Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

Meeting Agenda

Wednesday, August 27, 2025

3:00 p.m. – 5:00 p.m.

Location: **In Santa Cruz County**:
Central California Alliance for Health, Board Room
1600 Green Hills Road, Suite 101, Scotts Valley, CA
In Monterey County:
Central California Alliance for Health, Board Room
950 East Blanco Road, Suite 101, Salinas, CA
In Merced County:
Central California Alliance for Health, Board Room
530 West 16th Street, Suite B, Merced, CA
In San Benito County:
Community Services & Workforce Development (CSWD)
CSWD Conference Room
1161 San Felipe Road, Building B, Hollister, CA
In Mariposa County
Mariposa County Health and Human Services Agency
Catheys Valley Conference Room
5362 Lemee Lane, Mariposa, CA

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows. Note: Livestreaming for the public is listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 872-242-9041
    Phone Conference ID: 884 369 938#

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 Monday, August 25, 2025, to the Clerk of the Board at clerkoftheboard@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 three minutes.
    b. In person, from an Alliance County office, during the meeting when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to three minutes.

1. **Call to Order by Chairperson Jimenez. 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 three 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 three 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. – 16C.): 3:30 p.m.

5. **Accept Chief Executive Officer (CEO) Report.**
   - Reference materials: Chief Executive Officer (CEO) Report.

   Pages 5-1 to 5-8

6. **Accept Alliance Dashboard for Q2 2025.**
   - Reference materials: Alliance Dashboard for Q2 2025 Report as above.

   Page 6-1

7. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the six-month ending June 30, 2025.**
   - Reference materials: Financial Statements as above.

   Pages 7-1 to 7-22

8. **Approve the response to the Santa Cruz County Civil Grand Jury (SCCCGJ) Findings and Recommendations published June 26, 2025, and authorize staff to make any final edits in coordination with the County for the purpose of alignment and clarity.**
   - Reference materials: SCCGJ Report as above.

   Pages 8-1 to 8-14

9. **Approve Care-Based Incentive (CBI) 2026 Program Proposal.**
   - Reference materials: CBI 2026 Program Proposal as above.

   Pages 9-1 to 9-3

10. **Approve Medi-Cal contract amendments: CY 25 A.**
    - Reference materials: Medi-Cal contract amendment as above.

    Page 10-1

11. **Approve Medi-Cal contract amendment 23-30273 A 04 State-Only.**
    - Reference materials: Medi-Cal contract amendment as above.

    Page 11-1

12. **Approve Revision to Board Designated Reserve Policy 700-2000.**
    - Reference materials: Revision to Policy 700-2000 as above.

    Pages 12-1 to 12-4

13. **Approve Revision to Quality Improvement and Health Equity Transformation Program (QIHET) Policy 401-1101.**

Pages 13-1 to 13-30

Minutes: (14A. – 14G.):

14A. **Approve Commission regular meeting minutes of June 25, 2025.**
- Reference materials: Minutes as above.

Pages 14A-1 to 14A-6

14B. **Accept Finance Committee Meeting Minutes of March 26, 2025,**
- Reference materials: Finance Meeting Minutes as above.

Pages 14B-1 to 14B-3

14C. **Accept Compliance Committee Meeting Minutes of May 21, 2025 and June 18, 2025.**
- Reference materials: Minutes as above.

Pages 14C-1 to 14C-8

14D. **Approve Whole Child Model Clinical Advisory Committee Meeting Minutes of March 20, 2025.**
- Reference materials: Minutes as above.

Pages 14D-1 to 14D-4

14E. **Accept Whole Child Model Family Advisory Committee Meeting Minutes of May 5th, 2025.**
- Reference materials: Minutes as above.

Pages 14E-1 to 14E-4

14F. **Accept Member Services Advisory Group Meeting Minutes of May 8, 2025.**
- Reference materials: Minutes as above.

Pages 14F-1 to 14F-5

14G. **Accept Quality Improvement Health Equity Committee Meeting Minutes of April 2, 2025.**
- Reference materials: Minutes as above.

Pages 14G-1 to 14G-24

Appointments: (15A. – 15C.)

15A. **Approve appointment of Kristynn Sullivan to Finance Committee.**
- Reference materials: Staff report and appointment letter on above topic.

Page 15A-1

15B. **Approve appointment of Kazzandra Cunningham and Megan Atkinson to the Whole Child Model Family Advisory Committee.**
- Reference materials: Staff report and appointment letter on above topic.

Page 15B-1

15C. **Approve the renewal of Jamie Berry to the Member Services Advisory Group.**
- Reference materials: Staff report and reappointment letter on above topic.

Page 15C-1

Reports: (16A. – 16C.)

16A. **Accept Peer Review and Credentialing Committee Report.**

- Reference materials: Peer Review and Credentialing Committee Report as above.

Page 16A-1

16B. Accept Quality Improvement Health Equity Transformation Q1 2025 Work Plan Report.

- Reference materials: QIHET Q1 2025 Work Plan Report as above.

Pages 16B-1 to 16B-32

16C. Accept UM Q1 2025 Work Plan Report.

- Reference materials: Peer Review and Credentialing Committee Report as above.

Page 16C-1 to 16C-17

Regular Agenda Items: (17. – 19.): 3:30 p.m. – 4:40 p.m.

17. Data Sharing (3:30 p.m. - 3:50 p.m.)

A Mr. Cecil Newton will review Data Sharing.

- Reference materials: Staff report on above topic

Page 17-1

18. Employee Engagement Survey Results and Trends (3:50 p.m. – 4:10 p.m.)

A. Ms. Lisa Artana, Director of Human Resources, will review the latest Employee Engagement Survey Results and Trends

- Reference materials: Staff report on above topic.

Pages 18-1

19. Update on State Budget and Federal H.R.1 (4:10 p.m. – 4:40 p.m.)

A. Mr. Michael Schrader and Ms. Lisa Ba will give an update on the State Budget and H.R.1.

- Reference materials: Staff report on above topic.

Pages 19-1-19-2

Information Items: (20A. – 20F.)

A.	Alliance in the News	Pages 20A-1 to 20A-7
B.	Membership Enrollment Report	Page 20B-1
C.	Alliance Fact Sheet	Pages 20C-1 to 20C-2
D.	Provider Bulletin -June 2025	Pages 20D-1 to 20D-12
E.	Member Newsletter – June 2025 (English)	Pages 20E-1 to 20E-12
F.	Member Newsletter – June 2025 (Spanish)	Pages 20F-1 to 20F-8

Announcements:

Meetings of Advisory Groups and Committees of the Commission

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

- Finance Committee
  Wednesday, October 22, 2025; 1:30-2:45 p.m.
- Member Services Advisory Group
  November 6, 2025; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, September 4, 2025; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [*Remote teleconference only*]
  Thursday, September 18, 2025; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, November 3, 2025; 1:30 – 3:00 p.m.

The above meetings will be held in person unless otherwise noticed.

The next regular meeting of the Commission, after this August 27 meeting, unless otherwise noticed:

Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
Wednesday, September 24, 2025; 3:00 – 5:00p.m.

Locations for the meeting (linked via videoconference from each location):

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

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

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

In San Benito County:
Community Services & Workforce Development (CSWD)
1161 San Felipe Road, Building B, Hollister, CA

In Mariposa County:
Mariposa County Health and Human Services Agency
5362 Lemee Lane, Mariposa, CA

Members of the public interested in attending should call the Alliance at (831) 430-2568 to verify meeting date and location prior to the meeting.

The complete agenda packet is available for review on the Alliance website at https://thealliance.health/about-the-alliance/public-meetings/. 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) 430-2568. 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 August 27, 2025

TO Governing Commission of the Central California Alliance for Health

FROM Michael Schrader, Chief Executive Officer

SUBJECT CEO Report

Government Relations. The Alliance as a public entity that administers a public benefit program, is impacted by Federal and State legislation, policy, and funding. As such, we closely monitor, inform, and advocate at the local, state, and federal levels.

State Budget and H.R. 1. On July 1 and July 4, respectively, the 2025–26 State Budget and the Federal Reconciliation Bill H.R. 1 were signed into law by the Governor and the President. These spending measures include provisions that significantly affect the Medi-Cal program, Staff, in collaboration with our trade associations, are actively reviewing and analyzing these provisions to assess their impact on Medi-Cal enrollment, program operations, and financial resources. An update will be provided to the board at the August 27 meeting.

DHCS Medi-Cal Transformation Concept Paper. DHCS released its Continuing the Transformation of Medi-Cal Concept Paper on July 23, initiating a 30-day public comment period. This paper outlines DHCS's strategic vision for Medi-Cal beginning in 2027, following the expiration of the current 5-year CalAIM federal waivers on December 31, 2026. It provides a historical overview of significant Medi-Cal reforms over the past two decades, highlights current priorities and progress achieved under CalAIM, and details the initiatives for which the state plans to seek renewed federal authority to continue beyond 2026.

Provider Network. The Alliance maintains contracts with thousands of providers across and beyond the five counties we serve. Our network includes hospitals, primary care clinics, specialists, ancillary service providers, and long-term-care facilities, ensuring comprehensive access to care for our members.

Planned Parenthood. The Federal Reconciliation Bill H.R. 1 includes provisions that prohibit Medicaid reimbursements to "Prohibited Entities" which include health care organizations meeting specific criteria that align with the profile of Planned Parenthood.

On July 24, 2025, two Planned Parenthood clinics contracted with the Alliance, Gilroy and Santa Cruz Downtown/Westside, closed their doors, and a third clinic in Watsonville discontinued its primary care services.

The Alliance is notifying more than 1,000 Medi-Cal members previously assigned to the Santa Cruz Downtown/Westside clinic, and over 1,100 members currently assigned to the Watsonville clinic, that they will need to select a new primary care provider. Members who

do not make a selection will be automatically assigned to a local clinic. Three partner clinics, Salud Para La Gente, Santa Cruz Community Health Centers, and Santa Cruz County Health Services Agency (HSA), have offered to accept these member assignments.

Planned Parenthood's Watsonville, Salinas, and Seaside clinics will continue to offer specialty services, including reproductive health and abortion care.

The Alliance will continue to reimburse providers, including Planned Parenthood, for abortion care services, as these are covered under our secondary contract with DHCS. This contract encompasses state-supported services that are independent of federal Medicaid funding. Additionally, the Alliance will maintain reimbursement for all other services provided by contracted Planned Parenthood clinics throughout the duration of the applicable court injunction related to H.R.1.

The Alliance will also continue to reimburse family planning services delivered by providers that do not meet the H.R.1 definition of "Prohibited Entities," including Federally Qualified Health Centers (FQHCs).

Community Engagement, Health Education, and Marketing. The Alliance is a local plan that is invested in the communities we serve across our five counties.

Community Engagement

Members Who May Be Hesitant. As we navigate an evolving landscape, the Alliance remains committed to refining our outreach strategies to foster meaningful connections, particularly with members who may feel hesitant or uncertain about engaging. By meeting individuals where they are, we aim to build trust, address concerns, and create inclusive pathways for participation.

Summer School Lunch Distribution Programs. This summer, the Alliance launched a series of pop-up tabling events in collaboration with school lunch distribution programs throughout our service area. These events were intentionally designed to meet families in familiar, trusted settings, offering information and support in a welcoming, low-pressure environment.

Back To School Events. The Alliance participated in several back-to-school events, including the Mariposa Back to School Resource Fair, Dignity's Build a Backpack event in Merced, and the Special Resource Conference in Salinas. These engagements allowed us to foster connection, build trust, and ensure that families had access to the resources they need as the school year begins.

Alliance/County Leadership Meetings. The Alliance has conducted mid-year check-ins with leadership teams across each of our partner counties. These collaborative discussions have

been helpful to aligning local priorities, identifying emerging community concerns, and reinforcing the foundation for stronger partnerships and sustained engagement.

Health Education

Member Workshops. This year, the Alliance Health Education team has delivered 33 member workshops, offering programs in a variety of formats, including virtual, telephonic, and in-person sessions, to meet members where they are. Workshops are available in both English and Spanish and are offered throughout the year. Current programs include:

- Healthier Living Program: Offers education and support for members managing chronic conditions.
- Live Better with Diabetes Program: Supports members diagnosed with diabetes or prediabetes through targeted education and resources.
- Healthy Weight for Life Program: Provides parents and guardians of Alliance pediatric members with guidance on healthy eating, physical activity, and effective parenting strategies.

Marketing and Communications

Bilingual Brand Awareness Campaign. In July, the Alliance launched a bilingual brand awareness campaign with a targeted paid media focus in Merced County. The campaign reinforces the Alliance's trusted local presence, deep expertise, and longstanding role as the region's Medi-Cal plan. Outreach tactics include digital advertising, placements in Motor Vehicle Division (MVD) offices, radio spots, and social media engagement. The campaign will continue through the end of the year.

Alliance's Merced Health Fair. The Alliance's Merced Health Fair is scheduled for October. In the lead-up to the event, promotional efforts will begin to roll out in September, including flyers, website updates, targeted social media posts, text message outreach, and radio advertisements. On the morning of the fair, the event will feature live radio broadcasting on-site to amplify community engagement and visibility.

TotalCare HMO D-SNP. The team is actively advancing marketing and communications efforts to support the launch of the Alliance's Medicare program, TotalCare HMO D-SNP. The strategy includes a comprehensive mix of tactics:

- Sales materials and event support
- Direct mail postcards to all dual-eligible individuals
- Newsletter articles and social media outreach

A dedicated TotalCare website is also in development, with a focus on delivering a seamless experience for members at go-live.

NCQA Accreditations. The team has made significant progress in integrating our NCQA accreditation across branded materials. Updates have been completed for the Alliance

website, Fact Sheet, press release, PowerPoint templates, email newsletters, and email signatures. Materials currently in development include Member and Provider Bulletins, corporate letterhead, and social media profiles to ensure consistent branding and visibility.

Outbound Text Messages. The Alliance sent nearly 77,000 text messages to members in July related to new member welcome, new mothers, behavioral health and eligibility redeterminations.

Alliance Workforce. Our robust culture is built on the premise that the Alliance exists to serve members, and most of our employees live in the communities we serve across our five counties. To enrich our culture there are All-Staff meetings, interactive town halls, coffee talks with executives, annual employee engagement surveys, and biannual performance reviews.

Staffing Numbers. As of July 28, 2025, the Alliance has 730 budgeted positions, of which 666 are filled. Moreover, the Alliance has 58 temporary employees supporting our workforce needs. In total, the organization is 88% staffed.

Long-Term Staffing Strategy. In response to the FY2025/26 state budget and the Federal Reconciliation Bill H.R. 1, the Alliance anticipates a 22% reduction in Medi-Cal enrollment over the next four calendar years. This decline is expected to unfold in two distinct phases.

Our long-term staffing strategy is designed to align our full-time equivalent (FTE) count with this projected membership reduction, while preserving Regular staff positions.

Phase I (Now through 2026)

- Experience a gradual membership decline of approximately 6%
- Eliminate vacant positions where and when appropriate
- Backfill vacancies with contractors, temporary personnel, and defined-term employees where and when possible

Phase II (2027–2028):

- Experience sharper membership declines: ~9% in 2027 and ~8% in 2028
- Backfill vacancies with contractors, temporary personnel, and defined-term employees where and when possible
- Eliminate selective contractor and temporary roles, as needed
- Allow defined-term roles to expire without renewal, as needed

This strategy was shared with all employees during a recent Town Hall and reinforced through follow-up written communication.

Importantly, this strategy reflects our current understanding based on available information. As new information and guidance become available from DHCS and CMS, our membership projections, and corresponding staffing plans, may evolve. We remain committed to keeping employees informed as updates arise.

The long-term staffing strategy will be covered at the August 27, 2025 board meeting as part of the presentation on the State Budget for FY2025/26 and Federal Reconciliation Bill H.R. 1.

Implementation of Long-Term Staffing Strategy, As part of our long-term staffing strategy, we have initiated a temporary pause and review of current recruitments during the month of August. During this period, department directors were asked to assess their current vacancies based on business need and to identify roles that may be appropriately hired using contractors, temporary staff, or defined-term positions as part of our ongoing staffing efforts.

Mid-Year Evaluations. The Alliance conducts two formal check-in cycles per year – one at mid-year and one at year end. All supervisors are expected to actively participate in the process by providing meaningful feedback in key areas, including goal progress, strengths, and any identified focus areas for development or improvement. Supervisors also assess core competencies, job relates competencies and leadership competencies, if applicable. Supervisors completed mid-year check-ins in July 2025.

Alliance Two-Year Marathon (2024-2025) to Implement Six Priority Initiatives. Our two-year marathon has involved a heavy organizational workload, competing priorities, regulatory submissions, and strict deadlines. Despite these challenges, the Alliance team has been motivated by the chance to more fully and better serve our members.

The team has made tremendous progress, successfully completing five-of-the-six initiatives to date.

- ECM Enrollment: In 2024, we increased ECM enrollment sixfold, with continued growth into 2025. The percentage of our Medi-Cal members enrolled in ECM now surpasses that of nearly all other Medi-Cal managed care plans.
- Quality & Health Equity: In 2024, in collaboration with 15 clinics across Merced County, the Alliance improved quality scores, reflecting higher percentages of children receiving preventative care, including immunizations, lead screenings, and well-child visits.
- Jiva Care Management System: In the summer of 2024, the team successfully completed a major systems conversion to the Jiva Care Management System, enhancing our operational capabilities
- NCQA Accreditations: In the summer of 2025, the Alliance achieved two NCQA accreditations: Health Plan Accreditation and Health Equity Accreditation.
- BH Insourcing: On July 1, 2025, the Alliance team successfully brought the behavioral health benefit in-house, granting us direct control and a better opportunity to improve access for members, support providers, and collaborate with counties and schools

One initiative remains active.

- TotalCare HMO D-SNP – The Alliance is preparing to launch a Medicare Dual Special Needs Plan (D-SNP) by January 1, 2026. This new product will enable the Alliance to serve as a single, comprehensive plan for individuals eligible for both Medi-Cal and Medicare, including low-income seniors and people with disabilities. Key highlights since the last CEO Report include implementation of provider trust tool to streamline provider credentialing verification, updating website content, and execution of the State Medicaid Agency Contract (SMAC). Additionally, the team is currently implementing various other systems to manage the DSNP product, including Cozeva

for risk adjustment, Market Prominence for member enrollment, and Edifecs for encounter management.

Regulatory Audits and Compliance. The Alliance has structured processes to ensure that we operate in an ethical and compliant manner, so that we protect our members' rights. Like all Managed Care Plans, the Alliance is in a continuous state of preparing routine audits, experiencing them, or following up on regulators' requests. Following is a summary of regulatory audit activity that occurred since my last report.

2025 DHCS Medi-Cal Audit. DHCS auditors conducted a limited scope annual audit in January of 2025, and preliminary results were shared with the Alliance in May of 2025. The Preliminary Findings Report included only two findings, related to resolution of quality grievance, oversight of grievance and appeals, which the plan did not dispute. We received the DHCS' Final Findings Report on June 5, 2025. On July 18,2025, we provided the DHCS with our corrective action plan (CAP). As part of the CAP process, we must provide DHCS with monthly updates on our progress toward correction. We anticipate fully correcting our deficiencies and closing this CAP well in advance of the DHCS' 6-month corrective action timeline.

2025 DMHC Financial Examination. DMHC auditors initiated their virtual audit in January of 2025, reviewing the Alliance's fiscal and administrative affairs, including claims payment practices. We received our Preliminary Findings Report in June 2025, in which there were three findings related to Claims, Provider Disputes, and our Anti-FWA Plan filing. On July 18, 2025, we submitted our preliminary response addressing the DMHC's findings. Currently, we are awaiting the DMHC's Final Report.

2025 DMHC Medical Survey. We received DMHC's preliminary report from its 2024 Medical Survey of the Alliance that occurred in March 2024. Agenda item 10, There were preliminary audit findings in the areas of Grievances, Utilization Management, Pharmacy, and Behavioral Health. As is standard process, we accepted certain findings as opportunities to improve and have clarified or contested others. We provided the DMHC with our response in May 2025.

2025 DHCS Network Adequacy Validation Audit. DHCS contracts with the Health Services Advisory Group (HSAG) to assess whether the Alliance is able to meet the DHCS' time and distance standards for provider access. This audit, which will occur (virtually) on August 25, 2025, reviews the Alliance's data systems, methodologies, and outputs to ensure we're accurately calculating and reporting our provider network adequacy.

MCAS/HEDIS Update**.** Health Services Advisory Group (HSAG) completed the Measurement Year 2024 HEDIS® compliance audit for the Alliance on June 13, 2025. In accordance with the July 15 regulatory deadline, HSAG submitted the final audit reports to both NCQA and DHCS, which accepted the filings without requesting any corrective action—affirming the Alliance's ongoing adherence to NCQA audit standards and state reporting requirements. In accordance with DHCS' shift to plan-level reporting across all counties, the Alliance reported results for 50 measure indicators, attained high-performance status on 10 of them, and exceeded the minimum-performance level (MPL) on 32 measure indicators, demonstrating robust quality outcomes under the expanded aggregate evaluation framework. Compared to the prior year, the measures Immunizations for Adolescents - Combo 2, Lead Screening in Children, and Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits also increased above the MPL in Merced County.

Alliance Medi-Cal Capacity Grant Program (MCGP). The Alliance makes investments to strengthen health care and community organizations across the five counties we serve. The purpose is to pursue the Alliance's vision of heathy people and healthy communities. These investments focus on increasing the availability, quality and access of health care and supportive resources for Medi-Cal members. They also address social drivers that influence health and wellness.

Trends in the Number of Awards and Total Spend. The MCGP has paid out $19M to date for calendar year 2025. New MCGP awards year-to-date in the five-county service area total $21M, which is 60% of the 2025 total award amount target of $35M. The application deadline for the third and final funding round in 2025 is August 19, 2025 with award decisions on October 31, 2025. Details of all 2025 awards will be included in the mid-year report in the September 2025 Board packet and in the end-of-year report in the January 2026 Board packet.

DHCS Incentive Programs. As of December 2024, DHCS sunset three incentive programs. The Alliance continues to provide funding awards to community partners with any remaining funds.

CalAIM Incentive Payment Program (IPP). The Alliance earned a total of $47.8 million from IPP. Supplemented by the Alliance's Medi-Cal Capacity Grant Program (MCGP), a total of $48.4M has been awarded through IPP to help new ECM and CS providers launch their programs and assist existing ECM providers in expanding into new counties or targeting new populations. The remaining funds available are currently earmarked for future Transitional Rent provider IPP awards. Transitional Rent is a new Community Support that will be offered effective January 1, 2026.

Housing and Homeless Incentive Program (HHIP) / Alliance Housing Fund. The Alliance earned a total of $40.8 million from HHIP and is winding down with only three remaining open awards to county agencies. A large portion of HHIP funds along with a contribution from the MCGP were combined to create the Alliance Housing Fund which awarded $42.4M for transitional and permanent housing projects across the five-county service area. There are no remaining funds to award. Staff continue to execute Letters of Agreements for approved projects, as well as an agreement with Housing Accelerator Fund which will administer a pilot revolving loan program using Alliance Housing Fund dollars to support new housing developments in Santa Cruz County.

Student Behavioral Health Incentive Program (SBHIP). SBHIP closed June 2025 upon distribution of the final payments. In all, the Alliance earned and distributed 100% of DHCS allocation ($12.6M) for SBHIP. Going forward, the Alliance's Behavioral Health team will manage the Alliance's relationships with local education agencies for next steps associated with Children and Youth Behavioral Health Incentive (CYBHI) Fee Schedule, as well as next steps associated with 2026 MOU requirements (APL 23-029).

Q2 2025 Organizational Dashboard. The Q2 2025 Organizational Dashboard provides a structured overview of the organization's performance for the second quarter of the year. It is included in this month's Board packet under Agenda Item 6.

The Dashboard monitors four core processes, each consisting of multiple subprocesses:

- **Engage and Support Members**
- **Manage and Improve Care**
- **Develop and Maintain the Provider Network**
- **Pay Providers** (which fell below the performance threshold this quarter)

Cybersecurity. The Alliance takes a comprehensive approach to safeguarding our members' protected health information (PHI) through advanced technologies, robust practices, and strict policies. We proactively address cyber threats and are committed to continuously improving and strengthening our security posture.

Here are key insights from the Q2 2025 Security Office Report:

Key Achievements:

- Implementation of advanced threat detection systems.
- Network Segmentation: Contracting and licensing activities extended into Q2, delaying implementation. Technical kickoff is now scheduled for early Q3.
- Privileged Access Management (PAM): Project entered the pre-implementation phase, with prerequisites nearly complete. A formal deployment roadmap is under development to improve control over privileged accounts.
- HIPAA/NIST Gap Assessment: Vendor selection continued. Q4 launch is targeted, though options to accelerate the timeline are being explored.
- Cybersecurity Response Plan (CIRP): Policy design is complete, and implementation is underway. Scenario-based runbooks are being developed in line with NIST 800-61r2 and CSF guidance, with a focus on ransomware response.
- Identity and Access Management (IAM): IAM efforts progressed with workflow design for onboarding and offboarding, and Okta integration planning is on track for Q3 Phase I completion.

Challenges:

- Addressing the increasing sophistication of cyber threats.
- Ensuring continuous compliance with evolving regulatory standards.
- Managing the integration of new security technologies with existing systems.

Future Plans:

- Expand the scope of security audits to include third-party vendors.
- Implement a comprehensive incident response plan.
- Continue to enhance employee training programs on cybersecurity awareness.
- Invest in advanced security technologies to stay ahead of emerging threats.

Alliance Dashboard

Quarter 2, 2025

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%.

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

Core Processes

Deliver value to our members, providers and community

98.3% Of Target

Manage & Improve Care

SUBPROCESSES
- Manage Care Use
- 100 Improve Care

82.0% Of Target

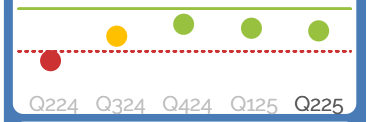
Pay Providers

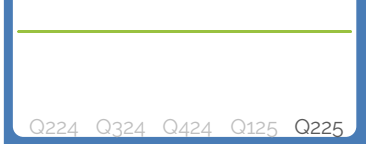
SUBPROCESSES
- 100 Payment Models and Rates
- Provider Payments
- Payment Integrity
- 61.8 Incentivize Providers

Managerial Processes

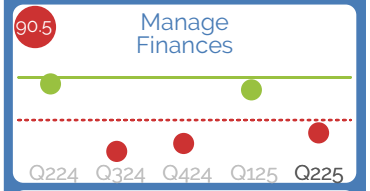
Guide core and support processes

96.4 Enhance Operational Effectiveness

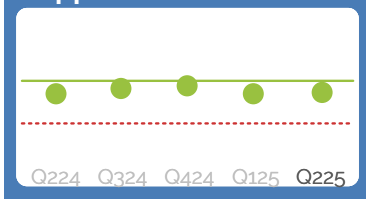


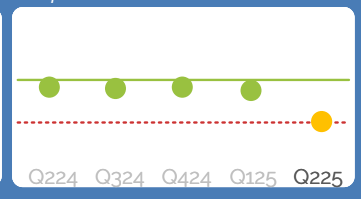


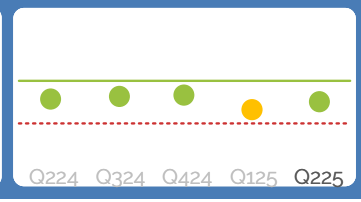
90.5 Manage Finances

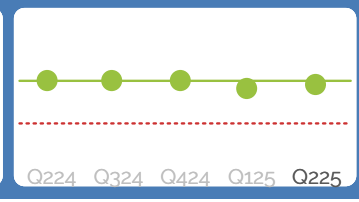


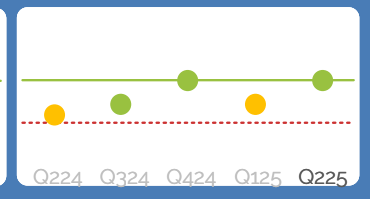
Support Processes *Enable core processes to work*











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DATE: August 27, 2025

TO: Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Sixth Month Ending June 30, 2025

For the month ending June 30, 2025, the Alliance reported an Operating Loss of $2.0M. The Year-to-Date (YTD) Operating Loss is $14.7M with a Medical Loss Ratio (MLR) of 96.2% and an Administrative Loss Ratio (ALR) of 5.1%. The Net Income is $7.6M after accounting for Non-Operating Income/Expenses.

The budget expected an Operating Loss of $16.6M for YTD June. The actual result is favorable to the budget by $1.9M or 11.2%, driven by rate variances.

	Jun-25 MTD ($ In 000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
**Membership*	*444,968*	*438,804*	*6,164*	*1.4%*
Revenue	$190,601	$173,831	$16,771	9.6%
Medical Expenses	183,655	167,769	(15,886)	-9.5%
Administrative Expenses	8,915	10,207	1,291	12.6%
Operating Income	(1,970)	(4,145)	2,176	52.5%
Net Income	$2,061	($2,844)	$4,905	100.0%
MLR %	96.4%	96.5%	0.1%	
ALR %	4.7%	5.9%	1.2%	
Operating Income %	-1.0%	-2.4%	1.4%	
Net Income %	1.1%	-1.6%	2.7%	

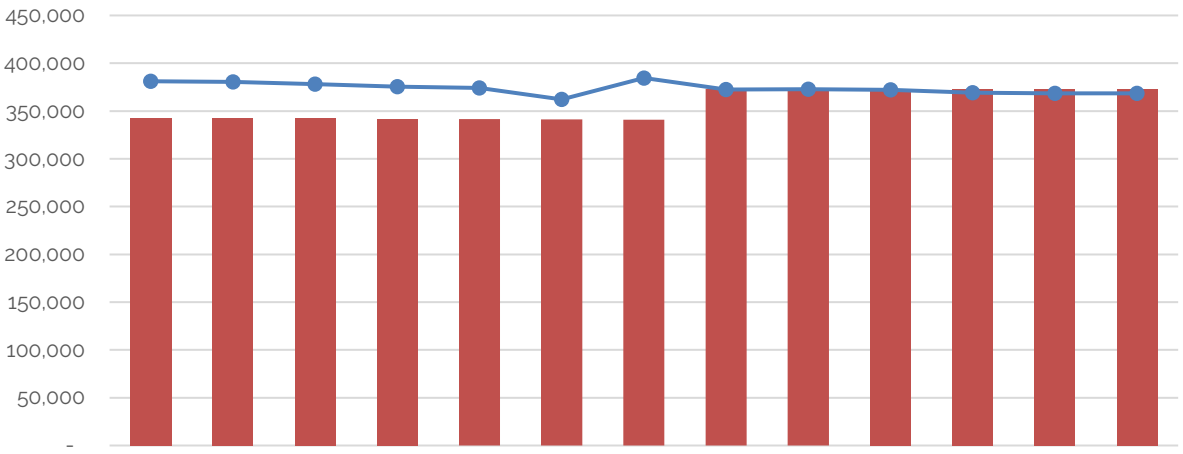
Jun-25 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*2,672,270*	*2,632,908*	*39,362*	*1.5%*
Revenue	$1,137,368	$1,042,986	$94,383	9.0%
Medical Expenses	1,093,665	1,001,576	(92,089)	-9.2%
Administrative Expenses	58,401	57,966	(435)	-0.8%
Operating Income/(Loss)	(14,697)	(16,556)	1,858	11.2%
Net Income/(Loss)	$7,583	($5,207)	$12,791	100.0%
PMPM				
Revenue	$425.62	$396.13	$29.48	7.4%
Medical Expenses	409.26	380.41	(28.86)	-7.6%
Administrative Expenses	21.85	22.02	0.16	0.7%
Operating Income/(Loss)	($5.50)	($6.29)	$0.79	12.5%
MLR %	96.2%	96.0%	-0.2%	
ALR %	5.1%	5.6%	0.5%	
Operating Income %	-1.3%	-1.6%	0.3%	
Net Income %	0.7%	-0.5%	1.2%	

Per Member Per Month: Capitation revenue and medical expenses are variables based on enrollment fluctuations; therefore, the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not usually correspond with enrollment and should be evaluated at the dollar amount.

At a PMPM level, revenue is $425.62, which is favorable to budget by $29.48 or 7.4%. Medical cost PMPM is $409.26, which is unfavorable by $28.86 or 7.6%. This results in a favorable gross margin of $0.63 or 4.0% compared to the budget. The operating loss PMPM is ($5.50), compared to the budget of ($6.29).

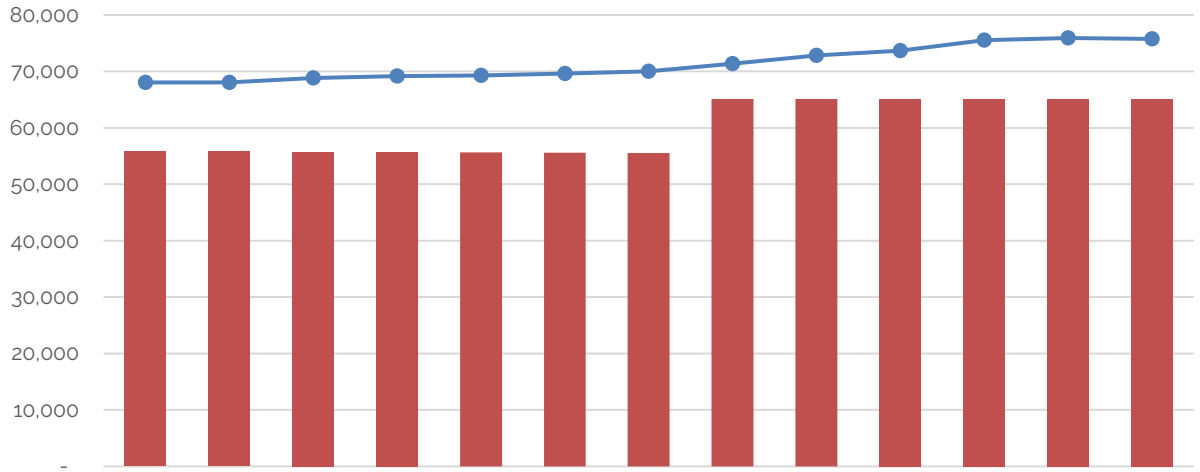
Membership: June 2025 membership is favorable to the budget by 1.4%. The 2025 budget assumed a flat budget with 438k members per month for all of 2025. Please note that SIS membership continues to decline through the redetermination process, while UIS enrollment has shown consistent growth but began to soften in June.

SIS Membership



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Budget	342,976	342,635	342,293	341,952	341,610	341,268	340,927	373,030	373,030	373,030	373,030	373,030	373,030
Actual	381,173	380,535	378,241	375,458	374,061	362,135	384,572	372,395	372,699	372,081	369,053	368,416	368,576
Var	38,197	37,900	35,948	33,506	32,451	20,867	43,645	(635)	(331)	(949)	(3,977)	(4,614)	(4,454)
Var %	11.1%	11.1%	10.5%	9.8%	9.5%	6.1%	12.8%	-0.2%	-0.1%	-0.3%	-1.1%	-1.2%	-1.2%

UIS Membership



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Buget	55,837	55,788	55,739	55,691	55,642	55,594	55,545	65,096	65,096	65,096	65,096	65,096	65,096
Actual	68,054	68,045	68,841	69,181	69,289	69,632	69,990	71,363	72,834	73,668	75,528	75,909	75,742
Var	12,217	12,257	13,102	13,490	13,647	14,038	14,445	6,267	7,738	8,572	10,432	10,813	10,646
Var %	21.9%	22.0%	23.5%	24.2%	24.5%	25.3%	26.0%	9.6%	11.9%	13.2%	16.0%	16.6%	16.4%

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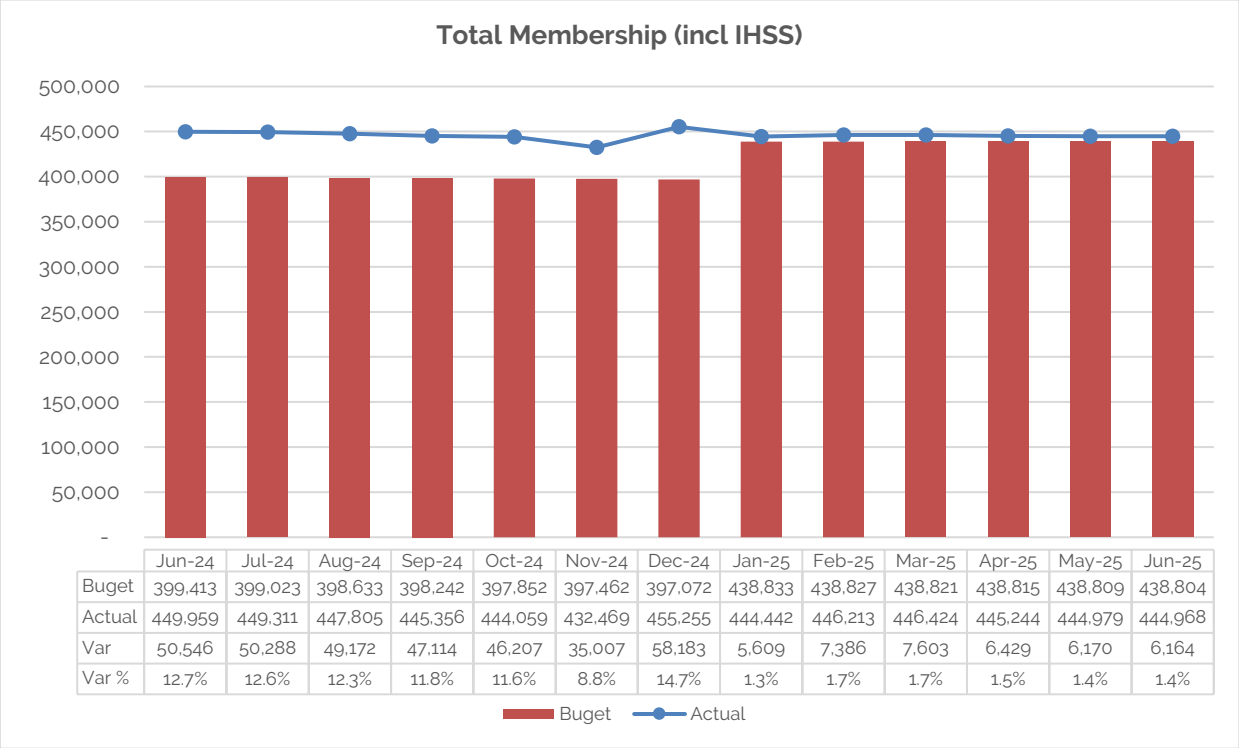

	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Buget	399,413	399,023	398,633	398,242	397,852	397,462	397,072	438,833	438,827	438,821	438,815	438,809	438,804
Actual	449,959	449,311	447,805	445,356	444,059	432,469	455,255	444,442	446,213	446,424	445,244	444,979	444,968
Var	50,546	50,288	49,172	47,114	46,207	35,007	58,183	5,609	7,386	7,603	6,429	6,170	6,164
Var %	12.7%	12.6%	12.3%	11.8%	11.6%	8.8%	14.7%	1.3%	1.7%	1.7%	1.5%	1.4%	1.4%

Revenue: The 2025 revenue budget was based on the Department of Health Care Services (DHCS) 2025 draft rate package (dated 10/21/24), which reflected a –0.1% rate decrease, over the CY 24 Final Amended rates (dated 12/30/24), not including the Targeted Rate Increase (TRI) and Enhanced Care Management (ECM). Furthermore, the budget assumed breakeven performances for the San Benito Region and for our Unsatisfactory Immigrant Status (UIS) population. The CY 2025 Prospective rates from DHCS (dated 1/27/2025, including Maternity) represented a 5.0.% increase over CY 2024 Final Amended Rates, excluding TRI and ECM.

Jun-25 YTD Capitation Revenue Summary (In $000s)

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	$837,595	$786,561	$51,034	12,694	38,340
CEC UIS	237,684	209,534	28,149	3,106	25,043
SBN SIS	47,596	34,446	13,150	820	12,330
SBN UIS	9,426	9,943	(517)	(1,343)	826
Total*	**$1,132,301**	**$1,040,484**	**$91,817**	**$15,278**	**$76,539**

*Excludes Jun-25 In-Home Supportive Services (IHSS) premiums revenue of $2.8M and State Incentive Revenue of $2.3M.

As of June, actuals exceeded the budget by $16.8M, representing a 9.6% positive variance. This is driven by favorable enrollment, which contributes $2.6M, and rate variances totaling $14.2M, resulting from increases in prospective rates compared to the budget. Additionally, a portion of the favorable rate variance was offset by risk corridors, including a $0.6M

payable related to the UIS Risk Corridor. The ECM Risk Corridor, which was already budgeted at $7.0M, contributed $0.5M in favorable impact this month with a total ECM Risk Corridor of $7.5M for June. Please note that the ECM expenses are higher than the budget, and the net loss is limited to 5% of the ECM revenue.

As of June 2025 YTD, operating revenue stands at $1,137.4M, surpassing the budget by $94.4M or 9.0%. This favorable variance includes $15.2M from increased enrollment and $79.2M from positive rate variances.

Medical Expenses: The 2025 budget assumed a 3.3% increase in utilization over the 2024 forecast, based on data from 2022 through September 2024, and a 4.2% increase in unit cost driven by changes in case mix and fee schedule adjustments. 2025 incentives include a $20M for the Hospital Quality Incentive Program (HQIP), $15M Care-Based Incentive (CBI), $12.5M for the Specialist Care Incentive (SCI), $4M Data Sharing Incentives, $3.7M Behavioral Health Value Based Program (BH VBP) and $1M Risk Adjustment Incentives.

Jun-25 YTD Medical Expense Summary ($ In 000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	$304,448	$284,865	($19,583)	($4,251)	($15,332)
Inpatient Services - LTC	106,115	102,676	(3,440)	(1,506)	(1,933)
Physician Services	242,993	255,930	12,937	(3,847)	16,784
Outpatient Facility	127,068	110,309	(16,759)	(1,644)	(15,115)
ECM	81,575	54,809	(26,767)	(824)	(25,943)
Community Supports	38,632	20,228	(18,404)	(304)	(18,100)
Behavioral Health	43,870	43,528	(342)	(653)	311
Other Medical*	146,653	129,232	(17,421)	(1,898)	(15,523)
State Incentives	2,310	-	(2,310)	-	(2,310)
TOTAL COST	$1,093,665	$1,001,576	($92,089)	($14,928)	($77,161)

*Other Medical actuals include Allied Health, Non-Claims HC Cost, Transportation, and Lab.

June 2025 Medical Expenses of $183.7M are $15.9M or 9.5% unfavorable to the budget. June 2025 YTD Medical Expenses of $1,093.7M are above budget by $92.1M or 9.2%. Of this amount, $14.9M is due to higher enrollment, and $77.2M is due to rate variances. The unfavorability is primarily driven by ECM, and Community Supports (CS) from the higher-than-budget enrollment, followed by the Other Medical category, specifically from transportation and Hospice.

At a PMPM level, YTD Medical Expenses are $409.26, unfavorable by $28.86 or 7.6% compared to the budget.

Jun-25 YTD Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$113.93	$108.19	($5.73)	-5.3%
Inpatient Services - LTC	39.71	39.00	(0.71)	-1.8%
Physician Services	90.93	97.20	6.27	6.5%
Outpatient Facility	47.55	41.90	(5.65)	-13.5%
ECM	30.53	20.82	(9.71)	-46.6%
Community Supports	14.46	7.68	(6.77)	-88.2%
Behavioral Health	16.42	16.53	0.12	0.7%
Other Medical	54.88	49.08	(5.80)	-11.8%
State Incentives	0.86	-	(0.86)	-100.0%
TOTAL MEDICAL COST	**$409.26**	**$380.41**	**($28.86)**	**-7.6%**

Inpatient Services: Inpatient Services remain slightly unfavorable to budget due to the prior period adjustments, including high-dollar claims, which also increased incurred but not reported (IBNR) by $4.9M in June to account for Q1 activity. Excluding these prior-year adjustments, the 2025 YTD PMPM stands at $108.99, slightly above the budgeted $108.19. This suggests prior year costs were under budgeted, but the rest of 2025 is expected to align with projections.

Inpatient Services—Long Term Care (LTC): LTC utilization trends slightly lower than budget, this is offset by increases in 2025 rates, which came in slightly higher than budgeted. June results are generally consistent with the budget.

Physician Services: Favorability is influenced by lower utilization of the Targeted Rate Increase (TRI) and Provider Supplemental Payment (PSP) budgets. DHCS will add new provider types to TRI eligibility in 2025, which is expected to improve budget alignment as more TRI-eligible payments are processed. Currently, just over half of the TRI budget is utilized for Primary Care. Please note that the Specialty Physicians category includes a $52M supplemental payment in 2025, funded by Board-approved reserves, with an estimated $25.8M to be utilized as of June YTD.

Outpatient Facility: The Outpatient Facility category consists of both Outpatient and Emergency Room (ER) services. ER continues to show an upward trend in both utilization per 1k and unit cost, as expected. Outpatient continues to come in above budget due to higher utilization for all of 2025, including significantly higher utilization in January. Combined on an incurred basis, YTD PMPM actuals are $44.74 vs budgeted at $39.21, with outpatient being underbudgeted so far in 2025.

ECM: The ECM budget for 2025 was based on a cautious enrollment growth projection with an anticipated 15.4k enrollments by year-end, as the program is on its path toward stabilization. However, ECM enrollments started the year at 16k and have increased to 21k

by May but softened to 20k in June. Before adjusting for the risk corridor, ECM's YTD loss through June is $55.6M. It is projected to total approximately $117M for the whole year based on our revised enrollment growth assumptions and recent enrollment softening. The risk corridor will mitigate $109.9M, resulting in a net loss of $7.4M.

Community Supports: Enrollments for the Community Support (CS) program were modestly budgeted due to its newness and limited history. Since the budget preparation, there has been a significant increase in CS enrollments. The YTD 2025 PMPM expense is trending at $15.08, 90% higher than the budget and 75% higher than the revenue PMPM of $8.51. June enrollments slightly decreased but continued to trend at 24k. As a result, our monthly loss for CS is averaging $3M, with a YTD loss of $17.5M through June. Based on current trends, full-year losses may surpass the initially projected $26M to $31.5M. We expect the unfavorable variance in ECM and CS to continue throughout the year.

We have actively engaged with the State, sharing this most recent ECM and CS data to underscore the need for rate adjustment, as the current revenue is insufficient to offset the higher expenses.

Behavioral Health: Behavioral Health is tracking closely to budget, as the Targeted Rate Increase (TRI) dollars have been appropriately incorporated starting in March and for all subsequent months. The budget also accounts for anticipated growth in utilization and unit cost in the second half of the year, in preparation for the planned transition to bring Behavioral Health services in-house.

Other Medical: The Other Medical category is over budget primarily due to increased utilization and higher unit costs. Transportation is the largest contributor, which accounts for a $10.5M unfavorable variance. This is driven by higher utilization in Non-Medical Transportation and increased unit costs in both Air Transportation and Non-Emergency Medical Transportation (NEMT). The higher NEMT costs reflect add-on payments associated with bariatric transport, which require specialized equipment and support. Hospice services contributed a $4.1M variance driven by higher-than-expected utilization and under-budgeted unit costs. Additionally, Allied Health accounted for a $3.3M variance, primarily due to increased utilization of physical therapy services. These factors account for the majority of unfavorable variance in the Other Medical category.

Administrative Expenses: June YTD Administrative Expenses are unfavorable to the budget by $0.4M or 0.8% with 5.1% ALR. Salaries are unfavorable by $0.1M due to temporary services and medical allocation. Non-salary administrative expenses are unfavorable by $0.3M, or 1.6%, due to the timing of actuals versus budget under Professional Fees and Supplies & Other.

Non-Operating Revenue/Expenses: June YTD Net Non-Operating Income is $22.3M, which is favorable to budget by $10.9M. The favorability is from the YTD Investment Income of $34.9M, which is favorable to the budget by $8.7M due to the higher interest rates. The YTD Other Revenue is $1.3M and is above budget by $0.2M. The YTD Non-Operating Expense is $13.9M, mainly from the grant distribution. This is favorable to budget by $2.1M.

Summary of Results: Overall, the Alliance generated a YTD Net Income of $7.6M, with an MLR of 96.2% and an ALR of 5.1%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Sixth Month Ending June 30, 2025
(In $000s)

Assets	
Cash	$92,172
Restricted Cash	300
Short Term Investments	943,235
Receivables	392,637
Prepaid Expenses	3,508
Other Current Assets	4,296
Total Current Assets	**$1,436,147**
Building, Land, Furniture & Equipment	
Capital Assets	$83,239
Accumulated Depreciation	(48,554)
CIP	2,126
Lease Receivable	4,133
Subscription Asset net Accum Depr	13,214
Total Non-Current Assets	**54,157**
Total Assets	**$1,490,305**
Liabilities	
Accounts Payable	$204,451
IBNR/Claims Payable	355,766
Provider Incentives Payable	31,271
Other Current Liabilities	11,724
Due to State	(26,158)
Total Current Liabilities	**$577,055**
Subscription Liabilities	10,590
Deferred Inflow of Resources	3,899
Total Long-Term Liabilities	**$14,489**
Fund Balance	
Fund Balance - Prior	$891,178
Retained Earnings - CY	7,583
Total Fund Balance	**898,761**
Total Liabilities & Fund Balance	**$1,490,305**
Additional Information	
Total Fund Balance	**$898,761**
Board Designated Reserves Target	526,744
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	139,176
Value Based Payments	46,100
Provider Supplemental Payments	140,096
Total Reserves	**908,816**
Total Operating Reserve	**($10,055)**

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Sixth Month Ending June 30, 2025
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*444,968*	*438,804*	*6,164*	*1.4%*	*2,672,270*	*2,632,908*	*39,362*	*1.5%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$190,149	$173,422	$16,727	9.6%	$1,132,301	$1,040,484	$91,817	8.8%
State Incentive Programs	(0)	-	(0)	0.0%	2,310	-	$2,310	100.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	$0	0.0%
Premiums Commercial	452	409	43	10.6%	2,757	2,502	256	10.2%
Total Operating Revenue	**$190,601**	**$173,831**	**$16,771**	**9.6%**	**$1,137,368**	**$1,042,986**	**$94,383**	**9.0%**
Medical Expenses								
Inpatient Services (Hospital)	$49,319	$47,717	($1,602)	-3.4%	$304,448	$284,865	($19,583)	-6.9%
Inpatient Services (LTC)	18,993	17,197	(1,796)	-10.4%	106,115	102,676	(3,440)	-3.3%
Physician Services	43,104	42,684	(420)	-1.0%	242,993	255,930	12,937	5.1%
Outpatient Facility	22,643	18,477	(4,165)	-22.5%	127,068	110,309	(16,759)	-15.2%
ECM	14,093	9,181	(4,912)	-53.5%	81,575	54,809	(26,767)	-48.8%
Community Supports	7,079	3,388	(3,690)	-100.0%	38,632	20,228	(18,404)	-91.0%
Behavioral Health	6,092	7,480	1,387	18.5%	43,870	43,528	(342)	-0.8%
Other Medical**	22,332	21,645	(688)	-3.2%	146,653	129,232	(17,421)	-13.5%
State Incentive Programs	(0)	-	0	0.0%	2,310	-	(2,310)	-100.0%
Total Medical Expenses	**$183,655**	**$167,769**	**($15,886)**	**-9.5%**	**$1,093,665**	**$1,001,576**	**($92,089)**	**-9.2%**
Gross Margin	**$6,946**	**$6,061**	**$885**	**14.6%**	**$43,703**	**$41,410**	**$2,294**	**5.5%**
Administrative Expenses								
Salaries	$5,686	$6,562	$875	13.3%	$39,343	$39,205	($138)	-0.4%
Professional Fees	625	451	(173)	-38.4%	2,958	2,674	(284)	-10.6%
Purchased Services	1,143	1,313	170	12.9%	6,509	6,727	217	3.2%
Supplies & Other	618	972	354	36.4%	5,120	4,677	(442)	-9.5%
Occupancy	118	122	3	2.9%	673	748	75	10.0%
Depreciation/Amortization	725	787	62	7.9%	3,798	3,935	137	3.5%
Total Administrative Expenses	**$8,915**	**$10,207**	**$1,291**	**12.6%**	**$58,401**	**$57,966**	**($435)**	**-0.8%**
Operating Income	**($1,970)**	**($4,145)**	**$2,176**	**52.5%**	**($14,697)**	**($16,556)**	**$1,858**	**11.2%**
Non-Op Income/(Expense)								
Interest	$3,478	$3,343	$135	4.1%	$24,525	$22,890	$1,635	7.1%
Gain/(Loss) on Investments	3,800	500	3,300	100.0%	10,619	3,750	6,869	100.0%
Bank & Investment Fees	(25)	(62)	36	59.1%	(225)	(370)	145	39.2%
Other Revenues	301	186	115	61.5%	1,272	1,078	193	17.9%
Grants	(3,373)	(2,667)	(706)	-26.5%	(13,524)	(16,000)	2,476	15.5%
Community Reinvestment	(152)	-	(152)	-100.0%	(387)	-	(387)	-100.0%
Total Non-Op Income/(Expense)	**4,030**	**1,301**	**2,729**	**100.0%**	**22,281**	**11,348**	**$10,932**	**96.3%**
Net Income/(Loss)	**$2,061**	**($2,844)**	**$4,905**	**100.0%**	**$7,583**	**($5,207)**	**$12,791**	**100.0%**
MLR	*96.4%*	*96.5%*			*96.2%*	*96.0%*		
ALR	*4.7%*	*5.9%*			*5.1%*	*5.6%*		
Operating Income	*-1.0%*	*-2.4%*			*-1.3%*	*-1.6%*		
Net Income %	*1.1%*	*-1.6%*			*0.7%*	*-0.5%*		

**Other Medical includes Pharmacy and IHSS.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Sixth Month Ending June 30, 2025
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*444,968*	*438,804*	*6,164*	*1.4%*	*2,672,270*	*2,632,908*	*39,362*	*1.5%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$427.33	$395.22	$32.12	8.1%	$423.72	$395.18	$28.54	7.2%
State Incentive Programs	(0.00)	-	(0.00)	0.0%	0.86	-	0.86	100.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	1.02	0.93	0.08	9.1%	1.03	0.95	0.08	8.6%
Total Operating Revenue	**$428.35**	**$396.15**	**$32.20**	**8.1%**	**$425.62**	**$396.13**	**$29.48**	**7.4%**
Medical Expenses								
Inpatient Services (Hospital)	$110.84	$108.74	($2.09)	-1.9%	$113.93	$108.19	($5.73)	-5.3%
Inpatient Services (LTC)	42.68	39.19	(3.49)	-8.9%	39.71	39.00	(0.71)	-1.8%
Physician Services	96.87	97.27	0.40	0.4%	90.93	97.20	6.27	6.5%
Outpatient Facility	50.89	42.11	(8.78)	-20.8%	47.55	41.90	(5.65)	-13.5%
ECM	31.67	20.92	(10.75)	-51.4%	30.53	20.82	(9.71)	-46.6%
Community Supports	15.91	7.72	(8.19)	-100.0%	14.46	7.68	(6.77)	-88.2%
Behavioral Health	13.69	17.05	3.35	19.7%	16.42	16.53	0.12	0.7%
Other Medical**	50.19	49.33	(0.86)	-1.7%	54.88	49.08	(5.80)	-11.8%
State Incentive Programs	(0.00)	-	0.00	0.0%	0.86	-	(0.86)	-100.0%
Total Medical Expenses	**$412.74**	**$382.33**	**($30.40)**	**-8.0%**	**$409.26**	**$380.41**	**($28.86)**	**-7.6%**
Gross Margin	**$15.61**	**$13.81**	**$1.80**	**13.0%**	**$16.35**	**$15.73**	**$0.63**	**4.0%**
Administrative Expenses								
Salaries	$12.78	$14.95	$2.17	14.5%	$14.72	$14.89	$0.17	1.1%
Professional Fees	1.40	1.03	(0.38)	-36.5%	1.11	1.02	(0.09)	-9.0%
Purchased Services	2.57	2.99	0.42	14.1%	2.44	2.55	0.12	4.7%
Supplies & Other	1.39	2.22	0.83	37.3%	1.92	1.78	(0.14)	-7.8%
Occupancy	0.27	0.28	0.01	4.2%	0.25	0.28	0.03	11.3%
Depreciation/Amortization	1.63	1.79	0.17	9.2%	1.42	1.49	0.07	4.9%
Total Administrative Expenses	**$20.04**	**$23.26**	**$3.22**	**13.9%**	**$21.85**	**$22.02**	**$0.16**	**0.7%**
Operating Income	**($4.43)**	**($9.45)**	**$5.02**	**53.1%**	**($5.50)**	**($6.29)**	**$0.79**	**12.5%**
Non-Op Income/(Expense)								
Interest	$7.82	$7.62	$0.20	2.6%	$9.18	$8.69	$0.48	5.6%
Gain/(Loss) on Investments	8.54	$1.14	7.40	100.0%	3.97	1.42	2.55	100.0%
Bank & Investment Fees	(0.06)	(0.14)	0.08	59.7%	(0.08)	(0.14)	0.06	40.1%
Other Revenues	0.68	0.42	0.25	59.2%	0.48	0.41	0.07	16.2%
Grants	(7.58)	(6.08)	(1.50)	-24.7%	(5.06)	(6.08)	1.02	16.7%
Community Reinvestment	(0.34)	$0.00	(0.34)	-100.0%	(0.14)	-	(0.14)	-100.0%
Total Non-Op Income/(Expense)	**$9.06**	**$2.97**	**$6.09**	**100.0%**	**$8.34**	**$4.31**	**$4.03**	**93.4%**
Net Income/(Loss)	**$4.63**	**($6.48)**	**$11.11**	**100.0%**	**$2.84**	**($1.98)**	**$4.82**	**100.0%**
MLR	*96.4%*	*96.5%*			*96.2%*	96.0%		
ALR	*4.7%*	*5.9%*			*5.1%*	5.6%		
Operating Income	*-1.0%*	*-2.4%*			*-1.3%*	-1.6%		
Net Income %	*1.1%*	*-1.6%*			*0.7%*	-0.5%		

*Prior Year Revenue consist of revenue booked in the current calendar year for services rendered in prior years.
**Other Medical includes Pharmacy and IHSS.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Sixth Month Ending June 30, 2025
(In $000s)

	MTD	YTD
Net Income	$2,061	$7,583
Items not requiring the use of cash: Depreciation	(148)	1,062
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	(1)	4
Receivables	(84,894)	31,606
Prepaid Expenses	(591)	(2,672)
Current Assets	(1,020)	(436)
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**(86,506)**	**28,498**
Changes to Payables:		
Accounts Payable	66,425	(178,983)
Other Current Liabilities	(1,794)	203
Incurred But Not Reported Claims/Claims Payable	25,292	(121,426)
Provider Incentives Payable	(23,025)	(12,188)
Due to State	(6,886)	(42,828)
Subscription Liabilities	0	0
Net Changes to Payables	**60,012**	**(355,223)**
Net Cash Provided by (Used in) Operating Activities	**(24,581)**	**(318,080)**
Change in Investments	(6,641)	95,441
Other Equipment Acquisitions	131	(1,431)
Net Cash Provided by (Used in) Investing Activities	**(6,510)**	**94,010**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**(31,091)**	**(224,070)**
Cash & Cash Equivalents at Beginning of Period	**123,264**	**316,238**
Cash & Cash Equivalents at June 30, 2025	**$92,172**	**$92,172**

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DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Response to the Santa Cruz County Civil Grand Jury Findings and Recommendations

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Recommendation. Staff recommends the board approve the response to the Santa Cruz County Civil Grand Jury (SCCCGJ) Findings and Recommendations published June 26, 2025 and authorize staff to make any final edits in coordination with the County for the purpose of alignment and clarity.

Background. The SCCCGJ published a report on June 26, 2025, summarizing its findings and recommendations in its report titled "If You Can't Measure It, You Can't Manage It – The Challenges Facing the Management of High Cost Beneficiaries in the Health Services Agency. The report detailed the SCCGJ's review and investigation of services provided by the Santa Cruz County Health Services Agency (SCHSA) to "high-cost beneficiaries" which the SCCCGJ described as individuals who, due to frequent and repeated interactions with city and/or other county agencies, incur substantial costs – many of whom are served by both the Alliance and the County.

Discussion. The SCCCGJ report included seven (7) findings and eight (8) recommendations several of which were directed to the Alliance and SCHSA jointly. The SCCCGJ requires responses from the Alliance Board to three (3) of the findings and six (6) of the recommendations. Alliance staff reviewed the report and developed responses in coordination with SCHSA. The Alliance's response is attached for your Board's approval to be submitted to the SCCCGJ by September 24, 2025.

Fiscal Impact. There is no financial impact.

Attachments. Central California Alliance for Health – Response to the 2024-2025 Santa Cruz County Civil Grand Jury

The 2024-2025 Santa Cruz County Civil Grand Jury

Requires the

Governing Board, Central California Alliance for Health

to Respond by September 24, 2025

to the Findings and Recommendations listed below which were assigned to them in the report titled

If You Can't Measure It, You Can't Manage It.

The Challenges Facing the Management of High-Cost Beneficiaries in the Health Services Agency

Required Responses apply to elected officials, elected agencies or department heads, elected boards, councils, and committees. The respondent is **required** to respond and to make the response available to the public under California Penal Code (PC) §933(c). A required response will be considered **compliant** under PC §933.05 if it contains an appropriate comment on **all** findings and recommendations **which were assigned to you** in this report.

Invited Responses are encouraged but are not required by the California Penal Code.

Please follow the instructions below when preparing your response.

Instructions for Respondents

Your assigned Findings and Recommendations are listed on the following pages with check boxes and an expandable space for summaries, timeframes, and explanations. Please follow these instructions, which paraphrase PC §933.05:

1. ***For the Findings, mark one of the following responses with an "X" and provide the required additional information:***
   a. **AGREE with the Finding**, or
   b. **PARTIALLY DISAGREE with the Finding** – specify the portion of the Finding that is disputed and include an explanation of the reasons why, or
   c. **DISAGREE with the Finding** – provide an explanation of the reasons why.

2. ***For the Recommendations, mark one of the following actions with an "X" and provide the required additional information:***
   a. **HAS BEEN IMPLEMENTED** – provide a summary of the action taken, or
   b. **HAS NOT YET BEEN IMPLEMENTED BUT WILL BE IN THE FUTURE** – provide a timeframe or expected date for completion, or
   c. **REQUIRES FURTHER ANALYSIS** – provide an explanation, scope, and parameters of an analysis to be completed within six months, or
   d. **WILL NOT BE IMPLEMENTED** – provide an explanation of why it is not warranted or not reasonable.

3. ***Please confirm the date on which the assigned responses were approved during an official meeting:***

   We approved these responses in a regular public meeting as shown

   in our minutes dated _____.

4. ***Please attach a PDF version of your completed responses to an email sent to:***

   The Honorable Judge: Katherine Hansen Katherine.Hansen@santacruzcourt.org
   and

   The Santa Cruz County Grand Jury: grandjury@scgrandjury.org.

If you have questions about this response form, please contact the Grand Jury by calling (831) 454-2099 or by sending an email to grandjury@scgrandjury.org.

Findings

F3 . Clinical: Santa Cruz County does not have a Level of Care Tool to track and manage High-Cost Beneficiaries. The Central California Alliance for Health does have a Level of Care Tool to track and manage High-Cost Beneficiaries. The parties are partners in the delivery of services and their resources could be leveraged to create a unified Level of Care tool.

__ **AGREE**

X **PARTIALLY DISAGREE**

__ **DISAGREE**

Response explanation (required for a response other than **Agree**):

The Alliance utilizes available data to identify and track high-cost beneficiaries (HCBs) that would benefit from care management and other wraparound services to help them manage their conditions and navigate the healthcare system. The Alliance shares member-level data that identifies HCBs with Santa Cruz County (SCC), as follows.

1. The Department of Health Care Services' (DHCS') Enhanced Care Management (ECM) benefit specifies the criteria plans must use to identify high-cost, high-need members eligible for ECM services. The Alliance generates lists of members using this criterion and provides lists of eligible members to contracted providers for outreach. While the Behavioral Health Department does not participate in ECM, SCC Health Services Agency clinic is an Alliance-contracted ECM provider and routinely receives lists of members meeting criteria for ECM.

2. DHCS' No Wrong Door (NWD) approach to behavioral health services requires plans and counties to use common clinical criterion and a shared assessment tool, referred to as the Screening and Transition of Care Tools for Medi-Cal Mental Health Services, to determine whether members should be served by the specialty or non-specialty mental health system. The Alliance refers members needing Specialty Mental Health Services (SMHS) or substance use disorder (SUD) services to SCC and maintains a shared tracking list to ensure all referred members obtain services. The Alliance partners with SCC, and the four other county mental health plans in its service area, align on the assessment tool, and manage the process to connect members to the correct delivery system.

3. Admit, discharge and transfer (ADT) data from local hospitals is shared with SCHIO and then with SCC to enable timely provider follow up with members, including follow up after hospitalization for substance use challenge (FUA) and follow up after hospitalization for mental health challenge (FUM).

4. Lists of linked members with a high volume of ED visits are shared with contracted Primary Care Providers (PCPs), including SCC, to support PCP follow-up with members to ensure post-discharge care is received and coordinated.

F5 . Data, Clinical & Administrative: The Central California Alliance for Health (Alliance) has substantial financial reserves, and Santa Cruz County has seats on the governing board of the Alliance. Clinical, financial and operational collaboration between these agencies, who are both insurers and providers, needs to be better coordinated and integrated at all levels to improve treatment and outcomes for all clients.

__ **AGREE**

__ **PARTIALLY DISAGREE**

X **DISAGREE**

Response explanation (required for a response other than **Agree**):

The Alliance and SCC work collaboratively to meet the needs of our mutual members and meet routinely to coordinate care for individual members and to improve systems and processes that allow for collaboration and data sharing with the goal of improving health outcomes.

There are legal and regulatory factors that limit the extent to which the Alliance and SCC can "integrate at all levels." California law (§WIC 5600 and 14684) provides counties exclusive responsibility for providing specialty mental health services (SMHS). Additionally, California's 1915(b) waiver "carves out" SMHS to county mental health plans. Integration would require statutory and regulatory changes as well as clarification of oversight authority and accountability.
Therefore, integration would require statutory and regulatory changes as well as clarification of oversight authority and accountability. In July 2025, DHCS released a Concept Paper titled, "DHCS Continuing The Transformation of Medi-Cal." The purpose of this concept paper is to outline DHCS' vision and goals for the next five years, including plans for advancing the renewal of the CalAIM waivers and other initiatives. The concept paper states, DHCS is committed to increasing efficiency in the managed care program and reducing fragmentation across delivery systems. Under CalAIM, DHCS considered a full integration proposal that would have allowed an MCP, in partnership with one or more BHPs (County Behavioral Health Plans), to apply to bring together physical, behavioral, and oral health benefits under a single entity contracted with DHCS. Due to operational complexities, DHCS did not launch any full integration pilots during the CalAIM waiver period and is considering streamlining the member experience and improving outcomes through more limited integration, such as piloting the integration of oral health benefits into managed care.

Additionally, the Alliance is a regional agency with a five-county governing board. The Alliance is required by statute and regulation to have financial reserves to ensure the long-term financial viability of the organization, including providing uninterrupted services to its members, timely and adequate reimbursement to its providers, compliance with regulatory requirements, and ensuring organizational capacity to respond to short and long-term capital needs and opportunities consistent with the Alliance's strategic plans. To that end, the board has set a reserve target and has allocated remaining reserves to support ongoing operational and strategic requirements including provider payments, implementing a Medicare Advantage (MA) Dual Eligible Special Needs Program (D-SNP) product as required by DHCS, and enhancing provider payments across the five-county service area.

With recent federal budget cuts and policy changes affecting Medicaid funding, and a worsening state budget, the Alliance is experiencing a decline in financial reserves, and projects this decline will continue over the next four years. The Alliance is obligated to meet members' needs and fulfill its contracts and obligations to its community, which cover five different counties. Additionally, Alliance reserves are to address obligations across all five counties, under the authority of the Alliance five-county governing Board.

F7 . Compassion: Throughout the Grand Jury investigation, the Jury found that the staff and leadership of the Health Services Agency, Santa Cruz County Sheriff's Office, and the Central California Alliance for Health are compassionate in the treatment of people experiencing behavioral health or substance use disorder. Patients are treated with dignity and respect, despite sometimes difficult conditions.

X **AGREE**

__ **PARTIALLY DISAGREE**

__ **DISAGREE**

Response explanation (required for a response other than **Agree**):

The Alliance agrees with this finding and appreciates the acknowledgement.

Recommendations

R3 . Ongoing External Reporting: In order to leverage their partnership with the Mental Health Advisory Board (MHAB) and raise public awareness around Behavioral Health in Santa Cruz County, the Health Services Agency and the Central California Alliance for Health should jointly report to the MHAB. Their reporting should occur at least bi-annually starting no later than June 30, 2026. Their report should discuss their collaborative efforts towards implementing a LoC tool, their progress towards developing value-based financing and should include Year-to-Date statistics on HCBs.

—	**HAS BEEN IMPLEMENTED –** summarize what has been done
—	**HAS NOT YET BEEN IMPLEMENTED BUT WILL BE IN THE FUTURE –** summarize what will be done and the timeframe
—	**REQUIRES FURTHER ANALYSIS –** explain the scope and timeframe (not to exceed six months)
X	**WILL NOT BE IMPLEMENTED –** explain why

Required response explanation, summary, and timeframe:

The Alliance is accountable to DHCS as articulated in statute, regulation, and state contracts, and DHCS oversees Alliance operations and compliance by reviewing required reports and conducting regulatory audits. The Alliance maintains an oversight structure, as required by DHCS, that includes obtaining member and provider input into our programs and operations via a Member Services Advisory Board and Physician Advisory Board, both of whom report to the Board in an advisory capacity.

R4 . Ongoing External Reporting: At least bi-annually beginning no later than September 30, 2025, Health Services Agency (HSA) and the Central California Alliance for Health (Alliance) should meet jointly with Serving Communities Health Information Organization (SCHIO). The meeting agenda should include a review of the data HSA and the Alliance submit to SCHIO and the SCHIO data and reporting features that HSA and the Alliance use. The goal is to leverage their partnership and better integrate the dissemination of accurate information to health care professionals and law enforcement about the treatment and needs of their clients. The outcome of the meeting should be reported to the Mental Health Advisory Board.

—	**HAS BEEN IMPLEMENTED –** summarize what has been done
—	**HAS NOT YET BEEN IMPLEMENTED BUT WILL BE IN THE FUTURE –** summarize what will be done and the timeframe
—	**REQUIRES FURTHER ANALYSIS –** explain the scope and timeframe (not to exceed six months)
X	**WILL NOT BE IMPLEMENTED –** explain why

Required response explanation, summary, and timeframe:

Data sharing between the Alliance, SCC, and other providers does routinely occur, as required by state law, and as permitted by federal law. Examples of this data sharing are noted above and include ADT data, NWD referrals, ECM chase lists, and data routinely shared with PCPs for their linked members. Health information exchanges are one method for sharing data; however, plans and providers frequently share data directly. What is important is that the data is shared to ensure coordination for members as they access care across the system.

The Alliance has also instituted data sharing incentives for providers who share data with SCHIO and has made available funding for providers to improve their data sharing capability through the MCGP.

In addition, there are statewide efforts underway aimed at expanding data sharing between entities involved in providing medical and physical care to members, as well as those supporting care coordination and navigation of the healthcare system.

As an example, in line with the California Data Exchange Framework, the Alliance is actively working with SCC to develop a uniform consent to release information, which, if signed by patients, would allow for broader data sharing for care coordination.

In addition, the Local Health Plans of California, an association representing all local Medi-Cal Plans (MCPs), including the Alliance, has co-sponsored AB 618 with the County Behavioral Health Directors Association (CBHDA). This bill will require DHCS to develop clear and directive guidance to mandate data sharing between MCPs and MHPs, including the data to be shared and the timeframe for sharing such data. By providing explicit direction on what data must be shared, this bill intends to remove the gray area in current privacy law that prevents entities from sharing data. This bill would also mandate the use of the aforementioned uniform consent form by all providers in California. If AB 618 is enacted by the Legislature, and upon receipt of such guidance, the Alliance will be better positioned to assess the feasibility of implementing this recommendation.

R5 . Clinical Integration. Annually, beginning January 1, 2026, the Santa Cruz County Health Services Agency and the Central California Alliance for Health should review, align, and jointly publish their aligned clinical and program delivery methods and goals for all levels of Behavioral Health and Substance Use Disorder patients.

X	**HAS BEEN IMPLEMENTED –** summarize what has been done
—	**HAS NOT YET BEEN IMPLEMENTED BUT WILL BE IN THE FUTURE –** summarize what will be done and the timeframe
—	**REQUIRES FURTHER ANALYSIS –** explain the scope and timeframe (not to exceed six months)
__	**WILL NOT BE IMPLEMENTED –** explain why

Required response explanation, summary, and timeframe:

In recognition of the bifurcated mental health delivery system, DHCS requires that MCPs and MHPs enter into Memorandum of Understanding (MOU) that delineates each party's specific responsibility in providing BH services and clarifies roles and responsibilities for coordination of care, including specific procedures that will be used. The Alliance and SCC have been operating pursuant to an MOU since 2014 and review the MOU at minimum annually.

R6 . Administrative, Financial & Clinical. By July 1, 2026, the Santa Cruz Health Services Agency and the Central California Alliance for Health should have a shared database and shared criteria for identifying potential High-Cost Beneficiaries. This Level of Care tool should track costs, services, and outcomes for not only Behavioral Health and Substance Use Disorder High-Cost Beneficiaries, but for all clients. The following California Health Care Foundation brief provides a starting point for building a more integrated system of care over the long term: Better Integrate Physical and Behavioral Health Care.

—	**HAS BEEN IMPLEMENTED –** summarize what has been done
—	**HAS NOT YET BEEN IMPLEMENTED BUT WILL BE IN THE FUTURE –** summarize what will be done and the timeframe
—	**REQUIRES FURTHER ANALYSIS –** explain the scope and timeframe (not to exceed six months)
X	**WILL NOT BE IMPLEMENTED –** explain why

Required response explanation, summary, and timeframe:

Currently, routine and timely information sharing is already well-established from the Alliance to SCC for high-cost beneficiaries through multiple channels, including ADT data, NWD referrals, ECM chase lists, and routine data exchanges with PCPs for their attributed members.

The Alliance understands that the Behavioral Health Services Act (BHSA) enhances data collection and transparency for behavioral health services and includes the development of a statewide dashboard. The Alliance is willing to support SCC in these efforts.

R7 . Administrative Integration. The Santa Cruz County Health Services Agency and the Central California Alliance for Health should develop a seamless administrative process that uses standardized and shared data, reports and goals. No later than December 31, 2026, a report shall be submitted to the respective governing boards outlining the processes established to integrate network management, provider payment, and data collection and reporting.

—	**HAS BEEN IMPLEMENTED –** summarize what has been done
—	**HAS NOT YET BEEN IMPLEMENTED BUT WILL BE IN THE FUTURE –** summarize what will be done and the timeframe
—	**REQUIRES FURTHER ANALYSIS –** explain the scope and timeframe (not to exceed six months)
X	**WILL NOT BE IMPLEMENTED –** explain why

Required response explanation, summary, and timeframe:

As noted above, the two parties are separate legal entities with differing statutory and regulatory responsibilities and further integration would require legal and statutory changes. Further, as Alliance is a regional agency serving five counties, administrative integration with SCC is not feasible.

R8 . Financial Integration. On or before July 1, 2027, the County Health Services Agency and the Central California Alliance for Health should report to their respective governing boards the steps they have taken towards financial integration of all behavioral health services and substance use services using a value-based financing process. Braiding Medicaid Funds described in August 2024 Brief from the California Health Care Foundation provides a framework for achieving this necessary integration.

—	**HAS BEEN IMPLEMENTED –** summarize what has been done
—	**HAS NOT YET BEEN IMPLEMENTED BUT WILL BE IN THE FUTURE –** summarize what will be done and the timeframe
—	**REQUIRES FURTHER ANALYSIS –** explain the scope and timeframe (not to exceed six months)
X	**WILL NOT BE IMPLEMENTED –** explain why

Required response explanation, summary, and timeframe:

As noted above, the two parties are separate legal entities with differing statutory and regulatory responsibilities. Financial integration is not feasible as the Alliance serves 5 separate counties and must follow strict requirements regarding financial viability, which are closely monitored through reporting and auditing by DHCS and DMHC.

The California Health Care Foundation report, *How California Can Build on CalAIM to Better Integrate Physical and Behavioral Health Care* (2022), found that attempts to further integrate the behavioral health systems were largely unsuccessful due to these legal barriers, a view that was reiterated by DHCS when they removed their vision for behavioral health integration from their most recent and afore-mentioned concept paper.

DATE: August 27, 2025

TO: Santa Cruz–Monterey–Merced–San Benito–Mariposa Managed Medical Care Commission

FROM: Dr. Dianna Myers, Medical Director and Interim Chief Health Equity Officer

SUBJECT: Care-Based Incentive Program 2026

Recommendation. Staff recommend that the Board approve the Care-Based Incentive (CBI) Program proposal described below for 2026.

Summary. This report provides an overview of the Care-Based Incentive Program and makes a recommendation for structural program changes to CBI 2026.

Proposed changes to 2026 programmatic measures are:

- Change Controlling High Blood Pressure from Exploratory to a Paid Measure.

Background. Since 2010, the Alliance's CBI program has encouraged primary care physicians to adopt and implement the Patient Centered Medical Home model. CBI aligns with the Alliance's Strategic Priorities for Health Equity to eliminate health disparities and achieve optimal health outcomes for children and youth, offering an upside-risk value-based payment to primary care providers. This promotes better health outcomes, improved access to care, and promotes the delivery of high-value care. These health outcomes are reflected in part by the health plan's annual reporting to the Department of Health Care Services (DHCS) for the National Committee for Quality Assurance (NCQA)'s Healthcare Effectiveness and Data Information Set (HEDIS), referred to as Medi-Cal Managed Care Accountability Set (MCAS). This includes measures from NCQA HEDIS, the Centers for Medicare and Medicaid Services (CMS), and the Dental Quality Alliance (DQA).

Historically, CBI has aligned with many DHCS mandated reported measures, but other state policies have also impacted measure selection including the California State Auditor's reports, DHCS All Plan Letters (APL), and California Governor directives. Measure selection for CBI has also taken into consideration preventive service measure gaps with a focus on health equity in alignment with the DHCS Comprehensive Quality Strategy and the Alliance Strategic Plan as a way to support the Medi-Cal population. Prior to bringing recommended changes to our Board, we also solicit provider feedback through our Physician Advisory Group (PAG).

Discussion. The following tables show each measure in the different categories, with an explanation of the recommendations following each table.

Application of Dental Fluoride Vanish to accept dental claims via the Alliance Provider Portal Data Submission Tool, and change the application from one to two occurrences, which will align more with the MCAS Topical Fluoride Varnish Measure.

Measure Category	Measure Name
Care Coordination – Access Measures	Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents
	Application of Dental Fluoride Varnish
	Developmental Screening in the First 3 Years
	Initial Health Appointment
	Post-Discharge Care
Care Coordination – Hospital & Outpatient Measures	Plan All-Cause Readmission
	Preventable Emergency Visits
	Ambulatory Care Sensitive Admissions

The proposed 2026 programmatic Quality of Care measures will transition the Controlling High Blood Pressure measure from an exploratory to a programmatic status. All other Quality of Care measures will stay the same.

Measure Category	Measure Name
Quality of Care Measures	Breast Cancer Screening
	Cervical Cancer Screening
	Child and Adolescent Well-Care Visits (3-21)
	Chlamydia Screening in Women
	Colorectal Cancer Screening
	Controlling High Blood Pressure
	Diabetic Poor Control >9%
	Immunizations: Adolescents
	Immunizations: Children (Combo 10)
	Lead Screening in Children
	Screening for Depression and Follow-up Plan
	Well-Child Visit in The First 15 Months
	Well-Child Visits for Age 15 months–30 months of Life

For CBI 2026 Fee-For-Service measures, as part of the board approved provider supplemental payments, the Social Determinants of Health (SDOH) measure will be updated to pay $100.00 per visit per member for Z or G SDOH diagnostic codes. A $50 per member referral for ECM will be added as part of the board approved supplemental payments. All other Fee-For-Services measures will stay the same.

Measure Category	Measure Name
Fee-For-Service	Adverse Childhood Experiences (ACEs) Training and Attestation
	Behavioral Health Integration
	Cognitive Health Assessment Training and Attestation
	Diagnostic Accuracy and Completeness Training
	ECM Referrals
	Patient-Centered Medical Home (PCMH) Recognition
	Quality Performance Improvement Projects
	Social Determinants of Health (SDOH) ICD-10 Z Code Submission

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

Attachments. N/A

DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services Contract Amendment: CY 2025-A

Recommendation. Staff recommends the board authorize the Chair to sign amendment CY 2025 A to the Alliance contract with Department of Health Care Services (DHCS).

Background. The Alliance contracts with DHCS to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey, Merced, San Benito and Mariposa counties. The Alliance entered into the primary Agreement 23-03421 with DHCS on January 1, 2024. The agreement has subsequently been amended via written amendments A 01 through A 05.

Discussion. DHCS is preparing a contract amendment to the Alliance's State Medi-Cal contract to incorporate changes containing new language, updates and edits in the following areas.

- Adds new requirements for Foster Youth Aid Codes, Emergency Preparedness, ECM Presumptive Authorization, ECM Referral Standards, Minor Consent, Community Reinvestment, and Non-Specialty Mental Health Services Outreach and Education
- Updates existing language for Claims Processing, Operations Deliverables, Changes in Member Circumstances and Memorandum of Understanding Updates.

Staff have reviewed the language and are assessing operational impact and any necessary implementation steps to ensure compliance.

Fiscal Impact. There is no financial impact.

Attachments. N/A

DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services Contract Amendment: State-Only Secondary Contract

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Recommendation. Staff recommend the Board authorize the Chairperson to sign contract Amendment 23-30273 A04 to the Alliance's State-only Secondary contract to incorporate updated language to the Unsatisfactory Immigration Status (UIS) Member definition and the Change Order Process.

Background. The Alliance contracts with the Department of Health Care Services (DHCS) to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey, Merced, San Benito, and Mariposa counties. The Alliance entered into secondary (State-Only) Agreement 23-30273 with DHCS on January 1, 2024. The Agreement has subsequently been amended via written amendments A01 – A03.

Discussion. DHCS has issued an amendment to the Alliance's secondary State Medi-Cal contract including revisions to the definition of UIS and updating the Change Order language to align with the Primary Contract.

Staff have reviewed the language and assessed operational impacts and any necessary implementation steps to ensure compliance

Fiscal Impact. N/A

Attachments. N/A

DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Policy Revision – 700-2000 Board Designated Reserve ("Reserve")

Recommendation. Staff recommend the Board approve revisions to Alliance Policy 700-2000 – Board Designated Reserve ("Reserve").

Background. On December 3, 2014, in approving the Alliance investment framework, the Alliance's Board increased the Health Care Expense Reserve target from two times to three times the annual average of the monthly premium capitation. The Board also approved the framework for the strategic use of reserves, resulting in the establishment of the Medi-Cal Capacity Grant Program (MCGP).

On February 25, 2015, the Board explicitly and separately approved the Health Care Expense Reserve, the Board-designated reserve target of three times the average monthly premium capitation.

On June 22, 2022, the Alliance's Board approved an updated Health Care Expense Reserve Policy recognizing the Board-designated reserve target at three times the average monthly premium capitation. The Reserve Target is a component of the Alliance's financial plan, which provides that surplus funds are used to expand access, improve benefits, or augment provider reimbursement. The policy states that annually, following the acceptance of the annual independent financial audit, the Alliance's Board may strategically allocate a fund balance that exceeds the Reserve Target to enable the implementation of future programs and/or to the Medi-Cal Capacity Grant Program (MCGP) to strengthen the local delivery system for the future.

On August 28, 2024, the Alliance's Board approved revisions to Policy 700-200—Board Designated Reserve ("Reserve") to explicitly state that the Board may allocate excess reserve to make provider supplemental payments to improve realized network access and advance health equity in addition to funding future program requirements and the Medi-Cal Capacity Grant Program.

Discussion. The Alliance's Board permits the use of reserves to expand access, improve benefits, and augment provider reimbursement. Staff recommend that the Board approve minor updates to Policy 700-200—Board Designated Reserve ("Reserve") to clarify the definition of operating reserve.

Fiscal Impact. There is no fiscal impact. The Alliance fund balance in internal or regulatory reporting remains the same as the current policy. The internal fund balance reporting will show the amount for each strategic use.

Attachments.

1. Alliance Policy 700-2000 – Board Designated Reserve ("Reserve")

	POLICIES AND PROCEDURES
Policy #: 700-2000	**Lead Department:** Finance
Title: Board-Designated Reserve ("Reserve")	
Original Date: 8/1/2022	**Date Published:**
Approved by: Lisa Ba, Chief Financial Officer	

Purpose:
Central California Alliance for Health (the Alliance) implements a financial plan to ensure the long-term financial viability of the organization, including providing uninterrupted services to its members, timely and adequate reimbursement to its providers, compliance with regulatory requirements, and ensuring organizational capacity to respond to short and long-term capital needs and opportunities consistent with the Alliance's strategic plans. The financial plan ensures the creation of prudent reserves and provides for use of surplus funds to expand access, improve benefits, and augment provider reimbursement. This policy addresses requirements around the creation of a prudent Health Care Expense Reserve ("Reserve") and allocation of surplus funds beyond the required Reserve Target.

Maintaining appropriate levels of reserves is a fiscal responsibility of the Alliance and is a legal requirement pursuant to the Knox-Keene Health Care Services Plan Act of 1975 ("Act"). The minimum tangible net equity (TNE) required by the Act and the Title 28 California Code of Regulations ("Rule"). is a minimum required amount and is not considered by the State of California Department of Managed Health Care ("DMHC") or by the Alliance Board as an appropriate or sufficient reserve amount. The Alliance observes this Reserve policy to ensure an appropriate or sufficient reserve.

Policy:
As required by the DMHC and the Alliance's Medi-Cal contract, the Alliance shall always maintain the minimum TNE required by Section 1376 of the Act, calculated in accordance with Rule Section 1300.76.

The Alliance shall observe a Reserve Target, or Board designated reserve target, at three times its monthly Premium Capitation.

The Alliance shall develop and implement cost containment measures if the Alliance's financial projection indicates that reserves would fall below 300% of the TNE level.

The Alliance's provider payments must be in line with revenue rate, utilization trends, and industry benchmarks.
Annually, following the acceptance of the annual independent financial audit, the Board may allocate Operating Reserve~~net income~~ which, if reserved would result in a fund balance that exceeds the Reserve Target, to:

a. Pay provider supplemental payments to improve realized network access and advance health equity.
b. Enable implementation of future program requirements, with such funds remaining in Alliance reserves until expended.
c. Make allocation to the Medi-Cal Capacity Grant Program, with such funds not available for other purposes.

	POLICIES AND PROCEDURES
Policy #: 700-2000	**Lead Department:** Finance
Title: Board-Designated Reserve ("Reserve")	
Original Date: 8/1/2022	**Date Published:**
Approved by: Lisa Ba, Chief Financial Officer	

Definitions:

1. **Reserve** is an organization's net assets, also called fund balance. It represents the surpluses or deficits it has accumulated over time.

2. **Tangible Net Equity ("TNE")**, as defined by the Rule, means a health plan's total assets minus total liabilities reduced by the value of intangible assets and unsecured obligations of officers, directors, owners, or affiliates outside of the normal course of business. The required TNE for a full-service plan is the greater of 1 million dollars or a percentage of premium revenues or a percentage of healthcare expenses.

3. **Reserve Target** is the **Health Care Expense Reserve Target** or **Board Designated Reserve Target**. It is an amount identified and maintained in the Alliance's financial records in order to meet expected future payments and other obligations designated by the Board.

4. **Premium Capitation** is the regularly scheduled payments made by the Department of Health Care Services to the Alliance to operate the Medi-Cal program. Monthly Premium Capitation is the monthly per member per month (PMPM) rate for health care services multiplied by the number of members assigned to the Alliance. The Premium Capitation excludes revenues from incentive programs, supplemental payments, special pass-through payments such as Hospital Quality Assurance Fees (HQAF) payments, intergovernmental transfers (IGT), or MCO tax revenue.

5. **Operating Reserve** is the excess fund balance after subtracting already allocated reserves.

Procedures:

The Accounting Department is responsible for ensuring that the TNE calculation is in accordance with regulatory requirements and that the presentation of TNE in the financial statements is accurate.

1. On a monthly basis, the Accounting Director or designee shall calculate the Reserve Target based on the average monthly Premium Capitation for the previous three months.
2. The Chief Financial Officer (CFO) shall develop and implement a cost containment plan when the reserve balance is below the 300% TNE level. The CFO shall report the status of the plan and the reserve balance to the Board on a semi-annual basis, or more frequently as directed by the Board.
3. When negotiating and setting the provider reimbursement rates, the CFO or designee must ensure the provider payment is in line with revenue rate, utilization trends, and industry benchmarks.

Annually, following the acceptance of the annual independent financial audit, the Accounting Director or designee shall calculate the amount above the Reserve Target. The CFO or designee

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	POLICIES AND PROCEDURES
Policy #: 700-2000	**Lead Department:** Finance
Title: Board-Designated Reserve ("Reserve")	
Original Date: 8/1/2022	**Date Published:**
Approved by: Lisa Ba, Chief Financial Officer	

may recommend that the Board allocate the excess amount above the Reserve Target as provided in Provision a.

References:
Alliance Policies:
Impacted Departments:
Regulatory:
Title 28 California Code of Regulations, Section 1300.76
Legislative:
Contractual (Previous Contract): DHCS Medi-Cal Contract Exhibit A, Attachment 2, Provision 1.A
Contractual (2024 Contract): Medi-Cal Contract, Exhibit A, Attachment 3, Provision 1.2.1
DHCS All Plan Letter:
NCQA:
Supersedes:
Other References:
Attachments:

Lines of Business This Policy Applies To	**LOB Effective Dates**
☒ DSNP	(01/01/2026 – present)
☒ Medi-Cal	(01/01/1996 – present)
☒ Alliance Care IHSS	(07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
07/01/2024	07/01/2024	Dulcie San Paolo, Administrative Specialist	Lisa Ba, Chief Financial Officer
06/24/2025	06/23/2025	Jimmy Ho, Accounting Director	Lisa Ba, Chief Financial Officer

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DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Andrea Swan, RN, Quality Improvement and Population Health Director

SUBJECT: Policy Revision – 401-1101 – Quality Improvement and Health Equity Transformation Program

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Recommendation. Staff recommend the Board approve revisions to Alliance Policy 401-1101 Quality Improvement and Health Equity Transformation Program (QIHETP).

Background. The 2024 Medi-Cal contract requires establishment of a Quality Improvement and Health Equity Transformation Program to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services (DHCS) requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 438.330 and 438.340.

Discussion. The Quality Improvement and Health Equity Transformation Program (QP) was modified to align with the DHCS request to confirm that the Plan has a Behavioral Heath Manager and Behavioral Health Medical Director that represents at the Utilization Management Work Group (UMWG).

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

Attachments.

1. Alliance Policy 401-1101 – Quality Improvement and Health Equity Transformation Program

	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement & Health Equity Transformation Program (QIHETP)	
Original Date: 02/01/1996	**Date Published:** ~~04/30/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Purpose

To describe Central California Alliance for Health's (the Alliance) Quality Improvement & Health Equity Transformation Program (QIHETP[1]). The QIHETP is an organizational-wide, cross-divisional, and comprehensive program that encompasses the Alliance's commitment to the delivery of quality and equitable health care services including the integration of quality, population health, and health equity principles[2]

Policy

The QIHETP[3] exists to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services (DHCS) requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 438.330 and 438.340[4]. The QIHETP aligns efforts with DHCS' Comprehensive Quality Strategy Report ~~and also~~and reviews actions items identified through DHCS' reports including, but not limited ~~to~~to, the Technical Report, Health Disparities Report, Preventive Services Report, Focused Studies, and Encounter Data Validation Report. Additionally, QIHETP oversight entities may electively incorporate best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) into the QIHETP as they deem appropriate.

Vision: *"Quality for All"A Quality is everyone, every time, and everywhere*

The QIHETP strives to achieve high quality, safe and excellent care, delivered in an equitable and collaborative manner, to achieve optimal health outcomes for all members in the communities we serve. It is guided by the Alliance's vision of *Healthy People, Health Communities*, our mission of *accessible, quality health care guided by local innovation*, and Alliance values of *Improvement, Integrity, Collaboration and Equity.*

QIHETP Values

The QIHETP provides a comprehensive structure that meets the following requirements:

Continuous Quality Improvement (CQI)[5]

1. Develop and maintain structures and processes that support CQI methodologies by demonstrating organizational commitment to the delivery of quality health care services through jointly developed goals and objectives across Divisions, approved by the Alliance Board, and periodically evaluated and updated.
2. Apply CQI to all aspects of Alliance's service delivery system through analysis, evaluation, and systematic enhancements of the following: 1) quantitative and qualitative data collection and data-driven decision-making, 2) up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals (consensus of professionals if none exist); and
3. Feedback provided by members and network providers in the design, planning, and implementation of its CQI activities.

Equitable and Person-Centered

1. Ensure all medically necessary covered services are: available and accessible to all members in any setting, regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender,

gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56[6], and provided in a culturally and linguistically appropriate manner[7].

2. Provide tailored, consistent, and whole-person care across all member-facing team that meet the needs and experience of our members.
3. Ensure delivery of health care services complies with all mental health parity requirements in 42 CFR section 438.900 for Alliance, Subcontractors, Downstream Subcontractors, Network Providers, and other entities.

Safe, Accessible, and Effective Quality of Care and Services

1. Ensure integration with all departments within the Alliance, current community health priorities, standards, and public health goals;
2. Continuously review, evaluate, and improve access to and availability of services, including obtaining appointments within established standards;
3. Ensure consistent patient safety processes through proactive surveillance, investigation, and appropriate actions to address quality issues related to care, service, or satisfaction; and
4. Ensure effectiveness of the quality of care and services delivered across the continuum of care by addressing preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, behavioral and ancillary care services, including complex health needs, emerging risk, and multiple chronic conditions for improved health outcomes.

Population Health Management Interventions[8]

Designed to identify, evaluate, and address social drivers of health, reduce disparities in health outcomes experienced by different subpopulations of members, and work towards achieving health equity by:

1. Developing equity focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services; and
2. Engaging in a member and family-centric approach in the development of interventions and strategies, and in the delivery of health care services.

Comprehensive Quality Strategy Guiding Principles[9]

1. Eliminating health disparities through anti-racism and community-based partnerships
2. Data-driven improvements that address the whole person
3. Transparency, accountability, and member involvement
4. Meet disparity reduction targets for specific populations and/or measures identified by DHCS.

Scope

The Alliance ensures that its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors participates and are updated on activities, findings, and recommendations of the QIHEC's QIHETP and Population Needs Assessment (PNA)[10], and represent the providers who provide health care services to Members including, but not limited to Members affected by health disparities, limited English proficiency (LEP) Members, children with special health care needs, seniors and persons with disabilities, and persons with chronic conditions. The QIHETP encompasses quality of care, quality of services, patient safety, and member experience:[11]

1. Quality of care services including, but not limited to: clinical quality of physical health care, behavioral health care focused on recovery, resiliency, and rehabilitation, preventive care, chronic disease, perinatal care, family planning services, and reduction in health disparities.

2. Quality of services including, but not limited to: availability and regular engagement with Primary Care Providers, access to primary and specialty health care, grievance process, coordination, and continuity of care across settings and at all levels of care (including transitions of care), and information standards.
3. Standards for patient safety including, but not limited to: facility site reviews, credentialing of practitioners, and quality of care/peer review.
4. Standards in member experience with respect to clinical quality, access, and availability, and culturally and linguistically competent health care and services, and continuity and coordination of care. This includes, but not limited to: satisfaction surveys and assessments, monitoring of member complaints, phone queue monitoring, access measurement and member grievance timeliness.

Goals and Objectives

The goal and objective of the QIHETP is to objectively and systematically monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all its Providers in any setting, and take appropriate action to improve upon Health Equity[12] :

1. Quality and safety of healthcare and services provided by the Alliance's provider network:
   - 1.a. Incorporate provider and other appropriate professional involvement in the QIHETP through review of findings, study outcomes, and on-going feedback for program activities
   - 1.b. Conduct facility site reviews/medical record reviews at provider sites and reviewing quality issues or trends referred for further investigation and follow-up actions
   - 1.c. Develop and maintain a high-quality provider network through credentialing, re-credentialing, and peer review processes[13]
   - 1.d. Maintain an ongoing oversight process by incorporating annual performance metrics of QIHETP-related functions performed by practitioners, providers, and delegated or independently contracted/sub-contracted delegates
   - 1.e. Ensure that care and resources are available, appropriate, accessible, and timely for all members according to standards of care and evidence-based practices
   - 1.f. Mechanisms to detect, review, and analyze results of both over/underutilization of services, but not limited to, outpatient prescription drugs[14]. Refer to Alliance Policy 404-1108 - – Monitoring of Over/Under Utilization of Services.

2. Quality of services provided by the Alliance to its members, providers, the community, and internal staff:
   - 2.a. Align quality improvement activities with activities that promote the continuous development of a provider network that meets member needs, such as the annual Access Plan
   - 2.b. Implement innovative practices, such as telephonic or virtual means, to ensure that members obtain care which is timely and meets their needs
   - 2.c. Utilize data-driven approaches and effective analysis, implementation, and evaluation towards improved clinical outcomes, services, and experiences
   - 2.d. Ensure care is provided regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and linguistically appropriate manner[15]

2.e. Identify population-based strategies to identify, evaluate, and reduce healthcare disparities through analysis, equity-focused interventions, and meeting disparity reduction targets[16]
2.f. Provide access to services and communication in alternate formats to ensure non-discrimination of members as defined in Section 1557 of the Patient Protection and Affordable Care Act[73]
2.g. Education regarding accessing the health care system and support on obtaining care and services when needed
2.h. Concerns resolved quickly and effectively including the right to voice complaints or concerns without fear of discrimination
2.i. Engagement in the discussion about services, regardless of cost or benefit coverage
2.j. Confidence that they can reach the Alliance quickly and be satisfied with the information received.
2.k. Maintain Member confidentiality in quality Improvement discussions.

3. Members' experience of care and service provided by the Alliance and its contracted providers:
3.a. Monitor member satisfaction with quality of care and services received from network providers, practitioners and delegates and acting upon identified opportunities
3.b. Obtain information on member's values, needs, preferences, and health-related goals through feedback mechanisms and touch points, such as surveys, focus groups, member outreach, care management, and other means
3.c. Establish population health programs to empower and encourage members to actively participate in and take responsibility for their own health through the provision of health education, evidence-based tools, and shared goals for optimal health
3.d. Create a trusted health care system to assure feelings of safety, self-efficacy, and effective communication with all their care partners
3.e. Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all members[17];Integrate with current community health priorities, standards, and public health goals.

Definitions

1. California Children's Services (CCS) Program[18] (as part of the Whole Child Model Program): CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years of age can get the health care and services they need for CCS-eligible conditions. CCS also provides medical therapy services that are delivered at public schools through their Medical Therapy Unit (MTU).
2. Community Supports: Services or settings offered by a Medi-Cal health plan that are offered in place of services or settings covered under the California Medicaid State Plan, and are medically appropriate, cost-effective substitutes for services or settings under the State Plan. Services are offered at the plan's option and an enrollee cannot be required to use them.
3. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Standardized surveys of Agency for Healthcare Research and Quality (AHRQ), the CAHPS' surveys health plan members to measure their experiences with a variety of areas, including access to care and satisfaction with the health plan.
4. Corrective Action[19]: Specific identifiable activities or undertakings of the Alliance that address program deficiencies or problems.

5. Enhance Care Management (ECM): ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person centered.
6. External Accountability Set (EAS)[20]: Performance Measures: The EAS performance measures consist of a set of Healthcare Effectiveness Data Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). The EAS performance measures may also include other standardized performance measures and/or DHCS developed performance measures selected by DHCS for evaluation of health plan performance.
7. Healthcare Effectiveness Data and Information Set (HEDIS)[21]: The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.
8. High Performance Level (HPL): DHCS establishes an HPL for each required HEDIS performance measure and publicly acknowledges Managed Care Plans (MCPs) that meet or exceed the HPLs. DHCS's HPL for each required measure is the 90th percentile of the national Medicaid results.
9. Long Term Care Services: Long-term care benefit standardization and transition of members to managed care, including managing the long-term care of members in skilled nursing facilities.
10. Managed Care Accountability Set (MCAS): A set of measures based on the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets, and NCQA are selected by DHCS for evaluation of health plan performance.
11. Minimum Performance Level (MPL): Medi-Cal managed care health plans must meet or exceed the DHCS established MPL for each required HEDIS performance measure. If MPL is not met, then an Improvement Plan must be completed. DHCS's MPL for each required measure is the 50th percentile of the national Medicaid results.
12. National Committee for Quality Assurance (NCQA)[22]: A non-profit organization that committed to evaluating and publicly reporting on the quality of managed care plans.
13. Performance Improvement Projects (PIPs)[23]: Studies selected by the Alliance, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes[24].
14. Plan, Do, Study, Act (PDSA): A cyclical, four-step management method used for continuous improvement and monitoring of processes. The methodology is a rapid cycle/continuous quality improvement process designed to perform small tests of change, which allows more flexibility to make adjustments throughout the improvement process[25].

Procedures

The QIHETP is structured to develop and maintain an integrated system to continually identify, assess, measure, and improve member health outcomes. Providers and members are an integral part of the QIHETP. QIHETP activities are overseen and approved in the following manner:

1. Maintain Accountability of Care Systems
   Accountability for the QIHETP development and performance review includes the Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board), the Quality Improvement Health Equity Committee (QIHEC), Chief Health Equity Officer or designee, the Peer Review and Credentialing

Committee (PRCC), the Compliance Committee, the Chief Medical Officer (CMO), and Alliance network providers[26].

1.a. Alliance Board[27]: The Alliance Board promotes, supports, and has ultimate accountability and authority for a comprehensive and integrated QIHETP. Alliance Board responsibilities include:
- 1.a.1. Annual review and approval of the QIHETP and applicable QIHETP reports;
- 1.a.2. Appointment of an accountable entity or entities to provide oversight of the QIHETP;
- 1.a.3. Routine review of written progress reports from the QIHEC0;
- 1.a.4. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and DHCS Comprehensive Quality Strategy;
- 1.a.5. The Alliance Board has delegated direct supervision, coordination, and oversight of the QIHETP by the Quality Improvement Health Equity Committee (QIHEC), with the Chief Executive Officer (CEO) and Alliance Quality Improvement and Population Health (QIPH) Department under the supervision of the Chief Medical Officer (CMO) in collaboration with the Chief Health Equity Officer or designee. The CMO regularly provides QIHETP operational reports to the Alliance Board.

1.b. Quality Improvement Health Equity Committee (QIHEC)[28]: The QIHEC has oversight and performance responsibility of the QIHETP – excluding credentialing and recredentialing[29] activities, which are directed by the PRCC – as described by Alliance Policy 401-1201 – *Quality Improvement Health Equity Committee.*

1.c. Peer Review and Credentialing Committee (PRCC): The PRCC participates in the QIHETP under the authority of the Alliance Board. The PRCC maintains oversight and performance responsibility of the Alliance's credentialing and recredentialing activities, as described in Alliance Policy 300-4020 – *Peer Review and Credentialing Committee – Authority, Roles, and Responsibilities*.

1.d. Compliance Committee: The Compliance Committee participates in the QIHETP under the authority of the Alliance Board. The Compliance Committee maintains oversight and performance responsibility of the Alliance's delegated oversight activities, as described in Alliance Policy 105-0004 – *Delegate Oversight*.

1.e. Other Committees: In addition to the Alliance Board, QIHEC, PRCC, and Compliance Committee, the following committees and workgroups contribute to the Alliance's QIHETP:

- 1.e.1. Quality Improvement Health Equity Workgroup (QIHEW): The QIHEW, under the direction and guidance of the QIHEC, is responsible for ongoing QIHETP activities and addressing high-priority and emerging quality and health equity trends requiring organization-wide and/or cross-departmental response as described in Alliance Policy 401-1201 –*Quality Improvement Health Equity Committee*.

1.e.2. Care-Based Incentives Workgroup (CBIW): The CMO (or designee) chairs the CBIW. Core membership includes: QIPH Director, Quality and Health Programs Manager, QI Program Analysts, Quality Improvement Program Advisors, Quality and Population Health Manager, QI Project Specialist, Medical Directors, Pharmacy Director (or designee), PS Director (or designee), Contracts Manager, Analytics Director, and Analytics Manager.

1.e.3. Physicians Advisory Group (PAG): The PAG operates under the authority of the Alliance Board and participates in the QIHETP. as described in Alliance Policy 400-1109 – *Physicians Advisory Group Responsibilities and Functions*.

1.e.4. Utilization Management Work Group (UMWG): The UMWG is a mechanism to review, monitor, evaluate, and address utilization-related concerns as well as recommend and implement interventions to improve appropriate utilization and resource allocation. The UMWG reports to the ~~CQIC~~QIHEC and is co-chaired by an Alliance ~~-~~Medical Director and Utilization Management~~/Complex Case Management~~ (UM~~/CCM~~) Director. Core UMWG membership includes: CMO, Medical Directors, UM/CCM Director, UM/CCM Managers for Concurrent Review, UM/CCM Manager for Prior Authorization, Community Care Coordination (CCC) Director, QIPH Director, Pharmacy Director, Behavioral Health Managers and Director, and Health Services Authorization Supervisor.

1.e.5. Pharmacy and Therapeutics Committee (P&T): The P&T Committee operates under the authority of the ~~CQIC~~QIHEC and participates in the QIHETP as described in Alliance Policy 403-1104 – *Mission, Composition and Functions of the Pharmacy & Therapeutics Committee*.

1.e.6. Staff Grievance Review Committee (SGRC): The SGRC participates in the QIHETP as described in Alliance Policies 200-9004 – *Staff Grievance Review Committee* and 200-9001 – *Grievance Reporting, Quality Improvement and Audits*.

1.e.7. Whole Child Model Clinical Advisory Committee (WCMCAC): The WCMCAC operates under the authority of the Alliance Board and serves to advise on clinical issues relating to CCS conditions including treatment authorization guidelines, as described in Alliance Policy 400-1112 – *Whole Child Model Clinical Advisory Committee Responsibilities and Functions.*

1.e.8. Whole Child Model Family Advisory Committee (WCMFAC): The WCMFAC operates under the authority of the Alliance Board and serves as a venue to discuss perspective on issues relating to diagnosis and treatment of CCS conditions as well as to review and offer advice about policies, programs and initiatives relating to care of members in the WCM program. as described in Alliance Policy 280-0003 – *Whole Child Model Family Advisory Committee.*

1.e.9. Network Development Steering Committee:
The Network Development Steering Committee's (NDSC) primary responsibility is to: 1. Monitor and evaluate member access to care through:~~–~~ Comprehensive, coordinated, and

regular review of access inputs, including but not limited to survey outcomes, regulatory compliance, and process-related information (e.g., grievances). 2. Support improved member access to care through oversight of the development and execution of an annual provider network Access Plan.

1.e.10. Member Support and Engagement Committee:
The Member Support and Engagement Committee (MSEC) is an interdepartmental collaborative intended to evaluate the Alliance processes that assist members in navigating the health care system. The Alliance's goal is to ensure members are supported and engaged, while being confident that they will receive appropriate care from providers and excellent service from the health plan. This committee facilitates the collaboration and integration of relevant service indicators as defined by the monitoring process, analysis, action, and measurement. Through monitoring of appropriate indicators, MSEC will identify areas of opportunity to improve processes and implement interventions. The committee also works on member outreach to provide guidance to the Your Health Matters Outreach Program as appropriate to this committee's charter and any Quality Improvement Activities within the scope of this committee.

1.e.11. Member Reassignment Committee: Reassignment requests are presented to the Reassignment Committee for review and discussion. Determination is made by the Medical Director (MD).

1.e.12. Communications Committee: On-going updates on the QIHETP are provided to the committee to support planning, promotion, and communication of QIHETP activities.

1.f. Task Force: For emerging issues or priorities, a Task Force may be convened to cross-collaborate on needed actions or follow up until resolution or goals are met (e.g., Public Health Response Task Force, Pediatric Equity Task Force).

1.g. Program Staff
Alliance staff participating in the QIHETP are described below. Specific qualifications and training for each role are available in the respective position description for each role.

1.g.1. Chief Executive Officer (CEO): The CEOs primary role in the QIHETP is fourfold: maintain a working knowledge of clinical and service issues targeted for improvement; provide organizational leadership and direction; participate in prioritization and organizational oversight of QIHETP activities; and ensure availability of resources necessary to implement the QIHETP.

1.g.2. Chief Medical Officer (CMO): The CMO is responsible for assuring the availability and quality of health care services for Alliance members. Responsibilities include leadership and direction of UM, Quality Management and CM programs, including medical management

policies and effective operation of the Health Services (HS) Division. The CMO uses the health plan's systems and data to analyze HS Division issues and policies and is responsible for communicating findings and recommendations within the health plan, to the governing board, to physician committees and other providers, and to other stakeholders. This position is an advocate and liaison for the provider network and participates in strategic planning for new programs, lines of business, and special projects at the health plan. The CMO is also responsible for direction and supervision of the Medical Directors.

The CMO shall ensure that that the organization's medical personnel follow medical protocols and rules of conduct. The CMO shall participate directly in the implementation of Quality Improvement and Health Equity activities~~.~~, The CMO shall participate directly in the design and implementation of the Population Health Management Strategy and initiatives~~.~~, The CMO shall participate actively in the execution of Grievance and Appeal procedures~~.~~, The CMO shall ensure that the that Contractor engages with local health department~~.~~, The CMO or designee's information shall be posted in an easily accessible location in their provider portal website~~.~~,

1.g.3. Chief Health Equity Officer (CHEO)[30] or designee: Provide leadership to ensure health equity is prioritized and health inequities are addressed within the QIHETP. This role acts as part of the Regional Quality and Health Equity team.

1.g.4. Medical Directors: The Medical Directors provide clinical leadership within one or more of the HS functional areas including but not limited to: UM/CCM, QIPH, Pharmacy, and CCC. The Medical Directors are responsible for guidance and direction of QIHETP activities.

1.g.5. Quality Improvement and Population Health (QIPH) Director: Under the direction of the CMO, the QIPH Director is responsible for strategic direction and management of the Alliance QIHETP. The QIPH Director manages the Alliance's preparations and response to regulatory and internal medical audits and manages implementation of selected NCQA standards. The QIPH Director is also responsible for engagement with internal and external stakeholders in the QIHETP. This role acts at the Performance Improvement Lead or may delegate this role to staff across the organization for the quality and health improvement efforts across the organization~~.~~, This role acts as part of the Regional Quality and Health Equity team.

1.g.6. Quality and Performance Improvement Manager (QPIM): Under the direction of the QIPH Director, and in collaboration with the Medical Directors, the QPIM: manages and leads quality and performance improvement initiatives; supports development, management and implementation of practice coaching program activities in the community clinics to improve clinical outcomes; accountable for collaborating with staff in the implementation of the QIHETP, and assists in coordinating member experience surveys, such as the annual

Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This role acts as part of the Regional Quality and Health Equity team.

1.g.7. Quality and Population Health Manager (QPHM): Under the direction of the QIPH Director, and in collaboration with the Medical Directors, the QPHM provides technical leadership and expertise in clinical data for one or more of the following areas in implementation of the QIHETP: data management and retrieval, reporting standards and complex analysis, state policy and procedure implementation, and systems configuration and research for Alliance HS Division leadership. The QPHM also: provides statistical modeling methodologies in the development of health plan, provider, and member analysis; coordinates HEDIS/MCAS reporting activities; and prepares and participates in audits conducted by regulatory agencies. This role acts as part of the Regional Quality and Health Equity team.

1.g.8. Clinical Safety Quality Manager (CSQM): Under the direction of the QIPH Director, and in collaboration with the Medical Directors, the CSQM provides clinical leadership and expertise in clinical data for one or more of the following areas in implementation of the QIHETP: reporting standards, state policy and procedure implementation, Potential Quality Issue investigative process, Facility Site Review audit process, and prepares and participates in audits conducted by regulatory agencies regarding all clinical quality issues.

1.g.9. Quality and Health Programs Manager (QHPM): Under the direction of the QIPH Director and in collaboration with the Medical Directors, the QHPM maintains administrative oversight and is responsible for all aspects of planning and managing the Alliance Health Education and Disease Management programs and Cultural and Linguistic services as well as the Member Incentive and Health Education Materials approval process for the Alliance. The QHPM also coordinates the Health Education and Cultural and Linguistic Population Needs Assessments reporting activities and participates in audits conducted by regulatory agencies.

1.g.10. Quality and Health Programs Supervisor(s) (QHPS): Under the direction of the QHPM, the QHPS coordinates and implements the Alliance Health Education and Disease Management programs and Cultural and Linguistic services (oversees interpretation and translation services and vendors) and processes. The QHPS also leads preparing health and disease management program promotional materials, including newsletter articles, and member/provider communications. The QHPS also supervises the Health Educators and Care Coordinator.

1.g.11. Health Educator(s): Under the direction of the QHPM and QHPS, the Health Educators primary responsibility is to provide outreach to members participating in health education and disease management programs and implement specific programs as assigned. Health education and disease management programs are provided by the Health Educators directly by telephonic and/or workshops. They co-facilitate health education and disease

management member programs, such as trainings, workshops, and community presentations.

1.g.12. Care Coordinator I: Under the direction of the QHPS, the Care Coordinator I assists with coordination of Language Assistance services via the Alliance's internal care tracking system, and other duties as needed.

1.g.13. Quality Improvement Nurse (RN) Supervisor: Under the direction of the QPHM, the QI Nurse Supervisor coordinates and implements QIPH programs and processes, including Facility Site Review (FSR), Medical Record Review (MRR), Physical Accessibility Review (PAR), and Potential Quality Issues. The QI RN Supervisor also supervises, mentors, develops, coordinates, and conducts training for QIPH staff.

1.g.14. QI Program Advisor IV (QIPA IV): Under the direction of the QPHM, the QIPA IV leads the planning, implementation, and management of select QIPH programs, including but not limited to Care Based Incentive (CBI), HEDIS/MCAS, and Performance Improvement. The QIPA IV provides orientation, training, and mentorship to subordinate QIPH staff and acts as the subject matter expert in support of QIHETP objectives. This role acts as part of the Regional Quality and Health Equity team.

1.g.15. QI Program Advisor III (QIPA III): Under the direction of the QPIM, QIPA III's lead the planning, implementation, and management of select QIPH programs, including but not limited to CBI, HEDIS, and Performance Improvement; and provide training and expertise in support of QIHETP objectives. This role acts as part of the Regional Quality and Health Equity team.

1.g.16. QI Program Advisor II (QIPA II): Under the direction of the QPHM, or QPIM, the QIPA II supports QIPH Department leadership with program administration; conducts studies and analyzes data to evaluate the Alliance's performance; and analyzes, develops, and implements improvement activities to increase performance against national, state and/or regional benchmarks and definitions. This role acts as part of the Regional Quality and Health Equity team.

1.g.17. QI Program Advisor I (QIPA I): Under the direction of the QPH Manager, the QIPA I assists with monitoring data received from external partners. The QIPA I develops, writes, and produces reports to monitor compliance with contractual and regulatory requirements. The QIPA I also supports the department with ad hoc reporting for internal and external stakeholders. This role acts as part of the Regional Quality and Health Equity team.

1.g.18. QI Nurse: Under the direction of the QI RN Supervisor, QPHM or the QPIM, the QI Nurse develops, manages, and measures a comprehensive preventive health care strategy in collaboration with internal stakeholders and network providers to promote best evidence-

based practices and improve member health outcomes. The QI Nurse participates in local, regional, and state audits and improvement initiatives.

1.g.19. Senior QI Nurse: Under the direction of the QI RN Supervisor, QPHM or the QPIM, the Senior QI Nurse develops, manages, and measures a comprehensive preventive health care strategy in collaboration with internal stakeholders and network providers to promote best evidence-based practices and improve member health outcomes. The Senior QI Nurse participates in local, regional, and state audits and improvement initiatives. In addition, the Senior QI Nurse trains, and mentors other QIPH department nurses.

1.g.20. Coding Resource Specialist: Under the direction of the QPIM, the Coding Resource Specialist acts as the clinical coding expert across all departments for the Alliance and utilizes advanced knowledge of professional coding to review and recommend changes to systems, policies, and/or procedures to guarantee current and appropriate coding guidelines are maintained.

1.g.21. QI Project Specialist: Under the direction of either the QPIM or QI RN Supervisor, the QI Project Specialist acts as a key program assistant by coordinating efforts for QIPH programs such as CBI, C&L, FSR, Health Programs, Potential Quality Issue (PQI) and HEDIS. The QI Project Specialist supports in the planning of departmental projects and communication activities.

1.g.22. QIPH Administrative Specialist (QIPH Admin): Under the direction of the QIPH Director, the QIPH Admin performs multiple administrative functions in support of the QIHETP and QIPH department; and performs administrative staff support to QIHETP committees as needed.

1.g.23. Chief Compliance Officer: Under the direction of the CEO, the Chief Compliance Officer is responsible for overseeing and coordinating Compliance Program activities, including serving as Chair of the Compliance Committee and providing oversight of delegate oversight activities in accordance with Alliance policy 105-0004 – *Delegate Oversight*.

1.g.24. Utilization Management Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of Utilization Management Program staff.

1.g.25. Community Care Coordination (CCC) Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of CCC Program staff.

1.g.26. Pharmacy Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of Pharmacy Program staff.

1.g.27. Grievance Staff: Alliance Grievance staff is responsible for routing grievances to QIPH for research and analysis, routing, and resolution of clinically related member or provider complaints.

1.g.28. Credentialing Staff: Alliance Credentialing staff is responsible for ensuring the accuracy and completion of provider credentialing files prior to PRCC review. Credentialing staff oversee the completion of credentialing application information in accordance with Alliance Policies 300-4020 – *Peer Review and Credentialing Committee – Authority, Roles, and Responsibilities* and 300-4040 – *Professional Provider Credentialing Guidelines*. The Credentialing staff monitors timeliness of review for re-credentialing[31]. The Credentialing staff also ensure the ongoing monitoring of provider credentials and issues in accordance with Alliance Policy 300-4090 – *Ongoing Monitoring of Provider Credentials and Issues*.

1.g.29. Community Engagement Director. The Community Engagement Director and team are responsible for ensuring regional input is considered in the design and implementation of the QIHET.

1.g.30. Other staff: The Alliance encourages active involvement of all Alliance staff in the design and implementation of the QIHETP.

1.h. QIHETP Alliance Board Reports

1.h.1. Quality Improvement Health Equity Work Plan (QIHE-WP): The QIHE-WP is developed and maintained by QIPH staff. The CMO, QIPH Director, and QIPH Managers review the QIHE -W and obtain approval from QIHEW and the QIHEC prior to sending it to the Alliance Board for final approval.

1.h.2. Committee Minutes: QIHEC, Compliance Committee minutes, and PRCC credentialing/re-credentialing related reports, are reviewed by the Alliance Board on a routine basis[32]. QIHEC minutes are submitted to DHCS upon Alliance Board review and approval. A written summary of the QIHEC activities publicly available on the Alliance website at least on a quarterly basis.[33]

1.h.3. QIHEP Annual Report: The QIHE Annual Report is submitted to the QIHEC for its review, approval, and submission to the Alliance Board[34], and subsequent submission to DHCS. The QIHE Annual Report includes a comprehensive assessment of QIHE activities, including an evaluation of areas of success and needed improvements. The report addresses clinical quality of physical, behavioral health, access and engagement or providers, continuity and coordination across setting and all levels of care, and Member experience. Effective in 2024, the evaluation includes but is not limited to: the QIHE-WP, analyses of fully delegated subcontractor's and downstream fully delegated subcontractor's performance measure results and actions to address any deficiencies, actions taken to address the annual External Quality Review (EQR) technical report and evaluation reports, planned equity-

focused interventions to address identified patterns of over- or under-utilization, description of member and/or family focused care such as Community Advisory Committee (CAC) findings, Population Health management activities and findings, and outcomes/findings from Performance Improvement Projects, member satisfaction surveys, and collaborative initiatives as appropriate.

~~1.h.3.~~1.h.4. The QIHE Annual Report also includes copies of all independent private accrediting agencies (e.g., NCQA) if relevant, including accreditation status, survey type, and level, as applicable; accreditation agency results, including recommended actions or improvements, corrective actions plans, summaries of findings; and expiration date of accreditation[35].

2. Maintain Continuous Quality Monitoring Utilizing Specific Quality and Performance Improvement Methods: The QIHETP uses a variety of mechanisms to identify potential quality of service issues, ensure patient safety, and ensure compliance with standards of care across the care continuum (i.e., preventative health services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services). These mechanisms include, but are not limited to:

   2.a. External Quality Review[36]: The Alliance incorporates external quality review requirements into the QIHETP as described in Alliance Policy 401-1607 – *Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight*. The Alliance is contractually required to annually track and report on a set of Quality Performance Measures and Health Equity measures. The Alliance works with the EQRO to undergo an external quality review using MCAS performance measures. MCAS performance measures consist of a set of CMS Adult and Child measures developed by NCQA, other standardized performance measures, and/or DHCS developed performance measures. DHCS selected MCAS measures will be stratified by various demographics, as required.

   2.b. Site Review[37]: The Alliance incorporates site review requirements into the QIHETP as described in Alliance Policies 401-1508 – *Facility Site Review Process*, 401-1510 – *Medical Record Review and Requirements* and 401-1521 – *Physical Accessibility Review*. The Alliance conducts a Facility Site Review (FSR) for new primary care providers (PCPs) before initial credentialing and a minimum of every three (3) years thereafter as a requirement for participation in the California State Medi-Cal Managed Care Program. Physical Accessibility Reviews (PARs) are conducted during the initial FSR for new primary care provider sites, and at a minimum of every three (3) years upon re-credentialing[38]. Specialists and Ancillary sites that serve a high-volume of SPD members (providers whose monthly average of encounters for SPD members are above the monthly average of encounters) receive a PAR at a minimum of every three (3) years[39]. The Alliance ensures that member medical records are maintained by health care providers in accordance with contractual obligations[40]. The Alliance submits site review data to DHCS up to quarterly, or in a manner or timeframe specified by DHCS[41].

   2.c. Disease Surveillance[42]: The Alliance incorporates disease surveillance requirements into the QIHETP as described in Alliance Policy 401-1519 – *Infection Control Practices*. The Alliance requires

providers report diseases or conditions that must be reported to public health authorities to applicable local, state, and federal agencies as required by law.

2.d. Credentialing and Recredentialing[43]: The Alliance incorporates credentialing and recredentialing requirements into the QIHETP as described in Alliance Policies 105-0004 – *Delegate Oversight*[44], 300-4020 – *Peer Review and Credentialing Committee - Authority, Roles and Responsibilities*, 300-4030 – *Credentialing Criteria and Identified Issues*, 300-4040 – *Professional Provider Credentialing Guidelines*, 300-4090 – *Ongoing Monitoring of Provider Credentials and Issues*, 300-4110 – *Organizational Providers Credentialing Guidelines*, and 401-1523 – *Non-Physician Medical Practitioner: Scope of Practice and Supervision*.

2.d.1. The Alliance delegates oversight of credentialing, re-credentialing, recertification, and physician reappointment activities to the PRCC. The Alliance credentialing standards, as approved by PRCC, are aligned with applicable DHCS and Department of Managed Health Care (DMHC) credentialing and certification requirements[45].

2.d.2. The Alliance maintains a system of reporting serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Disciplinary actions include: reducing, suspending, or terminating a practitioner's privileges. The Alliance maintains an appeal process[46].

2.e. Timely Access Monitoring[47]: The Alliance incorporates timely access monitoring requirements into the QIHETP as described in Alliance Policies 300-1509 – *Timely Access to Care* and 300-8030 – *Monitoring Network Compliance with Accessibility Standards*. The Alliance ensures the provision of covered services in a timely manner consistent with the DMHC Timely Access requirements and participation in the EQRO's network adequacy validation studies. The Alliance continuously reviews, evaluates, and seeks to improve access to and availability of services. This includes ensuring that members are able to obtain appointments from contracted providers according to established access standards.

2.f. Member Satisfaction Monitoring[48]: The Alliance incorporates member satisfaction monitoring requirements into the QIHETP as described in Alliance Policies 401-2001 – *Member Surveys*, 200-9001 – *Grievance Reporting, Quality Improvement and Audits*, and 200-9004 – *Staff Grievance Review Committee*. Member satisfaction survey results are reviewed and monitored for variations. Grievance data is reviewed and analyzed regularly to identify trends as part of the Alliance's efforts to improve and optimize the delivery and management of health care services. Grievance staff refers individual cases for clinical review to QIPH staff as appropriate and the SGRC reports trends in quality issues to the QIHEW.

2.g. Provider Satisfaction Monitoring[49]: The Alliance incorporates provider satisfaction monitoring requirements into the QIHETP as described in Alliance Policy 300-3092 – *Provider Satisfaction Survey*. The Alliance conducts annual surveys of contracted physicians to determine provider

satisfaction with the Alliance's performance and to identify any provider concerns with compliance with various regulatory standards.

2.h. Claims Encounter Data Monitoring: The Alliance incorporates claims encounter data monitoring requirements into the QIHETP as described in Alliance Policy 105-3002 – *Program Integrity: Special Investigations Unit Operations*. Should claims review identify potential fraud, waste or abuse concerns appropriate referrals are made to the Alliance Special Investigations Unit (SIU). QIPH works with Compliance to address any PQIs, provider preventable conditions, or any other variations in practice. Appropriate actions are taken based upon these claim reviews and other fraud, waste, and abuse investigations.

2.i. Encounter Data Validation[50]: The Alliance participates in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements.

2.j. Potential Quality Issue (PQI) processes: The Alliance incorporates PQI monitoring requirements into the QIHETP as described in Alliance Policy 401-1301 – *Potential Quality Issue Review Process*. The Alliance maintains a systematic review process to identify, analyze and resolve potential quality of care issues to ensure that services provided to members meet established standards, and address any patient safety concerns.

2.k. Under/Over-Utilization Monitoring[51]: The Alliance incorporates under/over-utilization monitoring requirements into the QIHETP as described in Alliance Policies 404-1101 – *Utilization Management Program* and 404-1108 – *Monitoring of Over/Under Utilization of Services*. The UM Program serves to ensure appropriate, high quality, cost-effective utilization of health care resources and that these resources are available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on evidence-based criteria, and expert clinical opinion when needed.

2.l. Population (PNA)[52]: The PNA evaluates the health education and cultural and linguistic needs of members, and the findings are used to guide the development and implementation of cultural and linguistic health education interventions. The Alliance prepares a PNA annually.[50] The Alliance will incorporate county or region-specific Population Needs Assessment, as detailed in the Population Health Management Policy Guide, to build community partnerships, improve member participation, and to fully understands the barriers preventing all populations from receiving care and preventive services as well as identify and address social drivers of health.

2.m. Community Health Assessment (CHA)/Community Health Improvement Project (CHIP): Based on participating in the CHA/CHIP process The Alliance must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:

2.m.1. Targeted health education materials for Members, including Member-Facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services (NSMHS).
2.m.2. Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and
2.m.3. Wellness and prevention programs.

2.n. Seniors and Persons with Disabilities (SPD) Activities[53]: The Alliance incorporates SPD activity requirements into the QIHETP as described in Alliance Policies 404-1114 – *Continuity of Care*, 405-1112 – *Care Management of Seniors and Persons with Disabilities for Medi-Cal*, and 401-3101 – *Health Education and Disease Management Program*. The Alliance conducts studies for SPDs or persons with chronic conditions that are designed to assure the provision of case management, coordination, and continuity of care services, including ensuring availability, access to care, and clinical services.

2.o. Focused Studies: The Alliance participates in the external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided[54].

2.p. Technical assistance: The Alliance implements EQRO's technical guidance in conducting mandatory and optional activities described in 42 CFR 438.358[55]

2.q. Ad Hoc Data Studies: The Alliance also conducts other stratified data studies to evaluate the population as needed.

2.r. Quality Improvement Health Equity Work Plan (QIHE-WP) Development and Review: The QIHE-WP is an annually developed, dynamic document that reflects the progress of QIHETP activities throughout the year. It includes measurable yearly objectives to help the organization monitor for continuous performance improvement. These are achieved through active engagement and cross-collaboration with all departments within the Alliance.

2.s. Behavioral Health Services Monitoring: The Alliance incorporates behavioral health services monitoring requirements into the QIHETP as described in Alliance Policy 408-1305 – *Behavioral Health Services for Medi-Cal to ensure delivery of Medically Necessary non-specialty and specialty mental health services*. Oversight and monitoring of any delegated portions of mental health services are outlined in Policy 105-0004 – *Delegate Oversight*.

2.t. Quality Improvement Delegate Oversight Activities[56]: The Alliance incorporates QIPH delegate oversight activities into the QIHETP as described in Alliance Policies105-0004 – *Delegate Oversight* and 401-1201 –*Quality Improvement Health Equity Committee*. The Alliance may delegate QIPH functions to subcontracting entities, as outlined in Alliance Policy 105-0004 – *Delegate Oversight*.

These delegated functions are set forth in the Alliance's contracts with subcontracting entities and include specific performance and reporting standards that must be met.

2.u. Enhance Care Management (ECM) Monitoring[57]: The Alliance monitors the utilization of and/or outcomes resulting in the provision of the ECM including any activities, reports, and analysis to understand the impact of ECM delivery for Alliance members as described in Alliance Policy ECM Overview. In addition, the Alliance will work collaboratively across all departments to accomplish required audits and/or case reviews, supplemental reporting requirements, and monitor provider performance with ECM contractual terms and conditions.

2.v. Community Supports (CS)[58]: The Alliance monitors the utilization of and/or outcomes resulting in the provision of CS including any activities, reports, and analysis to understand the impact of CS delivery for Alliance members as described in Alliance Policy 405-1310 Community Supports Overview.

2.w. Long Term Care Services: The Alliance monitors quality monitoring, assurance, and improvement efforts for Long Term Care services in institutional settings to support and improve the access to and quality of long-term care provided by the Alliance's contracted facilities.

2.x. Patient Level Data Submissions: The Alliance will utilize the DHCS' EQRO File Transfer Protocol (FTP) website when sending communications containing patient-level data.

3. Analyze and Evaluate Annual Data, Incorporate Provider Feedback and Develop Interventions
Using the methods outlined above, QIPH analyzes data using current evidence-based standards as benchmarks. As stated in the provider manual, providers, practitioners, and facilities must make performance data available to the Alliance to cooperate with and participate in quality improvement activities. Significant quality, service, or utilization issues are analyzed for barriers, trends, or root causes. This process incorporates provider review and feedback into performance improvement activities and may include a multidisciplinary team, quantitative and qualitative analysis, and development of interventions that are implemented and/or planned for continuous monitoring.

3.a. Analyze and Evaluate Annual Data: Analysis is performed utilizing various current evidence-based standards as benchmarks:

3.a.1. Meet health disparity reduction targets for specific populations and measures as identified by DHCS[59];

3.a.2. CMS Child and Adult Core Set Standards

3.a.2.a. Exceeding MCAS HPLs and MPLs for each quality Performance and health equity measures[60];

3.a.2.b. Under-utilization of DHCS identified performance measures as part of the MCAS which will be measured as part of the EQRO compliance audit[61]; and

3.a.2.c. CAHPS Survey results[62].

3.a.3. Preventive Care Guidelines: The preventive care guidelines address periodic health and behavioral risk screening and preventive services for asymptomatic adults and children. Individuals identified as being at high risk for a given condition may require more frequent or additional screening tests specific to the condition. These guidelines establish the minimum standard of preventive care. Further details are included in Alliance Policy *401-1502- Adult Preventive Care*, and *401-1505 - Childhood Preventive Care*.

3.a.3.a. Adult preventive care guidelines include[63]:

1. The United States Preventive Services Task Force (USPSTF) guidelines;
2. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (CDC ACIP); and
3. The State of California DHCS Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004.

3.a.3.b. Pediatric preventive care guidelines include[64]:

1. The provision of the Early and Periodic Screening, Diagnostic, and Treatment Services inclusive of education and outreach for members under the age of 21 years old in accordance with the American Academy of Pediatrics (AAP) Bright Future guidelines (All Plan Letter 23-005 and AB 2340);
2. CDC ACIP;
3. Child Health and Disability Prevention Program (CHDP); and
4. The DHCS MMCD Policy Letter 14-004.

3.a.4. Standards of Care: Standards of care criteria and guidelines are used to determine whether to authorize, modify or deny health care services and are based on nationally recognized guidelines, professionally recognized standards, review of applicable medical literature, and peer review. These criteria and guidelines are reviewed annually by the QIHEC (or sub-committee) as outlined in Alliance Policy 401-1501 – *Standards of Care*.

3.a.5. MCG (formerly Milliman Care Guidelines): MCG is utilized as outlined in Alliance Policy 404-1112 – *Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests*.

3.b. Incorporate Provider Feedback[65]: The Alliance ensures participation of network providers, fully delegated subcontractors, and downstream fully delegated subcontractors in the QIHETP and PNA, including distribution of information regarding QIHETP programs, activities, reports and actively elicits provider feedback through one or more of the following:

3.b.1. Distribution of Provider Bulletins, memorandums, and email communication;

3.b.2. Regular updates to Member and Quality Reports in the Provider Portal;

3.b.3. Publication of Board Reports;

3.b.4. CBI workshops and performance reviews including:
- 3.b.4.a. Comparison of provider performance to average Alliance-wide performance;
- 3.b.4.b. Reports showing provider deviation from a benchmark or an established threshold; and
- 3.b.4.c. Recommended interventions to improve performance;

3.b.5. Inclusion of providers in PDSA activities and on PIP teams;

3.b.6. Medical Director and Provider Services' onsite and network communication; Coordination and facilitation of external committee meetings, including Safety Net Clinic Coalition, and hospital and clinic Joint Operation Committees (JOC);

3.b.7. Coordination and facilitation of Alliance physician committees, including QIHEC, PAG, PRCC, and WCMCAC. Outcomes from these committees requiring modifications to the operational QIHETP are incorporated by way of receipt of directives from the Alliance Board[66] and/or by receipt of reports from the CMO, and;

3.b.8. On-going provider, fully delegated subcontractors, and downstream fully delegated subcontractor's meetings or outreach, such as technical assistance, practice coaching, or other means to provide updates on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results.

3.c. Develop Interventions

3.c.1. Priority Setting: Use of personnel and other resources is prioritized by the QIHEC annually, taking into consideration contractual and regulatory requirements, high volume/high risk services, and quality of care issues that are relevant and meaningful to the member population. Another factor which may be considered when selecting improvement opportunities to pursue is the extent to which the issue affects care, or the likelihood of changing behavior of members or practitioners. To maximize the use of resources, QIPH activities may be selected based on their ability to satisfy multiple QIHETP requirements.

3.c.2. Performance Improvement work including Performance Improvement Projects (PIP)[67,68]: Under consultation and with guidance from the External Quality Review Organization (EQRO) and DHCS, the Alliance conducts a minimum of two (2) DHCS-approved PIPs. One PIP must be either an internal PIP or a small group collaborative. The second PIP must be a DHCS-facilitated state-wide collaborative.

PIPs are developed by identifying targeted areas for improvement (clinical or nonclinical) and are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and include the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

In addition to Performance Improvement Projects quality improvement and health equity teams will participate in statewide and/or regional collaboratives that may improve quality and equity of care Medi-Cal members as directed by DHCS on a quarterly basis at a minimum, and these meetings may be in-person~~.~~ . The Alliance will leverage existing regional quality and health equity teams, where available, to support QI and health equity work for all counties across the various DHCS designated regions.

The Alliance will ensure appropriate staff resources are available to complete PIP submissions in a timely manner and status of each PIP at least annually to DHCS[69].

3.c.3. Corrective Action Plans (CAPs):

3.c.3.a Provider CAPs resulting from FSR and Medical Record Review (MRR) must be addressed and documented, consistent with Alliance Policy 401-1508 – *Facility Site Review Process*. PCP sites that do not correct cited deficiencies are to be terminated from the network[70]; and

3.c.3.b. Provider CAPs may be an intervention for certain PQIs, as deemed appropriate by the CMO or a Medical Director[71]. Refer to Alliance Policy 401-1306 - *Corrective Action Plan for Quality Issues.*

3.c.4. Improvement Plan[72]:

The Alliance must submit a PDSA Cycle Worksheet to DHCS for each MCAS measure with a rate that does not meet the MPL or is given an audit result of "Not Reportable" (NR). Additionally, the Alliance will conduct Quality Improvement and health equity improvement projects in areas where performance is below DHCS' established MPLs as determined in the MCAS: Quality Improvement and Health Equity Framework Policy Guide. DHCS will notify MCPs of the due date. Submission includes analysis of barriers, targeted interventions, relevant data to support analysis, targeted interventions, and a rapid cycle /continuous quality improvement process to guide PDSA outcomes. The Alliance will conduct at least a quarterly evaluation of ongoing rapid-cycle quality improvement efforts to determine whether progress is being made.

3.c.5. Quality and Health Programs:

3.c.5.a Disease Management: Consistent with Alliance Policy 401-3101 – *Health Education and Disease Management Program*, the Alliance maintains an evidence-based disease management programs that incorporate health

education interventions, target members for engagement and seek to close care gaps for members participating in these programs[73].

3.c.5.b Health Education and Promotion: Consistent with Alliance Policy 401-3101 – *Health Education and Disease Management Program*, the Alliance offers important health education and promotion programs for its members. These programs are intended to assist members to improve their health, properly manage illness, and avoid preventable conditions. These programs have been implemented in all Alliance service areas, and are routinely reviewed for access, quality, and outcomes and reported as part of the QIHETP[74].
Health Programs services and information is shared with providers through the Provider Portal and special mailings for general performance reports, which may include:

a. Listings of members who need specific services;
b. Listings of members who need intervention based on pharmacy indicators; and
c. Alliance-sponsored training directed at improving performance.

3.c.5.c. Care-Based Incentive (CBI): The CBI Program provides incentive payments to providers and members for a variety of activities and serves as a mechanism to identify specific areas of a provider's care that are below the standard of care and may be amenable to improvement through various interventions. Details of the CBI Program are updated annually and available in the Alliance Provider Manual and on the Alliance website. Refer to Alliance Policy 401-1705 - *Care-Based Incentive Program*

3.c.5.d. Internal Improvement Projects: The Alliance implements internal improvement projects as necessary based upon monitoring activities that have identified opportunities for improvement.

References:

Alliance Policies:

105-0004 – Delegate Oversight
105-3002 – Program Integrity: Special Investigations Unit Operations
200-9001 – Grievance Reporting, Quality Improvement and Audits
200-9004 – Staff Grievance Review Committee
280-0003 – Whole Child Model Family Advisory Committee
300-1509 – Timely Access to Care
300-3092 – Provider Satisfaction Survey
300-4020 – Peer Review and Credentialing Committee – Authority, Roles, and Responsibilities
300-4030 – Credentialing Criteria and Identified Issues
300-4040 – Professional Provider Credentialing Guidelines
300-4090 – Ongoing Monitoring of Provider Credentials and Issues
300-4102 – Reporting to the Medical Board of California and the National Practitioner Data Bank
300-4103 – Fair Hearing Process for Adverse Decisions

300-4110 – Organizational Providers Credentialing Guidelines
300-8030 – Monitoring Network Compliance with Accessibility Standards
400-1109 – Physicians Advisory Group Responsibilities and Functions
400-1112 – Whole Child Model Clinical Advisory Committee Responsibilities and Functions
401-1201 – -Quality Improvement Health Equity Committee
401-1301 – Potential Quality Issue Review Process
401-1306 – Corrective Action Plan for Quality Issues
401-1501 – Standards of Care
401-1502 – Adult Preventive Care
401-1505 – Childhood Preventive Care
401-1508 – Facility Site Review Process
401-1510 – Medical Record Review and Requirements
401-1519 – Infection Control Practices
401-1521 – Physical Accessibility Review
401-1523 – Non-Physician Medical Practitioner: Scope of Practice and Supervision
401-1607 – Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight
401-1705 – Care-Based Incentive Program
401-2001 – Member Surveys
401-3101 – Health Education and Disease Management Program
401-4101 - Cultural and Linguistic Services Program
403-1104 – Mission, Composition and Functions of the Pharmacy and Therapeutics Committee
404-1101 – Utilization Management Program
404-1108 – Monitoring of Over/Under Utilization of Services
404-1112 – Medical Necessity- The Definition and Application of Medical Necessity Provision to Authorization Requests
404-1114 – Continuity of Care
405-1112 – Care Management of Seniors and Persons with Disabilities for Medi-Cal
408-1305 – Behavioral Health Services
450-0002 – Population Needs Assessment and Population Health Strategy Deliverable

Impacted Departments:
Behavioral Health
Community Care Coordination
Community Engagement
Compliance
Member Services
Pharmacy Services
Provider Services
Utilization Management

Regulatory:
California Evidence Code Section 1157
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2

California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.70
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.70(b)(c)
Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 440, Subpart B, Section 440.262
Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 438, Subpart E, Section 438.330
Code of Federal Regulations, Title 42, 438.330(d) incorporated via [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
DHCS communication dated 8/2016 related to Title 42, Code of Federal Regulations, Section 440.262;

Legislative:

Assembly Bills, AB-2340 Medi-Cal: EPSDT Services: informational materials

Contractual (Previous Contract):

DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2

Contractual (2024 Contract):

Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.A-D
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6.K
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6.L

DHCS All Plan Letter:

MMCD PL 14-004 Site Reviews: Facility Site Review and Medical Record Review
DHCS APL 15-023 Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers
DHCS APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, And Treatment Services for Medi-Cal Members Under the Age Of 21
DHCS APL 19-017 Quality and Performance Improvement Adjustments Due to Covid-19
DHCS APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of The California Advancing and Innovating Medi-Cal Initiative
DHCS APL 24-004 Quality Improvements and Health Equity Transformation Requirements

NCQA:

HEDIS Volume 2 Technical Specifications for Health Plans

Supersedes:

Other:

Alliance Provider Manual

Attachments:

Attachment A: Quality Improvement Health Equity Transformation Reporting Structure
Attachment B: Quality Improvement and Population Health Organizational Chart

Lines of Business This Policy Applies To

☐ DSNP
☒ Medi-Cal
☒ Alliance Care IHSS

	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement & Health Equity Transformation Program (QIHETP)	
Original Date: 02/01/1996	**Date Published:** ~~04/30/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
01/26/2024	01/26/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
03/20/2024	03/20/2024	Sarina King, Quality and Performance Improvement Manager	QIHEW
04/25/2024	04/25/2024	Sarina King, Quality and Performance Improvement Manager	QIHEC
08/29/2024	08/29/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEW
09/24/2024	09/24/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
02/14/2025	02/14/2025	Kristen Rohlf, MPH, Quality and Population Health Manager	QIHEW
04/02/2025		Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
05/08/2025	05/08/2025	Kelly Tlemcani, Business Analyst II	QIHEW
06/26/2025		Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	

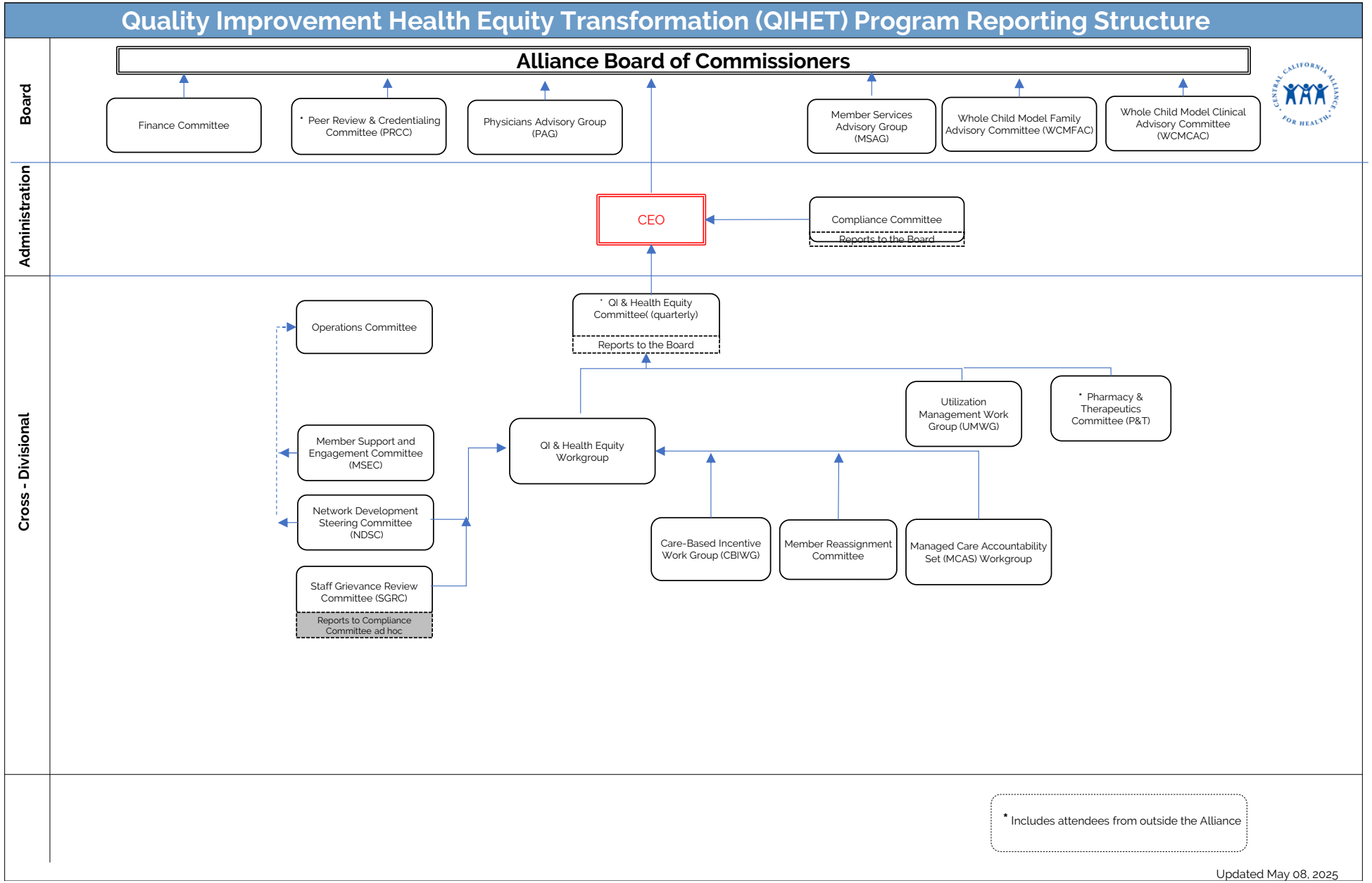
[1] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[2] DHCS State Medi-Cal Contract, Exhibit A, Attachment 34, Provision 2.2.6
[3] DHCS State Medi-Cal Contract, Exhibit A, Attachment 34, Provision 2.2
[4] DHCS Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2
[5] DHCS Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2B
[6] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[7] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[8] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.C.
[9] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[10] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6.
[11] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.A.
[12] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[13] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.12
[14] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6M
[15] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6F
[16] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6G
[17] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6P
[18] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[19] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[20] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions

[21] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[22] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[23] DHCS All Plan Letter 19-017
[24] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[25] DHCS All Plan Letter 19-017
[26] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.1
[27] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.2
[28] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3
[29] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[30] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 1.1.7
[31] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provisions 2.2.12
[32] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.12
[33] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3D
[34] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[35] [MMC Final Rule] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7.
[36] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[37] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision5.2.14
[38] MMCD PL 14-004; DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[39] DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[40] DHCS State Medi-Cal Contract, Exhibit A, Attachment , Provision 5.2.14
[41] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.14
[42] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.11
[43] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[44] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[45] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[46] Policy 300-4103 – Fair Hearing Process for Adverse Decisions; Policy 300-4102 – Reporting to the Medical Board of California and the National Practitioner Data Bank; 401-1306 – Corrective Action Plan for Quality Issues; 300-4090 – Ongoing Monitoring of Provider Credentials and Issues
[47] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2, DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.5
[48] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision2.2.9.C,; DHCS All Plan Letter 19-017
[49] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)
[50] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision2.2.9E
[51] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.3.3
[52] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.2
[53] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[54] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9F
[55] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9G
[56] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.5
[57] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.4.16A
[58] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.5.13C
[59] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9.A4
[60] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[61] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[62] Policy 401-2001 – Member Surveys
[63] Policy 401-1502 – Adult Preventive Care

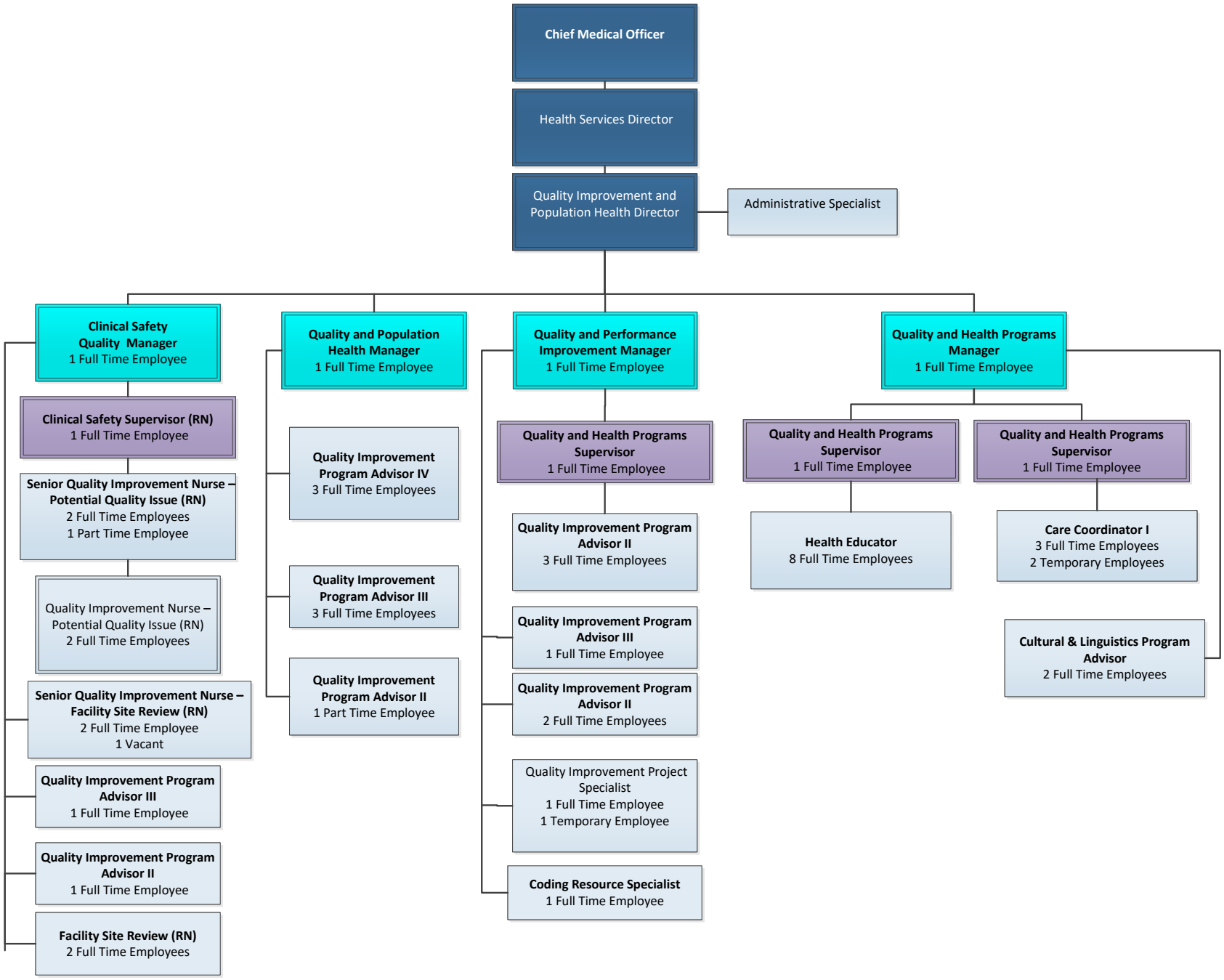
	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement & Health Equity Transformation Program (QIHETP)	
Original Date: 02/01/1996	**Date Published:** ~~04/30/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

[64] Policy 401-1505 – Childhood Preventative Care
[65] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.4
[66] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1
[67] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9; DHCS All Plan Letter 19-017
[68] 42 CFR 438.330(d), Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9B
[69] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9B5
[70] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.14; MMCD PL 14-004
[71] Policy 401-1301 – Potential Quality Issue Review Process; Policy 401-1306 – Corrective Action Plan for Quality Issues
[72] DHCS All Plan Letter 19-017
[73] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.10
[74] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.7
[75] DHCS APL 24-004 Quality Improvements and Health Equity Transformation Requirements

Quality Improvement Health Equity Transformation (QIHET) Program Reporting Structure



Back to Agenda


Chief Medical Officer
Health Services Director
Quality Improvement and Population Health Director
Administrative Specialist
Clinical Safety Quality Manager
1 Full Time Employee
Clinical Safety Supervisor (RN)
1 Full Time Employee
Senior Quality Improvement Nurse – Potential Quality Issue (RN)
2 Full Time Employees
1 Part Time Employee
Quality Improvement Nurse – Potential Quality Issue (RN)
2 Full Time Employees
Senior Quality Improvement Nurse – Facility Site Review (RN)
2 Full Time Employee
1 Vacant
Quality Improvement Program Advisor III
1 Full Time Employee
Quality Improvement Program Advisor II
1 Full Time Employee
Facility Site Review (RN)
2 Full Time Employees
Quality and Population Health Manager
1 Full Time Employee
Quality Improvement Program Advisor IV
3 Full Time Employees
Quality Improvement Program Advisor III
3 Full Time Employees
Quality Improvement Program Advisor II
1 Part Time Employee
Quality and Performance Improvement Manager
1 Full Time Employee
Quality and Health Programs Supervisor
1 Full Time Employee
Quality Improvement Program Advisor II
3 Full Time Employees
Quality Improvement Program Advisor III
1 Full Time Employee
Quality Improvement Program Advisor II
2 Full Time Employees
Quality Improvement Project Specialist
1 Full Time Employee
1 Temporary Employee
Coding Resource Specialist
1 Full Time Employee
Quality and Health Programs Manager
1 Full Time Employee
Quality and Health Programs Supervisor
1 Full Time Employee
Health Educator
8 Full Time Employees
Quality and Health Programs Supervisor
1 Full Time Employee
Care Coordinator I
3 Full Time Employees
2 Temporary Employees
Cultural & Linguistics Program Advisor
2 Full Time Employees

SANTA CRUZ – MONTEREY – MERCED – SAN BENITO – MARIPOSA MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, June 25, 2025
3:00 p.m. – 5:00 p.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
San Benito County Health and Human Services Agency
1111 San Felipe Road, Building B, Hollister, CA
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Commissioners Present:

Ms. Anita Aguirre,	At Large Health Care Provider Representative
Dr. Maximiliano Cuevas,	Health Care Provider Representative
Ms. Kim De Serpa	County Board of Supervisors
Ms. Janna Espinoza,	Public Representative
Mr. Mark Hendrickson	Assistant County Executive Officer
Dr. Donaldo Hernandez,	Health Care Provider Representative
Ms. Elsa Jimenez,	County Director of Health Services
Dr. Kristina Keheley	Interim Health and Human Services Agency Director
Mr. Michael Molesky,	Public Representative
Supervisor Josh Pedrozo,	County Board of Supervisors
Dr. James Rabago,	Health Care Provider Representative
Dr. Allen Radner,	At Large Health Care Provider Representative
Ms. Wendy Root Askew	County Board of Supervisors

Commissioners Absent:

Ms. Leslie Abasta-Cummings,	At Large Health Care Provider Representative
Dr. Ralph Armstrong,	At Large Health Care Provider Representative
Ms. Tracey Belton,	County Health and Human Services Agency Director
Ms. Dorothy Bizzini,	Public Representative

Staff Present:

Mr. Michael Schrader,	Chief Executive Officer
Dr. Omar Guzman,	Chief Health Equity Officer
Ms. Jenifer Mandella,	Chief Compliance Officer
Ms. Lisa Ba,	Chief Financial Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong,	Chief Operating Officer
Dr. Dianna Myers	Medical Director
Ms. Jessica Finney	Community Grant Director
Mr. Jimmy Ho	Accounting Director
Ms. Anne Brereton,	Deputy County Counsel, Monterey County
Ms. Hayley Tut,	Interim Clerk of the Board
Ms. Lisa Demmert,	Executive Assistant

1. Call to Order by Chair Jimenez.

Chairperson Jimenez called the meeting to order at 3:02 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

Chair Jimenez acknowledged Commissioner Hendrickson's contributions to the board since February 2025 and announced this would be his last board meeting.

[Commissioner De Serpa arrived at this time: 3:02 p.m.]

2. Oral Communications.

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

There was no public comment.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

Commissioner Keheley announced the hiring of a new Deputy Director for Behavioral Health and Recovery Services, Michael Wilson, and expressed excitement about his experience and the role he will play.

4. Comments and announcements by Chief Executive Officer.

Michael Schrader discussed serval topics during the CEO announcements.

- **State Budget**: He shared changes to the State Budget proposals, including a freeze on new enrollment for full-scope medical coverage for adults, implementation of a $30 monthly premium for adults aged 19-59, and elimination of full-scope dental coverage for adults. He also mentioned the reinstatement of the medical asset limit and elimination of certain drug classes for over-the-counter purchase. The Legislature and the Governor have until June 30th to reach the final agreement on the budget which will be effective July 1, 2025.
- **Federal Reconciliation Bill**: He highlighted the Senate Finance Committee's version of the budget reconciliation bill, which includes cuts to Medicaid, stricter rules for provider taxes, and potential impacts on California's MCO and HQAF taxes. The bill also includes provisions for more frequent redeterminations, work requirements, and copays for non-emergency hospital visits.
- **CMS Data Release**: Michael addressed the issue of CMS sharing personally identifiable information of Medicaid enrollees with the Department of Homeland Security. He mentioned that California senators have requested detailed information from CMS by July 9.
- **Meetings with Elected Officials**: He informed the board about recent meetings with Congressman Jimmy Panetta, Assembly Member Dawn Addis, and State Senator Anna Caballero's staff to discuss the state budget, federal reconciliation bill and CMS data release.
- **Kaiser Expansion**: Michael announced that DHCS informed the Alliance about Kaiser's plan to expand its medical services into Monterey County, expected to start in January 2027 pending approval by DHCS.
- **Priority Initiatives**: He provided an update on the Alliance's six priority initiatives, noting that four have been completed, including securing two NCQA accreditations. The remaining initiatives include bringing behavioral health in-house on July 1, 2025 and launching the Medicare D SNP program by January 2026.
- **Employee Engagement**: Michael shared the results of the 2025 employee engagement survey, revealing an 84% engagement rate, the highest in five years. He mentioned that a detailed presentation on the survey results will be provided in the August meeting.

Consent Agenda Items: (5. – 9B.): 3:17 p.m.

Chair Jimenez opened the floor for approval of Consent Agenda items 5-9B.

MOTION: Commissioner Pedrozo moved to approve Consent Agenda items 5 through 9B, seconded by Commissioner Aquirre.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Aguirre, Askew Cuevas, De Serpa, Espinoza, Hendrickson, Keheley, Jimenez, Molesky, Pedrozo, Rabago and Radner.

Noes: None.

Absent: Commissioners, Abasta-Cummings, Armstrong, Belton, Bizzini, and Hernandez

Abstain: None.

Regular Agenda Items: (10. – 12.): 3:19 p.m.

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10. **Strategic Allocation of Reserves (3:19 – 3:40 p.m.)**
Lisa Ba, Chief Financial Officer highlighted that the Alliance generated $29.2 million in operating income and $56.4 million in net income for 2024, with an MLR of 93.2% and ALR of 5.3%. At year-end, the total fund balance was $891.2 million. The board designated reserve target increased to $483.3 million due to higher enrollment and revenue. Ms. Ba explained that the operating reserve available for allocation was $12.9 million, representing 1% of the total fund balance.

She recommended allocating the $12.9 million operating reserve to the Medical Capacity Grant Program to strengthen its long-term sustainability and ensure continued investment in the communities. It was noted that the Alliance had set aside $198.5 million for provider payments over the last two years, and the Medical Capacity Grant had a lower balance of $139.8 million at year-end. Allocating an additional $12.9 million would support the program's goals and ensure continued investment.

A discussion ensued upon the commissioners.

The board approved the allocation of $12.9 million to the Medical Capacity Grant Program.

MOTION: Commissioner Askew moved to approve the strategic allocation of reserves seconded by Commissioner Cuevas.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Aguirre, Askew, Cuevas, De Serpa, Espinoza, Hendrickson, Hernandez, Keheley, Jimenez, Pedrozo, and Rabago.

Noes: Commissioner Molesky.

Absent: Commissioners, Abasta-Cummings, Armstrong, Belton, and Bizzini.

Abstain: Commissioner Radner.

[Commissioner Hernandez arrived at this time: 3:31 p.m.]

11. **Medi-Cal Capacity Grant Program Funding Allocation and Equity Grantmaking Methodology Recommendation (3:40 – 4:22 p.m.)**

Jessica Finney, Community Grants Director, explained that the Medical Capacity Grant Program (MCGP) focuses on increasing the availability, quality, and access to healthcare and supportive resources for medical members across the alliance's five-county service area. The program addresses social drivers of health and supports community-based organizations.

The current methodology splits the allocation of funds from excess reserves into the grant program, with half distributed based on membership volume and the other half equally across the five counties.

Ms. Finney proposed shifting from county-specific budgets to one service area budget for the grant program. This approach aims to invest most significantly where the highest need exists, supporting cross-county partnerships and improving overall efficiency. The new equity methodology would guide grant-making based on three factors: medical membership volume, MCAS measures below the minimum performance level, and Healthy Places Index (HPI) scores.

This methodology aims to target investments to address health disparities and ensure a minimum amount invested in each county.

The proposed changes align with the alliance's commitment to health equity, address artificial geographic barriers, encourage cross-county collaboration, and support responsive and flexible investments. If approved, the changes would go into effect in January 2026, with the first round of awards under the new methodology in April 2026.

A discussion ensued upon the commissioners.

The board approved the recommendation recognizing the need for continued investment in community health infrastructure.

MOTION: Commissioner Aguirre moved to approve the strategic allocation of reserves seconded by Commissioner Cuevas.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Aguirre, Askew, Cuevas, De Serpa, Espinoza, Hendrickson, Hernandez, Keheley, Jimenez, Molesky Pedrozo, Rabago and Radner.

Noes: None

Absent: Commissioners, Abasta-Cummings, Armstrong, Belton, and Bizzini.

Abstain: None.

12. **CBI 2026 Program Proposal (4:22 p.m. – 4:34 p.m.)**

Dr. Dianna Myers, Medical Director, explained the Care-Based Incentive (CBI) program is designed to reward primary care providers for meeting assigned measures. The program aims to promote evidence-based practice, access, value, and quality of care, aligning with DHCS quality strategy and the Alliance strategic plan.

Dr. Myers shared that the payment methodology involves providing a maximum award for each practice based on eligible member months. Providers receive CBI incentives when they meet goals or show improvement. There were no significant changes, except for accepting dental fluoride varnish data from clinic systems with embedded dental clinics and requiring two fluoride treatments.

Dr. Myers made a proposal to change the controlling high blood pressure measure to a paid measure. This measure looks at the percentage of members aged 18 to 85 with hypertension whose blood pressure is controlled. Changes include paying $100 for each social determinants of health Z code submission and $50 per ECM referral which was previously approved by the board.

Staff recommended the board approve the proposed changes for CBI 2026, specifically changing the controlling high blood pressure measure to a paid measure. The proposal aims to enhance the alignment with managed care accountability metrics and improve the quality of care provided to members.

A discussion ensued upon the commissioners.

The board attempted to approve the proposed changes for CBI 2026, but the motion did not pass due to a lack of necessary Aye votes. It was decided to bring the proposal back to the next meeting of the board.

MOTION:	Commissioner Espinoza moved to approve the CBI 2026 Program Proposal seconded by Commissioner De Serpa.
ACTION:	The motion did not pass due to lack of quorum and conflicts of interest.
Ayes:	Commissioners Espinoza, Keheley, Molesky, and Pedrozo.
Noes:	None.
Absent:	Commissioners Abasta-Cummings, Armstrong, Belton, Bizzini, Hendrickson. Rabago and Radner
Abstain:	Commissioners Aguirre, Cuevas, De Serpa, Hernandez, and Jimenez

The Commission adjourned its regular meeting of June 25, 2025, at 4:35 p.m. to the regular meeting of August 27, 2025, at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa unless otherwise noticed.

Respectfully submitted,

Ms. Hayley Tut
Interim Clerk of the Board

Minutes were supported by AI-generated content.

FINANCE COMMITTEE
SANTA CRUZ – MONTEREY – MERCED – SAN BENITO – MARIPOSA MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, March 26, 2025

Commissioners Present:

Ms. Anita Aguirre,	At Large Health Care Provider Representative
Ralph Armstrong, DO,	At Large Health Care Provider Representative
Ms. Elsa Jiménez,	County Health Director
Mr. Michael Molesky,	Public Representative
Allen Radner, MD,	At Large Health Care Provider Representative

Commissioners Absent:

Supervisor Josh Pedrozo,	County Board of Supervisors

Staff Present:

Ms. Lisa Ba,	Chief Financial Officer
Mr. Michael Schrader,	Chief Executive Officer
Ms. Dulcie San Paolo,	Finance Administrative Specialist

1. Call to Order. (1:40 - 1:41 p.m.)

Chairperson Molesky called the meeting to order at 1:40 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:41 – 1:41 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.

Consent Agenda Items:

3. Approve minutes of the November 6, 2024, meeting of the Finance Committee. (1:41 – 1:42 p.m.)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the November 6, 2024 meeting.

MOTION: Commissioner Jiménez moved to approve the minutes, seconded by Commissioner Radner

ACTION: The motion passed with the following vote:

Ayes: Commissioners Aguirre, Jiménez, Molesky, Radner

Noes: None

Absent: Commissioners Armstrong and Pedrozo

Abstain: None

Regular Agenda Items:

4. Preliminary 2024 Financial Results (Unaudited as of 1/30/25). (1:42 – 2:05 p.m.)

Ms. Lisa Ba, the Chief Financial Officer (CFO), presented the preliminary and unaudited financial results for 2024 as of January 30, 2025. The results show a favorable operating income of $25.9 million, which is 1.3% higher than the budgeted $22.3 million. The Medical Loss Ratio (MLR) stands at 93.4%, and the Administrative Loss Ratio (ALR) is 5.3%.

Medical costs were higher than budgeted due to increased utilization, which was driven by higher-than-expected enrollment and increased acuity. Additionally, Enhanced Care Management (ECM) and Community Supports (CS) expenses have contributed to these costs. It is anticipated that the losses from Community Supports expenses in 2024 could approach $40 million. At year-end, the estimated operating reserve was approximately $13.4 million.

[Commissioner Armstrong arrived at this time: 1:55 p.m.]

Ms. Ba explained that the results are preliminary and the external auditors are still finalizing the audited statement. The independent auditors will present the final audited results at the May 2025 Board meeting.

5. SFY 23/24 Rate Development Template (RDT) Findings. (2:05 – 2:20 p.m.)

Ms. Ba provided the commissioners with an overview of the findings from the State Fiscal Year (SFY) 23/24 Rate Development Template (RDT). She explained that the rates for 2026 are based on claims experience from July 2023 to June 2024, reflecting a delay of 18 to 30

months. The submitted RDTs indicated a 7.4% increase in both utilization and cost compared to the previous base period. However, with the managed care efficiency adjustment, we typically expect an annual rate increase of 2 to 5 percent.

It is important to note that Enhanced Care Management (ECM) and Community Supports (CS) have seen significant growth during the base period and continue to expand. Behavioral Health services have experienced rising unit costs and increased utilization. With the transition to in-house care for Behavioral Health services scheduled to begin in July 2025, these trends are expected to continue. The effects of federal and state budgets and policies on the 2026 rates are still unknown.

6. CY 2024 Investment Update through December 2024. (2:20 – 2:38 p.m.)

Ms. Ba introduced Mr. Jimmy Ho, Accounting Director, who provided an investment update as of December 2024. Mr. Ho reminded the commissioners that staff manage the Alliance's investment portfolio according to the Board-approved investment policy, which emphasizes the safety of principal, liquidity, social responsibility, and total return. Future investment strategy includes reinvesting maturing bonds into higher-yield bonds before anticipated rate cuts in 2025 and 2026.

The commissioners deliberated on possible innovative investment strategies to boost returns.

7. Financial Audits. (2:38 – 2:42 p.m.)

Lastly, Ms. Ba updated the commissioners on the ongoing financial audits, including the California Department of Managed Health Care (DMHC) routine financial examination, the CY 2024 Financial Statement Audit conducted by Moss Adams, and the RDT audit for the 2025 rate.

The Finance Committee adjourned its meeting of March 26, 2025, at 2:42 p.m.

Respectfully submitted,

Ms. Dulcie San Paolo
Finance Administrative Specialist

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, May 21, 2025
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
Anne Lee	Financial Planning and Analysis Director
Arti Sinha	Application Services Director
Bob Trinh	Technology Services Director
Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Dianna Myers	Medical Director
Fabian Licerio	Risk Adjustment Director
Jenifer Mandella (chair)	Chief Compliance Officer
Jessica Finney	Community Grants Director
Kay Lor	Payment Strategy Director
Krishan Patel	Data Analytics Services Director
Kelsey Riggs	Care Management Director
Lilia Chagolla	Community Engagement Director
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Lilia Chagolla	Member Services Director
Michael Schrader	Chief Executive Officer
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Nicolette Shalita Vega	NCQA Compliance Program Manager
Omar Guzman	Chief Health Equity Officer
Ronita Margain	Community Engagement Director
Ryan Inlow	Facilities & Administrative Services Director
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Shelly Papadopoulos	Operations Management Director
Tammy Brass	Utilization Management Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Committee Members Excused:

Bryan Smith	Claims Director
Dave McDonough	Legal Services Director
Gray Clarke	Behavioral Health Medical Director
Jessie Dybdahl	Provider Services Director
Jimmy Ho	Accounting Director
Michael Wang	Medical Director
Ryan Markley	Compliance Director
Tammy Brass	Utilization Management Director

Ad-Hoc Attendees:

Aaron McMurray	Information Security Analyst
Anita Guevin	Medicare Compliance Program Manager
Kat Reddell	Compliance Specialist
Paige Harris	Regulatory Affairs Specialist
Rachel Siwajek	Compliance Specialist
Rebecca Seligman	Compliance Manager
Stephanie Vue	Regulatory Affairs Specialist
Vanessa Paz	Health Equity Program Manager

1. Call to Order by Chairperson Mandella.

Chairperson Jenifer Mandella called the meeting to order at 9:04 a.m.

2. Review and Approval of April 16, 2025 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of April 16, 2025, meeting noting that the agenda should be updated to reflect 2025.

3. Consent Agenda.

1. **Policy Hub Approvals**
2. **Quarterly Policy Updates**
3. **Regulatory and All Plan Letter Updates**
4. **Delegate Oversight Quarterly Report**

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. NCQA Accreditation Update

Shalita-Vega, NCQA Compliance Program Manager, provided updates on accreditation status noting that the plan expects to achieve full Health Equity accreditation with a perfect score of 100%. Shalita-Vega reported the Health Plan accreditation survey was nearing completion and projected the plan's score to be above threshold for receiving

accreditation. She advised the Committee that a process to ensure ongoing survey readiness is being developed.

2. HIPAA Privacy and Security Quarterly Report

Seligman, Compliance Manager, and McMurray, Information Security Analyst, presented the Q1 2025 HIPAA Privacy & Security Report.

Seligman reported on the transition to using the DHCS online portal for HIPAA report submissions and the resulting revisions to the external records request process.

Seligman reviewed HIPAA reporting trends for the quarter, noting that of the 30 referrals received, 10 were determined to be incidents requiring state reporting, 8 were determined to be non-events, and 12 were determined to be non-reportable; there were no breaches. The most common root causes for HIPAA disclosures in the quarter were incorrect selection/entry and verbal disclosures.

Seligman reviewed HIPAA program metrics included on the Alliance Dashboard noting good performance as related to timely reporting of incidents to regulators and prevention of repeat incidents.

McMurray, Information Security Analyst, provided an update on the assessment of cybersecurity measures related to phishing attacks for Q125, noting a slight increase in opened and failed phishing attempts. McMurray also reported an update to the security remediation program noting that network segmentation, cyber security response and identity and access management were emphasized over the quarter.

COMMITTEE ACTION: Committee reviewed and approved the Q1 2025 HIPAA Privacy & Security Quarterly Report.

3. Corrective Action Plans Monthly Update

Mandella, Chief Compliance Officer, provided an update on various Corrective Action Plans (CAPs) including internal, delegate, regulator, provider and potential CAPs emphasizing the purpose of reviewing CAPs is to proactively identify and resolve risks and ensure organizational awareness to enable cross-functional solutions.

Closed CAPs:

- NOA Readability – MedImpact
- Provider Preventable Conditions
- ECM Provider Encounter Data CAPs for select providers

Opened CAPs:

- Timely reporting of suspected FWA to DHCS
- Timely resolution of contracted provider disputes
- Continuity of Care Member Noticing
- Receipt of Preliminary Report for 2025 DHCS Medical Audit

Ongoing CAPs:

- Receipt of Preliminary Report for 2024 DMHC Medical Survey
- Settlement of DMHC Enforcement Action 23-803
- Process Improvement related to Assisted Living services
- 5 CAPs remain open in a monitoring status, with non-substantive updates since the April update.

The meeting adjourned at 9:54 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, June 18, 2025
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
Anne Lee	Financial Planning and Analysis Director
Arti Sinha	Application Services Director
Bob Trinh	Technology Services Director
Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Dave McDonough	Legal Services Director
Dianna Myers	Medical Director
Fabian Licerio	Risk Adjustment Director
Gray Clarke	Behavioral Health Medical Director
Jenifer Mandella	Chief Compliance Officer
Jessica Finney	Community Grants Director
Jessie Dybdahl	Provider Services Director
Jimmy Ho	Accounting Director
Kay Lor	Payment Strategy Director
Kelsey Riggs	Care Management Director
Krishan Patel	Data Analytics Services Director
Lilia Chagolla	Community Engagement Director
Lisa Ba	Chief Financial Officer
Michael Schrader	Chief Executive Officer
Michael Wang	Medical Director
Navneet Sachdeva	Pharmacy Director
Nicolette Shalita Vega	NCQA Compliance Program Manager
Ronita Margain	Community Engagement Director
Ryan Markley (chair)	Compliance Director
Ryan Inlow	Facilities & Administrative Services Director
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Shelly Papadopoulos	Operations Management Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Lizette Podwalny	Health Services Operations Manager

Committee Members Excused:

Bryan Smith	Claims Director
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Nicole Krupp	Regulatory Affairs Manager
Omar Guzman	Chief Health Equity Officer
Tammy Brass	Utilization Management Director

Ad-Hoc Attendees:

Anita Guevin	Medicare Compliance Program Manager
Ka Vang	Compliance Specialist
Kat Reddell	Compliance Specialist
Margarita Shull	Program Integrity Specialist
Paige Harris	Regulatory Affairs Specialist
Rachel Siwajek	Program Integrity Specialist
Rebecca Seligman	Compliance Manager
Sara Halward	Compliance Specialist
Stephanie Vue	Regulatory Affairs Specialist
Vanessa Paz	Health Equity Program Manager

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

   Chairperson Ryan Markley called the meeting to order at 9:03 a.m.

2. **Review and Approval of May 21, 2025 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of May 21, 2025, meeting noting that the agenda should be updated to reflect 2025.

3. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Regulatory and All Plan Letter Updates**
   3. **NCQA Accreditation Status**

   COMMITTEE ACTION: Markley informed the Committee of the Plan's full accreditation for both Health Plan and Health Equity. Committee reviewed and approved Consent Agenda.

4. **Regular Agenda**

   1. **Using AI In Our Workplace**

      Markley, Compliance Director, discussed the importance of addressing staff use of artificial intelligence (AI), and emphasized the importance of reducing risk and ensuring safe and compliant use of AI with plan policy and training.

Markley outlined a tiered training model focusing on different levels of employees and their requirements. Markley provided examples of both approved and prohibited uses of AI and stressed the importance of human oversight in all instances.
Markley announced the formation of an AI Governance body which will continue to develop and implement guidelines and conduct departmental tiered training where appropriate.

Committee members provided feedback and suggestions, as follows. Markley and Mandella to ensure these action items are completed through AI Governance.

- Wang requested to be a part of AI Governance meetings.
- Wang also suggested that staff identify when vendors use AI to ensure appropriate protections; requested a list of approved AI platforms; and suggested that staff begin to research which AI platforms are best for various purposes.
- Dybdahl and Margain requested support with messaging around disclosing that AI was used to develop certain materials.
- Mandella requested feedback on how best to roll out departmental training and obtain details on use of AI. Committee members suggested outreach to staff in advance of departmental training, followed by ensuring staff attest to following plan guidelines when using AI.

2. Internal Audit & Monitoring Quarterly Report

Halward, Compliance Specialist III, presented the Q1 2025 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 5 internal audits were conducted, 4 of which received a passing score.

Halward reported performance metrics from the Alliance Dashboard noting that Q125 efficiency metrics met target performance; quality metrics are reported annually and 2024 performance was reported earlier this year. Halward also reviewed outcomes of the monitoring of 34 Alliance Dashboard metrics related to regulatory requirements, noting that 33 metrics met their established thresholds during the review period.

Halward reviewed one exemplar internal audit, related to Non-Medical Transportation (NMT) and ensuring NMT requests meet requirements for private conveyance, bus pass, and mileage reimbursement.

Halward previewed the operational areas scheduled for internal audit in Q2 2025 and reported updates on several regulatory audits including the status of findings and steps being taken to continue ongoing support for bringing remaining open findings to a close

COMMITTEE ACTION: Committee reviewed and approved the Q1 2025 Internal A&M Quarterly Report.

3. Program Integrity Quarterly Report

Siwajek, Program Integrity Specialist III, presented the Q1 2025 Program Integrity Activity Report. Siwajek reported that 38 concerns were referred to Program Integrity in the quarter, 20 of which resulted in the opening of a matter under investigation (MUI). There were 65 active MUIs in the quarter.

Siwajek reviewed referral trends for the period noting the following:

- 6 provider related
- 5 member related
- 5 state requests
- 4 categorized as other

Siwajek reported performance of the Program Integrity performance metrics from the Q1 2025 Alliance Dashboard noting that the quality metric was above the target performance each month in the quarter and the efficiency metric was below the target performance each month in the quarter.

Siwajek reviewed Q125 Program Integrity Financials reporting the total requested recoupment was $1,822.63 and completed recoupment was $9,045.12.

COMMITTEE ACTION: Committee reviewed and approved the Q1 2025 Program Integrity Report.

The meeting adjourned at 9:57 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, March 20, 2025
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

John Mark, MD	Provider Representative
Lena Malik, MD	Provider Representative
James Rabago, MD	Board Representative
Ibraheem Al Shareef, MD	Provider Representative
Camille Guzel. MD	Provider Representative
Nicole Shelton, PA	Provider Representative
Devon Francis, MD	Provider Representative
Jennifer Yu, MD	Provider Representative
Cal Gordon, MD	Provider Representative

Committee Members Absent:

Hue Nguyen, MD	Provider Representative
Michelle Perez, MD	Provider Representative
Sarah Smith, MD	Provider Representative

Staff Present:

Dianna Myers, MD	Medical Director
Tammy Hoeffel	Enhanced Health Services Director
Lisa Moody, RN	Senior Complex Case Manager
Ronita Margain	Community Engagement Director
Cynthia Bali	Provider Relations Supervisor
Kelsey Riggs, RN	Care Management Director
Jenna Stromsoe, RN	Complex Case Management Supervisor
Ashley McEowen, RN	Complex Case Management Supervisor
Jacqueline Morales	Provider Relations Representative
Sarah Sanders	Grievance & Quality Manager
Tracy Neves	Clerk of the Committee

Other Representatives Present:

Aditi Mhaskar, MD	Provider Representative
Linda Smith, RN	Provider Representative
Becky Shaw	Provider Representative
Kevin Smith	FAC Representative
Janna Espinoza	FAC Representative
Amanda Wright	Aveanna Healthcare

1. **Call to Order by Chairperson Dr. Dianna Myers.**
   Chairperson Myers called the meeting to order at 12:05 p.m.
   Roll call was taken.

2. **Oral Communications.**

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

No members of the public addressed the Committee.

3. Consent Agenda Items.

A. Approval of WCMCAC Minutes
Minutes from the December 19, 2024, meeting were reviewed.

B. Grievance Update
Grievance data and update were provided to the Committee.

M/S/A Consent agenda items approved.

4. Regular Business Items.

A. Whole Child Model Overview
Jenna Stromsoe, RN provided an overview of the Whole Child Model (WCM) program, its history, member demographics and the role of the pediatric complex case management team. Jenna emphasized the importance of California Children's Services (CCS) paneling and making CCS referrals for eligible patients.

The Whole Child Model program was authorized by Senate Bill 586 in September 2016 to better support CCS children and their families. Under the WCM program, many of the functions that were previously assigned to CCS were integrated into the health plan. The program aims to alleviate confusion and improve outcomes by having the managed care plan steward the CCS benefit. The WCM program was implemented in July 2018 in Santa Cruz, Monterey, and Merced counties. In January 2025, the program expanded into San Benito and Mariposa counties. Jenna also highlighted the differences between independent and dependent counties in terms of medical eligibility determinations. The Alliance case management team is the primary contact for any case management needs and works closely with county partners. The Complex Case Management team is a multidisciplinary team consisting of registered nurses, care coordinators, and medical social workers. The team collaborates with various providers and internal teams to ensure comprehensive care for pediatric members. Dr. Myers noted that the case management team is also available to support members without CCS. The team serves members up to 17 years of age and to 21 years of age if a CCS member. Annual assessments are completed with members to identify the members' needs and determine who is best suited to provide assistance. Providers need to be paneled for CCS eligibility, even with the Whole Child Model program implementation. Prior to applying as a CCS program provider, providers' National Provider Identifier (NPI) number must be enrolled with Medi-Cal. Links to the application and DHCS provider paneling standards were shared and providers encouraged to become paneled and make referrals. Jenna discussed the CCS medical eligibility guidelines and the importance of making referrals for potential CCS eligible conditions. Links to the guidelines were provided. It was noted 'there is "no wrong door" and the team will connect members with staff that can assist. A provider empathized that there is a great benefit for children and families to be connected with CCS.

B. Family Advisory Committee
Kevin Smith and Janna Espinoza discussed the Family Advisory Committee (FAC) and its purpose, meeting schedule, and the need for new members. They highlighted the accessibility of the meetings and the importance of family input. Kevin explained that the FAC promotes open communication between families with children who have special health care needs, Alliance leadership, and local family support providers. The FAC serves as a mutual learning forum to improve care for CCS beneficiaries. Currently FAC members are needed in the following counties: 1 member in Mariposa, 2 members in Merced, 2 members in Monterey, 2

members in Santa Cruz and 1 member in San Benito. A provider noted she is not clear which patients are in the WCM program. **Action:** Ashley will generate a report for the provider with WCM member information. A provider noted receiving feedback on what is working and what are the challenges at future WCMCAC meetings would be beneficial.

The FAC meetings are held once per quarter for about an hour and a half on Mondays from 1:30 to 3:00 PM. Appointed members may receive a stipend for each meeting attended. Kevin and Janna highlighted the need for new members from various counties, including family representatives and parent center representatives. They provided information on how to apply and encouraged providers to share the opportunity with interested families. Janna emphasized the accessibility of FAC meetings, noting that members can call in and participate remotely making it easier for families with complex schedules and medical needs to attend.

C. WCM CCS Referral Volumes

Ashley McEowen, RN presented on CCS referrals and WCM membership volumes, noting a decrease in referral approval rates and an increase in membership. The team is working to validate referral data and investigate potential causes for the changes. Ashley presented data on CCS referrals for quarter 4, showing a total of 276 referrals, with 107 in Merced, 120 in Monterey, and 49 in Santa Cruz. Ashley noted a decrease in referral approval rates compared to the previous quarter. The average approval rate for quarter 4 was 68.5%, a slight decrease from 72.8% in quarter 3. Ashley emphasized the importance of sending high-quality referrals and mentioned the team's efforts to validate the data. Comparison data from 2023 and 2024 was reviewed and it was noted the team monitors referrals and trends closely. WCM members that aged out in all counties from January to March this year included 201 members. The team makes referrals to the adult case management team regarding the age out members.

The WCM membership volumes have increased, with a current total of 8,955 members, including 440 CCS children from San Benito and Mariposa counties. The pediatric team continues their ongoing efforts to monitor and support these members. The team is working closely with CCS partners to validate referral data and investigate potential causes for the changes in referral volumes. This includes ensuring accurate data reporting from the new care management platform.

5. Open Discussion.

Dr. Myers opened the floor for the Committee to have an open discussion.
A provider in Santa Cruz noted he appreciates the collaboration with the Alliance, and they are working with DHCS on oversight and monitoring of the CCS programs. Also noted was that there could be potential budgetary issues for the counties.

Several providers mentioned the impact of immigration fears on patient attendance at appointments, noting a significant drop in visits to Stanford clinics and other healthcare services. They emphasized the need to address this issue and support affected families. Dr. Myers suggested connecting with Stanford's social workers and the Alliance to provide targeted support for families. The team discussed the importance of addressing these fears and finding ways to ensure families can access the care they need. The discussion included the potential for increasing telehealth services to mitigate the impact of immigration fears on patient attendance. This approach could help maintain continuity of care for families reluctant to travel. Another provider in Monterey county noted having Kaiser come into the county has caused some confusion with members. There was a suggestion to discuss ongoing patient fears and share best practices at a future meeting.

Adjourn.

The meeting adjourned at 1:00 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Committee

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

Meeting Minutes

Monday, May 5, 2025

Teleconference Meeting

Members Present:

Voting Members

Alicia Zambrano	Merced County – CCS WCM Family Member
Frances Wong	Monterey County – CCS WCM Family Member
Irma Espinoza	Merced County – CCS WCM Family Member
Janna Espinoza	Monterey County – CCS WCM Family Member
Katrina Hodges	Monterey County – CCS WCM Family Member
Kevin Smith	Merced County – Parent Resource Center
Paloma Barraza	Monterey County – CCS WCM Family Member

Non-voting Members

Anna Rubaclava	Merced County - County of Merced
Barbara Hurtado	Merced County – Parent Resource Center
Cristina Farias-Gonzalez	Alliance Care Coordination Supervisor - Pediatric
Denise Sanford	Santa Cruz County - County of Santa Cruz
Heloisa Junqueira, MD	Monterey County - Provider
Kayla Zoliniak	Alliance Community Engagement Administrative Specialist
Kelsey Riggs, RN	Alliance Care Management Director
Lisa Moody, RN	Pediatric Care Management and California Childrens Services Manager
Ronita Margain	Alliance Community Engagement Director
Susan Paradise	Santa Cruz County – County of Santa Cruz
Susan Skotzke	Santa Cruz County – CCS WCM Advocate

Members Absent:

Voting Members

Heidi Boynton	Santa Cruz County – Local Consumer Advocate
Janell White	San Benito County – CCS WCM Family Member
Kim Pierce	Monterey County – Parent Resource Center

Non-voting Members

Ashley McEowen	Alliance Complex Case Management Supervisor - Pediatric
Carissa Grepo	Alliance Utilization Management Manager – Prior Authorizations
Christine Betts	Monterey County – County of Monterey
Dianna Myers, MD	Alliance Medical Director
Esperanza Compean	Merced County - Parent Resource Center
Jose Francisco Hernandez	Monterey County – Parent Resource Center
Kevin Low	Monterey County – County of Monterey
Manuel López Mejia	Monterey County – CCS WCM Advocate
Michael Molesky	Santa Cruz County – Alliance Commissioner
Oscar Flores	Monterey County – Parent Resource Center
Sarah Sanders	Alliance Grievance and Quality Manager

Guests:

Adourin Malco	Alliance Community Engagement Specialist
Desirre Herrera	Quality and Health Programs Manager
Ulises Cisneros-Abrego	Alliance Community Engagement Specialist

1. **Call to Order by Chairperson Espinoza.**
   Chairperson Espinoza called the meeting to order.

   Committee introductions and roll call was taken.

2. **Oral Communications.**
   Chairperson Espinoza opened the floor for any members of the public to address the Committee on items not listed on the agenda. No oral communications from the public.

Consent Agenda Items:

3. **Accept WCMFAC Meeting Minutes from Previous Meeting**
   Chairperson Espinoza opened the floor for approval of the meeting minutes of the previous meeting on February 3, 2025. Minutes were approved with no further edits.

Regular Agenda Items:

4. **Health Education Services and 2025 Priorities**
   D. Herrera, Quality and Health Programs Manager, provided an overview of the health education services.

The Alliance distributes the health education flyers through the Alliance offices, community outreach events, provider visits, and community organizations. The health education services flyers will be shared with the committee members.

Committee members asked about a more generic gift card for the incentive. The Alliance is looking into other options, but it would not start until at least next year.

A committee member asked about medical exemption for the vaccine incentive. The Alliance will look into the answer.

Committee members asked about preventative care training for caregivers such as how to safely lift children and wheelchairs.

Committee members asked about resources for wheelchair accessible cars. Community organizations may be able to assist with funding for accessibility modifications.

Committee members asked about how to acquire, organize, store, and clean supplies and equipment.

5. **Community Partner Presentation**
   U. Cisneros-Abrego, Community Engagement Specialist, provided an overview of the presentation used to inform community partners about the Alliance.

   A committee member recommended connecting with SPIN.

6. **Community Impact Report Highlights**
   A. Malco, Community Engagement Specialist, shared highlights from the 2025 Community Impact Report.

   A committee member asked about Pedialyte no longer being covered by the Alliance. An Alliance case manager will reach out to the member. Committee members agreed that Pedialyte coverage would be beneficial.

7. **CCS Advisory Group Representative Report**
   L. Moody provided updates from the most recent CCS Advisory Group meeting.

   Priorities for 2025 include the age out process, quality metrics, and monitoring the Whole Child Model expansion. Alliance staff will confirm which quality metrics are prioritized.

   A committee member asked about end of life and bereavement services. Committee members agreed that end of life and bereavement services and conversation would be beneficial.

8. Updates and Announcements

A committee member shared the One Stop Community Center Open House & Resource Fair – 2025 flyer. Alliance staff will send the flyer to the committee members.

Alliance staff announced Tammy Hoeffel, Enhanced Health Services Director, is no longer at the Alliance. If you were working with her, please reach out to another Alliance staff person for assistance.

A committee member asked about gas reimbursement for appointments.

Review Action Items

K. Zoliniak reviewed the actions items.

Future Agenda Items

- Equipment and Supplies
- End of Life and Bereavement Services
- Preventative Care for Caregivers
- Gas Reimbursement

Adjourn:

The meeting adjourned at 2:59 p.m.

The meeting minutes are respectfully submitted by Kayla Zoliniak, Community Engagement Administrative Specialist.

Next Meeting: Monday, August 4, 2025.

Meeting Minutes

Thursday, May 8, 2025
10 – 11:30 a.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
Community Services & Workforce Development – Conference Room
1161 San Felipe Road, Building B, Hollister, CA. 95023
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Members Present:

Adriana Zoghlami	Community Advocate
Alma Mandujano-Orta	Community Advocate
Aluriel Ceballos	Community Advocate
Carolina Meraz	Consumer
Doris Drost	Consumer
Francis Wong	Consumer
Guadalupe Barajas-Iniguez	Consumer Advocate
Humberto Carrillo	Consumer
Jamie Berry	Consumer
Janna Espinoza	Consumer, Commissioner
John Beleutz	Community Advocate
Michael Molesky	Consumer, Commissioner
Stephanie Auld	Consumer

Members Absent:

Candi Walker	Consumer
John Alexander	Community Advocate
Mimi Park	Consumer
Moncerat Politron	Community Advocate
Rebekah Capron	Community Advocate

Staff Present:

Becky Tyler	Behavioral Health Program Manager
Clarisa Gutierrez	Community Engagement Coordinator
Desirre Herrera	Quality and Health Programs Manager
Dianna Myers, MD	Medical Director
Elvia Contreras	Call Center Quality Analyst
Gabriela Chavez	Community Engagement Manager
Julia Valdez	Temp Community Engagement Coordinator
Kayla Zoliniak	Administrative Specialist
Maria Colomer	Community Engagement Coordinator
Maria Elena Villalobos	Administrative Specialist
Rebecca McMullen	Behavioral Health Manager
Ronita Margain	Community Engagement Director
Sonia Menjivar	Call Center Quality Analyst
Ulises Cisneros-Abrego	Community Engagement Specialist

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 10:03 a.m.

Roll call was taken and a quorum was met.

2. Oral Communications.

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

No members of the public addressed the Advisory Group.

3. Comments and announcements by Member Services Advisory Group (MSAG) members.

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

An advisory group member announced the Capitola City Council voted no to a rail and trail and commented on the importance of transportation for Alliance members to doctors appointments, especially specialty appointments in San Jose, and the transportation of caregivers of Alliance members to their homes. The advisory group member encouraged the Alliance to provide input to the Regional Transportation Commission or make a statement.

An advisory group member announced that one of the two pharmacies in Mariposa is closing resulting in only one pharmacy that closes at 5 p.m. on weekdays and is closed on the weekends. The advisory group member asked if Alliance members can get their prescriptions delivered.

4. Comments and announcements by Alliance staff.

Chairperson Beleutz opened the floor for Alliance staff to make comments.

R. Margain welcomed and thanked current and new advisory group members.

R. Margain announced one of the agenda topics will be a written survey to collect feedback.

Consent Agenda Items (5 – 7):

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

The minutes of March 13, 2025 will be amended to include Jamie Berry on the members absent list.

Action: Consent Agenda items were approved.

Regular Agenda Items (8 – 11):

8. Health Education Services and 2025 Priorities

D. Herrera, Quality and Health Programs Manager, provided an overview of the health education services.

An advisory group member recommended the Alliance provide the information in hospitals, especially assisting new parents sign up for appointments and sending appointment reminders.

An advisory group member recommended cooking classes, potentially in partnership with All Moms Matter.

An advisory group member recommended gym membership as a benefit.

An advisory group member recommended encouraging providers to be a safe place, especially for teenagers, and providing the opportunity to speak in private.

9. Behavioral Health Services

R. McMullen, Behavioral Health Manager, and B. Tyler, Behavioral Health Program Manager, provided an over of non-specialty mental health benefits.

The Alliance's Nurse Advice Line is included in the no wrong door system and will intake behavioral health requests. The Alliance is working with county partners to have mobile crisis teams available.

An advisory group member recommended viewing behavioral health services as preventative care.

An advisory group member recommended working with schools to address bullying. The member also commented on the need for a system for children to be able to make reports without fear of punishment.

An advisory group member recommended creating an incentive program for individuals who have lived experience with behavioral health challenges to speak to and inspire individuals who are experiencing behavioral health challenges.

An advisory group member recommended social media and sponsored content.

An advisory group member stated youth may experience cultural restrictions from parents and may benefit from being able to reach out to receive behavioral health services on their own in a more private method such as text messages.

10. Community Resources

R. Margain, Community Engagement Director, provided an overview of community resources and communication.

Advisory group members recommended hard copies of the newsletters at provider office waiting rooms, QR codes, cork boards, and check-in stations.

An advisory group member stated some members do not have internet and some members are not able to read. Some members may be afraid to seek medical care due to immigration status and not knowing which doctors are safe. Another member recommended Head Start's welcome conversations as a potential way to share information with members who are not able to read.

The Alliance promotes events through the website homepage, social media, The Beat, and the MSAG Community Engagement Report.

An advisory group member suggested videos in doctor's offices. The Alliance is working with Golden Valley Health Centers for promotions on their video screens.

An advisory group member encouraged sharing community events with the Alliance for them to potentially be able to attend and share information.

The Alliance works with libraries to share information in the community. The Alliance also partners with the Mercy Mobile Clinic Van in Merced to provide information in the community.

11. Survey

Advisory groups members completed the written survey.

Adjourn:

The meeting adjourned at 11:24 a.m.

Respectfully submitted,
Kayla Zoliniak
Administrative Specialist
Member Services Advisory Group Coordinator

Quality Improvement Health Equity Committee

Date: April 2, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

Chair: **Omar Guzman, MD, Chief Health Equity Officer, Interim CMO**			**Minutes by:** **Jacqueline Van Voerkens**
	Members Present:	Dr. Caroline Kennedy, Family Medicine and Dr. Jessica Langenhan, Psychiatrist, Carelon	
	Members Absent:	Dr. Eric Sanford, Family Medicine, Gary Proctor, MD, Psychiatrist, Dr. Minoo Sarkarati, Internal Medicine/Pediatrics, Dr. Madhu Raghavan, Pediatrician, Dr. Oguchi Nkwocha, Family Medicine, Dr. Stephanie Chang, Family Medicine, Dr. Stephanie Graziani, Pediatrics, Stacey Kuzak, GVHC Director of Nursing, and Susan Harris, MFA COO.	
	Central California Alliance for Health staff:	Ms. Andrea Swan – QI/ Population Health Director Ms. Carissa Grepo – UM Manager – Prior Authorizations Ms. DeAnna Leamon – Clinical Safety Quality Manager Ms. Desirre Herrera – Quality and Health Programs Manager Ms. Emily Kaufman – Clinical Safety Supervisor (RN) Ms. Georgia Gordon – Quality Improvement Program Advisor II Dr. Gray Clarke – Behavioral Health Medical Director, Psychiatric and Psychosomatic Medicine Mr. Jim Lyons – Provider Relations Manager Ms. Kelsey Riggs – Care Management Director Ms. Kristen Rohlf – Quality Improvement Manager Ms. Lilia Chagolla – Member Services Director Dr. Mai Bui-Duy, MD – Medical Director, Internal Medicine Dr. Michael Wang – Medical Director, Internal Medicine and Clinical Informatics Ms. Rebecca McMullen – Behavioral Health Program Manager Ms. Sarah Sanders – Grievance and Quality Manager Ms. Sarina King – Quality and Performance Improvement Manager Mr. Scott Fortner – Chief Administrative Officer Ms. Viki Doolittle – Utilization Management Manager	

Quality Improvement Health Equity Committee

Date: April 2, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

		Ms. Tammy Brass Utilization Management Director	
	Guest Speakers	Dr. Jill Young, and Dr. Mandeep Kullar, Psychiatrists, Carelon	
Item No.	**Agenda Item**		
I.	**Call to Order**	Dr. Omar Guzman called the meeting to order at 12:05 PM and welcomed the members. Dr. Guzman opened the floor for any announcements. No announcements were received from the Committee. Announcement: Dr. Guzman introduced new members of the committee	
Items for Approval		**Discussion**	**Action/Recommendation**
II.	**Review & Approve Minutes**	**Due to lack of quorum, the minutes from the March 20, 2025 QIHEC Meeting were approved via email.** **Committee approved March 20, 2025 QIHEC as presented.*	*The QIHEC approved the March 20, 2025 QIHEC meeting minutes.*
Action Item Follow Up			
III. 9/24/24 QIHEC	Q2 2024 Utilization Management Work Plan	Ms. Brass will follow up with Dr. Sanford Ed utilization and changing it to rates by member ship in the county. **Action Pending**	
9/24/24 QIHEC	Q2 2024 Utilization Management Work Plan	Dr. Guzman will connect with Dr. Sanford to collaborate on the outreach and health literacy training program. **Action In Process**	
9/24/24 QIHEC	Utilization Management Criteria	Dr. Langenhan from Carelon to provide neuropsychological testing referral guidelines, follow up on closing the loop on communication between the reference and the referee, and connect regarding the release of information work around. **Action Complete:**	*Action Complete*

MINUTES

		Please see referral guidelines; there is no prior authorization needed for Neuropsychological testing. Reasons for Neuropsychological Testing: The member usually is not receiving mental health services. A member who is experiencing cognitive impairments that interfere with day-to-day functioning may require neuropsychological testing to better define, localize, and quantify the deficits, aid in diagnostic clarity, and inform appropriate medical and behavioral treatment planning. Testing is designed to assess disorders that primarily impact cognitive functioning including; traumatic brain injury, dementia and Alzheimer's disease and stroke; etc.	
9/24/24 QIHEC	Q2 2024 QIHET Workplan	Ms. Swan will work with Sarah Sanders and provide a Quality of Care and Access grievance data comparison between other counties and/or insurance groups to Dr. Sanford. **Action In Process**	
9/24/24 QIHEC	Discussion	Dr. Guzman will reach out to Dr. Sanford regarding Street Medicine. **Action In Process**	
12/18/24 QIHEC	Q3 2024 QIHET Workplan	**Behavioral Health Service Meeting:** Ms. McMullen will arrange a meeting with Dr. Kennedy's staff to discuss the Carelon transition. **Action Complete.** BH and PS will attend a meeting on 4/16/25 to present on the Carelon Transition.	*Action Complete*
12/18/24 QIHEC	Q3 2024 Utilization Management Work Plan	Dr. Wang and Ms. Grepo to create a one-page genetic testing criteria guide for providers for easier reference. **Action Pending**	
3/20/25 QIHEC	2025 Annual UM Program Evaluation	Tammy Brass, UM Director will add the readmission rates to the 2025 Annual UM Program Evaluation for a more comprehensive analysis. Develop reporting to capture mortality rates as related to LOS and consider inclusion in 2025 Annual UM program eval. **Action Pending**	

Quality Improvement Health Equity Committee

Date: April 2, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

3/20/25 QIHEC	Q4 2024 UMWP Review	Dr. Mike Wang, Medical Director will analyze the reasons for genetic testing denials and provide education to providers if needed. **Action Pending**	
Items for Review/Approval		**Consent Agenda Items**	**Action/Recommendation**
IV.	**Review**	Subcommittee/Workgroup Meeting Minutes	
		• Pharmacy and Therapeutic (P&T) Committee Minutes	*Approved via email.*
		• Quality Improvement Health Equity Workgroup (QIHEW) Minutes	*Approved via email.*
		2025 Quality Improvement Health Equity Transformation Program Workplan and Executive Summary	*Approved via email.*
		Pharmacy and Therapeutics Committee Charter	*Approved via email.*
		QIHEC Charter	*Approved via email.*
		QIHEC Roles and Responsibilities	*Approved via email.*
		Delegate Oversight Report: The VSP Q3 2023 and the Carelon Q3 2023 quarterly delegate oversite summary included in consent agenda meeting packet.	*Approved via email.*
Policies: Require QIHEC Approval			
Number/Title		**Significant Changes**	**Action/Recommendation**
401-1101 QI HETP		• Annual Review • Contract provisions as suggested by Stephanie Vue, letter F and subsections F1–F3 have been added to page 17. • Policy references have been updated throughout the policy • Added in reference to Assembly Bills, AB-2340 Medi-Cal: EPSDT Services: informational materials	*Approved via email.*

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	• Added Community Health Assessment (CHA)/Community Health Improvement Project (CHIP): Based on participating in the CHA/CHIP process The Alliance must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy	
401-1201 Quality Improvement Health Equity Committee	• Annual Review • Minor Content Changes • The Alliance Quality Improvement Health Equity `Committee policy language was minorly modified to update the structure, committee membership, reporting, subcommittee information, and to include notations of actions which fulfill NCQA requirements.	*Approved via email.*
401-1501 Standards of Care	• Annual Review. • No major changes to this policy. CCC removed and Case Management added.	*Approved via email.*
401-1502 Adult Preventive Care	• Annual Review • Added "For the purposes of this policy, an adult refers to those aged 21 or older, unless otherwise specified herein." to meet 18 and yr older requirement of AB 2132 • Added Action item 8,9,10 and 14 of AB 2132 with discusses TB screening/testing, assessment and follow up requirements. • Added reference to policy 405-1313 Adult Complex Case Management	*Approved via email.*
401-1511 Initial Health Appointment	• Annual Review, no content changes • LOB table update	*Approved via email.*
401-3109 Comprehensive Tobacco Cessation Services	• Annual review • Added: The USPSTF recommendation for behavioral interventions for the cessation of pregnant women who use tobacco • Updated language that PCPs will ask tobacco use status for every patient once a year and ask tobacco users about tobacco use at every visit using an assessment tool.	*Approved via email.*

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404-1102 Inpatient Review	edits for BHIP	*Approved via email.*
404-1108 Monitoring of Over/Under Utilization of Services	edits for BHIP	*Approved via email.*
404-1109-Disclosure of Utilization Management Process to Providers Member and the Public	edits for BHIP	*Approved via email.*
404-1111-Utilization Management_Assessment Process	Annual Review	*Approved via email.*
404-1114 Continuity_of_Care	Edits for APL 24-015	*Approved via email.*
404-1201 Authorization Request Process	edits for BHIP	*Approved via email.*
404-1202 After-Hours Availability of Plan or Contract Physician	edits for BHIP	*Approved via email.*
404-1307 Medical Second_Opinions	edits for SB 729	*Approved via email.*
404-1310 Auth Process for RAFS to OOSA & NCSP	edits for BHIP	*Approved via email.*
404-1521 Hospital Stays Where Discharge Death or Transfer Occurs on the Day of Admission-	Annual review	*Approved via email.*
404-1524 Long Term Care for Medi-Cal Members	Edits for APL 25-002	*Approved via email.*

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404-1525 Skilled Nursing Facility Program Policy For Medi-Cal	Edits for APL 25-002	*Approved via email.*
404-1702-Provision of_Family_Planning_Services_to_Members-	edits for SB 729	*Approved via email.*
404-1704 Dental Anesthesia for Alliance Medi-Cal Members-	Annual review	*Approved via email.*
404-1705 Dental Services for Medi-Cal Members-	Annual review	*Approved via email.*
404-1712-Biofeedback Training_Urinary_Incontinence	Annual review	*Approved via email.*
404-1714 Technology Assessment-	. edits for AB 2105	*Approved via email.*
404-1724-Hospital Transportation_from_Primary_Care_Physician_Office	Updated for clarity	*Approved via email.*
404-1726-Non-Emergency Medical Transportation	Updated for clarity	*Approved via email.*
404-1731 Medication Assisted Treatment	Edited for AB 1842 Medication-Assisted Treatment	*Approved via email.*
404-1737 Panniculectomy and Other Lipectomy	updated for clarity	*Approved via email.*
404-1738 Community Health Worker Services	edits for BHIP/ APL 24-007	*Approved via email.*
404-1739 Doula Services-	edited for AB 1936/ annual review	*Approved via email.*
404-1740 Complex Cancer Care	Annual review	*Approved via email.*

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404-1742 UM MCP Transition Policy	Edits for APL 24-015	*Approved via email.*

Policies: Informational

Number/Title	Significant Changes	Action/Recommendation
401-1401 QI Long Term Services and Supports	• Annual Review • The Quality Improvement (QI) team has revised this policy to align with recent updates in Long-Term Services and Supports (LTSS) guidelines, specifically APLs 24-009, 24-010, and 24-011. Key revisions include streamlining the policy by removing language pertaining to the management of LTSS members, ensuring a more focused and relevant framework within QI practices. • Added policy references	*Approved at QIHEW*
401-1518 Medical Assistants Scope of Practice and Supervision	Annual review, No content changes	*Approved at QIHEW*
401-1519 Infection Control Practices	Annual review, No content changes	*Approved at QIHEW*
401-1521 Physical Accessibility Review	• Annual review. • Updated in response to the Behavioral Health Integration Project (BHIP) in response to the policy updates identified for DHCS/DMHC: Removed "Managed Behavioral Health Services" from the delegated entity list. Reworded it to state "Behavioral Health Providers" in the list of provider types excluded from PARs.	*Approved at QIHEW*
401-3101 Health Education and Disease Management Program	• Annual review. • Updated policy language to note the DHCS requirements of implementation and maintenance of health education system that includes programs, services, functions and resources necessary to provide health education, health promotion and patient education for all Members. • Added Prenatal/Postpartum Education programs	*Approved at QIHEW*

MINUTES

	• Removed Healthy Breathing for Life program	
401-3102 Health Education Materials	• Annual review. • Updated Definitions • Added reference to APL 18-016 in the Procedures section indicating only a Qualified Health Educator may assess and approve written health education materials.	*Approved at QIHEW*
401-3103 Health Promotion Incentive for Member	• Annual review • Incentive titles updated • SI End of Program Evaluations timeframe has been changed to 60 days from 45 days after the last survey was completed. • Updated DHCS responsible reporting party to Regulatory Affairs • Updated the LOB table and references section	*Approved at QIHEW*
401-3106 Perinatal Services	• Annual review • Updated policy in response to AB 1936 • Added Definition of Contracting obstetric provider. • Added Definition of maternal Mental Health Condition. • Added in the procedures section off the provider responsibilities the recommendation providers use ACOG guidelines which includes recommendations on the screening and diagnosis of perinatal mental health conditions including depression, anxiety, bipolar disorder, acute postpartum psychosis, and the symptom of suicidality. • Update Prenatal education to include postpartum • Included notation of the promotion of information on maternal mental health is included in the Member Newsletter, and through various outreach methods. • Added screening requirements per AB 1936 • Combined sections, deleted 6 a& b and moved C to 5b • Added maternal mental health as an education topic per AB 1936 • Updated the references section.	*Approved at QIHEW*

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401-3107 Breastfeeding Support Benefit, Standards and Promotion Program		• Annual Review • Added Human Milk language for compliance Per AB 3059 • Updated references section	*Approved at QIHEW*
		Regular Agenda	**Action/Recommendation**
IV.	QIHET Program Description	Quality Improvement and Health Equity Program Description (QI 1A) consists of: o Scope of QIHET Program o Quality Improvement and Health Equity Program Goals and Objectives o Cultural & Linguistics Program o Members with Complex Health Needs o Health Education o Behavioral Health/Initiative o Quality Improvement and Health Equity Resources o Organizational Structure o QIHE Committees and Subcommittees o Annual Quality Improvement and Health Equity Program Evaluation o Quality Improvement and Health Equity Work Plan Reviewed and updated annually, presented to QIHEC and the Board for approval.	Due to lack of quorum, the QIHET Program Description was approved via email.
	Q4 2024 Quality Improvement Health Equity Transformation (QIHET) Program Work plan	The **MCAS Intervention** is a key part of the QIHET Work Plan for Quarter 4. The Provider Partnership program shows MCAS performance improvement. Data as of September 2024 indicates year-over-year and year-to-date upward trends in 9 out of the 10 selected measures for the 5 sites. The overall strategic goal is to improve Merced County Pediatric Measures by a 5 percentile increase each year through 2026. The measures and their goals include: • **Child and Adolescent Well-Care Visits (WCV)**: Target of 48.0% (45th percentile)	Due to lack of quorum, the Q4 2024 Quality Improvement Health Equity Transformation (QIHET) Program Work plan was approved via email.

		• **Childhood Immunizations - Combo 10 (CIS-10)**: Target of 24.5% (14th percentile) • **Immunizations for Adolescents - Combo 2 (IMA-2)**: Target of 35.2% (50th percentile) • **Lead Screening in Children (LSC)**: Target of 53.2% (25th percentile) • **Well-Child Visits in the First 15 Months - Six or More Well-Child Visits (W30-6)**: Target of 45.6% (16th percentile) • **Well-Child Visits for Age 15 Months to 30 Months - Two or More Well-Child Visits (W30-2)**: Target of 60.8% (28th percentile) • **Breast Cancer Screening (BCS)**: Target of 52.6% (50th percentile) • **Chlamydia Screening in Women (CHL-Tot)**: Target of 56.04% (50th percentile). The intervention includes detailed tables showing baseline, target, and actual performance for various measures. For example: • **Child and Adolescent Well-Care Visits (WCV)**: Baseline of 45.64% (35th percentile), 2023 target of 46.7% (40th percentile), actual performance of 50.49%, and 2024 target of 48.0% (45th percentile)2. • **Childhood Immunizations - Combo 10 (CIS-10)**: Baseline of 16.06% (4th percentile), 2023 target of 22.2% (9th percentile), actual performance of 19.71%, and 2024 target of 24.5% (14th percentile). In Quarter 4, the team met with almost all departments to discuss department interventions. As of December 2024, Childhood Immunizations - Combo 10 is the only measure that did not reach the goal. The **Care-Based Incentive (CBI) program** aims to enhance the Provider Portal reports to streamline access to reports and increase the availability of functions and measures on a monthly basis. All goals related to this enhancement were completed by the end of Q3 2024. The next steps involve ticket assignment and completion of continuous enrollment and trending graphs to quality reports. Additionally, the program aims	

		to increase access to introductory CBI program information for network providers, with all goals completed by the end of Q3 2024 The **Basic Population Management** outlined several goals and achievements related to health education services and member health rewards programs. In Quarter 4, a total of 5 presentations on health education services and member health rewards programs were coordinated and completed. These presentations were delivered to various audiences, including the Alliance Community Grants Team, Merced County Office of Education, Merced Maternal Wellness Coalition, A Community Counteracting Tobacco (ACCT) Coalition, and ECM Provider (ClinNEXUS). Additionally, there were 2 member informing efforts completed in Q4: the December 2024 Member Newsletter included an article on health resources and self-management tools, and health educators completed 1,318 outgoing calls to offer members health education programs and services. Facility Site Review and Potential Quality Issues (PQI) from your presentation: **Facility Site Review:** • The goal was to complete 80% of existing primary care provider sites with an FSR/MRR due this quarter within three years of their last FSR date. This goal was achieved with 5 out of 6 reviews completed (83%). • Additionally, 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submitted a plan to address the CAP within regulatory timeframes. This goal was also achieved with 6 out of 6 practices meeting the requirement. • However, there were some issues identified, such as the resignation of one master-trained FSR nurse, leaving only one available to support the organization until three new hires are onboarded, trained, and certified by DHCS. This is estimated to be completed by the end of 2025. • Planned activities to accomplish goals include onboarding two new employees in Q1 2025, maintaining communication with the FSR MCP Collaborative, and collaborating with Provider Services to develop a	

		report for routine checks and balances of in-network facilities requiring site reviews. **Potential Quality Issues (PQI):** • 100% of member grievances received by QI related to potential medical quality of care issues were resolved within the regulatory timeframes for Member Grievances. This goal was achieved with all 112 cases closed on time. • 80% of non-grievance related PQIs were completed within 90 calendar days. This goal was partially achieved with 75% of cases (40 out of 53) closed on time. • Identified issues include regulatory 30-day member grievance-driven PQIs dominating the team's bandwidth, forcing the 90-day PQIs to be less than 100% compliant (75%). Ensuring adequate staffing levels to balance regulatory PQIs, internal PQI referrals, collaborative efforts, and quality studies to enhance the quality of care for members was also a challenge. • Planned activities to accomplish goals include updating Policy 401-1301 to extend the turnaround goal from 90 to 120 days, temporarily declining collaborative work, and being selective about participating in Quality Studies until the team can achieve 100% compliance in closing regulatory and internal referral PQIs. Operational processes will be examined in Q1 2025 to identify inefficiencies and pinpoint opportunities for improvement. **Appeals & Grievance** (AG) tracks AG data such as appeal topics, quality of care, service, and access issues. Upon the launch of the new system (Jiva), AG regulatory performance declined to 95% during Quarter 3 but improved to 98% during Quarter 4. New aging reports were initiated with IT for better visibility of AG pending case timeframes. Allegations of discrimination were identified, tracked, and submitted for appropriate escalations.	

		Quality of Care & Access Grievance data indicated fluctuations in the number of grievances received and the rate of grievances over the quarters. Quality of Service & Discrimination Grievance data indicated fluctuations in the number of grievances received and the rate of grievances over the quarters. A noticeable increase in appeals during Q4 were noted. The majority of the appeals involved the Community Supports benefit, particularly Medically Tailored Meals (MTM). Many requests submitted directly by the vendor lacked appropriate medical records or supportive documentation. Policy adjustments to the community supports – MTM benefit occurred in Q4 2024. Further updates on Appeals & Grievance include Quality of Care issues that trended down after an increase in Q2, while Access issues trended up in Q3 and then down for Q4. Quality of Service issues peaked in Q3 and then trended down for Q4. Discrimination cases are closely monitored and stabilized at a rate under .01 per 1,000 member months. Issues raised during this period involved race disparity, disability, and gender or sexual orientation. Issues that may have impacted AG requirements and regulatory performance included staffing deficiencies that emerged in Q2 2024 after two long-term AG employees transitioned out of the unit. Active recruitment efforts were completed during Q4 2024 to ensure appropriate staffing to improve regulatory compliance. AG staff participated in system stabilization efforts, and new reporting tools were implemented for enhanced visibility with pending cases and timeframes **Continuity of Care (COC) for Medical & Behavioral Health** primary goal is to increase the utilization of Behavioral Health (BH) benefits overall by 2.5% within the Behavioral Health network in Merced County, from a baseline of 4.07% by December 31, 2024. This will be achieved by increasing provider and member education about BH benefits offered. **Current Utilization:** • From Q4 2023 to Q3 2024, Merced overall CCAH membership dropped by almost 2000 members2.	

		• Mariposa is a neighboring county where utilization is 3.11%. • BH services occurring within the Physical Health Space for Merced are similar penetration to Monterey and Santa Cruz, bringing overall utilization up. • Last Quarter Merced was reported at 4.06% but has since increased to 4.18% due to claims lag. **Interventions in Q1, Q2, and Q3:** • BH Manager presented on BH benefits to MSAG and WCM advisory committee. • BH Manager and QI team presented at PAG in May 2024 on current BH measures, including discussions from providers related to BH benefits. • BH Managers were invited to several hospital JOC meetings, where psychiatric hospitalizations (FUA FUM measures) were discussed. • Weekly meetings with Carelon to review data on BHT referrals and linkage to care. • BH Managers met with Monterey group of pediatricians, along with other alliance and Carelon staff, in July 2025 and September 2025 to discuss BH services and referral process and barriers. • Outreach events attended by BH manager in the two new counties. • Workgroup started with Merced BHRS in June 2024 on high utilizers and ED visits, and in-person collaborative occurred with Merced BHRS to discuss interventions. • BH Manager attended two outreach events in Merced County in 2024. • Engagement with BH providers by the plan in preparation for insourcing on July 1, 2025, began in Q3/Q4. **Barriers:** • Lack of accessible in-person appointments within 10 business days for many BH providers/members not having the first appointment within 10 business days.	

		• Discovery of pending BHT referrals through Carelon not linked to services in a timely manner. • BH team informed by BH providers of difficulty with credentialing timelines and referral questions. • From Q4 2023 to Q3 2024, Merced County Membership for CCAH reduced by 2000 members. • Local EDs lacking engagement and awareness of the most appropriate referral options for BH care. • Local ED having turnover in leadership. **Planned Activities:** • At minimum, annual BH team member attendance at PAG and QIHEC meetings to discuss BH services. • At minimum, annual BH team member attendance at MSAG or other similar member forums to discuss BH services such as WCM advisory committee. • Increase in provider outreach and education via provider newsletters. • Promotion of BH services at outreach activities (at least three) in Merced County. • Meet with Delegate (Carelon) monthly and MHPs at minimum quarterly to track and discuss appropriate referrals and transitions to the NSMHS benefit. • Outreach and engage local Merced EDs in collaboration on referrals to BH care. **Next Steps:** • BH services will be insourced on July 1, 2025, with the goal to increase utilization and member and provider experience. • Annual communication to members and providers via a "NSMHS outreach and education plan" draft completed and will be posted on the external website for members and providers once approved by DHCS.	

		• BH Manager to continue ongoing monthly collaboration with Merced BHRS to discuss BH interventions at local ED. • BH team will present on BH benefits and/or BH coordination of care at QIHEC and PAG in Q1 2025, and MSAG in Q2 2025. • BH team doing a presentation to providers at "Lunch and Learn" in May 2025. The **Provider Satisfaction Survey** is conducted annually by SPH Analytics / Press Ganey and surveys in-area PCPs, Specialists, and Behavioral Health providers. The survey comprises a set of standard (Book of Business) and custom questions, providing a snapshot of providers' experience with the Alliance in the areas of health plan operations and perception of access to services. The survey results offer: • Insight into whether core processes are meeting providers' needs. • Ideas for focus or alignment in the coming year. • Opportunities for intervention to improve provider satisfaction1. **Satisfaction by Provider Type:** • PCP Satisfaction: 89% • Specialist Satisfaction: 89%2. **Satisfaction by County:** • Merced: 90% • Monterey: 90% • Santa Cruz: 85%2. **Satisfaction by Provider Type for Behavioral Health (NPMH):** • 79%3. These ratings are based on the top 2 ratings on a 5-point scale, with a sample size of 175 for PCPs and Specialists, and 106 for Behavioral Health provider **Telephone Access** overview included the goals and performance metrics for Member Services calls. The goals include answering 80% of calls within 30 seconds and maintaining a call abandonment rate of no more than 5%. The performance metrics for each quarter are as follows:	

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		• **Q1:** 63% of calls answered within 30 seconds, 6% call abandonment rate. • **Q2:** 94% of calls answered within 30 seconds, 1.5% call abandonment rate. • **Q3:** 90% of calls answered within 30 seconds, 2% call abandonment rate. • **Q4:** 81% of calls answered within 30 seconds, 3% call abandonment rate. • **Total:** 82% of calls answered within 30 seconds, 3% call abandonment rate. Additional FTEs were hired to provide support for staff who were promoted to other departments and LOAs. Despite a decrease in service levels, the goals were maintained. It is important to always have sufficient staff to support the needs of members via phone or walk-ins. The member walk-in volume continues to remain high, with the Merced office having the highest member walk-in volume. In total, 1,071 members were assisted in all 5 locations. Workforce Management Tool was discussed, which will eliminate manual tracking of staff attendance, forecast, track, and trend calls. The Call Audit Optimization, where dedicated staff perform call audits, identify trends, skills gaps, and opportunities was discussed. This allows Call Center Supervisors to coach in real-time to optimize the member's experience. Ongoing FTE assessment is taking place to ensure adequate staff are prepared for increased volume of work. There is an open recruitment for an additional Call Center Supervisor/DSNP. **Cultural & Linguistics** Q4 updates included updates on goals. • **Goal 1:** A total of 2 presentations on Cultural & Linguistics (C&L) services were coordinated and completed in Quarter 4. The goal was to increase member utilization of C&L services by 2.5% compared to the 2023 baseline by December 31, 2024. The presentations were delivered to the following audiences: o Alliance Community Grants team o Clinica de Salud del Valle de Salinas (CSVS). • **Goal 2:** Inform members of C&L services available to them with at least 1 member informing modality per quarter. The goal was to increase	

		member utilization by 2.5% compared to the 2023 baseline by December 31, 2024. There was 1 member informing effort completed: o December Member Newsletter: The article in the newsletter informed members of their rights to have written information in alternative formats (Alternative Format Selection/AFS)1. • **Goal 3:** Collect member feedback on their experience with language assistance services in a clinical setting with a goal of establishing a baseline for 2024 to target improvements in 2025. A total of 26 member experience surveys were collected. According to the member feedback collected for language assistance services in a clinical setting: o Over 96% of members reported the highest rating of satisfaction with the interpreter at their doctor visit. o 100% surveyed reported they would use the interpreting services again. o When asked for recommendations to improve the experience, 96% of members reported no improvements needed. o 4% shared recommendations such as training all interpreters to provide the same quality of service as high-performing interpreters. • **Goal 4:** Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2023 baseline utilization data. There were significant increases in both types of interpreting services available for providers to use with members: o Phone interpreting services: There was a 38% increase in provider utilization of phone interpreting services in Q4 2024 compared to Q4 2023. o Face-to-Face (F2F) interpreting services: There was a 35% increase in provider requests for F2F interpreting services in Q4 2024 compared to Q4 2023.	

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	Q4 2024 Carelon UM Audit Results	**Carelon Audit Results:** Rebecca McMullen, Jill Young, and Mandeep Kullar presented the quarterly utilization management audit results for Carelon, highlighting that they passed the audit for quarter four with over a 90% pass rate. However, there were some issues with timely approval for UM decision making, which Carelon had already identified and addressed internally. ○ **Audit Process:** the quarterly utilization management audit of Carelon involves reviewing approvals, denials, adverse determinations, and modifications. They randomly select 15 charts, audit 10 of them, and assess them against NCQA requirements, including timely access and decision-making. ○ **Audit Results:** Carelon passed the audit for quarter four with over a 90% pass rate. However, three out of ten charts did not meet the timely approval for UM decision-making. Carelon had already identified this issue in their internal audit and implemented a corrective action plan to address it. ○ **Internal CAP:** Carelon's internal corrective action plan (CAP) was put in place to address the identified issues with timely UM decision-making. This plan aims to improve the areas where the audit found deficiencies, ensuring better performance in future audits. • **Outpatient Penetration and Screenings:** a significant increase in volume from county partners was noted and a 19% increase in unique utilizers for BHT services from 2023 to 2024. The conversion rate for attended appointments was 39%, slightly below the all-plan average. ○ **Volume Increase: A** significant increase in volume from county partners, contributing to a 19% rise in unique utilizers for BHT services from 2023 to 2024. This increase is partly attributed to the implementation of DHCS standardized screening tools in 2023. ○ **Conversion Rate:** The conversion rate for attended appointments was 39%, slightly below the all-plan average of 44%. Members who self-refer for services tend to have higher engagement and	

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		attendance rates compared to those referred by primary care physicians. ○ **Referral Challenges:** Dr. Kennedy raised concerns about patients not being aware of their referrals to Carelon, leading to missed connections. **Mandeep Kullar** acknowledged this issue and suggested that members might not recognize Carelon as the behavioral health services provider, contributing to lower conversion rates. ○ **Improvement Strategies: Mandeep Kullar** discussed potential strategies to improve conversion rates, such as educating primary care physicians, implementing real-time handoffs, and providing Flyers to ensure members understand their referrals for behavioral health services. • **Utilization and Penetration Rate:** the overall utilization and penetration rate for the medical line of business shows an increase in unique utilizers and a penetration rate of 5.13%, slightly above the all-plan average. The top diagnoses were depression, anxiety disorders, and adjustment disorders. ○ **Utilization Increase:** a quarter-over-quarter increase in unique utilizers for the medical line of business, indicating that more members are accessing services. This trend aligns with the additional volume received from county partners. ○ **Penetration Rate:** The penetration rate for the medical line of business was 5.13%, slightly above the all-plan average of 5.01%. This rate reflects the proportion of members accessing services relative to the total eligible population. ○ **Top Diagnoses:** The top diagnoses among utilizers were depression (35%), anxiety disorders (34%), and adjustment disorders (17%). These conditions represent the most common reasons for members seeking behavioral health services.	

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		○ **Age Breakdown:** The penetration rates were broken down by age, with the 0-18 age group in blue and the 19+ age group at 6.01%. The adult population showed higher utilization rates compared to children and youth. • **BHT Services Growth:** highlights included a 19% increase from 2023 to 2024. The penetration rate also increased, and there was a significant growth in the number of younger children entering BHT services. ○ **Utilizer Growth:** a 19% increase in unique utilizers for BHT services from 2023 to 2024. This growth is attributed to efforts by the referral and access team to get children into services more quickly. ○ **Penetration Rate:** The penetration rate for BHT services also increased, reflecting a higher proportion of eligible members accessing these services. This trend indicates improved outreach and service delivery. ○ **Young Children:** There was significant growth in the number of younger children (0-4 years) entering BHT services. This early intervention is crucial for achieving better outcomes in behavioral health treatment. ○ **Claims Lag:** the data is based on claims, and there may be a lag in reporting. Therefore, the actual number of unique utilizers for quarter four of 2024 may be higher as more claims are submitted and processed. • **Provider Performance Metrics:** the average time from initial authorization to the first billed appointment was 14.8 business days. Additionally, 81% of parents received parent training, and 61% of hours were delivered in-home. ○ **Authorization to Appointment:** The average time from initial authorization to the first billed appointment was 14.8 business	

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		days. This metric reflects the efficiency of providers in scheduling and delivering services to members. ○ **Parent Training:** 81% of parents received parent training, which is considered a high rate compared to other regions. This training is essential for supporting families in managing their children's behavioral health needs. ○ **Service Delivery:** 61% of service hours were delivered in-home, providing a convenient and effective option for families. There was also an increase in center-based programming, offering additional support for families who may have challenges with in-home services. ○ **Center-Based Services: highlights of** the benefits of center-based services were reviewed, especially for families with working parents or multiple children. These centers provide a structured environment for children to receive their full authorized hours of intervention. • **Inter-Rater Reliability:** the inter-rater reliability results were covered, stating that all licensed staff, medical directors, and peer advisors met or exceeded the 90% benchmark, with an overall group average of 99%. Dr. Gray Clarke asked for clarification on the percentage of ABA services delivered in facilities versus in-home, noting a discrepancy in the reported data. Jill Young responded, confirming that 61% of ABA services were delivered in centers and 45% in-home, correcting the earlier mistake.	

Action Items

Agenda Item	What is the action item	Due date	
Vote on Consent and Regular agenda items	Jacqueline Van Voerkens will distribute an email to the QIHEC Members requesting a vote on the April 2, 2025 items requiring approval.	**4/2/25**	

Quality Improvement Health Equity Committee

Date: April 2, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

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	Action: complete		
Meeting adjourned at (time)			
Next Meeting June 26, 2024			
Approved by Committee Date: June 26, 2025	***Signature:*** *Andrea Swan, RN, Quality Improvement Population Health Director*		**Date: June 26, 2025**

DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Finance Committee: Commissioner Appointment

Recommendation. Staff recommend that the Board approve the appointment of Commissioner Kristynn Sullivan to the Finance Committee.

Background. The Board established the Finance Committee as authorized in the Bylaws of the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission. Only Commissioners may serve on the Finance Committee, and the committee must be comprised of less than a quorum of voting commissioners.

Discussion. Commissioner Sullivan has indicated interest in serving on the Finance Committee, and Board appointment is required.

Finance Committee members include:

1. Commissioner Aguirre
2. Commissioner Armstrong
3. Commissioner Jimenez
4. Commissioner Molesky
5. Commissioner Pedrozo
6. Commissioner Radner

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Whole Child Model Family Advisory Committee: Member Appointments

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Recommendation. Staff recommend the Board approve the appointment of the individuals listed below to the Whole Child Model Family Advisory Committee (WCMFAC).

Background. The Board established WCMFAC pursuant to Welfare and Institutions Code §14094.17(b)(1) (SB 586 – Statutes 2015).

Discussion. The following individuals have indicated interest in participating on the WCMFAC.

Name	Affiliation	County
Kazzandra Cunningham	Parent/Guardian	Mariposa
Megan Atkinson	Parent Center	Mariposa

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

Attachments. N/A

DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Services Advisory Group: Member Appointment

Recommendation. Staff recommend the Board approve the reappointment of the individual listed below to the Member Services Advisory Group (MSAG).

Background. The Board established MSAG pursuant to Welfare and Institutions Code §14094.17(b)(1) (SB 586 – Statutes 2015).

Discussion. The following individual has indicated interest in participating on MSAG.

Name	Affiliation	County
Jamie Berry	Consumer	Mariposa

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

Attachments. N/A

DATE: August 27, 2025

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

FROM: Dr. Mike Wang,, Medical Director and Interim Chief Medical Officer

SUBJECT: Peer Review and Credentialing Committee Report of March 2025

Recommendation. Staff recommend the Board accept the decisions from the March 12 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 six-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.

June 2025 Meeting

- New Providers:
  - 20 Physician Providers (MD, DO, DPM)
  - 25 Non-Physician Medical Practitioners
  - 18 Allied Providers
  - 497 Behavioral Health
  - 18 Organizations
  - 8 ECM/CS

- Recredentialed Providers:
  - 49 Physician Providers (MD, DO, DPM)
  - 23 Non-Physician Medical Practitioners
  - 6 Allied Providers
  - 17 Organizations

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

Attachments. N/A

DATE: August 27, 2025
TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
FROM: Andrea Swan, RN, Quality Improvement and Population Health Director
SUBJECT: Quality Improvement Health Equity Transformation Workplan – Q1 2025

Recommendation. Staff recommend the Board accept the Q1 2025 Quality Improvement Health Equity Transformation (QIHET) Workplan report.

Summary. This report provides pertinent highlights, trends, and activities from the Q1 2025 QIHET Workplan. The workplan includes contractual required Performance Improvement Projects, operational performance metrics, health programs and cultural and linguistic services, and development of the population health management program. Refer to the QIHET Workplan attachment for additional details.

Background. The Alliance is contractually required by the Department of Healthcare Services (DHCS) to maintain a Quality Improvement Program (QIS) to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. The QIHET workplan is approved by the Quality Improvement Health Equity Committee, and ultimately, the Santa Cruz-Monterey-Merced - San Benito – Mariposa Managed Medical Care Commission (Board). The Board can direct and provide modifications to the quality improvement system on an on-going basis to ensure that actions and improvements meet the overall Alliance mission.

Discussion: Approve the Q1 2025 Quality Improvement Health Equity Transformation Workplan.

QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION

Reporting purpose is to execute completed Annual QI Evaluation meeting DHCS and NCQA standards. Finalize Annual Evaluation for presentation to QIHEC.

Report Previously Identified Issues /Highlights:

No issues are identified. The 2024 QI Annual Evaluation is set to complete by the end of Q2 2025, including added sections for National Committee for Quality Assurance (NCQA) Health Equity (HE) Accreditation requirements for Culturally and Linguistically Appropriate Services (CLAS) evaluation, and Reducing Health Care Disparities. The new content evaluations will continue into the 2025 QI Annual Evaluation.

Report Changes/Updates: No additional report changes.

PROGRAM DESCRIPTION

Reporting purpose is to execute a completed Annual QI Program Description meeting DHCS and NCQA standards. Finalize Annual Program Description for presentation to QIHEC.

Report Previously Identified Issues /Highlights:

For the first objective, 2024 implementation of Provider Partnerships and the Workforce Support for Care Gap Closure Grant led to greater access for members and improved performance on the majority of MCAS measures in Merced County. Targeting our DHCS sanctions for the measurement years of MY2022 and MY2023, the efforts of the program led to the improvement of all eight HEDIS measures.
Due to lack of continuous enrollment data for new counties, it was initially tough to identify measures of focus (grant activities) for San Benito and Mariposa County.

No issues are identified. The 2025 Program Description was finalized and approved by QIHEC April 2025.

Report Changes/Updates: No additional report changes.

QUALITY OF CLINICAL CARE
Medi-Cal Managed Care Set (MCAS) Intervention:
Reporting purpose is to:

1. Close pediatric care gaps in Merced and Mariposa County to have all pediatric measures at or above MPL or have a 5% increase in the measure.

   Measurement Year (MY) 2023, Reporting Year (RY) 2024 MCAS rates for Merced County:
   - Child and Adolescent Well-Care Visits (WCV) - 50.49%
   - Childhood Immunizations - Combo 10 (CIS-10) - 19.71%
   - Immunizations for Adolescents - Combo 2 (IMA–2) - 32.02%
   - Lead Screening in Children (LSC) - 47.01%
   - Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6) - 48.69%
   - Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 61.10%

2. Improve Follow-Up After ED Visit for Mental Illness - 30 days (FUM) and Follow-Up After ED Visit for Substance Use - 30 days (FUA) measure rates by establishing monthly data file sharing from all five County Behavioral Health departments to the Alliance. These data files will capture services performed by the county departments for carved out services for regulatory DHCS MCAS reporting.

   Goal is to exceed the MPL for MY24 or increase MY23 by 5%.
   - FUM MY 2023, RY 2024 rate was 34.55% Santa Cruz/Monterey, 20.42% for Merced County Re-porting.
   - FUA MY2023, RY 2024 rate was 39.37% for Santa Cruz/Monterey, and 39.97% for Merced.

Report Previously Identified Issues /Highlights:

For the first objective, 2024 implementation of Provider Partnerships and the Workforce Support for Care Gap Closure Grant led to greater access for members and improved performance on the majority of MCAS measures in Merced County. Targeting our DHCS sanctions for the measurement years of MY2022 and MY2023, the efforts of the program led to the improvement of all eight HEDIS measures.
Due to lack of continuous enrollment data for new counties, it was initially tough to identify measures of focus (grant activities) for San Benito and Mariposa County.

For the second objective, Q1 updates included completion of the first and second planned activity to analyze last year's ad hoc data, and outreach to all counties. Identified issues included concerns of following data protection guidelines for HIPAA privacy and 42 CFR part 2 Final Rule; completion of DHCS MOUs with all Mental Health Plans; technology and staffing capacity to abstract data and share through the requested templates; and difficulties with accommodating the data request by the end of Q1.

Report Changes / Updates: Not changes or updates to report:
Updated language to use the terminology, "Mental Health Plans."

Care Base Incentive
Reporting purpose is to:

1. Increase CBI program resources and support to Mariposa and San Benito County participating providers. Goal is to increase county specific targeted December 2024 rates to exceed the Minimum Performance Level (MPL) or increase by 5% by December 2025.

   Mariposa County CBI Measures of Focus as of December 2024:
   - Child and Adolescent Well-Care Visits (37.76%)
   - Controlling High Blood Pressure (20.56%)
   - HbA1c Poor Control >9% (66.97%)
   - Cervical Cancer Screening (25.16%)
   - Chlamydia Screening in Women (48.91%)

   San Benito County CBI Measures of Focus as of December 2024:
   - Developmental Screening in the First Three Years of Life (21.51%)
   - Controlling High Blood Pressure (11.07%)
   - HbA1c Poor Control >9% (89.84%)
   - Cervical Cancer Screening (43.78%)

Report Previously Identified Issues /Highlights:
No current or prior issues identified. The CBI team has assigned slides, and prep work for the planned activities for the CBI into video.

Report Changes / Updates: Not changes or updates to report:

Basic Population Health Management
Reporting purpose is to provide an update on Basic Population Health goals and activities.

Goal 1:
Provide chronic disease management programs and wellness programs for members. A minimum of 4 workshops will be offered per quarter.

- **Q1 progress:** A total of 4 member workshops were completed in Q1. Virtual, telephonic and in-person workshops were completed.

Goal 2:
On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2025.

- **Q1 progress:** The project team included 1 article in the March 2025 Member Newsletter informing members of health and wellness programs available. Additionally, the Health Educators completed 1,224 outgoing calls to members to offer health and wellness programs. A new text message campaign and online sign-up form were launched in Q1 resulting in 83 members proactively signing up for programs immediately following the text message.

Goal 3:
On a bi-annual basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact.

- **Q1 progress:** Surveys will be collected in Q2.

Goal 4:
On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal and external partners. A minimum of 2 presentations will be conducted per quarter.

Report Previously Identified Issues /Highlights: No previously identified issues to report.

Report Changes / Updates: Not changes or updates to report:
Q1 progress: A total of 6 presentations on Health Education services and Member Health Rewards were coordinated and completed in Q1. This included internal and external audiences.

SAFETY OF CLINICAL CARE

Facility Site Review and Potential Quality Issues

Reporting purpose is to outline goals, activities, and target completion dates for the Safety of Clinical Care related to Facility Site Review and Potential Quality Issues.

Facility Site Review:
Report Previously Identified Issues /Highlights:
Identified Issue:
Staffing challenges continue to impact the ability to complete site reviews on time.
Goal Results:
1. 13/14 (93%) of PCP sites with an FSR/MRR due were completed within the three-year compliance window (target: 80%).
2. 14/14 (100%) of sites with Corrective Action Plans (CAPs) submitted responses within regulatory timeframes (target: 100%).

Report Changes / Updates:

The FSR team exceeded performance targets through proactive planning, early provider outreach, and consistent CAP monitoring.

Three QI RNs are being onboarded to address staffing limitations, with certification expected by Q4 2025 or Q1 2026. The DHCS-certified QI RN was promoted to Clinical Safety Supervisor for FSR, and recruitment is underway to fill the vacated position. Continued provider engagement remains a priority to maintain timely review completion.

Potential Quality Issues

Report Previously Identified Issues /Highlights:
Identified Issue:

Current staffing must balance increasing PQI volume, CAP management, regulatory timeframes, and support for collaborative efforts and quality studies.

Goal Results:

1. 124/124 (100%) of grievances related to potential quality of care concerns were resolved within regulatory timeframes (target: 100%).
2. 29/52 (56%) of non-grievance PQIs were completed within 90 calendar days (target: 80%).

Report Changes / Updates:

Regulatory grievance resolution remains the top priority and accounts for the majority of QI RN workload. Process improvements are in progress for exempt grievances and overall PQI management. As a result, resources are currently focused on regulatory and 120-day PQI reviews. Quality study referrals will be deferred until core compliance metrics are consistently met.

Grievance and Appeals

Reporting purpose is to provide an update and review of AG performance, trends, and activities for the Appeals and Grievance Program during Q1 2025.

Report Previously Identified Issues /Highlights:

Goal 1:

Meet Regulatory Requirements 98% of the time for timely acknowledgements and resolutions. Enhanced operational monitoring occurred to support deadlines.

- **Q1 Results**: The AG team met all deadlines up to 98%. Missed deadlines occurred primarily due to non-responsive or incomplete provider information and volume increases,

Goal 2:

Maintain the AG rate below 2 for QOC and QOS

- **Q1 Results**: Grievance trends with provider availability (access), provider and plan customer service, while appeal trends center on community support benefits, both medically tailored meals and housing support.

Goal 3:
Improve AG data quality and reporting.

- Developed and implemented a new report to help guide provider support and trends for substantiated issues.

Goal 4:
Improve monitoring and documented oversight

- Developed reportable notations to improve real time transparency of AG oversight and reviews.

Report Changes / Updates: No changes or updates to report:

MEMBER EXPERIENCE
Member Satisfaction Survey – CAHPS
Reporting purpose is to provide an update on the progress of CAHPS work and 2025 focus area.

Report Previously Identified Issues /Highlights:
Previously reported in Q4 2024, there were issues getting organizational involvement and alignment on CAHPS interventions.

Report Changes / Updates:
MY2023 (2024 results) were shared out amongst the system in Q1 at QIHEW and MCAS workgroup. To sustain organizational involvement and provide direction and support for on-going intervention work, a CAHPS workgroup was planned and executed by the end of Q1.
Additionally, a focus area was chosen based on MY2023 results and additional system-wide efforts to impact Cultural and Linguistic Services as an element of our Health Equity Strategic Goal #2. Therefore, the composite of "How Well Doctor's Communicate" was chosen, focusing are efforts organizationally on member experience with communication.

QUALITY OF SERVICE
Access and Availability
Reporting purpose is to comply with DMHC Timely Access Survey Requirements and review provider member ratios.

Report Previously Identified Issues /Highlights: No previously identified issues to report.

Report Changes / Updates: Not changes or updates to report:
MY2024 PAAS Survey results were received in Q12025, below is an overview of the results:
For the IHSS line of business: Non-Urgent appointments received a compliance rate of 67% for all provider survey types.
For the Medi-Cal line of business: Non-Urgent appointments received a compliance rate of 76% for all provider survey types.

For the IHSS line of business: Urgent appointments received a compliance rate of 84% for all provider survey types
For the Medi-Cal line of business: Urgent appointments received a compliance rate of 66% for all provider survey types.

Within both lines of business there was an increase in compliance for non-urgent appointments for all surveyed provider types.

Geo Access
Reporting purpose is to comply with time and distance requirements in accordance w/ DHCS timelines.

Report Previously Identified Issues /Highlights: No previously identified issues to report.

Report Changes / Updates:

The Alliance has submitted the Annual Network Certification (ANC) Filling to DHCS in Q1 2025, which includes the Geo Access reports.

DHCS is reviewing and will provide outcomes once available.

Telephone Access
Reporting purpose is to ensure timely assistance for members when connecting with the plan, through Member Services Call Center.

Report Previously Identified Issues /Highlights:

- Goals met due to the Call center is staffed correctly with FTE's, temp MSR's and leadership.
- Member walk-in volume continues to increase in our high functioning offices: Salinas and Merced.
- New Member welcome calls in-sourced eff 5/1. Pilot stage began February 2025, we assign 2-3 MSRs daily to make outbound calls.

Report Changes / Updates:
Addition of FTE/ Call Center Supervisors successful, working on a workforce Management Tool and new phone system to increase efficiency.

Culture and Linguistics
Reporting purpose is to provide an update on cultural and linguistic (C&L) program goals and activities.

Report Previously Identified Issues /Highlights: No previously identified issues to report.

Report Changes / Updates:

Goal 1:
Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2024 baseline utilization data.

- **Q1 progress – phone interpreting services:** There was a total of 8,284 calls in Q1 by provider sites. This reflects an increase of 39% compared to Q1 2024.
- **Q1 progress – Face-to-Face (F2F) interpreting services:** There was a total of 1,745 requests in service counties for F2F. This reflects an increase of 12% compared to Q1 in 2024.
    - Santa Cruz County had 747 requests in Q1. This was a 7% decrease compared to Q1 2024.
    - Merced County had 394 requests in Q1. This was a 15% decrease compared to Q1 2024.
    - Monterey County had 580 requests in Q1. This was a 110% increase compared to Q1 2024.
    - San Benito County had 24 requests in Q1. This was a 2300% increase compared to Q1 2024.
    - Mariposa County had 0 requests in Q1. There was no change compared to Q1 2024.

Goal 2:
Collect member feedback on their experience with language assistance services in a clinical setting.

- **Q1 progress:** Surveys will be collected bi-annually. Surveys will be collected in Q2.

Goal 3:
On a quarterly basis, inform members and providers of language assistance services utilizing at least 1 member and 1 provider informing modality.

- **Q1 progress:**
    - **Member Newsletter:** The project team included 1 article in the March 2025 Member Newsletter informing members of language assistance services available to them.
    - **Provider Bulletin:** The project team included 1 article in the March 2025 Provider Bulletin informing providers of language assistance services and how to access the services to support communication with members.

Goal 4:
On a quarterly basis, provide at least 1 C&L services presentations to Alliance internal department staff that interact with members or providers to increase awareness of C&L services available for members.

- **Q1 progress:** A total of 4 presentations on C&L services were completed in Quarter 1.

Delegation Oversight

Reporting purpose is to ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations, and ensure oversight of all delegated activities by governing board.

No previously identified issues were noted.

Report Changes / Updates:

All delegate reports for the quarter were received and reviewed with no gaps identified. No issues with delegate reports.

Conclusion: The QIHET Workplan does not have any critical areas of concern that require further intervention or follow-up. There is continued progress toward goals for the initiatives and operational metrics, including addressing any barriers to achieve outcomes. The pandemic

continues to impact provider staffing and active engagement; however, there are efforts in participation and the team is providing support as needed.

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

Attachments.

1. Q1 2025 Quality Improvement and Population Health Transformation Program Workplan.

SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Execute completed Annual QI Evaluation meeting DHCS and NCQA standards. Finalize Annual Evaluation for presentation to QIHEC.	1. Update the 2024 Evaluation document, ensuring any regulatory updates, and assignment of sections for each respective business owner. 2. Monitor progress of evaluation update by business owners and provide feedback. 3. Create business requirements for a new section of the Alliance website to share evaluation.	8/1/2025-8/30/2025 9/1/2025-12/31/2025 12/1/2025-12/31/2025	Kristen Rohlf, MPH, Quality and Population Health Manager	1st update- The 2024 QI Annual evaluation is under review, set to complete by end of Q2 2025. The updates include new sections to capture the National Committee for Quality Assurance (NCQA) Health Equity (HE) Accreditation Section 5 requirements for Culturally and Linguistically Appropriate Services (CLAS) evaluation, and HE Section 6 Reducing Health Care Disparities report evaluation material. The first planned activities for the 2025 Annual QI Evaluation are set to begin in the middle of Q3.	1: No issues identified.	1. Once the 2024 annual QI evaluation is completed, assessment will begin for updated 2025 accreditation standard requirements, and any new contractual requirements from DHCS.	☐ Yes ☑ No	Planned activities are on track for completion.

PROGRAM DESCRIPTION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Finalize 2025 Program Description for presentation to QI stakeholders.	1. Ensure all required sections of the workplan meet DHCS and NCQA requirements.	1/31/2025-2/15/2025	Andrea Swan, Quality Improvement & Population Health Director		1: No previously identified issues	1 N/A	☑ Yes ☐ No	

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2. Presentation of the Program Description to both the QIHEW, and QIHEC for approval by 4/02/2025	2. Submission of Program Description to QIHEW staff	3/1/2025-3/24/2025	Andrea Swan, Quality Improvement & Population Health Director	1st update: 2025 Program Description was finalized and approved by QIHEC April 2025.			☐ Yes ☐ No	
3. Develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS and NCQA requirements.	3. Review all DHCS and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2025-12/31/2025	Andrea Swan, Quality Improvement & Population Health Director		2:	2:	☐ Yes ☐ No	
							☐ Yes ☐ No	

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Execute a QI annual work plan that captures ongoing activities throughout the year and addresses all DHCS and NCQA requirements	1. Create a workplan that captures yearly activities, time frame for each activity's completion, staff members responsible for each activity, monitoring of previously identified issues, and evaluation of QI program.	1/1/2025-2/24/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 1:			☐ Yes ☐ No	
2. Ensure all workplan elements are properly documented and reflect appropriate follow-up by each business owner.	2. Regularly quarterly check-ins to review workplan entries with regular feedback provided to business owners when applicable.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 2			☐ Yes ☐ No	
3. Review and approval of workplan quarterly by QIHEC.	3. Review of all workplan entries prior to each committee to ensure appropriate documentation.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 3:			☐ Yes ☐ No	
1.	1.			Qtr. 4:			☐ Yes ☐ No	

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SECTION 2: QUALITY OF CLINICAL CARE

MEDI-CAL MANAGED CARE SET (MCAS) INTERVENTION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Close pediatric care gaps in Merced and Mariposa County to have all pediatric measures at or above MPL or have a 5% increase in the measure. 2. Measurement Year (MY) 2023, Reporting Year (RY) 2024 MCAS rates for Merced County: 3. Child and Adolescent Well-Care Visits (WCV) - 50.49% 4. Childhood Immunizations - Combo 10 (CIS-10) - 19.71% 5. Immunizations for Adolescents - Combo 2 (IMA–2) - 32.02% 6. Lead Screening in Children (LSC) - 47.01% 7. Well-Child Visits in the First 15 Months—Six or More	1. Analyze data - Q1 2. Identify providers and measures- Q2. 3. Provide workforce care gap closure grants to providers with large member populations in Merced and Mariposa Q3. 4. Continue Provider Partnership program in Merced and expand to Mariposa County to support providers in their interventions that focus on measures that are below MPL Q4.	2/1/2025-12/31/2025	Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor III Georgia Gordon, Quality Improvement Program Advisor II Jada Edwards, Quality Improvement Program Advisor II Juan Velarde, Quality Improvement Program Advisor IV Annecy Majoros, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III Britta Vigurs, Quality Improvement Program Advisor III	Qtr. 1: 2024 performance was analyzed for Provider Partnerships and the grant program. We looked at measure performance data, and qualitative feedback from practices and liaisons. In Q1 information was shared with department leadership, MCAS workgroup, QIPH department meeting, and Q1 Merced County Provider Meeting. A presentation and narrative summary were created detailing efforts. Data was analyzed for the 2025 grant that put practices in funding tiers based on the number of members that need to reach MPL. The first round of 2025 saw 8 Merced practices apply and receive the Workforce Grant Round two will begin in June 2025 targeting any Merced and Mariposa practices who were outreached to but didn't	Given the nature of continuous enrollment within CBI and our new counties, it was initially tough to get a clear picture of what measures they were struggling with.	Move on to our second waves of Workforce Grant applications in May and June. Continue to build upon and foster new relationships within Provider Partnerships.	☑ Yes ☐ No	All activities planned for Q1 have been completed, and activities for the rest of the year are ongoing.

Well-Child Visits (W30-6) - 48.69% 8. Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 61.10% Note: Mariposa County will be reported for the first time in MY2024, RY 2025.				apply first round, as well as SC and Monterey Counties. Provider Partnerships has continued with four Merced practices and was expanded to San Benito Health Foundation (San Benito County) and Jon C. Fremont Clinic (Mariposa County). Liaisons are in the process of setting up time to meet with the practices.				
				Qtr. 2:			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
1. Improve Follow-Up After ED Visit for Mental Illness - 30 days (FUM) and Follow-Up After ED Visit for Substance Use - 30 days (FUA) measure rates by establishing monthly data file sharing from all five County Behavioral Health departments to the Alliance. These data files will capture services performed by the county departments for carved out services for regulatory DHCS MCAS reporting. Goal is to exceed the MPL for MY24 or increase MY23 by 5%. 2. FUM MY 2023, RY 2024 rate was 34.55% Santa Cruz/Monterey,	1. Analyze last year's Merced, Monterey, and Santa Cruz County Behavioral Health Department MCAS ad hoc data files for process improvements in Q1. 2. Contact Merced, Monterey, Mariposa, Santa Cruz, and San Benito County Behavioral Health Departments for new monthly data sharing request during Q1-Q3. 3. Provide technology support and QA of received files for file layout compliance during Q1-Q4. 4. Creation of a new Alliance database to store county data in Q2-Q4.	1/1/25 -3/31/25, 1/1/25-9/30/25, 1/1/25-12/31/25, 3/1/25-12/31/25, 3/1/25-12/31/25	Magdalena Kowalska, Quality Improvement Program Advisor IV Shae Redwine, Behavioral Health Program Analyst	Qtr. 1: Completed analysis of data for last year's ad hoc data files from Monterey, Merced, and Santa Cruz Mental Health Plans. All counties received initial and follow-up data requests from CCAH by Q1.	Concerns that data sharing follows all applicable data protection guidelines for HIPAA privacy and 42 CFR part 2 Final Rule. DHCS MOUs are still in process with the Santa Cruz Mental Health Plan. Technology and staffing capacity to abstract data and share through the requested templates. Mariposa and San Benito could not accommodate the data request by the end of Q1. Mariposa additionally expressed	To re-engage data discussions with Mariposa and San Benito, and to start discussions with Santa Cruz, Monterey and Merced for monthly data file sharing.	☐ Yes ☐ No	All activities planned for Q1 have been completed, and activities for the rest of the year are ongoing.
				Qtr. 2:			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	

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20.42% for Merced County Reporting. 3. FUA MY2023, RY 2024 rate was 39.37% for Santa Cruz/Monterey, and 39.97% for Merced. Note: Mariposa and San Benito Counties will be reported for the first time in MY2024, RY 2025. Single plan health plan rates will be submitted to NCQA, and county specific rates submitted to DHCS.	5. Integration of new files for HEDIS vendor software extraction in Q2-Q4.			Qtr. 4:	concerns about not having member level detailed information readily available.		☐ Yes ☐ No	

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase CBI program resources and support to Mariposa and San Benito County participating providers. Goal is to increase county specific targeted December 2024 rates to exceed the MPL or increase by 5% by December 2025. Mariposa County CBI Measures of Focus as of December 2024: 2. Child and Adolescent Well-Care Visits (37.76%) 3. Controlling High Blood Pressure (20.56%) 4. HbA1c Poor Control >9% (66.97%) 5. Cervical Cancer Screening (25.16%) 6. Chlamydia Screening in Women (48.91%) San Benito County CBI Measures of Focus as of December 2024: 7. Developmental Screening in the First Three Years of Life (21.51%) 8. Controlling High Blood Pressure (11.07%) 9. HbA1c Poor Control >9% (89.84%) 10. Cervical Cancer Screening (43.78%)	1. Analyze CBI Forensics (CBIF) meeting requests from 2024 from Mariposa and San Benito in Q1-Q2 2. Analyze Alliance Provider Portal Data Submission Tool (DST) usage and training requests from 2024 from Mariposa and San Benito in Q1-Q2 3. Analyze CBI Q4 2024 final programmatic rates from Mariposa and San Benito CBI group providers in Q1-Q2 4. Outreach to providers in Mariposa and San Benito to schedule CBIF and additional provider portal report and DST submission training based on Q4 2024 performance, DST submission usage, and past forensics requests in Q2-Q3. 5. Create, record, and publish the CBI Intro Video to the Alliance website for the CBI 2025 program year. Add information on new portal reports like HEDIS (MCAS) Reports to training material. Complete in Q1-Q3	1/1/25-6/30/25, 1/1/25-6/30/25, 1/1/25-3/30/25, 3/1/25-8/30/25, 1/1/25-8/30/25	Alex Sanchez, MPH, Quality Improvement Program Advisor III Annecy Majoros, Quality Improvement Program Advisor III Britta Vigurs, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III Juan Velarde, Quality Improvement Program Advisor IV	Qtr. 1: The CBI team has assigned slides, and prep work for the planned activities for the CBI into video. Qtr. 2 Qtr. 3: Qtr. 4:	No current or prior issues identified.	Analysis the CBI forensics, data submission tool submissions, and Q4 2024 programmatic rates in preparation for outreach by end of Q2. Finalize the CBI intro slides and recording by end of Q3.	☐ Yes ☑ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Goals have not yet been met but are on track for completion by the target end date for the first activities due by the end of Q2.

BASIC POPULATION HEALTH MANAGEMENT (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provide members with chronic disease management programs and wellness programs. A minimum of 4 member workshops will be provided per quarter.	1. The Health Educators will conduct a minimum of 4 member workshops per quarter. 2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs.	1/1/2025 -3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: A total of **4 member workshops** were completed in Q1. The following workshop modalities and languages were provided: • 1 in-person Live Better with Diabetes (LBD) group in Spanish. Provided at the San Benito Health Foundation. • 1 telephonic Healthier Living Program (HLP) group in English. • 1 telephonic Live Better with Diabetes (LBD) group in Spanish 1 telephonic Healthier Living Program (HLP) group in Spanish.	No issues to report in Q1.	The project team will continue to schedule member workshops in Q2.	☑ Yes ☐ No	Member workshops have started off well in Q1 with a new in-person site (San Benito Health Foundation). The site has requested additional workshops to be scheduled in-person in 2025.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
2. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.	1. The project team will conduct outreach and education activities to inform members of services available to them via: • Member outreach calls • Member newsletter articles • MSAG presentation • Social media and/or texting campaigns	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: The following activities were completed in Q1 to inform members of Health and Wellness programs: • Member Newsletter: The project team included 1 article in the March 2025 Member Newsletter informing members of health and wellness programs available to them. • Member text campaign: In collaboration with the Communications team a text message was sent out to members on 2/26/25 to inform them of HWL workshops and linked to the health education programs website page.	No issues to report in Q1.	The project team will continue to conduct member informing activities in 2025.	☑ Yes ☐ No	The ongoing member informing activities have been successful at increasing member enrollment. The text message campaign exceeded expectations in member response and will continue to be used as a method of informing members of the services available.

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				The page had a new member sign-up form that allowed members to sign up for programs they were interested in. This resulted in **83 members** signing up for programs immediately following the text message. • Member outreach calls: The Health Education team completed **1,224 outgoing outreach calls** in Q1 to offer members health and wellness programs. Additionally, the Health Education Line received **689 incoming calls** from members, providers and the community regarding Quality and Health Programs services. • PCP referrals: The Health Educators received **156 PCP referrals** to health education services in Q1.			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
3. On a bi-annual basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact. A minimum of 50 surveys will be collected annually.	1. The project team will conduct member satisfaction surveys to evaluate: • Information about the overall program • Usefulness of the information shared • The percentage of members indicated that the program helped them achieve health goals. 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning of health education activities.	1/1/2025-3/31/2025 7/1/2025-9/30/2025	Kevin Lopez, C&L Program Advisor Veronica Lozano, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: Surveys will be scheduled bi-annually. The team will report out survey results in Q2 report.	No issues to report in Q1.	The project team will schedule surveys to be completed in Q2.	☐ Yes ☑ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

4. On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal and external partners. A minimum of 2 presentations will be conducted per quarter.	1. The project team will reach out to internal and external partners to schedule presentations. 2. Deliver Health Education and Member Health Rewards services presentations. 3. Request input regarding presentation content and any member needs that they have encountered regarding Health Education services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: A total of **6 presentations** on Health Education services and Member Health Rewards were coordinated and completed in Quarter 1. Presentations were delivered to the following audiences: • Monterey County Public Health • Merced County Public Health • Alliance Member Services team • Alliance Quality Improvement and Population Health Orientation • Alliance Provider Relations team • Alliance Health Educator team.	No issues to report in Q1.	The project team will continue to schedule internal and external presentations in Q2.	☑ Yes ☐ No	This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members. There has been an increased interest in presentations for external audiences including providers and community-based organizations to increase knowledge of services available for members.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

SECTION 3: SAFETY OF CLINICAL CARE

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.	1. Enhance provider scheduling support by onboarding three additional QI RNs dedicated to conducting facility site reviews. 2. Implement proactive planning by reviewing all upcoming site reviews one quarter in advance. 3. Streamline scheduling by offering provider sites a selection of review dates two months before the review due date. 4. Maintain continuous communication with provider sites until a review date is confirmed.	01/01/2025-03/31/2025	Joana Castaneda, Quality Improvement Program Advisor; Tisha Criswell, Senior Quality Improvement Nurse, Yvette Sullivan, Quality Improvement Nurse, and Breena Siliznoff, Quality Improvement Nurse	Qtr. 1: Achieved goal with 13 out of 14 reviews completed (93%). Onboarding is underway for three FSR positions. Q1 reviews were proactively assessed during Q4 for planning. Initial communications have been sent to providers regarding Q1 reviews. Qtr. 2: Qtr. 3: Qtr. 4:	Due to current staffing constraints and the limited availability of only one DHCS master-trained nurse, a recent PCP site review could not be completed as scheduled. This gap has been identified as a key issue impacting our ability to meet site review requirements. To address this, the onboarding of three additional FSR QI Registered Nurses is currently in progress. Completion of their training and certification is anticipated in Q4 2025 or Q1 2026, at which point the team will be adequately staffed to meet site review obligations across all five counties.	Ongoing collaboration with HR to recruit three QI RN positions for FSR. The DHCS master trained QI RN has been promoted to Clinical Safety Supervisor for Facility Site Review and will collaborate with Human Resources to initiate the recruitment process for a backfill position. Maintain communication with providers with site reviews due in Q2 2025, ensuring follow-up on date selection until each review date is confirmed.	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	The FSR team successfully met the Q1 2025 goal, completing 93% of required primary care provider site reviews exceeding the 80% target. Proactive planning and early outreach to providers supported timely scheduling despite staffing limitations. One review fell out due to the limited capacity of a single DHCS master-trained nurse, highlighting a critical staffing gap. In response, onboarding three additional QI RNs is in progress with full deployment expected by Q4 2025 or Q1 2026. Additionally, promoting the DHCS-certified nurse to

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								Clinical Safety Supervisor strengthens leadership capacity, with efforts underway to backfill the vacated position. Continued collaboration with HR and ongoing provider engagement will maintain momentum into Q2 2025.
2. 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.	1. Enhance CAP management support by onboarding three additional QI RNs for facility site reviews. 2. Send email reminders to provider sites regarding upcoming CAP due dates. 3. Directly contact non-responsive providers via phone, involving PRRs as necessary.	01/01/2025-03/31/2025	Joana Castaneda, Quality Improvement Program Advisor; Tisha Criswell, Senior Quality Improvement Nurse, Yvette Sullivan, Quality Improvement Nurse, and Breena Siliznoff, Quality Improvement Nurse	Qtr. 1: Achieved goal results of 14 out 14 (100%). Onboarding is underway for three FSR positions. Reminders regarding upcoming due dates have been sent to providers with CAPs. Qtr. 2: Qtr. 3: Qtr. 4:	Due to current staffing constraints and the limited availability of only one DHCS master-trained nurse, a recent PCP site review could not be completed as scheduled. This gap has been identified as a key issue impacting our ability to meet site review requirements. To address this, the onboarding of three additional FSR QI Registered Nurses is currently in progress. Completion of their training and certification is anticipated in Q4 2025 or Q1 2026, at which point the team will be adequately staffed to meet site review obligations across all five counties.	Ongoing collaboration with HR to recruit three QI RN positions for FSR. The DHCS master-trained QI RN has been promoted to Clinical Safety Supervisor for Facility Site Review and will collaborate with Human Resources to initiate the recruitment process for a backfill position. Maintain consistent communication with providers regarding CAP due dates. Follow up with non-responsive providers through direct phone calls involving PRRs as needed.	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	The FSR team achieved full compliance in the review period, completing 100% of required site reviews (14 out of 14). This success reflects strong proactive coordination and consistent provider communication, including timely reminders for CAP due dates. However, staffing limitations remain a known risk, as the team continues to rely on a single DHCS master-trained nurse. In response, onboarding for three new FSR QI RNs is underway, with full capacity expected by Q4 2025 or Q1 2026. The recent promotion of the DHCS-certified nurse to Clinical Safety Supervisor for FSR further strengthens leadership, and recruitment for the backfill position is in progress. Sustained collaboration with HR and direct provider follow-up, including PRR involvement when needed, will support ongoing compliance and review readiness.

POTENTIAL QUALITY ISSUES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 100% of member grievances received by QI concerning potential medical quality of care issues are resolved within the regulatory timeframes for Member Grievances.	1. Establish due dates in SharePoint for PQIs that allow sufficient time for investigation, translation needs (if applicable), and for the Grievance Coordinator to resolve the case. 2. Promptly request medical records necessary for the PQI investigation upon case assignment to the QI RN. 3. Ensure timely coordination of discussions if the case requires MD guidance or potential P2/P3 recommendations.	01/01/2025-03/31/2025	Emily Kaufman, Clinical Safety Supervisor; Eleni Pappazisis, Quality Improvement Program Advisor; Naomi Kawabata, Senior Quality Improvement Nurse; Katie Lutz, Senior Quality Improvement Nurse; Sandy Clay, Senior Quality Improvement Nurse; Karen de Leon, Quality Improvement Nurse and Bethany Fung, Quality Improvement Nurse	Qtr. 1: Achieved goal results of 100% with 124 cases closed on time. Due dates have been established in SharePoint to facilitate the closure of regulatory PQIs. The QI RN requested medical records promptly for PQIs investigations. Timely discussions were conducted with MDs regarding P2/P3 cases. Qtr. 2: Qtr. 3: Qtr. 4:	Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals. CAP management collaborative efforts, and quality studies to enhance the quality of care for members.	Continue establishing due dates in SharePoint to prioritize promptly closing regulatory-based PQIs. Maintain the practice of requesting medical records as needed for investigations to ensure timely case closures. Conduct weekly MD meetings to discuss potential P2/P3 cases requiring guidance ensuring that these discussions do not hinder timely case resolution.	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Although 100% of member grievances received by the Quality Improvement (QI) team concerning potential medical quality of care issues are resolved within the required regulatory timeframes, this work area demands most of the QI RN's time and focus to maintain compliance. With current process improvement efforts underway for the exempt grievance workflow, member grievance oversight, and Potential Quality Issue (PQI) volume have seen a noticeable increase. As a result, the team's capacity has been primarily directed toward managing regulatory PQIs and ensuring timely grievance resolution. Consequently, other QI responsibilities—such as 120-day PQI reviews and quality study referrals—have been impacted. At this time, 120-day PQIs are the team's second priority, while referrals to quality studies will be deferred until performance goals are consistently met for regulatory and 120-day PQI cases.
2. 80% of non-grievance related PQIs are completed within 120 calendar days.	1. Triage and prioritize incoming internal referrals for the following case types: 2. Known providers for tracking and trending. 3. Providers on a CAP or involved in an open Quality Study.	01/01/2025-03/31/2025	Emily Kaufman, Clinical Safety Supervisor; Eleni Pappazisis, Quality Improvement Program Advisor; Naomi Kawabata, Senior Quality Improvement Nurse; Katie Lutz, Senior Quality Improvement Nurse; Sandy Clay, Senior Quality Improvement Nurse; Karen de Leon, Quality Improvement Nurse	Qtr. 1: Achieved goal results of 56% with 29 out of 52 cases closed on time. The team effectively triaged and prioritized incoming internal referrals for the following case types. • Known providers for tracking and trending. • Providers on a CAP or involved in an open Quality Study.	Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals, collaborative efforts, and quality studies to enhance the quality of care for members.	Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals. CAP management collaborative efforts, and quality studies to enhance the quality of care for members.	☐ Yes ☑ No	See above.

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	4. LTSS members.		and Bethany Fung, Quality Improvement Nurse	• LTSS members. Qtr. 2: Qtr. 3: Qtr. 4:			 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Meet regulatory requirements 98% of the time for timely acknowledgments and resolutions.	1. Monitor appeal and grievance inventory for daily, weekly, and monthly oversight. 2. Ensure standard appeals and grievances are acknowledged within 5 days and resolutions occur within 30 calendar days.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-Aug 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Achieved goal by meeting regulatory timeframes with grievance correspondence 99% of the time during 25Q1. Correspondence reports went live in Q125 to better monitor real-time activities. Qtr. 2 Qtr. 3: Qtr. 4:	Staffing concerns emerging due to continued high volume and filings.	Continue close monitoring of approaching due dates and raise staffing concerns. Explore additional efficiencies through process improvement project.	☑ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	Regulatory timeframes with member correspondence was met during this timeframe. *Note that provider responses impact resolution timeframes due to delayed or incomplete provider responses which causes a downstream impact on timely and complete resolutions.
2. Monitor and maintain Grievance rates below 2 per 1,000 members per month for Quality-of-Care concerns; below 2 per 1,000 members per month for Quality-of-Service concerns (NCQA standard).	1. Track and trend appeal & grievance data by both NCQA primary categories & DHCS categories for quality of care (QOC), quality of service (QOS) and access issues. 2. Track grievance and appeals for emerging quality of care and service trends. Inclusive of access trends, system issues, and actionable corrections needed.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Achieved goal by restructuring reports into NCQA category structure and maintaining a rate below 2 in these areas. Emerging trends around Community Support and ECM providers. Qtr. 2:	Requesting business owners bring actions to SGRC (Staff Grievance Review Committee) around trends and corrections occurring.	Continue tracking and trending issues. Encourage business owners to propose corrections for actionable trends.	☑ Yes ☐ No ☐ Yes ☐ No	

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				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
3. Improve Appeal and Grievance (AG) data quality and reporting.	1. Identify reporting needs, gaps and areas for improvement. 2. Develop report for substantiated grievances to support identification of systemic issues and opportunities for improvement.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Achieved goal by launching the AG Process Improvement Project. Initial steps included development and implementation of reports on substantiated grievances.	Requesting continued interdepartmental engagement to refine the AG process, initiate efficiencies, improve quality, and complete resolutions. Provider Services monitor, respond and share actions when needed.	Continue improving quality with data and reporting by providing timely feedback.	☑ Yes ☐ No	
				Qtr. 2:			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
4. Improve monitoring and documented oversight.	1. Initiate reportable notes within appeals and grievance (AG) system to improve transparency with oversight. 2. Develop report to quality oversight activities.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Achieved goal by launching the AG process improvement project which will refine oversight. Developed reportable notes to support future reports on oversight.	No previously identified issues.	Continue implementing monitoring and oversight activities.	☑ Yes ☐ No	
				Qtr. 2:			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

SECTION 4: MEMBER EXPERIENCE

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start& end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Improve CAHPS rates for "How Well Doctors Communicate" for members 0-18 years from 91.5% to 94.4%.	1. Elicit feedback from relevant teams to develop interventions. 2. Implement interventions. 3. Study and adjust interventions.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025,	Jada Edwards, Quality Improvement Program Advisor Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor Additional intervention collaboration from QIPH staff, provider relations	Qtr. 1: Planning and execution of a system wide CAHPS workgroup. The aim of 2025 is to provide direction, and support for on-going strategies/interventions to target member satisfaction rates. Made up of 15 teams/departments, workgroup administration documents and tracks interventions made throughout the system in our focus area.	Will need to ensure there is proper awareness across the organization on the primary objectives of the workgroup as there is much overlap in priorities, as to not duplicate efforts.	Monthly workgroup. Share and track interventions.	☑ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
2. Improve CAHPS rates for "Health Plan Customer Service" for adult members from 87.8% to 89.8%.	1. Elicit feedback from relevant teams to develop interventions. 2. Implement interventions. 3. Study and adjust interventions.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025	Jada Edwards, Quality Improvement Program Advisor Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	

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			Additional intervention collaboration from customer service team, member services	Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

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SECTION 4: QUALITY OF SERVICE

ACCESS & AVAILABILITY (AA) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with DMHC Timely Access Survey Requirements	1. Ensure 90% of After-hours triage compliance in Timely Access Survey. (Provider Appointment Availability Survey [PAAS]). 2. Ensure 75% Urgent and routine appointment access compliance, as well as next available follow up appointment for non-physician mental health care, within required time frames. 3. PAAS work begins in the summer with vendor engagement and finalization of the project plan and contact lists. The survey is launched from August to November/December. Results are available in Q1 of the subsequent year.		Jessie Dybdahl, Provider Service Director	Qtr. 1: MY2024 PAAS Survey results were received in Q12025, below is an overview of the results: **For the IHSS line of business**: Non-Urgent appointments received a compliance rate of 67% for all provider survey types. **For the Medi-Cal line of business**: Non-Urgent appointments received a compliance rate of 76% for all provider survey types. **For the IHSS line of business**: Urgent appointments received a compliance rate of 84% for all provider survey types **For the Medi-Cal line of business**: Urgent appointments received a compliance rate of 66% for all provider survey types. Within both lines of business there was an increase in compliance for non-urgent appointments for all surveyed provider types.	No previously identified issues.	Begin preparing for the kickoff of the MY2025 PAAS Survey.	☑ Yes ☐ No	On track for the kick off of the MY2025 PAAS.

				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3			☐ Yes ☐ No	
				Qtr. 4			☐ Yes ☐ No	
2. Quarterly review of provider to member ratios for PCPs and High-volume/high-impact Specialties. To ensure all ratios meet regulatory requirements.	1. Ensure provider to member ratios are w/in compliance and mitigate if out of compliance on a quarterly basis. 2. Tableau report is monitored no less than quarterly to ensure provider to member ratios are met for each required provider type.		Jessie Dybdahl, Provider Service Director	Qtr. 1: Review ratios and any outcomes. Based on the policy, standards are well within compliance for provider to member ratios for all provider types, minus two. - Medi-Cal Internal Medicine - Medi-Cal Allergy & Immunology Those that we are not within compliance with, we will continue to monitor quarterly and work with necessary departments to address.		- Inform Grants of specialties where we aren't in compliance. - Inform Network Develop Team of necessary new specialties for recruitment. - Continue monitoring quarterly for compliance.	☐ Yes ☐ No	Current metrics are in line with requirements, except Allergy & Immunology and Internal Medicine.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with Time or Distance Standards set forth by DHCS	1. Ensure the network meets time or distance standards in compliance with DHCS requirements when a provider is available. 2. Monitor areas where no provider is available and ensure		Jessie Dybdahl, Provider Service Director	Qtr. 2			☐ Yes ☐ No	

	alternative access requests are in place on a quarterly basis. 3. Evaluate the non-contracted provider network to determine if recruitment might remedy access gaps. Launch recruitment efforts as applicable.			Qtr. 4:			☐ Yes ☐ No	

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provider Satisfaction Survey	1. Monitor Provider Satisfaction annually. Ensure no less than 5% decrease in overall satisfaction with the plan from prior year. 2. The Provider Satisfaction Survey (PSS) is launched in the summer with vendor engagement in spring. Contact lists are sent for primary care, specialty care, and non-physician mental health care. The survey is launched from July to August. Results are available in quarter 4.	7/1/2025 - 12/31/2025	Jessie Dybdahl, Provider Service Director	1st update:			☐ Yes ☐ No	

TELEPHONE ACCESS (VERONICA OLIVARRIA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of calls to Member Services answered within 30 seconds.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. Improvement efforts slated for 2024: • The adoption of a Workforce Management Tool to assist with call forecasting and representative scheduling, ensuring we have appropriate levels of staff supporting the queues at any given time/day. • Call Audit Optimization: We are developing formal call audit guidelines and defined audit methodology to ensure	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Lilia Chagolla, Member Services Director Veronica Olivarria, Call Center Manager	Qtr. 1: The call center has hired additional staff to support the calls and members walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Ensure staff are available during peak hours 11am-2:30pm. Trainings coordinated in small teams to maximize service level. Call Center Supervisors review Queue data throughout the day to determine if changes need to made immediately.	This goal was met for Q1 by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members.	The Call Center team will continue to ensure we are fully staffed by continuing to review the needs of our callers and ensure our staff have the most current resources and/or trainings.	☑ Yes ☐ No	This goal was met and will be increasing every month by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members.

	staff are adhering to Alliance updates and processes. • Developing additional call circles (queues) to: 1. Optimize resource availability. 2. Improve the speed of answering. 3. Reduce representative training time. 4. Increase member satisfaction. • Computer Telephone Enhance HSP/Finesse by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time on the phone for the MSR and will make each call more efficient. Integration: Assess staffing needs due to increase in membership			Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
2. The call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Lilia Chagolla, Member Services Director Veronica Olivarria, Call Center Manager	Qtr. 1: The call center has hired additional staff to support the calls and members walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Assign staff to support offices to assist with member walk-ins. Eliminate unnecessary meetings and focus meetings/trainings on business needs. Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules. Trainings coordinated in small teams to maximize service level.	Q1 is the busiest time of the year in the Call center, we prepared by hiring and training staff to be Ready to assist callers for Jan 1.	Working on additional FTEs for new WFM tool and phone system upgrade, Behavior Health and DSNP integration	☑ Yes ☐ No	This goal was met by ensuring the Call center is fully staffed, trained and prepared to meet the needs of our members via phone or face to face. Call center Supervisors are focused on coaching real time, ensuring resources are available and HSP updates are current to allow staff to focus on the needs of the caller.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2024 baseline utilization data.	1. The project team will track utilization for the following services: • Phone interpreting services. • Face-to-Face (F2F) interpreting services. 2. Use quarterly utilization data to identify potential need to training provider network on language assistance services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: **Provider Utilization for Q1** was as follows: **Phone interpreting services:** There was a total of **8,284 total calls in Q1** by provider sites. This reflects an **increase of 39%** compared to Q1 in 2024. **Face-to-Face (F2F) interpreting services:** There was a total of **1,745 requests in all service counties for F2F in Q1**. This reflects an **increase of 12%** compared to Q1 in 2024. • **Santa Cruz County** had 747 requests in Q1. This is 7% decrease compared to Q1 2024. • **Merced County** had 394 requests in Q1. This is 15% decrease compared to Q1 2024. • **Monterey County** had 580 requests in Q1. This is 110% increase compared to Q1 2024. • **San Benito County** had 24 requests in Q1. This is 2300% increase compared to Q1 2024. • **Mariposa County** had 0 requests in Q1. There is no change compared to Q1 2024.	No issues to report in Q1.	The C&L team will continue informing providers of the services available and offer training and support services as requested.	☑ Yes ☐ No	There continues to be increases overall in utilization of language assistance services by providers.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

2. On a bi-annual basis, collect member feedback on their experience with language assistance services in a clinical setting. A minimum of 50 surveys will be collected annually.	1. The project team will conduct satisfaction surveys with members to evaluate: • Individual ratings of access to language services. • Overall rating of interpretation services. • Access to language services at a health care encounter. • Gather individual experiences with the services. 2. Request input from members regarding programs and services. 3. Incorporate member feedback into planning and identifying areas of improvement for the services.	1/1/2025-3/31/2025 7/1/2025-9/30/2025	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager Ivonne Munoz, Quality and Health Programs Supervisor	Qtr. 1: Surveys will be scheduled bi-annually. The team will complete surveys in Q2.	No issues to report in Q1.	The project team will schedule surveys to be completed in Q2.	☐ Yes ☑ No	Evaluation will be completed in Q2.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
3. On a quarterly basis, inform members and providers of language assistance services utilizing at least 1 member and 1 provider informing modality.	1. The C&L team will conduct outreach and education activities to inform members and providers of services available: a. Member newsletter articles b. Provider bulletin articles c. Education materials including flyers d. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning health education activities.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor	Qtr. 1: The following activities were completed in **Q1** to inform members of C&L Services: • <u>Member Newsletter:</u> The project team included 1 article in the March 2025 Member Newsletter informing members of language assistance services available to them. • <u>Provider Bulletin:</u> The project team included 1 article in the March 2025 Provider Bulletin informing providers of language assistance services and how to access the services to support communication with members.	No issues to report in Q1.	The project team will continue to work on planning efforts to increase awareness of language assistance services to the provider network in 2025.	☑ Yes ☐ No	Utilization of language assistance services continues to increase each quarter. These increases can be partly attributed to consistent information being available regarding the availability of these services. Consistent messaging also allows new members to receive the information.
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

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4. On a quarterly basis, provide at least 1 C&L services presentations to Alliance internal department staff that interact with members or providers to increase awareness of language assistance services available for members.	1. The C&L team will reach out to internal and external partners to schedule C&L services presentations. 2. Deliver C&L services presentation. 3. Request input regarding presentation content and any member needs that they have encountered regarding C&L services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: A total of **4 presentations** on C&L services were coordinated and completed in **Quarter 1**. Presentations were delivered to the following audiences: • Alliance Member Services team • Alliance Quality Improvement and Population Health Orientation • Alliance Provider Relations team • Alliance Health Educator team	No issues to be reported in Q1.	The project team will continue to coordinate presentations for internal departments and external partners in 2025.	☑ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations.	1. Quarterly review of delegate reports to ensure compliance, and identification of any issues.	3/31/2025,6/30/2025 9/30/2025,12/31/2025	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1: Delegate reports reviewed with no issues identified.	No previously identified issues.	Continue monitoring	☑ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	

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				Qtr. 4:			☐ Yes ☐ No	
2. Ensure oversight of all delegated activities by governing board.	2. Present quarterly updates of all reviewed activities with identification of any issues to the governing board for review, and feedback.	3/31/2025,6/30/2025 9/30/2025,12/31/2025	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1: Delegate reports reviewed with no issues identified.	No previously identified issues.	Continue monitoring	☑ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

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Central California Alliance for Health
2025 Utilization Management Work Plan and Evaluation

I. Projects and Initiatives
- A. Pediatric and Adult Case Management
- B. Enhanced Health Services: ECM and CS
- C. Reducing Readmissions Initiative
- D. Pharmacy Led Academic Detailing (PLAD) Program
  Naloxone Distribution Program
- E. Phone System Replacement Project
- F. BHT Provider and Caregiver Engagement

II. Operational Performance
- A. Routine Prior Authorization Turn Around Time
- B. Prior Authorization Request Determination Metrics
- C. Top 10 Prior Authorization Medical Necessity Denials
- D. Inter-Rater Reliability - Nurses
- E. Inter-Rater Reliability - BHT
- F. Inter-Rater Reliability - MDs
- G. Inter-Rater Reliability - Pharmacy
- H. Routine Pharmacy Turn Around Time
  Pharmacy Request Determination Metrics
  Written Notification of Pharmacy NOAs to Members and Providers
- I. Written Notification of BH NOAs to Members and Providers
- J. Written Notification of PA NOAs to Members and Providers
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III. Utilization Performance
- A. Inpatient Utilization
- B Ambulatory Care Sensitive Admissions (ACSA)
- C Readmissions
- D Alternatives to Acute Inpatient Days
- E Long-term Care
- F Emergency Department Utilization
- G Pharmacy Utilization
- H Out-of-Network Specialist Utilization Metric
- I Under / Over Utilization Tracking and Reporting
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IV. UM Delegate Oversight
- A. UM Delegate Oversight Quarterly Report Summary-complete
- B. Medi-Cal Mental Health Utilization Rates
- C. Beacon UM File Audit

INITIAL WORK PLAN AND EVALUATION APPROVAL:

Submitted and approved by UMWG Date: 3/18/2025

Submitted and approved by QIHEC Date: 3/20/2025

Submitted and approved by Board Date: _____

Mike Wang, MD, Medical Director Date: 3/18/2025

Omar Guzman, Chief Medical Officer Date: 3/18/2025

Tammy Brass, RN

Tammy Brass, RN, Utilization Management Director Date: 3/18/2025

FINAL EVALUATION APPROVAL:

Submitted and approved by UMWG Date: _____

Submitted and approved by QIHEC Date: _____

Submitted and approved by Board Date: _____

Mike Wang, MD, Medical Director Date: _____

Omar Guzman, MD, Chief Medical Officer Date: _____

Tammy Brass, RN, Utilization Management Director Date: _____

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I. Projects and Initiatives

A.(a) Pediatric Case Management

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

2025 Evaluation									
Time Period	**Total # of Eligible members by County**	**# Newly Eligible by County**	**# Aged Out by County**	**# Approved NICU/PICU by County**	**# High Risk NCQA Members**	**# High Risk Members (non-NCQA)**	**# Low Risk Members**	**# ICPs**	**Comments/ Recommendations**
1st Quarter	Santa Cruz: 1176 Monterey: 4083 Merced: 3278 Mariposa 67: San Benito: 375	Santa Cruz: 30 Monterey: 57 Merced: 91 Mariposa:1 San Benito:6	Santa Cruz: 27 Monterey: 78 Merced: 92 Mariposa:0 San Benito:1	Santa Cruz: 33 Monterey: 145 Merced: 109 Mariposa:0 San Benito:11	**84**	**96**	**176**	**41**	**N/A**
2nd Quarter	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:					
3rd Quarter	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:					
4th Quarter	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:					
Year End	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:					

A.(b) Adult Case Management

Adult Case Management Program is focused on improving the health of our Complex Case Managment members. The goal is to increase the number of compliant NCQA qualifying mbrs.				
2025 Evaluation				
Time Period	**Total # of NCQA Eligible members**	**# Enrolled NCQA members**	**# NCQA members with a completed Assessment, POC and open for 60 days**	**Comments/ Recommendations**
1st Quarter	**751**	**280**	**126**	Total # of NCQA Eligible mbrs are all mbrs we have attempted to outreach to. We continue to try to get mbrs engaged in CM.
2nd Quarter				
3rd Quarter				
4th Quarter				
Year End				

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B. Enhanced Health Services: Enhanced Care Managment (ECM) and Community Supports (CS)

Time Period	Objective	Contracted Providers By County: Total Numbers and Capacity	Member Enrollment Totals by County	Comments/Recommendations
1st Quarter	Support the ongoing development of contracted providers capacity to provide ECM core services, including for new populations of focus.	Santa Cruz: 3,351 Monterey: 6,988 Merced: 10,062 Mariposa: 173 San Benito: 684	Santa Cruz: 3,248 Monterey: 6,885 Merced: 10,255 Mariposa: 182 San Benito: 672	This has been demostrated by the implementation of monthly EHS Huddles, contiued monthly office hours, and including providers when necessary in IDT rounds with CR nurse and hospitals. New population of focus is the Justice Involved population. Working with CDCR, DHCS and other MCP. Attending monthly county specific CPI meetings to support providers with community collaborations and updates from the MCP. Continued quarter over quarter increases in ECM enrollment in all counties.
2nd Quarter	Align with PS dept to support the contracting and development of new providers to be prepared to support the incoming pediatric populations and 2 new Community Supports (CS) services for 7/1/23.	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	
3rd Quarter	Support the ongoing development of contracted providers capacity to provide ECM core services.	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	
4th Quarter	Align with PS dept. to provide contracted and noncontracted potential ECM and CS providers with information about the new populations of focus for 2025. Support the expansion of the ECM/CS network to assist these new populations of focus in 2025.	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	Santa Cruz: Monterey: Merced: Mariposa: San Benito:	
Year End				

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C. Reducing Readmissions Initiative

To support reducing hospital readmissions, UM and CM will track and evaluate the impact of Population Health Management and Transitions of Care activities as it relates to reductions in readmissions for members participating in these services.

2025 Evaluation									
Time Period	**OOA RCFE /CLF Placements**	**Total RCFE/CLF Placements**	**Merced County 30 day Readmissions**	**Monterey County 30 day Readmissions**	**Santa Cruz County 30 day Readmissions**	**Mariposa County 30 day Readmissions**	**San Benito County 30 day Readmissions**	**Total 30 day Readimssion**	**Comments/ Recommendations**
1st Quarter	5 RCFE/4 CLHF	14	21%	18%	22%	18%	17%	21%	New report for OOA RCFE/CLF in progress and will represent baseline data once complete. Q1 25 manual pull tableau/excel spreadsheet. Majority of plcmts in area, with OOA for TBI and some more complex plcmts. Currently, CM has 30 day check in with members/facilites for needs for RCFE. CLF are a PRN check in as they are considered LTC. Collaborative IDT process in development for when a member from CLF is sent to acute, facility to notify the plan for RCA.
2nd Quarter									
3rd Quarter									
4th Quarter									
Year End									

D. Pharmacy Programs

Pharmacist-Led Academic Detailing (PLAD) Program

Using academic detailing methods, Alliance Pharmacists provide evidence-based educational sessions to clinicians in primary care settings. Currently offered for diabetes, hypertension, and asthma medication management.

Time Period	# Providers	# Sessions	Comments
1st Quarter	11	20	Q1 focused on hypertension and diabetes. Additional provider outreach planned in Q2 based on 2024 MCAS results.
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

Naloxone Distribution Program

As part of Naloxone Distribution Project (NDP) by DHCS, the program aims to reduce opioid overdose deaths through provision of free naloxone (Narcan). Narcan is available in the Alliance offices and during community events. Focus is on Merced and Mariposa counties.

Time Period	Total # Distributed	# Distributed (Merced/Mariposa)	# Reversals Reported (Lives Saved)	Comments
1st Quarter	146	128	2	Majority of naloxone continues to be distributed in Merced, the county of focus.
2nd Quarter				
3rd Quarter				
4th Quarter				
Year End				

E. Phone System Replacement Project

In pursuit of the Alliance goal of work optimization and simplication, introduction of a new phone system will begin in 2025. Within 1 quarter after introduction of the new system, look for a 3% reduction in abandonment rates for all auth phone lines.

Time Period	AuthReq Abandonment %	AuthStat Abandonment %	NEMT Abandonment %	Comments
1st Quarter	10.50%	7.31%	17.66%	Pre-phone system replacement #'s
2nd Quarter				Phone system replaced 6/17/25
3rd Quarter				
4th Quarter				
Year End				

Time Period	AuthReq Avg Wait Time	AuthStat Avg Wait Time	NEMT Avg Wait Time	Comments
1st Quarter	3:18	3:37	4:54	Pre-phone system replacement #'s
2nd Quarter				Phone system replaced 6/17/25
3rd Quarter				
4th Quarter				
Year End				

F. BHT Caregiver & Provider Engagement

Effective 7/1/2025: In pursuit of the Alliance goal of quality of care, Alliance BCBA's will provide outreach to members and providers who have been identified to have BHT-case management needs (e.g. underutilization of caregiver hours, lack of transition/discharge planning).

Time Period	Member vs Provider Call Volume	Percentage Increased Caregiver Involvement or Progress after Intervention	Total Number Members Enrolled in BHT by County	Comments
1st Quarter				
2nd Quarter				
3rd Quarter				
4th Quarter				
Year End				

II. Operational Performance

A. Routine Prior Authorization Turn Around Time

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

	2025 Evaluation			
Time Period	Goal	Results	Assessment & Interventions	Recommendation for Future
1st Quarter	100%	99.2%	Authorization volumes 43,937 of 44,299 auths completed timely for a turnaround (TAT) rate of 99.18%	Despite changes in staffing and multiple projects in flight, the PA team's average TAT remained near goal at 99.2%. Continued close monitoring of the daily auth volumes and proper distribution and redistribution of authorizations to monitor and aim for 100% goal.
2nd Quarter	100%			
3rd Quarter	100%			
4th Quarter	100%			

A2. Routine BHT Authorization Turn Around Time - Effective 7/1/2025 post go live

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

	2025 Evaluation		
Results	Assessment & Interventions	Recommendation for Future

B. Prior Authorization Request Determination Metrics

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

	2025 Evaluation					
Time Period	#PA Volume	# Medical Necessity Denials	# Appeals	#Appeals Upheld	# Overturned	Assessment & Interventions
1st Quarter	65,657	1,919	136	89	33	Slight increase in medical necessity denials from the usual < 2% per quarter to 2.9% this quarter. The rise in the number of Community Supports authorizations has resulted in a closer review of these benefits and review of the criteria in place for the beneifts.CS authorizations account for most of the denials and appeals for PA.
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End						

B2. BHT Request Determination Metrics -Effective 7/1/2025 post go live

Monitoring of BHT authorization volume, and appeals.–TAT goal NOA's: denial letters sent within 2 business days.

2025 Evaluation			
# Appeals	#Appeals Upheld	# Overturned	Assessment & Interventions

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

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

	2025 Evaluation	
Time Period	List Denials	Assessment & Interventions
1st Quarter	1. Nutritional Counseling S9470 (1171) 2. Meals, Per Diem S9977 (991) 3. Home Delivered Meals S5170 (203) 4. Medical Nutrition Therapy 97803 (69) 5. Medical Nutrition Therapy 97802 (67) 6. Exome 81415 (52) 7. Exome 81416 (46) 8. Excision 15830 (20) 9. Genetic Testing 81443 (18) 10. Injection Of Sclerosan 36471 (13)	Consistent with previous quarters, Community Supports (specifically Medically Tailored Meals- MTM), genetic testing and treatment of varicose veins make up the Top 10 services denied for medical necessity. Close review of MTM and the policy utilized to review MTM authorizations to ensure that the guidance complies with regulatory requirements and clearly identify those authorizations that are to be approved for the MTM benefit. Increased provider and member outreach and education regarding MTM benefits continues. Close monitoring and review of the genetic testing authorizations and policy to ensure that the guideline correctly reflects the reasons to approve genetic testing. Further internal review of genetic testing authorizations was prompted by NCQA audit file pull and ongoing discussions between internal and external MDs are underway. The treatment of varicose veins is another benefit under review by the department after ongoing discussions from internal and external MDs. Review of the denial rate of varicose veins is in progress to assess next steps in review of varicose vein treatment, though overall denial rate remains low with only 13 cases denied in Q1.
2nd Quarter		
3rd Quarter		
4th Quarter		

D. Inter-rater Reliability Review – Nurses

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

2025 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	100%			

E. Inter-rater Reliability Review – BCBA's

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

2025 Evaluation	
Comments	**Recommendation for Future**

F. Inter-rater Reliability Review – Physicians

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

2025 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	100%			

G. Inter-rater Reliability Review – Pharmacists

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

2025 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	100%			

H. Pharmacy

Pharmacy Prior Authorization Timeliness Report

Percent of Pharmacy prior authorizations completed timely. Includes Medi-Cal and IHSS LOB.

Time Period	Results (%)	Assessment	Interventions
1st Quarter	**of**	95.8% authorizations completed within 24 hours reciept. Small percentage of requests received during weekends or holidays. Technician PTO's and audit prep pulled staff from queues	Emphasized checking failed fax and correspondence not sent reports in multiple technician meetings as well as assigning epiodes to another technician for planned PTO. Reintorduced pharmacy services coordinator role for member letter compliance
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

Pharmacy Prior Authorization Request Determination Metrics

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

Time Period	# Auth Volume	# Denials	# Appeals	# Appeals Upheld	# Overturned	#SFH	Assessment
1st Quarter	1912	52	2	1	1	0	6.4% PA volume increase from previous quarter however a decrease in denial rate from previous quarter at 2.3% (vs. 3.7%). For appeal, upheld denial on hyaluronan and denial overturned for ferric carboxymaltose. Will continue to monitor.
2nd Quarter							
3rd Quarter							
4th Quarter							
Year End							(2024 avg: 1821 PAs and 4.5% denial rate)

Top 5 Physician Administered Drugs that Result in Medical Necessity Denial

List of top 5 Pharmacy prior authorization medical necessity denials, by volume.

Time Period	List of Drugs	Assessment	Interventions
1st Quarter	1. Denosumab 2. Aflibercept, Triamcinolone 4. Onabotulinumtoxina, Hyaluronan	Top denied drugs consistent with previous quarter	Reviewing criteria for triamcinolone for alopecia in Q2 P&T Committee, with planned provider outreach on appropriate use. Updated PA criteria for long-acting G-CSFs and anti-VEGF for eye (aflibercept).
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

Written Notification of Pharmacy NOAs to Members & Providers

Audit of a sample of pharmacy denial letters sent to members and providers. Focus is on individualized content: specific reason for the denial in language that is easy to understand, and reference to a criterion on which the denial decision was based.

Time Period	Results (%)	Assessment	Interventions
1st Quarter	**83.0%**	Several member letters included technical abbreviation and diagnoses without defining. Few mistakes when copy/pasting into member letters.	New workflow introduced, Pharmacy Services Coordinator assignment reintroduced in March 2025 for implementation in Q2, all member NOAs sent to assigned technician for additional review for completeness and accuracy of member letters.
2nd Quarter			Team training on member letter requirements performed for all staff in April 2025.
3rd Quarter			
4th Quarter			
Year End			

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I. BHT Written Notification of NOA to Members & Providers -Effective 7/1/2025 post go live

Audit of a sample of BHT Notice of Action (NOA) letters sent to members and providers. Focus is on individualized content: specific reason for the additional information requested in language that is easy to understand, and reference to a criterion on which the request was based.

Time Period	Results (%)	Assessment	Interventions
1st Quarter			
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

J. PA Written Notification of NOA to Members & Providers

Audit of a sample of PA NOA letters sent to members and providers. Focus is on individualized content: specific reason for the additional information requested in language that is easy to understand, and reference to a criterion on which the request was based.

Time Period	Results (%)	Assessment	Interventions
1st Quarter	95.6%	NOA timeliness in Q1 2025 meets the Compliance threshold of 95%. The timeliness of NOAs has been identified as an area of opportunity for improvement within the PA team.	PA supervisors are working closely with Data Analytics to uncover the discrepancies between the report findings and manual review of the NOAs flagged as untimely. Errors at the beginning of the year may have also been caused by new staff who onboarded in Q3/Q4 2024 and individual coaching has taken place for those individuals. Continued close monitoring of NOA timeliness in upcoming quarters.
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

K. CR Written Notification of NOA to Members & Providers

Audit of a sample of CR NOA letters sent to members and providers. Focus is on individualized content: specific reason for the additional information requested in language that is easy to understand, and reference to a criterion on which the request was based.

Time Period	Results (%)	Assessment	Interventions
1st Quarter	95.4%	NOA timeliness in Q1 2025 meets the Compliance threshold of 95%. The timeliness of NOAs has been identified as an area of opportunity for improvement within the CR team.	AC/CR supervisors are working closely with Data Analytics to uncover the discrepancies between the report findings and manual review of the NOAs flagged as untimely. Errors at the beginning of the year may have also been caused by new staff who onboarded in Q3/Q4 2024 and individual coaching/compentcy has taken place for those individuals. Continued close monitoring of NOA timeliness in upcoming quarters.
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

III. Utilization Performance

A. Inpatient Utilization

The goals per line of business and by Medi-Cal aid category groupings were developed using Alliance historical performance, and DHCS state benchmarks. The bed-days per K/Y goal was established by utilizing historical data and state averages. The Alliance Bed Ambulatory Care Sensitive Admissions (ACSA) and 30-day Readmissions tracked per line of business and region.

IHSS						Goal						
Time Period	2024 Admit/K/Y Reported	2025 Admit/K/Y	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	ACSA%	Readmits %	Assessment	Interventions
1st Quarter	52	66	3.0	201	314	200	-0.57	27%	0%	Increase in Amb Care Services.	Continued support of TCS when IHSS mbr is in Acute Hospital for any Post-Acute Care needs. Variance in updated BD r/t post service submissions.
2nd Quarter	84		-			200					
3rd Quarter	45		-			200					
4th Quarter	64		-			200					
YTD/Year End	62		-			200					

Medi-Cal Child and Family Aid Codes (OTLIC + other)						Goal						
Time Period	2024 Admit/K/Y Reported	2025 Admit/K/Y	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	48	54	3.7	198	186	170	-9%	25.7%	2.7%	5%	ALOS continues to be the same as 2024 data.	Continued support of TCS post discharge
2nd Quarter	51					170						
3rd Quarter	52					170						
4th Quarter	51					170						
YTD/Year End	49					170						

Medi-Cal Seniors and Persons with Disabilities Aid Codes (SPD+Dual)						Goal						
Time Period	2024 Admit/K/Y Reported	2025 Admit/K/Y	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	239	248	6.1	1513	1426	1300	-10%	10.4%	13.6%	21%	ALOS continues to be the same as 2024 data. Readmissions increased slightly, expected as time of year.	Weekly IDTs for complex members including MSW, CM, ECM for short term and long term placement options.
2nd Quarter	239		-			1300						
3rd Quarter	229		-			1300						
4th Quarter	216		-			1300						
YTD/Year End	235		-			1300						

New Medicaid Expansion Members (i.e. former LIHP, as well as new M aid code and 7U/7W aid code members) (ACA+Other)						Goal						
Time Period	2024 Admit/K/Y Reported	2025 Admit/K/Y	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	72	78	5.2	409	372	375	1%	1.4%	9.0%	14%	Admit K/Y reported down from last Q, readmissions remain down.	Continue to monitor.
2nd Quarter	70		-			375						
3rd Quarter	77		-			375						
4th Quarter	76		-			375						
YTD/Year End	72					375						

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Total Medi-Cal Inpatient Utilization: -BD/K/Y goal based on historical data and state averages.

Time Period	2024 Admit/K/Y Reported	2025 Admit/K/Y	ALOS	BD/K/Y Reported	BD/K/Y Updated	Goal BD/K/Y	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	63	70	4.5	316	**299**	290	-3%	6.6	10	Admit /K/Y stable and staying in line with 2024. ALOS remains the same	Ongoing IDTs, partnerships with providers/facilites, JOCs, multidisciplinary team approach with ECM/CM/MSW/TCS
2nd Quarter	65		-			290					
3rd Quarter	65		-			290					
4th Quarter	66		-			290					
YTD/Year End	**65**		-			290					

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

Ambulatory Care Sensitive Admissions (ACSA) per region.

Time Period	Santa Cruz ACSA %	Monterey ACSA %	Merced ACSA %	Mariposa ACSA %	San Benito ACSA%	Assessment	Interventions
1st Quarter	5.86%	6.38%	6.84%	5.33%	5.86%	Data relatively unchanged from prior quarters. Maripisa slighly higher by 2%.	Continued interventions with ECM and providers to provide sooner access to chronic disease managment, PCP post-acute visits.
2nd Quarter							
3rd Quarter							
4th Quarter							
YTD/Year End							

C. Readmissions (%)

*30-day Readmissions per region

	Santa Cruz %					Monterey %					Merced %					Mariposa%				San Benito%						
Time Period	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18YO	19-55 YO	Over 55 YO	Total Readmission %	0-18YO	19-55YO	Over 55 YO	Total Readmission %	% CCS	Assessment	Interventions
1st Quarter	7.30%	9.73%	14.93%	10.89%	0.7%	6.29%	8.62%	14.15%	9.35%	0.8%	8.91%	8.45%	14.02%	9.68%	0.9%	0.00%	7.44%	5.08%	6.43%	3.37%	9.22%	14.84%	9.89%	0.1%	Overall rates continue to be within 10-15%, normal increase in numbers in older age groups.	Cont. TC support, outreach and IDTs as well as integration of ECM/CS services.
2nd Quarter																										
3rd Quarter																										
4th Quarter																										
YTD/Year End																										

D. Alternatives to Acute Inpatient Days - Skilled Nursing Facility

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

Time Period	#SNF Beddays (Updated #)	PKPY SNF SPD (Updated #)	PKPY IPT Beddays SPD (Updated #)	Total # STR	STR Readmits After Discharge	Assessment	Interventions
1st Quarter	1591	352	1406	250	47	Increase in BD, decrease in readmits.	Continued IDTs with support of CM/ECM with difficult placements post SNF BD.
2nd Quarter							
3rd Quarter							
4th Quarter							
YTD/Year End							

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E. Long-term Care

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

Time Period	# of New Admissions	# of LTC	Total # of Members in LTC	Total # of Medi/Medi	Assessment	Interventions
1st Quarter	215	1925	335	1590	No change noted from 2024	LTC members are reassessed PRN/yearly, when able to move to LLOC, support of ECM/CM back into community is utilized
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End						

F. Emergency Department

The ED utilization goals by Medi-Cal aid category groupings were developed using Alliance historical performance, industry benchmarks (including MCG actuarial projects) and comparison to other County Organized Health Systems (COHS) data. Performance is assessed against goals based on historical data and state averages for ED visits/K/Y. -Total ED visits and Avoidable ED visits tracked per line of business and region. Note: DHCS Popluation Aid Code Groupings may differ slightly from Tableau.

IHSS				Goal				
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	~~Total Visits K/Y State Average~~	Assessment	Interventions
1st Quarter	14.49%	415	465	N/A		~~N/A~~	No change from 2024	Continue to monitor for trends
2nd Quarter				N/A		~~N/A~~		
3rd Quarter				N/A		~~N/A~~		
4th Quarter				N/A		~~N/A~~		
YTD/Year End				N/A		~~N/A~~		

Medi-Cal Child and Family				Goal				
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	% CCS Visits	Assessment	Interventions
1st Quarter	17.76%	520	519	400	-30%	19.26%	Avoidable visits decreased from Q4 2024	Continued lack of PCP/Urgent care in counties represents higher utilization of ER
2nd Quarter				400		-		
3rd Quarter				400		-		
4th Quarter				400		-		
YTD/Year End				400		-		

Medi-Cal Seniors and Persons with Disabilities				Goal				
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	% CCS Visits	Assessment	Interventions
1st Quarter	11.09%	1045	995	830	-20%	12.21%	Avoidable visits increased from Q4 2024., %CCS visits down.	Lack of PCP/Urgent Care in counties. ECM providers being engaged to supoprt members more efficiently.
2nd Quarter				830	100%	-		
3rd Quarter				830	100%	-		
4th Quarter				830	100%	-		
YTD/Year End				830	100%	-		

F. Emergency Department

Medicaid Expansion (i.e. former LIHP, as well as new M aid code and 7U/W aid code members)				**Goal**				
Time Period	**Avoidable Visits %**	**Total Visits/K/Y Reported**	**Total Visits/K/Y Updated**	**Total Visits K/Y**	**Total visits: Variance**	**% CCS Visits**	**Assessment**	**Interventions**
1st Quarter	10.60%	576	567	420	-35%	12.64%	Metrics stable Quarter over Quarter.	Continue work as before.
2nd Quarter				420		-		
3rd Quarter				420		-		
4th Quarter				420		-		
YTD/Year End				420		-		

ED Visits per County												
Time Period	**Santa Cruz Avoidable Visits %**	**Santa Cruz Total Visits/K/Y**	**Monterey Avoidable Visits %**	**Monterey Total Visits K/Y**	**Merced Avoidable Visits %**	**Merced Total Visits K/Y**	**Mariposa Avoidable Visits %**	**Mariposa Total Visits K/Y**	**San Benito Avoidable Visits %**	**San Benito Total Visits K/Y**	**Assessment**	**Interventions**
1st Quarter	11.98%	83	16.00%	252	14.61%	184	14.31%	7	15.10%	39	Note: weighted average goal for total Medi-Cal ED visits for 2025 (in Alliance Dashboard) is 590	N/A
2nd Quarter												
3rd Quarter												
4th Quarter												
YTD/Year End												

G. Pharmacy

Drug Utilization Review (DUR) Program

Summary of interventions performed based on DUR analyses.

Time Period	**List of DURs**	**Comments**	**Interventions**
1st Quarter	1. High-dose opioids (>90MME daily) 2. Concomitant opioids and benzodiazepines 3. Antidepressants in children	1. Opioid: no concerns found on members. Low percentage of naloxone prescriptions. 2. Members may not be picking up naloxone due to lack of education on importance. 3. Considering more robust interventions after BH integration.	1. Social media outreach on naloxone. 2. Opioid/BZD: collaborated with CM on member outreach about naloxone For June publication: 1. Provider bulletin article on best practices on naloxone prescribing 2. Member newsletter on importance of keeping naloxone on hand 3. Provider bulletin article on depression treatment guidelines in children & adolescents
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

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

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

Time Period	Total Auths	Approvals	Denials	Voided / Canceled	Top 5 Specialty Types by County	Assessment & Interventions
1st Quarter	1,075	1,072	3	0	Merced: Other (163), Surgery Orthopedic (52), Ophthalmology (40) Monterey: Other (50), Ophthalmology (10), Sugery General (4) Santa Cruz: Other (18), Ophthalmology (5), Surgery (1)	An increase in OON specialty use was noted from Q4 2024 to Q1 2025.In review of the data, it appears that Q4 2024 took a 40% dip from the previous quarter. Q1 thru Q3 2024 were roughly consistent. Continued monitoring of reports after transition to Jiva to assess accuracty of the data.Close partnership with Data Analytics team to resolve any data inaccuracies identified.
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End						

I. Under / Over Utilization Tracking and Reporting

Under-over utilization is closely monitored and UM investigates identified cases, develops interventions and works closely with other departments such as Program Integrity, QI and Provider Services. As authorization codes are waived as part of the Auth Reduction Project, we will monitor to assure there is no resulting inappropriate over utilization. Auto approved or no TAR required (NTR) utilization will be monitored when an increase/decrease of 20% from the previous reporting quarter is identified in the emerging analysis (see Section J).

	2025 Evaluation			
Time Period	Monitored Category	Over or Under	Assessment	Interventions
1st Quarter	1.EMG 2. Auth Redesign Codes (As identified) 3. IHA 4. Breast Cancer Screening 5. Colon Cancer Screening 6. Lead Screening 7. ACE Screening 8. Mental Health Visits 9. ED Utilization	1.Under 2. Under 3. Under 4. Under 5. Under 6. Under 7. Under 8. Under 9. Over	Auth requirements for EMG/nerve conduction studies were removed in Q4 2024. Continued monitoring of these auth types after removal of auth requirements. Screenings for breast and colon cancer, lead and ACE continue to be under utilized quarter over quarter and is consistent with last year's findings and an area of interdepartmental focus. Mental Health Visits continue to be under utilized quarter over quarter and is also consistent with last year's trends. Behavioral health will be insourced to the Alliance next quarter and is expected to positively impact this metric.	Review of these monitored categories is underway to determine if there are additional categories whose utilization patterns should be better tracked.
2nd Quarter	1.EMG 2. Auth Redesign Codes (As identified) 3. IHA 4. Breast Cancer Screening 5. Colon Cancer Screening 6. Lead Screening 7. ACE Screening 8. Mental Health Visits	1.Over 2. Over 3. Under 4. Under 5. Under 6. Under 7. Under 8. Under 9. Over		
3rd Quarter	1.EMG 2. Auth Redesign Codes (As identified) 3. IHA 4. Breast Cancer Screening 5. Colon Cancer Screening 6. Lead Screening 7. ACE Screening 8. Mental Health Visits	1.Over 2. Over 3. Under 4. Under 5. Under 6. Under 7. Under 8. Under 9. Over		
4th Quarter	1.EMG 2. Auth Redesign Codes (As identified) 3. IHA 4. Breast Cancer Screening 5. Colon Cancer Screening 6. Lead Screening 7. ACE Screening 8. Mental Health Visits 9. ED Utilization	1.Over 2. Over 3. Under 4. Under 5. Under 6. Under 7. Under 8. Under 9. Over		

J. Emerging Under / Over Utilization Analysis

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

Time Period	Top 5 Over	Top 5 Under	Service / Benefit Type	Top 5 Auto Approved/NTR Codes	Assessment
1st Quarter	1. G9012 OTHER SPECIFIED CASE MANAGEMENT (49,565) 2. 1036F CURRENT TOBACCO NON-USER (6,069) 3. G9920 SCREENING PERFORMED AND NEGATIVE (5,692) 4. 3008F BODY MASS INDEX (3,472) 5. T1019 PERSONAL CARE SERVICES (3,225)	1. CHW 2. Dyadic Care 3. Doula 4. Street Medicine 5. Depression Screening	1. Misc Non Benefit codes (supplies, pdn) 2. Misc. Dressings, medical supplies 3. Nerve Conduction tests 4. Z codes, EPSDT 5. Supervised	1. T1000-T5999, Not valid for Medicare (773) 2. A6000-A6412, Dressings (571) 3. 95905-95913, Nerve Conduction Tests (301) 4. Z4300 - Z5999, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (159) 5. 97010-97028 Supervised (148)	ECM/CS services continue with increased utilization, substantiated by high utilization of G9012 and 1036F. Now that members are aware of and utilizing ECM/CS benefits. organizational efforts are being made to further ensure the quality of ECM/CS services that members are receiving. Continued trend with the top 5 under utilized services consistent with previous quarters. Continued efforts to ensure members requiring CHW and doula services are able to obtain the benefits. No concerns regarding the top 5 auto approved and NTR codes.
2nd Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	
3rd Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	
4th Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	

H2. Out of Area / Out of Network BHT providers Utilization Metric

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

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

I2. Under / Over Utilization Tracking of BH codes (-Effective 7/1/2025 post go live

Under/over utilization is closely monitored and UM investigates identified cases, develops interventions and works closely with other departments such as Program Integrity, QI and Provider Services. We will monitor to assure there is no resulting inappropriate over utilization.

		2025 Evaluation			
Time Period		Monitored Category (BH Services)	Over or Under	Assessment	Interventions
1st Quarter					
2nd Quarter					
3rd Quarter					
4th Quarter					

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IV. UM Delegate Oversight

A. UM Delegate Oversight Quarterly Report (Analysis Summary). After 7/1- (BHT reporting)*

Q4-23: Reported - Q1-24	Carelon	1/20/2025	1/17/2025	Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	All UM Committee meeting minutes held as required and reviewed; aligned with reports submitted and current status of CAPs during Q4 2024. Clinical Criteria for UM decisions completed by Relevant staff and practitioners UM decisions (approvals and denials/adverse modifications) made by appropriately qualitied professionals Timeliness of UM decisions- overall, carelon reports 98.6% timeliness met for "Number Decided Within 5 Business Days" . During our Q4 UM Audit, 4 out of 10 charts did not meet timeliness, being 12-19 business days and reason of processing error noted in charts (Um5c) Carelon reported already placing themselves on internal CAP for this reason, as in previous quarters, identifying root analysis, barriers and action steps This area is the area of continued improvement noted in our sample of charts reviewed quarterly but not a formal improvement plan at this time, given overall timeliness is met however sample review did not. Clinical information on sample of charts consistently meets criteria Denial notices-For Carelon purposes these are generally considered Adverse Determinations and/or modifications rather than true denials, however in review of sample charts of ADs, they meets requirements of documentation required to send CoC-reviewed file sent and no concerns however to note this is only for BHT members on this file, only 2 members noted
Q1-24: Reported - Q2-24	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q2-24: Reported - Q3-24	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q3-24: Reported - Q4-24	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	

B. Medi-Cal Mental Health Utilization Rates

Carelon Health Options (Carelon) is contracted with CCAH to provide mild to moderate mental health services. Carelon supplies this data in a quarterly report that is presented in quarterly meetings with each County Behavioral Health Department. Utilization percentage rates for children and adolescents and for adults are reported by for each county managed by CCAH. Utilization rates reflect a rolling 12 month measurement ending at the Quarter. Utilization percentage is calculated by dividing the number of unique members in each age cohort within each County into the number of members that have received Carelon services from that same County and age cohort within each quarter. Utilization percentage goals were developed by Carelon Health Options and are based on best reviewing data from other states, national benchmark data, historical data on county mental health utilization, and the structure of the California delivery system. The goals are in a mature market of 3 years of operation (market maturity: lower rates are expected in new markets and higher ranges are typical for mature markets with 3-5 years of Carelon presence). This area after 7/1 to be moved to Utilization performance most likely -R mcmullen RM exploring adjustments to goals with Process excellance team

Time Period	Santa Cruz	Monterey	Merced	Mariposa	San Benito	GOAL	Assessment	Interventions
1st Quarter							For 0-12 all counties met within goal, For 13-18, Mariposa was slightly below. For 19+, both Mariposa and SB were below Goal. Note this is only the BH network. Any BH interventions that occur within the physical health care space are not included here	due to insourcing 7/1, bringing in a robust BH provider network, increasing provider and member outreach, satisfaction and education is goal to increase penetration in our underserved communities.
0-12	7.25%	5.08%	3.47%	2.73%	3.35	2.5% - 4%		
13-18	8.79%	7.31%	4.68%	2.44	3.22	2.5% - 4%		
19+	11.83%	6.77%	4.90%	3.99	3.42	4.5% - 6.5%		
2nd Quarter								
0-12						2.5% - 4%		
13-18						2.5% - 4%		
19+						4.5% - 6.5%		
3rd Quarter								
0-12						2.5% - 4%		
13-18						2.5% - 4%		
19+						4.5% - 6.5%		
4th Quarter								
0-12						2.5% - 4%		
13-18						2.5% - 4%		
19+						4.5% - 6.5%		

C. Carelon UM File Audit*

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

Time Period	% Compliance	Summary of Non-Compliance	Follow-up Actions
1st Quarter	98	Out of the eleven reviewed charts, three charts were outside of the timeliness requirement (>5 days) for determination. The three charts determinations were 6-10 business days with no documented reason for processing delay. Also two of the denial charts were missing the signature from the reviewing practitioner	Carelon met all areas but timely resposne to UM decisions, which brought overall compliance from 100 down to 98%. Follow up to Carelon included:Ensure the timeliness decisions is less than 5 business days. Provide additional training on current processes as needed. Please continue to ensure Carelon staff who are pre-auditing charts internally are labeling the elements on both the approval and denial charts. Continue to clearly document within the chart the case management referral outcomes (ie referral submitted, not needed, etc). Also check each chart to confirm the appropriate practitioner's signature is included.
2nd Quarter			
3rd Quarter			
4th Quarter			

D. MedImpact Delegate Oversight

MedImpact Pharmacy File Audit

Review occurring every quarter that looks at previous quarter MedImpact work. For review, 5 files are randomly selected. While 100% is expected, 90% is the juncture at which a corrective action plan would be apprised if needed. Non-compliance with any of the elements require follow up analysis and correction by the vendor. Categories for review include: timeliness of decisions and notifications, appropriate practitioner review of denials, relevant information used for decisions, appeal rights communications to member, content of notifications to member and provider, in easily understandable language.

Time Period	% Compliance	Summary of Non-Compliance	Follow-up Actions
1st Quarter	100%	MedImpact audit passed both turnaround time (TAT) and readability.	Ongoing Corrective Action Plan (CAP) for readability of member letters for PA denial types from 2024Q4. Currently in monitoring phase.
2nd Quarter			
3rd Quarter			
4th Quarter			

MedImpact Per Member Per Month (PMPM)

Line of Business	Per Month (PMPM) Cost						Change from 2024
	2024	2025 Q1	2025 Q2	2025 Q3	2025 Q4	2025 YTD	
IHSS	$258.51	$357.87				$357.87	38.4%

MedImpact Medical Necessity Pharmacy Denials Per Quarter

Monitoring of Pharmacy prior authorization volume and appeals.

Time Period	# Auth Volume	# Denials	# Appeals	# Appeals Upheld	# Overturned	Assessment
1st Quarter	42	8	1	1	0	Auth volume 47, removed 4 PA not required and 1 withdrawn request from final PA count. Total 8 denials 4 administrative and 4 clinical necessity. 19% denial rate.
2nd Quarter						
3rd Quarter						
4th Quarter						
Year End						(2024 avg: 36.5 PAs, 21% denial rate)

DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Cecil Newton, Chief Information Officer & Information Security Officer

SUBJECT: Data Sharing Incentive Program Update

Recommendation. This report is informational only

Summary. The Data Sharing Incentive Program has shown significant progress in enhancing data sharing among healthcare providers. This update provides an overview of the program's achievements, challenges, and future plans.

Background. The Data Sharing Incentive Program was initiated in December 2022 as part of the Alliance Data Management Strategy to improve the exchange of patient information among healthcare providers. Since its inception, the program has facilitated better coordination of care, reduced duplication of services, and improved patient outcomes.

Discussion. The program has successfully integrated data from multiple sources, allowing for a comprehensive view of patient health records. Key achievements include:

- Integration of electronic health records (EHR), specifically ADTs from:
  - 6 hospitals (completed), 7 hospitals (in progress)
  - ADT data from 40+ contracted SNFs (Skilled Nursing Facilities) via PointClickCare
  - 80% inpatient data collection, up from 20% beginning CY 2024
- Implementation of secure data sharing protocols.
- Training sessions for healthcare providers on data sharing best practices.

Challenges faced include:

- HIE Bandwidth limitations and limited data sharing between QHIOs
- Addressing technical issues related to data integration.
- Encouraging participation from all healthcare providers.

Future plans involve expanding the program to include more providers and enhancing the data quality to provide actionable insights for patient care.

Fiscal Impact.

HQIP payments:

- $4.9M in FY 2024 and $4.2M in Q1 and Q2 of 2025.

DSI payments:

- $610K through Q1 2025.

Hospital Exchange Incentive payments:

- The calculation process of determining Hospital Exchange Incentive payments is currently underway.

Attachments.

- N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Lisa Artana, Human Resources Director

SUBJECT: 2025 Employee Engagement Survey Results

Recommendation. This is informational only.

Summary. The Alliance provides staff the opportunity to complete an annual Employee Engagement Survey measuring engagement and satisfaction in several key areas. This presentation will provide background and results, and the next steps of our 2025 results.

Background. The organization conducted its annual survey in May to assess workforce satisfaction, gather feedback on 18 survey topics, and identify opportunities for improvement. The survey was conducted via an independent third-party to ensure confidentiality and encourage candid responses and comments. Participation was strong with 78% of employees responding. Results are primarily benchmarked against prior-year performance to ensure the organization is improving in identified areas based on the prior results. Department Directors received department specific results (pending size of the departments) enabling them to focus on specific areas of improvement within their own teams. Action plans are being developed by department leadership as well as organization-focused areas for the coming 12 months.

Discussion. In a year with six high-impact organization initiatives (1. ECM Enrollment and Community Supports, 2. Medicare D-SNP implementation, 3. NCQA Accreditation, 4. Quality & Health Equity in Merced and Mariposa Counties, 5. JIVA Care Management Systems, and 6. insourcing our Behavioral Health benefit), the Alliance is pleased to share that the 2025 Employee Engagement Survey results improved in 17 of the 18 survey topics, ranging from 1 to 7 points of improvement. The one focus area that did not see improvement remained flat at 79% favorability. Notably, the Engagement score increased by 4% from last year, reaching 84% favorability. Additionally, the 5-year trend, since moving to an annual cadence, has improved significantly in this area, from 78% in 2021 to 84% in 2025. This indicates a positive trend in overall job sentiment and engagement. Department and Executive Leadership are currently assessing areas of focused improvement for the coming year.

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

Attachments. N/A

DATE: August 27, 2025

TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Update: State Budget 2025-26 and H.R. 1

Recommendation. This agenda item is informational only.

Background. The California State Legislature adopted a spending plan for the 2025-26 State Fiscal Year which was signed by the Governor to be effective July 1, 2025 – June 30, 2026 and Congress passed H.R. 1 – the One Big Beautiful Bill Act which was signed by the President effective July 4, 2025. These two pieces of legislation contain significant changes to the Medi-Cal program including eligibility and funding and will result in major changes with varying effective dates between now and 2027 and beyond.

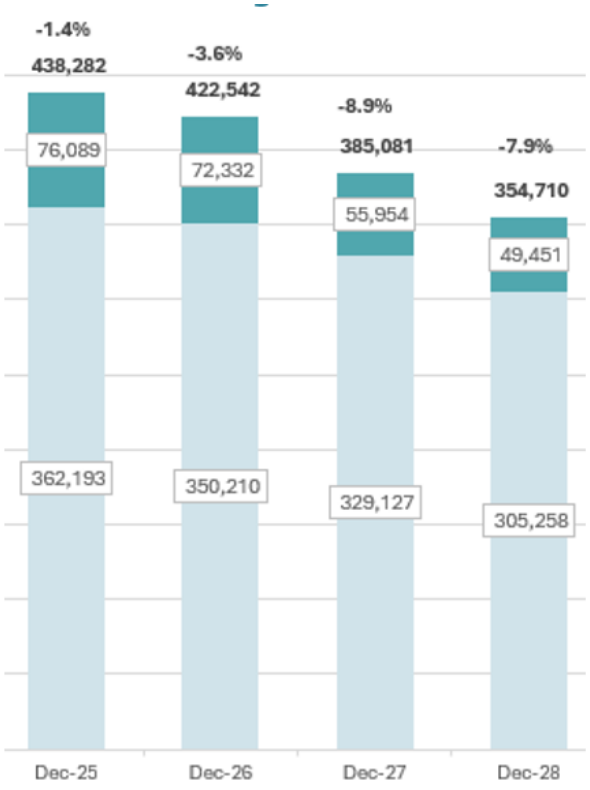
Discussion. At the meeting on August 27, 2025, Staff will provide the Board with an update on key provisions including those impacting eligibility and enrollment and will share the Alliance's multi-year enrollment projections which include an estimated 22% decline in enrollment over the next four calendar years. Staff will discuss current planning and action steps to mitigate impacts.

Following is a summary of key enrollment and eligibility provisions beginning January 1, 2026.

Source	Eligibility Change	Effective Date
State Budget	Enrollment freeze for full-scope MCal for UIS for ages 19+	Jan 1, 2026
State Budget	Reinstatement of MCal asset limit to $130K for an individual	Jan 1, 2026
State Budget	$30 monthly premium for members with UIS, ages 19-59	Jul 1, 2027
Federal HR1	Redeterminations every 6 months for ME adults	Jan 1, 2027
Federal HR1	Work requirements for ME adults 19-64 w/o dependents	Jan 1, 2027*
Federal HR1	Retroactive coverage restricted to 1 month before application	Jan 1, 2027
Federal HR1	Elimination of 90-day elig while verifying immigration status	Oct 1, 2026
Federal HR1	Asset limit of $1M ceiling for permissible home equity values	Jan 1, 2027

*State option to delay implementation until Dec 31, 2028, with Secretary approval

Below represents the Alliance's projected enrollment for CYs 2025 – 2028 reflecting enrollment reductions associated with these program changes.



Fiscal Impact. N/A

Attachments. N/A

Information Items: (20A. – 20F.)

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

August 2025 Board Report

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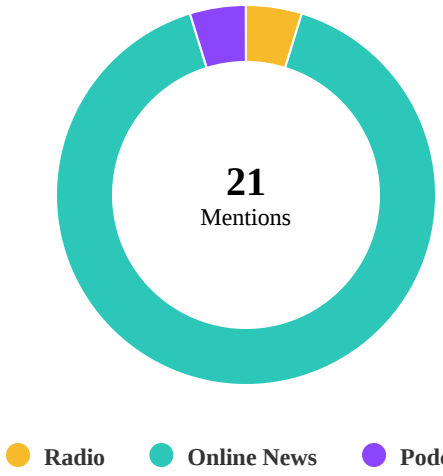
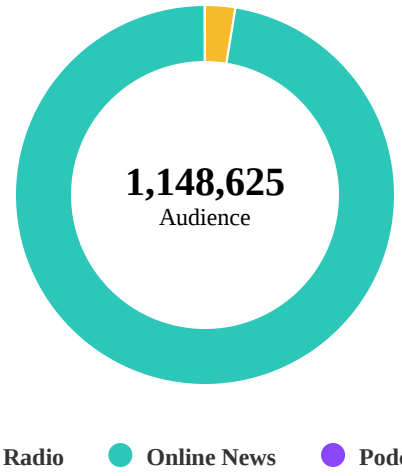
Mention Analytics

Mentions by Media Type



Audience by Media Type



Publicity by Media Type

21 Total Mentions

Mentions 21 **Audience** 1,148,625 **Publicity** USD $13,220

Aug 6, 2025 2:21 PM EDT Pos. 1

Casa de Esperanza breaks ground in King City

Source King City Rustler **Market** King City, CA **Type** Digital News **Category** Local

... the $16.7 million needed to revive this development and bring much-needed housing and renewed hope for local residents." Dignitaries and speakers at the event included Supervisor Chris Lopez, King City Mayor Mike LeBarre, County Administrative Officer Sonia De La Rosa and representatives from the **Central**

Jul 30, 2025 4:06 PM EDT Neu. 2

Aztecas Academy hosts annual camp at Freedom Elementary | Youth soccer

Source Register Pajaronian **Market** Watsonville, CA **Type** Digital News **Category** Local

... . "They're like, 'I got this, we're gonna do this.' We just love what we're doing." CORRECTION: An earlier version of this story said the Aztecas Academy soccer camp was three days long, which is incorrect. The camp was a week-long event. The story also stated the Aztecas received a grant from the **Central California**

Jul 28, 2025 6:09 PM EDT Pos. 3

Community Health Worker Program Celebrates First Graduates

Source UC Merced News **Market** United States **Type** Digital News **Category** Academic

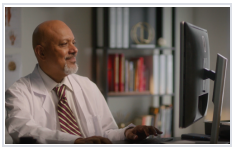
Online News

... it inspired me to find better ways to serve our community. The camaraderie among mycohort was incredibly encouraging, and meeting face-to-face at the graduation celebration brought it all full circle." The online program costs $895; 120 students had their tuition covered through a grant from the **Central California**

Jul 14, 2025 12:18 PM EDT Pos. 4

AI Healthtech Firm Partners with EngageWell and CVS Health Foundation on NYC Senior Ca…

Source StreetWise Reports **Market** United States **Type** Digital News **Category** Trade



... . In Alberta, Canada, patient volume increased by 112% year-over-year, with 36,779 patients served in the past 12 months. Physician participation also grew from 22 to 70 over the same period, a 218% rise. Rocket Doctor has also entered into new partnerships, including a virtual care program with **Central California Alliance**

Jul 12, 2025 7:36 AM EDT Neu. 5

Santa Cruz County Civil Grand Jury; Report: Fees rise for high-cost patients

Source Santa Cruz Sentinel (California) **Market** Santa Cruz, CA **Type** Print **Category** Local

... for Medi-Cal enrollees. "As an insurer, most healthcare organizations develop a number of tools and business models to manage the underlying risk," the jury commented. A good place to start, as recommended by the jury, would be for the county to further deepen its collaboration with the **Central California Alliance for**

Jul 11, 2025 8:13 PM EDT Neu. 6

Santa Cruz County Civil Grand Jury: Better administration, collaboration needed to curb bal…

Source Modesto Bee **Market** Modesto, CA **Type** Digital News **Category** Local

... for Medi-Cal enrollees. "As an insurer, most healthcare organizations develop a number of tools and business models to manage the underlying risk," the jury commented. A good place to start, as recommended by the jury, would be for the county to further deepen its collaboration with the **Central California Alliance for**

Jul 11, 2025 8:12 PM EDT Neu. 7

Santa Cruz County Civil Grand Jury: Better administration, collaboration needed to curb bal…

Source San Luis Obispo.com **Market** San Luis Obispo, CA **Type** Digital News **Category** Local

... for Medi-Cal enrollees. "As an insurer, most healthcare organizations develop a number of tools and business models to manage the underlying risk," the jury commented. A good place to start, as recommended by the jury, would be for the county to further deepen its collaboration with the **Central California Alliance for**

Jul 11, 2025 4:14 PM EDT Neu. 8

Santa Cruz County Civil Grand Jury: Better administration, collaboration needed to curb bal…

Source Santa Cruz Sentinel **Market** Santa Cruz, CA **Type** Digital News **Category** Local

SANTA CRUZ — Providing care to patients who need it the most is not easy or cheap, and given Santa Cruz County's current fiscal challenges, how can local public health officials do so in a more efficient and effective way, while maintaining a compassionate approach? The Santa Cruz County Civil Grand Jury attempted to

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Jul 10, 2025 10:42 AM EDT Pos. 9

Remodeled Family Practice Clinic reopens in Merced

Source MercedCountyTimes.com **Market** Merced, CA **Type** Digital News **Category** Local

The newly remodeled Family Practice Clinic in south Merced reopened on Tuesday with fanfare and touching words from local health care leaders. The milestone is the result of a collaborative effort between Dignity Health Mercy Medical Center and **Central California Alliance for Health**, who have worked together to enhance

Jul 8, 2025 8:29 AM EDT Pos. **10**

Treatment.com AI Announces Momentum Following Acquisition of Rocket Doctor, Highlighti…

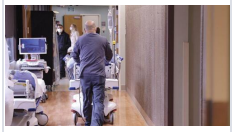
Source Bakersfield.com **Market** Bakersfield, CA **Type** Digital News **Category** Local

... aligning AI-powered clinical intelligence with a proven virtual care delivery platform. Rocket Doctor patient volume grew 112% in Alberta year-over-year, with over 36,000 patients seen in 2024 and physician adoption growing 218%. New partnerships launched in California and Canada, including with **Central California**

Jul 4, 2025 10:38 PM EDT Neg. **11**

Federal and state Medi-Cal cuts are expected to put a strain on the county's health care syst…

Source Monterey County Now **Market** Seaside, CA **Type** Digital News **Category** Local

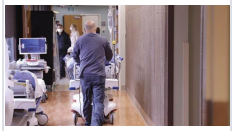


... Monterey County officials are expecting between 17 to 25 percent of Medi-Cal recipients – approximately 33,000 to 45,000 people – will be impacted by cuts at the federal and state levels, says Prashant Shinde, the County of Monterey's clinic services director. It has Michael Schrader, CEO of the **Central California Alliance**

Jul 3, 2025 3:25 AM EDT Neg. **12**

Federal and state Medi-Cal cuts are expected to put a strain on the county's health care syst…

Source Monterey County Weekly **Market** United States **Type** Digital News



With nearly 45 percent of Monterey County's residents – just under 195,000 people – receiving Medi-Cal, California's version of Medicaid, the impending cuts to the nation's health safety net will impact not just those whose benefits are decreased or cut, but the entire community, according to local health officials. They

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Jun 30, 2025 10:48 AM EDT Pos. **13**

KVPR-FM

Station KVPR-FM (NPR) **Market** Fresno, CA DMA: 55

1:00

Chip that helped guide me in the situation now meets had about breastfeeding baby related research and housework begun some changes when bennett makes about the job for always something there was always incredible experience even the really challenging ones but do this is for someone without insurance can cost anywhere

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Jun 30, 2025 7:51 AM EDT Pos. **14**

June 30th: How Doulas Are Filling A Critical Gap In Maternal Healthcare

Podcast Central Valley Daily **Market** United States **Category** News

changes would be like about the job it's always something new it's always incredible experience even the really challenging ones but dual services for someone without insurance can cost anywhere from a few hundred to a few thousand dollars and vip so she wouldn't have a duel at all if we weren't covered by medical she's enrolled in

Jun 27, 2025 8:31 PM EDT

Pos. 15

Mariposa County is a maternity care desert. Doulas are bridging the gap.

Source KVPR **Market** United States **Type** Digital News **Category** Organization

... time-consuming paperwork and lag between having an appointment and getting a paycheck. But, she recently received a grant that is helping with some of the challenges. A growing resource, businesses To help bring more doulas into the Medi-Cal space, the local agency that administers Medi-Cal, the **Central California**

Jun 27, 2025 8:13 AM EDT

Neu. 16

County struggling to track its highest-cost patients amid tight health care budgets, grand ju…

Source Lookout Santa Cruz **Market** Santa Cruz, CA **Type** Digital News **Category** Local

... government manages and pays for the care of high-cost patients, such as spending more on programs and staff, and focusing on the underlying issues caused by homelessness as well as physical and mental health conditions. Jurors also pointed to the nearly 30-year partnership the county has with the **Central**

Jun 27, 2025 7:47 AM EDT

Neu. 17

County struggling to track its highest-cost patients amid tight health care budgets, grand ju…

Source Lookout Santa Cruz **Market** United States **Type** Digital News

Quick Take Santa Cruz County's health agency is managing a large number of high-cost patients and has weak systems for tracking them, a government watchdog warned Thursday in a new report that recommends expanding partnerships, improving administrative and financial reporting and boosting funding despite recent

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Jun 17, 2025 9:42 AM EDT

Pos. 18

Rocket Doctor Launches Virtual Care Program with Central California Alliance for Health to …

Source GlobeNewswire **Market** United States **Type** Digital News **Category** Press Wire

Partnership now live, with services available for eligible patients across Central California ●Rocket Doctor has officially launched its partnership with **Central California Alliance for Health**, a Medi-Cal managed care plan serving ~450,000 members across Mariposa, Merced, Monterey, San Benito, and Santa Cruz

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Jun 17, 2025 8:33 AM EDT

Pos. 19

Rocket Doctor Launches Virtual Care Program with Central California Alliance for Health to ...

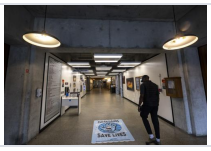
Source Bakersfield.com **Market** Bakersfield, CA **Type** Digital News **Category** Local

Partnership now live, with services available for eligible patients across Central California ●Rocket Doctor has officially launched its partnership with **Central California Alliance for Health**, a Medi-Cal managed care plan serving ~450,000 members across Mariposa, Merced, Monterey, San Benito, and Santa Cruz

Jun 10, 2025 8:13 AM EDT Neg. **20**

‘People will die’: Local doctors, clinicians say Santa Cruz County health cuts pose big risk

Source Lookout Santa Cruz **Market** Santa Cruz, CA **Type** Digital News **Category** Local



... listed 22 specific concerns they had raised to HSA management. At the top of the list is a concern about a worsening budget crisis. If clinics lose lab and radiology services, the doctors fear the quality of care will drop to a point that they no longer qualify for care-based incentives from the **Central California Alliance for Health**,

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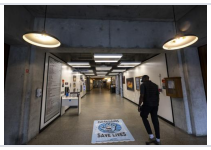
Jun 10, 2025 8:10 AM EDT Neg. **21**

‘People will die’: Local doctors, clinicians say Santa Cruz County health cuts pose big risk

Source Lookout Santa Cruz **Market** United States **Type** Digital News



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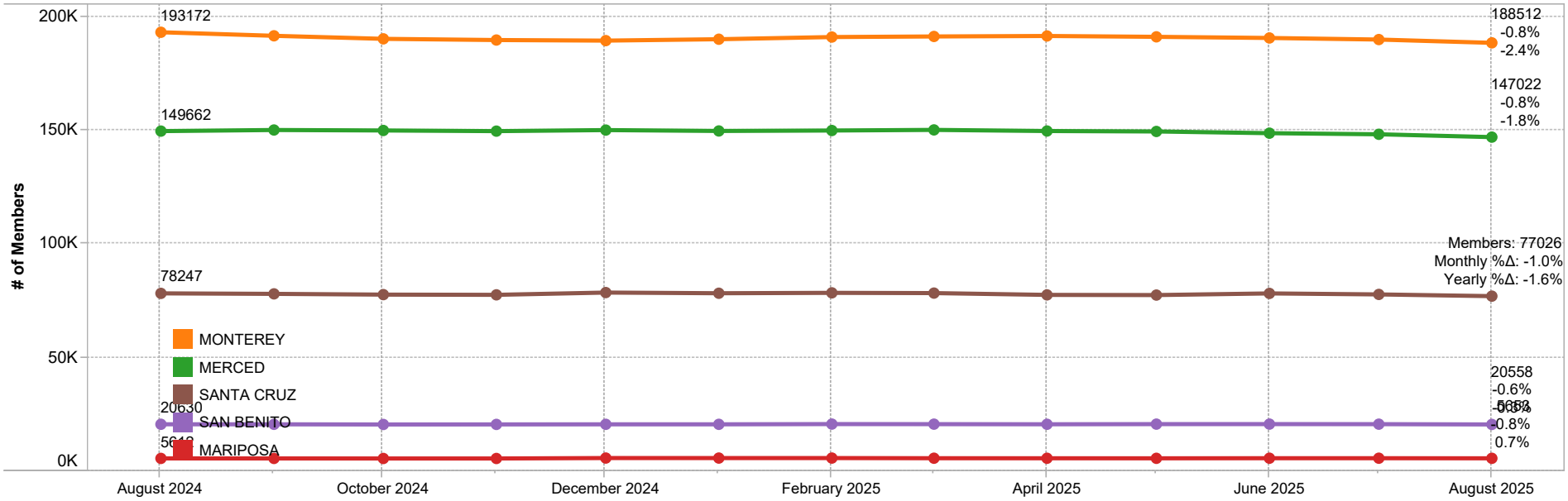
Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *8/1/2025 6:41:01 AM*

Enrollment Month
8/1/2024 to 8/31/2025

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



LOB	County	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025
Medi-Cal	SANTA CRUZ	78,247	78,030	77,697	77,602	78,602	78,303	78,477	78,367	77,579	77,501	78,227	77,786	77,026
	MONTEREY	192,449	190,893	189,563	189,043	188,800	189,420	190,384	190,645	190,868	190,504	190,006	189,313	187,832
	MERCED	149,662	150,150	149,945	149,654	150,113	149,728	149,927	150,194	149,701	149,508	148,751	148,266	147,022
	MARIPOSA	5,612	5,598	5,580	5,580	5,768	5,760	5,761	5,693	5,673	5,653	5,697	5,697	5,653
	SAN BENITO	20,630	20,616	20,547	20,574	20,612	20,611	20,718	20,689	20,634	20,701	20,710	20,683	20,558
IHSS	MONTEREY	723	717	709	702	693	684	680	675	663	654	650	648	680
Total Members		**447,323**	**446,004**	**444,041**	**443,155**	**444,588**	**444,506**	**445,947**	**446,263**	**445,118**	**444,521**	**444,041**	**442,393**	**438,771**

Alliance Fact Sheet
Q3 2025

About the Alliance

The Central California Alliance for Health is an award-winning regional managed care health plan. The Alliance has provided trusted, no cost Medi-Cal health care from local teams to families since 1996. Using the State s County Organized Health System (COHS) model, we currently serve more than **442,276 members** in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We have a local presence in the communities we serve, so we understand the unique needs of these communities and our members. Together with our contracted providers, we work to promote prevention, early detection and effective treatment and to improve access to quality, equitable health care. The Alliance is governed with local representation from each county on our Board of Commissioners.

Quick Facts

1996
Year Established

672
Number of Employees

$2.09B[1]
Annual Revenue

5.7%[1]
Administrative Overhead

$46.4M[2]
Community Grants

VISION

HEALTHY PEOPLE.
HEALTHY COMMUNITIES.

MISSION

Accessible, quality health care guided by local innovation.

VALUES

Collaboration:
Working together toward solutions and results.

Equity:
Eliminating disparity through inclusion and justice.

Improvement:
Continuous pursuit of quality through learning and growth.

Integrity:
Telling the truth and doing what we say we will do.

What We Do

The Alliance is a local health ally for compassionate and trusted health care that supports the whole person. We ensure quality care for all ages and stages of life and for any health condition. We go beyond just providing health care, connecting our members to day-to-day resources.

Who We Serve

Our members represent 41%[3] of the population in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income parents and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled and low-income, childless adults ages 19–64.

Provider Partnerships

The Alliance partners with 100% of hospitals in our service areas and a network of approximately 13,876 providers (99% of primary care physicians and 98% of specialists within our service areas) to ensure members receive timely access to the right care, at the right time. The Alliance also partners with more than 1,145 providers to deliver behavioral health and vision services. Effective July 1, 2025, the Alliance has insourced Behavioral Health Services. As this is a new benefit, many providers are being added to the network, and we anticipate this network to grow over the remainder of 2025.

Our Members[4]

1 out of every 3
Mariposa County residents.

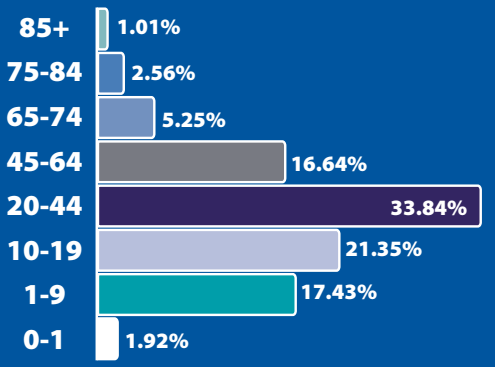
1 out of every 2
Merced County residents.

1 out of every 2
Monterey County residents.

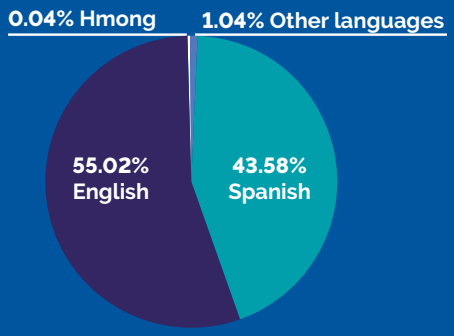
1 out of every 3
San Benito County residents.

1 out of every 3
Santa Cruz County residents.

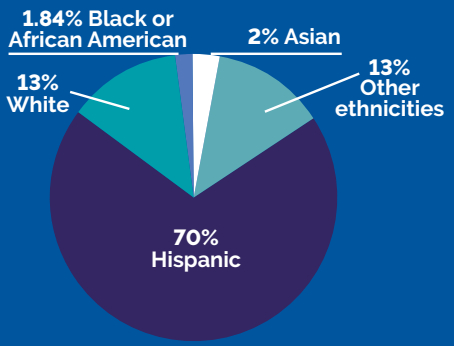
Membership by Age Group



Preferred Language



Race/Ethnicity



Executive Leadership

Michael Schrader
Chief Executive Officer

Dr. Dianna Myers
Interim Chief Health Equity Officer

Lisa Ba
Chief Financial Officer

Cecil Newton
Chief Information Officer

Scott Fortner
Chief Administrative Officer

Dr. Mike Wang
Interim Chief Medical Officer

Jenifer Mandella
Chief Compliance Officer

Van Wong
Chief Operating Officer

Governing Board

The Alliance's governing board, the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan.

In alphabetical order, current Board members are:

- **Leslie Abasta-Cummings,** Chief Executive Officer, Livingston Community Health, Alliance Board Vice Chairperson, At Large Health Care Provider Representative
- **Anita Aguirre,** Chief Executive Officer, Santa Cruz Community Health, At Large Public Representative
- **Ralph Armstrong,** DO FACOG, Hollister Women's Health, At Large Health Care Provider Representative
- **Wendy Root Askew,** Supervisor, County of Monterey, County Board of Supervisors Representative
- **Tracey Belton,** Health and Human Services Agency Director, San Benito County, County Health Department Representative
- **Dorothy Bizzini,** Public Representative
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas, Health Care Provider Representative
- **Kimberly De Serpa,** Supervisor, County of Santa Cruz, County Board of Supervisors Representative
- **Janna Espinoza,** Public Representative
- **Donaldo Hernandez, MD,** Health Care Provider Representative
- **Elsa Jimenez,** Director of Health Services, Monterey County Health Department, Alliance Board Chairperson, County Health Department Representative
- **Kristina Keheley, PhD,** Health and Human Services Agency Director, Mariposa County Health and Human Services Agency, County Health Department Representative
- **Michael Molesky,** Public Representative
- **Supervisor Josh Pedrozo,** County of Merced, County Board of Supervisors Representative
- **James Rabago, MD,** Merced Faculty Associates Medical Group, Health Care Provider Representative
- **Allen Radner, MD,** President/CEO, Salinas Valley Health, At Large Health Care Provider Representative
- **Kristynn Sullivan,** Public Health Director, Merced County, County Health Department Representative
- **Vacant,** County Health Department Representative

Unless otherwise stated, Fact Sheet data as of July 1, 2025.

[1]Amounts based on 2025 annual budget.

[2]Represents 2024 investments through the Alliance's Medi-Cal Capacity Grant Program.

[3]County population data source: U.S. Census Bureau 2023 population estimate (as of Jul. 1, 2023).

[4]Represents an approximate visual representation. Membership percentage by county: Mariposa (34 percent) Merced (51 percent); Monterey (44 percent); San Benito (30 percent); Santa Cruz (30 percent).

June 2025

Provider **Bulletin**

A **quarterly** publication for providers.

Caring for the whole person: We're bringing behavioral health in-house

Starting July 1, the Alliance will provide behavioral health services, previously offered through Carelon. Aligning with our vision of healthy people, healthy communities, this integration also supports California's CalAIM program, which seeks to improve outcomes for Medi-Cal members by addressing behavioral health needs alongside physical health conditions, ensuring more coordinated and comprehensive care. As a result, this one-stop referral process will enable a more seamless and consistent experience for both providers and members alike.

Moving forward, behavioral health providers will need to contract directly with the Alliance to continue serving our members. To support a smooth transition, we have been working diligently to ensure network adequacy, contacting providers who already serve our members and seeking to partner with providers who may not be as familiar with us.

Referring members to behavioral health services is straightforward; for a refresher on how to make a referral, please see page 7. You'll also find important information on depression screening tools to assist you in identifying members who may benefit from behavioral health support.

We remain open to contracting with new behavioral health providers, so if you know a provider who may be a good fit, please encourage them to email **joinus@thealliance.health**.

Our provider network remains our strongest partner in achieving our shared vision. Thank you for your continued commitment to supporting our members.

Michael Schrader

Michael Schrader, CEO

Alliance Board Meetings

Wednesday, June 25
3 p.m. to 5 p.m.

Wednesday, Aug. 27
3 p.m. to 5 p.m.

Whole Child Model Clinical Advisory Committee Meetings

Thursday, June 26
Noon to 1 p.m.

Thursday, Sept. 18
Noon to 1 p.m.

Physicians Advisory Group Meetings

Thursday, Sept. 4
Noon to 1 p.m.

Back to Agenda

What to know about the IHA

The initial health appointment (IHA) is a comprehensive visit that is completed by the member's linked primary care physician and must occur **within a member's first 120 days of enrollment**. The IHA is a regulatory requirement, with minimum standards set by the Department of Health Care Services (DHCS) and the California code of regulations.

During the IHA, providers assess and manage a new member's acute, chronic and preventive health needs. Documentation of IHA completion or documentation of a member receiving the IHA within 12 months prior to eligibility is required. Providers must document all IHA components in the patient's medical record.

Many of the elements, like screenings, **may be completed over multiple visits**. During an audit, medical records will be examined for the date of service requested and historically to account for members who may have established care prior to Alliance eligibility.

IHA components like the **member risk assessment and the mental health status examination/ behavioral assessments** are two separate and distinct elements required for completing the IHA. One from each category is mandatory. All screenings should be administered during the IHA and repeated annually during follow-up assessments. Documentation should include the service provided, name of the screening instrument and/or assessment, and score.

A member risk assessment includes examples such as:

- Social determinants of health assessment.
- Cognitive health assessment, ages 65-plus (Medi-Cal members without Medicare coverage).
- Adverse childhood experiences screening (for pediatric and adult patients).

A mental status exam and behavioral assessment screens for depression, anxiety, and **unhealthy alcohol and drug use.** It includes examples such as:

- Alcohol Use Disorders Identification Test (AUDIT-C).
- Patient Health Questionnaire (PHQ-9).
- Edinburgh Postnatal Depression Scale (EPDS).
- Drug Abuse Screening Test (DAST-10).

For new members under the age of 21, follow the anticipatory guidance covered in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule: **downloads.aap.org/AAP/PDF/ periodicity_schedule.pdf**.

For more details on all required IHA elements, visit our website:

- **www.thealliance.health/initial-health-appointment-form**.
- **www.thealliance.health/ health-assessments**.

Members get rewarded for taking care of their health

Through the Alliance's Health Rewards Program, members can earn gift cards just by taking steps to stay healthy! When members stay on track, providers can benefit too. We offer financial incentives for provider practices who achieve vaccination and checkup rate benchmarks through our Care-Based Incentive (CBI) program.

Health Rewards Program

Who is the reward for?	What is the reward?	What do members have to do to get the reward?
All members	Entry into a monthly raffle for a $50 gift card.	Call the Alliance **Nurse Advice Line** at **844-971-8907** (TTY: **711**) to talk to a nurse. This service is available 24/7 to all Alliance members at no cost.
Adult members with chronic conditions	Up to a $50 gift card.	Participate in a six-week ***Healthier Living Program*** workshop.
Adult members with diabetes (NEW)	Up to a $50 gift card.	Participate in a six-week ***Live Better with Diabetes*** workshop.
Child members	Up to a $100 gift card.	Parents/guardians participate in a 10-week ***Healthy Weight for Life*** workshop.
Infant members	Entry into a monthly raffle for a $100 gift card.	Complete second flu dose by 2nd birthday.
Pregnant mothers	Entry into a monthly raffle for a $50 gift card.	In the ***Healthy Moms, Healthy Babies*** program, complete a prenatal care visit within the first 13 weeks of pregnancy or six weeks of joining the Alliance.
Mothers with infants	$25 gift card.	In the ***Healthy Moms, Healthy Babies*** program, complete a postpartum visit one to 12 weeks after having a baby.

Healthy Start Program

Who is the reward for?	What is the reward?	What do members have to do to get the reward?
Ages under 15 months	$50 gift card.	Have six checkups with their doctor by 15 months.
Ages 15-30 months	$25 gift card.	Have two checkups with their doctor by 30 months.
2-year-olds	$100 gift card.	Have received all needed vaccines from their doctor by 2nd birthday.
13-year-olds	$50 gift card.	Complete one checkup with their doctor within the previous 12 months and complete all needed vaccines from their doctor by 13th birthday.
Ages 18-21 years	$25 gift card.	Have one checkup with their doctor.

Questions about eligibility? Members or providers can call the Alliance Health Education Line at **800-700-3874, ext. 5580**.

The Alliance offers language assistance

The Alliance offers a variety of language assistance services that our provider network can utilize to communicate with our members, including:

- Telephonic interpreting services.
- Face-to-face interpreting services.

The Alliance's Cultural and Linguistics team can provide training and support for our provider network to make sure providers and staff are aware of how to use the interpreting services available for Alliance members.

The Alliance can also provide resources such as language assistance flyers and materials for office staff to utilize when working with members.

For additional information on the Alliance Language Assistance Services, please visit our website at **www.thealliance.health/language-assistance** or call the Alliance Health Education Line at **800-700-3874, ext. 5580**.

Providers can also reach out to their Alliance Provider Relations Representative for any language assistance training needs.

Cognitive health assessment benefit

Medi-Cal members 65 years of age or older – without Medicare coverage – should receive a cognitive health assessment annually. Licensed Medi-Cal providers are required to complete the Dementia Care Aware training (**www.dementiacareaware.org/page/show/139067**) and use Department of Health Care Services-approved screening tools (**www.dementiacareaware.org/page/show/139061**) before billing the Alliance.

Billing code	Description	Billing frequency
CPT 1494F	Members 65-plus years of age.	Once per year, per same provider.
CPT 99483	Comprehensive E&M visit, establish or confirm a diagnosis of cognitive impairment.	N/A
CPT 96125	Time spent administering assessment, interpretation of results.	1 service(s) allowed in 1 day – all providers.

Note: **99483 and 96125 cannot be billed with 1494F**.

Required medical record documentation:

- Screening tool(s).
- Screening results and verification they were reviewed by a provider.
- The interpretation of results.
- Details discussed with the member and/or authorized representative and appropriate actions taken regarding screening results.

Alliance network providers may be requested to provide medical record documentation to ensure that the appropriate screening tools are being used and necessary follow-up is being completed.

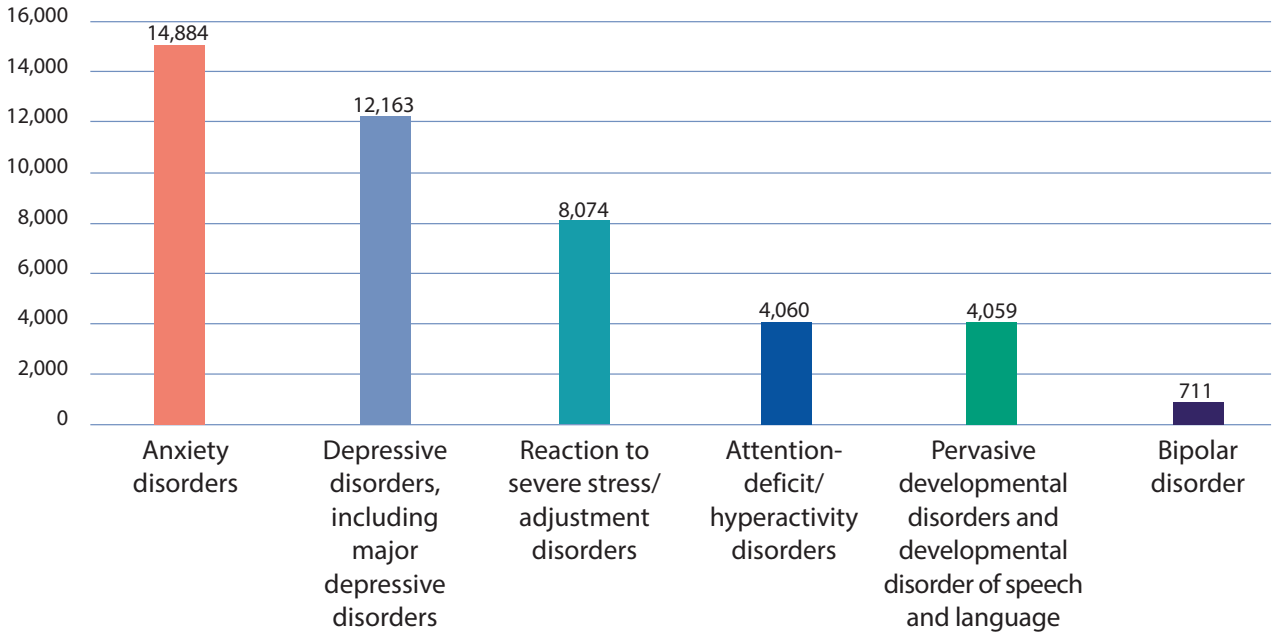
ADDRESSING DEPRESSION:

Screening resources for PCPs

In 2024, the Alliance provided behavioral health services to over 12,000 members diagnosed with major depressive disorder or a depressive episode, making depression the second most common mental health diagnosis among our members. Alliance members' utilization of individual psychotherapy (the most commonly recommended service for depression) has doubled from 2019 to 2024, highlighting the growing demand for mental health care.

Screenings are essential for identifying individuals struggling with depression, even if they haven't recognized it themselves. Regular screenings during annual checkups or for pregnant and postpartum individuals ensure comprehensive care. Primary care providers (PCPs) play a vital role in supporting mental health by conducting screenings, understanding referral processes and collaborating with behavioral health care providers.

Top 6 Alliance mental health diagnosis codes in 2024



The graph above is based on 2024 claims in both the physical health and behavioral health networks. Mariposa, Merced, Monterey, San Benito and Santa Cruz counties are totaled. Trends may be slightly different in individual counties.

Depression screening and mental health clinical resources

Some helpful services include:

- **California Child and Adolescent Mental Health Access Portal (Cal-MAP; cal-map.org).** Cal-MAP offers no-cost, real-time consultations between primary care providers and child/adolescent psychiatrists regarding screening, diagnosis and treatment for youth from birth through age 25. The program is designed to improve timely access to pediatric mental health care, particularly in underserved and rural areas of California.
- **988 Lifeline (www.988lifeline.org).** This free, 24/7 hotline is available to your patients in English and Spanish and offers confidential care for mental health crises.

Additionally, please refer to the following screenings and references:

- **Patient Health Questionnaire-9 (www.thealliance.health/phq9):** recommended to assess depression. Annual screening is recommended for youth ages 12 through 21.
- **Edinburgh Postnatal Depression Scale (www.thealliance.health/epds):** for maternal mental health. For Alliance Care IHSS members, depression screening is required at least once during pregnancy and within six weeks postpartum, as directed by AB-1936 (**www.thealliance.health/ab1936**). To follow best practices, the Alliance also recommends that this be done for Medi-Cal members.
- **Columbia-Suicide Severity Rating Scale (cssrs.columbia.edu):** for members who screen positive for depression and may need to be assessed for potential suicide risk.
- **Depression Toolkit (www.thealliance.health/dt) and Depression Screening for Adolescents and Adults Tip Sheet (www.thealliance.health/depressiontipsheet):** tips to implement depression screening into clinical practice.

Referring members to behavioral health services

Member needs behavioral health services

- Member can self-refer by calling the Alliance (effective July 1, 2025) or Carelon (until June 30).
- Member can call contracted behavioral health provider directly.
- Member can call/walk in to county mental health plan (MHP) for screening and assessment.
- PCP can refer a member using the forms on our website.

Member is screened using DHCS screening tool

- If the member is referred to the Alliance or the county MHP, a behavioral health staff member will screen the member for the correct system of care and provide referrals within timely access requirements. The Alliance and our MHPs coordinate daily.

Member is connected to services

- Member will be offered help making an appointment and getting connected to a provider within timely access requirements. The Alliance behavioral health care management team follows up to ensure no additional services are needed.

More information:

- The Alliance Provider Manual: **www.thealliance.health/provider-manual**.
- The Alliance behavioral health webpage: **www.thealliance.health/bh**.

Asthma management: AIR and SMART treatment

Among the advancements in asthma management are **anti-inflammatory reliever (AIR)** and **single maintenance and reliever therapy (SMART)**. These treatment strategies aim to simplify asthma regimens, improving patient adherence while minimizing the need for frequent medication adjustments.

AIR

AIR therapy combines a low-dose inhaled corticosteroid (ICS) and formoterol (a long-acting beta agonist, or LABA) and is used for symptom relief. It can also be taken preemptively before exercise or allergen exposure.

Non-formoterol LABAs combined with ICS should not be used as relievers.

SMART

SMART therapy combines a daily maintenance dose of ICS-formoterol with the same medication used as a reliever when symptoms occur. This regimen improves patient convenience and adherence by combining both maintenance and relief in one inhaler.

SMART can only be used with ICS-formoterol combinations, like budesonide-formoterol (Symbicort). Other combinations, like ICS with non-formoterol LABAs or ICS-SABA, are not appropriate for SMART.

Practice points for ICS-formoterol in mild asthma

Patients 12 years and older: budesonide-formoterol 160/4.5 mcg, 1 inhalation as needed. Max 12 inhalations per day.

Patients 6 through 11 years: budesonide-formoterol 80/4.5 mcg, 1 inhalation as needed. Max 8 inhalations per day.

Why not use short-acting beta-2 agonists (SABA) alone?

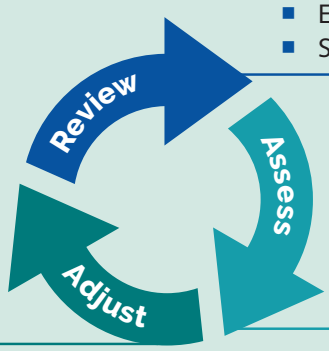
Regular use of SABA, even for just one or two weeks, is associated with increased airway hyper responsiveness, reduced bronchodilation and higher allergic response (*Cockcroft 2006*). A Cochrane meta-analysis (2021) showed that as-needed ICS-formoterol reduced severe exacerbations by 55% and emergency visits by 65% compared to SABA alone. This demonstrates the benefit of combining ICS with LABA for both immediate relief and long-term asthma control.

Introducing AIR and SMART treatment strategies offers patients and clinicians more efficient and effective treatment options, combining maintenance and reliever therapies.

GINA 2024 – adults and adolescents 12-plus years

Personalized asthma management

Review, assess, adjust for individual patient needs.



- Symptoms.
- Exacerbations.
- Side effects.
- Lung function.
- Comorbidities.
- Patient satisfaction.

- Treatment of modifiable risk factors and comorbidities.
- Non-pharmacological strategies.
- Asthma medications, including ICS.
- Education and skills training.

- Confirmation of diagnosis, if necessary.
- Symptom control and modifiable risk factors.
- Comorbidities.
- Inhaler technique and adherence.
- Patient preferences and goals.

Treating depression in children and adolescents

It's important to normalize treating depression! Around 40% of children and adolescents with depression do not receive treatment. Depression is one of the leading factors contributing to suicide, which is the second most common cause of death among adolescents.

American Academy of Child & Adolescent Psychiatry and American Academy of Family Physicians guidelines

Treatment. Treatment planning should be collaborative with patients and their families.

- **Mild depression:** Consider six to eight weeks of supportive care, such as counseling and treatment options, and monitor the patient closely. If no improvement, then treat as persistent mild depression.
- **Persistent mild, moderate or severe depression:** Treat with an antidepressant medication alongside psychotherapy. Evidence suggests that adolescents have the highest likelihood of achieving remission when both treatments are used together.

Antidepressant medications. Fluoxetine (Prozac) and escitalopram (Lexapro) are the only two medications approved by the U.S. Food and Drug Administration to treat depression in children and adolescents.

- **Prescribing tips:** It usually takes at least two weeks for the medication to start working and eight weeks for full effect. If there's not a significant improvement after eight weeks on an antidepressant, consider titrating the dose or changing the medication. If there is improvement on an antidepressant, continue medication for at least six to nine months after symptoms resolve.
- **Counseling patients about fluoxetine/escitalopram:** Patients should take the medication in the morning, unless it causes drowsiness, in which case they should take in the evening. When first starting an antidepressant, patients should continue taking the medication even if they don't feel better right away – it takes time for the medication to start working.
- **Common side effects:** nausea, headache, dizziness, sleep disturbances (insomnia or drowsiness).
- **Serious side effects (rare but require immediate attention):**
  - Suicidal ideation: increased suicidal thoughts or actions in some children.
  - Serotonin syndrome: severe nausea, dizziness, headache, agitation, hallucinations, diarrhea, tachycardia or muscle rigidity.

988 is the mental health equivalent of 911. If a member needs to talk about urgent mental health concerns related to thoughts of self-harm or suicide, refer them to call or text **988**.

Prescribing naloxone saves lives!

Naloxone is a lifesaving medication that reverses opioid overdose. Prescribers must offer a naloxone prescription to patients at risk of opioid overdose under Assembly Bill 2760. The law does not limit its requirement to the physician who prescribed the opioid to the patient. Prescribers seeing a patient – even if seen for unrelated matters – must offer a prescription for naloxone if patient is at risk of overdose.

Consider prescribing naloxone to all patients on long-term opioid therapy to reinforce its role as a standard of care for opioid safety. Additionally, encourage patients with risk factors for opioid overdose to keep naloxone readily available.

Examples of risk factors for opioid overdose include patients who:

- ✓ Take an opioid and benzodiazepine or other sedatives.
- ✓ Take an opioid and have an underlying mental health problem.
- ✓ Take an opioid and have respiratory problems.
- ✓ Take an opioid and have renal/liver disease.
- ✓ Have a history of opioid overdose.
- ✓ Have a history of alcohol or other substance use disorder.
- ✓ Are switching from one opioid to another.
- ✓ Have caregivers, family members and friends who might witness or assist a person at risk of an opioid overdose.
- ✓ Are taking an opioid dose of 50 MMEs/day or above.
  - Morphine milligram equivalents (MME) help standardize opioid dosing by converting various opioids to an equivalent morphine dose. For example:
    - Morphine 15mg: 4 tablets per day = 60 MME
    - Oxycodone 15mg: 4 tablets per day = 90 MME

For an MME dose conversion chart, see **www.thealliance.health/CDC-MME-dose-guide**.

Resources

Medical Board of California, guidelines for prescribing controlled substances, **www.thealliance.health/MBC-controlled-substances-guidelines**.

Center for Innovative Academic Detailing on Opioids & Stimulants information, **www.ciaosf.org/materials**.

The Alliance's physician-administered drugs list and procedures

The Alliance's physician-administered drug list, restrictions, prior authorization criteria, policies and their updates are available on the Pharmacy Services page: **www.thealliance.health/pharmacy-services**. If you would like to request physical copies, please contact the Pharmacy Department at **831-430-5507**.

Ensure accuracy: Verify and document services billed!

Your complete and accurate medical recordkeeping is vital for both patient care and ensuring the Alliance can appropriately reimburse you for services rendered to Alliance members.

Prior authorization

You must obtain prior authorization from the Alliance before providing certain medical services to a member.

To evaluate these requests, the Alliance uses evidence-based criteria, including Medi-Cal criteria, MCG criteria and internally developed guidelines, to determine whether the requested services are appropriate and/or medically necessary.

What does it mean when an authorization request is approved?

When your authorization request is approved, it means the Alliance has reviewed and authorized the services for the member.

- This approval does not guarantee payment or give you permission to bill the Alliance for the authorized services.
- Payment depends on the services being provided to the member and proper documentation in the medical record.
- Medi-Cal regulations require that all billed services must have been provided to the member and must be fully supported by documentation in the medical record.

For more information about the Alliance's authorization process, see page 77 of the Alliance Provider Manual at **www.thealliance.health/provider-manual** or Alliance Policy #404-1201.

Regulatory requirements

- **California Code of Regulations (CCR), Title 22, § 51476** requires Medi-Cal providers maintain and keep records that are easily accessible, clearly showing the type and extent of services provided to a Medi-Cal member. These records should be created at or around the time the service is delivered. Review this regulation for more details on recordkeeping.
- **California Code of Regulations (CCR), Title 22, § 51470** states that a provider shall not bill or submit a claim for Medi-Cal benefits not provided to a Medi-Cal member.

When providers complete documentation at the time of service, it helps ensure appropriate payment for services delivered to Alliance members.

Billing repeat procedures

When billing for repeated procedures, such as repeat EKG, use of the appropriate modifier will ensure correct processing of your claim and reduce the chance your claim will be denied as a duplicate. This includes situations where two different vendors are billing the same service for the same rendering physician.

Refer to **Policy 600-1036** Modifier Reference Grid.

Claim denial follow-up

To follow up on a claim denial:

Make the necessary changes to your claim and resubmit as a new claim. Please do not use the Provider Inquiry Form (PIF) process to submit a corrected claim or request retro authorization. To obtain retro authorization, fax your authorization request to **831-430-5850**. To follow up on an authorization status, reach out to the UM Department at **831-430-5511**.

If you disagree with the adjudication of a claim, reach out to the **Claims Customer Service Line** at **831-430-5503**.

Important phone numbers

Provider Services	**831-430-5504**
Claims	**831-430-5503**
Authorizations	**831-430-5506**
Status (non-pharmacy)	**831-430-5511**
Member Services	**831-430-5505**
Web and EDI	**831-430-5510**
Cultural & Linguistic Services	**831-430-5580**
Health Education Line	**831-430-5580**

Partnering with local doctors and specialists to ensure that Alliance members get access to the right care, at the right time.

Welcome, new physicians and specialists

Merced County

Primary care

- Jose Buenrostro, MD, Family Medicine
- Eugenia Garcia, MD, Family Medicine
- Albertina Smith-Banks, MD, Pediatrics

Referral physician/specialist

- Noriko Anderson, MD, Neurology
- Veronique Au, MD, Emergency Medicine
- William Hurtt, DPM, Podiatry
- Christina Ma, DPM, Podiatry
- Lina Ya'Qoub, MD, Internal Medicine
- Aleksandr Yelenskiy, MD, Ophthalmology
- Donald Zweig, MD, Emergency Medicine

Monterey County

Primary care

- Jennifer Archer, MD, Family Medicine
- Alexandra Arnold, MD, Family Medicine
- Benjamin Berthet, DO, Internal Medicine
- Blake Bischoff, MD, Pediatrics
- Daniel Camarillo, MD, Family Medicine
- Sundeep Gupta, MD, Family Medicine
- Daniel Jenkins, DO, Family Medicine

Referral physician/specialist

- Timothy Albert, MD, Cardiovascular Disease
- Anushi Bulumulle, MD, Hematology
- Jamil Matthews, MD, Vascular Surgery
- Santosh Oommen, MD, Diagnostic Radiology
- David Parsons, MD, Gastroenterology
- Daniel Shin, MD, Diagnostic Radiology
- Maheep Singh Sangha, MD, Gastroenterology

Santa Cruz County

Referral physician/specialist

- Michael Hajek, MD, Otolaryngology
- Nicole Steinmuller, MD, Family Medicine

Welcome, new Enhanced Care Management (ECM) and Community Supports (CS) providers

Castle Family Health Centers: ECM. Merced County.

Eden Housing Resident Services, Inc.: CS. Housing tenancy and sustaining services. Monterey, Santa Cruz counties.

Healthy House Within a Match Coalition (Healthy House of Merced): ECM/CS. Housing suite, produce/grocery delivery services. Mariposa, Merced counties.

Merced County Community Action Agency: CS. Recuperative care and short-term post hospitalization services. Merced County.

Rosarium Health: CS. EAA home modifications services. Mariposa, Merced, Monterey, San Benito, Santa Cruz counties.

Zocalo Medical Group: CS. Housing transition and navigation services. Mariposa, Merced, Monterey, San Benito, Santa Cruz counties.

Living **Healthy**

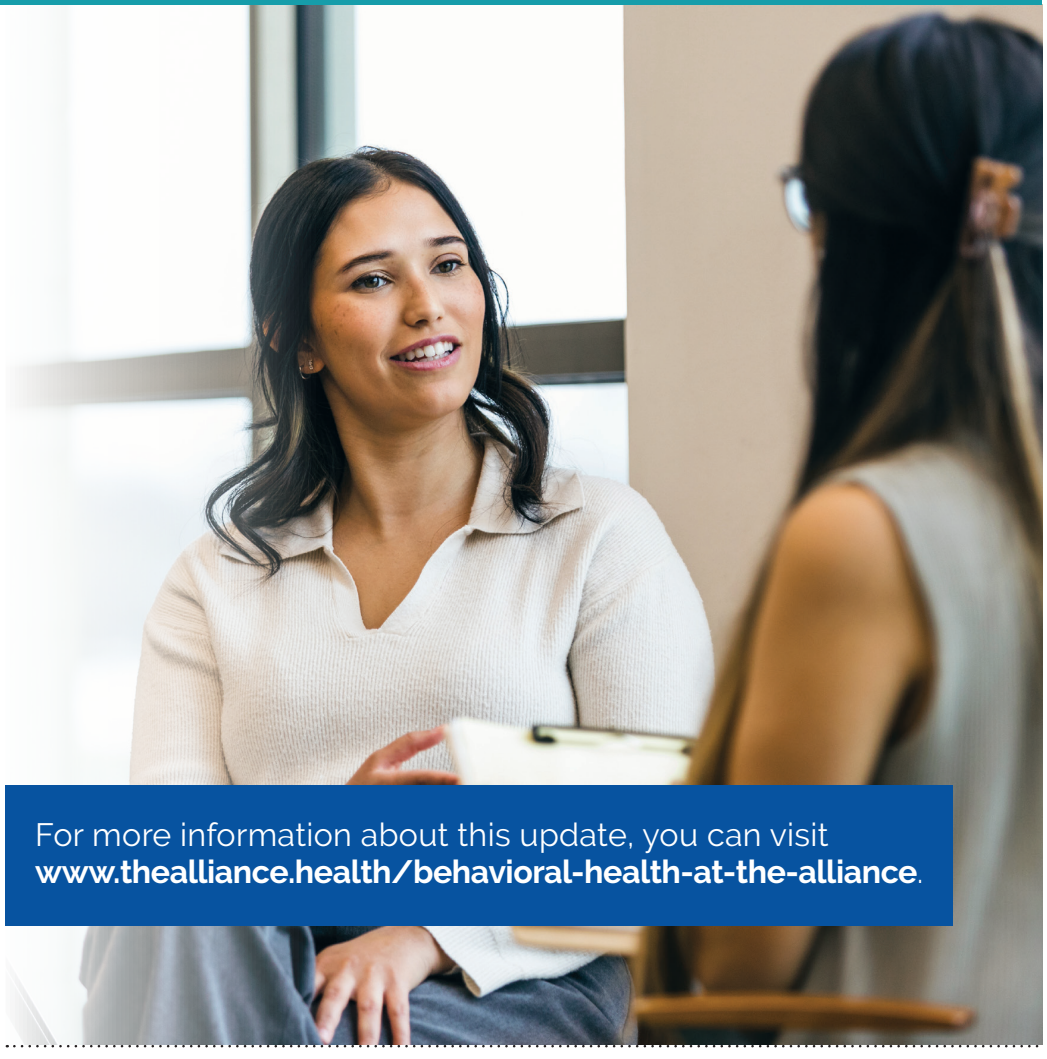
A newsletter for the members of
Central California Alliance for Health

June 2025 | VOLUME 31, ISSUE 2

Behavioral health care is moving to the Alliance

As an Alliance member, you can get help for behavioral health and substance use disorders. Right now, a company called Carelon handles these services. Starting July 1, 2025, the Alliance will provide them. This means the Alliance will handle both your behavioral health care and your physical health care. This will make it easier for you to get the help you need. The goal is to give you complete and connected care for your overall health.

Members will be able to see therapists or psychiatrists without needing approval for most services. There's no limit on how many visits you can have. If you're already seeing a doctor, you can keep seeing them for up to 12 months, even if they aren't in the Alliance's network. The Alliance will work with your doctor or help you find another one who can meet your needs. You can schedule a therapy appointment directly or call Member Services at **800-700-3874** for help.



For more information about this update, you can visit **www.thealliance.health/behavioral-health-at-the-alliance**.

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1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Talking with your primary care provider

Practicing good communication with your primary care provider (PCP) is an important way to embrace your personal health care journey. Clear and honest communication between you and your PCP can help you both build a safe connection. Talking about your concerns can help you make informed choices about your health care.

We know that talking with your PCP is not always easy. At right are some examples of questions to talk about with your PCP if you have health concerns during your visit.

Other tips for your visit to the doctor:

- Bring a list of all the medications you are taking.
- If you have any medical needs, such as wheelchair access, or require language assistance or interpreting services, let the doctor's office staff know so they can help you.

The Alliance can also help with letting your doctor know what you need. Call Member Services at **800-700-3874** (TTY: Dial **711**), Monday through Friday, 8 a.m. to 5:30 p.m.

Question	Example
What am I feeling that I want the PCP to check?	My left ear aches each time I blow my nose.
When did it begin?	It started about a week ago when I first caught a cold.
What makes it better or worse?	It feels worse when I blow my nose and feels better in the morning after I shower.
What questions do I have, and what worries me?	When will I start to feel better? Does the medicine have side effects?

Feeling sick and have questions? Call the Nurse Advice Line

The Nurse Advice Line is a service available to all Alliance members. You can call if you have questions about your health or your child's health. A registered nurse will help you with what to do next.

The service is available **24 hours a day, 7 days a week,** at no cost to you.

Call **844-971-8907** (TTY: Dial **711**) to talk to a nurse.

For more information about the Nurse Advice Line, visit **www.thealliance.health/NAL**.

If you are having a medical emergency, call 911 or go to the nearest emergency room.

Ask the **doctor**

Why it's time to schedule back-to-school checkups

Dr. Dianna Myers is a Medical Director for Central California Alliance for Health with over 15 years of primary care experience.

You may be thinking, "Summer has just started. Isn't it a little early to do a back-to-school checkup for my child?" It might seem like the school year is far away, but appointments fill up fast! **Now is the time to schedule a visit to your child's doctor to make sure the child gets the vaccines and sports physicals they may need.** Checkups are offered at no cost to Alliance members.

Why are back-to-school checkups important?

Checkups with your child's doctor are a great time to ask questions, make sure your child's health is on track and keep up with the vaccines the child needs to stay healthy.

Your child should get a checkup every year. At a back-to-school checkup, your child can:

- Get a physical to play school sports. Sports physicals are often required for middle school and high school sports. Contact your child's school to check if the child needs a physical before starting sports.
- Get the vaccines they need for the school year.

Which vaccines does my child need for school?

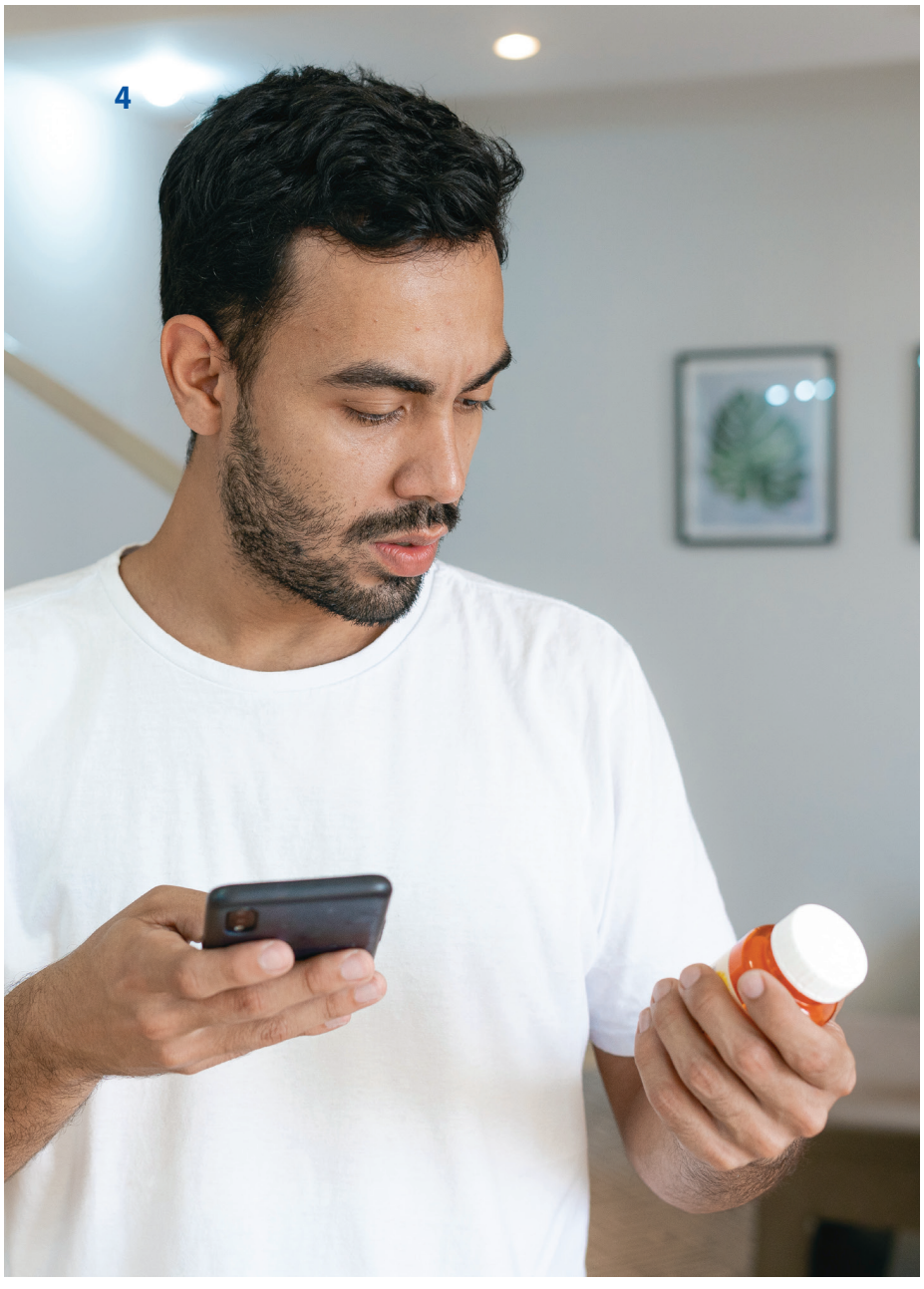
Your child is required to get certain vaccines to enter transitional kindergarten or kindergarten as well as seventh grade. Visit **www.thealliance.health/vaccinesforschool** to learn more. They might also need to get caught up on vaccines at other ages if they have missed any.

Talk to your child's doctor about which vaccines the child needs.

Does the Alliance offer any rewards programs for checkups and vaccines?

Yes! Our *Healthy Start* program allows you to earn rewards for the things you are doing that can help keep your family healthy.

Members from birth to age 21 can get a healthy start on life and get rewarded! Get gift cards totaling up to $250 by making sure your child is up to date with vaccines and checkups. To learn more, visit **www.thealliance.health/healthy-start**.



You have prescription benefits!

If you are a Medi-Cal member, your prescription drugs that are filled at a pharmacy are covered by Medi-Cal Rx and not the Alliance. To find out if a drug is covered, call **800-977-2273** (TTY: Dial **711**) or go to **www.medi-calrx.dhcs.ca.gov**.

If you are an IHSS member, pharmacy services are managed by MedImpact. You can view the list of covered drugs at **www.thealliance.health/prescriptions**. You can request a mailed copy by calling Member Services at **800-700-3874** (TTY: Dial **711**). You can also call Member Services if you have questions about whether a drug is covered.

Drugs given in doctor's office or clinic

These are considered physician-administered drugs. You can view the list of covered drugs and any changes to the list at **www.thealliance.health/prescriptions**. If you would like a mailed copy, call Member Services at **800-700-3874** (TTY: Dial **711**).

Lead tests can protect children's health

Lead can harm your child's brain development and make it hard for them to learn and pay attention. It can slow their growth and cause other health problems. Young children can be exposed to lead through old paint, dust and water pipes.

Luckily, a lead test is quick and easy. A doctor will prick your child's finger to check lead levels. Your child should get tested for lead at ages 12 and 24 months.

If the test finds lead, your doctor will help you lower your child's lead exposure and prevent more harm. Eating healthy foods with iron, calcium and vitamin C can help slow lead absorption.

Ask your child's doctor for a lead screening and how to keep your child safe from lead.

Learn more about protecting your family from lead exposure at **www.thealliance.health/cdc-lead-prevention**.

We are committed to your satisfaction!

We want you to be happy with your health care and our service. But sometimes, you might not be. When that is the case, we want to hear about it.

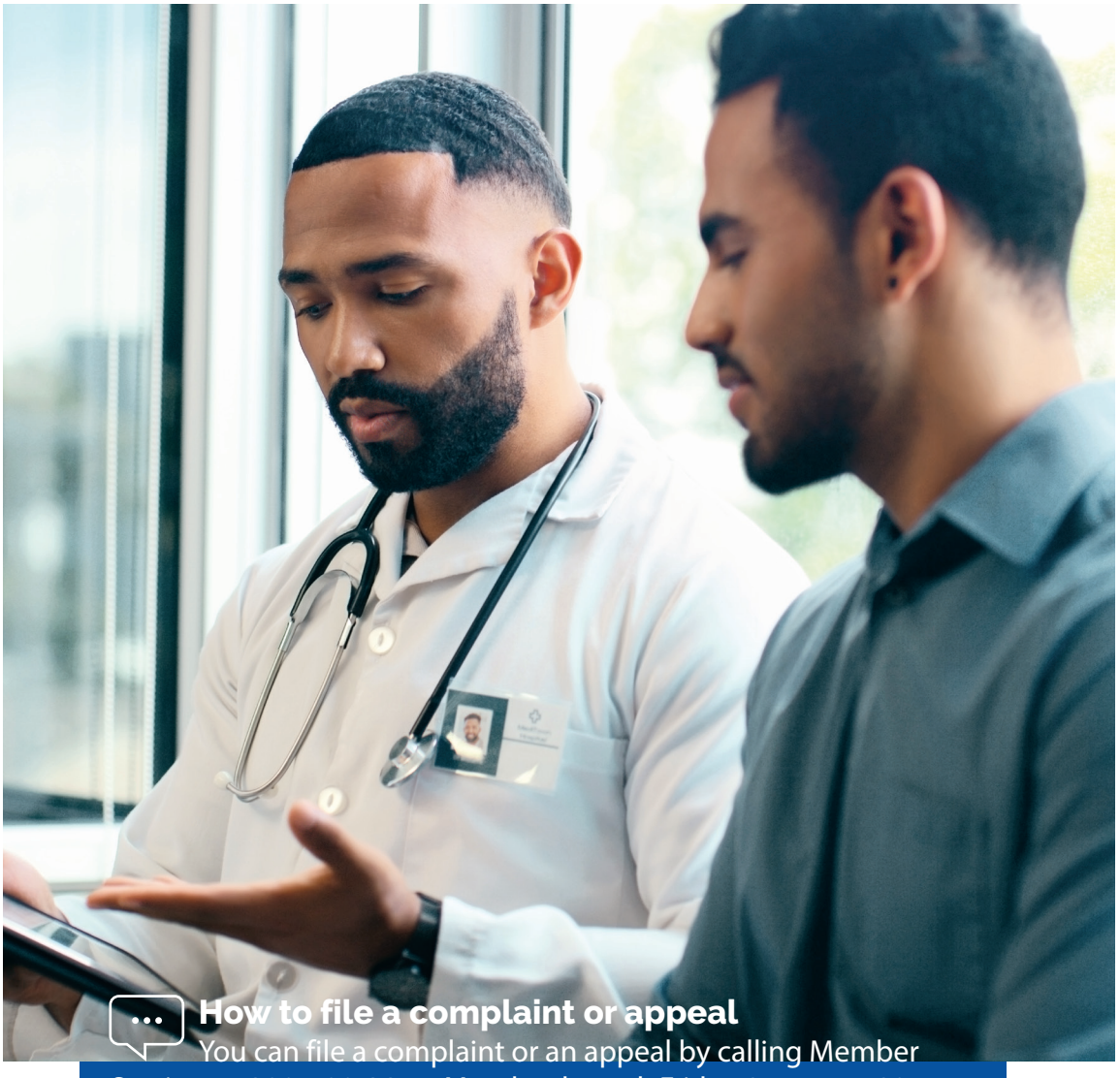
If you would like to talk to the Alliance about a problem, we are here to help.

You may file a **complaint** (also called a **grievance**) if:

- You are not happy with the care you received from your doctor or how you were treated in the office.
- You are not happy with your experience in a hospital or other facility.
- You received a bill for services covered by the Alliance.
- You are not able to get the care you need.
- You are not happy with the services you get from the Alliance.
- You feel a health care provider or the Alliance failed to give trans-inclusive health care.

There are other reasons you might file a complaint with us. These are listed in your Member Handbook, which you can find online at **www.thealliance.health/memberhandbook**.

If you are not happy with a decision we made, you can file an **appeal**. An appeal is a request for us to review and change a decision we made about your services.



How to file a complaint or appeal

You can file a complaint or an appeal by calling Member Services at **800-700-3874**, Monday through Friday, 8 a.m. to 5:30 p.m. You can also file a complaint or appeal in writing or through our website at **www.thealliance.health/file-a-grievance**.

Next steps

Once you let us know about your complaint or appeal, we will look into your concern. We will do all we can to help you. The information you share also helps us improve as an organization and helps our health partners. If you are still unhappy after we try to resolve your case, we will tell you what steps you can take next.

Community Corner

Naloxone: A lifesaving tool for your first-aid kit

Overdoses can happen to anyone, anywhere—even at home. Naloxone can stop an opioid overdose if used right away. If someone you love overdoses, having naloxone in your first-aid kit or with you can save their life!

Why have naloxone

Opioids like OxyContin, Percocet or fentanyl can slow or even stop breathing. Naloxone works fast to help someone breathe again and gives you time to get emergency help.

- It's easy to use and safe for people of all ages.
- Just like having a fire extinguisher at home, having naloxone can save lives in an emergency.
- It won't cause harm when used on someone who isn't overdosing.

How to help someone overdosing

1. Yell "Wake up!" and gently shake them.
2. Tilt their head back and spray naloxone into one nostril by pressing the plunger down.
3. Call **911**.
4. If they don't respond in two to three minutes, give them another dose of naloxone.
5. Stay with them until help arrives.

How to get naloxone

Alliance members can get naloxone at any Alliance office at no cost. Alliance offices are open Monday through Friday, 8 a.m. to 5 p.m.

- **Mariposa County:** 5362 Lemee Lane, Mariposa.
- **Merced County:** 530 W. 16th St., Suite B, Merced.
- **Monterey County:** 950 E. Blanco Road, Suite 101, Salinas.
- **San Benito County:** 1111 San Felipe Road, Suite 109, Hollister.
- **Santa Cruz County:** 1600 Green Hills Road, Suite 101, Scotts Valley.

You can also ask your pharmacist for naloxone. There is no prescription needed.

REMEMBER: When you get naloxone, show your loved ones where it is and how to use it!

Get low-cost internet at home!

The Internet For All Now program offers discounts on internet plans. If you get Medi-Cal, CalFresh, SSI or other assistance programs, you may qualify for special discounts.

Visit **www.internetforallnow.org** to learn more. Need help signing up? Call **833-938-3298**.

Benefit spotlight

Get Health Rewards

The Alliance's Health Rewards Program rewards you and your family for taking actions that support your health.

Here are the programs that members can participate in and the rewards you could earn.

Healthy Start

Birth to 15 months

- Have six or more well-child visits on or before turning 15 months.
- **$50** Target gift card.

15 to 30 months

- Have two well-child visits on or before turning 30 months.
- **$25** Target gift card.

Birth to 2 years

- Complete immunizations by their second birthday.
- **$100** Target gift card.

9 to 13 years

- Get all needed vaccines by their 13th birthday and have one well-care visit within the last 12 months.
- **$50** Target gift card.

18 to 21 years old

- Have one annual checkup with their doctor.
- **$25** Target gift card.

Nurse Advice Line

- Call the Alliance Nurse Advice Line if you have a health question.
- Members can call **844-971-8907** (TTY: Dial **711**) to talk to a nurse.
- Monthly raffle for a **$50** Target gift card.

Healthier Living Program

- Complete the six-week workshop.
- Up to a **$50** Target gift card.

Live Better with Diabetes

- Complete the six-week workshop.
- Up to a **$50** Target gift card.

Healthy Weight for Life Program

- Complete the 10-week workshop.
- Up to a **$100** Target gift card.

Healthy Moms & Healthy Babies Program

Prenatal

- See your doctor within the first 13 weeks of being pregnant or six weeks of joining the Alliance.
- Monthly raffle for a **$50** Target gift card.

Postpartum

- See your doctor for a postpartum visit one to 12 weeks after having a baby.
- **$25** Target gift card.

Members with other health insurance, besides Medi-Cal, are not eligible for these rewards.

Visit our website at **www.thealliance.health/health-rewards** to learn more. Or call the Health Education Line at **800-700-3874, ext. 5580**.

Wellness for all

Vaccines protect you and your child!

Vaccines protect your child and the community around them from diseases. Vaccines are one of the best ways to keep you and your child healthy.

1. **Vaccines protect you and your child from serious diseases.** Vaccines prevent diseases that make children very sick. They protect against six types of cancers, measles, mumps, polio and more. Vaccines teach your child's immune system to fight these diseases.
2. **Vaccines protect the whole community.** When your child gets vaccinated, they protect others, especially babies and elderly adults who can get diseases easily. The more people who get vaccinated, the less disease there is to spread. This is called *herd immunity*.
3. **Vaccines are safe.** Vaccines are tested for years before they are used. Common side effects include a sore arm or slight fever and are temporary. Serious side effects are very rare.
4. **Vaccines can prevent missed school and work.** Diseases can cause your child to miss school or day care and can lead to long hospital stays. Vaccines help keep children healthy so they can go to school and parents don't miss work.
5. **Vaccines help stop diseases from spreading.** When we all use vaccines, we can get rid of serious diseases and protect future generations.

Vaccines protect your child from serious diseases, help keep your community healthy and are safe. If you don't know which vaccines your child needs, talk to your doctor—they can help!

The safest way to protect against measles is to get the MMR (measles, mumps and rubella) vaccine. To also protect against chickenpox, children may get the MMRV (measles, mumps, rubella and varicella) vaccine. Vaccines give stronger immunity than getting the diseases. Most people who get the MMR or MMRV will be protected for life.

We are texting members!
The Alliance texts members to help them keep up to date on Alliance benefits and services. Alliance texts are from the short code **59849**. To learn more, visit our website at **www.thealliance.health/member-texting**.

At every life stage.
For any health condition.

Trusted, no cost Medi-Cal health care from a local team that understands you.

The Alliance—your ally in being your healthiest self.

LIVING HEALTHY is published for the members and community partners of CENTRAL CALIFORNIA ALLIANCE FOR HEALTH, 1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066, telephone 831-430-5500 or 800-700-3874, ext. 5505, website www.thealliance.health.

Information in LIVING HEALTHY comes from a wide range of medical experts. If you have any concerns or questions about specific content that may affect your health, please contact your health care provider.

Models may be used in photos and illustrations.

Editor — Randi Motson

Quality and Health Programs Supervisor — Ivonne Muñoz

www.thealliance.health

Nondiscrimination Notice

Discrimination is against the law. Central California Alliance for Health (the Alliance) follows State and Federal civil rights laws. The Alliance does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

The Alliance provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Alliance between 8 a.m. and 5:30 p.m., Monday through Friday, by calling **800-700-3874**. If you cannot hear or speak well, please call **800-735-2929** (TTY: Dial **711**). Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
800-700-3874
800-735-2929 (TTY: Dial **711**)

HOW TO FILE A GRIEVANCE

If you believe that the Alliance has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with the Alliance's Civil Rights Coordinator, also known as the Senior Grievance Specialist. You can file a grievance by phone, in writing, in person, or electronically:

- **By phone:** Contact the Alliance's Senior Grievance Specialist between 8 a.m. and 5:30 p.m., Monday through Friday, by calling **800-700-3874**. Or, if you cannot hear or speak well, please call **800-735-2929** (TTY: Dial **711**).
- **In writing:** Fill out a complaint form or write a letter and send it to:
  Central California Alliance for Health
  Attn: Senior Grievance Specialist
  1600 Green Hills Road, Suite 101
  Scotts Valley, CA 95066
- **In person:** Visit your doctor's office or the Alliance and say you want to file a grievance.
- **Electronically:** Visit the Alliance's website at **www.thealliance.health**.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- **By phone:** Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- **In writing:** Fill out a complaint form or send a letter to:
  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at **www.dhcs.ca.gov/Pages/Language_Access.aspx**.
- **Electronically:** Send an email to **CivilRights@dhcs.ca.gov**.

This newsletter is also available in large print and audio formats at **www.thealliance.health/otherformats**.

Taglines

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **800-368-1019**. If you cannot speak or hear well, please call TTY/TDD **800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at **www.hhs.gov/civil-rights/filing-a-complaint/index.html**.

- **Electronically:** Visit the Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

Daim ntawv tshaj xo no los kuj muaj ua ntawv luam loj thiab kaw ua suab nyob ntawm **thealliance.health/hmn/tag/alternative-access**.

Este boletín también está disponible en formato de letra grande y audio en **thealliance.health/es/tag/alternative-access**.

English Tagline

ATTENTION: If you need help in your language call 1-800-700-3874 (TTY: 1-800-735-2929). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-700-3874 (TTY: 1-800-735-2929). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929).
تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل والخط الكبير. اتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Simplified Chinese)

请注意：**如果您需要以您的母**语提供帮助，请致电 1-800-700-3874 (TTY: 1-800-735-2929)。**我**们另外还提供针对残疾人士的帮助和服务，**例如盲文和大字体**阅读，**提供您方便取用**。请致电 1-800-700-3874 (TTY: 1-800-735-2929)。这些服务都是免费的。

Taglines

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با 1-800-700-3874 (TTY: 1-800-735-2929) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-800-700-3874 (TTY: 1-800-735-2929) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は 1-800-700-3874 (TTY: 1-800-735-2929)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 1-800-700-3874 (TTY: 1-800-735-2929)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-800-700-3874 (TTY: 1-800-735-2929). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-800-700-3874 (TTY: 1-800-735-2929). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-700-3874 (TTY: 1-800-735-2929). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-700-3874 (TTY: 1-800-735-2929). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

Taglines

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский слоган (Russian)
ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)
ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-700-3874 (TTY: 1-800-855-3000). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-700-3874 (TTY: 1-800-855-3000). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)
ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)
УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Các dịch vụ này đều miễn phí.

La Vida **Saludable**

Un boletín informativo para los miembros de Central California Alliance for Health

Junio 2025 | VOLUMEN 31, NÚMERO 2

El cuidado de salud de la conducta se muda a la Alianza

Como miembro de la Alianza, puede obtener ayuda para la salud de la conducta y los trastornos por uso de sustancias. En este momento, una empresa llamada Carelon se encarga de estos servicios. A partir del 1º de julio de 2025, la Alianza los proporcionará. Esto significa que la Alianza se encargará tanto de su cuidado de la salud de la conducta como de su cuidado de la salud física. Esto le hará más fácil obtener la ayuda que necesita. El objetivo es brindarle un cuidado completo y conectado para su salud en general.

Los miembros podrán ver a terapeutas o psiquiatras sin necesidad de aprobación para la mayoría de los servicios. No hay límite a la cantidad de visitas que puede hacer. Si ya está viendo a un doctor, puede seguir viéndolo hasta durante 12 meses, incluso si no están en la red de la Alianza. La Alianza trabajará con su doctor o le ayudará a encontrar otro que pueda satisfacer sus necesidades. Puede programar una cita de terapia directamente o llamar a Servicios para Miembros al **800-700-3874** para obtener ayuda.

Para obtener más información sobre esta actualización, puede visitar **www.thealliance.health/behavioral-health-at-the-alliance**.

Hablando con su proveedor de cuidado primario

Practicar una buena comunicación con su proveedor de cuidado primario (Primary Care Provider; PCP, por sus siglas en inglés) es una forma importante de comprometerse con su viaje personal de cuidado de la salud. La comunicación clara y honesta entre usted y su PCP puede ayudarles a ambos a crear una conexión segura. Hablar de sus preocupaciones puede ayudarle a tomar decisiones informadas sobre el cuidado de su salud.

Sabemos que hablar con su PCP no siempre es sencillo. A la derecha hay algunos ejemplos de preguntas sobre las que puede hablar con su PCP durante su visita si tiene problemas de salud.

Otros consejos para su visita al doctor:

- Lleve una lista de todos los medicamentos que esté tomando.
- Si tiene alguna necesidad de salud, como acceso a una silla de ruedas, o necesita asistencia en su idioma o servicios de interpretación, dígaselo al personal de la oficina del doctor para que puedan ayudarle.

La Alianza también puede ayudar a decirle a su doctor lo que necesita. Llame a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**), de lunes a viernes, de 8 a.m. a 5:30 p.m.

Pregunta	Ejemplo
¿Qué estoy sintiendo que quiero que el PCP revise?	Me duele la oreja izquierda cada vez que me sueno la nariz.
¿Cuándo comenzó?	Comenzó hace como una semana cuando primero me resfrié.
¿Qué mejora o empeora?	Se siente peor cuando me sueno la nariz y se siente mejor por la mañana después de bañarme.
¿Qué preguntas tengo y qué me preocupa?	¿Cuándo empezaré a sentirme mejor? ¿El medicamento tiene efectos secundarios?

¿Se siente enfermo y tiene preguntas? Llame a la Línea de Consejos de Enfermeras

La Línea de Consejos de Enfermeras es un servicio disponible para todos los miembros de la Alianza. Puede llamar si tiene preguntas sobre su salud o la de su hijo. Una enfermera registrada le ayudará con lo que debe hacer a continuación.

El servicio está disponible **24 horas al día, 7 días a la semana**, sin costo para usted.

Llame al **844-971-8907** (TTY: Marque **711**) para hablar con una enfermera.

Para obtener más información sobre la Línea de Consejos de Enfermeras, visite **www.thealliance.health/es/NAL**.

Si tiene una emergencia médica, llame al 911 o acuda a la sala de emergencia más cercana.

Pregúntele al **doctor**

Por qué es hora de programar chequeos de regreso a clases

La Dra. Dianna Myers es Directora Médica de Central California Alliance for Health con más de 15 años de experiencia en cuidado primario.

Puede que esté pensando: "El verano acaba de comenzar. ¿No es un poco temprano para hacerle un chequeo de regreso a clases a mi hijo?" Puede parecer que el año escolar está lejos, ¡pero las citas se llenan rápidamente! **Ahora es el momento de programar una visita al doctor de su hijo para asegurarse de que el niño reciba las vacunas y los exámenes físicos deportivos que pueda necesitar.** Los chequeos se ofrecen sin costo a los miembros de la Alianza.

¿Por qué son importantes los chequeos de regreso a clases?

Los chequeos con el doctor de su hijo son un buen momento para hacer preguntas, asegurarse de que la salud de su hijo esté al día con las vacunas que el niño necesita para mantenerse saludable.

Su hijo debe hacerse un chequeo todos los años. En un chequeo de regreso a clases, su hijo puede:

- Hacerse un examen físico para practicar deportes escolares. A menudo se necesitan exámenes físicos deportivos para los deportes de la escuela intermedia y secundaria. Comuníquese con la escuela de su hijo para verificar si el niño necesita un examen físico antes de comenzar a practicar deportes.
- Obtener las vacunas que necesita para el año escolar.

¿Qué vacunas necesita mi hijo para la escuela?

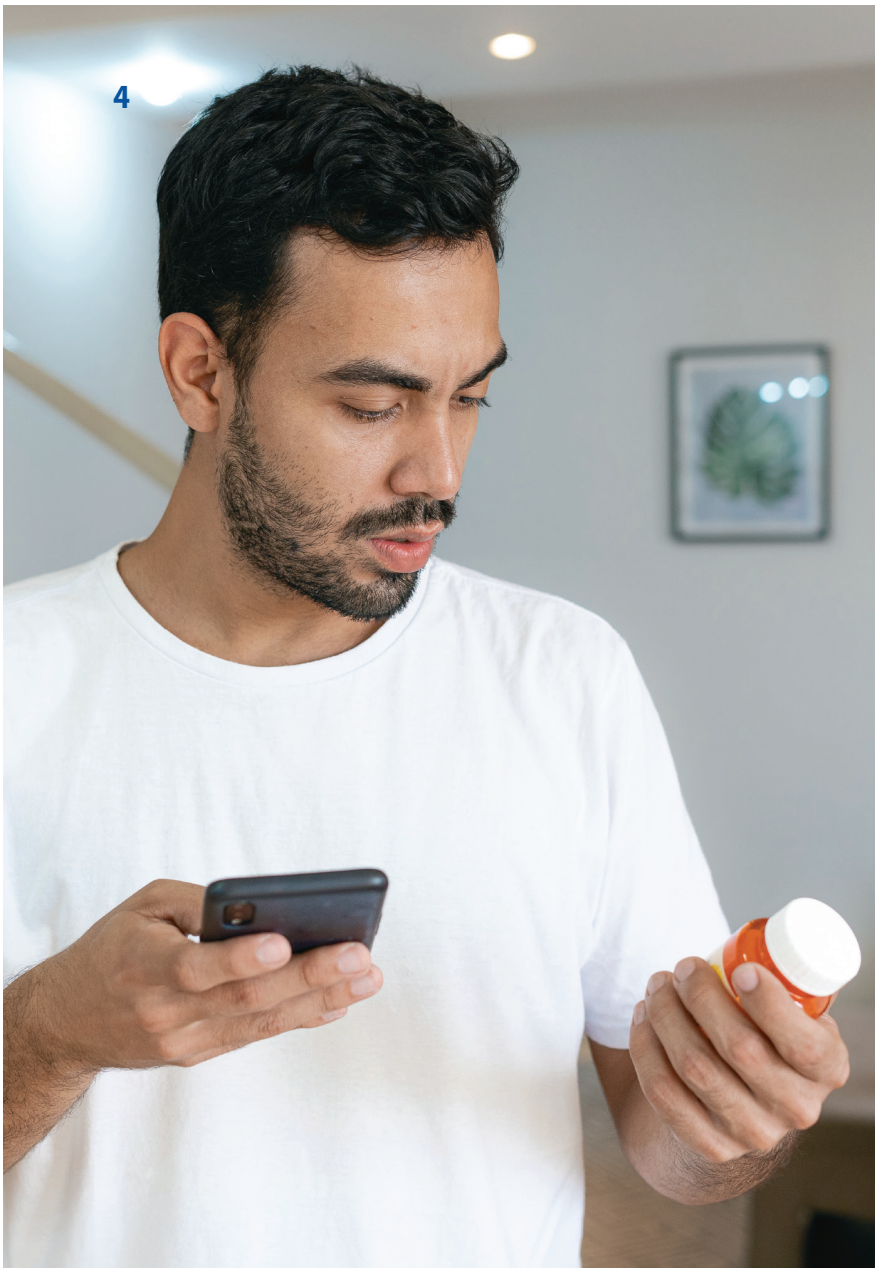
Se requiere que su hijo reciba ciertas vacunas para entrar al kínder transicional o al kínder, así como al séptimo grado.

Visite **www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/School/Spanish-tk12.aspx** para obtener más información. También es posible que deban ponerse al día con las vacunas a otras edades si se han saltado alguna. Hable con el doctor de su hijo sobre las vacunas que necesita el niño.

¿La Alianza ofrece algún programa de recompensas para chequeos y vacunas?

¡Sí! Nuestro programa *Comienzo Saludable* (*Healthy Start*) le permite ganar recompensas por las cosas que está haciendo y que pueden ayudar a mantener sana a su familia.

¡Los miembros desde el nacimiento hasta los 21 años de edad pueden tener un comienzo saludable en la vida y obtener recompensas! Obtenga tarjetas de regalo por un total de hasta $250 asegurándose de que su hijo esté al día con las vacunas y los chequeos. Para aprender más, visite **www.thealliance.health/es/healthy-start**.



¡Tiene beneficios de medicamentos recetados!

Si es usted miembro de Medi-Cal, sus medicamentos recetados que se surten en una farmacia están cubiertos por Medi-Cal Rx y no por la Alianza. Para averiguar si un medicamento está cubierto, llame al **800-977-2273** (TTY: Marque **711**) o vaya a **www.medi-calrx.dhcs.ca.gov**.

Si usted es miembro de IHSS, los servicios de farmacia son manejados por MedImpact. Puede ver la lista de medicamentos cubiertos en **www.thealliance.health/es/prescriptions**. Puede solicitar una copia por correo llamando a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**). También puede llamar a Servicios para Miembros si tiene preguntas sobre si un medicamento está cubierto.

Medicamentos que se administran en la oficina del doctor o en la clínica

Estos se consideran medicamentos administrados por el doctor. Puede ver la lista de medicamentos cubiertos y cualquier cambio en la lista en **www.thealliance.health/es/prescriptions**. Si desea que se le envíe una copia por correo, llame a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**).

Las pruebas de plomo pueden proteger la salud de los niños

El plomo puede dañar el desarrollo del cerebro de su hijo y dificultar su aprendizaje y concentración. Puede retrasar su crecimiento y causarle otros problemas de salud. Los niños pequeños pueden verse expuestos al plomo a través de pintura vieja, polvo y tuberías de agua.

Afortunadamente, una prueba de plomo es rápida y fácil. Un doctor picará el dedo de su hijo para revisar los niveles de plomo. Su hijo debe hacerse la prueba de plomo a los 12 y 24 meses de edad.

Si la prueba detecta plomo, su doctor le ayudará a reducir la exposición al plomo de su hijo y a prevenir más daños. Comer alimentos saludables con hierro, calcio y vitamina C puede ayudar a retrasar la absorción de plomo.

Pídale al doctor de su hijo que le haga una prueba de detección de plomo y cómo mantener a su hijo a salvo del plomo.

Obtenga más información sobre cómo proteger a su familia de la exposición al plomo en **www.thealliance.health/cdc-lead-prevention**.

¡Tenemos un compromiso con su satisfacción!

Queremos que esté satisfecho con el cuidado de su salud y con nuestro servicio. Pero a veces, quizás no lo esté. Cuando ese sea el caso, queremos escucharle.

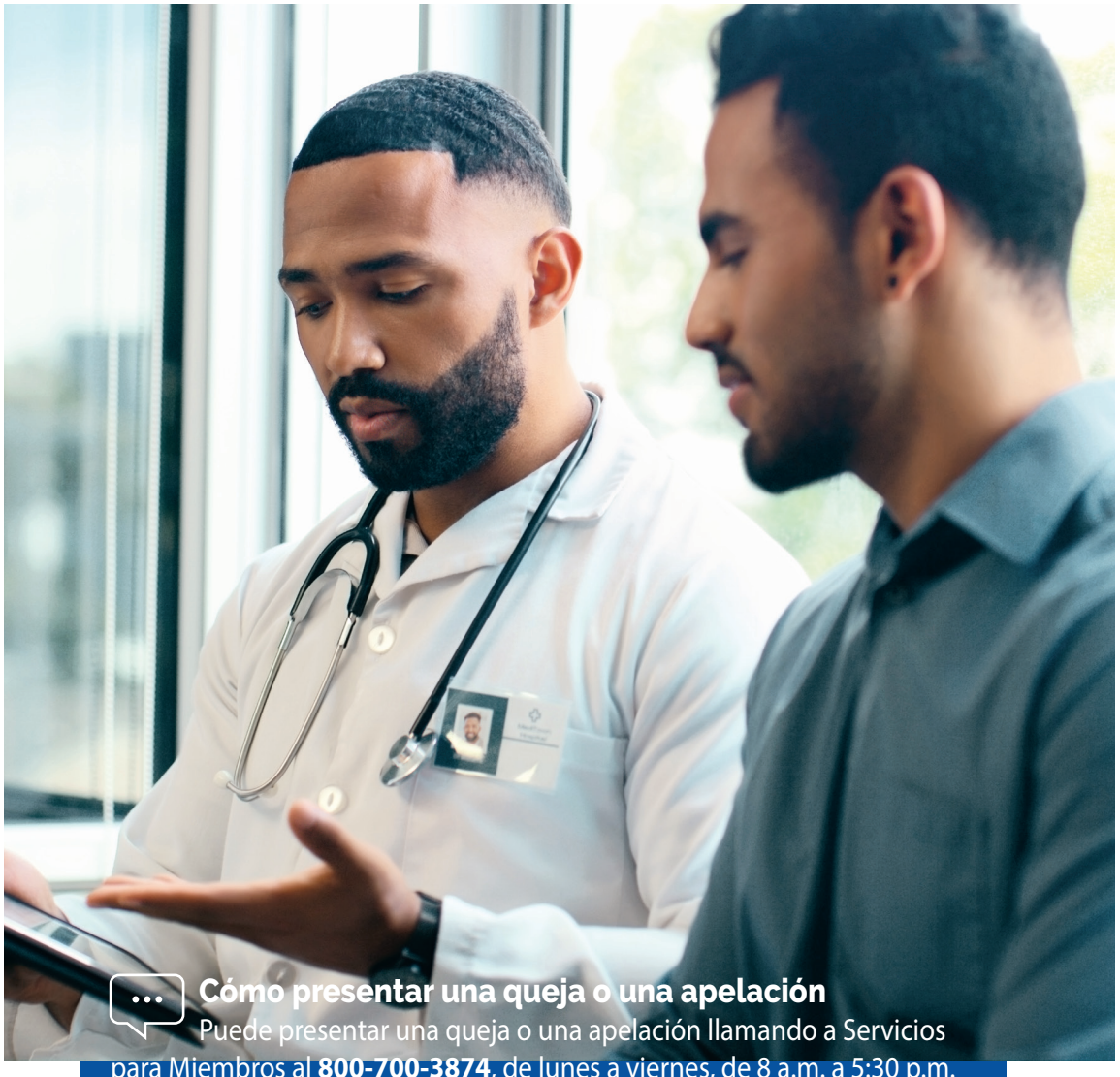
Si desea hablar con la Alianza sobre algún problema, estamos aquí para ayudarle.

Usted puede presentar una **queja** (también llamada **reclamación**) si:

- No está satisfecho con el cuidado que recibió de su doctor o cómo lo trataron en la oficina.
- No está satisfecho con su experiencia en un hospital u otro centro.
- Recibió un cobro por servicios que están cubiertos por la Alianza.
- No puede recibir el cuidado que necesita.
- No está satisfecho con los servicios que recibe de la Alianza.
- Piensa que un proveedor de cuidado de la salud o la Alianza no brindaron cuidado de la salud inclusivo para personas trans.

Hay otros motivos por los que podría presentar una queja ante nosotros. Estos se enumeran en su Manual para Miembros, que puede encontrar en línea en **www.thealliance.health/es/memberhandbook**.

Si no está satisfecho con una decisión que hayamos tomado, puede presentar una **apelación**. Una apelación es una solicitud para que revisemos y cambiemos una decisión que tomamos sobre sus servicios.



Cómo presentar una queja o una apelación

Puede presentar una queja o una apelación llamando a Servicios para Miembros al **800-700-3874**, de lunes a viernes, de 8 a.m. a 5:30 p.m. También puede presentar una queja o apelación por escrito o a través de nuestro sitio web en **www.thealliance.health/es/file-a-grievance**.

Siguientes pasos

Una vez que nos informe sobre su queja o apelación, analizaremos su solicitud. Haremos todo lo que podamos para ayudarle. La información que usted comparte también nos ayuda a mejorar como organización y ayuda a nuestros socios de salud. Si todavía no está satisfecho después de que intentemos resolver su caso, le diremos qué pasos puede dar a continuación.

Rincón de la comunidad

Naloxona: Una herramienta que salva vidas para su botiquín de primeros auxilios

Las sobredosis le pueden ocurrir a cualquier persona, en cualquier lugar, incluso en casa. La naloxona puede detener una sobredosis de opioides si se utiliza de inmediato. ¡Si uno de sus seres queridos sufre una sobredosis, tener naloxona en su botiquín de primeros auxilios o con usted puede salvarle la vida!

Por qué tener naloxona

Los opioides como OxyContin, Percocet o el fentanilo pueden hacer que la respiración sea más lenta o incluso se detenga. La naloxona actúa rápidamente para ayudar a alguien a respirar de nuevo y le da tiempo a usted para buscar ayuda de emergencia.

- Es fácil de usar y seguro para personas de todas las edades.
- Igual que tener un extintor de incendios en casa, tener naloxona puede salvar vidas en una emergencia.
- No causará daño cuando se use en alguien que no tenga una sobredosis.

Cómo ayudar a alguien que sufre una sobredosis

1. Grite "¡Despierta!" y sacúdalo suavemente.
2. Incline la cabeza de la persona hacia atrás y rocíe naloxona en una fosa nasal presionando el émbolo.
3. Llame al **911**.
4. Si la persona no responde en dos o tres minutos, déle otra dosis de naloxona.
5. Quédese con la persona hasta que llegue ayuda.

Cómo obtener naloxona

Los miembros de la Alianza pueden obtener naloxona en cualquier oficina de la Alianza sin costo. Las oficinas de la Alianza están abiertas de lunes a viernes de 8 a.m. a 5 p.m.

- **Condado de Mariposa:** 5362 Lemee Lane, Mariposa.
- **Condado de Merced:** 530 W. 16th St., Suite B, Merced.
- **Condado de Monterey:** 950 E. Blanco Road, Suite 101, Salinas.
- **Condado de San Benito:** 1111 San Felipe Road, Suite 109, Hollister.
- **Condado de Santa Cruz:** 1600 Green Hills Road, Suite 101, Scotts Valley.

También puede pedirle naloxona a su farmacéutico. No se necesita receta.

RECUERDE: Cuando obtenga naloxona, ienséñeles a sus seres queridos dónde está y cómo usarla!

¡Consiga internet de bajo costo en casa!

El programa Internet For All Now ofrece descuentos en planes de Internet. Si usted recibe Medi-Cal, CalFresh, SSI u otros programas de asistencia, puede cumplir los requisitos para descuentos especiales.

Visite **www.internetforallnow.org** para obtener más información. ¿Necesita ayuda para registrarse? Llame al **833-938-3298**.

Centro de atención de los beneficios

Obtenga Recompensas de Salud

El Programa de Recompensas de Salud de la Alianza les recompensa a usted y a su familia por tomar acciones que apoyan su salud.

Estos son los programas en los que pueden participar los miembros y las recompensas que usted puede ganar.

Comienzo Saludable (Healthy Start)

Del nacimiento a los 15 meses

- Tener seis o más visitas de bienestar infantil al cumplir o antes de cumplir los 15 meses.
- Tarjeta de regalo de Target de **$50**.

De 15 a 30 meses

- Tener dos visitas de bienestar infantil al cumplir o antes de cumplir los 30 meses.
- Tarjeta de regalo de Target de **$25**.

Del nacimiento a los 2 años

- Vacunas completas antes de su segundo cumpleaños.
- Tarjeta de regalo de Target de **$100**.

De 9 a 13 años

- Recibir todas las vacunas necesarias antes de que cumpla 13 años y tenga una visita de bienestar infantil en los últimos 12 meses.
- Tarjeta de regalo de Target de **$50**.

De 18 a 21 años

- Hacerse una chequeo anual con su doctor.
- Tarjeta de regalo de Target de **$25**.

Línea de Consejos de Enfermeras

- Llame a la Línea de Consejos de Enfermeras de la Alianza si tiene alguna pregunta sobre la salud.
- Los miembros pueden llamar al **844-971-8907** (TTY: Marque **711**) para hablar con una enfermera.
- Sorteo mensual de una tarjeta de regalo de Target de **$50**.

Programa *Tomando Control de Su Salud (Healthier Living)*

- Lleve a cabo el taller de seis semanas.
- Una tarjeta de regalo de Target de hasta **$50**.

Programa *Viva Mejor con Diabetes (Live Better with Diabetes)*

- Lleve a cabo el taller de seis semanas.
- Una tarjeta de regalo de Target de hasta **$50**.

Programa *Peso Sano de Por Vida (Healthy Weight for Life)*

- Lleve a cabo el taller de 10 semanas.
- Una tarjeta de regalo de Target de hasta **$100**.

Programa *Mamás Saludables y Bebés Sanos (Healthy Moms & Healthy Babies* Program)

Prenatal

- Consulte a su doctor en las primeras 13 semanas del embarazo o seis semanas después de unirse a la Alianza.
- Rifa mensual de una tarjeta de regalo de Target de **$50**.

Posparto

- Consulte a su doctor para una visita posparto entre una y 12 semanas después de tener un bebé.
- Tarjeta de regalo de Target de **$25**.

Los miembros con otro plan de salud, además de Medi-Cal, no son elegibles para estas recompensas.

Visite nuestro sitio web en **www.thealliance.health/es/health-rewards** para aprender más. O llame a la Línea de Educación de Salud al **800-700-3874, ext. 5580**.

Bienestar para todos

¡Las vacunas los protegen a usted y a su hijo!

Las vacunas protegen de enfermedades a su hijo y a la comunidad que lo rodea. Las vacunas son una de las mejores maneras de mantenerlos sanos a usted y a su hijo.

1. **Las vacunas los protegen a usted y a su hijo de enfermedades graves.** Las vacunas previenen enfermedades que hacen que los niños se enfermen gravemente. Protegen contra seis tipos de cáncer, sarampión, paperas, poliomielitis y más. Las vacunas le enseñan al sistema inmunitario de su hijo cómo combatir estas enfermedades.
2. **Las vacunas protegen a toda la comunidad.** Cuando su hijo se vacuna, protege a los demás, especialmente a los bebés y a los adultos mayores que pueden contagiarse de enfermedades con facilidad. Cuantas más personas se vacunen, menos enfermedades se propagarán. A esto se le llama *inmunidad de manada*.
3. **Las vacunas son seguras.** Las vacunas se prueban durante años antes de utilizarse. Los efectos secundarios comunes incluyen dolor en el brazo o fiebre leve y son temporales. Los efectos secundarios graves son muy infrecuentes.
4. **Las vacunas pueden evitar que falten a la escuela y al trabajo.** Las enfermedades pueden hacer que su hijo falte a la escuela o a la guardería y pueden provocar largas estancias en el hospital. Las vacunas ayudan a mantener a los niños sanos para que puedan ir a la escuela y que los padres no falten al trabajo.
5. **Las vacunas ayudan a detener la propagación de enfermedades.** Cuando todos usamos vacunas, podemos librarnos de enfermedades graves y proteger a las generaciones futuras.

Las vacunas protegen a sus hijos de enfermedades graves, ayudan a mantener a su comunidad saludable y son seguras. Si no sabe qué vacunas necesita su hijo, hable con su doctor, ¡él puede ayudarle!

La forma más segura de proteger contra el sarampión es recibir la vacuna MMR (sarampión, paperas y rubéola). Para protegerse también contra la varicela, los niños pueden recibir la vacuna MMRV (sarampión, paperas, rubéola y varicela). Las vacunas proporcionan una inmunidad más fuerte que la de contagiarse de las enfermedades. La mayoría de las personas que reciben la MMR o la MMRV quedarán protegidas de por vida.

¡Enviamos mensajes de texto a los miembros!
La Alianza envía mensajes de texto a los miembros para ayudarles a mantenerse al día sobre los beneficios y servicios de la Alianza. Los textos de la Alianza son del código corto **59849**. Para obtener más información, visite nuestro sitio web en **www.thealliance.health/es/member-texting**.

En todas las etapas de la vida.
Para cualquier condición médica.

De confianza; cuidado de salud de Medi-Cal sin costo ofrecido por un equipo local que le entiende.

The Alliance: su aliado en ser su versión más saludable.

LA VIDA SALUDABLE se publica para los miembros y socios comunitarios de CENTRAL CALIFORNIA ALLIANCE FOR HEALTH, 1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066, teléfono 831-430-5500 ó 800-700-3874, ext. 5508, sitio web www.thealliance.health/es.

La información de LA VIDA SALUDABLE proviene de una gran variedad de expertos médicos. Si tiene alguna inquietud o pregunta sobre el contenido específico que pueda afectar su salud, sírvase comunicarse con su proveedor de cuidado médico.

Se pueden usar modelos en fotos e ilustraciones.

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www.thealliance.health/es