>
</tr>
<tr>
<td>Incurred But Not Reported Claims/Claims Payable</td>
<td>16,748</td>
<td>33,316</td>
</tr>
<tr>
<td>Estimated Risk Share Payable</td>
<td>1,253</td>
<td>(147)</td>
</tr>
<tr>
<td>Due to State</td>
<td>-</td>
<td>(19,706)</td>
</tr>
<tr>
<td><strong>Net Changes to Payables</strong></td>
<td><strong>$15,403</strong></td>
<td><strong>$106,702</strong></td>
</tr>
<tr>
<td><strong>Net Cash Provided by (Used in) Operating Activities</strong></td>
<td><strong>$18,177</strong></td>
<td><strong>$45,279</strong></td>
</tr>
<tr>
<td>Change in Investments</td>
<td>($13)</td>
<td>$110,683</td>
</tr>
<tr>
<td>Other Equipment Acquisitions</td>
<td>(30)</td>
<td>(1,658)</td>
</tr>
<tr>
<td><strong>Net Cash Provided by (Used in) Investing Activities</strong></td>
<td><strong>($43)</strong></td>
<td><strong>$109,025</strong></td>
</tr>
<tr>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td><strong>$18,134</strong></td>
<td><strong>$154,304</strong></td>
</tr>
<tr>
<td>Cash &amp; Cash Equivalents at Beginning of Period</td>
<td>$214,245</td>
<td>$78,075</td>
</tr>
<tr>
<td>Cash &amp; Cash Equivalents at August 31, 2020</td>
<td>$232,379</td>
<td>$232,379</td>
</tr>
</tbody>
</table>
Meeting Minutes

Wednesday, September 23, 2020

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

Commissioners Present:
Ms. Dorothy Bizzini Public Representative
Mr. Dan Brothman Hospital Representative
Ms. Leslie Conner Provider Representative
Supervisor Ryan Coonerty County Board of Supervisors
Dr. Maximiliano Cuevas Provider Representative
Dr. Larry deGhetaldi Provider Representative
Ms. Julie Edgcomb Public Representative
Ms. Mimi Hall County Health Services Agency Director
Ms. Elsa Jimenez County Health Director
Ms. Shebreh Kalantari-Johnson Public Representative
Supervisor Lee Lor County Board of Supervisors
Mr. Michael Molesky Public Representative
Ms. Rebecca Nanyonjo Director of Public Health
Supervisor Jane Parker County Board of Supervisors
Ms. Elsa Quezada Public Representative
Dr. James Rabago Provider Representative
Dr. Allen Radner Provider Representative
Dr. Joerg Schuller Hospital Representative
Mr. Rob Smith Public Representative
Mr. Tony Weber Provider Representative

Commissioners Absent:
Dr. Gary Gray Hospital Representative

Staff Present:
Ms. Stephanie Sonnenshine Chief Executive Officer
Ms. Lisa Ba Chief Financial Officer
Dr. Dale Bishop Chief Medical Officer
Ms. Marina Owen Chief Operating Officer
1. **Call to Order by Chairperson Coonerty.**

Commission Chairperson Coonerty called the meeting to order at 3:00 p.m.

Roll call was taken and a quorum was present.

Chair Coonerty welcomed new Board member, Mr. Dan Brothman.

No changes to the agenda were made.

2. **Oral Communications.**

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

No members of the public addressed the commission.

3. **Comments and announcements by Commission members.**

Chair Coonerty opened the floor for Commissioners to make comments.

Commissioner Molesky recognized leadership, staff and the Board’s efforts during the pandemic and area wildfires.

[Commissioner Rabago arrived at this time: 3:07 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 reminded the Board of teleconference meeting procedures and Closed Session logistics.

Ms. Sonnenshine provided an update on federal Medicaid policy. The Centers for Medicare and Medicaid Services recently announced a decision to withdraw the Medicaid Fiscal Accountability Rule. The proposed rule jeopardized California’s public hospital financing, renewal of the Managed Care Organization tax, the Hospital Quality Assurance Fee program, intergovernmental transfers, disproportionate share hospital funds and other supplemental payments.

**Consent Agenda Items: (5. – 9H.): 3:14 p.m.**

[Commissioner Smith arrived at this time: 3:14 p.m.]

Chair Coonerty opened the floor for approval of the Consent Agenda.
Commissioner Parker inquired about current financial challenges and their impact to the organization. Ms. Sonnenshine responded that Ms. Lisa Ba, Chief Financial Officer, plans to bring the financial forecast information to the October Board meeting for a comprehensive overview and discussion.

Commissioner deGhetaldi asked why commercials earn more in this time and which aid categories are seeing growth.

**MOTION:** Commissioner Bizzini moved for approval of the Consent Agenda, seconded by Commissioner Cuevas.

**ACTION:** The motion passed with the following vote:

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

**Noes:** None.

**Absent:** Commissioner Gray.

**Abstain:** None.

**Regular Agenda Item:** (10. - 12.): 3:14 p.m.

10. **Consider approving recommendations on Medi-Cal Capacity Grant Program Funded Pilots. (3:14 – 3:54 p.m.)**

Ms. Sonnenshine introduced Ms. Kathleen McCarthy, Strategic Development Director. Ms. McCarthy provided background on the Post-Discharge Meal Delivery Pilot and presented the evaluation findings and recommendations.

Chair Coonerty advised that all Commissioners are eligible to discuss and vote on item 10, #1.

**MOTION:** Vice Chair Conner moved to 1) transition the Post-Discharge Meal Delivery Pilot to an Alliance-only benefit, effective January 2021; and 2) extend the Post-Discharge Meal Delivery Pilot until the benefit is implemented, and allocate up to $70K in bridge funding from the Medi-Cal Capacity Grant Program unallocated budget to continue enrollment of Monterey County members for the duration of the pilot, seconded by Commissioner Parker.

**ACTION:** The motion passed with the following vote:

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

**Noes:** None.

**Absent:** Commissioner Gray.

**Abstain:** None.
Ms. McCarthy provided background on the Intensive Case Management (ICM) Program and presented the evaluation findings and recommendation. Commissioners discussed the long term value of ICM and alternative options for improved health outcomes in the future.

Chair Coonerty reminded the Board that those who perceive that they are at risk for conflicts of interest are advised to refrain from influencing the discussion and abstain from voting on item 10, #2.

**MOTION:** Commissioner Parker moved to approve retirement of the Intensive Case Management Program, effective December 31, 2020, seconded by Commissioner deGhetaldi.

**ACTION:** The motion passed with the following vote:

- **Ayes:** Commissioners Bizzini, Brothman, Coonerty, deGhetaldi, Edgcomb, Hall, Kalantari-Johnson, Lor, Molesky, Nanyonjo, Parker, Quezada, Rabago, Radner, Schuller, and Smith.
- **Noes:** None.
- **Absent:** Commissioner Gray.
- **Abstain:** Commissioners Conner, Cuevas, Jimenez and Weber.

**11. Discuss 2020 Health Education and Cultural and Linguistic Population Needs Assessment. (3:54 – 4:10 p.m.)**

Ms. Sonnenshine introduced Ms. Michelle Stott, Quality Improvement & Population Health Director. Ms. Stott provided an overview of the Population Needs Assessment (PNA) requirements, reviewed key PNA findings and reviewed next steps.

[Commissioner Molesky departed at this time: 3:55 p.m.]

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

Due to time constraints, Item 12 was presented when the Board reconvened to Open Session.

**Adjourn to Closed Session**

Chair Coonerty moved the commission into Closed Session at 4:11 p.m.

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

**14. Closed session pursuant to Government Code Section 54956.9, subdivision (d)(2) – Conference with Legal Counsel - Related to litigation exposure.**
[Commissioner Nanyonjo departed at this time: 4:13 p.m.]

[Commissioner Parker departed at this time: 4:24 p.m.]

[Commissioner Rabago departed at this time: 4:44 p.m.]

Return to Open Session

Chair Coonerty reconvened the meeting to Open Session at 4:47 p.m.


Chair Coonerty reported from Closed Session that no action was taken by the Board.

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

Chair Coonerty 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 recommendation. The vote passed with 17 ayes and four absent.

12. Discuss Alliance response to environmental disruptions. (4:48 – 4:58 p.m.)

Ms. Sonnenshine, CEO, discussed the Alliance’s response to COVID-19 and the recent wildfires impacting service areas. Despite these disruptions, performance is on track in most areas as indicated by the Q2 2020 Quarterly Dashboard. Staff continue to monitor case progression and continue outreach and engagement with providers and members to ensure access to care. Staff will also continue to monitor the status of the emergency order both at the State and federal level as well as the outcomes from the November 2020 election.

Ms. Sonnenshine informed the Board that the Q2 2020 Quarterly Dashboard and detailed staff reports on COVID-19 and the Alliance’s emergency response to area wildfires were provided in the September 23, 2020 Board packet.

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

The Commission adjourned its meeting of September 23, 2020 at 4:58 p.m. to October 28, 2020 at 3:00 p.m. via videoconference from Alliance offices in Scotts Valley, Salinas, and Merced unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board
COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, July 15, 2020
8:30 – 10:00 a.m.

Via Videoconference

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

Committee Members Excused:
None

Ad-Hoc Attendees:
Kate Knutson  Compliance Supervisor
Paige Harris  Compliance Specialist

1. Call to Order by Chairperson Mandella.

Chairperson Jenifer Mandella called the meeting to order at 8:32 a.m.

2. Review and Approval of June 17, 2020 Minutes.

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

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

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

   1. Delegate Oversight Quarterly Report

Somoza, Compliance Manager, presented the Delegate Oversight Quarterly Activity Report which included the 2020 Annual Review, Continuous Oversight Activities for Q1 2020, and Continuous Oversight Follow-up Activities for Q4 2019.

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

Staff recommended approval of the following activities:
   • Beacon/CHIPA: Compliance and Finance
   • CareNet: Member Compliance and Cultural and Linguistic Services (C&L)
   • MedImpact: Compliance and Finance
   • VSP: Compliance and Member Rights - PHI

Staff recommended holding approval of the following activities pending staff review of documentation as described below:
• Beacon/CHIPA: Quality Improvement (QI) and Utilization Management (UM)
• MedImpact: Provider Disputes
• PAMF: Credentialing
• SCVMC: Credentialing
• UCSF: Credentialing
• VSP: Finance

COMMITTEE ACTION: Committee reviewed and approved the 2020 Annual Review and assigned the following action items:
- Gillette-Walch to review Beacon/CHIPA QI documents and complete annual review.
- Brusuelas to review Beacon/CHIPA UM documents and complete annual review.
- Alvarez to review MedImpact Provider Disputes documentation and complete annual review.
- Dybdahl to review PAMF, SCVMC and UCSF Credentialing documentation upon receipt and complete annual review.
- Ba to review VSP Finance documentation upon receipt and complete annual review

Q1 2020 Continuous Oversight Activity
Staff recommended approval of the following Q1 2020 reports received from delegates:
- Beacon/CHIPA: Claims, Member Grievance, Network Adequacy, QI and UM
- ChildNet: Credentialing
- MedImpact: Network Adequacy, Provider Disputes
- SCVMC: Credentialing
- UCSF: Credentialing
- VSP: Claims, Credentialing, Member Grievance and QI

Staff recommended holding approval of the following activities pending staff review of documentation as described below:
- Beacon/CHIPA: Credentialing, Member Connections and Provider Disputes
- LPCH: Credentialing
- MedImpact: Credentialing
- PAMF: Credentialing
- VSP: Member Connections and Provider Disputes

COMMITTEE ACTION: Committee reviewed and approved staff recommendations related to the Q1 2020 Continuous Oversight Activities and assigned the following action items:
- Dybdahl to review Beacon/CHIPA, LHPC, MedImpact and PAMF Credentialing documents and complete quarterly review.
- Torres to review Beacon/CHIPA and VSP Member Connections documents and complete quarterly review.
- Alvarez to review Beacon/CHIPA and VSP Provider Disputes documents and complete quarterly review.

Follow-Up to Q4 2019 Continuous Oversight Activity
Staff recommended approval of the following Q4 2019 quarterly reports received from the following delegates:
- Beacon/CHIPA: Member Grievance and UM
COMMITTEE ACTION: Committee reviewed and approved staff recommendations related to the follow up to Q4 2019 Continuous Oversight Activities and assigned the following action items:

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

2. HIPAA Quarterly Report

Mandella, Compliance Officer, presented the Q2 2020 HIPAA Quarterly Report, noting that staff have been focused on assisting the organization in maintaining operations in a HIPAA compliant manner during the COVID-19 pandemic and shelter-in-place orders.

Mandella reviewed HIPAA disclosure notifications received in Q2 2020 and reviewed trends for HIPAA related events in Q2 2020, noting that the most notable trend was the increase in incidents and breaches impacting greater than 500 members. Two separate incidents impacting over 500 members were reported during Q2 2020, both of which were the result of phishing attacks. Mandella reviewed actions taken in response to these incidents, including Compliance Committee and staff trainings on phishing and social media hacking. The group discussed limiting emails containing protected health information by emailing links to internal files as a possible solution.

Trinh, Security Officer, presented security updates for Q2 2020 and provided an overview of email rejection rates for malicious emails sent to Alliance staff. Trinh reported that the following security related activities took place in Q2 2020:

- Review of Alliance-owned domain
- Review of Alliance staff with access to Iron Mountain for retrieval of backup tapes
- Implementation of additional safeguards through Mimecast to block phishing emails attempting to impersonate a Chief
- Completion of email phishing training course for all Alliance staff
- Installation of updates and patches to the firewalls in Scotts Valley and Merced
- Disabling access to Outlook via webmail until two-factor authentication can be enabled

COMMITTEE ACTION: Committee reviewed and approved the Q2 2020 HIPAA Quarterly Report.

3. DMHC Follow Up Survey Update

Carlson, Government Relations Director, provided an update to the follow-up survey performed by the Department of Managed Health Care (DMHC) in relation to the deficiencies found during the 2017 Medical Survey. Deficiencies centered around DMHC required statutory language in member EOCs and UM and Pharmacy denial letters. Carlson reported that, although all deficiencies have been corrected, DMHC will be imposing a fine which could range from $15,0000-$300,000.
The Committee discussed current processes for reviewing and correcting language in
documentation and reviewed the efficacy of those processes and controls. Mandella noted
that process improvement and implementation of workflows is ongoing.

The meeting adjourned at 9:18 a.m.

Respectfully submitted,

Robin Sihler
Administrative Assistant - Compliance
Meeting Minutes
Wednesday, May 27, 2020
1:30 – 2:45 p.m.

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

Commissioners Present:
Ms. Leslie Conner
Ms. Mimi Hall
Ms. Elsa Jiménez
Supervisor Lee Lor
Mr. Michael Molesky
Mr. Allen Radner
Mr. Tony Weber

Provider Representative
County Health Services Agency Director
County Health Director
County Board of Supervisors
Public Representative
Provider Representative

Staff Present:
Ms. Lisa Ba
Ms. Stephanie Sonnenshine
Ms. Tina Bernard

Chief Financial Officer
Chief Executive Officer
Finance Administrative Specialist
1. Call to Order by Chairperson Molesky. (1:30 p.m.)

Chairperson Molesky called the meeting to order at 1:30 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:33 – 1:34 p.m.)

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

No members of the public addressed the Committee.

3. Approve minutes of February 26, 2020 meeting of the Finance Committee. (1:34 – 1:37 p.m.)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the February 26, 2020 meeting. Commissioner Conner moved to approve the minutes, seconded by Commissioner Webber. Motion carried with 7 votes affirmative and was so ordered.

4. Payment Assessment for Medical Cost Analysis (Discussion) – Edrington Healthcare Consulting. (1:40 – 2:03 p.m.)

Edrington Health Consulting was engaged by the Plan to assess its provider payment structure. The firm provides actuarial consulting support to health plans, state agencies, provider and advocacy groups, and other stakeholders. The firm is engaged by ten of the sixteen local Medi-Cal health plans in California.

The Medi-Cal delivery system utilizes different types of reimbursement with a higher focus on capitated arrangements. The Alliance employs capitated contracts less frequently than other Medi-Cal plans with a higher direct fee-for-service (FFS) arrangement. This exposes the Alliance to the risk of utilization changes and scrutiny from DHCS on the appropriateness of those contracted levels. One of the advantages of direct contractual arrangements from the health plan perspective is the collection of more timely and reliable encounter data.

The firm benchmarked a broad level of expense categories against geographically similar plans to identify expense level themes. They determined that the Alliance hospital rates for Inpatient Services are 25% higher when compared to other plans that generally follow the State’s All Patients Refined Diagnosis Related Groups (APR-DRG) payment mechanism for direct contracts. APR-DRG is the State’s gold standard within its FFS payment structure that allows for transparent payment levels. The second theme identified is Specialists who are reimbursed at a higher rate closer to the Medicare payment structure, which is commonly applied across the State for Specialty services.

Mr. Edrington noted that changes in the State's 2020-21 May Revision budget might potentially address higher levels of payment within the Alliance's counties. DHCS intends to standardize rates and the rate development process across all managed care plans by implementing regional rates. The State will issue rates in phases over the next few years, beginning with blended rates across all counties. In the second phase, regions will be created across multiple counties to further standardize rates within those counties. The date of implementation is undetermined given the current pandemic environment. Mr. Edrington advised that the Plan proactively implement cost containment strategies to mitigate adverse financial implications in the future.

Ms. Lisa Ba, Chief Financial Officer (CFO), provided the background for the cost containment work. The Alliance will lose more than $200M for the three years ending 2020, and operating reserve will continue to fall below the Board Designated Reserve target. Staff analysis identified reimbursement rates above industry standard as the primary cause of loss. The Alliance’s goals are to align medical costs and utilization with revenue trends; align contracts to industry standard payment methods; maintain and/or improve provider network services for Alliance members; and maintain and improve operational efficiency of Alliance staff and providers.

Ms. Ba presented a five-year financial look back and five-year projection under the Plan’s current payment structure. The loss totaled $89M in 2018, $73M in 2019, and a $53M loss is budgeted in 2020. The fund balance in 2024 will be less than $100M and two times below the State Tangible Net Equity (TNE), opening the Alliance to risk of intervention from the Department of Managed Health Care (DMHC).

Ms. Ba explained staff’s cost analysis started with a review of year-over-year admin costs. Staff employed comprehensive cost reduction measures that lowered admin ratio from 7.7% to the current target of 6.9%. Staff continued with an analysis of the top medical expense categories. Inpatient Hospital and Outpatient Facility costs have increased respectively 16% year-over-year. Inpatient increase is due to an average 10% year-over-year increase in contract rates, combined with an increase in utilization. Increase to outpatient cost is due to changes in provider billing practices. For example, one hospital contracted with the Alliance purchased outpatient clinics and billed pharmacy injectables at the outpatient hospital rate. The Plan anticipates a 2-4% annual increase from DHCS after the State-wide efficiency adjustment is applied. The gap between inpatient revenue and cost is close to $50M and is projected at $105M after factoring in the State’s May Revision.

Ms. Ba commented that the rate setting methodology used by the Department of Health Care Services (DHCS) is based on unit cost, utilization, and efficiency adjustment. The Alliance has not met its utilization targets, and higher utilization coalesced with year-over-year provider rate increases is the root cause of the Plan’s ongoing financial loss.

Staff reviewed factors that impact medical costs and implemented initiatives to control utilization, such as the Intensive Care Management, Post-discharge Meal Delivery, and Respite Care programs. In conjunction, member outreach activities increased to promote a healthier population. The remaining factor to address is high Inpatient Hospital rates.

Analysis showed that the Alliance could achieve a savings of $84M over the next four years if the APR-DRG payment structure is implemented. An additional savings of $12M is projected if outpatient reimbursement is reduced to 120% of the Medi-Cal fee schedule. The State’s May Revision budget includes an inpatient maximum fee schedule at APR-DRG with efficiency adjustments for Emergency Departments (ED) and Physician Administered Drugs (PAD). Underwriting gain will be reduced from 2.0% to 1.5%. Funding for supplemental programs such as Prop 56, Community Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) will be redirected towards the expansion of Medi-Cal. The May Revision also reduce the Plan bridge period rate by 1.5%, retroactive to July 2019.

Staff recommend that the Plan move to the current Medicare Physician Fee Schedule in 2021 for specialists and offset the cost by eliminating the Specialty Care Incentive (SCI) program. The Provider Advisory Group (PAG) approved staff modifications to the 2021 Care-Based Incentive (CBI) criteria for Primary Care Physicians (PCP) and Federally Qualified Health Centers (QHC) in
March 2020. Staff does not recommend changes to other provider types at this time.

Ms. Ba recapped staff considerations based on known and unknown factors. The known factors are that costs are above revenue, inpatient reimbursement rates do not align with industry benchmark, reserve is below the Board Designated Reserve target and the State’s 2020-21 May Revision budget. The unknown factors are revenue reduction in 2021, benefit changes, enrollment levels, and future State budget reductions. Staff recommend immediate action to address the known factors and prepare the Alliance for upcoming uncertainty.

Staff asked the Committee for directives to implement a medical cost containment plan to achieve provider rates in line with revenue rate, utilization trends and industry standard payments. The Plan will allow staff to renegotiate hospital contracts and implementation of Medicare Physician Fee Schedule for referral Specialists, effective January 1, 2021. Staff also asked the Committee to adopt a measure of performance of achieving a minimum net income of 1.5% by 2024.

Ms. Ba opened the floor for discussion.

FINANCE COMMITTEE ACTION: Chairperson Molesky moved to approve staff recommendations to implement a cost containment plan and adopt a measure of performance for net income of 1.5% by 2024. Motion carried with 7 votes affirmative and was so ordered.

Staff’s next steps are to evaluate network access, develop a mitigation plan, engage the PAG, and perform outreach to key providers before June’s Board Meeting. The Finance Committee’s cost containment recommendations will be presented to the Board on June 24, 2020.

The Commission adjourned its meeting of May 27, 2020 at 2:45 p.m. to September 23, 2020 at 1:30 p.m. via videoconference from the Alliance office in Scotts Valley, Salinas, and Merced.

Respectfully submitted,

Ms. Tina Bernard
Finance Administrative Specialist
Meeting Minutes
Thursday, June 18, 2020
12:00 p.m. - 1:00 p.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California

In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California

In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California

Committee Members Present:
Liz Falade, MD Provider Representative
Robert Dimand, MD Provider Representative
Gary Gray, DO Board Representative
John Mark, MD Provider Representative
Patrick Clyne, MD Provider Representative
Jennie Jet, MD Provider Representative

Committee Members Absent:
Amanda Jackson, MD Provider Representative
Karen Dahl, MD Provider Representative
Salem Magarian, MD Provider Representative

Staff Present:
Dale Bishop, MD Chief Medical Officer
Maya Heinert, MD Medical Director
Lilia Chagolla Regional Operations Director
Mary Brusuelas, RN UM & Complex Case Management Director
Michelle Stott, RN Quality Improvement & Population Health Director
Hillary Gillette-Walch, RN, MPH Clinical Decision Quality Manager
Sarah Sanders Grievance and Quality Manager
Tammy Brass, RN UM Manager - Prior Authorizations
Tracy Neves Clerk of the Committee

Hospital Representatives Present:
Sherrie Sager Hospital Representative

1. Call to Order by Chairperson Bishop.

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

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

No members of the public addressed the Committee.

3. Consent Agenda Items.

A. Approval of WCMCAC Minutes
   Minutes from the March 19, 2020 meeting were reviewed.

B. Grievance Update
   Sarah Sanders, Grievance and Quality Manager, provided a brief Grievance update. Noted was a decline in grievances.

M/S/A Consent agenda items approved.

4. Old Business

A. Alliance Whole Child Model (WCM) Program Optimization
   Mary Brusuelas, UM Director & Tammy Brass, UM Manager, provided a WCM Program update. Mary noted that since the last meeting pediatrics has integrated into the UM department and there has been a tremendous amount of work into the WCM optimization with input from Dr. Diallo & Dr. Dimand as well as others. Moving forward, there may be changes and topics that will be brought to this committee for discussion as the program evolves. Mary noted Tammy has put together a strong team.

   Tammy shared that the team includes Mary, Tammy, two supervisors, a registered nurse (RN) team, and care coordination team. Work began long before the March go-live date. There are five areas below that have been the main focus in building the program:
   • Risk Stratification
   • Individualized Care Plan
   • Eligibility
   • Age Out Process
   • Communication

   Risk stratification helps to identify CCS eligible members and follow them closely and appropriately. A tool was developed to better define high risk. High Risk is increased risk of adverse health outcome or worsening health status if member does not have an individualized care management plan.

   High Risk Examples:
   • Member has no UM or claims data on record, unable to contact.
   • Hospitalizations in last 90 days or 3+ in the past year.
   • Inpatient meals or lodging requests.
   • 3 or more ER visits in the past year.
   • Behavioral Health diagnosis or Developmental Disability + chronic medical diagnosis or social concern.
• End stage renal disease, transplant, cancer, AIDS, pregnancy, on oxygen past 90 days, polypharmacy, antipsychotic medication.

Low risk members are followed by the care coordination team and high risk by the RN team.

The Age Out process was previously initiated at 3 months but now is done at 6 months.
  • Report identifying members 6 months in advance.
  • Cases are assigned out to the team monthly.
  • Age Out Assessment Tool Developed
    • PCP, prescriptions, DME, food/housing/resources, apt scheduling, assess. specialists/needs, transportation. Conservatorship if needed.
  • Hand off to internal Adult CM.
  • 3 year tracking.

The team works with the member to transition into the adult world.

Early improvements include:
  • 100% of staff completed self-audits using our comprehensive audit tool.
  • Care Plan (ICP) rates are over 90% for our high risk members; approximately 500 ICPs as of this week.
  • Inpatient Report utilized to identify high risk members and demonstrates early identification and awareness of these members (1-2 new referrals per week).
  • Cross training and ongoing training is provided at regular frequency to the team.

An overview of the team’s internal and external communication was provided to the committee. A provider noted that communication has improved. Dr. Bishop thanked Tammy & Mary for all their work and efforts and to the WCMCAC for communicating gaps in care.

5. New Business
A. COVID-19

Dr. Bishop noted that within the first few weeks of shelter-in-place, the pediatric team began calling members to inquire about any difficulties they were experiencing; there were issues regarding testing and food insecurity.

Tammy noted the requests were in regard to durable medical equipment (DME), food, masks and household items. Feedback from members has been positive regarding telehealth visits. There was testing that was being directed to Stanford and the team worked to obtain testing locally for members. Provider noted they are conducting video visits and it is going well. Other providers noted they have been conducting COVID testing in office prior to the member's operations/procedures. There have been some issues around technology and telehealth so some of the providers are checking in with members the day before their visits. It was also noted many classes for members have been moved to online and it has been working well.
B. **Resuming Care**  
Dr. Bishop noted the Alliance has encouraged members to seek care and the pediatric team began working on outreach early. The Alliance received feedback that some members were afraid to seek care.

There has been a big effort to reach out to vulnerable members and pediatrics. The Alliance is working with Scripps on a resuming care program that is going to begin shortly.

6. **Open Discussion**  
Chairperson Bishop opened the floor for Committee to have open discussion.

No further discussion.

The meeting adjourned at 1:00 p.m.

Respectfully submitted,

Ms. Tracy Neves  
Clerk of the Advisory Committee

The Whole Child Model Clinical Advisory Committee is a public meeting.
DATE: October 28, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Stephanie Sonnenshine, Chief Executive Officer
SUBJECT: DHCS Medi-Cal Contract Amendments #08-85216 A-44 and #08-85223 A-11

Recommendation. Staff recommend the Board authorize the Chairperson to sign Amendment #44 to the Alliance’s primary Medi-Cal contract number 08-85216 and Amendment #11 to the Alliance’s secondary Medi-Cal contract number 08-85223 to extend the term of the contract to December 31, 2021.

Summary. The Alliance Medi-Cal contracts with the Department of Health Care Services (DHCS) currently extend through December 31, 2020. DHCS is seeking to extend the term of the agreements an addition 12 months.

Background. The Alliance contracts with DHCS to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey and Merced counties. The Alliance entered into the primary Agreement 08-85216 and the secondary agreement 08-85223 with DHCS on January 1, 2009. Each have subsequently been amended via written amendments (A-1 through A-43 and A-1 through A-10 respectively).

Discussion. DHCS has prepared amendments to the Alliance’s State Medi-Cal contracts to extend the term of the contracts to December 31, 2021, to obtain a continuation of the services identified in the original agreements. Board authorization for the Chairperson to sign the Amendments is required.

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

Attachments. N/A
Delegate Oversight - Annual Review

The Alliance performs annual reviews of delegates to ensure these entities continue to meet Alliance standards as set forth in contracts, legislation and regulations. Annual reviews consist of reviewing delegate documents for delegated activities as well as for non-delegated activities to ensure delegates meet all requirements imposed on the Alliance by its regulators. When non-compliance is identified and/or if questions arise from the review, the Alliance pends the approval of that function, and follows up with the delegate to obtain additional information.

Delegated and Non-Delegated Functions Reviewed Annually (13)

- Quality Improvement
- Claims Payment
- Network Management
- Compliance
- Fraud, Waste and Abuse
- Finance
- Utilization Management
- Member Connections
- Member Grievances
- Provider Disputes
- Credentialing
- Culture & Linguistics
- Member Rights

Entities Approved for 2020 Delegation

This chart displays the total amount of reviewed functions per entity that are approved for CY 2020.

As of Q2-2020, 84% of delegated functions for 2020 were approved via the Alliance’s Delegate Oversight Program.

* Pending functions are defined as Not Reviewed/Outstanding

Continuous Delegate Oversight - Q1-2019 Review

The Alliance conducts oversight, monitoring and evaluation of functional areas that are delegated to Delegate Entities. The Alliance reviews data and regular reports from delegates on standards and metrics are met on a quarterly basis. When non-compliance is identified, the Alliance pends the approval of that function, and follows up with the delegate to obtain additional information. If non-compliance continues for two or more consecutive quarters, the Alliance may issue the delegate a Deficiency Letter, and/or impose a Corrective Action Plan on the delegate.

Delegated Functions Reviewed Quarterly (8)

Quarterly Reports Reviewed & Approved

This chart displays the status of the total quarterly report inventory reviewed for delegated functions. The Alliance conducts monitoring of delegated functions through quarterly reviews of submitted reports by delegates.

For Q1-2020, 47 of 85 reports are Approved. 38 reports are Pending Approval.

* Pending functions are defined as Not Reviewed/Outstanding

Delegate Entity Compliance Oversight Activities

In addition to annual and quarterly reviews, the Alliance may conduct additional performance management activities to ensure adequate performance goals are achieved.

Warning letters: Official notifications to delegates informing them of potential deficiencies, and that failure to address the concern(s) will result in Corrective Action(s);

Corrective Actions: Action plans imposed on delegates to address identified deficiencies, which require specific actions and follow up activities.

During Q1-2020, no new CAPs or Warning Letters were opened. There is 1 open CAP related to Quality Improvement function; resolution is in progress.
Reports of Suspected Disclosures by Quarter
Compliance received a total of 19 reports of suspected unauthorized disclosures of Protected Health Information (PHI) during Q2-2020 (This is all suspected events, whether or not they were deemed reportable upon investigation)

Sources of Disclosures: Internal (Alliance) & External (Non-Alliance)
Compliance tracks whether the disclosure was caused by internal Alliance departments or by external entities, including providers and delegates.

*Excludes Non-Events and Duplicates

Impact of Reportable Events (excludes Non-Events and Events Pending Investigation)
9 of 13 reportable events had an impact of low; 4 of 13 had an impact of of medium; 0 had an impact of high.

Impact levels are determined by analyzing whether PHI was disclosed to a HIPAA covered entity, whether the PHI has been destroyed or recovered, and the amount of time passed between discovery and notification to Compliance.

Final Classification
Staff are required to report all suspected unauthorized disclosures of PHI. Breaches are unauthorized disclosures of PHI to a non-covered entity; Incidents are unauthorized disclosures to covered entities; non-events are when the investigation reveals that no unauthorized disclosure of PHI occured.

Member Impact
47,772 members were impacted by HIPAA events in Q2-2020; 1,729 were due to incidents and 46,043 were due to breaches.

An incident occurs when PHI has been compromised or has a high probability of being compromised. A breach is when PHI has been compromised and can only be determined as such by the Alliance Privacy Officer.
Compliance
Internal Audit Dashboard - Q2-2020
Prepared for the Alliance Board

Reviews Completed by Risk Level
Compliance conducted a total of 8 risk-based internal reviews during Q2-2020. Items were selected for the work plan by prior year’s audit findings, new requirements, and DMHC sanctions of other plans. The internal audit program formally launched in April of 2018 and included internal audits and mock audits specifically related to Knox-Keene readiness and DHCS audit preparation.

Q2-2020 Reviews by Operational Area & Risk Level
Each review is assigned a SME department who has oversight responsibility of the requirement. The reviews are associated with a risk level that is assigned using objective risk criteria such as impact and complexity. The chart shows the number of reviews conducted by department within each risk level.

Q2-2020 Review Results by Operational Area
8 of 8 completed reviews received a passing score

Mitigation for Failed Reviews
Compliance partners with departments to ensure deficiencies are corrected through the following:

- Recommending process improvements
- Requesting action plans from departments to cure the deficiency
- Re-auditing in following quarters to ensure correction

Trending and Quarterly Review Results by Risk Level
Information presented here depicts where Compliance has issued findings based on risk level.

Q2-2020 Outcomes
High Risk Areas: 100% Passed
Medium Risk Areas: 100% Passed
Low Risk Areas: 100% Passed
Overall Result: 100% Passed
Matters Under Investigation (MUIs)
MUIs are classified by the target of the allegation/concern. 
["Other" example: if a member alleged a non-Alliance member used his/her Alliance ID card to fraudulently obtain prescription medications.]

<table>
<thead>
<tr>
<th>MUI Source</th>
<th>Waste</th>
<th>Member</th>
<th>State Request</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

MUIs by Status
If MUIs undergo a status change in a single quarter, they are reported once under current status at end of quarter. MUIs by status does not account for MUIs not in an Opened or Closed status in the quarter.

<table>
<thead>
<tr>
<th>Status</th>
<th>Opened</th>
<th>Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opened during quarter</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Closed during quarter</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

MUIs by County
Most MUIs are assigned a county affiliation. Where a provider serves multiple Alliance counties, or a member receives services in multiple Alliance counties, the county affiliation is identified by the billing address or mailing address, respectively.

- **Unaffiliated**: 10
- **Santa Cruz**: 2
- **Monterey**: 3
- **Merced**: 14

MUI Reporting Staff Department
The referral source represents the origin of the referral, not the nature of the allegation/concern.

- **ATS**: 1
- **Claims**: 2
- **Compliance**: 2
- **External - Anonymous**: 4
- **External - Delegate**: 5
- **External - Member**: 3
- **External - Provider**: 1
- **External - State Agency**: 6
- **External - Vendor**: 1
- **FWAP Activities**: 4
- **Medical Affairs Admin**: 1
- **Pharmacy**: 1
- **Provider Services**: 3
- **Quality Improvement**: 5
- **SIU Activities**: 6
- **Utilization Management**: 2

Investigation Duration Average
- Statistics are in business days, excluding holidays.
- Statistics represent the average of all MUIs closed in previous 12 months.

- **Average**: 104 Days

Financial Reporting
MUI's represents claims recovered by the SIU subsequent to the resolution of an MUI. Note, some MUI's may have originated as an audit project and escalated due to the nature of the audit findings.

Audit Projects represents claims recovered by the FWAP Program subsequent to the completion of an audit of multiple providers. Reported recoveries can be inclusive of various projects throughout a quarter (e.g. Provider Sampling; Upper Billing Limit; Smoking Cessation).

No Recoveries in Q2-2020

SCMMMCC Meeting Packet | October 28, 2020 | Page 8B-04
DATE: October 28, 2020
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.** During the month of September and early October, rates of new COVID-19 positive cases and hospitalizations have decreased significantly in Merced County and somewhat in Monterey County while a slight uptick in case rates and hospitalizations has been observed since mid-September in Santa Cruz County.

As of October 12, the total number of cases, deaths, and recent percent of positive tests reported in each county website was as follows:

<table>
<thead>
<tr>
<th>County</th>
<th>Positive Cases</th>
<th>Deaths</th>
<th>Positive Case % in last 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merced</td>
<td>9,149</td>
<td>150</td>
<td>3.6</td>
</tr>
<tr>
<td>Monterey</td>
<td>10,684</td>
<td>80</td>
<td>5.8</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>2,609</td>
<td>20</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Disparities in infection rates in all three counties continue to be observed with rates remaining highest among the Latino population, 74% of the positive cases in Merced and Monterey Counties occurring among this population. In Santa Cruz County, the Latino population is also the majority of cases at 51% with the Caucasian population second at 42%. Case rates remain highest in South Merced, East Salinas, South Monterey County and South Santa Cruz County. Following the wildfire in North Santa Cruz County, a localized outbreak was anticipated due to evacuation and sheltering in close proximity, however, case rates in the North County population have not increased.

Rates of COVID-19 hospitalizations and deaths in Alliance membership remain significantly lower than those noted county-wide.

**Discussion.**

**COVID-19 Organizational Performance.** Operational actions responsive to the pandemic have continued. Actions as previously reported included the adaptation of operational processes to mitigate service impacts and monitoring of core operational process performance through a daily organizational dashboard. Daily monitoring of core operational processes supports timely and informed actions responsive to evolving needs. Key insights from this operational process monitoring during Q3 2020 include:
• **Core operational performance** achieved 99.3% of target during the quarter, trending flat over Q2 2020 performance on average. Daily operational metrics monitored include member complaint resolution timeliness, member and provider telephonic service levels, and authorization decision timeliness.

• **Core operational inventory volumes** remained mixed during Q3 2020, with inbound member calls, authorization inventory and provider inquiries/disputes averaging 65.8%, 68.9% and 85.2% of pre-pandemic baseline volumes, respectively. Exceptions to below baseline inventory include inbound calls to the Nurse Advice Line and claims inventory, which averaged 105.6% and 142.2% of baseline during Q3 2020.

• **Claims inventory** initially declined by approximately 25%-30% during the first two months of the Pandemic (April-May). In Q3 the overall claims volume seems to have stabilized at approximately 95% of pre-pandemic levels. It should be noted that August claims volume was slightly lower than the quarterly average and may have been adversely impacted by evacuations caused by the fires in our service area. Available indicators reveal ongoing achievement of all applicable regulatory, contractual and core program obligations at this time.

**Community Coordination.** On September 21, 2020, the Alliance held a Central Valley Home and Community Based Services (HCBS) convening in Merced County to discuss ways to leverage existing community resources to support older adults and people with disabilities at risk of COVID-19, as well as to discuss ways to provide care after hospitalization for COVID-19 infection safely in non-congregate living settings. Medi-Cal Managed Care Plans, like the Alliance, were asked by the Department of Health Care Services (DHCS) to hold these convenings in Central Valley Counties in which a plan operates. The objective of the convening is to strengthen communication, collaboration, and home and community-based service referrals among local participants for Alliance/Medi-Cal members. Invited participants included hospitals, Community Based Adult Services centers, skilled nursing facilities, county programs such as Adult Agency on Aging, MSSP, IHSS, and other LTSS organizations. The convening addressed how the agencies and providers can work together to close gaps in care and to offer care at home when feasible. One of the convening deliverables is the development of a HCBS document to promote provider awareness of these available community resources. Additional convenings will be scheduled quarterly (or sooner, if necessary, in the case of a surge in cases).

Convenings with the Public Health departments to collaborate on health promotion and testing were held in early October. Public Health Department leadership informed Alliance staff of their current and upcoming priorities regarding member and provider messaging and testing. Several opportunities for the Alliance to join community collaboratives including the Farm Worker Protection Collaborative in Monterey County and the Santa Cruz Testing Taskforce were identified.

As a health plan who serves the most underserved populations in our service area, the Alliance is positioned to support the efforts of county leaders, community-based organizations, and providers to inform and educate members on the value of prevention efforts.
COVID-19 Community Response. The Alliance continues to respond to the COVID-19 pandemic affecting our communities. To keep informed with the most recent resources, efforts, and needs within each county, Alliance staff engage in regular calls and collaborative work with county leaders and local organizations to support the existing efforts to protect the community, planning strategies to address local needs, and provide information to support member needs and care coordination, especially for the Alliance’s most vulnerable populations. As the need and resources vary in each county, coordination is critical to assure members and community partners are provided current information around resources available in their community.

Resuming Care Task Force (RCTF). The RCTF continues to meet weekly with the goal of facilitating the safe and timely resumption of care to reduce health disparities by connecting with members by providing education and support, coordinating provider outreach and communicating with community partners.

Resuming Care Communications. In September, Alliance Communications promoted the “Check-in Check-up” campaign which included two 30 minute staff radio interviews in English and Spanish, six editorials in local papers, and multiple public service announcements. In October, Communications pivoted to “Save a Life, Get a Flu Shot” campaign wherein flu vaccine is being promoted.

Resuming Care: Member Outreach Calls. The goal of member outreach calls is to provide specific, useful information to families and individuals that include:

1. Reconnecting with their healthcare provider for an appointment, whether in-person or virtual.
2. How to safely return to a provider’s office.
3. Why routine check-ups are important even when you’re not sick.
4. Why vaccinations including the flu shot are a critical part of individual healthcare especially during the COVID pandemic.

Multiple teams including the Your Health Matters Outreach volunteer staff were involved in making these important calls.

The Alliance Complex Case Management team continues to reach out to members to offer case management for high-risk pediatric and adult members with chronic conditions, and members needing follow-up of hospital discharge. Additional verbiage encouraging the safe resumption of care was added to these outreach calls.

Outreach to families of pediatric members to resume preventive care visits starting with 0-3 years began in early October and will move to older children throughout the fall.

Resuming Care: Provider Updates. In late September, hospitals in Merced and Monterey began to see decreases in COVID-19 admissions. Santa Cruz has had small upticks in hospitalizations in October but all regional hospitals have capacity at this time. Skilled Nursing Facility (SNF) access has also remained adequate.

During the last week of September and into mid-October, an outbreak occurred at a Watsonville Skilled Nursing Facility potentially exposing 53 Alliance dual covered Medicare-
Medi-Cal members. Several members were hospitalized and as of October 7, there were two deaths of dual covered Alliance (Medicare-Medi-Cal). Santa Cruz Public Health, the National Guard and local EMT organizations assisted and Alliance concurrent review staff communicated frequently with SNF staff. At this time, the situation appears to have stabilized.

Provider Services continues to conduct weekly outreach to outpatient providers to answer questions, troubleshoot and share relevant information. The Provider Call Campaign (Campaign), launched in April 2020 with the objectives of connecting with, educating, and supporting providers.

Over 3,000 calls have been placed to providers as part of the Campaign, with messaging varying both in content and audience based on emerging needs. Complementing phone calls are eNewsletters, fax and email messaging, and the Alliance Provider Bulletin, all of which provide information on topics related to resuming care, such as expanded telehealth allowances. Weekly summaries of Campaign activities are produced and distributed to Alliance leadership, further supporting the coordination of outreach efforts to providers. The Campaign will continue through the end of the year with evolving messaging focused on testing, member guidance, and telehealth flexibilities.

Workspace Reentry Taskforce (WRT). As communicated to the Board in late July, staff evaluated the need for and requirements to safely reopen the Alliance’s offices to inform a reentry plan. This assessment included an evaluation of the business need to physically reopen Alliance offices and the risks of doing so. The outcome of that analysis was a decision to reopen the Alliance’s offices no sooner than February 1, 2021. Key to this decision are the Alliance’s demonstrated ability to deliver on our obligations under remote operations, the increasing cases in all three counties, the likelihood of increased infection for Alliance staff if working indoors in close-proximity, and the costs and resource intensity of implementing precautionary measures to allow non-essential staff back into buildings.

Additional recommendations to keep the essential staff working safely onsite were also approved. Safety measures implemented include an audit of who needs to work onsite and reducing the number of essential staff onsite, implementing daily health screening protocols, separating workspaces to increase physical distancing, and improving building ventilation to increase intake of outside air.

A COVID-19 Workplace Health & Safety Plan to provide written procedures and guidelines to ensure staff health and safety for the duration of the COVID-19 pandemic was developed. To address ergonomic health needs, the Alliance implemented a contactless procedure for staff to pick-up technology and workstation items curbside.

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

Attachments. N/A
DATE: October 28, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Danita Carlson, Government Relations Director
SUBJECT: 2020 Legislative Session Wrap-up

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

Summary. Staff provides a summary of the 2020 legislative session including outcomes of bills of interest and potential impact.

Background. The official end of the 2020 legislative session came at midnight on September 30, 2020 with the deadline for Governor Newsom to sign or veto bills passed by the legislature prior to recessing for the year.

At the Board's meeting on February 26, 2020, the board adopted the following legislative priorities for the 2020 legislative session:

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

Staff, in conjunction with the Local Health Plans of California and our Sacramento representatives, Edelstein, Gilbert, Robson and Smith, identified, tracked and monitored bills meeting the above criteria and provides the following report.

Discussion. The Alliance was tracking 24 bills, including eight Tier 1 priority bills which included one bill that the board approved an official position of support. Of the 24 bills, seven were signed into law, four were vetoed and 13 failed in the legislature.

Following is an update on Tier 1 priority bills:

Support.

- **AB 2164 (Rivas) – Telehealth.** Provides that an FQHC or RHC “visit” includes an encounter between an FQHC or RHC patient and a health care provider using telehealth by synchronous interaction or asynchronous store and forward. Specifies that an FQHC or RHC is not precluded from establishing a patient who is located within the FQHC’s or RHC’s federal designated service area through synchronous interaction or asynchronous store and forward as of the date of service if specified requirements are met.

  Final Disposition. Vetoed by the Governor.
Watch

- **AB 890 (Wood) - Nurse practitioners: scope of practice: practice without standardized procedures.** Authorizes a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances.  
  Final Disposition. Signed by the Governor.

- **AB 2100 (Wood) – Pharmacy Benefits.** Requires the department to establish the Independent Prescription Drug Medical Review System (IPDMRS), commencing on January 1, 2021, which generally models the above-described requirements of the Knox-Keene Health Care Service Plan Act.  
  Final Disposition. Vetoed by the Governor.

- **AB 2157 (Wood) – Health Care Coverage: independent dispute resolution process.** Requires the procedures established by DMHC to include a process for each party to submit into evidence information that will be kept confidential from the other party, in order to preserve the confidentiality of the source contract.  
  Final Disposition. Signed by the Governor.

- **AB 2276 (Reyes) – Childhood lead poisoning: screening and prevention.** Requires a contract between the department and a Medi-Cal managed care plan to require the Medi-Cal managed care plan, on a quarterly basis, to identify every enrollee who is a child without a record of completing the blood lead screening tests, and to remind the contracting network provider of the requirement to perform the required blood lead screening tests and the requirement to provide the oral or written guidance to a parent or guardian relating to risk of childhood lead poisoning.  
  Final Disposition. Signed by the Governor.

- **AB 2360 (Maienschein) – Telehealth: mental health.** Requires health care service plans to provide access to a telehealth consultation program that meets specified criteria and provides providers who treat children and pregnant and certain postpartum persons with access to a mental health consultation program, as specified.  
  Final Disposition. Vetoed by the Governor.

- **SB 29 (Leyva) – Medi-Cal eligibility.** Extends eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status.  
  Final Disposition. Failed in Legislature.
• **SB 803 (Beall) – Mental health services; peer support specialist certification.** Requires DHCS, by July 1, 2022, subject to any necessary federal waivers or approvals, to establish statewide requirements for counties or their representatives to use in developing certification programs for the certification of peer support specialists, who are individuals who self-identify as having lived experience with the process of recovery from mental illness, substance use disorder, or both.

  **Final Disposition.** Signed by the Governor.

Staff continue to review all applicable bills that were signed into law by the Governor to identify implementation issues and impact on the plan or providers and will report to the Board on any significant issues that may arise from this review that warrant Board attention.

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

**Attachments.** N/A
DATE: October 28, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Michelle N. Stott, RN, MSN, Quality Improvement & Population Health Director
SUBJECT: Quality Improvement Workplan – Q2 2020

Recommendation. Staff recommend the Board approve the report on the Quality Improvement (QI) Workplan for Q2 2020.

Summary. This report provides pertinent highlights, trends, and activities from the Q2 2020 QI Workplan.

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

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

Discussion.

QI Workplan Outcomes and Evaluation. DHCS PIPs: Immunizations: The Alliance remains focused on increasing the HEDIS Childhood Immunization Status (CIS) rates in Merced County from 19.71% to 34.47% for children 2-years of age. At the start of 2020, the Alliance was partnered with Castle Family Health Center on a PIP similarly to increase their CIS rates from 7.28% to 14.76%. In response to the pandemic, DHCS closed out on June 30, 2020; but has since reinstated this requirement of the Plan. QI is restarting this PIP during Q3 2020. During the interim, the Alliance’s focus has been on work through the Resuming Care Task Force to message all providers about best practices for pediatric care, including on time vaccinations during the pandemic (“Check-In, Check-Up”).
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 June 30, 2020. At the end of this quarter, the AWC rate for LCH using a 12-month rolling methodology and 90-day claims lag was 47.94%, a one percentage point from the previous quarter.

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. In response to the pandemic, DHCS temporarily suspended the requirement for the providers to complete the IHA and the IHA rate decreased by five percentage points from the previous quarter to 38.52%. Although the 2020 CAHPS results for Getting Care Quickly and the Third Next Available Appointment data was not available until Q3, the team continued to promote the different options that are available to the members to access care like the Nurse Advice Line and Urgent Visits. The avoidable ED visits decreased sharply to 11.33% from 20.6% in the previous quarter to meet the goal.

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. The topic for the Collaborative was chosen as “Member Access and No-Shows” based on provider feedback on some of the main challenges the providers were facing during the pandemic. The Collaborative was scheduled in Q3 to give enough time for transition from an in-person to virtual setting. Although the majority of the Practice Coaching projects were put on hold by the providers to focus on the pandemic, the team did meet their goal for the quarter to engage with at least one new provider site. As a result of the pandemic, it was decided to conduct the Practice Transformation Academy through a virtual setting rather than in-person. The team partnered with Training and Development to develop a structure to transition from an in-person to virtual training and also, solicited feedback from the providers on their level of interest and willingness to dedicate time and resources for the Academy.

Operational Performance. The QPIP includes surveillance to maintain and improve the clinical safety of services to members. Two key clinical safety operational functions Facility Safety Review (FSR) and Potential Quality Improvement (PQI) programs are reported below.

The FSR team monitors all network primary care providers to ensure that facilities are safe and accessible, care is evidence-based, and safe for our members. The FSR team’s goals are for 100% compliance with operational metrics for 2020. During Q2 2020 four sites (43%) completed a full site review within three years of the last FSR. No Critical Elements were
identified and therefore not needing correction (N/A). The two clinics that were issued Corrective Action Plans (CAP) were both (100%) able to submit a CAP plan within 45 calendar days. Three of six clinics (50%) requiring a CAP plan verification were completed on time (by 90-days). During Q2 the Alliance received DHCS guidance on contractual modifications which impacted FSR by suspending contractual requirements for in-person site reviews. FSR staff have developed a process to conduct remote reviews. Challenges in meeting these goals were driven by office closures and modified hours, barriers to gaining Electronic Medical Record system access and additional work modifications to facilitate reviews. For the Potential Quality Issue (PQI) Program, the team reviewed 100% of the 547 member grievances and accepted additional reports of patient safety concerns from across the Alliance. Examples of a PQI include a member who falls while inpatient, clinics not following up on lab results, inappropriate opioid prescribing that result in injury to the member. Program’s aim is to close cases within 60 calendar days of receipt; Q2 performance was 69% (N=64) of PQIs. Alliance staff and network clinics have been slowed due to reduced workforce and new care priorities during the pandemic, impacting record retrieval, correspondence and timely resolution of cases. Additional temporary staffing was added to support the program.

Conclusion. There were impacts in quality measure performance as providers were prioritizing COVID-19 activities in Q2 2020. The QI team continues to engage the providers through virtual means as able, monitoring on-going performance, and implementing initiatives as an organizational-wide effort through the Resuming Care Task Force.

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

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

### Awards by Focus Area

- **Provider Capacity**: 64% ($71.3M)
- **BH/SUD**: 17% ($19M)
- **High Utilizer**: 17% ($19.4M)
- **HEAL**: 2% ($2.3M)

### Award Status

- **Active**: 204
- **Completed**: 256
- **Closed**: 79

* Withdrawn by grantee/terminated.

### October 2015 through August 2020

- **Total Awarded**: $112.3M
  - **Santa Cruz**: 31% ($35.1M)
  - **Merced**: 32% ($35.4M)
  - **Monterey**: 37% ($41.8M)

- **Total Grants Awarded**: 539
  - **Merced**: 240
  - **Monterey**: 188
  - **Santa Cruz**: 188

### Applications Received and Grants Awarded

- **Merced**: 249
- **Monterey**: 299
- **Santa Cruz**: 240

* Applications received vs. grants awarded.*
**Provider Recruitment Program**

262 grants totaling $31.8M awarded to subsidize recruitment expenses for new health care professionals to serve the Medi-Cal population.

<table>
<thead>
<tr>
<th>MERCED</th>
<th>MONTEREY</th>
<th>SANTA CRUZ</th>
<th>Total</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
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<td>Type Recruited</td>
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<tr>
<td>Total Recruited</td>
<td>34</td>
<td>27</td>
<td>42</td>
<td>21</td>
</tr>
</tbody>
</table>

34% of total 35% of total 31% of total

21 recruited primary care physicians specialize in Pediatrics.

181 new providers hired to date.

79% retention of new recruits.

54% increase in primary care sites open to accepting new members.

Specialties Recruited

- Public Health Nursing
- Obstetrics/Gynecology
- Psychiatry
- Dentistry
- Family Medicine
- Cardiology
- Pediatrics
- Internal Medicine
- Physical Therapy
- Pain Medicine
- Pulmonary Medicine
- General Surgery
- Optometry
- Podiatry
- Orthopedics
- Neurology
- Oncology Hematology
- Ophthalmology
- Urology
- Gastroenterology
- Rheumatology
- Clinical Social Work
- Vascular Surgery
- Palliative Medicine
- Substance Use Disorder Counseling
- Otolaryngology
Technical Assistance Program

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

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

<table>
<thead>
<tr>
<th>Project Categories</th>
<th>Number of Grants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased access to services</td>
<td>4</td>
</tr>
<tr>
<td>Integration of services and team-based care</td>
<td>1</td>
</tr>
<tr>
<td>Improved, patient-centered care</td>
<td>4</td>
</tr>
<tr>
<td>System optimization and service delivery</td>
<td>4</td>
</tr>
</tbody>
</table>

Intensive Case Management Program

11 grants totaling $4.9M awarded to high-volume primary care practices to add staff to provide intensive case management services for medically complex Medi-Cal patients within the patient centered medical home. Three-year pilot launched 01/01/2018.

Members Currently Enrolled: 100

- Monterey: 57
- Santa Cruz: 43

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

6 FTE case managers providing ICM services at clinics.

Workforce Development Investments

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

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

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

**54 grants* totaling $64M** awarded for the expansion, construction, renovation, and/or acquisition of health care facilities that will serve the Medi-Cal population in the Alliance service areas. Capital grants are also available for projects that expand access to Medi-Cal services through transitional or permanent supportive housing for the Alliance’s most medically fragile Medi-Cal members.

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

#### Capital Projects

- **36 Capital Projects**
  - Pre-Development: 8
  - Construction Phase 1: 8
  - Construction Phase 2: 1
  - Construction Phase 3: 2
  - Facility Open: 17

- **Capital Projects**
  - Primary Care or Specialty Care Clinic
  - BH/SUD Facility
  - Supportive Housing

- **Santa Cruz**
  - MERCED: 6
  - MONTEREY: 7
  - SANTA CRUZ: 7
  - TOTAL: 20

- **161K** Medi-Cal members anticipated to be served by new and expanded facilities.

### Infrastructure Program

**27 grants* totaling $3.7M** awarded for information technology systems that expand Medi-Cal capacity in the Alliance service area.

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

#### Infrastructure Projects

- **21 Infrastructure Projects**
  - Planning: 1
  - Implementation: 5
  - Project Complete: 15

- **Infrastructure Projects**
  - Community Referral Systems
  - General Health Information Technology
  - Health Information Exchange/Connectivity
  - Implementation and Upgrades to Electronic Health Records
  - Telehealth Technology and Equipment

- **Santa Cruz**
  - MERCED: 1
  - MONTEREY: 2
  - SANTA CRUZ: 3
  - TOTAL: 8
Post-Discharge Meal Delivery Pilot

3 grants totaling $550K awarded to fund the delivery of 12 weeks of ready-made, nutritious meals to Medi-Cal members recovering from an inpatient hospital stay. Two-year pilot launched 11/01/2018.

Members Enrolled to Date: 422
To date, 41% completed 12-week program.

Meals Delivered to Date: 59,298

<table>
<thead>
<tr>
<th>County</th>
<th>Members</th>
<th>Meals Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Cruz</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>Monterey</td>
<td>238</td>
<td></td>
</tr>
<tr>
<td>Merced</td>
<td>117</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County</th>
<th>Members</th>
<th>Meals Delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Cruz</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Monterey</td>
<td>33,446</td>
<td></td>
</tr>
<tr>
<td>Merced</td>
<td>16,941</td>
<td></td>
</tr>
</tbody>
</table>

Partners for Healthy Food Access Program

14 grants totaling $1.7M awarded to support a variety of innovative partnerships between health care providers, community-based organizations and/or government agencies to improve food security in the Medi-Cal population.

Projects by County: 14

<table>
<thead>
<tr>
<th>County</th>
<th>Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Cruz</td>
<td>8</td>
</tr>
<tr>
<td>Monterey</td>
<td>2</td>
</tr>
<tr>
<td>Merced</td>
<td>4</td>
</tr>
</tbody>
</table>

Food Access Projects Focus On:

Food Insecurity Screening

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

Referrals to Supportive Services
- Cal-Fresh Enrollment

Knowledge & Skill Building
- Nutrition/Health Classes
- Community Gardening
- Cooking Classes
Equipment Program

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

Practice Coaching Program

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

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

COVID-19 Response Fund

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

Highlights of Alliance grants and their impact on the lives of Medi-Cal members.

Healthy House Within a MATCH Coalition (Healthy House) was awarded a grant from the Alliance's COVID-19 Response Fund in May 2020 for a two-part outreach project to families and individuals impacted by the pandemic. Healthy House delivered “mom packs” that included diapers, baby wipes, formula, and baby food to low-income women of color who belong to an African-American church-based network throughout Merced County as well as to other families though distribution at local elementary schools. Healthy House also provided supplies to at-risk individuals experiencing homelessness who were relocated to motels due to the pandemic. These supplies included masks, water, sanitizer and soap. It is estimated that the entire project provided supplies to nearly 900 Medi-Cal members in Merced County.

The Alliance awarded MidPen Housing (MidPen) a Capital Implementation grant to fund the construction of Moon Gate Plaza, an affordable housing development consisting of 90-units in Salinas' Chinatown district. MidPen has allocated 20 units for medically complex Alliance Medi-Cal members who receive supportive services through Monterey County Health Department’s Whole Person Care Program. Moon Gate Plaza began welcoming new residents in January 2020 and completed move-ins in June 2020. The four-story complex includes a community room with a kitchen, courtyard with community gardens, bicycle storage, library, multi-purpose room and parking garage.

Residents receive on-site supportive services from three full-time case managers with individualized plans to accomplish their health and personal goals, with the ultimate goal being housing retention and high quality of life. Services provided to residents include health and wellness programs, referrals to supportive services, crisis intervention, one-on-one and group support, community building activities, life skills development, conflict resolution, and coordination with other benefit and service organizations. Through a collaboration of local nonprofits, the ground floor of the development will incorporate arts, health and wellness, culture, and educational programming to serve all Chinatown neighborhood residents.
United Way of Merced County was awarded a Partners for Healthy Food Access grant in October 2018 to be the fiscal sponsor for Project Grow, a two-year project led by the Community Initiatives for Collective Impact that addresses food insecurity in Merced County. Prior to the COVID-19 pandemic, community health workers conducted outreach at Merced Faculty Associates Medical Group (MFA) and the County of Merced Human Services Agency (HSA) to administer food insecurity screenings and provide up-to-date information to individuals about how to access healthy food in the community. One of those resources is Project Grow’s very own Pop-Up People’s Pantry near downtown Merced that provides donated fresh fruits and vegetables for free to the community. Take-home gardens are also available at the pantry and have been immensely popular with clients who want to learn how to grow their own food. During the pandemic, Project Grow has successfully pivoted to utilize social media to engage community members, including peer-lead videos on Facebook Live with topics that include how to purchase the most nutritious food at local markets on a tight budget, ideas for fun and healthy kids’ snacks, and how to access services like CalFresh and WIC. Project Grow aims to develop a grassroots coalition to organize and support people in Merced County to improve food insecurity together. The project team will present key findings at the American Public Health Association’s Annual Meeting to be held virtually in October 2020. Visit www.facebook.com/popuppeoplespantry.

Santa Cruz Community Health Centers (SCCHC) hired therapist Christine Lacy, LCSW, in October 2018 with support from a Provider Recruitment Program grant. Christine has been an important addition to SCCHC as a Spanish-speaking licensed therapist with experience working with both children and adults using a trauma-informed approach. Christine has made strong connections with her patients at East Cliff Family Health Center and her panel filled very quickly. With the addition of Christine to the Behavioral Health team, SCCHC increased access and timeliness for behavioral health appointments by expanding capacity for Spanish-speaking clients, serving an additional 209 Medi-Cal patients from May 2019 – May 2020.
Recommendation. Staff recommend the Board approve grant recommendations that total $1,475,000 for Group A of funding recommendations under Consent Agenda Item 8G.

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

Background. Since the launch of the MCGP in July 2015, the Alliance Board has approved 539 grants for a total of $112.3M to expand Medi-Cal capacity in the Alliance service area in the MCGP’s four priority focus areas: Provider Capacity, Behavioral Health and Substance Use Disorder Services (BH/SUD), High Utilizer Support Resources and Healthy Eating and Active Living (HEAL). Consent Agenda Item 8F includes the MCGP Performance Dashboard which provides details on grants awarded to date.

Discussion.

Grant Application Review and Recommendation Process. Grant applications in the current round of funding were due on July 20, 2020. This funding cycle, the Alliance received 14 applications from 8 organizations. Staff carefully reviewed each application to determine eligibility and is recommending approval of 9 out of the 14 eligible applications received.

An internal committee reviewed and selected applications to recommend to the Board for approval based on the eligibility and program criteria previously approved by the Board. The internal review committee included: Stephanie Sonnenshine, Chief Executive Officer; Dr. Dale Bishop, Chief Medical Officer; Lisa Ba, Chief Financial Officer; Marina Owen, Chief Operating Officer, Jordan Turetsky, Provider Services Director; and Kathleen McCarthy, Strategic Development Director. All applicants received a letter notifying them whether or not their application was being recommended for approval in October 2020.

Of the 9 grant applications being recommended for approval, 33% (3) are from Merced County, 56% (5) are from Monterey County and 11% (1) are from Santa Cruz County. The majority of applications recommended for approval (89% or 8 applications) fall under the Provider Capacity focus area. There is one application recommendation under the HEAL focus area. The 9 grant applications recommended for approval are distributed across programs as follows:
The table below lists the grant award recommendations by group and county, with totals by group affiliation.

<table>
<thead>
<tr>
<th>Grant Program</th>
<th>Number of Awards Recommended</th>
<th>Award Amount Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Recruitment</td>
<td>7</td>
<td>$618,250</td>
</tr>
<tr>
<td>Capital Implementation</td>
<td>1</td>
<td>$1,200,000</td>
</tr>
<tr>
<td>Partners for Healthy Food Access</td>
<td>1</td>
<td>$50,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>$1,868,250</strong></td>
</tr>
</tbody>
</table>

Grant Award Recommendations. Funding recommendations are grouped for two separate approval actions so that Board members with a conflict may abstain from voting where applicable. The two groups are included in the Consent Agenda as two separate items, as follows: Item 8G (Group A) includes applications not affiliated with Board members; and Item 8H (Group B) includes applications affiliated with Board members.

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

<table>
<thead>
<tr>
<th>County</th>
<th>Group A</th>
<th>Not Board Affiliated</th>
<th>Group B</th>
<th>Board Affiliated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Cruz</td>
<td>$125,000</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Monterey</td>
<td>$1,200,000</td>
<td></td>
<td>$393,250</td>
<td>$0</td>
</tr>
<tr>
<td>Merced</td>
<td>$150,000</td>
<td></td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$1,475,000</td>
<td></td>
<td>$393,250</td>
<td></td>
</tr>
</tbody>
</table>

Total Grant Award Recommendation: $1,868,250

Fiscal Impact. Recommended grant awards totaling $1,868,250 would be funded by the MCGP budget which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan’s reserves to create the MCGP.

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

### Grant Recommendations

**GROUP A: Not Affiliated with Alliance Board Members**

### Provider Recruitment Program

<table>
<thead>
<tr>
<th>County</th>
<th>Page*</th>
<th>Organization</th>
<th>Award**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merced</td>
<td>1</td>
<td>Golden Bear Physical Therapy Sports Injury Center</td>
<td>$50,000</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Golden Bear Physical Therapy Sports Injury Center</td>
<td>$50,000</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>Golden Bear Physical Therapy Sports Injury Center</td>
<td>$50,000</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>2</td>
<td>Thaila Ramanujam MD Inc.</td>
<td>$75,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Subtotal</strong></td>
<td>$225,000</td>
</tr>
</tbody>
</table>

### Capital Program

<table>
<thead>
<tr>
<th>County</th>
<th>Page*</th>
<th>Organization</th>
<th>Award**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monterey</td>
<td>3</td>
<td>Coastal Kids Home Care</td>
<td>$1,200,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Implementation: Acquisition and Renovation of Coastal Kids Clinic</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Subtotal</strong></td>
<td>$1,200,000</td>
</tr>
</tbody>
</table>

### Partners for Healthy Food Access Program

<table>
<thead>
<tr>
<th>County</th>
<th>Page*</th>
<th>Organization</th>
<th>Award**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Cruz</td>
<td>4</td>
<td>Pacific Cancer Care</td>
<td>$50,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Subtotal</strong></td>
<td>$50,000</td>
</tr>
</tbody>
</table>

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

**Final grant awards will depend on verification of actual expenses but will not exceed the recommended amount.
### Medi-Cal Capacity Grant Program

#### Recommendation Summary

<table>
<thead>
<tr>
<th>Applicant:</th>
<th>Golden Bear Physical Therapy Sports Injury Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>County:</td>
<td>Merced</td>
</tr>
<tr>
<td>Medi-Cal Services:</td>
<td>Alliance – Allied</td>
</tr>
<tr>
<td>Grant Award History:</td>
<td>Provider Recruitment (4) $195,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Recruitment Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Services:</strong></td>
</tr>
<tr>
<td><strong>Provider Type:</strong></td>
</tr>
<tr>
<td><strong>Provider Specialty:</strong></td>
</tr>
<tr>
<td><strong>Provider Hours:</strong></td>
</tr>
<tr>
<td><strong>Practice Name:</strong></td>
</tr>
<tr>
<td><strong>Practice Location:</strong></td>
</tr>
<tr>
<td><strong>Amount Requested:</strong></td>
</tr>
<tr>
<td><em>Recommended Award:</em></td>
</tr>
</tbody>
</table>

| **Services:**                | Allied                                           |
| **Provider Type:**           | Physical Therapist                               |
| **Provider Specialty:**      | N/A                                              |
| **Provider Hours:**          | Full Time                                        |
| **Practice Name:**           | Golden Bear Physical Therapy Sports Injury Center Inc. |
| **Practice Location:**       | 3184 Collins Dr., Merced, CA 95348                |
| **Amount Requested:**        | $50,000                                          |
| *Recommended Award:*         | $50,000                                          |

| **Services:**                | Allied                                           |
| **Provider Type:**           | Physical Therapist                               |
| **Provider Specialty:**      | N/A                                              |
| **Provider Hours:**          | Full Time                                        |
| **Practice Name:**           | Golden Bear Physical Therapy Sports Injury Center Inc. |
| **Practice Location:**       | 1400 Mercey Springs Rd., Ste. I, Los Banos, CA 93635 |
| **Amount Requested:**        | $50,000                                          |
| *Recommended Award:*         | $50,000                                          |

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.*
Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: Thaila Ramanujam MD, Inc.
County: Santa Cruz
Medi-Cal Services: Alliance - Specialty
Grant Award History: N/A

Provider Recruitment Program

Services: Specialty Care
Provider Type: Non-Physician Medical Practitioner (NPMP)
Provider Specialty: Rheumatology
Provider Hours: Full Time
Practice Name: Thaila Ramanujam MD, Inc.
Practice Location: 1505 Soquel Dr., Ste. 9, Santa Cruz, CA 95065
Amount Requested: $100,000
'Recommended Award: $75,000

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.
### Medi-Cal Capacity Grant Program

**Recommendation Summary**

<table>
<thead>
<tr>
<th>Applicant:</th>
<th>Coastal Kids Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>County:</td>
<td>Monterey</td>
</tr>
<tr>
<td>Grant Award History:</td>
<td>Capital Planning (1) $8,000</td>
</tr>
</tbody>
</table>

### Capital Program - Implementation

<table>
<thead>
<tr>
<th>Project Name:</th>
<th>Coastal Kids Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Site Address:</td>
<td>427 Pajaro St., Salinas, CA 93901</td>
</tr>
<tr>
<td>Type of Capital Project:</td>
<td>Acquisition and Renovation</td>
</tr>
<tr>
<td>Proposed Start/End Dates:</td>
<td>11/01/2020 - 8/31/2021 (10 months)</td>
</tr>
<tr>
<td>Total Project Budget:</td>
<td>$1,700,000</td>
</tr>
<tr>
<td>Request Amount:</td>
<td>$1,200,000</td>
</tr>
<tr>
<td><em>Recommended Award:</em></td>
<td>$1,200,000</td>
</tr>
</tbody>
</table>

**Proposal Summary:** Coastal Kids Home Care seeks funding to purchase office space to expand services for children with complex medical and behavioral health needs and provide space for Coastal Kids Home Care’s growing team. The new facility would increase administrative and home health clinician productivity, while also providing counselors with private offices to meet with children and families facing behavioral health challenges.

Coastal Kids Home Care services are available to any child in Santa Cruz, Santa Clara, San Benito, and Monterey counties, newborn to age 21, living with a medical need that can be met with in-home nursing or therapy. One hundred percent of the children served are seriously ill, developmentally and/or physically disabled or coping with mental health concerns. Sixty-five percent of patients are Medi-Cal members. Coastal Kids is the sole provider of pediatric palliative and end-of-life care in the region. Licensed counselors have joined the staff to expand behavioral health services through Beacon Health.

Coastal Kids Home Care currently operates out of two office spaces owned by other providers. Space for staff and multidisciplinary team meetings is limited. Nurses and clinical staff share desks and computers for charting. Demand for Coastal Kids Home Care services continues to increase with the addition of two new programs: shift nursing and counseling through Beacon Health. Coastal Kids Home Care has added 25 staff over the past twelve months to meet new billing, scheduling and hiring requirements. The new facility will include dedicated charting stations for nurses and therapists, and have space for multidisciplinary team meetings, staff and Board meetings, and clinical trainings. This project will allow Coastal Kids Home Care to expand their array of pediatric home health service, behavioral health services, and administrative functions that support the growing organization.

**Objectives:** By November of 2020, Coastal Kids Home Care will have purchased a suitable facility to house and expand their operations. They will move in to the new facility by January 2021 and complete renovations by August 2021.

**Impact:** Increasing the clinical and administrative space will increase pediatric home health services by 15% over the next 36 months with an additional 40 patients receiving more than 600 home visits. Pediatric Physical Therapists will expand clinic based service, increasing their patient volume by 20% to a total of 26 children. Coastal Kids Home Care plans to expand behavioral health services to include children with mild to moderate behavioral health issues. Acquiring a permanent office location for clinic-based behavioral health will result in a conservative 20% increase in behavioral health counseling patients from 50 in 2020 to 60 in 2021.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.*
Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: Pacific Cancer Care
County: Monterey
Grant Award History
  Equipment (1) $17,059
  Provider Recruitment (5) $750,000

Partners for Healthy Food Access Program

Project Name: Food Insecurity Mitigation for Cancer Patients
Project Partner: Camacho Produce
Proposed Start/End Dates: 11/01/2020 – 02/28/2022 (16 months)
Total Project Budget: $200,000
Request Amount: $200,000
*Recommended Award: $50,000

Proposal Summary: Pacific Cancer Care seeks to decrease food insecurity in their patients by conducting clinic-wide food insecurity screening and enrolling eligible patients into an eight-week program. The program will consist of weekly nutrition education, plant-based cooking demonstrations, and community supported agriculture (CSA) boxes supplied through partnership with Camacho Produce. Participants will be provided handouts of weekly recipes and summaries of nutrition education topics throughout the program’s duration.

Pacific Cancer Care will screen and identify food-insecure patients using the Hunger Vital Sign (HVS) screening tool. To ensure broad acceptance and administration of the screening tool, staff will be trained on the prevalence of food insecurity in Monterey County and surrounding areas, the importance of screening, how to administer the tool, how to document results in the patient’s EMR, and what to do when a patient screens positive. Results will be documented in the patient’s EMR. When a patient screens negative, they will be asked if they would like to be rescreened in three months, as food insecurity is dynamic and their status may change.

Program participants will receive CSA boxes with nutritious plant-based foods. The weekly CSA boxes will be delivered by Camacho Produce and will consist of a variety of fresh, in-season produce. Additionally, an Instant Pot (pressure cooker/slow cooker combination) will be purchased and supplied to each program participant at the first weekly meeting along with instructions for care and use.

Assessments will be conducted at baseline and at the end of the 8-week program to assess participant outcomes. Weekly knowledge checks to assess progress will also be conducted.

Objectives: The project objectives are to: 1) identify and enroll approximately 100 food insecure participants into the program annually; 2) increase average daily servings of fruit and vegetables by two servings at end of 8-week program in 75% of participants; and 3) have program participants score at least 80% on weekly knowledge check quizzes.

Impact: The project will serve 100 individuals annually, 60% of whom will be Medi-Cal members. It is expected that the program will foster self-efficacy through the nutrition education and cooking demonstrations which will continue to benefit the participant after program completion.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.
DATE: October 28, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Kathleen McCarthy, Strategic Development Director
SUBJECT: Medi-Cal Capacity Grants: Funding Recommendations (Group B)

Recommendation. Staff recommend the Board approve grant recommendations that total $393,250 for Group B of funding recommendations under Consent Agenda Item 8H, voted upon separately due to conflicts of interest.

Summary. See report at Item 8G for content, background and process for this agenda item. This is the second of two recommendations to allow a separate vote on those items for which Board members may have a conflict.

Discussion.

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

<table>
<thead>
<tr>
<th>County</th>
<th>Group A</th>
<th>Not Board Affiliated</th>
<th>Group B</th>
<th>Board Affiliated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Cruz</td>
<td></td>
<td>$75,000</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Monterey</td>
<td></td>
<td>$1,250,000</td>
<td></td>
<td>$393,250</td>
</tr>
<tr>
<td>Merced</td>
<td></td>
<td>$150,000</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$1,475,000</td>
<td></td>
<td>$393,250</td>
</tr>
</tbody>
</table>

Total Grant Award Recommendation: $1,868,250

Fiscal Impact. Recommended grant awards totaling $1,868,250 would be funded by the MCGP budget which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan’s reserves to create the MCGP.

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

**GROUP B: Affiliated with Alliance Board Members**

#### Provider Recruitment Program

<table>
<thead>
<tr>
<th>County</th>
<th>Page</th>
<th>Organization</th>
<th>Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monterey</td>
<td>1</td>
<td>Clinica de Salud del Valle de Salinas</td>
<td>$150,000</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Monterey County Health Department - Clinic Services Bureau</td>
<td>$150,000</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Taylor Farms Family Health &amp; Wellness Center</td>
<td>$93,250</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Subtotal</strong></td>
<td><strong>$393,250</strong></td>
</tr>
</tbody>
</table>

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

**Final grant awards will depend on verification of actual expenses but will not exceed the recommended amount.*
### Medi-Cal Capacity Grant Program

#### Recommendation Summary

| Applicant: | Clinica de Salud del Valle de Salinas |
| County:   | Monterey   |
| Medi-Cal Services: | Alliance – Primary Care |
| Grant Award History: | |
| Capital Implementation (1) | $1,059,000 |
| Equipment (1) | $20,000 |
| Intensive Case Management (2) | $989,376 |
| Practice Coaching (1) | $25,000 |
| Provider Recruitment (6) | $900,000 |

### Provider Recruitment Program

| Services: | Primary Care |
| Provider Type: | Physician |
| Provider Specialty: | N/A |
| Provider Hours: | Full Time |
| Practice Name/Location: | Gonzales Clinic, 126 5th St., Gonzales, CA 93926; or King City Clinic, 122 San Antonio Dr., King City, CA 93930; or Soledad Clinic, 799 Front St., Soledad, CA 93960 |
| Amount Requested: | $150,000 |
| *Recommended Award: | $150,000 |

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.*
## Medi-Cal Capacity Grant Program
### Recommendation Summary

<table>
<thead>
<tr>
<th>Applicant</th>
<th>Monterey County Health Department - Clinic Services Bureau</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
<td>Monterey</td>
</tr>
<tr>
<td>Medi-Cal Services</td>
<td>Alliance – Primary Care</td>
</tr>
<tr>
<td>Grant Award History</td>
<td>Capital Implementation (1) $497,500</td>
</tr>
<tr>
<td></td>
<td>Equipment (1) $201,874</td>
</tr>
<tr>
<td></td>
<td>Intensive Case Management (3) $1,094,688</td>
</tr>
<tr>
<td></td>
<td>Practice Coaching (2) $50,000</td>
</tr>
<tr>
<td></td>
<td>Provider Recruitment (5) $750,000</td>
</tr>
</tbody>
</table>

### Provider Recruitment Program

<table>
<thead>
<tr>
<th>Services</th>
<th>Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type</td>
<td>Physician</td>
</tr>
<tr>
<td>Provider Specialty</td>
<td>N/A</td>
</tr>
<tr>
<td>Provider Hours</td>
<td>Full Time</td>
</tr>
<tr>
<td>Practice Name/Location</td>
<td>Laurel Pediatric Clinic 1441 Constitution Blvd., Bldg. 200, Ste. 101-103, Salinas, CA 93906; or Laurel Family Practice 1441 Constitution Blvd., Bldg. 400, Ste. 300, Salinas, CA 93906; or Laurel Internal Medicine 1441 Constitution Blvd., Bldg. 151, Suite 16, Salinas, CA 93906; or Seaside Family Health Center 1156 Fremont Blvd., Seaside, CA 93955</td>
</tr>
</tbody>
</table>

| Amount Requested | $150,000 |
| Recommended Award | $150,000 |
**Applicant:** Taylor Farms Family Health & Wellness Center  
**County:** Monterey  
**Medi-Cal Services:** Alliance - Specialty  
**Grant Award History:**  
- Capital Implementation (1) $2,500,000  
- Capital Planning (1) $150,000  
- Equipment (2) $22,500  
- Provider Recruitment (5) $450,525

**Provider Recruitment Program**

- **Services:** Specialty Care  
- **Provider Type:** Non-Physician Medical Practitioner (NPMP)  
- **Provider Specialty:** Cardiology  
- **Provider Hours:** Full Time  
- **Practice Name:** Taylor Farms Family Health & Wellness Center  
- **Practice Location:** 850 5th St., Gonzales, CA 93926  
- **Amount Requested:** $93,250  
- **Recommended Award:** $93,250

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.*
DATE: October 28, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Lisa Ba, Chief Financial Officer
SUBJECT: Financial Forecast for Calendar Year 2020

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

Summary. The table below presents four key financial indicators across historical, budget, and current performance and forecast. Staff forecast an operating loss of $41.8M for calendar year 2020, which is favorable to budget by $11.4M.

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>2019 Actual</th>
<th>2020 Budget</th>
<th>Aug YTD Actual</th>
<th>2020 Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg. Enrollment</td>
<td>339,759</td>
<td>329,342</td>
<td>343,935</td>
<td>349,862</td>
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<tr>
<td>Dollar Revenue</td>
<td>1,221,378</td>
<td>1,231,242</td>
<td>856,902</td>
<td>1,308,456</td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>1,214,096</td>
<td>1,199,288</td>
<td>833,381</td>
<td>1,265,103</td>
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<tr>
<td>Administrative Expenses</td>
<td>80,610</td>
<td>85,130</td>
<td>55,417</td>
<td>85,128</td>
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<tr>
<td>Operating Income/(Loss)</td>
<td>(73,328)</td>
<td>(53,176)</td>
<td>(31,896)</td>
<td>(41,775)</td>
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<tr>
<td>PMPM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>299.57</td>
<td>311.54</td>
<td>311.43</td>
<td>311.66</td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>297.78</td>
<td>303.46</td>
<td>302.88</td>
<td>301.33</td>
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<tr>
<td>Administrative Expenses</td>
<td>19.77</td>
<td>21.54</td>
<td>20.14</td>
<td>20.28</td>
</tr>
<tr>
<td>Operating Income/(Loss)</td>
<td>(17.98)</td>
<td>(13.46)</td>
<td>(11.59)</td>
<td>(9.95)</td>
</tr>
<tr>
<td>MLR %</td>
<td>99.4%</td>
<td>97.4%</td>
<td>97.3%</td>
<td>96.7%</td>
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<tr>
<td>ALR %</td>
<td>6.6%</td>
<td>6.9%</td>
<td>6.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Operating Loss %</td>
<td>-6.0%</td>
<td>-4.3%</td>
<td>-3.7%</td>
<td>-3.2%</td>
</tr>
</tbody>
</table>

Background. The Alliance is committed to providing regular financial updates and forecasts that inform the Board of the current financial performance and what is expected for the remainder of the year compared to the 2020 Budget.

Discussion. The 2020 Forecast is based on August year-to-date (YTD) results and key enrollment, revenue, medical expense, and administrative expense assumptions that are described below.
Enrollment: The 2020 calendar year began at an enrollment base of 331,000 in January and grew to 360,000 in September. Staff applied a compound annual growth rate from this nine-month period and forecast the enrollment will end at 367,000 in December. The uptick is predominantly in the Adult Family and Adult Expansion categories of aid (COA).

Revenue: The 2020 forecast results in an annual revenue of $1,308.5M. This is a product of our membership forecast and 18-month bridge period capitation rates. The revenue reflects the 1.5% retro reduction, implemented by the State due to the State budget deficit. The impact is a $19.7M revenue reduction for 2020.

Medical Expense: The 2020 forecast results in an annual medical expense of $1,265.1M. The medical expense is driven by a per member per month (PMPM) medical cost assumption that is further influenced by historical utilization and cost per unit trends, developed at the category of service (COS) level. The top two COS include Inpatient Services (Hospital) and Inpatient Long-term Care.

Staff assumed a historical PMPM base period of nine months from December 2019 through August 2020. Then, factored in a 12% utilization decrease due to the COVID-19 pandemic and carried forward a similar cost per unit profile from the 2020 expense rate experience.

The cost decrease from the reduction in selective procedures during the pandemic is partially offset by the additional cost due to COVID, such as the 10% increase in Long-Term Care rate increase; mandated by the State, the COVID cases among our members, and certain claims advancement to assist our providers to meet short-term cash needs.

Administrative Expense: Staff expect to end the year within the budgeted administrative expense.

Fiscal Impact. Overall, staff forecast an operating loss of $41.8M for calendar year 2020, which is favorable to budget by $11.4M or 21.4%.

At a PMPM level, the cost is above the revenue. This PMPM loss coupled with enrollment will result in financial loss for the current year and future years. Therefore, it is an impetus to execute the board approved cost containment plan and achieve breakeven at a PMPM level.

Staff have been renegotiating with in-area hospitals since July. Most hospitals understand our financial situation and are willing to work with the Alliance. Few are reluctant and asked for even greater increases. Staff will continue efforts under the cost containment plan to ensure the solvency of the health plan in order to serve our mission of accessible, quality health care guided by local innovation.

Attachments: N/A
DATE: October 28, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Dr. Dale Bishop, Chief Medical Officer
SUBJECT: Medi-Cal Rx Implementation Update

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

**Summary.** This report describes the Department of Health Care Services (DHCS) Medi-Cal Rx program, which as of January 1, 2021 will remove most pharmacy services from Medi-Cal managed care plans’ benefit responsibility, and instead, provide these benefits to California’s Medi-Cal beneficiaries through the fee-for-service (FFS) delivery system. This report also describes staff preparation for the January 1, 2021 implementation and highlights key activities for the next 90-days towards the January 1, 2021 implementation.

**Background.** In January 2019, California Governor Gavin Newsom signed an Executive Order to transition pharmacy services from Medi-Cal managed care plans into FFS delivery system. The transition is intended to standardize the Medi-Cal pharmacy benefit statewide, improve access to pharmacy services and strengthen California’s ability to negotiate state supplemental drug rebates with drug manufacturers. In addition, this standardization was identified as a critical step for the success of the CalAIM initiatives being proposed by DHCS.

**Discussion.** Beginning January 1, 2021, DHCS will implement the Medi-Cal Rx program through which DHCS will deliver Medi-Cal pharmacy benefits to Medi-Cal beneficiaries through a contract with a pharmacy benefit manager (PBM) Magellan Medicaid Administration, Inc. (Magellan). All prescriptions for Medi-Cal members billed via pharmacy claims will become the responsibility of Medi-Cal Rx and will be directly paid for and administered by Magellan, on behalf of the state. This includes outpatient drugs, medical supplies, and enteral nutritional products.

There are currently no changes planned to pharmacy services provided to Medi-Cal members that are billed on medical and/or institutional claims; such services will remain the responsibility of the Medi-Cal managed care plans, including the Alliance. The Alliance will also maintain pharmacy benefit responsibility for individuals eligible and enrolled in the Alliance’s In-Home Supported Services (IHSS) program under its agreement with the Monterey County Public Authority.

As reported to the Alliance’s board in April 2020, the Alliance has been actively engaged in transition planning to ensure all health plan requirements to support the implementation are met on January 1, 2021. This includes active participation in various external stakeholder meetings (Medi-Cal Rx Advisory Workgroup, Medi-Cal Rx Public Forum, DHCS Managed Care Pharmacy Carve-out Workgroup, and Magellan Technical Subgroup) to ensure a smooth and successful transition.
Key implementation issues and activities over the next 90 days include the following.

1. **Member Outreach and Engagement**
   a. DHCS sent an initial member notice with information regarding Medi-Cal Rx.
   b. The Alliance will subsequently send members a 30-day member notice. In addition, the Alliance will conduct a Medi-Cal Rx Outreach Campaign utilizing different communication modalities such as an educational flyer, Member website landing page, Member Newsletter and social media posts.
   c. The Alliance is sending notices to members using out-of-network mail order and sterile compounding pharmacies whose prescriptions will need to be filled by a different pharmacy enrolled with Medi-Cal Rx.
   d. The Member Handbook – Evidence of Coverage will be updated to reflect changes due to Medi-Cal Rx.

2. **Provider Awareness and Training**
   a. DHCS has sent out provider and pharmacy notices regarding Medi-Cal Rx. In addition, DHCS has launched training and registration for the Medi-Cal Rx Portal for prescribers and pharmacies.
   b. The Alliance will leverage several platforms and methods to disseminate information regarding Medi-Cal Rx including both hospital and PCP Joint Operating Committees, Continuous Quality Improvement Committee (CQIC) meetings, the Provider Bulletin, and the Provider website landing page.
   c. The Alliance Provider Manual will be updated to reflect changes due to Medi-Cal Rx.
   d. The Alliance is reaching out to our network pharmacies to assess their readiness for Medi-Cal Rx and providing guidance on any issues or concerns.

3. **DHCS Implementation Deliverables and Activities**
   a. The Alliance will submit several required deliverables such as updates in policies, procedures and contracts due to Medi-Cal Rx changes, Member ID cards, etc.
   b. The Alliance is overseeing data exchange between the Alliance’s PBM, MedImpact, and DHCS’s PBM, Magellan. Thus, Magellan will have all the claims data to ensure continued and uninterrupted access to medically necessity medications for our members.
   c. There are some operational details for Medi-Cal Rx that remain unresolved and are being discussed with DHCS for possible resolutions via health plan associations (LHPC, CAHP).
      i. **Specialty Pharmacy Reimbursement and Access:** DHCS has indicated that under Medi-Cal Rx, specialty pharmacies will be contracted for dispensing services only. Currently, the Alliance specialty pharmacy both dispenses specialty medications and provides care management services supporting patient adherences to the specialty medication regimen. DHCS continues to look at how they might contract with specialty pharmacies to include such case management services. Given the lack of clarity, staff have a contingency plan to directly coordinate with the Medi-Cal Rx specialty pharmacy to support
member adherence with specialty medications as prescribed by their physician.

ii. After implementation, members appealing a Magellan final denial of authorization must utilize the DHCS State Fair Hearings process. This process is typically longer than the Alliance appeal process and does not rely on clinical expertise. The Alliance will continue to have discussion with DHCS to advocate for both timely resolution and consideration of clinical review for our members.

iii. **Medical Supplies**: Medi-Cal Rx does not include the provision of some medical supplies for some medications and nutritional supplements. Such supplies will be the responsibility of the Medi-Cal managed care plans. Currently, members get these medical supplies under the pharmacy benefit at their local pharmacies. To avoid disruption, staff are contracting with key pharmacies and DME providers and developing communication plans for members.

iv. **SureScripts**: Most of Alliance providers send prescriptions, check eligibility and medication history via an e-prescribing software known as SureScripts. Magellan is not contracted with SureScripts. Should Magellan not secure a contract with SureScripts prior to implementation, providers will need to alter their processes. This could lead to disruptions in our provider network daily operations. The providers will have to send prescriptions to pharmacies in alternative ways (i.e. phone, fax). Staff will communicate about this potential change in provider process through outreach.

v. **Contract Drug List**: Although the gap between Plan formularies and the DHCS Covered Drug List (CDL) has significantly narrowed, a gap remains. Based on the DHCS pharmacy transition policy, members can continue on their medications at the time of implementation for at least 180 days. DHCS will continue to work on decreasing the gap between CDL and plans’ formularies. We are advocating to DHCS to send out notices to members and providers for medications that will require prior authorization beyond 180 days.

4. **Operational Readiness**
   a. Prior to January 1, 2021, staff will engage in the following preparatory activities.
      i. Train all impacted departments.
      ii. Update internal documentation, share information through employee newsletter and develop and maintain speaking points and FAQs.
      iii. Provide oversight of Magellan Portal and Clinical Liaison Training for Designated Users at the Alliance.
      iv. Continue to identify key gaps in Alliance formulary and Medi-Cal Rx, assess member impact, and report to DHCS for formulary consideration.
      v. Develop workflows to handle medication care coordination with Magellan.
      vi. Prepare contingency plan for specialty medication access and specialty medication care management support.
b. January 1, 2021 and after (at least through 180 days transition period), staff will engage in the following to ensure members and providers are adequately supported through the transition.
   i. Track all inquiries from members and providers to identify issues and to monitor trends which merit attention.
   ii. Review daily data feeds from Magellan to monitor for member medication access issues.
   iii. Utilize Magellan Portal and Clinical Liaison for all care coordination needs.
   iv. Review MedImpact denied claims reports to monitor for claims submitted for Medi-Cal members as opposed to IHSS members. Staff will follow up with any pharmacy to ensure no disruption in member care and that claims are properly submitted to Magellan.

**Fiscal Impact.** Revenue attributable to medical cost for the Medi-Cal Rx related pharmacy services is approximately $200M. DHCS has communicated that rates for 2021 and beyond will include a component for the costs associated with the remaining pharmacy services to be administered by the health plan. A definitive fiscal impact will not be available until Q4 2020, after 2021 rates are received from DHCS and analyzed by staff.

**Attachments.**
1. Member Notice
2. Provider Notice

**Websites.**
Medi-Cal Rx
[https://medi-calrx.dhcs.ca.gov/home/](https://medi-calrx.dhcs.ca.gov/home/)
DHCS Medi-Cal Rx website
[https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx](https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx)
90/60-Day Notice to FFS and MCP Members
Medi-Cal Rx Transition

September 25, 2020

Dear Medi-Cal Beneficiary (or Legal Representative):

This letter does not apply to you if your health plan is one of the following:

- Senior Care Action Network (SCAN)
- Programs of All-Inclusive Care for the Elderly (PACE)
- CalMediConnect (CMC)
- Major Risk Medical Insurance Program (MRMIP) Plan.

For everyone else in Medi-Cal, your prescription medications will be covered by “Medi-Cal Rx” starting on January 1, 2021. This does not change your Medi-Cal eligibility or benefits.

If you are eligible for both Medicare and Medi-Cal, the new plan may cover prescriptions Medicare does not.

What is changing?
On January 1, 2021, your Medi-Cal prescription drug coverage will change. The Department of Health Care Services (DHCS) is working with a new contractor, Magellan Medicaid Administration, Inc. (Magellan) to provide Medi-Cal Rx pharmacy services.

There will be no change in how you pay for your medications. For most Medi-Cal beneficiaries, there is no cost.

Drug List and Pharmacy List changes are detailed in this letter.

What do I need to do?
Most people in Medi-Cal will not need to do anything. Your health plan, doctors, and pharmacies know about the changes and know what to do.

Will I need to change my medication?
Most people will not have to change their medications. The list of drugs that require prior approval may be different. Your doctor may need to get approval to refill...
prescription(s). He or she may talk to you about changing to a medication that does not require prior approval.

Will my pharmacy change?
Most pharmacies will accept Med-Cal Rx. You can contact the Medi-Cal Member Help Line (1-800-541-5555, TTY 1-800-430-7077) to ask if your pharmacy will accept Medi-Cal Rx. If you need help finding a pharmacy on or after January 1, 2021, use the Medi-Cal Rx Pharmacy Locator online at www.Medi-CalRx.dhcs.ca.gov or call Customer Service at 1-800-977-2273.

What happens now?
On or after January 1, 2021, take your Benefits Identification Card (BIC) when you go to the pharmacy. The pharmacy will use it to fill your prescription. If you are enrolled in a Medi-Cal managed care plan, also bring your health plan ID card. If you need help, talk to your doctor or use the table below.

What if I have questions?
You can email DHCS at RxCarveOut@dhcs.ca.gov. Make sure to write in the email that you have a question about Medi-Cal Rx. Please do NOT include personal information in your first email.

<table>
<thead>
<tr>
<th>If you belong to a Medi-Cal Managed Care Plan (MCP)</th>
<th>On or Before December 31, 2020</th>
<th>On or After January 1, 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If you have questions about your medication or other pharmacy services, please call your Managed Care Plan.</td>
<td>• You can call the Medi-Cal Rx Call Center Line (1-800-977-2273 twenty-four hours a day, seven days a week or 711 for TTY, Monday thru Friday, 8am to 5pm).</td>
<td>• Or use the Medi-Cal Rx Pharmacy Locator online at <a href="http://www.Medi-CalRx.dhcs.ca.gov">www.Medi-CalRx.dhcs.ca.gov</a></td>
</tr>
<tr>
<td>• If you have questions about this notice or have Medi-Cal Rx general questions, contact the Medi-Cal Member Help Line (1-800-541-5555, TTY 1-800-430-7077), Monday thru Friday, 8am to 5pm.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you get your care from Fee For Service (FFS) Medi-Cal</th>
<th>On or Before December 31, 2020</th>
<th>On or After January 1, 2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If you have questions about this notice or have Medi-Cal Rx general questions, contact the Medi-Cal Member Help Line (1-800-541-5555, TTY 1-800-430-7077), Monday thru Friday, 8am to 5pm.</td>
<td>• You can call the Medi-Cal Rx Call Center Line (1-800-977-2273 twenty-four hours a day, seven days a week or 711 for TTY, Monday thru Friday, 8am to 5pm).</td>
<td>• Or use the Medi-Cal Rx Pharmacy Locator online at <a href="http://www.Medi-CalRx.dhcs.ca.gov">www.Medi-CalRx.dhcs.ca.gov</a></td>
</tr>
</tbody>
</table>
Starting January 1, 2021, the new plan will accept and resolve any complaints. You can submit a complaint in writing or by telephone.

- Visit www.Medi-CalRx.dhcs.ca.gov or,
- Call Customer Service at 1-800-977-2273 or 711 for TTY

Your health plan will no longer handle pharmacy complaints or appeals on or after January 1, 2021.

How can I appeal a benefit decision?
The California Department of Social Services has a State Hearing process if you want to appeal a pharmacy benefit decision. If you get your prescriptions through a Medi-Cal managed care plan, the appeal process with the State Hearing is different from the appeals process you may have used previously. In a State Hearing, a judge reviews your request with clinical input from DHCS pharmacists to make a decision that aligns with Medi-Cal pharmacy policy.

If a prescription is denied or changed, a form to request a State Hearing will automatically be sent to you with the notice of the denial or change. If you do not agree with a denial or change related to your pharmacy services and benefits under Medi-Cal Rx, you can ask for a State Hearing. You can ask for a State Hearing by sending the State Hearing request form to:

California Department of Social Services  
State Hearings Division  
P.O. Box 944243, MS 19-37  
Sacramento, CA 94244-2430

You may also call to ask for a State Hearing toll-free at 1-800-952-5253 (TTY: 1-800-952-8349). Please note that the number can be very busy so you may get a message to call back later.

To get more information about the State Hearing Process, visit www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx.

On or after January 1, 2021, you can also get the State Hearing request form by going to www.Medi-Cal.Rx.dhcs.ca.gov or by calling Customer Service at 1-800-977-2273 twenty-four hours a day, seven days a week, or 711 for TTY Monday thru Friday, 8am to 5pm.
***PROVIDER NOTICE***

TO: State of California Pharmacy Provider Community
DATE: DATE
SUBJECT: Medi-Cal Rx - Transition of Medi-Cal Pharmacy Administration Services to Magellan Medicaid Administration, Inc.

On January 1, 2021, Magellan Medicaid Administration, Inc. (MMA) will assume operations for Medi-Cal Rx on behalf of the State of California Department of Health Care Services.

Claim Submission Differences:

All pharmacy claims must be processed using the new Medi-Cal Bank Identification Number (BIN), Process Control Number (PCN), and Group ID which are included in the table below.

The following claim submission fields and requirements are being highlighted to assist in your claim filing success during this transition. All claims must be submitted under the National Council for Prescription Drug Program (NCPDP) Telecommunication Standard Version/Release D.0, effective January 1, 2021.

The table below references the Transaction Type, Transaction Code, BIN, PCN and Group ID values.

<table>
<thead>
<tr>
<th>Transaction Header Segment</th>
<th>Transaction Type</th>
<th>Transaction Code</th>
<th>BIN 1Ø3-A3</th>
<th>PCN 1Ø3-A3</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Claim Billing Request</td>
<td>B1</td>
<td>022659</td>
<td>6334225</td>
</tr>
<tr>
<td></td>
<td>Claim Billing Reversal Request</td>
<td>B2</td>
<td>022659</td>
<td>6334225</td>
</tr>
<tr>
<td></td>
<td>Claim Rebill</td>
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<tr>
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<td>Eligibility Verification Request</td>
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<td>Prior Authorization Reversal</td>
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<tr>
<td></td>
<td>Prior Authorization Inquiry</td>
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**Payer Sheets**

Payer sheets will be available online at [www.medi-calrx.dhcs.ca.gov](http://www.medi-calrx.dhcs.ca.gov) by mid-October, 2020. The payer sheet will include the claim submission fields and requirements to assist in claim filing. We encourage you to contact your software vendor to make them aware of the upcoming transition.

**Pharmacy Testing**

MMA encourages pharmacies to submit test claims prior to the transition. MMA is offering a testing window **October 5, 2020 through November 20, 2020**. If you would like to submit test claims, please email MRxPharmacyTesting@magellanhealth.com with your Contact Name, Phone Number, Pharmacy NPI, and Switch information.

**Batch and Paper Submitters**

If you are currently submitting batch or paper pharmacy claims and expect to continue to submit either batch or paper, please email MRxPharmacyTesting@magellanhealth.com to be contacted by MMA for further information.

**Additional Information**

Please refer to [www.medi-calrx.dhcs.ca.gov](http://www.medi-calrx.dhcs.ca.gov) for additional information and announcements.

Sincerely,

Harry Hendrix, Jr.
Contracting Officer
Department of Health Care Services
Pharmacy Benefits Division

Enclosure:

CC: Ivana Thompson
DATE: October 28, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Dr. Dale Bishop, Chief Medical Officer and Jennifer Mockus, Community Care Coordination Director
SUBJECT: Selection of Managed Behavioral Health Organization Vendor

Recommendation. Staff recommend the Board authorize staff to enter into contract negotiations with Beacon Health Options/College Health Independent Physicians Association for a Managed Behavioral Health Organization (MBHO) Agreement effective July 1, 2021 for a period of two years.

Summary. This report provides background on the Medi-Cal behavioral health benefit and contains information about the MBHO request for proposal process, key areas of consideration in choosing the best vendor, and next steps towards implementation.

Background. In January 2014, the Department of Health Care Services (DHCS) implemented a Medi-Cal behavioral health benefit to provide mental health and substance use disorder (SUD) services delivered through a bifurcated system of shared responsibilities between the Medi-Cal Managed Care Plans (MCPs) and County Mental Health Plans (CMHPs). The Alliance Medi-Cal behavioral health benefit provides outpatient services for mental health disorders that treat mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Covered services include individual and group mental health evaluation and treatment (psychotherapy); psychological testing, when clinically indicated to evaluate a mental health condition; outpatient services for the purposes of monitoring drug therapy; outpatient laboratory, drugs, supplies, and supplements; and psychiatric consultation. The benefit also provides behavioral health therapy services (BHT) as well as EPSDT screenings and treatment as medically necessary for children under the age of 21.

Provision of specialty mental health services (SMHS) is the responsibility of the CMHPs. SMHS services include outpatient treatment for individuals with significant impairment in functioning; and inpatient services that include acute psychiatric inpatient hospital services, psychiatric health facility services, and, in some cases, psychiatric inpatient hospital professional services. In addition to SMHS, Counties are responsible for SUD services which include outpatient drug-free services including narcotic treatment services, intensive outpatient treatment, and residential treatment services. Voluntary inpatient detoxification services are covered through DHCS.

In December 2013, the Alliance contracted with Beacon Health Strategies/College Health Independent Physicians Association (Beacon) as the Alliance’s MBHO to provide mild to moderate behavioral health services for Medi-Cal members and for necessary mental health and SUD services for IHSS members. Overall, the Alliance has had success working with Beacon to deliver member access to behavioral health care that meets State expectations and aligns to overall average statewide BH program performance. Beacon
continues to provide mild to moderate behavioral health services to Alliance members. The Beacon MBHO Agreement ends at the end of June 2021.

Staff provide the Alliance’s Board with periodic reports regarding the Medi-Cal behavioral health program performance. In September 2019, staff reported that the Alliance behavioral health program offers adequate utilization when compared to available benchmarks, acceptable member satisfaction rates, meets quality requirements, and a network which meets regulatory requirements. Staff’s assessment and the Board’s feedback identified opportunities for ongoing improvement in behavioral health benefit management, including continuous improvement in network development and in provider language capability, as well as ongoing development towards integrated medical and behavioral health delivery. In addition, staff identified opportunities to ensure MBHO and BH provider understanding of community needs and resources, continuous improvement in coordination between mild-to-moderate, SMI and SUD services, and to close gaps in geographic disparities in utilization across the service area. Access to counseling in Santa Cruz is above statewide average utilization rates. Utilization rates in Monterey and Merced have improved since 2014 yet remain below Santa Cruz County. To this end, staff discussed with the Board conducting a request for proposal for the Alliance’s MBHO in 2020 for implementation in 2021.

Staff also assessed whether to build out the infrastructure to manage the behavioral health benefit internally. Staff’s assessment found that it would be more effective to continue with use of an MBHO and to focus staff resources on improved care coordination across services available to members in the Alliance’s delivery system. To that end, in early 2020, staff implemented a Community Care Coordination Department, responsible for overseeing the behavioral health program as well as collaborating with clinical and social service agencies, improving member navigation across the health care system in the Alliance’s service area.

**Request for Proposal (RFP) Process.** At the end of January 2020, the Alliance released the RFP for MBHO services. The RFP process required offerors to submit compliant and complete written responses and for the top two offerors to participate in a video-conference interview to explore the proposals. The successful offeror was required to demonstrate the ability to comply with all contractual requirements and to support the Alliance mission and objectives. The Alliance’s primary objective for the MBHO agreement is to provide all necessary mild to moderate mental health services for Medi-Cal members and all necessary mental health and SUD services for Alliance Care IHSS members. These BH services are intended to improve health outcomes and reduce overall healthcare costs for populations served by the Alliance and to provide Alliance members comprehensive, coordinated, and integrated behavioral health care that promotes access and wellness.

An RFP team comprised of staff from the Compliance, Finance, Quality Improvement/Population Health, Community Care Coordination, Medical Affairs and Provider Services Departments reviewed the written proposals and conducted the video-conference interviews. The review team considered the quality of each proposal, each MBHO’s expertise, technical offerings, operational capabilities, plans for implementation, and fees and contract terms to assess the MBHO’s ability to meet the primary objective. In addition, staff considered each MBHO’s account management teams and references provided. The review of written proposals identified Beacon and Magellan as the top two
offerors. Each finalist provided best and final pricing, a review of the Alliance contract, and participated in a video-conference interview with the Alliance review team.

Key Areas of Consideration. The written proposals submitted by Beacon and Magellan were both strong and were scored within 0.43 points of each other. This indicates that either offeror has the organizational capacity to deliver the necessary services under the agreement. In evaluating which proposal to recommend to the Board, staff considered each proposal in the context of the COVID-19 pandemic, the impact to members and providers of the January 2021 Medi-Cal Rx implementation and, alignment with the Alliance’s cost containment plan. Staff focused their evaluation on a few key RFP criteria, including each MBHO’s expertise with the Medi-Cal program, implementation plan, and overall cost.

Discussion. After assessment of all relevant factors, staff find Beacon to be the stronger candidate for this two-year MBHO contract.

With regards to expertise, staff considered each offeror’s experience providing Medi-Cal managed care. As stated above, Beacon has provided mild to moderate behavioral health services since January 2014 to Alliance members. In addition to the experience with Alliance members and providers, Beacon provides MBHO services to many other Medi-Cal managed care plan counties in the state of California. Magellan has less expertise providing Medi-Cal managed care services. Magellan has experience in Medicaid administration of behavioral health services in other states, but those delivery systems differ from California’s bifurcated service delivery model. Magellan provides MBHO services to a single MCP in California and for commercial coverage in California. Beacon’s expertise in Medi-Cal managed care, and in the Alliance service area specifically, yields a stronger proposal.

With regards to cost, Beacon offered a financial proposal that was less costly than what was offered by Magellan.

With regards to implementation, Beacon has an established network in the Alliance’s service area. Beacon has established relationships with County and community partners, including each county specialty mental health plan. Members and providers have experience in accessing Beacon services through the Beacon network. Staff, Beacon and county partners have worked to establish processes to coordinate care and have a shared understanding of the opportunities to improve member experience and utilization. The implementation of the new agreement would not present disruption to members, to providers, to community partners and to staff. Efforts could be focused on improvements in access, quality and care coordination.

Staff noted that Magellan had a strong implementation plan. A key consideration was Magellan’s need to build a network rather than relying on an established network. To the extent Magellan may be unable to contract with the same network providers that are currently available to Alliance members, some members may need to re-establish care with a different provider contracted in Magellan’s network. Magellan and the Alliance would need to educate the community about the implementation of Magellan’s MBHO operations in the Alliance’s service area during the pandemic. Provider trainings and relationship building with the counties, regional centers, large safety net providers, and others would
need to occur prior to implementation in July 2021. Staff would need to understand Magellan’s processes for member’s accessing care and for coordination with County partners. Magellan and the Alliance would need to work together to educate members and providers about these changes from existing process.

In considering the strength of the proposals relating to implementation, staff considered the environmental factors of the COVID-19 pandemic and the pending implementation of Medi-Cal Rx and whether the Magellan proposal offered significant improvement in access, quality or cost that would outweigh the disruption of a change in MBHO during a period of pandemic-response and significant Medi-Cal program change. Staff assessed that Magellan offered a strong proposal, but its value did not outweigh the disruption of implementation.

**Conclusion.** After evaluating all factors, staff’s recommendation is to retain Beacon as the MBHO for the Alliance. Other offerors did not demonstrate measurable benefit above and beyond that which is available to members through Beacon. As noted above, both proposals were strong and were scored very closely. Magellan’s strengths included their emphasis on using IT solutions to improve outcomes and streamline member care, and the terms in their proposal had more provider follow-up, member services support, and quality improvement guarantees. However, Beacon has had demonstrated success in managing the Medi-Cal benefit and offers more consistency and less disruption to members during this very uncertain period. Beacon’s proposal was scored slightly above Magellan’s and offers rates more closely in line with revenue. Given Beacon’s current role as the Alliance’s MBHO, implementation of the new MBHO agreement would not disrupt existing member-provider relationships or community care coordination efforts. There is the opportunity for staff to work towards improved access and quality through its oversight of the MBHO agreement. For these reasons, staff believe that Beacon is the stronger candidate for this 2-year contract period.

**Fiscal Impact.** Costs for services provided through the MBHO agreement are included in the annual medical and administrative budgets approved by the Alliance’s board in December. Costs are anticipated to increase 5% over the current agreement, beginning in July 2021.

**Attachments.** N/A
Recommendation. Staff recommend the Board approve the 2021 schedule of Alliance Board Meetings.

Background. Meetings are held from 3:00 to 5:00 p.m. (fourth Wednesdays) at the following locations via videoconference unless otherwise noted, and are open to the public.

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

Based on guidance from the California Department of Public Health and pursuant to Governor Newsom’s Executive Order N-29-20 to minimize the spread of COVID-19, some meetings may be held by teleconference with no access to Alliance offices. Information for attending meetings remotely will be included in the agenda.

Schedule of Alliance Board Meetings 2021

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<td>March</td>
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<td>December</td>
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As meeting dates and locations can change, please visit the Alliance website or contact the Clerk of the Board (see below) to verify the date and location.

The complete agenda packet is available for review at Alliance offices, and on the Alliance website at [www.ccah-alliance.org/boardmeeting.html](http://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 attend meetings should contact the Clerk to 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 in person meetings smoke and scent free.

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

**Attachments.** N/A
Information Items: (13A. – 13B.)

A. Alliance in the News  Page 13A-01
B. Membership Enrollment Report  Page 13B-01
Virtual Job Fair Slated for October 22
Century Link via Santa Cruz Sentinel
Coast Lines
Donald Fukui

September 21, 2020

An Access 2 Employment virtual job fair will be held from 1-3 p.m. Oct. 22.

The event is open to the public and is free for both employers and job seekers.

Employers participating include Allied Universal Security, Cabrillo College, California Conservation Corp, Central California Alliance for Health, Lifespan Care, Michael’s Transportation, Monterey Bay Economic Partnership, Santa Cruz Nutritionals, UC Santa Cruz, Your Future is Our Business, and more.

Each business will conduct a short presentation to share insight on their company, open positions, hiring process, and workplace culture. Brief Q&A sessions will follow to offer job seekers an opportunity to chat with hiring managers and get answers to their questions.

Registration is required. To register, visit Access2Employment.com.

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Santa Cruz Sentinel
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Donald Fukui
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Registration is required. To register, visit Access2Employment.com.

Merced Mariposa County Medical Society
E-newsletter mention
September 17, 2020

The Alliance Issues a Press Release Encouraging Parents to Vaccinate Their Children

The Central California Alliance for Health (the Alliance), the Medi-Cal managed health care plan for residents of Monterey, Merced and Santa Cruz counties, issued a press release this week urging the public to contact their doctors and ask if they are due for vaccines and check-ups.

According to the State’s Department of Public Health, childhood vaccinations in CA have plummeted more than 40% since last year. Equally concerning is that residents of all ages are not seeing doctors when they might need to for medically related visits: The California Health Care Foundation estimates that hospital outpatient visits are down by nearly 25% from pre-COVID levels.

Within the Alliance service area, about half of the 2 year-olds are up-to-date on all of their vaccines. However, the rates for Merced County are lower - only 1 in 5 toddlers is protected.

THE ALLIANCE PRESS RELEASE

Reasons to Take Your Child to the Doctor – Even During COVID
TPG – Aptos Times, Page 27
Opinion Column & Blogs
Dr. Dianna Diallo
September 17, 2020

Being up-to-date with immunizations is crucial for your child.

Immunizations remain a vital component of pediatric health care, even during the COVID-19 pandemic. Immune systems are still developing in children and infants, and vaccinations produce antibodies that allow the immune system to build up the ability to fight a particular disease. Despite the current need to maintain social distancing, vaccine-preventable diseases such as chickenpox and measles continue to circulate, so vaccines provide the protection children need if exposed.

Unfortunately, childhood immunization rates plummeted 40% following the stay-at-home order. This drop in vaccinations has put children at risk for preventable diseases. This issue
is even more serious for children in vulnerable populations. For example, as of August in Santa Cruz County, just over half of 2-year-olds on Medi-Cal are up-to-date with shots; the stats for 13-year-olds are only slightly better at 56%. While these numbers are higher than the Medicaid national average – 35% for both age groups – that means nearly one out of every two kids is not protected!

And don’t forget that flu season is right around the corner! A yearly flu shot is recommended for anyone 6 months or older. Why? A vaccine made against 2019 flu viruses may not protect against the viruses circulating in 2020. Also, immunity to the flu declines over time and may be too low to provide protection beyond one year.

The number and frequency of vaccines don’t overwhelm your child’s immune system…they protect them!

The recommended vaccine schedules are designed to protect children when they’re most vulnerable to the diseases vaccines prevent. Although infants do receive a lot of shots, they are given at the time babies are most at risk of illness and serious complications. Older children need boosters of many of the shots they had as infants to remain protected.

Non-standard schedules that spread out vaccines, or start when a child is older, don’t provide the protection infants and young children need. Vaccines are well-studied to make sure that it’s safe to give them at the recommended intervals.

[The CDC offers parent-friendly vaccine schedules for infants to teens, or you can download the CDC’s free app for smartphones.]

Vaccines are safe – they do not cause conditions such as autism.

Several studies have looked for a connection between vaccines and autism, but scientific evidence doesn’t show any link between the two. The CDC, the AAP, the National Institutes for Health and the Institute of Medicine agree that vaccines do NOT cause autism. Vaccines are continually monitored for safety. Choosing not to vaccinate doesn’t protect children from autism…what it does do is leave them vulnerable to potentially long-term and life-threatening harm from vaccine-preventable diseases.

Doctors have protocols in place to protect you and your child from COVID at in-person check-ups.

Most doctors have specific hours and locations where they can examine healthy kids for regular check-ups and vaccines. Of course, it’s still important for people over 2 years of age to wear a mask and for everyone to sanitize their hands often and social distance from anyone not in their family. And if you or your child are sick, please stay home.

The most important thing to do is check in with your doctor’s office over the phone – they can give you specific details about whether it’s necessary to bring your child into the office for a check-up.
Well-check appointments are about more than immunizations. They address the whole child!

At well-check visits, your doctor will access many health indicators beyond immunizations: your child’s overall health, growth and development, mental and emotional status, how they are doing in school.

For younger children, the doctor can see if they are progressing in developmental milestones. For teenagers, the doctor will often ask if the teen wants some time alone to ask questions about their body, sexuality, drugs, vaping or their fears about COVID-19.

Also, with so many normal school and extracurricular activities currently shut down, your child’s pediatrician might be one of the few adults they encounter outside the home who are looking out for their well-being. Now is a very important time in your child’s life to understand the importance of having a trusted doctor looking out for their welfare.

Check in, check up.

Call your pediatrician. Find out when your child is due for immunizations or a well-child check and schedule that appointment. If your child hasn’t had a flu shot this year, now is the time to schedule that too.

Dianna Diallo, MD is Medical Director of the Central California Alliance for Health, a Medi-Cal managed care health plan focused on improving access to health care for over 347,000 residents of Merced, Monterey and Santa Cruz counties. Dr. Diallo has over 15 years of pediatric care experience.

Preventative care is critical to the health of you and your family.

Preventive care is routine checkups that can detect and prevent hidden illness early, typically before visible symptoms arise. It helps you maintain optimal health throughout your lifetime, improving quality of life and longevity. These routine visits include wellness exams – like physicals or well-child visits – vaccinations and cancer screenings.

Immunizations remain a vital component of health care, even during the COVID-19 pandemic. Vaccines protect kids against 16 serious diseases (the CDC provides a complete list of recommended vaccines by age), and if children don’t get all of the necessary vaccines at the right time, they may need to start a new or different vaccine schedule to ensure full immunization. Regular and timely vaccinations also safeguard adults against diseases like the chicken pox. And don’t forget that flu season is right around the corner! A
yearly flu shot is recommended for anyone 6 months or older. Flu vaccines are updated each year to protect against ever-changing flu viruses. Avoiding care now often leads to health problems later.

Wellness visits are essential, especially for those with chronic or underlying health conditions, such as diabetes, high blood pressure, heart disease and asthma. In the U.S., 7 out of 10 deaths are caused by chronic disease, which can often be detected – and caught early – during preventative care appointments and screenings. Underlying health issues that are left undiagnosed and untreated can have serious consequences like respiratory failure (infections like COVID-19 can exacerbate conditions) or even death.

The best way to prevent illness is by getting age-appropriate screenings (such as cancer screenings or monitoring for high blood pressure) that can detect early signs of chronic disease. This is especially critical for vulnerable populations. There’s a sizable health gap between rural and urban residents. Several demographic, environmental, economic, and social factors put rural residents at higher risk from the five leading causes of death in the U.S.: heart disease, cancer, unintentional injury, chronic lower respiratory disease and stroke.

About 15 percent of Merced County residents live in rural areas, which matches the percentage of rural area residents in the entire United States.

Addressing the gaps in health in rural areas begins with prioritizing preventative care.

COVID-19 has made preventative care even more important.

Due to the pandemic, it’s been necessary to keep distance from others, and there’s been a marked decrease in the usual in-person interaction. For many, this quarantine has negatively affected their mental health. We’ve seen this to be especially true with our senior population, who might not be as familiar or as comfortable with the virtual interaction and technology we’ve relied upon during social distancing. Physical distancing from loved ones and a general isolation from others has led to feelings of loneliness, grief, anxiety and chronic stress that can have long-standing psychological effects.

Mental health screenings are part of regular doctor check-ups. Mental health and well-being is important for everyone, and if someone is struggling, his or her doctor can connect them to the resources they need.

For children, preventative care may be even more important. With so many normal school and extracurricular activities currently shut down or modified, a child’s pediatrician might be one of the few adults they encounter outside the home who are looking out for their well-being. Right now is a very important time in a child’s life to understand the importance of having a trusted doctor looking out for their welfare.

Doctors have protocols in place to protect you and your family from COVID.

Doctor’s offices have implemented extra steps to make sure your in-person visit is safe, like having specific hours and locations for well-visits, keeping sick patients and well patients separated and limiting the number of people in waiting rooms.
Of course, it’s still important for people over 2 years of age to wear a mask and for everyone to sanitize their hands often and social distance from anyone not in their family. And if you or a family member is sick, please stay home.

Check in, check up.

Regular check-ups are essential monitors of overall health status – keeping up with your preventative care maximizes your well-being. This includes getting your flu shot every year. Instead of guessing whether your regular check-up can wait, check in with your doctor. If you have a health concern, or questions regarding preventive care appointments, call your doctor for information on scheduling both physical and virtual health check-ups.

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Top 5 Reasons it’s Important to Take Your Child to Pediatrician. Even During COVID.

Being up-to-date with immunizations is crucial for your child.

Immunizations remain a vital component of pediatric health care, even during the COVID-19 pandemic. Immune systems are still developing in children and infants, and vaccinations produce antibodies that allow the immune system to build up the ability to fight a particular disease. Despite the current need to maintain social distancing, vaccine-preventable diseases such as chickenpox and measles continue to circulate, so vaccines provide the protection children need if exposed.

Unfortunately, childhood immunization rates plummeted 40% following the stay-at-home order. The drop in vaccinations has put children at risk for preventable diseases. This issue is even more serious for children in vulnerable populations. For example, as of August in Monterey County, just over half of 2-year-olds on Medi-Cal are up-to-date with shots; the stats for 13-year-olds are only slightly better at 62%. While these numbers are higher than the Medicaid national average – 35% for both age groups – that means nearly one out of every three kids is not protected!

And don’t forget that the flu season is right around the corner! A yearly flu shot is recommended for anyone 6 months or older. Why? A vaccine made against 2019 flu viruses may not protect against the viruses circulating in 2020. Also, immunity to the flu declines over time and maybe too low to provide protection beyond one year.

The number and frequency of vaccines don’t overwhelm your child’s immune system...they protect them.
The recommended vaccine schedules are designed to protect children when they're most vulnerable to the diseases vaccines prevent. Although infants do receive a lot of shots, they are given at the time babies are most at risk of illness and serious complications. Older children need boosters of many of the shots they had as infants to remain protected.

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For younger children, the doctor can see if they are progressing in developmental milestones. For teenagers, the doctor will often ask if the teen wants some time alone to ask questions about their body, sexuality, drugs, vaping, or their fears about COVID-19.

Also, with so many normal school and extracurricular activities currently shut down, your child's pediatrician might be one of the few adults they encounter outside the home who are looking out for their well-being. Now is a very important time in your child's life to understand the importance of having a trusted doctor looking out for their welfare.
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Doctor’s Orders
Edible Monterey Bay
Mark C. Anderson
September 1, 2020

Produce prescriptions are preventing disease and saving local lives.

Maia’s handwritten testimonial is clear, simple and powerful.

“Many thanks because my family eats more vegetables and greens,” it reads. “Thank you for the money to buy them. Thank you to all the people who cultivate them. I give thanks to God that people exist who care about my family, my health and my children.”

Clear, simple and powerful also work as themes for this story, particularly how powerful something as simple as access to fresh produce can be in saving swaths of citizens from scary health outcomes, and in saving society massive amounts in medical expenditures. It’s also about the very type of food that moves the Edible Monterey Bay community—healthy, local, delicious, life-affirming organic fare—that frequently doesn’t reach those who need it most.

Maia, who wrote that note and whose name has been changed for this piece, participates in the produce prescription program called Fresh Rx administered by nonprofit Everybody’s Harvest—a program that is part of a movement called Food as Medicine.

At its five farmers’ markets, Everyone’s Harvest takes prescriptions issued by doctors at the Alisal and Seaside Family Health Centers and enrolls food-insecure families at increasing rates. What started out serving 10 families now caters to 150-plus.

Fresh Rx works like this: A physician like Dr. Pedro Moreno at Alisal Health Center meets with a family at his safety net clinic in Salinas and discovers they’re not eating as many healthy foods as they’d like and writes a produce prescription. The family takes the prescription to the info table at a market, registers and receives roughly $25 in tokens to spend on fruits and vegetables. Everyone’s Harvest pays the vendors for the tokens they bring at the conclusion of the market.
“Thanks to Everyone’s Harvest, I can ‘prescribe’ the best ‘medicine’ for my patients: fresh organic fruits and vegetables in our farmers’ markets,” Moreno wrote in a note to the nonprofit’s board. “On behalf of my patients, our most sincere gratitude.”

Everyone’s Harvest executive director Reid Norris and his farmers filled $80,000 in produce prescriptions last year alone.

“I know the families love it enough to keep coming,” he says. “Nutrition programs are my favorite part of the job, and have become such a big part of what we do. I feel like we’re a nutrition company that also runs farmers’ markets.”

Salinas Valley Memorial Hospital clinical dietitian Sara Housman is another healthcare professional who directs vulnerable patients with recent heart events to Fresh Rx. “It’s not just, ‘Take your medicine and fix this,’” she says. “It’s putting the focus on food more than medication.”

While she admits it’s disheartening to hear patients say, “Well, that’s great, but I can’t afford to eat that way,” she has an answer. “It’s a fantastic feeling to say, ‘I can help with that.’ They feel supported. They can use their food money for other things, and don’t have to make hard decisions in the store,” she adds.

Those decisions are intense. Hunger in America studies have found 66% of food insecure individuals have to choose between food and healthcare and 57% percent are forced to make the same impossible calls between food and housing.

Housman sees these market-fresh interventions interrupting a downward spiral: food insecurity contributing to illness, which incurs costs and missed work, which adds to insecurity, and so on.

“This can put a stopping wedge in that,” she says. “If we normalize [programs like] this, it would be a dream.”

HEALTHCARE REVOLUTION

Make no mistake. Food as Medicine programs are somewhat new, but the concept is timeless. Hippocrates said, Let food be thy medicine and medicine be thy food back in 400 BC.

What has changed is that a healthcare system that has long focused on treatment and pills is now getting far more serious about prevention and produce.

At EcoFarm 2020—remember when in person conferences were a thing?—the shift was described as nothing less than a “healthcare revolution.” Dr. Rita Nguyen of the San Francisco Department of Public Health juxtaposed the timelessness and new push for data with a dash of no duh.

“It’s crazy that we have this as a study!” she said as part of a panel titled Prescribing Organic Food as Medicine. “Every private insurance carrier is now at least dipping a toe into this
research. Policy makers and insurance carriers want to know [financial-savings] numbers in the food and medicine fields."

A few numbers to know: A modest subsidy to buy more fruits, vegetables, whole grains and seafood for adults within Medicare and Medicaid in the U.S. could prevent 3.28 million cardiovascular events, ward off 120,000 diabetes cases and save $100.2 billion in healthcare costs, according to researchers at Tufts University.

That’s $100.2 billion, with a “b”—more than the GDP of whole countries, four times what the U.S. spent sending a man to the moon.

But this is not as complex as managing the economy of Costa Rica or Kenya. This is not a moonshot. It’s simple sustenance for Americans on the margins, who have only multiplied in the context of the coronavirus pandemic. Making sure they have access to nutrition should be a moral imperative, a self-evident must-do. But even if governments didn’t care about saving lives, it’s still a no-brainer for the simple economics.

The bad news is it took us so long to get to this. Hippocrates would not be impressed. But there are reasons for that, including Big Pharma profits and an abiding there’s-a-pill-for-that mentality. In addition, many in the healthcare sector have long considered food and nutrition programs social services, not health interventions.

This despite food insecurity and chronic conditions like diabetes, heart disease and cardiovascular disease being closely connected. "Food insecurity is not uniquely a food or moral issue or economic issue," says Erin Franey, who collaborates with Nguyen as the program manager of the Food as Medicine Collaborative. "It’s a health issue. There’s a role for healthcare to play."

While that may not be the most tantalizing food story ever told, it ranks among the most important.

"True public health involves prevention, and communicating that message has never been sexy," Nguyen says. "But providers are starting to understand treatment is not just about technology and pills and hospital treatments; it’s everything, including housing and transportation and food."

Nguyen believes evolution in food awareness has helped bring on the shift. "Ten years ago, people weren’t talking about food the same way they are now," she says. "Culturally and generationally, people—and Millennials in particular—are much more conscious about the way they eat. People are into organics and really good sustainable food, not the microwaveable meals that I grew up with."

What has changed is that a healthcare system that has long focused on treatment and pills is now getting far more serious about prevention and produce.

SAVING MONEY, SAVING LIVES

A sweet Monterey Bay area senior we’ll call Amos (to protect his privacy) was having a tough go of it.
By 70 he had accumulated a history of past stroke, diabetes, hypertension and chronic obstructive pulmonary disease, much of it directly traceable to poor diet. Earlier this year his conditions landed him back in the hospital, but when he was released this time there was a big difference. Instead of returning to a diet of cheap and unhealthy foods, he was enrolled in a pilot program called Post-Discharge Meals. The clunkily named project furnishes medically tailored meals (MTMs) for Medi-Cal members returning home from being hospitalized, with a high likelihood of readmission.

The Central California Alliance for Health, which administers Medi-Cal benefits for Santa Cruz, Monterey and Merced counties, runs the pilot program; CCAH is also one of the regional entities participating in the Food as Medicine movement. A survey of Alliance clients revealed 50% percent of them, like Amos, are food insecure. (The U.S. Department of Agriculture, or USDA, defines food insecurity as a lack of consistent access to enough food for an active, healthy life.)

In Monterey and Merced counties, they partner with Mom’s Meals to provide plates like roasted pork loin with apple cranberry sauce over white rice and mixed vegetables. In Santa Cruz County, they count on Teen Kitchen Project to assemble 14 meals a week for 12 weeks for each participating patient.

While providing food delivery for the ill is inherently helpful—and TKP has scaled up from 840 meals to 1,582 weekly to support COVID-19 needs early in the pandemic—its model enjoys an added benefit. Staff chefs train student community-service volunteers (who are sometimes hired) in professional culinary skills. A peek at its menu reveals all sorts of tasty plates like orange ginger chicken, zucchini nut bread and cauliflower-mushroom casserole, and recipes are shared on its website.

“There’s something special about these meals besides the fact they’re fresh and not frozen,” says TKP’s executive director Angela Farley. “They’re high fiber, heart healthy, low sodium, low fat, organic, diabetes friendly.” The other something special: They’re saving lives. Studies of similar programs across the U.S. document 70% fewer emergency room visits and half as many return visits to the hospital for those eating medically tailored meals, denting the $160 billion-plus spent nationally on health-related expenses attributable to food insecurity.

Suddenly doctors are treating the source of the crisis and not symptoms.

The California Alliance is currently evaluating the pilot. “The early data is really promising,” says Kathleen McCarthy, CCAH’s strategic development director. “Not only do people really like being in the program, but there’s a clear return on investment: It improves health and lowers costs.”

Amos is among those thrilled to participate. He enthusiastically gobbled up his meals, thanked CCAH profusely and hasn’t needed the hospital and its spendy treatments since. As he started discovering fresher food sources, Amos and his wife have started replicating the recipes they came to love on the exit-meals program.
MTMs is one of a range of local measures at work. CCAH has awarded some $1.7 million in grants to 10 different organizations in Santa Cruz and Monterey counties to partner with healthcare providers to decrease food insecurity among the Medi-Cal population.

Community Bridges, for instance, does hospital screenings for food insecurity—just as doctors screen for things like age, gender and family history in determining treatment—and refers those eligible to family resource centers for food distribution and additional tools. Second Harvest Food Bank Santa Cruz County fields clinic and hospital referrals for nutrition prescription and a nutrition/cooking class. Esperanza Community Farms delivers diabetes patients nutrition group classes and CSA vegetable boxes.

FOOD AS MEDICINE

This spring, Salinas Valley Memorial Hospital—where Housman and her clients are loving the Fresh Rx program—was among scores of state community groups that signed a position paper sent to the California Department of Health Care Services. The groups—including Second Harvest, Teen Kitchen and Santa Cruz’s Go for Health!—called for extended medically supportive food and nutrition services.

The gist: As part of an ongoing effort to improve Medi-Cal, food-as-medicine interventions should be built into healthcare going forward. This way is working.

As one of the pioneers of the movement, Dr. Andrea T. Feinberg of the Geisinger Fresh Food Farmacy, puts it, "If one considers [healthy food] to be the equivalent of a drug covered by insurance and provided by the healthcare system, then this is essentially a disease management program—just more successful than most."

Katie Ettman helped draft the position paper as part of her work with Bay Area-based nonprofit think tank, SPUR, advocating for healthy, just and sustainable food systems. "When people think of 'food as medicine' they often think of juice cleanses and turmeric tea, but we are talking about something much more accessible: providing healthy food to more people," Ettman says. "Food as medicine is about investing in the prevention of disease so that we can help people before they get sick...the food-as-medicine movement may not be mainstream yet, but it should be."

Dr. Nguyen chose to work with the Food as Medicine Collaborative precisely because of its accessibility. Entrenched realities contribute to food insecurity, but she knows that those are far more difficult dragons to slay than diagnosing nutrition shortages and furnishing food access.

"If I could fix one thing that contributes to food insecurity, it would be inequality or racism, but I can’t fix those," she says. "The reason I picked food is it’s the most direct tangible link. This has impact. If you want to be impactful, go to the source of the problem." Hippocrates would be proud.
## Membership Totals by County and Program, % Change Month-over-Month and % Change Year-over-Year

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