DATE: Wednesday, June 24, 2020

TIME: 3:00 – 5:00 p.m.

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/256581933
   b. Or by telephone at:
      United States: +1 (872) 240-3412
      Access Code: 256-581-933
   c. New to GoToMeeting? Get the app now and be ready when your first meeting starts: https://global.gotomeeting.com/install/256581933

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, June 23, 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. – 9E.): 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 5-10

6. **Accept Alliance Balance Sheet, Income Statement and Statement of Cash Flow for four months ending April 30, 2020.**
   - Reference materials: Financial Statements as above.  
   Pages 6-01 to 6-03

7. **Accept Alliance Dashboard for Q1 2020.**
   Pages 7-01 to 7-02

**Minutes: (8A. – 8D.)**

8A. **Approve Commission meeting minutes of May 27, 2020.**
   - Reference materials: Minutes as above.  
   Pages 8A-01 to 8A-06

8B. **Accept Compliance Committee meeting minutes of April 15, 2020.**
   - Reference materials: Minutes as above.  
   Pages 8B-01 to 8B-06

8C. **Accept Finance Committee meeting minutes of February 26, 2020.**
   - Reference materials: Minutes as above.  
   Pages 8C-01 to 8C-06

8D. **Accept Physicians Advisory Group meeting minutes of March 5, 2020.**
   - Reference materials: Minutes as above.  
   Pages 8D-01 to 8D-05
Reports: (9A. – 9E.)

9A. **Accept report on COVID-19 Response Fund Grants.**
- Reference materials: Staff report and recommendation on above topic; and list of COVID-19 Response Fund grant awards.

9B. **Accept report on Centers for Medicare & Medicaid Services Interoperability Rule and approve a 2020 budget addition for procurement of an interoperability solution.**
- Reference materials: Staff report and recommendation on above topic.

9C. **Accept report on 2020 Legislative Session update and adopt a position of support on AB 2164 (Rivas) and direct staff to send a letter of support.**
- Reference materials: Staff report and recommendation on above topic.

9D. **Accept report on Peer Review and Credentialing Committee of June 10, 2020.**
- Reference materials: Staff report and recommendation on above topic.

9E. **Accept report on Quality and Performance Improvement Program Annual Report – 2019.**
- Reference materials: Staff report and recommendation on above topic.

Regular Agenda Items: (10. – 12.): 3:15 p.m.

10. **Consider approving report on Alliance Strategic Planning. (3:15 – 3:45 p.m.)**
   A. Ms. Stephanie Sonnenshine, CEO, and Ms. Bobbie Wunsch, Pacific Health Consulting Group, will review and Board will discuss strategic planning, consider approving a new Alliance Vision Statement, and recommendation to approve a revised September 2020 Board meeting schedule.
   - Reference materials: Staff report and recommendation on above topic; and biography of Ms. Bobbie Wunsch.

11. **Discuss California State Budget for FY 2020-2021. (3:45 – 4:15 p.m.)**
   A. Ms. Danita Carlson, Government Relations Director, will review and Board will discuss above topic.
   - Reference materials: News article: California Legislature OK’s budget, but changes coming.

12. **Consider approving report on Medical Cost Containment Plan. (4:15 – 5:00 p.m.)**
   A. Ms. Lisa Ba, Chief Financial Officer, will review and Board will consider approving report on Medical Cost Analysis and recommendation of Cost Containment Plan.
   - Reference materials: Staff report and recommendation on above topic.

   A. Alliance in the News
   Page 13A-01

   B. Letters of Support
   Page 13B-01

   C. Membership Enrollment Report
   Page 13C-01

   D. Member Newsletter (English) – June 2020
   [https://www.ccah-alliance.org/pdfs/member_newsletters/CCAH-Member-June%202020-ENG-highres.pdf](https://www.ccah-alliance.org/pdfs/member_newsletters/CCAH-Member-June%202020-ENG-highres.pdf)

   E. Member Newsletter (Spanish) – June 2020
   [https://www.ccah-alliance.org/pdfs/member_newsletters/CCAH-Member-June%202020-SPA-highres.pdf](https://www.ccah-alliance.org/pdfs/member_newsletters/CCAH-Member-June%202020-SPA-highres.pdf)

   F. Provider Bulletin – June 2020
   [https://www.ccah-alliance.org/pdfs/provider_bulletins/PSBulletin_202006.pdf](https://www.ccah-alliance.org/pdfs/provider_bulletins/PSBulletin_202006.pdf)
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 Clinical Advisory Committee
  Thursday, June 18, 2020; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee
  Monday, July 13, 2020; 1:30 – 3:00 p.m.

- Member Services Advisory Group
  Thursday, August 13, 2020; 10:00 – 11:30 a.m.

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

- Finance Committee
  Wednesday, September 23, 2020; 1:30 – 2:45 p.m.

Locations for the above meetings unless otherwise noticed:

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 E. Blanco Road, Suite 101, Salinas, CA

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

The next meeting of the Commission, after this June 24, 2020 meeting:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, September 23, 2020, 3:00 – 5:00 p.m. (Pending Board approval)
  Location: Videoconference from Alliance offices in Scotts Valley, Salinas and Merced

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.

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The complete agenda packet is available for review at Alliance offices, and on the Alliance website at www.ccah-alliance.org/boardmeeting.html. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-5523. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.
DATE: June 24, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Stephanie Sonnenshine, Chief Executive Officer
SUBJECT: Executive Summary from the Chief Executive Officer

Executive

New Director of Department of Health Care Services (DHCS). Bradley Gilbert, MD resigned his position of Director of the DHCS effective June 12, 2020, citing his desire to retire and rejoin his family in Southern California as his reason for leaving. On June 15, 2020, Governor Newsom announced the appointment of Will Lightbourne to replace Dr. Gilbert as head of DHCS. Mr. Lightbourne most recently held the position of Director of the State Department of Social Services, which he left in January after having been in the position since 2011. Mr. Lightbourne previously served as County Social Services Director for San Francisco, Santa Clara and Santa Cruz counties before joining the state in 2011. He was also a founding board member on the Alliance board (then Santa Cruz County Health Options) in 1995.

Fiscal Year 2020-21 State Budget. In May, staff reported to the board on Governor Newsom’s May Revise budget proposals which included closing a projected $54B deficit by withdrawing previous proposals for expansion of Medi-Cal eligibility and transformation of the Medi-Cal delivery system as well as significantly reducing Medi-Cal benefits, provider payments and health plan revenue. The typical budget process includes each house of the legislature finalizing its own version of the budget and then Legislative leaders and the Governor meeting in June to address outstanding issues. To date, legislators have rejected most of the reductions proposed by the Governor in Medi-Cal benefits and provider payments and have shown some support for proposals to reduce health plan revenue. The Legislature must adopt a budget by the constitutional deadline of June 15, 2020. If the Legislature fails to do so, they will not be paid. As of this writing, the Legislature and the Governor have reportedly failed to come to agreement on a final budget plan. To meet the constitutional budget deadline, the Legislature adopted its budget plan on June 15, 2020, with the understanding that negotiations will continue with the Governor with a final budget agreement by June 30, 2020. Staff will provide an up-to-date report on budget activities and outcomes at the June board meeting.

Additional COVID-19 Provider Relief Funding for Medicaid/CHIP Providers and Safety Net Hospitals. On June 9, 2020, the U.S. Department of Health and Human Services (HHS) announced additional funding opportunities available to Medicaid/CHIP providers and safety net hospitals with $15B in provider relief funds available to providers and $10B for hospitals. This follows on DHCS’ request for comprehensive payment data from Managed Care Plans (MCPs) last month. DHCS indicates that the data submitted will be used to validate this next round of provider relief funding. This funding is intended to provide relief to Medicaid and CHIP providers experiencing lost revenues or increased expenses due to COVID-19. To be eligible for this funding, health care providers must not have received payments from the $50 billion
Provider Relief Fund General Distribution and either have directly billed their state Medicaid/CHIP programs or Medicaid MCPs for healthcare-related services between the dates of January 1, 2018 to May 31, 2020. Providers must submit their annual patient revenue information through an HHS Provider Relief Fund Portal to receive a distribution.

COVID-19 federal Legislation. On May 15, 2020, the House of Representatives passed the $3T HEROES Act, which included, among other things, relief for state and local governments in areas such as rent and mortgage relief, hazard pay and paid leave for frontline workers and expanded mail-in voting programs. However, the Senate has declined to take this package up. While Congress is expected to adopt an alternative relief package, it is expected that Congress will not act on another relief package until after the July recess.

2020 State Legislative Session. As reported in May, considering the COVID-19 pandemic and the associated impacts, the legislature is expected to move forward only a limited number of bills and initiatives to focus on priorities such as COVID-19, wildfires and homelessness. To that end, the volume of bills moving is significantly reduced from what would be seen during a typical legislative session. Staff continues to monitor those bills that are moving that will have an impact on the Alliance, providers and members. Currently, there is a significant focus and interest among the legislature on blood lead testing and screening and there are several bills that staff are watching. Additionally, staff have identified a bill to recommend for the board to take a position of support. AB 2164 is authored by Assemblymember Robert Rivas and provides Federally Qualified Health Center’s flexibilities regarding telehealth. Staff recommend that the Board support AB 2164. This is included as an action item on the Consent Agenda for the June board meeting.

Community Involvement. On June 10, 2020 I attended the June All Plan CEO Meeting via teleconference. On June 15, 2020 I participated on the Local Health Plans of California Board Meeting conference call and Health Improvement Partnership of Santa Cruz County Executive Committee Meeting on June 18, 2020 via teleconference. I plan to attend the MoRe Health Executive Team Meeting and the Santa Cruz Health Information Exchange Board Meeting via teleconference on June 25, 2020.

Health Services

Prior Authorization. In June 2020, several additional ED Direct Referral Codes will be added to address the need for rapid/24-hour subspecialist referral without the need for pre-authorization. The purpose of direct referrals is to bypass the need for admission or ED follow-up for certain conditions that typically require close follow-up. Initial Alliance ED Direct Referral Codes included ophthalmologic emergencies and orthopedic emergencies/fractures. The new codes will include cardiac complaints, GI bleeds, venous stasis ulcers, cellulitis, and second-degree burns.

Pharmacy Trends for May 2020. The emergency override prescription count and paid amount for May 2020 was minimal compared to our overall spend. There was a significant increase in prior authorizations in May 2020, probably due to the provider’s offices resuming care and subsequently initiating the prior authorization process. The Alliance Pharmacy team continued
to maintain the high quality of service by meeting our turnaround times despite the increase in prior authorizations and increase care coordination due to COVID-19 related activities. Per member per month (PMPM) peaked in March 2020 ($48.92) but has trended down to $43.24 in May 2020. The PMPM for Hepatitis C drugs increased to $1.02 in May 2020 from 0.98 in April 2020 due to increased utilization in May.

Population Needs Assessment. The Health Education and Cultural & Linguistic Group Needs Assessment (GNA) is an ongoing report that is required by DHCS. Previously, the Alliance Care Management Department conducted a comprehensive GNA of the Alliance membership every five years. With recent changes to All Plan Letter 19-011 that DHCS released, the GNA has now become the Population Needs Assessment (PNA). With a few key differences that include the frequency of the report submission, the discontinuation of the GNA standardized assessments survey, and the use of the DHCS Consumers Assessment of Healthcare Providers and Systems survey in its place to collect information about how well health plans are meeting the Education and Cultural & Linguistic needs of Alliance members. Other emerging themes are identifying gaps in access to care and addressing health disparities among our Medi-Cal membership. In addition, the Quality Improvement and Population Health Department will now provide direct oversight of the PNA report requirements and will support this work moving forward.

The primary purpose of the PNA is to improve health outcomes for Medi-Cal members by identifying needs and gaps in health education and cultural and linguistic services. Multiple internal and external data sources will be used, including claims/encounter data, the Healthcare Effectiveness Data and Information Set (HEDIS), and state and county-level data. Findings from the PNA highlight areas of success, as well as areas of opportunities for improvement in the health plan.

To continue supporting this work, the Quality and Health Programs team has started to conduct outreach calls with Alliance members as of May 11, 2020 to gather input from members on how well the Alliance is addressing their needs. The PNA report is due to DHCS on June 30, 2020.
Healthcare Effectiveness Data and Information Set. HEDIS 2020 reporting concluded on June 15, 2020. The Health Services Advisory Group conducted all audit phases without adverse findings. Final rate results indicate that measure performance is stable, with 68% of all benchmarked indicators exceeding the Minimum Performance Level threshold, of which 10 indicators exceeded the High-Performance Level as set by DHCS.

Finance

Financial Highlights for the Four Months Ending April 30, 2020

- The April Operating Loss for all lines of business stands at $16.6M
- Medical Expenses are unfavorable to budget by $4.2M or 4.2% with an MLR of 109.7%
- Administrative Expenses are unfavorable to budget by $0.2M or 2.3% with an ALR of 7.6%
- Fund Balance is $428.7M or 7.8 times the minimum Tangible Net Equity (TNE) required by the State

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>Apr-20 (In $000s)</th>
<th>% Variance to Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current Actual</td>
<td>Current Budget</td>
</tr>
<tr>
<td>Membership</td>
<td>339,740</td>
<td>330,532</td>
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<tr>
<td>Revenue</td>
<td>95,362</td>
<td>103,006</td>
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<tr>
<td>Medical Expenses</td>
<td>104,654</td>
<td>100,435</td>
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<tr>
<td>Administrative Expenses</td>
<td>7,279</td>
<td>7,112</td>
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<tr>
<td>Operating Income</td>
<td>(16,571)</td>
<td>(4,542)</td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>(15,581)</td>
<td>(5,121)</td>
</tr>
<tr>
<td>MLR %</td>
<td>109.7%</td>
<td>97.5%</td>
</tr>
<tr>
<td>ALR %</td>
<td>7.6%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Operating Income %</td>
<td>-17.4%</td>
<td>-4.4%</td>
</tr>
<tr>
<td>Net Income %</td>
<td>-16.3%</td>
<td>-5.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Indicators</th>
<th>Apr-20 YTD (In $000s)</th>
<th>% Variance to Budget</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>YTD Actual</td>
<td>YTD Budget</td>
</tr>
<tr>
<td>Membership</td>
<td>1,348,081</td>
<td>1,325,041</td>
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<tr>
<td>Revenue</td>
<td>416,330</td>
<td>413,057</td>
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<tr>
<td>Medical Expenses</td>
<td>410,401</td>
<td>403,325</td>
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<tr>
<td>Administrative Expenses</td>
<td>28,127</td>
<td>27,214</td>
</tr>
<tr>
<td>Operating Income</td>
<td>(22,197)</td>
<td>(17,483)</td>
</tr>
<tr>
<td>Net Income/(Loss)</td>
<td>(22,059)</td>
<td>(19,774)</td>
</tr>
<tr>
<td>MLR %</td>
<td>98.6%</td>
<td>97.6%</td>
</tr>
<tr>
<td>ALR %</td>
<td>6.8%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Operating Income %</td>
<td>-5.3%</td>
<td>-4.2%</td>
</tr>
<tr>
<td>Net Income %</td>
<td>-5.3%</td>
<td>-4.8%</td>
</tr>
</tbody>
</table>
Membership. April 2020 Member Months are favorable to budget by 2.8%. Favorability in Member Months is primarily driven by the “Family/Adult and Adult Expansion” Category of Aid, Whole Child Model, and In-Home Supportive Services, which account for 39.2% of the increase. Member Months are partially offset by unfavorability in “LTC and LTC Full Dual” Category of Aid by 21.0%. By county, Monterey is favorable to budget by 3.7%, followed by Merced at 2.3%, and Santa Cruz at 1.5%.

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

Revenue. April 2020 Medi-Cal capitation revenue is $95.1M, which is unfavorable to budget by $7.7M or 7.5%. The unfavorable variance is attributed to a revenue adjustment of $12.8M; $7.7M for the prior year and $5.1M for the current year-to-date (YTD). This is a result of the State’s May Budget Revision, which proposed a 1.5% rate reduction for Adult, Child, ACA OE, and SPD population for the bridge period of July 2019 through December 2020. The financial impact for the full bridge period is approximately $23.0M.

April 2020 YTD Medi-Cal capitation revenue of $415.3M is favorable to budget by $3.1M or 0.8%. Favorability in capitation revenue is primarily driven by $10.3M in enrollment favorability and is partially offset by $7.1M due to adjusted bridge rates.

<table>
<thead>
<tr>
<th>County</th>
<th>Apr-20 YTD Capitation Revenue Summary (In $000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>93,654</td>
</tr>
<tr>
<td>Monterey</td>
<td>180,375</td>
</tr>
<tr>
<td>Merced</td>
<td>141,278</td>
</tr>
<tr>
<td>Total</td>
<td>415,307</td>
</tr>
</tbody>
</table>

Note: Excludes Apr-20 YTD In-Home Supportive Services premiums revenue of $1.0M
Medical Expenses. April 2020 YTD Medical Expenses are $410.4M, which is unfavorable to budget by $7.1M or 1.8%, with an MLR of 98.6%. Inpatient Services (Hospital) are unfavorable by $5.6M or 4.5%, Pharmacy is unfavorable by $4.6M or 7.8%, Inpatient Services (LTC) are unfavorable by $2.7M or 5.7% and Other Medical Costs are unfavorable by $2.6M or 3.3%. Medical Expenses are partially offset by favorability in Physician Services of $5.2M or 7.4% and Outpatient Facility favorability of $3.2M or 12.7%.

Administrative Expenses. April 2020 YTD Administrative Expenses are $28.1M, which is unfavorable to budget by $0.9M or 3.4%, with an ALR of 6.8%. Unfavorability is driven by Salaries, Wages and Benefits of $2.0M or 11.1%. Administrative Expenses are partially offset by favorability in Supplies & Other of $0.5M or 19.2%, Professional Fees of $0.2M or 25.1%, Depreciation & Amortization of $0.2M or 6.8%, and Purchased Services of $0.1M or 4.3%.

Non-Operating Revenue. April 2020 YTD Total Non-Operating Revenue is favorable to budget by $1.1M or 34.5% and consists of $2.4M in interest income, $1.6M in unrealized investment gain and $0.4M in rental income for a total of $4.4M. 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. April 2020 YTD Total Non-Operating Expenses of $4.3M are favorable to budget by $1.3M or 23.3%. There is currently $156.0M in the Grant program, which is a non-operating expense.

Non-Operating Revenue/Expenses. April 2020 YTD Total Non-Operating Revenue of $4.4M was offset by $4.3M in grant distribution, resulting in a Net Non-Operating Revenue of $0.1M.

Fund Balance. The Fund Balance is currently $428.7M, which is 7.8 times the minimum TNE requirement established by the State of $55.3M. The Alliance’s reserves without grants are $272.7M, which is $38.0M or 12.2% below the Designated Reserves Target requirement 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 $310.7M, a decrease from the prior reporting period of $0.8M. This line on the Alliance’s Balance Sheet reflects three times capitation premiums and prior year adjustments.

Operations

Organizational Performance Update: Q1 2020 Alliance Dashboard. The Q1 2020 Alliance Dashboard is comprised of 151 metrics monitoring 61 health plan core, support and managerial processes. These 61 health plan processes are rolled-up to top-level (Level 1) processes for Board monitoring using a composite methodology, meaning the performance of these core processes are averaged to produce top-level process performance results, as displayed in the Alliance Dashboard. Staff continue to define and evaluate organizational processes, and in Q1 2020 two new Level 1 processes – Provide Administrative Services and Manage
Governmental & Community Relations – were added to the Alliance Dashboard as a result of this ongoing evaluation, for a total of 13 Level 1 processes in the Q1 2020 Alliance Dashboard.

In addition to Level 1 process performance, page 2 of the Alliance Dashboard contains a subset of the 151 metrics that the Board has requested for quarterly monitoring. The Q1 2020 Alliance Dashboard indicates healthy performance. Results for 10 of 13 Level 1 processes met or exceeded 95% of target, with all core Level 1 processes achieving that standard. Exceptions to the 95% standard and other notable performance are as follows:

- **Help Members Engage.** The Engage and Support Members process contains three subordinate processes: Help Members Engage, Help Members Navigate and Assess Member Experience. In Q1 2020 Help Members Engage dropped below threshold for the first time. The performance was due to staff inability to attend outreach events due to shelter-in-place restrictions. Staff telephonic outreach efforts beginning in April 2020 are anticipated to improve process performance in Q2 2020.
- **Acquire and Retain Employees.** Q1 2020 results were impacted by days to offer and voluntary turnover metrics. Human Resources (HR) is actively engaged in a process improvement effort to reduce days to offer and early results are demonstrating substantial improvements over Q1 2020 performance.
- **Manage Technology.** Q1 2020 performance achieved 100% of target, a 6-point increase over Q4 2019. Q4 2019 performance revealed an opportunity to evaluate and align performance targets with business requirements, which occurred and is reflected in Q1 2020 performance.
- **Manage Finances.** While performance at 88% of target remains below threshold (lowest acceptable level of performance), performance has improved quarterly since composite measurement began in Q2 2019. Operating Margin and Medical Loss Ratio metrics continue to impact performance in Q1 2020 at -1.8% and 95.3%, respectively. Specific actions to address financial performance are a central focus of staff and Board activities throughout 2020.
- **Manage Compliance Commitments.** Q1 2020 performance was impacted by timely protected health information disclosure reporting to the State, in which three of sixteen disclosures were not reported immediately. Performance expectations have been reinforced with relevant staff and process performance will continue to be monitored.

**Employee Services and Communications**

**Alliance Workforce.** As of June 8, 2020, the Alliance has 536 positions of which our active workforce number is 491 (active FTE and temporary workers). There are 20 positions in active recruitment, and 43 positions are vacant. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets.

As the nation mourns the murder of George Floyd, Alliance leadership addressed staff regarding the value of equity and initiated conversation regarding actions to address inequity for Alliance members and staff. Diversity and inclusion have always been important to the Alliance, but even more important today, as staff struggle with what is occurring nationally. The Alliance is committed to making a positive difference and will be creating proper channels to advance diversity and inclusion in our work place.
Facilities and Administrative Services. The Facilities Department is working on developing a construction schedule for the Capitola Manor Skilled Nursing Facility which is expected to begin late summer 2020.

For the purposes of business resiliency, the facilities team has procured a standby generator and electric quotes for future Public Safety Power Shutdown events.

COVID-19 Operations Update

The Alliance has transitioned out of emergency/business continuity response to the COVID-19 pandemic and has resumed “normal” operations in a newly defined environment (a yellow business continuity status). As noted, this status returns the organization to its standard reporting and management structure while maintaining awareness of and readiness to address an identified threat, the ongoing pandemic. As previously reported, several operational processes were adapted to mitigate service impacts and daily monitoring of core operational process was successfully implemented. Process modifications stabilized in June and remain in place. Results of management’s routine monitoring demonstrates these modified processes are effective. Available indicators reveal ongoing achievement of all applicable regulatory, contractual and core program obligations. Examples of key insights from this operational process monitoring include:

- **Claims Inventory:** Claims inventory was depressed for the eight-week period beginning March 23, 2020, due to the Alliance’s data entry vendor’s workforce disruptions, which impacted their processing ability. The overall percentage of claims paid under 30 days dropped during this timeframe to approximately 91% in comparison to 99.7% prior to the pandemic. Residual impact in the month of June should be nominal and it is anticipated that processing will return to normal levels by the end of June 2020.

- **Inbound Calls to Member Services:** Calls to Member Services remain at approximately 60% of baseline, consistent with the reduction in health care service utilization during the public health shelter-in-place period.

- **Inbound Calls to Nurse Advice Line:** Member calls to the Nurse Advice Line have trended flat at 28 calls per day on average across the Alliance’s tri-county service area, approximately 95% of baseline utilization.

- **Medical Authorization Inventory:** Medical authorization inventory increased 30% above the prior 10 week running average in June. As of June 4, 2020, the total authorization inventory is 36.5% higher than its lowest point during the COVID-19 pandemic and only 5.6% less than the inventory prior to the COVID-19 pandemic in early March. Despite this increase, medical authorization turnaround times continue to meet regulatory requirements indicating the shift in inventory appears immediately manageable.

- **Non-Emergency Medical Transports:** Member utilization of Non-Emergency Medical Transportation while actively symptomatic and/or COVID positive remained stable and low in May, with a weekly average of 2.5 members and 10 rides.
Additional highlights are as follows:

**Membership.** The month of June reflects a 3% overall increase to enrollment over the close of the prior quarter. This increase is primarily attributed to holds DHCS placed on the redetermination and disenrollment process through August to ensure continued coverage for COVID-19 related care.

Staff expect increases to Alliance enrollment due to the economic impact of the COVID-19 pandemic. Alliance staff continues to monitor publications, reports and local unemployment rates to forecast potential enrollment scenarios. Review of these data points indicates eligibility increases in the range of 8% to 17%. Increases are most likely in childless adults, children and families. There is uncertainty in these estimates, and it is notable that increased eligibility does not guarantee enrollment. Some who are newly unemployed may be unaware they qualify for Medi-Cal coverage, some may elect to pay premiums to continue commercial coverage, and others may elect to remain uninsured even if they are Medi-Cal eligible. Staff will provide an update on enrollment at the September Board meeting.

Health Services continues focused outreach to vulnerable members to provide resources and answer questions which began in the early days of the shelter in place. As of May 31, 2020, the COVID-19 Member Outreach Campaign connected with over 8,000 members via person-to-person phone calls and placed over 63,000 automated calls providing resources, phone numbers, and instructions. Utilization Management staff participates in daily Skilled Nursing Facilities conferences in conjunction with the Ombudsman program representatives. Given that inpatient census and emergency department utilization remained down in May 2020, member outreach has also emphasized using necessary emergency department and resuming necessary care. In addition, staff has been assessing alternative ways to provide qualified interpreters for telehealth visits which have been more prevalent in response to COVID-19.

**COVID-19 Alternate Care Sites and Community Resources for Members.** Alliance staff continue to attend meetings with local Office of Emergency Services, Department Operations Center Shelter and Care units, and hospitals to plan and prepare for the discharge of COVID positive homeless members back into the community. County teams have placed hundreds of members in alternate housing sites across the Alliance’s service region. Alternate Care Sites have been coordinated and are prepared to open in each county as needed. Coordination of additional sites is also in progress to accommodate for rise in positive cases. Alliance staff continue to utilize a community resource guide for internal use to support members experiencing a need for basic resources.

**Community Engagement.** Alliance staff continue to communicate with public health and other county and local organizations through different weekly calls across the service region during the COVID-19 pandemic. The calls support the understanding of 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. Alliance staff assist in the development of interagency coordination to provide support and services for those experiencing homelessness who may test positive for COVID-19. These members may need placement in an alternate care site or other forms of shelter and care. Staff
are coordinating with providers and county staff to assure members and their families receive appropriate care and services. The Alliance is informed of public health guidance, plans for surges in health care needs, and COVID-19 testing and supplies through additional calls facilitated by the counties. Counties are transitioning to focus on phase 2 of reopening the counties with a focus on safety and preventing the spread of COVID-19.

Provider Outreach Campaign. On April 6, 2020 the Provider Services Department launched a Provider Call Campaign (Campaign) in order to provide tailored support to the Alliance network during the COVID-19 pandemic. The objectives of the Campaign are to:

- **Connect**: Provide live outreach to selected providers to gather specific information and provide customized support.
- **Educate**: Inform providers of services available to them, of changed or adjusted processes, and of how to reach someone if they have questions.
- **Support**: Provide ongoing and proactive support to providers through the collection, consolidation, and dissemination of information.

On a weekly basis, information shared with providers is customized to ensure awareness of applicable regulatory changes, enhanced/expanded services, and to obtain feedback from providers on practice status. As of June 8, 2020, over 1,300 providers have been contacted as part of the Campaign. As we enter the third month of the Campaign, support is shifting from triaging clinic closures and supporting alternate methods of care delivery (e.g. telehealth) to assisting providers with efforts to resume care. Most recently, the Campaign focused on Primary Care Providers (PCP) and OBGYNs, with feedback that over 88% of all PCP and OBGYN practices are partially or fully open for the resumption of in-person care. Targeted outreach through the Campaign will continue in order to be responsive to provider needs as care resumes.

As staff look towards the future, two internal task forces have been formed towards the health plan’s resumption of normal operations while monitoring the threat and readiness for further responsive action as needed. First, a Resuming Care Task Force was initiated to coordinate and promote the resumption of care in a safe and organized manner. Outreach began in June 2020 to the most at-risk members first to promote prenatal and postpartum visits and pediatric visits under two years of age, with a concentrated effort towards members who self-identified as English as a second language.

Facilities assembled a Workspace Reentry Taskforce to develop plans for a safe reentry into Alliance offices. The Alliance’s Salinas and Merced offices are closed due to the COVID-19 Pandemic. Facilities continue to provide onsite essential services to ensure building security, mail processing, and to address any tenant needs.
# CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

## Balance Sheet

**For The Four Months Ending April 30, 2020**

*(In $000s)*

### Assets

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>$208,314</td>
</tr>
<tr>
<td>Restricted Cash</td>
<td>301</td>
</tr>
<tr>
<td>Short Term Investments</td>
<td>249,277</td>
</tr>
<tr>
<td>Receivables</td>
<td>162,223</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>3,070</td>
</tr>
<tr>
<td>Other Current Assets</td>
<td>6,207</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>$629,392</strong></td>
</tr>
</tbody>
</table>

**Building, Land, Furniture & Equipment**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Assets</td>
<td>$80,960</td>
</tr>
<tr>
<td>Accumulated Depreciation</td>
<td>(32,016)</td>
</tr>
<tr>
<td>CIP</td>
<td>4,010</td>
</tr>
<tr>
<td><strong>Total Non-Current Assets</strong></td>
<td><strong>52,954</strong></td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td><strong>$682,346</strong></td>
</tr>
</tbody>
</table>

### Liabilities

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts Payable</td>
<td>$55,668</td>
</tr>
<tr>
<td>IBNR/Claims Payable</td>
<td>181,245</td>
</tr>
<tr>
<td>Accrued Expenses</td>
<td>64</td>
</tr>
<tr>
<td>Estimated Risk Share Payable</td>
<td>5,237</td>
</tr>
<tr>
<td>Other Current Liabilities</td>
<td>7,172</td>
</tr>
<tr>
<td>Due to State</td>
<td>4,244</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>$253,631</strong></td>
</tr>
</tbody>
</table>

### Fund Balance

<table>
<thead>
<tr>
<th>Description</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>(22,059)</td>
</tr>
<tr>
<td><strong>Total Fund Balance</strong></td>
<td><strong>428,716</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities &amp; Fund Balance</strong></td>
<td><strong>$682,346</strong></td>
</tr>
</tbody>
</table>
### Income Statement - Actual vs. Budget
For The Four Months Ending April 30, 2020
(In $000s)

<table>
<thead>
<tr>
<th></th>
<th>MTD Actual</th>
<th>MDT 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>339,740</td>
<td>330,532</td>
<td>9,208</td>
<td>2.8%</td>
<td>1,348,081</td>
<td>1,325,041</td>
<td>23,040</td>
<td>1.7%</td>
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<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>$95,109</td>
<td>$102,782</td>
<td>($7,673)</td>
<td>-7.5%</td>
<td>$415,307</td>
<td>$412,161</td>
<td>$3,146</td>
<td>0.8%</td>
</tr>
<tr>
<td>Premiums Commercial</td>
<td>253</td>
<td>224</td>
<td>29</td>
<td>13.1%</td>
<td>1,023</td>
<td>896</td>
<td>127</td>
<td>14.2%</td>
</tr>
<tr>
<td><strong>Total Operating Revenue</strong></td>
<td>$95,362</td>
<td>$103,006</td>
<td>($7,644)</td>
<td>-7.4%</td>
<td>$416,330</td>
<td>$413,057</td>
<td>$3,274</td>
<td>0.8%</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>$33,316</td>
<td>$30,807</td>
<td>($2,509)</td>
<td>-8.1%</td>
<td>$129,239</td>
<td>$123,633</td>
<td>($5,606)</td>
<td>-4.5%</td>
</tr>
<tr>
<td>Inpatient Services (LTC)</td>
<td>12,632</td>
<td>11,677</td>
<td>(955)</td>
<td>-8.2%</td>
<td>49,390</td>
<td>46,722</td>
<td>(2,669)</td>
<td>-5.7%</td>
</tr>
<tr>
<td>Physician Services</td>
<td>16,621</td>
<td>16,310</td>
<td>(311)</td>
<td>-1.9%</td>
<td>65,613</td>
<td>70,829</td>
<td>5,216</td>
<td>7.4%</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>5,192</td>
<td>5,096</td>
<td>(96)</td>
<td>-1.9%</td>
<td>21,834</td>
<td>24,999</td>
<td>3,166</td>
<td>12.7%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>16,977</td>
<td>14,704</td>
<td>(2,273)</td>
<td>-15.5%</td>
<td>63,586</td>
<td>58,997</td>
<td>(4,589)</td>
<td>-7.8%</td>
</tr>
<tr>
<td>Other Medical</td>
<td>19,916</td>
<td>21,841</td>
<td>1,924</td>
<td>8.8%</td>
<td>80,739</td>
<td>78,146</td>
<td>(2,593)</td>
<td>-3.3%</td>
</tr>
<tr>
<td><strong>Total Medical Expenses</strong></td>
<td>$104,654</td>
<td>$100,435</td>
<td>($4,219)</td>
<td>-4.2%</td>
<td>$410,401</td>
<td>$403,325</td>
<td>($7,076)</td>
<td>-1.8%</td>
</tr>
<tr>
<td><strong>Gross Margin</strong></td>
<td>($9,292)</td>
<td>$2,570</td>
<td>($11,862)</td>
<td>-100.0%</td>
<td>$5,930</td>
<td>$9,732</td>
<td>($3,802)</td>
<td>-39.1%</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>$5,214</td>
<td>$4,587</td>
<td>($628)</td>
<td>-13.7%</td>
<td>$19,739</td>
<td>17,775</td>
<td>($1,964)</td>
<td>-11.1%</td>
</tr>
<tr>
<td>Professional Fees</td>
<td>138</td>
<td>206</td>
<td>68</td>
<td>33.0%</td>
<td>574</td>
<td>766</td>
<td>192</td>
<td>25.1%</td>
</tr>
<tr>
<td>Purchased Services</td>
<td>772</td>
<td>808</td>
<td>36</td>
<td>4.5%</td>
<td>3,100</td>
<td>3,241</td>
<td>140</td>
<td>4.3%</td>
</tr>
<tr>
<td>Supplies &amp; Other</td>
<td>518</td>
<td>828</td>
<td>310</td>
<td>37.5%</td>
<td>2,148</td>
<td>2,660</td>
<td>522</td>
<td>19.2%</td>
</tr>
<tr>
<td>Occupancy</td>
<td>109</td>
<td>134</td>
<td>25</td>
<td>18.4%</td>
<td>482</td>
<td>537</td>
<td>55</td>
<td>10.2%</td>
</tr>
<tr>
<td>Depreciation/Amortization</td>
<td>528</td>
<td>549</td>
<td>21</td>
<td>3.9%</td>
<td>2,082</td>
<td>2,235</td>
<td>152</td>
<td>6.8%</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>$7,279</td>
<td>$7,112</td>
<td>($167)</td>
<td>-2.3%</td>
<td>$28,127</td>
<td>$27,214</td>
<td>($913)</td>
<td>-3.4%</td>
</tr>
<tr>
<td><strong>Operating Income</strong></td>
<td>($16,571)</td>
<td>($4,542)</td>
<td>($12,029)</td>
<td>-100.0%</td>
<td>($22,197)</td>
<td>($17,483)</td>
<td>($4,715)</td>
<td>-27.0%</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>$434</td>
<td>$773</td>
<td>($339)</td>
<td>-43.8%</td>
<td>$2,427</td>
<td>$3,132</td>
<td>($706)</td>
<td>-22.5%</td>
</tr>
<tr>
<td>Gain/(Loss) on Investments</td>
<td>1,145</td>
<td>(46)</td>
<td>1,191</td>
<td>100.0%</td>
<td>1,622</td>
<td>(186)</td>
<td>1,809</td>
<td>100.0%</td>
</tr>
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<td>Other Revenues</td>
<td>91</td>
<td>84</td>
<td>7</td>
<td>8.8%</td>
<td>363</td>
<td>336</td>
<td>28</td>
<td>8.3%</td>
</tr>
<tr>
<td>Grants</td>
<td>(680)</td>
<td>(1,390)</td>
<td>710</td>
<td>51.1%</td>
<td>(4,274)</td>
<td>(5,572)</td>
<td>1,298</td>
<td>23.3%</td>
</tr>
<tr>
<td><strong>Total Non-Op Income/(Expense)</strong></td>
<td>$991</td>
<td>($579)</td>
<td>$1,570</td>
<td>100.0%</td>
<td>$138</td>
<td>($2,291)</td>
<td>$2,429</td>
<td>100.0%</td>
</tr>
<tr>
<td><strong>Net Income/(Loss)</strong></td>
<td>($15,581)</td>
<td>($5,121)</td>
<td>($10,459)</td>
<td>-100.0%</td>
<td>($22,059)</td>
<td>($19,774)</td>
<td>($2,286)</td>
<td>-11.6%</td>
</tr>
<tr>
<td>MLR</td>
<td>109.7%</td>
<td>97.5%</td>
<td>98.6%</td>
<td>97.6%</td>
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<td></td>
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</tr>
<tr>
<td>ALR</td>
<td>7.6%</td>
<td>6.9%</td>
<td>6.8%</td>
<td>6.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Income</td>
<td>-17.4%</td>
<td>-4.4%</td>
<td>-5.3%</td>
<td>-4.2%</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Net Income %</td>
<td>-16.3%</td>
<td>-5.0%</td>
<td>-5.3%</td>
<td>-4.8%</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

#### Statement of Cash Flow

**For The Four Months Ending April 30, 2020**

(In $000s)

<table>
<thead>
<tr>
<th>Description</th>
<th>MTD</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Income</td>
<td>($15,581)</td>
<td>($22,059)</td>
</tr>
<tr>
<td>Items not requiring the use of cash: Depreciation</td>
<td>528</td>
<td>2,082</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>94,961</td>
<td>12,137</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>(1,010)</td>
<td>(1,071)</td>
</tr>
<tr>
<td>Current Assets</td>
<td>(454)</td>
<td>1,230</td>
</tr>
<tr>
<td><strong>Net Changes to Assets</strong></td>
<td><strong>$93,497</strong></td>
<td><strong>$12,296</strong></td>
</tr>
<tr>
<td>Changes to Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts Payable</td>
<td>$13,795</td>
<td>$52,867</td>
</tr>
<tr>
<td>Accrued Expenses</td>
<td>(26)</td>
<td>(26)</td>
</tr>
<tr>
<td>Other Current Liabilities</td>
<td>510</td>
<td>2,195</td>
</tr>
<tr>
<td>Incurred But Not Reported Claims/Claims Payable</td>
<td>403</td>
<td>(3,688)</td>
</tr>
<tr>
<td>Estimated Risk Share Payable</td>
<td>(8,896)</td>
<td>(4,927)</td>
</tr>
<tr>
<td>Due to State</td>
<td>36</td>
<td>(19,706)</td>
</tr>
<tr>
<td><strong>Net Changes to Payables</strong></td>
<td><strong>$5,822</strong></td>
<td><strong>$26,716</strong></td>
</tr>
<tr>
<td><strong>Net Cash Provided by (Used in) Operating Activities</strong></td>
<td><strong>$84,266</strong></td>
<td><strong>$19,035</strong></td>
</tr>
<tr>
<td>Change in Investments</td>
<td>$42,882</td>
<td>$111,977</td>
</tr>
<tr>
<td>Other Equipment Acquisitions</td>
<td>(71)</td>
<td>(773)</td>
</tr>
<tr>
<td><strong>Net Cash Provided by (Used in) Investing Activities</strong></td>
<td><strong>$42,811</strong></td>
<td><strong>$111,204</strong></td>
</tr>
<tr>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td><strong>$127,076</strong></td>
<td><strong>$130,239</strong></td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at Beginning of Period</strong></td>
<td><strong>$81,237</strong></td>
<td><strong>$78,075</strong></td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at April 30, 2020</strong></td>
<td><strong>$208,314</strong></td>
<td><strong>$208,314</strong></td>
</tr>
</tbody>
</table>
Alliance Dashboard – Quarter 1 2020

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

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

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

### Core Processes
**Deliver value to our members, providers and community**

- **Engage & Support Members**
  - 95% Of Target
  - APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY

- **Manage & Improve Care**
  - 98% Of Target
  - APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY

- **Develop & Maintain the Provider Network**
  - 98% Of Target
  - APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY

- **Pay Providers**
  - 97% Of Target
  - APR MAY JUN JUL AUG SEP OCT NOV DEC JAN FEB MAR APR MAY

### Managerial Processes
**Guide the organization**

- **Help Members Engage**
  - 90
  - SUBPROCESSES

- **Help Members Navigate**
  - 96
  - SUBPROCESSES

- **Assess Member Experience**
  - 100

### Support Processes
**Enable organizational operations**

- **Acquire & Retain Employees**
  - 87

- **Manage Data**
  - 98

- **Manage Technology**
  - 100

- **Provide Administrative Services**
  - 100

- **Manage Governmental & Community Relations**
  - 96

### Processes
- **Acquire & Retain Employees**
  - Q219 Q319 Q419 Q120 Q220

- **Manage Data**
  - Q219 Q319 Q419 Q120 Q220

- **Manage Technology**
  - Q219 Q319 Q419 Q120 Q220

- **Provide Administrative Services**
  - Q219 Q319 Q419 Q120 Q220

- **Manage Governmental & Community Relations**
  - Q219 Q319 Q419 Q120 Q220

---

**Support Processes**
**Enable organizational operations**

- **Acquire & Retain Employees**
  - Q219 Q319 Q419 Q120 Q220

- **Manage Data**
  - Q219 Q319 Q419 Q120 Q220

- **Manage Technology**
  - Q219 Q319 Q419 Q120 Q220

- **Provide Administrative Services**
  - Q219 Q319 Q419 Q120 Q220

- **Manage Governmental & Community Relations**
  - Q219 Q319 Q419 Q120 Q220

---

**Back to Agenda**
# Alliance Dashboard
## Board Metrics

<table>
<thead>
<tr>
<th>No.</th>
<th>Metric</th>
<th>Period</th>
<th>Target</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Calls to Member Services Answered Within 30 Seconds</td>
<td>Q120</td>
<td>80.0%</td>
<td>64.5%</td>
</tr>
<tr>
<td>2</td>
<td>New Member Welcome Call Completion Rate</td>
<td>Q120</td>
<td>30.0%</td>
<td>34.4%</td>
</tr>
<tr>
<td>3</td>
<td>Timely Resolution of Member Complaints</td>
<td>Q120</td>
<td>100.0%</td>
<td>99.0%</td>
</tr>
<tr>
<td>4</td>
<td>Members' Favorable Rating of Health Plan (CAHPS) (Medi-Cal)</td>
<td>2019</td>
<td>Child: 86.0%</td>
<td>Adult: 73.0%</td>
</tr>
<tr>
<td>5</td>
<td>Members' Favorable Rating of Health Care (CAHPS) (Medi-Cal)</td>
<td>2019</td>
<td>Child: 84.5%</td>
<td>Adult: 70.5%</td>
</tr>
<tr>
<td>6</td>
<td>Timely Resolution of Facility Site Review Critical Elements</td>
<td>Q120</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>7</td>
<td>In Area PCP Market Share (all counties)</td>
<td>Q120</td>
<td>80.0%</td>
<td>85.6%</td>
</tr>
<tr>
<td>8</td>
<td>In Area Specialist Market Share (all counties)</td>
<td>Q120</td>
<td>80.0%</td>
<td>83.5%</td>
</tr>
<tr>
<td>9</td>
<td>Contracted PCP Open % (all counties)</td>
<td>Q120</td>
<td></td>
<td>60.0%</td>
</tr>
<tr>
<td>10</td>
<td>Overall Provider Satisfaction Rate</td>
<td>2019</td>
<td>95.0%</td>
<td>87.0%</td>
</tr>
<tr>
<td>11</td>
<td>Inpatient Bed Days/1,000 members/Year (Medi-Cal)</td>
<td>Q419</td>
<td>242.0</td>
<td>300.0</td>
</tr>
<tr>
<td>12</td>
<td>Admissions/1,000 Members/Year (Medi-Cal)</td>
<td>Q419</td>
<td>63.0</td>
<td>63.0</td>
</tr>
<tr>
<td>13</td>
<td>Ambulatory Care Sensitive Admissions (Medi-Cal)</td>
<td>Q419</td>
<td>8.0%</td>
<td>8.6%</td>
</tr>
<tr>
<td>14</td>
<td>Average Length of Stay (Medi-Cal)</td>
<td>Q419</td>
<td>4.5</td>
<td>4.8</td>
</tr>
<tr>
<td>15</td>
<td>Emergency Department Visits/1,000 Members/Year (all LOBs)</td>
<td>Q419</td>
<td>513.0</td>
<td>512.3</td>
</tr>
<tr>
<td>16</td>
<td>Avoidable Emergency Department Visits (all LOBs)</td>
<td>Q419</td>
<td>18.0%</td>
<td>17.6%</td>
</tr>
<tr>
<td>17</td>
<td>Behavioral Health Utilization Rate by County (All Ages)</td>
<td>Q419</td>
<td>3.6%</td>
<td>SC: 14.0%</td>
</tr>
<tr>
<td>18</td>
<td>Routine Medical/Surgical Prior Authorizations Adjudicated Timely</td>
<td>Q120</td>
<td>100.0%</td>
<td>99.9%</td>
</tr>
<tr>
<td>19</td>
<td>Medical/Surgical Authorization Denial Rate</td>
<td>Q120</td>
<td></td>
<td>1.2%</td>
</tr>
<tr>
<td>20</td>
<td>Pharmacy Cost/Member/Month - Retail, Outpatient &amp; Specialty</td>
<td>Q120</td>
<td>$47.55</td>
<td>$46.22</td>
</tr>
<tr>
<td>21</td>
<td>Generic Prescription %</td>
<td>Q120</td>
<td>88.0%</td>
<td>90.8%</td>
</tr>
<tr>
<td>22</td>
<td>Clean Claims Processed and Paid Within 30 Calendar Days</td>
<td>Q120</td>
<td>90.0%</td>
<td>99.7%</td>
</tr>
<tr>
<td>23</td>
<td>Employee Voluntary Turnover Rate</td>
<td>Q219 - Q120</td>
<td>Q120</td>
<td>Annual: 10.0%</td>
</tr>
<tr>
<td>24</td>
<td>Total Staffed Workforce</td>
<td>Q120</td>
<td>90.0%</td>
<td>92.5%</td>
</tr>
<tr>
<td>25</td>
<td>Board Designated Reserves Percentage</td>
<td>Q120</td>
<td>100.0%</td>
<td>92.3%</td>
</tr>
<tr>
<td>26</td>
<td>Net Income Percentage</td>
<td>Q120</td>
<td>0.5%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>27</td>
<td>Medical Loss Ratio</td>
<td>Q120</td>
<td>92.0%</td>
<td>95.3%</td>
</tr>
<tr>
<td>28</td>
<td>Administrative Loss Ratio</td>
<td>Q120</td>
<td>6.0%</td>
<td>6.5%</td>
</tr>
</tbody>
</table>
Meeting Minutes

Wednesday, May 27, 2020

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

Commissioners Present:
Ms. Dorothy Bizzini  
Public Representative
Ms. Leslie Conner  
Provider Representative
Supervisor Ryan Coonerty  
County Board of Supervisors
Dr. Maximiliano Cuevas  
Provider Representative
Dr. Larry deGhetaldi  
Provider Representative
Ms. Julie Edgcomb  
Public Representative
Dr. Gary Gray  
Hospital Representative
Ms. Mimi Hall  
County Health Services Agency Director
Ms. Elsa Jimenez  
County Health Director
Ms. Shebreh Kalantari-Johnson  
Public Representative
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. Tony Weber  
Provider Representative

Commissioners Absent:
Mr. Rob Smith  
Public Representative

Staff Present:
Ms. Stephanie Sonnenshine  
Chief Executive Officer
Ms. Lisa Ba  
Chief Financial Officer
Dr. Dale Bishop  
Chief Medical Officer
Mr. Scott Fortner  
Chief Administrative Officer
Ms. Marina Owen  
Chief Operating Officer
Ms. Van Wong  
Chief Technology Officer
Ms. Jordan Turetsky  
Provider Services Director
Ms. Kathy Stagnaro  
Clerk of the Board
1. **Call to Order by Chairperson Coonerty.**

Commission Chairperson Coonerty called the meeting to order at 3:03 p.m.

Roll call was taken and a quorum was present.

No changes to the agenda were made.

2. **Oral Communications.**

Chairperson 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.**

Chairperson Coonerty opened the floor for Commissioners to make comments.

Commissioner Kalantari-Johnson acknowledged the Alliance for the swift action and response to community needs and for the grants that were awarded throughout the tri-county area.

4. **Comments and announcements by Chief Executive Officer.**

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

Ms. Sonnenshine informed the Board that a report on COVID-19 response was not included on the regular agenda as the Alliance has moved from code orange (service disruption has occurred) to code yellow (potential threat/heightened state of readiness present) from a business continuity perspective.

The Alliance has not seen a significant increase in membership but continue to monitor what is happening at the county level. Estimates vary by source, but COVID-19 is expected to have a significant economic impact. The legislature’s budget is due to the Governor on June 15, 2020. Staff expect to bring content to the June meeting for further discussion on the budget.

The first COVID-19 Response Fund grant report was included on this month’s consent agenda. This report addressed funding local efforts to address food insecurity, provide necessary diapers, wipes, cleaning supplies and related personal protective equipment.

Anticipated topics for the June meeting include the medical cost containment plan developed through the Finance Committee, an update on the State budget and May revise, and discussion around the September 16, 2020 Board retreat agenda. Staff will provide a recommendation to the Board regarding whether to proceed with a retreat in September given the current circumstances, or hold a regular meeting and consider rescheduling the retreat to a date to be determined in 2021.
Ms. Sonnenshine reminded Commissioners to remain muted during each presentation and that all questions and comments will be taken at the end of each presentation.

Consent Agenda Items: (5. – 8F.): 3:12 p.m.

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

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

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioner Smith.

Abstain: None.

Regular Agenda Item: (9. - 12.): 3:15 p.m.

9. Consider accepting audited financial statements and management letters for Alliance’s fiscal year ending December 31, 2019 from Moss Adams, LLP, independent auditors. (3:15 – 3:31 p.m.)

Ms. Sonnenshine introduced Mr. Chris Pritchard, Partner, and Ms. Rianne Suico, Senior Manager, from Moss Adams who reported to the Board the outcomes of the annual independent financial audit. Mr. Pritchard indicated the audit process was completed and a non-modified audit opinion was issued acknowledging the financial statements are fairly presented in accordance with generally accepted accounting principles.

The asset composition included information derived from the statement of net position. Part of the audit included obtaining third party confirmation of bank balances and management prepared reconciliations, to ensure those balances agree and were prepared accurately. There were no issues with Management’s ability to reconcile the cash account. Capitation receivables from the State of California were reviewed. Collections received by the Plan in 2020 were found to be substantially collected subsequent to fiscal year end.

The short-term and Board designated investments were presented. Part of the audit procedure included obtaining third party financial statements or financial institution confirmations to ensure the amounts stated in the balance sheet were presented at fair market value in accordance with Governmental accounting standards basis. No discrepancies were found on the confirmed amount and investments and related disclosures are complete and accurate.
Capital assets and other assets remained consistent from the prior year and are properly capitalized and in accordance with Management’s capitalization policy. Other Assets balance remains fairly consistent with the prior year. Composition of liabilities and net positions for 2018 and 2019 were discussed. Medical claims liability was one of the largest estimates in the financial statements and included both non-claims and those that were incurred but not reported. The provider incentives payable balances were tested based on the calculations provided by staff and determined that nothing unusual was found during the testing methodology and are properly calculated. As part of the audit, 2020 payments were reviewed and found that expenses incurred in 2019 and not paid in 2020 were properly included in these liability amounts. The largest expense related to the organization is associated to medical payments which are mainly capitation expenses, claims expense payments, and pharmacy expenses. Management reported expenses the same as last year. There was consistency in how management are capturing these expenses, and are recorded in accordance with generally accepted accounting principles as they are known today.

The year-to-year comparisons of revenue and the accounting that is being applied is fairly consistent. There has been no significant change in the way the organization has been doing business and found management to be collaborative and very straightforward with providing the requested information to complete the audit. There were no audit adjustments as a result of the audit. The plan’s accounting policies are reviewed annually to ensure compliance with known accounting standards.

**MOTION:** Commissioner Weber moved to accept the financial statements and management letters for Alliance’s fiscal year ending December 31, 2019 from Moss Adams, LLP, independent auditors, seconded by Commissioner Gray.

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

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

Noes: None.

Absent: Commissioner Smith.

Abstain: Commissioner Cuevas.

10. **Discuss factors that impact financial performance. (3:31 – 4:13 p.m.)**

Ms. Sonnenshine introduced Mr. Tim Reilly, founder and partner of Pacific Health Consulting Group (PHCG). The Alliance has retained PHCG on strategic planning and invited Mr. Reilly to share insights as to strategic factors impacting health plan financial performance with the Board. Mr. Reilly provided context of the financial trends in Medi-Cal Managed Care (MCMC) pre COVID-19 and the new state of MCMC post COVID-19.

Mr. Reilly noted that beginning in 2014, MCMC had seen a period of significant growth in membership and revenue. Health plans and providers saw a substantial improvement in their
financial position relevant to Medi-Cal. The majority of MCMC plans made significant profits and built reserves and were thus able to enhance programs and payment rates to providers. In recent years, the Department of Health Care Services (DHCS) adjusted its cost and utilization trends downward for the Affordable Care Act expansion populations. In addition, Mr. Reilly noted that DHCS seeks to transform the Medi-Cal delivery system through standardizing benefits, enrollment categories, health plan rates, while emphasizing quality and value-based purchasing and alternatives to high cost inpatient care. These factors have forced health plans to reevaluate their financial condition and in many cases, provider contracts. Mr. Reilly opined that many public health plans need financial restructuring.

The Governor’s May revise in response to the post COVID-19 environment accelerated these trends with the inclusion of various efficiency factors and rate reductions to be applied to health plan rates. The May revise also proposes the elimination of optional benefits and proposes maximum rates for hospitals. The May Revise presents the Administration’s proposals only, with the Legislature required to approve its budget by June 15, 2020. Clearly with a state deficit projected to exceed $50B for State FY 2020-21, health plans can expect continued downward pressure on revenue while increasing the number of members they serve.

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

11. Discuss Alliance’s provider network adequacy and framework for evaluating access to care. (4:13 – 4:31 p.m.)

Ms. Sonnenshine introduced Ms. Marina Owen, Chief Operating Officer, and Ms. Jordan Turetsky, Provider Services Director. They provided the Board with information on promoting awareness of objectives and network adequacy requirements, discussed the approach to evaluating access to care, reviewed indicators of success and Alliance performance, and reviewed continuous improvement efforts.

[Commissioner Conner departed at this time: 4:21 p.m.]

[Commissioner Nanyonjo departed at this time: 4:26 p.m.]

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

12. Consider approving staff recommendation regarding Capitola Manor Skilled Nursing Facility. (4:31 – 4:56 p.m.)

Ms. Sonnenshine introduced Mr. Scott Fortner, Chief Administrative Officer, who reviewed the Capitola Manor Skilled Nursing Facility revised project estimate, revised project timeline and skilled nursing facility (SNF) capacity and demand.

Construction costs have risen, with no significant price drops, since purchase of the facility. A competitive bid process was conducted and the bids received were within 5% of each other. Rent from the facility would offset depreciation at 29 years with respect to return on investment. The project is a long term investment that benefits members for the duration.
There is significant need for SNF services and approximately 60% of beds will be available to Medi-Cal patients.

**MOTION:** Commissioner Molesky moved to approve a revised construction budget for the Capitola Manor Skilled Nursing Facility of $11.7M, seconded by Commissioner Jimenez.

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

Ayes: Commissioners Coonerty, Cuevas, deGhetaldi, Gray, Hall, Jimenez, Kalantari-Johnson, Molesky, Parker, Quezada, and Schuller.

Noes: Commissioners Edgcomb, Rabago and Weber.

Absent: Commissioners Conner, Nanyonjo, and Smith.

Abstain: Commissioners Bizzini, Lor and Radner.

The Commission adjourned its meeting of May 27, 2020 at 4:56 p.m. to June 24, 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, April 15, 2020
8:30 – 9:30 a.m.
Via Videoconference

Committee Members Present:

Bob Trinh Information Technology Director
Chris Morris Operational Excellence Director
Dale Bishop Chief Medical Officer
Danita Carlson Government Relations Director
Dana Marcos Member Services Director
David Gardner Cost Efficiency Director
Frank Souza Claims Director
Gordon Arakawa Medical Director, Merced County
Jayna Lee Project Management Office Director
Jennifer Mockus Regional Operations Director, Merced County
Jordan Turetsky Provider Services Director
Joy Cubbin Accounting Director
Lilia Chagolla Regional Operations Director, Monterey County
Linda Gorman Communications Director
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
Ryan Inlow Facilities & Administrative Services Director
Scott Fortner Chief Administrative Officer
Stephanie Sonnenshine Chief Executive Officer
Van Wong Chief Information Officer
Committee Members Absent:

Frank Song                  Analytics Director
Rick Dabir                  Technology Development Director

Committee Members Excused:

Kathleen McCarthy           Strategic Development Director
Marina Owen                 Chief Operating Officer

Ad-Hoc Attendees:

Kate Knutson               Compliance Supervisor
Paige Harris                Compliance Specialist
Sara Halward               Compliance Specialist

1. Call to Order by Chairperson Somoza.

Chairperson Luis Somoza called the meeting to order at 8:35 a.m.

2. Review and Approval of February 19, 2020 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of February 19, 2020 meeting.

3. Consent Agenda.

   1. Policy Hub Approvals Feb-Mar
   2. Quarterly Policy Review Monitoring
   3. Regulatory and All Plan Letter Updates Feb-Mar

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

   1. Delegate Oversight Quarterly Report

   Somoza, Interim Compliance Officer, presented the Delegate Oversight Quarterly Activity Report which included the 2020 Annual Review, Continuous Oversight Activities for Q4 2019, Continuous Oversight Follow-up Activities for Q3 2019-Q1 2019, and additional oversight activities performed in Q4 2019.

   2020 Annual Review
   Somoza provided a summary of the 2020 Annual Review, stating the review of 2 of 9 delegates is complete and 7 delegates remain under review.
Staff recommended approval of the following activities:
- Beacon/CHIPA: Claims, Credentialing, Cultural and Linguistic Services (C&L), FWAP, Member Connections, Member Grievance, Member Rights, Member Rights-PHI, Network Adequacy and Provider Disputes
- CareNet: Member Connections, Member Grievance, Member Rights and Member Rights-PHI
- ChildNet: Credentialing
- LPCH: Credentialing
- MedImpact: Claims, Credentialing, C&L, Finance, FWAP, Member Rights-PHI and Network Adequacy
- VSP: Claims, Credentialing, C&L, FWAP, Member Connections, Member Grievance, Member Rights, Network Adequacy, Provider Disputes and Quality Improvement (QI)

Staff recommended holding approval of the following activities pending staff review of documentation as described below:
- Beacon/CHIPA: Compliance, Finance, Quality Improvement (QI) and Utilization Management (UM)
- CareNet: Compliance and Cultural and Linguistic Services (C&L)
- MedImpact: Compliance, Finance and Provider Disputes
- PAMF: Credentialing
- SCVMC: Credentialing
- UCSF: Credentialing
- VSP: Compliance, Finance and Member Rights-PHI

COMMITTEE ACTION: Committee reviewed and approved the 2020 Annual Review and assigned the following action items:
- Santana to review Beacon/CHIPA, CareNet, MedImpact and VSP Compliance/BCDRP documents and complete annual review.
- Pineda to review CareNet follow-up documentation for Cultural and Linguistic Services and complete annual review.
- Ba to review MedImpact and VSP financial documents and complete annual review.
- Alvarez to review MedImpact Provider Disputes documentation upon receipt and complete annual review.
- Dybdahl to review PAMF, SCVMC and UCSF Credentialing documentation upon receipt and complete annual review.
- Harris to review VSP Member Rights-PHI documentation and complete annual review

Q4 2019 Continuous Oversight Activity
Staff recommended approval of the following Q4 2019 reports received from delegates:
- Beacon/CHIPA: Claims, Credentialing, Member Connections, Network Adequacy, Provider Disputes, Quality Improvement
- ChildNet: Credentialing
- LPCH: Credentialing
- MedImpact: Network Adequacy, Provider Disputes
- PAMF: Credentialing
- SCVMC: Credentialing
• UCSF: Credentialing
• VSP: Claims, Credentialing, Member Connections, Member Grievance, Provider Disputes, Quality Improvement

Staff recommended holding approval of the following activities pending staff review of documentation as described below:
• Beacon/CHIPA: Member Grievance, Utilization Management
• MedImpact: Credentialing

COMMITTEE ACTION: Committee reviewed and approved staff recommendations related to the Q4 2019 Continuous Oversight Activities and assigned the following action items:
- Marcos to review Beacon/CHIPA Member Grievance documents and complete quarterly review.
- Brusuelas to review Beacon/CHIPA Utilization Management documents and complete quarterly review.
- Dybdahl to review MedImpact Credentialing documents and complete quarterly review.

Follow-Up to Q3 2019 Continuous Oversight Activity
Staff recommended approval of the following Q3 2019 quarterly report received from the following delegates:
• Beacon/CHIPA: Credentialing

COMMITTEE ACTION: Committee reviewed and approved staff recommendations related to the follow up to Q3 2019 Continuous Oversight Activities.

Follow-Up to Q1 2019 Continuous Oversight Activity
Staff approval of the following Q1 2019 quarterly report received from the following delegates:
• Beacon/CHIPA: Network Adequacy

COMMITTEE ACTION: Committee reviewed and approved staff recommendations related to the follow up to Q1 2019 Continuous Oversight Activities.

Q4 2019 Additional Oversight Activity
Somoza reviewed Q4 2019 additional oversight activities, noting that Beacon did not meet Quality-related requirements. A deficiency letter was issued in October identifying the following areas of concern:
• Coordination of care measures
• Annual Member Satisfaction Survey results
• Beacon meeting minutes do not demonstrate discussion of identified deficiencies
Staff is reviewing and providing feedback to Beacon. Outcomes will be reported with next quarterly review.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2019 Delegate Oversight Report.
2. **Program Integrity Quarterly Report**

Knutson, Compliance Supervisor, presented the Q4 2019 Program Integrity Activity Report and reviewed select Matters Under Investigation (MUIs) under review during the quarter. Knutson reported that 21 concerns were referred to Program Integrity in Q4 2019. 8 of those were voided and 14 resulted in the opening of an MUI; 15 MUIs were closed during the quarter.

Knutson reviewed referral trends for the period noting that, of the 14 referrals resulting in MUI, 10 were provider/vendor related and 5 were member/other related. Knutson reviewed 3 cases.

**COMMITTEE ACTION:** Committee reviewed and approved the Q4 2019 Program Integrity Activity Report.

3. **HIPAA Quarterly Report**

Somoza, Interim Compliance Officer, presented the Q1 2020 HIPAA Quarterly Report, noting that the HIPAA Champions Program has been temporarily paused due to the shelter-in-place order and will resume when Compliance is fully staffed and the majority of the Alliance workforce is back in the office.

Somoza reviewed HIPAA reporting of disclosures and trends for Q1 2020 as follows:

- There were 20 event notifications received by Compliance staff;
  - 11 were categorized as incidents;
  - 4 were non-events;
  - 1 breach occurred in Q120.

Somoza advised the Committee of mitigations in place to reduce the number of HIPAA disclosures, including counseling employees on preventive measures and appropriate processes and verifying and updating provider contact information in Alliance systems.

Somoza reviewed trends and hot topics in HIPAA and reported that a new data point has been identified to identify primary causes of HIPAA events and that Compliance will begin reporting on that data annually beginning in Q1 2021.

Wong, Security Officer, presented security updates for Q1 2020 and provided an overview of email rejection rates for malicious emails sent to Alliance staff. Wong reported that the following security related activities took place in Q1 2020:

- Review of Alliance staff with access to Iron Mountain for retrieval of backup tapes;
- Patching of high-risk systems related to Windows vulnerability
- Review of Microsoft customer data exposure for Alliance specific details
- Review of Alliance staff with access to secure server rooms in all locations

**COMMITTEE ACTION:** Committee reviewed and approved the Q1 2020 HIPAA Quarterly Report.
4. Internal Audit & Monitoring Report

Halward, Compliance Specialist, presented the Q4 2019 Internal Audit and Monitoring Activity Report noting that 12 reviews were completed, 3 of which resulted in findings. Audited areas with findings will be monitored and follow-up audits will be performed in 2020.

Halward reported on additional activities in Q4 noting that a Preliminary Findings report was received from DMHC related to the 2019 Routine Financial Examination.

Halward reported that DHCS performed an onsite Medical Audit in November and a Preliminary Findings report was received from DHCS related to the onsite Medical Audit which took place in November. DHCS identified one finding as follows:
- Plan did not fully translate grievance and appeal resolution letters.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2019 Internal Audit and Monitoring Activity Report.

5. Annual Compliance Board Report

Somoza, Interim Compliance Officer, provided an overview of the 2019 Compliance Program Report which was submitted to the Board in April. In his report, Somoza reviewed Compliance statistics and Key Program Accomplishments in 2019 and provided an overview of revisions to the Code of Conduct in 2019.

The meeting adjourned at 9:22 a.m.

Respectfully submitted,

Robin Sihler
Administrative Assistant - Compliance
Meeting Minutes
Wednesday, February 26, 2020
1:30 – 2:45 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

Commissioners Present:
Ms. Leslie Conner Provider Representative
Ms. Mimi Hall County Health Services Agency Director
Ms. Elsa Jimenez County Health Director
Supervisor Lee Lor County Board of Supervisors
Mr. Michael Molesky Public Representative

Commissioners Absent:
Mr. Tony Weber Provider Representative

Staff Present:
Ms. Lisa Ba Chief Financial Officer
Ms. Stephanie Sonnenshine Chief Executive Officer
Oksana Chabanenko Financial Analyst I
Tina Bernard Finance Administrative Specialist
1. **Call to Order by Chairperson Michael Molesky.** (1:32 – 1:33 p.m.)

Chairperson Molesky called the meeting to order at 1:32 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.

[Commissioner Elsa Jimenez arrived at this time: 1:34 p.m.]

3. **Approve minutes of December 4, 2019 meeting of the Finance Committee.** (1:34 – 1:35 p.m.)

FINANCE COMMITTEE ACTION: Commissioner Molesky moved to approve the minutes of the December 4, 2019 meeting of the Finance Committee, seconded by Commissioner Conner. Motion carried with 4 votes affirmative, 1 absent and was so ordered.

4. **Year-to-date Preliminary December Financials as of 1/31/2020.** (1:35 – 1:39 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioner on the Alliance’s most recent financials. As of December 2019, the net operating loss stands at $8.0M, which is an 8% net loss. The Medical Loss Ratio (MLR) is 101% compared to the budget of 94.9%. The Administrative Loss Ratio (ALR) is slightly below budget at 6.4% versus the 7.2% budgeted. The overall net operating loss for 2019 is $72M, ending at a 5.5% net loss. The MLR is 99.3% versus 97.3% budgeted. The operating loss is primarily due to the State’s implementation of the Whole Child Model (WCM) for the Medi-Cal population.

Ms. Ba recalled that the 2019 mid-year forecast assumed breakeven performance of the WCM. Also, revenue and operation issues to convert members with high-dollar claims to the WCM program, such as the Neonatal Intensive Care Unit – Intervention (NICU-I) and High Infant Risk Follow-up (HRIF), resulted in a revenue loss of $30M.

Commissioner Leslie Conner asked about the possibility of retroactive reimbursement. Ms. Ba responded that no reimbursement is expected based on the State’s methodology. She informed the committee that dialogue with the Department of Health Care Services (DHCS) regarding WCM revenue deficiency began in December 2019. The next scheduled meeting is on March 10, 2020.

Commissioner Molesky inquired if WCM expenses are categorized to identify cost drivers. Ms. Ba reiterated inpatient hospital expenses are the root cause, specifically NICU-I and HRIF patients with high initial claims of $50-60K. The State built the revenue for WCM at All Patients Refined Diagnosis Related Groups (APR-DRG) rates, which are lower than the Plan’s reimbursement rate.
Ms. Ba reminded the Commissioners that the figures presented are preliminary and open to year-end adjustments pending the completion of the annual independent financial audit. Auditors from Moss Adams will report the results to the Board in May 2020.

5. **Medical Cost Analysis. (1:55 – 2:45 p.m.)**

Ms. Ba presented an update on the financial impact of the payment policy change analysis with options to bring cost in line with revenue. The Alliance has experienced financial loss since mid-year 2017. The projected reserve at the end of 2020 is 81% of the Board Designated Reserve target versus the current 95%. Staff analysis concluded that provider payment is the root cause of the Plan’s operating loss. Claim data from State Fiscal Year (SFY) 18/19, when the State implemented the WCM, confirmed our provider reimbursement rates exceeded industry standards. Ms. Ba emphasized the project goal is to align medical costs with the Plan’s revenue and industry standards; to maintain and improve provider network and services for Alliance members, and to maintain and improve operational efficiency of Alliance staff and providers.

Ms. Stephanie Sonnenshine, Chief Executive Officer (CEO), stated this initial discussion is a result of a directive from the Board at the October 23, 2019 meeting. The Board requested a broader analysis of the provider payment structure with recommendations to align cost with revenue. She advised the Commissioners’ approach a high-level policy discussion and petition information to present payment policy recommendations at the Finance Committee meeting on March 25, 2020. Proposals will be presented to the Board on April 22, 2020.

Ms. Ba continued with the project timeline. Staff performed financial and network impact analysis November 2019 through March 2020; the Finance Committee will review analysis, options and next steps today; staff performed provider outreach in February that will continue through March; staff will engage the Physician Advisory Group (PAG) in March to assess access impact; the Finance Committee will review payment policy proposal on March 25, 2020; the final proposal will be submitted to the Board on April 22, 2020 for approval. Staff plans to implement the new payment structure no earlier than October 1, 2020.

Ms. Ba moved on to a five-year review of financials from 2015-2020. The Medi-Cal Expansion revenue rates were high during 2014–2016 allowing the Alliance to accumulate reserves. The Plan earned $114M in 2015, $80M in 2016, and $30M in 2017. She reminded the committee that the provider reimbursement increase was implemented in 2016-2017 from Medi-Cal to 2015 Medicare Physician Fee Schedule. Hospital negotiated a 10% increase year-over-year for 2017-2019 resulting in $89M loss in 2018, $72M loss in 2019, and a $53M loss is budgeted in 2020.

Commissioner Conner suggested explaining the analytical approach and framework for analysis in the recommendation to the Board. For instance, admin cost might be interpreted as one of the factors. Ms. Sonnenshine agreed with the suggestion and confirmed the analysis factored admin cost. For two years the Plan reduced administrative cost to align with sister healthcare plans, with favorable variance to budget at 6.4% ending December 2019.
Ms. Ba continued with the five-year fund balance projections for 2019-2024. The forecasted budget showed a consecutive operating loss under the current provider payment structure. In 2021 the State of California will carve out the pharmacy benefit, resulting in a loss of expense and revenue associated with this benefit. The projected loss is $57M in 2021, with assumptions of 7% increase in revenue and 6% increase in medical cost. For 2022-2024, the projection assumes the expense grows 1% less than the revenue. Ms. Sonnenshine clarified the medical cost projections anticipate an increase in rate and utilization. Ms. Ba added that acuity drives the medical unit cost increase. A high-risk WCM member will have more stays in NICU versus medical/surgical day. Thus, the increase in unit cost is due to acuity, not the hospital contract rate. Calendar year (CY) 2022 is projected at a net operating loss of $44M, with break-even forecasted in 2026-2027.

The fund balance at the end of December 2019 is $452M, which is 830% of the State required Tangible Net Equity (TNE). The balance after grant exclusion is $292M, which is 95% or $14M below the Board target. Five-year projection of TNE revealed reserves in 2022 will be five times State requirements, with projections trending four times State requirements in 2023-2024. Data as of September 2019 confirmed the Alliance’s current TNE reserve is at industry benchmark when compared to other sister healthcare plans. Ms. Ba emphasized that TNE below four times State requirements will necessitate submission of a monthly report to the Department of Managed Health Care (DMHC) to monitor the Plan’s performance. The Alliance currently submits a quarterly report to DMHC. Ms. Sonnenshine strongly advised the Plan correct course to prevent State intervention inclusive of frequent on-site monitoring, as encountered by some local health plans.

Commissioner Conner questioned why three of the plans presented have higher TNE performance. Ms. Ba answered the plans are heavily delegated thereby shifting risk to an Independent Physician Associations (IPA), in addition to offering Medicare services. Ms. Sonnenshine added that plans in environments conducive to Medicare in a Medi-Cal fee structure with urban rates experienced higher TNE performance.

Ms. Ba revisited the top four medical cost results from the 2018 Rate Development Template (RDT). Inpatient hospital services are $314M or 30% of cost; Physician services is $210M or 20% of cost; Pharmacy is $162M or 16% of cost; Long Term Care is $130M or 13% of cost. The year-over-year analysis showed that inpatient and outpatient hospitals increased 16%, and accounted for 80% or $53M of the total increase in cost. She reviewed the rate development sequence noting the RDT for 2018 will establish rates for 2021. 2019 RDT is scheduled in the summer of 2020 to establish rates for 2022.

Commissioner Conner inquired if the analysis included Primary Care Physicians (PCP), both FQHCs and Private PCPs. Ms. Sonnenshine affirmed the analysis was inclusive of both. Ms. Ba stated that the budget assumed increased utilization in Primary Care in exchange for lower utilization in inpatient and emergency room. Commissioner Conner commented on the importance of including such information in the Board report.
Commissioner Jimenez questioned if there is any correlation between the increase of year-to-year inpatient hospital cost and the implementation of CalAIM in terms of rates with emphasis to redirect the line item cost to preventative care. Ms. Ba responded that CalAIM seeks cost effective in-lieu-of services to reduce inpatient, facility and long-term care cost. CalAIM’s region definition is unknown. The State will move from year-over-year rate setting to comparing utilization across regional health plans in the future. The State rates set utilization target for each health plan, and the Alliance has not met the target. Ms. Sonnenshine added that the State will assess plans with higher cost as outliers to apply state-wide averages.

Key takeaways are inpatient and outpatient facility cost increased 16% year-over-year, while DHCS expects a 2-4% annual increase after applying the state-wide efficiency adjustment. The gap between inpatient revenue and spend is $52M. DHCS will implement regional rates effective 2021, creating a sense of urgency for the Alliance to align cost structure to other Medi-Cal Managed Care plans. The Alliance completed a survey inclusive of the Plan’s pay structure by provider type for the State as part of the RDT process for 2018.

Commissioner Molesky inquired if the regional rate applies to all three service areas. Ms. Ba explained the State will issue rates in two phases. Phase I will introduce regional rates in 2021. Group rates averaging utilization across neighboring plans is scheduled for Phase II in 2023. A regional rate creates a financial disadvantage for the Alliance if compared to other plans with lower rates and higher network adequacy.

Ms. Ba presented three options recommended by staff to revise the provider payment policy. A passive approach under the current payment structure does not present an opportunity for the Plan to break-even. The moderate approach will bring cost in line with revenue rate trends and allow for the implementation of industry payment methods with break-even projected in 2025. The aggressive model brings cost in line with revenue rates and conservative utilization trends, allowing the Plan to implement industry standard payment methods with break-even projected in 2023.

Ms. Ba recommended the implementation of APR-DRG payment structure. APR-DRG is a system that classifies patients according to their reason for admission, severity of illness and risk of mortality. This method of reimbursement is adopted by the majority of Medi-Cal plans to pay inpatient claims. Under the Plan’s current per diem reimbursement structure, contracted hospitals receive an agreed upon rate for each day a member is in the hospital. APR-DRG rates are fixed amounts of the member’s stay, based on the member’s diagnosis. This model is designed to provide hospitals with an amount of reimbursement equal to its own admission diagnosis and discharge index. Accordingly, this eliminates the need to negotiate with hospitals individually and encourages hospitals to promote a model of care.

Revisions to the payment policy present the Alliance with an opportunity to move Specialists to the current Medicare Physician Fee Schedule. The fee-schedule is a national benchmark that allows a comparison of relative prices of all providers incorporating the local market price difference. The majority of specialists are currently reimbursed at the 2015 Medicare Physician Fee Schedule with locality 99. Since each of the Plan’s service areas has its own locality, there is an opportunity to bring the Specialists reimbursement to the current Medicare Fee Schedule with the appropriate
locality. Impact by provider type and an access analysis will be performed and reviewed by the Physician Advisory Group (PAG) prior to final recommendations.

Ms. Ba concluded the presentation with the financial impact of the options presented. The passive approach projects net operating reserve continues below the board target by $24.3M in 2022, $75.3M in 2023 and $109.7M in 2024. The moderate approach is forecasted to breakeven in 2025 and the net reserve is $36M below target in 2024. The aggressive method allows the Plan to break-even with a net operating positive reserve through 2023.

Ms. Sonnenshine recited the financial impact and solicited feedback from the committee about which option the Alliance should pursue.

Discussion ensued and the committee agreed to pursue a moderate to aggressive approach with staff exploring a phased approach. The committee requested an explanation of the analysis process, the impact access approach, contingency plans, utilization patterns, and opportunities to redirect members to lower cost services. The commissioners also agreed that offering incentives to hospitals and PCPs would encourage positive outcomes.

The meeting adjourned at 2:55 p.m.

Respectfully submitted,

Ms. Tina Bernard
Finance Administrative Specialist
Meeting Minutes
Thursday, March 5, 2020
12:00 - 1:30 p.m.

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

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

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

Group Members Present:
Dr. Devon Francis Provider Representative
Dr. Casey Kirkhart Provider Representative
Dr. Gordon Arakawa Provider Representative
Dr. Patrick Clyne Provider Representative
Dr. Shirley Dickinson Provider Representative
Dr. Caroline Kennedy Provider Representative
Dr. Diana Diallo Provider Representative
Ms. Becky Shaw Provider Representative

Group Members Absent:
Dr. Barry Norris Provider Representative
Dr. Scott Prysi Provider Representative
Dr. Allen Radner Provider Representative
Dr. Amy McEntee Provider Representative
Dr. Anjani Thakur Provider Representative
Dr. Chuyen Trieu Provider Representative
Dr. Jennifer Hastings Provider Representative
Dr. Kenneth Bird Provider Representative
Dr. James Rabago Provider Representative
Dr. Brian Moore Provider Representative

Staff Present:
Dr. Dale Bishop Chief Medical Officer
Dr. Maya Heinert Medical Director
Ms. Kathleen McCarthy Business Development Director
Ms. Jordan Turetsky Provider Services Director
Ms. Melanie Rager Care Management Director
Ms. Gina Rhoads Program Development Manager
Ms. Kristen Presleigh Quality Improvement Program Advisor
Ms. Hilary Gillette-Walch, RN Clinical Decision Quality Manager
1. Call to Order by Chairperson Dr. Bishop.

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

No supplements or deletions were made to the agenda.

2. Oral Communications.

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

No members of the public addressed the Group.

Consent Agenda

3. The group reviewed the December 5, 2019 Physicians Advisory Group (PAG) minutes.

Minutes approved as written.

4. Old Business - Updates

A. Behavioral Health Integration & Pharmacy Carve-Out Follow-up
Dr. Bishop noted there were 14 submissions from clinics for behavioral integration, and 8 were approved and sent to DHCS. The Alliance should hear back from DHCS by the 18th of this month and will keep the Group posted on the outcomes.

The Pharmacy carve-out is proceeding and the plan is to have outpatient and pharmacy benefits covered by Medi-Cal fee-for-service beginning January 1, 2021. Currently the Alliance is participating in pharmacy workgroups. Plans are sharing their formularies with DHCS and there are discussions regarding covered drug lists and aligning with the plan’s formularies. There will be a 90-day transition period (not finalized at this time). Discussions are also taking place regarding prior authorizations.

5. New Business

A. Focus Group Session for Alliance 2021-2023 Strategic Planning
Kathleen McCarthy led a focus group session with the Group to obtain their perspectives on the organization’s strengths and weaknesses. The Group was asked about the following topics and highlighted responses are included below:

**Network Provider Experience**

**Strengths:**
- QI Department has been very helpful in assisting with Care Based Incentive data.
- The quality of support from Case Management has improved.
- Care Based Incentive program aligns with medical best practices.
- Ease of obtaining follow-up appointments with most types of specialists.
- Responsiveness of the plan to offer needed benefits.

**Weaknesses:**
- Care Based Incentive data collection and reconciliation is time consuming.
- All counties expressed challenges with access to mental health services.
- Difficulty obtaining appointments with Beacon.

The group suggested a better understanding of roles and responsibilities between the Alliance and the clinics is needed to improve care coordination/case management.

**Access to Care:**
- In Santa Cruz County, overall access to care seems to have stayed relatively static.
- In Monterey County, there are significant improvements in access.
- In Merced County, if payments to specialists are reduced in the future, it could hurt the access gains.

Also noted, implementation of urgent visit access and Nurse Advice Line has been helpful.

**Quality issues impacting patients:**
- Providers want the ability to access data in a timelier manner.
- Make it easier for clinics to share data with the Alliance.
- Add a nutritionist to the Healthy Weight for Life program to improve outcomes.
- The Alliance should review claims data and inform the patient of upcoming annual visits.

**Challenges in managing care for Complex Populations:**
- Providers would like health navigators in the clinics to assist members to connect to medical, mental health, and social services.
- The Alliance should consider offering parenting classes (e.g. nutritional needs, oral hygiene, discipline, and healthy habits).

**Strategic Priorities for the next 3 years:**
- Share more information with providers to help them become more cost effective
- Assist with appropriate utilization.
- The Alliance should align with statewide initiatives for early childhood preventative care and gathering data on social determinates of health.
- Expand behavioral health system.
- Explore options for data sharing and referrals.
- Expand palliative care to include bi-lingual providers.
B. Care Based Incentives (CBI) 2021

Dr. Bishop noted the purpose of CBI is promotion of patient centered home. About a year ago, there was a governor’s order to improve HEDIS scores above the 50th percentile as the minimum performance level. Dr. Bishop also reviewed the Care Coordination measures.

- 30-Day Readmissions have been challenging, and care management is doing work in the hospitals in assisting patients and making certain they have follow-up appointments.
- Ambulatory Care Sensitive Admissions trended up in 2016 to 2018 and then declined in 2019.
- Preventable Emergency Visits have improved since 2016. There are now significant penalties for urgent care visits on the preventable ED visits metric because urgent care visits are currently counted the same as ED visits. The Alliance is going to propose that urgent care visits are not penalized the same as an ED visits, but instead count as ½ of an ED visit.
- Alcohol Misuse Screening and Counseling (AMSC) has improved.
- Initial Health Assessment had a slight decrease but overall still above the goal.
- Post-Discharge Care has also improved.

A summary of CBI 2019 results was also shared with the Group. The 2021 programmatic care coordination and access measures include:

- Measures performing below the 50th percentile will result in a reduced CBI payment.
- Add application of Fluoride Varnish to Access Measures.
- Change 30-Day Readmission to Plan All Cause Readmissions.
- Reduce Urgent Care visit value to half of ED visit value for preventable ED.
- Add Lead Screening for Children.

Provider noted regarding new measure to capture those below 50th percentile, they have fewer physicians and sometimes are penalized for this and it is difficult to achieve without staff. Also noted regarding data collection for CBI measures, it takes lots of effort to report and there are challenges on how to capture data in EHR.

C. Add PAG meeting in April to discuss medical cost and network analyses.

Dr. Bishop shared proposed payment changes for providers. The Board directed staff to align medical costs with revenue and staff is working on a proposal to be presented to the Board. The Group agreed to add a PAG meeting on April 9th to discuss the topic further.

6. Open Discussion

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

Provider noted that there were issues with a patient transferring from one county to another; the patient was not able to obtain medication for diabetes treatment. Is there a way to expedite the process of transferring Medi-Cal for county to another? Lilia noted the responsibility is within the county and the Department of Social Services. Dr. Bishop requested that the provider follow-up with the Alliance so the matter with the identified member can be investigated further.
The meeting adjourned at 1:30 p.m.
Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Group

The Physicians Advisory Group is a public meeting governed by the provisions of the Ralph M. Brown Act. As such, items of discussion and/or action must be placed on the agenda prior to the meeting.
Recommendation. Staff recommend the Board accept the report on COVID-19 Response Fund grants.

Summary. This report includes background on Alliance’s COVID-19 Response Fund and a list of grants awarded between May 16, 2020 and June 12, 2020.

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

When the fund was established, the Alliance Board approved three grants totaling $600,000 to support the food banks in each of the three counties the Alliance serves. The remaining $400,000 would be awarded to support the provision of essential services and supplies to Medi-Cal members, including procurement and distribution of food, diapers and baby food, hygiene supplies, and masks and gloves.

Discussion. Staff are closely monitoring how COVID-19 is impacting the communities the Alliance serves, what other funding sources are available and where the COVID-19 Response Fund can support immediate needs. In order to deploy resources quickly, the Alliance is not accepting unsolicited applications for COVID-19 Response Fund grants. Instead, the Alliance is inviting local organizations to apply for funds based on their ability to fill the needs identified in our service area. The Alliance will award grants on an ongoing basis while funds are available.

As of June 12, 2020, the Alliance has awarded 20 COVID-19 Response Fund grants, totaling $917,566. The amount remaining in the fund is below and a list of grant awards is attached.

<table>
<thead>
<tr>
<th>County</th>
<th>COVID-19 Response Fund Budget</th>
<th>Food Bank Grants</th>
<th>Community Grants</th>
<th>Remaining Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merced</td>
<td>$346,667</td>
<td>$208,000</td>
<td>$41,500</td>
<td>$97,167</td>
</tr>
<tr>
<td>Monterey</td>
<td>$391,667</td>
<td>$235,000</td>
<td>$142,000</td>
<td>$14,667</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>$291,066*</td>
<td>$157,000</td>
<td>$134,066</td>
<td>$0</td>
</tr>
<tr>
<td>Total</td>
<td>$1,029,400*</td>
<td>$600,000</td>
<td>$317,566</td>
<td>$111,834</td>
</tr>
</tbody>
</table>

* Funds transferred from terminated Partners for Healthy Food Access grant to a COVID-19 grant for the same grantee for food procurement and distribution.
Fiscal Impact. Of the $1,000,000 allocated to the COVID-19 Response Fund, $917,566 has been awarded and $111,834 is remaining as of June 12, 2020.

Attachment.


Note: Awards prior to May 16, 2020 were listed in the May 2020 Board packet.
### Medi-Cal Capacity Grant Program

**COVID-19 Response Fund**

$917,566 Total Awarded To Date

**List of Awards May 16, 2020 - June 12, 2020**

<table>
<thead>
<tr>
<th>County</th>
<th>Organization</th>
<th>Award Date</th>
<th>Amount</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merced</td>
<td>Merced County Rescue Mission</td>
<td>5/22/2020</td>
<td>$10,000</td>
<td>To purchase and distribute food and hygiene supplies to homeless individuals placed at Merced County Rescue Mission’s 17 housing sites during the COVID-19 pandemic.</td>
</tr>
<tr>
<td>Monterey</td>
<td>Love Our Central Coast</td>
<td>5/22/2020</td>
<td>$15,000</td>
<td>To prepare and deliver grocery bags to homeless encampment sites in Salinas.</td>
</tr>
<tr>
<td></td>
<td>Interim, Inc.</td>
<td>6/12/2020</td>
<td>$12,000</td>
<td>To provide cell phone service for clients to communicate with staff and participate in virtual programs during the COVID-19 pandemic.</td>
</tr>
<tr>
<td></td>
<td>Sun Street Centers</td>
<td>6/12/2020</td>
<td>$24,000</td>
<td>To purchase and distribute food, diapers and hygiene supplies for clients in residential and non-residential treatment programs, and to purchase technology for telehealth programs.</td>
</tr>
<tr>
<td></td>
<td>Boys and Girls Club of Monterey County</td>
<td>6/12/2020</td>
<td>$30,000</td>
<td>To distribute over 700 meal bags and 700 produce boxes weekly to families at low-income apartment complexes.</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>Common Roots Farm</td>
<td>5/22/2020</td>
<td>$12,000</td>
<td>To support the farming and provision of produce for Salvation Army’s Laurel Street Shelter’s hot meal program and weekly food distribution program.</td>
</tr>
<tr>
<td></td>
<td>Community Bridges</td>
<td>5/22/2020</td>
<td>$29,400</td>
<td>To expand food distribution at three Family Resource Centers.</td>
</tr>
<tr>
<td></td>
<td>Community Action Board of Santa Cruz County, Inc.</td>
<td>6/5/2020</td>
<td>$18,166</td>
<td>To purchase and distribute food to low-income populations, provide personal protective equipment and hygiene/sanitation supplies for staff and clients during outreach, and implement communications technology for social support programs for seniors and youth.</td>
</tr>
</tbody>
</table>
Recommendation. Staff recommend the Board approve a 2020 budget addition not to exceed $600K for the procurement (or purchase) of an interoperability solution.

Summary. The Centers for Medicare & Medicaid Services (CMS) Interoperability and Patient Access final mandated Rule (Rule) for payers, is effective on January 1, 2021 with enforcement deferred to July 1, 2021. Although the enforcement date was extended to July 1, 2021, this remains an aggressive timeframe. The Alliance will need to procure a compliant vendor solution and implement said solution no later than July 1, 2021. Research shows the anticipated cost of a vendor solution for Year 1 ranges between $400K to $750K, depending on a plan’s membership level and complexity of current data architecture. The budget estimate does not include staff hours needed to support planning, data analysis, requirements and some development for this effort.

Background. The Rule’s overarching goal is to enable patient access to personal health information along with the choice as to when, who, and how that information is shared and utilized. The Rule transforms healthcare by empowering patients to better make informed decisions about their healthcare. Patients will have easy access to:

- clinical and claims data, including treatment history and prescriptions
- up-to-date provider listing and pharmacy formulary for their health plan’s network
- share data between their providers
- bring their data with them when switching plans or providers
- see how their benefits are coordinated if they have other health coverage

As a Medi-Cal payer, the Alliance will have increased ability to provide more efficient and coordinated care by sharing health information with patients for better engagement, exchanging data with other payers to facilitate the best outcomes for patients, offering a shareable provider directory to help patients find the doctors they need, and maintaining historical claims and encounter data to help patients understand their rendered healthcare and expenses.

The Rule mandates technical standards that payers and health information technology vendors must use as a common interoperability framework for information exchange. This common framework not only enables data exchange but also encourages marketplace competition for third-party healthcare applications (e.g. mobile phone apps) which patients may elect to use for keeping their health data readily available.
The requested item is unbudgeted as staff needed to research rules implication and market options at the time of the 2020 budget planning season. In addition, the ruling was a proposal with no finalized timeline until April 2020.

Discussion. The Rule requires the Alliance to implement and support new technology and operations that make the members’ claims and encounters including financial information, and a subset of defined clinical data available to third parties authorized by the member. In addition, the Alliance must also make the provider directory and the drug formulary available to third parties in a Fast Healthcare Interoperability Resources API solution. CMS estimates that a Plan’s cost to comply ranges from $788K to $2.5M and specified that these costs shall be included in states’ development of Medi-Cal capitation rates. The payer to payer data exchange requirement, effective January 1, 2022, will require a concurrent implementation to begin once CMS defines the trusted data exchange security requirements.

Staff have participated in several Interoperability workshops and vendor introductions through both the Association for Community Affiliated Plans and the California Healthcare Foundation. The Alliance intends to undergo a Request for Proposal process with these vendors to identify a cost-effective solution that will be unique to the Alliance’s data architecture and infrastructure. Staff will need the ability to execute the contract quickly upon identification of the most appropriate solution, which is anticipated to be around September 2020.

Fiscal Impact. This would add $600K to the 2020 spend, resulting in an anticipated variance of less than 1% to the overall budget. Depending on the vendor solution, it may be capitalized.

Attachments. N/A
DATE:       June 24, 2020  
TO:         Santa Cruz-Monterey-Merced Managed Medical Care Commission  
FROM:       Stephanie Sonnenshine, Chief Executive Officer  
SUBJECT:    2020 Legislative Session Update

Recommendation. Staff recommend the Board accept staff’s report on the 2020 Legislative session and adopt a position of support on AB 2164 (Rivas) and direct staff to send a letter of support.

Background. At the February 2020 board meeting, your board decided to cease holding Legislation Committee meetings due to issues with lack of quorum, which resulted in over 50% of Legislation Committee meetings being cancelled over the past two years. Instead, your board directed staff to bring Legislative updates and requests for advocacy positions to the board at its regular board meetings in February, April and June, or as needed.

Discussion. Legislative deadlines are approaching for bills introduced this year with June 19, 2020 and June 26, 2020 being the deadline for Assembly and Senate bills to pass out of their respective house of origin.

Due to the COVID-19 pandemic and resulting fiscal impact, the number of bills being considered this year has been significantly reduced and many that are being considered are being held in the respective Appropriations Committee.

Staff work with representatives of the Local Health Plans of California (LHPC) to develop and monitor a bill list which includes 26 “Tier 1” priority bills that LHPC is watching and two new bills that LHPC supports.

AB 2164 (Rivas) – Telehealth is one of the bills on which LHPC has taken a position of support. This bill has recently been amended to incorporate language from California Primary Care Association’s sponsored telehealth bill, AB 2007. AB 2164 includes the following provisions.

If Federally Qualified Health Center (FQHC) services involve telehealth by synchronous real time or asynchronous store and forward: 1) prohibits face-to-face contact between the provider and beneficiary from being required to establish the patient; 2) allows a patient to be established with an FQHC at any time, including via telehealth; and 3) defines “visit” to include a visit using telehealth by synchronous real time or asynchronous store and forward.

Given this bill’s expansion of telehealth flexibilities for FQHCs and the prevalence of FQHCs in the Alliance’s network and the resulting potential for increased access and availability of services, staff recommend that the board adopt a position of support and direct staff to send a letter indicating the Alliance’s support for AB 2164.
Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments. N/A
DATE:       June 24, 2020
TO:         Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM:       Dr. Dale Bishop, Chief Medical Officer
SUBJECT:    Peer Review and Credentialing Committee Report of June 10, 2020

Recommendation. Staff recommend the Board accept the decisions from the June 10, 2020 meeting of the Peer Review and Credentialing Committee (PRCC).

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

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

Credentialed and Recredentialed Providers: PRCC Meeting of June 10, 2020

- New Providers:
  - 33 Physician Providers (MD, DO, DPM)
  - 22 Non-Physician Medical Practitioners
  - 3 Allied Providers
  - 7 Organizations

- Recredentialed Providers:
  - 74 Physician Providers (MD, DO, DPM)
  - 26 Non-Physician Medical Practitioners
  - 17 Allied Providers
  - 19 Organizations

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

Attachments. N/A
DATE:     June 24, 2020
TO:      Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM:    Michelle N. Stott, Quality Improvement and Population Health Director
SUBJECT: Quality and Performance Improvement Program Annual Report – 2019

Recommendation. Staff recommend the Board approve the 2019 Quality and Performance Improvement Program (QPIP) Annual Report.

Summary. This informational report provides the 2019 evaluation of the Quality Improvement (QI) workplan and pertinent activities for the Alliance’s QPIP. A written description of activities is reflected in the QI workplan, as evidenced by goals and objectives reviewed quarterly and evaluated on an annual basis. These activities are approved by the Continuous Quality Improvement Committee, and ultimately, the Alliance Board.

Background. The Alliance is contractually required to maintain a QPIP to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. Each year, the Alliance’s QPIP focuses on areas with actionable challenges and significant clinical outcomes that relate to a large proportion of members. The intent is to evaluate the quality and timeliness of care to inform interventions that will improve the quality of care and ultimately improve the health status of members. The 2019 QI workplan outcomes and evaluation are described in further detail in this report.

Discussion.

Summary of Quality Improvement Workplan. The 2019 QI workplan was developed to align with the Alliance Strategic Plan of Member Wellness, Access to Care, and Promotion of Value. Overall, goals were met in several areas of quality and access, including the Department of Healthcare Services (DHCS) Performance Improvement Projects (PIPs) for childhood immunizations, opioid initiative, third next available appointments (TNAA) (primary care), and positive trends for preventable emergency department (ED) visits and initial health assessment. The workplan included goals for chronic care management, such as asthma and diabetes measures, although priorities shifted mid-year towards pediatric measures in response to findings in the California State Auditor’s reports on pediatric preventive services and publication of the new DHCS Managed Care Accountability Set. Member experience survey for “getting care quickly” continues to be an area of opportunity despite promotion of several access initiatives. Operational goals included timely closure of corrective plans from facility site reviews and potential quality issues which were challenged as reported from provider clinics and internal staffing. A goal was developed for the QI team to facilitate data needs for the Health Services (HS) Division, and several reports were completed, including a clinic Joint Operating Committee (cJOC) report.
In addition to the 2019 QI workplan, the report highlights QPIP monitoring and demonstrated positive results for quality measures, increased provider engagement, and no audit findings from external entities. This is reflected in activities for the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness and Data Information Set (HEDIS) results, Care-Based Incentive (CBI) program, Kinetic Quality Improvement program, and Department of Healthcare Services (DHCS) Medical Audit.

Quality Improvement Workplan Outcomes and Evaluation

**Asthma Initiative.** The Asthma Initiative focused on increasing the application of evidence-based information in primary care physician (PCP) practices, notably routine use of controller medication with members that have persistent asthma. The goal was to improve health outcomes of members 5-85 years of age with persistent asthma living in Merced County to increase HEDIS Asthma Medication Ratio (AMR) scores from 66.21% to 71.93% (NCQA 90th). The QI and Pharmacy Departments reached out to providers to share rosters of members that were not compliant with AMR measure to recall members for education and prescriptions. A five percentage point increase in Merced County to 85.22% AMR (Q3 2019 CBI administrative data) was achieved. Finalized rates for HEDIS 2020 (measurement year 2019) are to be determined.

**Diabetes Initiative.** The goals set were to achieve a five percentage point increase of members with diabetes in good control (HbA1c<8.0) from baseline (54.99% Santa Cruz-Monterey counties, 50.36% Merced County) to at least 59.49% for Santa Cruz-Monterey County members and 55.47% for Merced County members. The strategy used was to convene an agency-wide diabetes workgroup to maximize communication and collaboration and increase HS staff’s general knowledge and ability to apply motivational interviewing skills to member engagement. The team met monthly and used that time to orient to each department’s diabetes activities and review available data about members with diabetes. Data included mapped rates of members in poor control by zip code to support other departments in identifying geographic focus areas. The focus was moved from diabetes to pediatric measures by mid-year and goals were not realized.

**Opioid Initiative.** The Alliance focused on decreasing the number of opioid fills by 50 per 1,000 members per year (PKPY) from a baseline of 216.9 and was able to achieve a 32.2 PKPY decrease to 184.7. In addition, efforts to address prescribing practices and member safety, the Alliance partnered with providers in Merced County on a PIP that targeted increasing the naloxone (Narcan) fill rate among members with chronic opioids in Merced County from 0.07% to 4.8% through academic detailing. At the conclusion of the PIP, the Narcan fill rate increased to 12.62%, well above the goal of 4.8% and the Alliance was recognized by DHCS as the 2018 Innovation Award runner-up for these efforts.

**Immunizations.** To improve health outcomes for pediatric members, the Alliance focused on increasing the HEDIS Childhood Immunization Status (CIS) Combination (Combo) 3 rate from 63.07% to 65.45% for children two years of age in Merced County and continue to monitor the Immunizations for Adults (IMA) rates. The Alliance partnered with Castle Family Health Center on a PIP to increase their CIS Combo 3 rates from 32% to 40%. Although the first intervention to increase awareness of the Alliance’s transportation benefit was unsuccessful in improving the...
project goal, the second intervention focused on recall strategy helped increase the CIS Combo 3 rate to 49%, well above the goal of 42%. However, the CIS Combo 3 rate for Merced County decreased and did not meet the HEDIS goal. The IMA rate increased for both, Merced and Santa Cruz/Monterey regions. The Alliance will to continue their partnership with Castle Family Health for the 2019-2021 PIP to increase their CIS Combo 10 rate.

**Access to Care.** The QPIP monitors member access to timely and coordinated care by achieving an increase of Initial Health Assessment (IHA) compliance within 120 days of enrollment, increase in member experience scores for the survey composite “getting care quickly”, increase of availability for the TNAA and decrease in avoidable ED visits. Continued provider education helped increase the IHA compliance to 44%. Despite partnering with providers on the Practice Coaching program to decrease no-show rates and promotion of the Nurse Advice Line (NAL) and Urgent Visits Initiative (UVI), the 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience survey scores for the composite “getting care quickly” did not meet the goals for both adult and child surveys. Uptrend in provider recruitment resulted in 55% compliance for primary care to meet the TNAA goal of 42%. However, 48% (goal 55%) was not achieved for specialty care for TNAA. Collaborating with providers through CBI forensic visits, provider portal reports, and promotion of the NAL and UVI helped decrease avoidable ED visits to 15.40% (goal 15.36%).

**Quality and Performance Improvement Program Operational Performance.** The QPIP includes surveillance to maintain and improve the clinical safety of services to members. Two key clinical safety operational functions facility site review (FSR) and PQI programs are reported below.

**Clinical Safety: Facility Site Review and Potential Quality Issues.** The FSR team monitors all primary care providers within the network to ensure that facilities are safe and accessible; care is evidence-based, prevention-focused and safe for our members. The FSR team set out to achieve all operational goals at 100% compliance for 2019. Four sites (100%) completed a full site review within three years of the last FSR. When Critical Element (CE) Corrective Action Plan (CAPs) were issued at a review, only five sites (40%) had the CAP resolved within 10 business days. CEs require near immediate resolution, including items like infection control practices. The clinics issued a CAP 88% (N=8) and were able to submit a CAP plan within 45 calendar days to the Alliance. Challenges in meeting these goals were driven by concerns reported from the providers: offices face competing priorities, limited hours in the office, a new Electronic Medical Record system, and urgent personal matters causing the CE CAP or CAP to exceed the due dates. Staff worked diligently to support providers in communicating FSR requirements. A local non-profit, Health Improvement Partnership of Santa Cruz County, has been engaged and worked on surveying providers and developing a workplan for staff to implement.

For PQI, the team reviewed 100% of the 674 member grievances and accepted additional reports of patient safety concerns from across the Alliance. Examples include a member who falls while inpatient, failure to follow through on lab results, inappropriate opioid prescribing that result in injury to the member. The aim is to complete investigation of cases within 60 calendar days of receipt and the team was successful for 86% of PQIs. The PQI program continues to be
developed. Changes include reporting to the Medical Board of California, collaboration with the Special Investigative Unit for substantial cases, weekly RN case-study groups and development of CAP policy. These changes have increased overall transparency to the Peer Review and Credentialing Committee and allowed additional follow-up for high risk providers.

Cross-Collaboration with Health Services Departments (Data). The QI Department serves as the support to develop technical data specifications and more often, the source of data clearinghouse ad hoc reports to departments within the division. Goals were developed to formalize the cross-functional collaboration on the top strategic priorities among HS Departments by utilizing the same clinical dashboards, outlining roles and responsibilities for each department, and providing quality improvement support and aligned approaches. In early 2019, cJOC meetings were initiated and the cJOC dashboard adopted for use to review clinic performance. The cJOC dashboards were well received by providers in the network and often instigate action on their behalf to address high cost members.

Monitoring of Quality Measures and Improvement Activities. The DHCS contract requires annual measure reporting to DHCS and NCQA for HEDIS measures. The CBI Program uses many of the same measures as HEDIS and financial rewards leveraged to support improvement needed for select HEDIS measures.

Healthcare Effectiveness and Data Information Set and Care-Based Incentive Programs. In early 2019, QI implemented new software and transitioned both HEDIS and CBI operations. HEDIS 2019 was very successful despite the move to a new system, receiving the Outstanding Performance Award 2019 for Medium Scale Medi-Cal Plan. The HEDIS team also pivoted from routine operations following the spring announcement of the Governor’s budget that prioritized pediatric health. This announcement included a new name for the HEDIS measures, “Managed Care Accountability Set”, and with a policy change to set the 50th percentile as the minimum performance level for plans and included proposed sanctions and CAPs for failure to meet these new requirements. Staff determined that additional focus on evidence-based practices for preventive pediatric health services would be worthwhile and held a learning collaborative for further PCP training. At the close of the year, member outreach was made with automated calls to ~35,000 pediatric members behind on well child/adolescent exams and/or vaccines.

The CBI 2019 program evaluation showed many promising trends that included decreases in preventable emergency visits, improvements in pediatric measures and Merced’s Quality of Care measures, particularly for childhood immunizations, and increases in timely prenatal care.

Kinetic Quality Improvement Program. The Kinetic QI Program framework was developed in 2018 based on a QI Needs Assessment indicating receptiveness from providers for technical support by the Alliance QI team. The program includes the following three key components: Practice Coaching, Learning Collaboratives and Practice Transformation Academy.

The Practice Coaching program was expanded to 11 additional providers in 2019 and included a range of engagements, from providing technical assistance in leveraging the provider’s existing electronic systems to implementation of best practices to clinic workflows like reducing no-
shows for scheduled appointments. The learning collaboratives were developed to share best practices through interactive meetings between the providers. Topics included 30-day Readmissions and Post-Discharge Care, and improving pediatric measures, specifically, childhood immunizations and well-visits for age 0-15 months. The Alliance launched its Practice Transformation Academy in Merced County with “ABCs of Quality Improvement” which was designed to train clinic staff and doctors on the basic principles of quality improvement.

Department of Health Care Services Medical Audit. The DHCS Medical Review Branch conducted an audit on November 4-15, 2019 for the audit period November 1, 2018 through October 31, 2019. In review of the quality management program, including facility site review and medical record review, there were no findings reported.

Conclusion. There were many noted accomplishments completed for the 2019 QPIP as described in this report. In 2020, QPIP activities will continue to be focused on core QPIP activities and enhancement of existing processes to prepare for and implement new requirements and improve care delivery.

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

Attachments. N/A
DATE: June 24, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Stephanie Sonnenshine, Chief Executive Officer
SUBJECT: Strategic Planning Update

Recommendation. Staff recommend the Board:
1. Cancel the Alliance board meeting scheduled for Wednesday, September 16, 2020 from 9:00 a.m. to 5:00 p.m., and schedule an Alliance board meeting for Wednesday, September 23, 2020 from 3:00 p.m. to 5:00 p.m.
2. Adopt Healthy people. Healthy communities as the Alliance vision statement.

Summary. In December 2019, the Central California Alliance for Health (the Alliance) began a facilitated strategic planning process towards a new organizational strategic plan to be effective January 1, 2021. This process includes adopting a new vision statement and a day-long planning retreat scheduled for September 16, 2020. Due to the impacts of the business continuity response to the COVID-19 pandemic, staff recommend taking a different approach to strategic planning. Ms. Bobbie Wunsch of Pacific Health Consulting Group (PHCG) will present for the board’s information and discussion, key environmental factors relating to health plan strategy in a post-COVID-19 environment. Staff will present recommendations to adjust the board’s meeting schedule in September, and a recommended new Alliance vision statement.

Background. The Alliance enacted a strategic plan in late 2017, prioritizing Member Wellness, Access to Care, Promotion of Value and Building Blocks for action between 2018 and 2020. In preparation for the expiration of the 2018-2020 strategic plan, in December 2019, staff initiated a strategic planning process towards a 2021 and beyond strategic plan. Staff retained Ms. Wunsch and Mr. Rafael Gomez of PHCG to facilitate the planning process with the Alliance board. The State of California’s CalAIM proposal, released on October 29, 2019, was a significant environmental factor expected to influence the Alliance’s 2021+ plan. CalAIM includes initiatives to transform the Medi-Cal delivery system with implementation dates beginning in January 1, 2021 and continuing through 2024.

In March of 2020, the COVID-19 pandemic resulted in the implementation of stay at home orders, altering the healthcare and economic landscape in ways that are not yet fully understood. As of the drafting of this report, the State Administration and the Legislature are working to reconcile the Governor’s May Revise budget proposal with the Legislative budget proposal. Each relies on different actions to achieve a balanced FY 2020-2021 budget. Despite the different Administration and legislative approaches, it is apparent that the Alliance can expect downward pressure on health plan revenue, increased Medi-Cal enrollment, and a hard pause on the CalAIM proposals for system transformation.
Discussion. In response to the changed healthcare environment, staff have adjusted the strategic planning approach for the Alliance’s next organizational strategic plan to contemplate two-steps. In the first step, staff will identify key operational priorities and objectives for calendar year 2021 which are responsive to the present ever-evolving environment. These priorities will be geared towards ensuring operational readiness to advance strategic priorities through collective effort in 2022. In the second step, staff will conduct parallel planning, re-engaging the Alliance’s board in strategic planning during 2021 to finalize a 2022+ strategic plan. To support the board’s understanding of strategic factors impacting the Alliance in 2021 and beyond, Ms. Wunsch of PHCG will present and the board may discuss such environmental factors during the June board meeting in its consideration of staff’s recommended approach to longer term planning.

The adjustment in strategic planning approach requires two actions by the Alliance’s board in June. First, staff recommend that the Board cancel the September 16, 2020 all-day board retreat and replace it with a standard Alliance board meeting to occur on Wednesday, September 23, 2020, from 3:00 p.m. to 5:00 p.m. by video-conference.

The basis of this recommendation is first and foremost the uncertainty as to whether meetings the size of the Alliance retreat will be permitted as of September. A day long retreat by video-conference is neither desirable nor likely effective. In addition, it will be difficult, if not impossible, to secure speakers relevant and impactful to the board’s planning. Finally, clarity with regards to California’s economic outlook, the availability of federal aid, and further waves of COVID-19 outbreaks will not be known in advance of the scheduled date. Staff anticipate recommending a date for a board retreat to occur in 2021 when the 2021 board meeting schedule is recommended in December 2020.

Second, staff recommend that the Board adopt a new Alliance vision statement. A key step in the Alliance’s previously planned 2021+ strategic planning process was the adoption of a new vision for the Alliance. A vision statement is a short, simple and specific declaration about an organization’s future goal. Even with a slowing of long-term strategic planning, the adoption of a revised vision statement ensures that both the 2021 operational priorities and 2022+ planning process align towards the Alliance’s declared vision.

The board has been building towards the adoption of a new vision statement since the development of the 2018-2020 strategic plan. During that planning process, the board directed staff to revisit the organizational vision statement to ensure consistency, impact and alignment across the Alliance’s pursuit of strategic priorities, the execution of operational responsibilities, and in collaborative actions with partners towards shared outcomes.

The board also discussed the Alliance’s mission statement *Accessible, quality healthcare, guided by local innovation,* and whether revisions might be recommended. After consideration, staff do not recommend changes to the Alliance’s mission. A mission statement articulates an organization’s core purpose and focus and can include actions in pursuit of that focus. In discussing the mission, the board supported the concepts of local determination, solutions, and effectiveness. The mission as articulated contains the concepts considered by the board. In particular, the use of the word *innovation* encapsulates the concepts of creation, development,
self-determination and improving efficiency and effectiveness. The statement as drafted is clear, conveys the organization’s purpose and emphasizes local determination, solutions and effectiveness.

The board considered vision in 2018 and identified the following key themes: a focus on the Alliance member, an emphasis on health and prevention, inclusion of the concept of healthy communities, the identification on a big picture goal, and a statement that would connect and resonate with members. Staff consolidated the Board’s direction into themes and then presented those themes to the Member Services Advisory Group (MSAG) for further input to ensure that the vision statement will resonate with members conceptually, and with Alliance staff to identify statements which are motivating, clear and will support alignment in action.

Staff narrowed all input down into two potential statements and reviewed those two statements against cultural and linguistic criteria and in translation to Spanish and Hmong to ensure the vision statements would translate well for Alliance members in these key threshold languages. It is notable that while the word member is meaningful to staff and the Alliance’s board, it doesn’t directly connect for members themselves or for providers. The word “people” is clearer to a wider audience. Two clear options emerged.

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<thead>
<tr>
<th>Preferred Option</th>
<th>English</th>
<th>Spanish</th>
<th>Hmong</th>
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<tbody>
<tr>
<td>communities.</td>
<td></td>
<td></td>
<td>zej zog muaj kev noj qab haus huv.</td>
</tr>
<tr>
<td>Runner Up</td>
<td>English</td>
<td>Mejor salud para todos.</td>
<td>Txhua tus muaj kev noj qab haus huv zoo tshaj.</td>
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<tr>
<td>Better health for all.</td>
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These statements are crafted to be direct, clear as to the outcome the Alliance seeks to achieve through its efforts, to resonate across Alliance stakeholders and to motivate staff. They are intended to convey the outcome sought through the Alliance’s collective effort and to convey inclusivity, equity and allow for the broadest definition of health. Staff conducted a poll to identify which statement was preferred across board members, MSAG members and staff. Seventy-seven percent of respondents preferred Healthy people. Healthy communities. Staff recommend that the Board adopt this statement.

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

Attachment,
1. Biography of Ms. Bobbie Wunsch
Biography of Ms. Bobbie Wunsch

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

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

Bobbie is well-known for organizing and facilitating high profile meetings for a wide variety of health organizations focused on issues impacting the safety net including her work with the California Department of Health Care Services on the last three 1115 waiver stakeholder groups, her on-going work with the DHCS Stakeholder Advisory Committee and CPCA’s Workforce Policy Coalition.

In 2017, Bobbie was the recipient of the California Primary Care Association’s Hero Award in recognition of her contributions.
DATE: June 24, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Stephanie Sonnenshine, Chief Executive Officer
SUBJECT: California State Budget for FY 2020-2021

California Legislature OK’s budget, but changes coming
By Adam Beam
AP News

SACRAMENTO, Calif. (AP) — Facing an estimated $54.3 billion budget deficit because of the coronavirus, California lawmakers on Monday approved a state spending plan that rejects most of Gov. Gavin Newsom’s proposed cuts to public education and health care with the hope that Congress will send the state more money by Oct. 1 to cover the shortfall.

But the budget likely won’t become law because it does not have the backing of Newsom, who has the power to sign, veto or alter whatever the Legislature sends him.

Lawmakers passed a budget anyway to make sure they met a constitutional deadline and will continue to be paid. Legislative leaders will continue to negotiate with the Newsom administration to reach an agreement before the start of the new fiscal year on July 1.

“While there will be changes to reflect the final agreement, we will not deviate from the principles we have outlined in this budget,” Senate President Pro Tempore Toni Atkins said.

Budget negotiations progressed on Monday when Newsom backed off some of his proposed cuts. Newsom had recommended making fewer low-income older adults eligible for government-funded health insurance to save nearly $68 million. He had also proposed 10% cuts to all child care programs that allow low-income parents to go to work.

Newsom agreed to drop those cuts, according to a senior administration official who spoke on condition of anonymity because they weren’t authorized to discuss publicly ongoing negotiations with Legislative leaders. Newsom’s concessions were signs budget talks are progressing, but many issues remain before the two sides can reach an agreement.

“I’m very pleased at the conversations we’ve been having,” Newsom said during a news conference on Monday. “I’m not going to say anything publicly that puts any of those conversations at risk.”

California’s budget problem is the same issue plaguing other states. Newsom ordered most people to stay at home for nearly three months to slow the spread of the coronavirus. That forced many businesses to close and more than 6 million Californians to file for unemployment benefits.
The state has already delayed its tax filing deadline to July 15, making it harder for state officials to know for sure how much money they will have to spend. The Newsom administration predicts state revenues will drop by $41 billion. The rest of the $54 billion deficit comes from the billions of dollars the state spent purchasing protective gear for health care workers and securing extra hospital beds to prepare for a potential surge in patients that never happened.

Plus, the state is preparing to pay for the many more people expected to sign up for government services like Medicaid and other safety net programs because of the economic downturn.

“In this budget there are a lot of things that we are assuming, but I can’t really say we know for certain what will happen,” said Phil Ting, a Democrat from San Francisco and chairman of the Assembly Budget Committee.

Newsom’s spending plan would cover the deficit by making billions of dollars in cuts to items such as public schools and health care services. The Legislature’s plan would cover the deficit by borrowing more from some of the state’s restricted funds, taking more money from the state’s savings accounts and delaying billions of dollars in payments to public schools. That means school districts could go ahead and spend the money and the state would pay them back later.

Both plans would eliminate cuts if Congress sends the state more money. But the Legislature’s plan gives Congress until Oct. 1 to send the money, while Newsom has a deadline of July 1.

In a separate vote on Monday, the Legislature approved Newsom’s proposal to temporarily raise taxes on some businesses to generate an extra $4.4 billion to help cover the shortfall. The changes will stop businesses with more than $1 million in revenue from claiming losses as a tax deduction for the next three years and limits how many tax credits businesses can claim.

“We have no idea where the rest of this budget is going to go. Yet we’re voting for more revenue to start the whole debate,” Republican state Sen. Jim Nielsen said. “My fear is, as usual, that will be revenue that goes down a dark hole (and) in another year we’ll be on the precipice of another deficit.”
DATE: June 24, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Lisa Ba, Chief Financial Officer
SUBJECT: Medical Cost Analysis and Recommendation of Cost Containment Plan

Recommendation. Staff recommend the Board:

1. Approve the execution of a medical cost containment plan to align financial performance with Department of Health Care Services (DHCS) revenue rate and utilization trends, and industry standard payments and to approve a measure of performance to achieve a minimum net income of 1.5% by 2024.
2. Approve reimbursement rates for specialists at the current Medicare physician fee schedule.

Background. In October 2019, the Board directed staff to work with the Finance Committee to evaluate medical cost and develop a comprehensive recommendation to address and ensure that medical costs align with revenue.

Between November 2019 and May 2020, the Finance Committee has reviewed medical cost analyses and cost containment options provided by staff and consultants. On May 27, 2020, Committee members unanimously approved a cost containment plan to align costs with revenue, utilization trends and industry standard payment and set a measure of performance to achieve an operating income of 1.5% by 2024.

On June 4, 2020, the Physicians Advisory Group (PAG) provided feedback to staff on how the Alliance can best address the impact of cost containment efforts, communicate with and support providers, and ensure continued access before and after the payment changes. Staff will incorporate the feedback from PAG in executing the cost containment plan.

The Alliance has experienced financial losses since 2018. By the end of 2020, the plan will have experienced losses exceeding $200M. The operating reserve has been below the Board Designated Reserve Target since September 2019.

The Alliance accumulated a substantial reserve fund between 2014 to 2017 primarily due to the influx of Affordable Care Act (ACA) Medi-Cal expansion members and the higher revenue rates attributed to this population. In 2016, to ensure network adequacy and member access, the board approved an increase to provider payment rates. The increase was subsidized using Alliance reserves gained via the above-mentioned ACA Medi-Cal expansion revenue rates. As more experience was gained with the ACA Medi-Cal expansion population, DHCS actuaries determined that the expansion rate had overestimated the inpatient cost for this population and adjusted the rates downward as a result. Higher provider reimbursement rates, coupled with an increase in utilization, have resulted in financial losses since 2018. The Alliance’s strong reserves covered losses for 2018-2019. However, the Alliance cannot sustain continued losses.
Without a robust cost containment plan, there is no breakeven in sight. A five-year financial forecast projects that the Plan will have $100M in fund balance, or less than two times the State required Tangible Net Equity by 2024 without mitigating actions.

At the October 23, 2019 Board meeting, the Board directed staff to work with the Finance Committee to undertake a comprehensive analysis of the provider payment structure with recommendations to align costs with revenue.

Discussion. Staff reviewed both the administrative costs as well as the medical costs. In 2019, significant action was taken to bring administrative costs under control and staff continue to be measured regarding spending. To that end, staff has reduced the administrative budget from 7.7% in 2018 to 7.4% in 2019, and 6.9% in 2020.

In analyzing the medical cost, staff identified the gap between revenue and expense for each cost category, compared the Alliance reimbursement policy with other local Medi-Cal health plans and consulted healthcare experts on industry benchmarks and factors impacting the financial forecast. The results indicated a significant delta between revenue and expense for hospital services, while other major cost categories were reasonably in line with expenses.

Medical cost analysis revealed that inpatient costs represented one third of the medical cost and is on average 25% higher than our sister plans in the Local Health Plans of California. The year-over-year increase in contract rate, combined with an increase in utilization resulted in continued financial losses. To address this, staff have identified an opportunity to benchmark Medi-Cal All Patients Refined Diagnosis Related Groups for inpatient payment structure.

Staff also reviewed all other provider payment reimbursement rates, including primary care, referral physician and ancillary providers. Staff determined that payment rates to primary care and ancillary providers align with industry standards. However, the Alliance currently reimburses specialists at the 2015 Medicare physician schedule, five years behind industry standards. Medicare is the benchmark for Specialists that is widely used throughout the State. There is an opportunity to bring the payment structure to the current Medicare fee schedule in 2021. The additional cost to do so can be mitigated by eliminating the Specialty Care Incentive program. With the alignment of Specialist payment to the current Medicare fee schedule, the demand for supplemental incentive payments is lessened.

Over the past few years, staff have implemented initiatives to control utilization, such as the Intensive Care Management, Post-discharge Meal Delivery, and Respite Care programs. In conjunction, staff increased member outreach activities to promote a healthier population. The remaining factor impacting medical costs is hospital payment rates, which is the root cause of losses, and specifically the hospital rates.

Fiscal Impact. This Cost Containment Plan will enable the Alliance to achieve breakeven in 2023 and generate a small margin in 2024.

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

A. Alliance in the News  
B. Letters of Support  
C. Membership Enrollment Report  
D. Member Newsletter (English) – June 2020  
E. Member Newsletter (Spanish) – June 2020  
F. Provider Bulletin – June 2020

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https://www.ccah-alliance.org/pdfs/member_newsletters/CCAH-Member-June%202020-ENG-highres.pdf

https://www.ccah-alliance.org/pdfs/member_newsletters/CCAH-Member-June%202020-SPA-highres.pdf

https://www.ccah-alliance.org/pdfs/provider_bulletins/PSBulletin_202006.pdf
DATE: May 27, 2020
TO: Santa Cruz-Monterey-Merced Managed Medical Care Commission
FROM: Chandra Duffy, Communications Project Specialist
SUBJECT: Alliance in the News

Santa Cruz County Food Bank Gets $157K
Patch Watsonville
Via Newswire
May 2, 2020

The Central California Alliance for Health (the Alliance), the Medi-Cal managed health care plan for residents of Monterey, Merced and Santa Cruz counties, will donate $600,000 to three local food banks through its newly-established COVID-19 Response Fund. Second Harvest Food Bank of Santa Cruz County will receive $157,000, Merced County Food Bank will receive $208,000 and the Food Bank of Monterey County will receive $235,000. The donation seeks to provide immediate relief to the surge of Monterey County residents facing hunger due to the pandemic.

"Our members are among the most vulnerable in our communities and are the most likely to go hungry as a result of this pandemic," said Alliance CEO Stephanie Sonnenshine. "These food banks serve a critical role in addressing our members' food insecurity, a key factor in determining overall health. The food banks are challenged to meet the growing needs caused by this pandemic as more and more people are now struggling to feed their families. The Alliance's COVID-19 Response Fund will provide critical support to our community partners serving Alliance members. We are all in this together."

The Alliance Board of Directors approved an allocation of $1 million dollars to establish the COVID-19 Response Fund as part of its Medi-Cal Capacity Grant Program (MCGP). The remaining COVID-19 Response fund monies will be awarded to community-based organizations working to meet the evolving needs of Alliance members during the pandemic, such as meal delivery services, access to diapers, or for personal protective equipment for food and homeless service providers.

Central California Alliance to Donate $157K to Second Harvest

TPG Online Daily
Via Newswire
May 5, 2020

The Central California Alliance for Health, the Medi-Cal managed health care plan for nearly one in four Santa Cruz County residents, will donate $157,000 to the Second Harvest Food Bank of Santa Cruz County through its newly-established COVID-19 Response Fund.

“Our members are among the most vulnerable in our communities and are the most likely to go hungry as a result of this pandemic,” said Alliance CEO Stephanie Sonnenshine. “The Second Harvest Food Bank of Santa Cruz County serves a critical role in addressing our members’ food insecurity, a key factor in determining overall health. The food banks are challenged to meet the growing needs caused by this pandemic as more and more people are now struggling to feed their families. The Alliance’s COVID-19 Response Fund will provide critical support to our community partners serving Alliance members. We are all in this together.”

The Alliance Board of Directors approved an allocation of $1 million to establish the COVID-19 Response Fund as part of its Medi-Cal Capacity Grant Program; 60 percent of the funding dollars will be disbursed to the local food banks.

Harvest Food Bank of Santa Cruz County reports food needs have doubled in the wake of the March 16 “shelter in place” order, which closed many nonessential businesses and left many people out of work.

“In the first few weeks, our Community Food Hotline received thousands of calls, and our drive-through distributions were able to provide food to 3,000 families in a single day, more than doubling our typical week’s distribution,” said Second Harvest Executive Director Willy Elliott-McCrea.

The remaining 40 percent of the COVID-19 Response fund monies will be awarded to community-based organizations working to meet the evolving needs of Alliance, such as meal delivery services, access to diapers, or for personal protective equipment for food and homeless service providers. Alliance staff will monitor how COVID-19 impacts local communities to assess the best way to respond.

The Medi-Cal Capacity Grant Program was established in 2015 following the Affordable Care Act’s implementation the previous year, which placed sudden growth demands on the health care delivery system. The program seeks to improve the availability, quality and access to health care and supportive services for 320,000 members in Santa Cruz, Monterey and Merced counties.

Recognizing the critical impact of food insecurity on member health, including poor health outcomes and reduced quality of life, the program addressed food insecurity in 2018 with the “Post-Discharge Meal Delivery Pilot” and “Partners for Healthy Food Access.”
Established in 1996, Central California Alliance for Health is an award-winning managed care health plan focused on prevention, early detection and effective treatment. For information, visit www.ccah-alliance.org.


Feeding Our Food Banks-Central California Alliance for Health
Press Banner
Katie Evans, Staff Reporter
May 8, 2020

For over 22 years, the Central California Alliance for Health (CCAH) has served our community, the entirety of Santa Cruz County, Monterey, and Merced as a nonprofit health care plan over 330,000 members. While 1 out of every 4 locals have visited their business, they’re hoping to support more than just their members during this time of crisis. Last week, the CCAH board pledged 1 million dollars from their Medi-Cal Capacity Grant Program (MCGP) as a COVID-19 relief fund, for community members in dire need. Kathleen McCarthy, the CCAH Strategic Development Director that oversees the MCGP, described how these funds would directly impact our county.

As soon as COVID-19 began to develop in the U.S., the CCAH started “reaching out to funders, current grantees, and community partners to ask about current community needs.” After many board discussions, the first allotment was decided. While the 1 million-dollars will be disbursed throughout the three counties for multiple causes overtime, the CCAH decided 600,000 of those 1 million-dollars should go to food banks immediately. Santa Cruz County has already received 157,000 dollars of the allotment as a donation to the Second Harvest Food Bank. McCarthy proudly asserts, “That’s equivalent to 628,000 meals.” The CCAH decided to donate as quickly as they could to the food bank because, “Food is most urgent, pressing need in our community right now… The food banks in all three counties we provide for have experienced anywhere from a 100% to 400% increase in calls and in person demand as of recently. So many need food in the current state of our economy, and many more are confused about getting food safely, so they contact the food bank.”

Food insecurity has concerned the CCAH for quite some time. According to a CCAH 2016 member survey, “close to 50% of our members were living in food insecure households, meaning they worried about affording food or were unable to purchase food.” McCarthy greatly sympathized, “It’s already hard enough right now, without deciding between rent, food, and medication.” The CCAH already has plans for the “remaining funds to be awarded over the coming weeks, but for now food is the most urgent, pressing concern… Other needs will present themselves as time goes on, but food banks have an immediate, tangible impact right now.”
While 60% of the MCGP will go directly to food banks, the CCAH is providing for other community needs as well. This past Friday, 20,000 dollars of the grant were approved for the Teen Kitchen Project, a Soquel nonprofit where teenagers provide community members with life-threatening illness healthy, home-cooked meals. The CCAH is also “deploying resources to other community organizations, to fund basic health needs, like providing diapers, baby wipes and formula, and delivery of groceries to higher-risk residents. McCarthy also emphasized the needs of “local organizations that serve the unhoused with water, soap, and masks, protective equipment for non-healthcare essential workers and front-line nonprofit organizations.

The remarkable motivation behind the grant stems from their mission, “to provide successful health care guided by local innovation,” according to McCarthy. “The CCAH is all about community and while all populations are being affected right now, our most vulnerable members of the community are disproportionately affected. We needed to do something to help out.” The grant program started donating to local organizations in 2015, in accordance with their mission statement, “to expand access and quality of healthcare in our community.” McCarthy looks forward to continuing that tradition, by “remaining flexible and aware of community needs,” and Santa Cruz County is grateful for it.

The Coronavirus and Oral Health
Santa Cruz Sentinel
By Dr. Sepi Taghvaei
May 10, 2020

Just a few months into the COVID-19 pandemic, we’ve learned a great deal about the novel coronavirus, and continue to learn more every day about the many ways it attacks our bodies and immune systems.

So how is the coronavirus connected to oral health? Not directly, as with heart or lung problems. But because oral health is part of overall health, anything that affects the health system ends up affecting oral health, and vice versa. For example, without routine oral health care, neglected dental problems can quickly become emergencies that end up in the hospital instead of the dentist’s chair. Dientes alone has provided emergency dental care for 500 patients so far during this crisis. Especially now, at a time when we want to preserve hospital emergency department resources for those with the most urgent needs, we want to keep as many people as possible out of the hospital.

For low-income people, emergency dental services are still being provided in our community by clinics such as Dientes and Salud Para La Gente. Along with other healthcare providers, these clinics are an important part of our local safety net and the health ecosystem. So far, the COVID-19 pandemic has threatened oral health care in Santa Cruz County by temporarily restricting oral health services for anything except emergencies. Soon, as essential care providers, dentists will be making more services available. In the longer term, the economic impact of the coronavirus may put pressure on the state budget to reduce coverage for dental care, as has happened in the past.
If that happens, it would be a huge loss — and not only for those who rely on dental clinics for care. We realize everyone has faced challenges and hardships during this crisis, but we are particularly concerned about pulling back on oral health care services at this moment. Over the past several years, Santa Cruz County has made great and encouraging progress in preventing the kinds of problems that end up as dental emergencies.

As a co-chair of the Oral Health Access coalition in our county, I’ve had a ringside seat to observe the collaborative work of community agencies to improve oral health care in our community. Central California Alliance for Health and First 5 have reached out to parents and providers to encourage them to start healthy oral health habits with our youngest residents. Our County Office of Education helped promote oral health screenings for kindergartners, reaching thousands of families and cutting in half the percentage of children who had never been to the dentist at all. The County’s oral health program has provided education to school children about the importance of brushing and flossing. Local medical clinics have made fluoride varnish at well-child visits a standard part of pediatric care, and more adults have access to quality dental care, too.

Like other aspects of our health, preventing oral health problems now is a much better option than treating them later. It’s our best opportunity for avoiding pain, suffering, and high healthcare costs. Too often, oral health has been an afterthought. In Santa Cruz County, we’ve made so much progress in making oral health a priority for every age group, by making it possible for more people to access early, routine care. We can’t afford to give this up!

If you are able, please consider donating to our local safety net clinics that provide oral health and other support to those in need. We’re grateful to our representatives, State Senator Bill Monning and Assembly members Robert Rivas and Mark Stone, for supporting access to health (including oral health) for all our residents. Stay tuned for more options to help them advocate for coverage as the state budget takes shape. Meanwhile, along with washing your hands, remember to brush and floss! All are good habits not only during this crisis, but every day.

Dr. Sepi Taghvaei is Dientes Chief Dental Officer.

June 8, 2020

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1325 J Street, Suite 1700
Sacramento, CA 95814

RE: Mental Health Student Services Act of 2019 RFA for Santa Cruz County;
Central California Alliance for Health Letter of Support

To whom it may concern:

On behalf of the Central California Alliance for Health (the Alliance), I am pleased to offer this letter of support for the grant application being submitted by the Santa Cruz County Behavioral Health Department and the Santa Cruz County Office of Education on behalf of dozens of partners in our schools and mental health services agencies. The Alliance is excited for the potential opportunity to strengthen and expand vital projects in the school mental health arena and as the Medi-Cal managed care plan for Santa Cruz County, the Alliance looks forward to partnering in these efforts.

For more than 14 months, Santa Cruz County has engaged in an effort to organize, synthesize and enhance student and family mental health and wellness in education through a partnership titled: Schools Integrated Behavioral Health Initiative (SIBHI). Through a comprehensive structure of a steering committee, operations team and three large convenings of the whole community, a number of results have occurred, which include resource mapping in school districts, detailed input from all key stakeholders and the creation of a roadmap for our county to follow. The Alliance has been a partner throughout this process and is ready to launch into the next phase.

Should our county be fortunate enough to receive funding from MHSSA, the Alliance will be a part of the new multi-agency care navigation team proposed to expand outreach and connection to schools to enhance the facilitation of access to appropriate services for students and families.

During this time of pending budget cuts in schools, public agencies and non-profits, even as the need for mental health and wellness supports increases in response to COVID-19 and its accompanying stressors, this targeted and timely funding would bring much needed resources to our community. Thank you for considering Santa Cruz County’s request.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer
May 26, 2020

Ms. Dori Rose Inda  
Chief Executive Officer  
Salud Para La Gente  
P.O. Box 1870  
Watsonville, CA 94077-1870

Dear Ms. Rose Inda:

I am writing this letter on behalf of the Central California Alliance for Health (the Alliance) in support of Salud Para La Gente’s (Salud) Asthma Mitigation Project application to The Center at Sierra Health Foundation.

The Alliance operates the Medi-Cal Managed Care plan serving Medi-Cal beneficiaries in Santa Cruz, Monterey and Merced counties. We work in partnership with Salud to promote prevention, early detection and effective treatment, and improve access to quality health care for those we serve. As a contracted Alliance Primary Care Provider, Salud plays a critical role in providing a patient-centered medical home to approximately 11,000 Alliance members who are linked to Salud for their primary care needs. Salud provides access to comprehensive, culturally competent and quality primary care services to these members.

Salud’s Asthma Mitigation Project will work with providers, social and legal services, the Alliance, and our health information exchange to serve families with language, cultural, and economic barriers to controlling chronic asthma. Salud’s project will adapt best practices, innovate culturally appropriate solutions including virtual in-home visits, and coordinate data-driven care to improve equitable access to care and address root causes including environmental triggers and toxic stress in the home.

Salud and the Alliance work together to improve and ensure access to quality healthcare for our linguistically and culturally diverse community, including the young and elderly. The Alliance is pleased to support Salud’s efforts to reach our region’s most vulnerable residents through its Asthma Mitigation Program.

Sincerely,

Stephanie Sonnenshine  
Chief Executive Officer
Enrollment Report

Year: 2017 & 2018  County: All  Program: IHSS & Medi-Cal
Aid Cat Roll Up: All  Data Refresh Date: 6/1/2020

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

Program County
- SANTA CRUZ
- MONTEREY
- MERCEDE

180K
160K
140K
120K
100K
80K
60K
40K
20K
0K


Medi-Cal  SANTA CRUZ  66,066  65,770  65,633  65,392  65,295  65,069  64,632  64,299  64,588  64,405  64,787  66,036  66,917
MONTEREY  153,913  151,675  150,922  150,695  150,207  149,793  149,282  149,404  151,889  151,843  153,293  154,341  155,631
MERCEDE  121,290  120,860  121,240  121,397  121,325  121,054  120,637  119,874  120,433  120,137  120,643  122,062  123,721
IHSS  MONTEREY  630  624  613  603  601  592  586  585  580  575  572  579  580

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