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

Meeting Agenda

Date: Wednesday, October 25, 2023

Time: Call to Order: 10:30 a.m.
Adjourn: 2:00 p.m.

Location: Seacliff Inn
Seacliff Room
7500 Old Dominion Court
Aptos, CA 95003

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, October 23, 2023 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, 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 Mr. Michael Schrader, Chief Executive Officer (CEO). 10:30 a.m.**

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.
C. Welcome and introductory comments by Commissioners.

2. **Election of Officers of the Commission. (10:45 – 10:55 a.m.)**

A. Board will nominate and elect Chairperson and Vice Chairperson.

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

Page 2-01

3. **Oral Communications.**

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.

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

A. Board members may provide comments and announcements.

5. **Board Activity: Vision and Values. (11:00 a.m. – 12:00 p.m.)**

A. Ms. Claire Laughlin, Claire Laughlin Consulting, will facilitate Vision and Values activity and Board will discuss themes and shared values to the larger group.

- Reference materials: Ms. Claire Laughlin biography.

Page 5-01

Consent Agenda Items: (6. – 9H.): 12:00 p.m.

6. **Accept Executive Summary from the Chief Executive Officer (CEO).**

- Reference materials: Executive Summary from the CEO.

Pages 6-01 to 6-09

7. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the eighth month ending August 31, 2023.**

- Reference materials: Financial Statements as above.

Pages 7-01 to 7-09

Minutes: (8A. – 8C.)

8A. **Approve Commission meeting minutes of September 27, 2023.**

- Reference materials: Minutes as above.

Pages 8A-01 to 8A-07

8B. **Accept Finance Committee meeting minutes of August 23, 2023.**

- Reference materials: Minutes as above.

Pages 8B-01 to 8B-04

8C. **Accept Quality Improvement Health Equity Committee meeting minutes of June 29, 2023.**

- Reference materials: Minutes as above.

Pages 8C-01 to 8C-05

Reports: (9A. – 9H.)

9A. Approve an unbudgeted expense not to exceed $250,000 for continuation of live member outreach related to the resumption of the full Medi-Cal eligibility redetermination process.

- Reference materials: Staff report and recommendation on above topic.
  Pages 9A-01 to 9A-02

9B. Approve recommendation to update Local Agency Investment Fund (LAIF) Authorization Resolution from Santa Cruz – Monterey – Merced Managed Medical Care Commission to Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission.

- Reference materials: Staff report and recommendation on above topic; and Resolution of Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission.
  Pages 9B-01 to 9B-02

9C. Authorize the Chairperson to sign Amendment 58 to Medi-Cal Contract 08-85216 to incorporate updated Capitation Payment rates for CY 2022.

- Reference materials: Staff report and recommendation on above topic.
  Page 9C-01

9D. Accept Medi-Cal Capacity Grant Program (MCGP) Performance Dashboard – October 2015 through September 2023.

- Reference materials: MCGP Performance Dashboard.
  Pages 9D-01 to 9D-09

9E. Approve Medi-Cal Capacity Grant Award Recommendations. (Group A)

A. Action on grants with no Board member affiliation.

- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; Recommendation Summaries by Organization; and Medi-Cal Capacity Grant Program Current Funding Opportunities.
  Pages 9E-01 to 9E-47

9F. Approve Medi-Cal Capacity Grant Award Recommendations. (Group B)

A. Action on grants with Board member affiliation.

- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; and Recommendation Summaries by Organization.
  Pages 9F-01 to 9F-29

9G. Approve Medi-Cal Capacity Grant Program Funding Recommendations.

- Reference materials: Staff report and recommendation on above topic.
  Pages 9G-01 to 9G-04

9H. Approve Medi-Cal Capacity Grant Program Funding Recommendation: Workforce Support for Care Gaps Closure.

- Reference materials: Staff report and recommendation on above topic.
  Pages 9H-01 to 9H-02

Lunch: 12:10 – 12:25 p.m.

<u>Regular Agenda Items</u>: (10. – 12.): 12:25 p.m.

10. Consider approving draft Bylaws of the Commission. (12:25 – 12:40 p.m.)

A. Mr. Michael Schrader, CEO, will review and Board will consider approving draft Bylaws of the Commission for submittal to Santa Cruz, Monterey, Merced, San Benito and Mariposa County Board of Supervisors for approval.

- Reference materials: Staff report and recommendation on above topic; and Draft Bylaws of the Commission.

Pages 10-01 to 10-28

11. Consider approving creation of Board Committees and Advisory Groups and appoint members, Board meeting schedule, and Board delegation and policies. (12:40 – 1:00 p.m.)

A. Mr. Michael Schrader, CEO, will review and Board will consider approving creation of Board Finance Committee, Physician and Member Services Advisory Groups, Whole Child Model Advisory Committees and appoint members to each.

B. Mr. Schrader will review and Board will consider approving schedule of Board meetings, Committees and Advisory Groups.

C. Ms. Jenifer Mandella, Chief Compliance Officer, will review and Board will consider approving delegation of Board authority and policies.

- Reference materials: Staff report and recommendation on above topic; Committee and Advisory Group Meeting Charters; Alliance Policies; Alliance Code of Conduct and Alliance Compliance Plan.

Pages 11-01 to 11-155

12. Board Discussion and Education: Conflicts of Interest. (1:00 – 2:00 p.m.)

A. Mr. Peter Roan and Mr. Agustin D. Orozco, Crowell & Moring LLP, will provide Board with information and facilitate discussion on the application of conflicts of interest rules governing Board members of a public health plan.

- Reference materials: Mr. Peter Roan and Mr. Agustin D. Orozco biography.

Pages 12-01 to 12-12

Announcements:

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

- Member Services Advisory Group
  Thursday, November 9, 2023; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, December 7, 2023; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [R*emote teleconference*]
  Thursday, December 13, 2023; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [*Remote teleconference*]
  Monday, November 6, 2023; 1:30 – 3:00 p.m.

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

Members of the public interested in attending should call the Alliance at (831) 430-5500 to verify meeting dates and locations prior to the meetings.

The next regular meeting of the Commission, after October 25, 2023 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced-San Benito-Mariposa Managed Medical Care Commission
  Wednesday, December 6, 2023; 3:00 – 5:00 p.m. (*pending Commission approval*)

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

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

Members of the public interested in attending the Board meeting should call the Alliance at (831) 430-5523 to verify meeting dates and locations prior to the meetings. Audio livestreaming will be available to listen/view the meeting. Note: Livestreaming for the public is listening/viewing only.

The complete agenda packet is available for review on the Alliance website at www.ccah-alliance.org/boardmeeting.html. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-5523. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.

DATE: October 25, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Election of Officers of the Commission

Recommendation. Staff recommend the Board nominate one member of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Commission) to serve as Chairperson and one member to serve as Vice Chairperson.

Background. The Commission must elect a Chairperson and Vice Chairperson, pursuant to section 3.2 of the bylaws.

Discussion. The Commission shall elect officers for one-year terms, at the first meeting in October of each year. Officers shall serve a term which begins on the day of the election and ends at the first meeting in October of the following calendar year.

Commissioners may be nominated by other Commissioners or may nominate themselves for offices.

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

Attachments. N/A

About Claire Laughlin

Claire Laughlin, MA, is a dynamic and engaging consultant who uses experiential and innovative methods to help teams and organizations achieve real results.

A highly regarded training expert, Claire has dedicated her career to studying and improving patterns of communication in organizations. She works across various industries, coaching executive teams and leaders as they strive for greater clarity and consistency, and creating large-scale, global-reaching training programs designed to uplift and support excellence across functions and cultural divides.

Claire brings over 25 years of diverse experience to her role, having worked with hundreds of organizations—public, private, and non-profit—and thousands of participants through in-person consulting and training as well as the professional development courses she offers online. Claire identifies challenges within organizations, and then guides teams toward results using training and coaching solutions for all levels of professional development. With every client, she seeks to build individual leadership potential, teach positive communication habits, and enhance trust among and between team members.

Claire's specialties include leadership development and executive offsites, team leadership skills, managerial coaching programs, self-management skills that lead to higher personal effectiveness, The Working Genius®, and teaching trainers to use her unique method of training design called, BeAnAmazingTrainer®. Claire is also certified facilitator of The Leadership Challenge®, a Master Facilitator for The Working Genius®, and a certified trainer for various other organizations including DDI, Korn-Ferry, and Covey Speed of Trust.

Claire's premiere LIVE and LIVE online training programs include:

- ***EVOLVE:*** The Leadership Transformation Program: https://www.clairelaughlin.com/evolve
- ***Coaching for Excellence:*** Become a Coaching Manager: https://www.clairelaughlin.com/coaching-for-excellence
- **Building a High Trust Workplace:** https://www.clairelaughlin.com/high-trust-workplace

For insights about leadership and personal effectiveness, read Claire's blog here: https://www.clairelaughlin.com/blog

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I'd love to hear from you!

Claire Laughlin, Consultant
831-239-8483
claire@clairelaughlin.com

DATE: October 25, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

Implementation of the new five-county Commission. Staff looks forward to the October 25, 2023 convening of the new five-county Board: The Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission. As set forth in County Ordinances, this first meeting of the new Commission will effectively terminate the existing tri-county Commission and the new Commission will assume all of the rights, duties, privileges, and immunities vested in the tri-county Commission. To that end, the October agenda will include a number of necessary administrative actions to ensure that the Board and staff are enabled to conduct the business of the Alliance.

County Expansion Updates. Progress continues in preparation for the January 1, 2024, "go-live" in San Benito and Mariposa counties. Provider and Member Services and Community Engagement teams continue activities in the communities including meetings with providers, community organizations, and county staff. Alliance staff have ongoing meetings scheduled with the outgoing Medi-Cal plans towards ensuring a seamless transition of services and transfer of data. Staff have secured office locations in each county's Social Services Department and have secured locations for Board meetings and other public meetings. Staff have been meeting with the Department of Health Care Services (DHCS) staff from the Capitated Rate Development, Managed Care Operations, and Managed Care Quality and Monitoring Divisions to discuss issues related to revenue rates, operational readiness and transition monitoring. Staff anticipates receipt of revenue rates and final contract language in October and November and will bring the rates and contract to the Board's December meeting for final approval.

Redetermination Update. A report on the effect of redetermination on Alliance enrollment is included in the Operations section of the Executive Summary. The October eligibility files indicate a total of 4,919 members disenrolled in September which includes 1,014 individuals disenrolled in Santa Cruz County, 2,033 in Monterey County and 1,872 in Merced County. Staff will continue to monitor and provide the board reports of enrollment numbers and the impact of redetermination.

Community Involvement. On October 2, 2023 I attended the virtual Association for Community Affiliated Plans Board of Director's meeting. I attended the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting and was a guest speaker at the Elderday Grand Opening on October 12, 2023. I attended the virtual HIPSCC Executive Committee meeting on October 19, 2023 and on October 23, 2023 I attended the Local Health Plans of California October Board meeting in Palm Desert. On October 25, 2023 I plan to attend the MoRE Health Quarterly Convening.

Health Services

The Health Services team has been busy preparing for county expansion, improving quality metrics, and improving ongoing operations. The Quality Team hosted the Merced Health Fair while also working on closing clinic-based incentive quality gaps in Merced. Utilization Management has continued its transitions of care work and successfully started moving patients from inpatient to residential care facilities for the elderly), which includes board and care as well as assisted living while also working on the JIVA replacement platform. Pharmacy continues its work on academic detailing around diabetes while also focusing on drug utilization review. This quarter the focus was on sedative/hypnotics. Community Care Coordination continues to focus on Enhanced Care Management, as well as county expansion. Behavioral Health continues to focus on Carelon improvement and accountability while increasing Behavioral Health literacy at the Alliance. Program Development continues to work on a number of DHCS initiatives, including a focus on the Equity and Practice Transformation Grants that has an application deadline of October 23, 2023.

Quality Improvement and Population Health (QIPH)

Merced Health Fair. QIPH partnered with Merced County Public Health and Golden Valley Health Centers to host a health fair and flu vaccine clinic in Merced on October 8, 2023. The health fair was a resounding success with about 500 community attendees, over 230 flu shots were administered, and 225 food boxes were distributed despite 90+ degree heat. The success of this event sets a good framework for future health fairs and vaccine and/or other care gap clinics.

Utilization Management

Inpatient and Emergency Department (ED). The Alliance continues to build upon Transitional Care Services (TCS), increasing interdisciplinary team meetings with internal and external stakeholders across the counties. Added focus has been on complex, long length of stay members, leveraging alternate discharge strategies such as Residential Care for the Elderly and Board and Care facilities to further support this population group in the most appropriate setting. Additional layering of transitional care member-specific interventions has likely supported reductions in average length of stay, with this metric down from 4.6 in Q2 to 4.1 in Q3.

Total 30-day readmission rates across the three counties also reflected a significant reduction with Q2 finalizing at 9%, down from 12% noted in Q1. This trend of reduced 30-day readmission rates continues into Q3 with sustained reductions in Santa Cruz and Monterey counties.

Long term care (LTC) admissions remain stable across the three counties, with slight decreases in Q3 and an overall reduced number of new LTC utilizers per month. Santa Cruz and Monterey remain with similar member counts, with Monterey having a larger population of members accessing LTC benefits. Overall, Emergency Department utilization has decreased over the peak seen in Q2, with avoidable Emergency Department continuing to trend down, dropping almost two points in Q3 (n=12.01 vs 13.77). Ongoing transitions of care interventions are likely impacting these metrics favorably, with robust efforts to connect members to outpatient services.

Prior Authorization. Jiva/ZeOmega work continues with the Essette system platform replacement on track for March 2024. Current work in the Jiva platform includes comprehensive mapping of current versus future states with assessment of areas where authorization efficiencies and

communications can be improved across modules. Optimization for both authorization and other key health services functions continue under full exploration as the new workflows are developed. Recent authorization framework enhancements have included automation of in network specialty referrals, with planning underway to fully remove these authorization requirements within the next few months.

County expansion work continues, with integrated cross-departmental Continuity of Care (CoC) workflows finalized to support new CoC requirements and prevent gaps in care for incoming San Benito and Mariposa members. System configurations and report development continues in preparation for comprehensive data sets expected in November and prior to the January County expansions. Plans are in place to engage in direct member CoC contact once November data is received.

Pharmacy

Drug Utilization Review (DUR) Program

Fraud, Waste and Abuse (FWA) – Sedative/Hypnotics. FWA is part of annual Managed Care Organization DUR report that requires the plan to review claims for potential FWA of controlled substances from prescribers, pharmacy providers and members. Sedatives and hypnotic drugs manifest a high abuse potential. Therefore, the pharmacy department reviewed over 100 member profiles for potential FWA. Prescribing patterns, early fills, multiple provider visits and multiple pharmacies fills by the members were all analyzed for those members and no concerns were found. A Provider Bulletin on 'Managing Insomnia' will be published soon to educate providers on a recent update on managing insomnia in primary care setting.

Pharmacist-Led Academic Detailing (PLAD). The PLAD diabetes program was developed to support Alliance primary care clinicians and improve the quality of care provided to patients with diabetes type 2. Between August 16 and September 29, 2023, we conducted 25 sessions to a total of eight providers (primary care physicians, nurse practitioners and physician assistants). The sessions are held in small groups of up to four clinicians and are tailored to each clinician's specific needs and interests, making it a personalized and effective approach. Each session covers a different aspect of diabetes medication management and involves interactive discussions, case studies and useful tools for implementing best practices in the clinical setting. Pre and post-training assessments at each session have shown a significant improvement in participants' knowledge and confidence in managing diabetes. Nineteen more sessions are planned to take place from now through the end of November which will complete a total of 10 sessions per provider. To evaluate patient impact, baseline A1C data was collected prior to program start for each clinic. Patients whose A1C was nine or above at the start of program will be reassessed six months after PLAD sessions completion to evaluate for positive outcomes. Knowledge gain will be assessed via a post-test at the program completion to evaluate for positive impact.

Community Care Coordination

Enhanced Care Management (ECM)/Community Supports (CS). The Alliance continues work towards expanding the ECM and CS provider network capacity in our service area. The focus has been on engaging hospital and medical providers, County partners, as well as local Community Based Organizations that have experience serving the existing populations of focus and

community supports services. Additional providers have been added to the network of ECM providers to support expansion of services. The Alliance is collaborating with Medi-Cal managed care plan (MCP) in San Benito and Mariposa to establish transition of services for ECM and CS services for county expansion.

In addition, there has been emphasis on identification and engagement of new providers who have experience serving the two new populations of focus that will go-live in January: individuals transitioning from incarceration and those providers that serve the birth equity population of focus. Ongoing meetings are occurring with the justice involved County departments, as well as those medical and behavioral providers that serve members in the incarcerated settings. These meetings are focused on collaboration and determining how to support members in the post-release setting as well as formulating support for the pre-release component that will help members have a congruent transition from incarceration into the community.

Complex Care Management

We are advancing efforts of the CalAIM Population Health Management Program project work. Through this phase of the project, we have been auditing and reviewing what is working well and what improvements we can make. We continue to work to strengthen the delivery of Complex Care Management services in alignment with National Committee for Quality Assurance standards. We have been collaborating with the Utilization Management (UM) team on TCS.

As the Alliance works toward county expansion in January 2024, the adult Care Management team has been preparing how to serve our new members while meeting regulatory requirements with special focus on our Seniors and Persons with Disabilities members. We also continue to work with the UM team toward a streamline process for our Continuity of Care (CoC) to meet the needs of all our new members.

Whole Child Model/Pediatric Complex Care Management. The Pediatric Complex Case Management team continues work with the Essette system platform replacement (Jiva/ZeOmega), with a go-live planned for March 2024. Work in the Jiva platform is in full swing across all teams with the current discovery, and gap analysis phase. Optimization for both California Children's Services (CCS) and case management and other key health services functions is under full exploration as the new platform is developed to best align with National Committee for Quality Assurance standards as well as other requirements.

The Alliance is preparing for the implementation of the two new counties that will be added to the service area with the County Expansion in January 2024. Unlike the existing Whole Child Model (WCM) counties, the new counties will be continuing the provision of the classic dependent county CCS service model, in alignment with County CCS programs, as well as DHCS. Meetings are ongoing for this implementation with both County CCS teams, as well as the Regional Centers. Though this is the short term plan, we are concurrently working towards the transition of the two new counties into WCM come January 2025. The counties and both DHCS are eager to begin the planning for the implementation of WCM in 2025.

Behavioral Health

Throughout September the Behavioral Health (BH) Department has maintained ongoing efforts to support Carelon in improving member care and policy communication. This includes oversight of trackers for legislation, all plan letter compliance and provider issues, as well as provision of regular feedback on routine operations verbally in weekly leadership meetings and in writing daily via email. We have also continued to serve as a communication bridge for providers requiring support such as rate adjustments. One area of concern previously cited with Carelon is significant leadership turnover which necessitates additional administrative work for the Alliance as well as causes setbacks in relationship-building. The issue arose again this month with the departure of Carelon's Director of Behavioral Health Services, who notified the BH Director of her departure at 3:57 p.m. of her last day via email, providing no opportunity to discuss a transition plan or maintenance of ongoing work.

Carelon delivered their annual quality report to Alliance staff this month, where concerns similar to those found in the prior month's Joint Operating Committee (JOC) meeting were noted by staff, such as unclear and inaccurate data. Alliance managers and directors across departments met to discuss the issues and compile written feedback for Carelon about data presentations with emphasis on the JOC. This feedback was delivered to Carelon in the hopes of guiding improvements to future data sharing and summary discussions. Further, the BH Director supported a lengthy leadership conversation with the executive team about strategizing for operational readiness for an improved BH future state.

As part of efforts to improve overall literacy about BH across the Alliance, the BH Director launched a series of learning sessions on various applicable topics. The inaugural sessions took place on the September 25 and 29, 2023 covering BH 101. The sessions were voluntary for staff and very well attended, with nearly 300 staff attending one of the two duplicative presentations. These presentations will continue to occur monthly for at least the next seven months.

To engage in deeper community relationships and advance understanding of community needs, the BH team conducted a second health equity tour in Merced. While there, the team met in person with county behavioral health leadership, which was productive both for business needs and building trust. The BH team also met virtually for the first time with county behavioral staff in the expansion counties in September to establish rapport.

Program Development

CalAIM Incentive Payment Program (IPP). Staff continues to execute letters of authorization for the newly contracted ECM/CS providers serving Populations of Focus (PoF) that went live July 1 and for the new PoF that will go live January 2024. Additionally, staff continue to have discussions with Anthem Blue Cross (exiting Medi-Cal plan in Mariposa and San Benito Counties) and California Health and Wellness (exiting Medi-Cal plan in Mariposa County) to prepare and submit Needs Assessments and Gap Filling Plans to DHCS and assume responsibility for IPP in Mariposa and San Benito Counties beginning in 2024.

Housing and Homelessness Incentive Program (HHIP). The final HHIP Submission 2 measure period ends on October 31, 2023, with the final submission due from MCPs to DHCS on December 29, 2023. Staff are working with each county's Continuum of Care to identify priorities in built

infrastructure needs to fill gaps in the housing continuum, utilizing HHIP funds. Staff have also been working with DHCS to identify data metrics by which MCPs can earn back funds withheld from Submission 1. These metrics will be due for submission by December 29, 2023, concurrently with Submission 2.

Student Behavioral Health Incentive Program (SBHIP). The Alliance received full funding for Submission 1; $1.4 million across the three service areas. This represents acceptance of all 11 Targeted Intervention Progress reports across all five school districts, impacting approximately 46,000 total K-12 students in Merced, Monterey, and Santa Cruz Counties. In addition, Transition Acknowledgement documents for Phase 1 and Phase 2 have been submitted to DHCS for San Benito and Mariposa Counties by the exiting plans. Meetings with San Benito and Mariposa SBHIP partners and the Alliance have started being held to facilitate a smooth transition.

Equity and Practice Transformation. The goal of this program is practice transformation to address health equity, population health, and movement towards value-based care. The program specifically targets primary care practices that provide primary care pediatrics, family medicine, internal medicine, primary care OB/GYN services, or behavioral health services that are integrated in a primary care setting who serve Medi-Cal members. Primary care practices must apply through the web-based application by October 23, 2023 at 11:59 p.m. Providers can only apply through one managed care plan, even if contracted with multiple. Staff continue to outreach to practices/providers that are eligible for the program and to host weekly information sessions on Wednesdays**,** at noon and at 5:15 p.m., to help complete the pre-application survey and the application. More information about the program, and how to apply, is available here: https://www.dhcs.ca.gov/qphm/pages/eptprogram.aspx

Employee Services and Communications

Human Resources

Alliance Workforce. As of September 11, 2023, the Alliance has 573.4 budgeted positions of which our active workforce number is 540 (active FTE and temporary workers). There are 48 regular and temporary positions in active recruitment, and we are 94.6% staffed. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets. Human Resources (HR) partners with Finance to ensure alignment in this area and provides a bi-weekly workforce dashboard to all Directors and Chiefs for transparency regarding our workforce statistics.

Competencies and Career Development. HR provided an update at the May Operations Committee meeting, announcing the new core, leadership, and director level competencies. HR is actively working with each department to validate competencies by classification and populating the new platform. Work is nearing completion, and both Talent Acquisition and Training and Development have commenced work on the navigation and career development module, with education and training sessions scheduled to start in Q4. This will include leadership training at the November 14, 2023, Leadership Forum, followed by training for all employees.

Annual FTE Request Process. HR facilitates the annual FTE Request Process as required for inclusion in the Alliance's budget cycle. This work provides a process and methodology for request, review and approval of new staff for the next fiscal/calendar year. This process is complete and HR will share with the leadership team upon budget approval.

Workforce Strategy Updates. HR has commenced work as we update policies and process documents related to our workforce strategy. As we adapt to the post-pandemic work environment, policies and procedures have been communicated to staff as it relates to our new work environment and HR is actively working on implementation and updates for a January 1, 2024 effective date.

Open Enrollment. HR is actively engaged in the open enrollment process, working closing with our benefits broker to review and evaluate current plan benefits. This includes working with the broker to ensure staff concerns are discussed, evaluating current market trends, ensuring our broker is working with other carriers for competitive pricing and benefits plan. Our goal is to provide a competitive benefits package that is robust and cost-efficient. Open Enrollment will commence in November 2023.

Facilities and Administrative Services

Service Area Expansion. Facilities is actively working with the County of Mariposa and San Benito to coordinate sub-leasing space with a targeted occupancy of November 1, 2023, in both service areas. Lease agreements have been executed.

Alliance Footprint Reduction. The Facilities Department has cleared out employee workstations/offices in the areas targeted for footprint reduction. The team is proceeding with an 80,000 square foot reduction of Alliance occupied square footage and an increase of potential space for leasing which was included in the Annual Facilities Management report. Several tenants are currently interested in the available space in Salinas and Merced.

Communications

Texting Program. We have submitted a formal project to stand up a permanent texting program at the Alliance. We have secured proposal quotes from the vendor and if approved through the project prioritization process, we will look to establish a cross-departmental committee to launch a program in 2024.

Flu Campaign. We launched our annual fall flu campaign in September, which will run through the fall season encouraging members to receive their flu vaccine. "You don't have time for the flu" is the theme and communication tactics include flyers, social media, website, mobile ads and outreach to providers and community organizations.

County Expansion. Staff is working throughout Q4 to update all corporate templates and materials with county expansion information. In addition, we will launch a targeted media campaign November 1, 2023 to reach potential members with messaging "We are the Alliance, your new Medi-Cal provider." Messaging also stresses that we are local, experienced and trusted. Communication tactics include website content, flyers, and newsletter articles for providers, members and community partners. Ads vary by county but include a combination of social media, closed circuit TV, streaming radio, YouTube, mobile, grocery carts, grocery store stuffers, transit shelters, and newspapers. We will also be distributing a press release on November 1, 2023 and will reach out to local media to coordinate an OpEd for Michael Schrader, Chief Executive Officer.

Operations

County Expansion. The Alliance is on track for the expansion into San Benito and Mariposa counties in January 2024. Key providers like San Benito Health Foundation, Hazel Hawkins, John C Fremont, Camarena Health, and the MACT Board, our first Indian Health Services provider, have either signed contracts or have contracts out for signatures. 800 mass amendments with new county information have gone out to our current network. Our Credentialing team is receiving provider rosters and credentialing packets that are going through the Peer Review Credentialing Committee (PRCC) process. Provider Relations Representatives continue to be our "boots on the ground" in both counties, meeting with providers, county staff, and community organizations. Provider Portal trainings and workshops have been scheduled.

Given the rural nature of the two counties, the Alliance has been focused on expanding Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) providers. Alliance staff have partnered with existing NMT and NEMT providers to understand what they would need to expand into new counties. These partnerships will continue to blossom as the Alliance Board recently approved grant funding to sustain and grow the Alliance NEMT and NMT network. The Alliance has several NEMT providers in Monterey and Merced counties interested in expanding into San Benito and Mariposa, respectively.

New, shared office spaces have been secured in Mariposa and San Benito counties, enabling the Alliance to be in the communities we serve. Community Engagement staff continues to engage in relationship building with expansion county providers and community-based organizations. An Alliance "Meet & Greet" is scheduled for Saturday, November 4, 2023 at the San Benito Foodbank in Hollister and another one is being planned for Mariposa for mid-November. Your Health Matters will be on hand at several events throughout October and November, including the Mariposa Farmers Market, the Harvest Festival, and the Hollister Farmers Market. These in-person events will allow community members in our new service areas to come learn about the Alliance and how we support Medi-Cal members.

Redetermination. We are in our fourth month of the Public Health Emergency unwinding and redetermination processes and systems issues in the counties and DHCS has somewhat stabilized. As part of this, the Alliance is seeing roughly 5,000 members being disenrolled per month across our service areas to date. Our communication and outreach strategy remains the same.

Access and Network Development. The Alliance ensures members' access to quality care by providing a robust network. As such, we strive to close access gaps identified from various inputs including our time and distance analysis and member voice. St. Michael's Nephrology in San Luis Obispo is now contracted with an effective date of September 1, 2023, successfully closing the nephrology gap in Southern Monterey County. Provider Relations continues recruitment outreach to close the specialty gaps of hematology and oncology in Southern Monterey County. Provider Services is also working closely with Carelon to address the remaining Psychiatry gap.

Additionally, the team has spent the last quarter reaching out to primary care provider (PCP) offices in Monterey County reminding them of Alliance contracted urgent visit options if the PCP offices are unable to provide timely appointments for urgent care.

Operational Efficiency. The Alliance continues to focus on operational efficiency opportunities to streamline our processes. An area of continuous improvement is our claims processing where our current claims auto adjudication rate is 77.88% and is the fourth highest auto adjudication rate since January 2020. Our goal is to reach an auto adjudication rate of 80% by year end, thus increasing the turnaround time of provider payments.

DATE: October 25, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Eighth Month Ending August 31, 2023

For the month ending August 31, 2023, the Alliance reported an Operating Income of $4.0M. The Year-to-Date (YTD) Operating Income is $79.7M, with a Medical Loss Ratio (MLR) of 87.8% and an Administrative Loss Ratio (ALR) of 5.3%. The Net Income is $94.3M after accounting for Non-Operating Income/Expenses.

The budget expected a $64.2M Operating Income for YTD August. The actual result is favorable to budget by $15.5M or 24.2%, driven primarily by rate variance and membership favorability.

	Aug-23 ($ In 000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*424,399*	*401,191*	*23,208*	*5.8%*
Revenue	136,381	127,083	9,298	7.3%
Medical Expenses	124,375	115,482	(8,894)	-7.7%
Administrative Expenses	8,046	8,424	378	4.5%
Operating Income	3,959	3,177	782	24.6%
Net Income	6,375	5,170	1,205	23.3%
MLR %	*91.2%*	*90.9%*	*-0.3%*	
ALR %	*5.9%*	*6.6%*	*0.7%*	
Operating Income %	*2.9%*	*2.5%*	*0.4%*	
Net Income %	*4.7%*	*4.1%*	*0.6%*	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

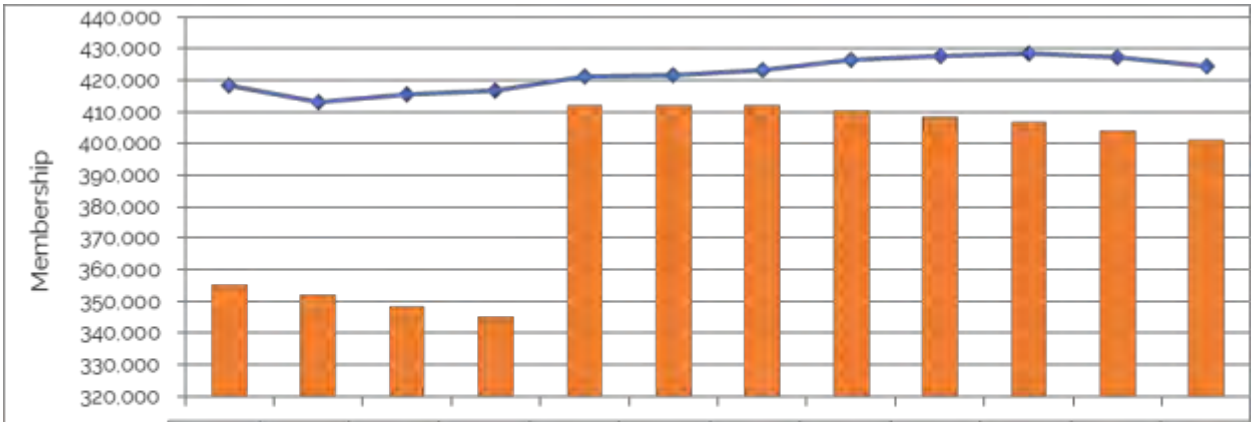
Aug-23 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*3,399,798*	*3,267,239*	*132,559*	*4.1%*
Revenue	1,144,976	1,037,504	107,472	10.4%
Medical Expenses	1,005,078	909,314	(95,764)	-10.5%
Administrative Expenses	60,200	64,014	3,815	6.0%
Operating Income/(Loss)	79,699	64,176	15,523	24.2%
Net Income/(Loss)	94,274	55,563	38,710	69.7%
PMPM				
Revenue	336.78	317.55	19.23	6.1%
Medical Expenses	295.63	278.31	(17.32)	-6.2%
Administrative Expenses	17.71	19.59	1.89	9.6%
Operating Income/(Loss)	23.44	19.64	3.80	19.3%
MLR %	87.8%	*87.6%*	*-0.1%*	
ALR %	*5.3%*	*6.2%*	*0.9%*	
Operating Income %	*7.0%*	*6.2%*	*0.8%*	
Net Income %	*8.2%*	*5.4%*	*2.9%*	

Per Member Per Month. Capitation revenue and medical expenses are variables based on enrollment fluctuations; therefore, the per member per month (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, YTD revenue is $336.78, which is favorable to budget by $19.23 or 6.1%. Medical cost PMPM is $295.63, which is unfavorable by $17.32 or 6.2%. Overall, this results in a favorable gross margin of $1.91 or 4.9% compared to budget. The resulting operating income PMPM is $23.44, which is favorable by $3.80 or 19.3% compared to the budget which is comprised of $1.91 gross margin and $1.89 favorable admin spend.

Membership. August 2023 membership is favorable to budget by 5.8%. Please note that the 2023 budget assumed the Public Health Emergency (PHE) would end in January 2023, with membership beginning to decline in April 2023. The Health and Human Services Department announced that the PHE ended on May 11, 2023. The Department of Health Care Services (DHCS) began the redetermination process in April 2023 for the June 2023 renewal month, with the actual enrollment loss beginning in July 2023.

Membership. Actual vs. Budget (based on actual enrollment trend for Aug-23 rolling 12 months)



	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
Budget	355,301	351,849	348,456	345,117	412,231	412,231	412,231	410,347	408,481	406,635	403,892	401,191
Actual	418,380	412,859	415,506	416,529	421,212	421,478	423,002	426,328	427,656	428,448	427,275	424,399
Variance	63,079	61,010	67,050	71,412	8,981	9,247	10,771	15,981	19,175	21,813	23,383	23,208
Variance %	17.8%	17.3%	19.2%	20.7%	2.2%	2.2%	2.6%	3.9%	4.7%	5.4%	5.8%	5.8%

Revenue. The 2023 revenue budget was based on the current (DHCS) 2022 draft rate package and included a 1.2% rate increase. Furthermore, the budget assumed breakeven for Enhanced Care Management and Community Supports, both were new programs in 2022. The prospective CY 2023 draft rates from DHCS (dated 12/8/2022, including Maternity) are favorable to the rates assumed in the CY 2023 budget by 0.7%.

August 2023 capitation revenue of $136.0M is favorable to budget by $9.3M or 7.3%, mainly attributed to higher enrollment of $7.3M and rate variances of $1.9M.

August 2023 YTD capitation revenue of $1,113.3M is favorable to budget by $78.5M or 7.6%. Of this amount, $37.9M is from boosted enrollment and $40.6M is due to rate variance. Rate variances include prior year revenue of $12.0M for the DHCS 2013-2016 MCO Tax Reconciliation and $2.2M for the July 2019-December 2020 Prop 56 adjustment.

August 2023 YTD State Incentive Programs of $28.7M consist of $6.2M for the Student Behavioral Health Incentive Program (SBHIP), $11.7M for the Housing and Homelessness Incentive Program (HHIP), and $10.9M for CalAim IPP. These are also included under Medical Expenses and assumed to be budget neutral.

Aug-23 YTD Capitation Revenue Summary (In $000s)

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	228,546	220,956	7,590	5,090	2,500
Monterey	477,767	443,969	33,798	19,292	14,506
Merced	406,975	369,825	37,149	13,561	23,589
Total*	**1,113,289**	**1,034,751**	**78,537**	**37,942**	**40,595**

*Excludes Aug-23 YTD In-Home Supportive Services (IHSS) premiums revenue of $3.0M and State Incentive Programs revenue of $28.7M.

Medical Expenses. The 2023 budget assumed a 5% increase in utilization from 2019 and a 3% unit cost increase that included case mix and changes in fee schedules. 2023 incentives include a $15M Care-Based Incentive, $10M for the Hospital Quality Incentive Program, and $5M for the Specialist Care Incentive.

August 2023 Medical Expenses of $124.4M are $8.9M or 7.7% unfavorable to budget. August 2023 YTD Medical Expenses of $1,005.1M are above budget by $95.8M or 10.5%. Of this amount, $30.2M is due to rate, and $36.9M is due to higher enrollment and $28.7 is due to State Incentive Programs. YTD Inpatient Services (Hospital) is unfavorable to budget by $32.5M or 9.5%. $13.8M is attributed to enrollment and $18.7M to increased spending primarily due to higher utilization. We are seeing similar increases in spending occurring in Physician Services and Other Medical. Other Medical includes Allied Health, Lab, Durable Medical Equipment, Behavioral Health, and Transportation.

The State Incentive Programs of $28.7M consist of $6.2M for the SBHIP, $11.7M for the HHIP, and $10.9M for CalAim IPP. These are also included under Revenue and assumed to be budget neutral.

Aug-23 YTD Medical Expense Summary ($ In 000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services - (Hospital)	372,535	340,079	(32,457)	(13,798)	(18,659)
Inpatient Services - (LTC)	113,959	121,801	7,842	(4,942)	12,784
Physician Services	212,025	190,106	(21,919)	(7,713)	(14,206)
Outpatient Facility	126,975	125,919	(1,056)	(5,109)	4,053
Other Medical*	150,877	131,409	(19,468)	(5,332)	(14,136)
State Incentives Programs	28,707	-	(28,707)	-	(28,707)
Total	**1,005,078**	**909,314**	**(95,764)**	**(36,893)**	**(58,871)**

*Other Medical Actual includes Allied Health, Non-Claims HC Cost, Transportation, Behavioral Health, and Lab.

At a PMPM level, YTD Medical Expenses are $295.63, unfavorable by $17.32 or 6.2% compared to the budget. Half of this unfavorable variance is due to budget neutral State Incentive Programs. The remaining variance is primarily due to unfavourability in Inpatient Services (Hospital), Physician Services and Other Medical. Unfavorable trends in Inpatient Services (Hospitals) are driven by higher utilization. Allied Health, Behavioral Health, Transportation, and Lab drive the Other Medical cost unfavourability of 10.3%.

Aug-23 YTD Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	109.58	104.09	(5.49)	-5.3%
Inpatient Services (LTC)	33.52	37.28	3.76	10.1%
Physician Services	62.36	58.19	(4.18)	-7.2%
Outpatient Facility	37.35	38.54	1.19	3.1%
Other Medical	44.38	40.22	(4.16)	-10.3%
State Incentive Programs	8.44	-	(8.44)	-100.0%
Total	**295.63**	**278.31**	**(17.32)**	**-6.2%**

Administrative Expenses. August YTD Administrative Expenses are favorable to budget by $3.8M or 6.0% with a 5.3% ALR. Salaries are slightly favorable by $1.4M driven by savings from vacant positions, benefits and PTO which offsets temporary services and the staff bonus accrual. Non-Salary Administrative Expenses are favorable by $2.4M or 12.1% due to savings and unspent budgets.

Non-Operating Revenue/Expenses. August YTD Net Non-Operating income is $23.2M favorable to the budget. Total Non-Operating Revenue is favorable to budget by $18.9M, attributed to $5.0M in unrealized gain on investments and $13.9M in interest income. Non-Operating Expenses are favorable by $4.3M due to the timing of grant expenses.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $94.3M, with an MLR of 87.8% and an ALR of 5.3%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Eighth Month Ending August 31, 2023
(In $000s)

Assets	
Cash	$37,286
Restricted Cash	300
Short Term Investments	749,489
Receivables	287,947
Prepaid Expenses	4,579
Other Current Assets	5,089
Total Current Assets	**$1,084,690**
Building, Land, Furniture & Equipment	
Capital Assets	$82,441
Accumulated Depreciation	(46,612)
CIP	369
Lease Receivable	2,539
Total Non-Current Assets	**38,737**
Total Assets	**$1,123,427**
Liabilities	
Accounts Payable	$26,385
IBNR/Claims Payable	299,581
Provider Incentives Payable	16,019
Other Current Liabilities	7,571
Due to State	10,433
Total Current Liabilities	**$359,989**
Deferred Inflow of Resources	$2,437
Total Long-Term Liabilities	**$2,437**
Fund Balance	
Fund Balance - Prior	$666,727
Retained Earnings - CY	94,274
Total Fund Balance	**761,001**
Total Liabilities & Fund Balance	**$1,123,427**
Additional Information	
Total Fund Balance	**$761,001**
Board Designated Reserves Target	412,575
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	171,905
Value Based Payments	46,100
Total Reserves	**687,280**
Total Operating Reserve	**$73,720**

* MCGP includes Additional Contribution of $48.6M

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Eighth Month Ending August 31, 2023
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*424,399*	*401,191*	*23,208*	*5.8%*	*3,399,798*	*3,267,239*	*132,559*	*4.1%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$136,000	$126,739	$9,261	7.3%	$1,113,289	$1,034,751	$78,537	7.6%
State Incentive Programs	-	-	$0	0.0%	28,707	-	$28,707	100.0%
Premiums Commercial	381	344	37	10.8%	2,981	2,753	228	8.3%
Total Operating Revenue	**$136,381**	**$127,083**	**$9,298**	**7.3%**	**$1,144,976**	**$1,037,504**	**$107,472**	**10.4%**
Medical Expenses								
Inpatient Services (Hospital)	$47,348	$43,189	($4,159)	-9.6%	$372,535	$340,079	($32,457)	-9.5%
Inpatient Services (LTC)	15,174	15,468	294	1.9%	113,959	121,801	7,842	6.4%
Physician Services	26,854	24,143	(2,711)	-11.2%	212,025	190,106	(21,919)	-11.5%
Outpatient Facility	18,040	15,991	(2,049)	-12.8%	126,975	125,919	(1,056)	-0.8%
Other Medical*	16,958	16,689	(269)	-1.6%	150,877	131,409	(19,468)	-14.8%
State Incentive Programs	-	-	-	0.0%	28,707	-	(28,707)	-100.0%
Total Medical Expenses	**$124,375**	**$115,482**	**($8,894)**	**-7.7%**	**$1,005,078**	**$909,314**	**($95,764)**	**-10.5%**
Gross Margin	**$12,006**	**$11,601**	**$405**	**3.5%**	**$139,899**	**$128,190**	**$11,708**	**9.1%**
Administrative Expenses								
Salaries	$5,199	$5,902	$703	11.9%	$42,822	$44,247	$1,424	3.2%
Professional Fees	526	391	(135)	-34.5%	1,695	2,294	599	26.1%
Purchased Services	1,237	853	(384)	-45.1%	7,246	7,169	(77)	-1.1%
Supplies & Other	641	870	229	26.3%	5,493	7,198	1,706	23.7%
Occupancy	186	123	(62)	-50.4%	875	881	6	0.7%
Depreciation/Amortization	259	286	27	9.6%	2,069	2,225	156	7.0%
Total Administrative Expenses	**$8,046**	**$8,424**	**$378**	**4.5%**	**$60,200**	**$64,014**	**$3,815**	**6.0%**
Operating Income	**$3,959**	**$3,177**	**$782**	**24.6%**	**$79,699**	**$64,176**	**$15,523**	**24.2%**
Non-Op Income/(Expense)								
Interest	$2,770	$1,025	$1,745	100.0%	$22,104	$8,198	$13,906	100.0%
Gain/(Loss) on Investments	98	2,312	(2,215)	-95.8%	(1,049)	(6,055)	5,006	82.7%
Other Revenues	150	156	(6)	-3.6%	1,238	1,241	(3)	-0.3%
Grants	(602)	(1,500)	897	59.8%	(7,719)	(11,997)	4,278	35.7%
Total Non-Op Income/(Expense)	**$2,415**	**$1,993**	**$422**	**21.2%**	**$14,574**	**($8,613)**	**$23,187**	**100.0%**
Net Income/(Loss)	**$6,375**	**$5,170**	**$1,205**	**23.3%**	**$94,274**	**$55,563**	**$38,710**	**69.7%**
MLR	*91.2%*	*90.9%*			*87.8%*	*87.6%*		
ALR	*5.9%*	*6.6%*			*5.3%*	*6.2%*		
Operating Income	*2.9%*	*2.5%*			*7.0%*	*6.2%*		
Net Income %	*4.7%*	*4.1%*			*8.2%*	*5.4%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Eighth Month Ending August 31, 2023
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*424,399*	*401,191*	*23,208*	*5.8%*	*3,399,798*	*3,267,239*	*132,559*	*4.1%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$320.45	$315.91	$4.55	1.4%	$327.46	$316.71	$10.75	3.4%
State Incentive Programs	-	-	-	0.0%	8.44	-	8.44	100.0%
Premiums Commercial	0.90	0.86	0.04	4.7%	0.88	0.84	0.03	4.1%
Total Operating Revenue	**$321.35**	**$316.76**	**$4.59**	**1.4%**	**$336.78**	**$317.55**	**$19.23**	**6.1%**
Medical Expenses								
Inpatient Services (Hospital)	$111.56	$107.65	($3.91)	-3.6%	$109.58	$104.09	($5.49)	-5.3%
Inpatient Services (LTC)	35.76	38.56	2.80	7.3%	33.52	37.28	3.76	10.1%
Physician Services	63.28	60.18	(3.10)	-5.1%	62.36	58.19	(4.18)	-7.2%
Outpatient Facility	42.51	39.86	(2.65)	-6.6%	37.35	38.54	1.19	3.1%
Other Medical*	39.96	41.60	1.64	3.9%	44.38	40.22	(4.16)	-10.3%
State Incentive Programs	-	-	-	0.0%	8.44	-	(8.44)	-100.0%
Total Medical Expenses	**$293.06**	**$287.85**	**($5.22)**	**-1.8%**	**$295.63**	**$278.31**	**($17.32)**	**-6.2%**
Gross Margin	**$28.29**	**$28.92**	**($0.63)**	**-2.2%**	**$41.15**	**$39.24**	**$1.91**	**4.9%**
Administrative Expenses								
Salaries	$12.25	$14.71	$2.46	16.7%	$12.60	$13.54	$0.95	7.0%
Professional Fees	1.24	0.97	(0.26)	-27.2%	0.50	0.70	0.20	29.0%
Purchased Services	2.91	2.13	(0.79)	-37.1%	2.13	2.19	0.06	2.9%
Supplies & Other	1.51	2.17	0.66	30.3%	1.62	2.20	0.59	26.7%
Occupancy	0.44	0.31	(0.13)	-42.1%	0.26	0.27	0.01	4.6%
Depreciation/Amortization	0.61	0.71	0.10	14.5%	0.61	0.68	0.07	10.6%
Total Administrative Expenses	**$18.96**	**$21.00**	**$2.04**	**9.7%**	**$17.71**	**$19.59**	**$1.89**	**9.6%**
Operating Income	**$9.33**	**$7.92**	**$1.41**	**17.8%**	**$23.44**	**$19.64**	**$3.80**	**19.3%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Eighth Month Ending August 31, 2023
(In $000s)

	MTD	YTD
Net Income	$6,375	$94,274
Items not requiring the use of cash: Depreciation	259	2,030
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	2	0
Receivables	(141,221)	(117,167)
Prepaid Expenses	(371)	(530)
Current Assets	(569)	8,326
Net Changes to Assets	**($142,161)**	**($109,371)**
Changes to Payables:		
Accounts Payable	1,064	(44,289)
Accrued Expenses	-	-
Other Current Liabilities	(1,423)	(137)
Incurred But Not Reported Claims/Claims Payable	(17,610)	17,212
Provider Incentives Payable	1,899	6,019
Due to State	311	5,387
Net Changes to Payables	**($15,759)**	**($15,808)**
Net Cash Provided by (Used in) Operating Activities	**($151,287)**	**($28,875)**
Change in Investments	(2,555)	(73,493)
Other Equipment Acquisitions	(299)	1,315
Net Cash Provided by (Used in) Investing Activities	**($2,854)**	**($72,178)**
Lease Interest Income	-	-
Net Cash Provided by (Used in) Financing Activities	**$0**	**$0**
Net Increase (Decrease) in Cash & Cash Equivalents	**($154,141)**	**($101,053)**
Cash & Cash Equivalents at Beginning of Period	**$191,424**	**$138,338**
Cash & Cash Equivalents at August 31, 2023	**$37,286**	**$37,286**

SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, September 27, 2023

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

Commissioners Present:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Dr. Maximiliano Cuevas	Provider Representative
Ms. Janna Espinoza	Public Representative
Dr. Charles Harris	Hospital Representative
Dr. Donaldo Hernandez	Provider Representative
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Ms. Mónica Morales	County Health Services Agency Director
Ms. Rebecca Nanyonjo	Director of Public Health
Ms. Julie Peterson	Hospital Representative
Dr. Allen Radner	Provider Representative

Commissioners Absent:

Ms. Leslie Abasta-Cummings	Provider Representative
Ms. Julie Edgcomb	Public Representative
Supervisor Zach Friend	County Board of Supervisors
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. James Rabago	Provider Representative
Dr. Joerg Schuller	Hospital Representative
Mr. Rob Smith	Public Representative

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Mr. Scott Fortner	Chief Administrative Officer
Dr. Dennis Hsieh	Chief Medical Officer
Ms. Jenifer Mandella	Chief Compliance Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
Ms. Jessica Finney	Grants Director
Ms. Kay Lor	Payment Strategy Director
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Jimenez.

Commission 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 acknowledge that today's meeting was the final meeting of this three county Commission. She recognized all commissioners who served on the three-county Board and particularly those who exited after this meeting based on the Board's restructuring to accommodate two new counties. In addition, she thanked them for their valued service and commitment to the Board and the community to ensure quality health care for our members towards our vision of Healthy People. Healthy Communities.

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.

No members of the public addressed the Commission.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

Commissioner Espinoza appreciated Board approval of the appointment of Ms. Paloma Barraza to the Whole Child Model Family Advisory Committee (WCMFAC) at the August meeting. She acknowledged that Ms. Barraza will be a good addition to the WCMFAC.

4. Comments and announcements by Chief Executive Officer.

Chair Jimenez opened the floor for Mr. Michael Schrader, Chief Executive Officer (CEO).

Mr. Schrader provided an update to the Board on redeterminations, county expansion and the convening of the new five-county Board.

The Department of Health Care Services (DHCS) projects that statewide 17% of Medi-Cal beneficiaries will be disenrolled over a 12-month period from July 2023 to June 2024. The disenrollment number for the Alliance equates to 6,000 members per month or 18,000 for the

first three months (July, August and September). In mid-September DHCS corrected an error in the CalSAWS eligibility system that resulted in another 4,600 Alliance members being shown as disenrolled. However, disenrollments may not be evenly spread across all 12 months since redeterminations are based on the months members were enrolled and many counties across the state have backlogs in processing renewals due to workforce and system issues. There is an organized outreach campaign to members. Participants include DHCS, counties, managed care plans, schools, providers, and community organizations. The Alliance has been sending text messages to all our members who were disenrolled for procedural reasons.

On September 1, 2023, DHCS informed us in writing that the Alliance has been approved to go live into San Benito and Mariposa counties on January 1, 2024. This approval is contingent on full completion of all Operational Readiness 2024 deliverables. More work remains to be done over the next few months, including receiving draft rates from DHCS, executing provider contracts and refurbishing office space. On October 1, 2023, DHCS plans to send 90-day notices to affected members in the two counties. There will also be 60 and 30-day notices sent.

All five counties have now made their appointments to the new five-county Alliance Board. On October 25, 2023, the five-county Board will convene for the first time at the Seacliff Inn in Aptos. The meeting will be in-person at a single location with representatives from all five counties in attendance. The agenda will be largely administrative, including the election of officers (Chair and Vice Chair), adoption of the Bylaws, approval of the annual meeting schedule, formation of and appointments to Board committees and advisory groups, delegation of Board authority, and conflict of interest training. A consultant plans to facilitate a session on Board member cohesion, shared vision and values, and our integrated region.

Consent Agenda Items: (5. – 9D.): 3:25 p.m.

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

Chair Jimenez reminded the Board that in order to manage any risk of conflict, staff have separated the approval action for the Voluntary Rate Range Program for rating period CY 2022 recommendation into two agenda items.

Items 5-8E and 9B-9D that are not affiliated with Board members, which all Board members may discuss and vote on; and Item 9A that is affiliated with Board members who may have a conflict. Item 9A should be voted on separately from items 5-8E and 9B-9D to facilitate two separate approval actions so that the Board may have separate votes and Board members with a conflict may abstain from discussion and voting on item 9A.

MOTION: Commissioner Bizzini moved to approve Consent Agenda items 5-8E and 9B-9D, seconded by Commissioner Askew.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Espinoza, Harris, Hernandez, Jimenez, Kalantari-Johnson, Molesky, Morales, Nanyonjo, Peterson and Radner.

Noes: None.

Absent: Commissioners Abasta-Cummings, Edgcomb, Friend, Pedrozo, Rabago, Schuller and Smith.

Abstain: None.

Commissioner Molesky moved to approve Consent Agenda item 9A, seconded by Commissioner Kalantari-Johnson.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Espinoza, Hernandez, Jimenez, Kalantari-Johnson, Molesky, and Peterson.

Noes: None.

Absent: Commissioner Abasta-Cummings, Edgcomb, Friend, Pedrozo, Rabago, Schuller and Smith.

Abstain: Commissioners Harris, Morales, Nanyonjo and Radner.

Regular Agenda Item: (10. - 11.): 3:27 p.m.

10. Consider approving: A) Medi-Cal Capacity Grant Program Governance: Revised Foundation Recommendation; B) Medi-Cal Capacity Grant Program Funding Recommendations; and C) Funding Recommendations for Transportation Capacity Expansion. (3:27 – 4:37 p.m.)

A) Medi-Cal Capacity Grant Program Governance: Revised Foundation Recommendation.

Ms. Jessica Finney, Grants Director, provided background on a previous planning effort to establish a 501(c)(3) non-profit foundation to administer the Alliance's grantmaking function, including information regarding an initial donation amount and other drivers that informed the recommendation to not establish a foundation and to continue Medi-Cal Capacity Grant Program operations within the health plan.

MOTION: Commissioner Cuevas moved to approve to continue operating the Medi-Cal Capacity Grant Program within the health plan and not move forward with establishing a 501(c)3 non-profit foundation as the structure for the Alliance's future grantmaking; and to direct staff to return in December 2023 with proposed governance policy changes to the Medi-Cal Capacity Grant Program and annual spending plan, seconded by Commissioner Conner.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Espinoza, Harris, Hernandez, Jimenez, Kalantari-Johnson, Molesky, Morales, Nanyonjo, Peterson and Radner.

Noes: None.

Absent: Commissioners Abasta-Cummings, Edgcomb, Friend, Pedrozo, Rabago, Schuller and Smith.

Abstain: None.

B) Medi-Cal Capacity Grant Program Funding Recommendations.

Chair Jimenez advised the Board that this item carried potential conflict of interest. Board members who perceived that they were at risk for conflict of interest were advised to abstain from discussion and voting on this item.

Ms. Finney provided background on current Medi-Cal Capacity Grant Program funding opportunities, outlined a forthcoming change to Community Supports Medically Tailored Meals/Medically Supportive Food services that impact the Food Access grant program and highlighted the critical need to support doula provider network development and outlined the recommendations related to grant funding in each of the three areas.

[Commissioner Peterson departed at this time: 4:14 p.m.]

Staff's recommendation included approval of changes and budget allocations for Medi-Cal Capacity Grant Program funding opportunities and to approve new funding opportunities to support network development for the Medi-Cal doula benefit. With a lack of quorum of Commissioners in attendance and eligible to vote due to conflict of interest, the changes and budget allocations for MCGP funding opportunities will be brought back to the Board at a future date for consideration.

MOTION: Commissioner Molesky moved to approve new funding opportunities to support network development for the Medi-Cal Doula Benefit, seconded by Commissioner Cuevas.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Cuevas, Espinoza, Harris, Jimenez, Kalantari-Johnson, Molesky, Morales, Nanyonjo and Radner.

Noes: None.

Absent: Commissioners Abasta-Cummings, Edgcomb, Friend, Pedrozo, Peterson, Rabago, Schuller and Smith.

Abstain: Commissioners Conner and Hernandez.

C) Funding Recommendations for Transportation Capacity Expansion.

Ms. Finney discussed the need to expand capacity for Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) in the Alliance's current three counties and two expansion counties, effective January 1, 2024, and reviewed how Medi-Cal Capacity Grant Program funds would be used to expand transportation capacity.

The Alliance provides NMT and NEMT services as Medi-Cal benefits. The current transportation network is challenged to meet member demand and the expansion counties have identified transportation as a top capacity need for member access to care. Next steps would include soliciting first round of grant applications in early October 2023 and the first round of application review and awards could be concluded by the end of November 2023. The NEMT would be removed from the Healthcare Technology Program criteria.

MOTION: Commissioner Molesky moved to approve $3M allocation from the Medi-Cal Capacity Grant Program unallocated budget for Transportation Infrastructure Program to expand Non-Medical Transportation and Non-Emergency Transportation services in the Alliance service area; and approve Chief Executive Officer authority for individual Transportation Infrastructure grant award approvals, seconded by Commissioner Cuevas.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Espinoza, Harris, Hernandez, Jimenez, Kalantari-Johnson, Molesky, Morales, Nanyonjo and Radner.

Noes: None.

Absent: Commissioners Abasta-Cummings, Edgcomb, Friend, Pedrozo, Peterson, Rabago, Schuller and Smith.

Abstain: None.

11. Consider approving proposed 2024 Hospital Quality Incentive Program. (4:37 – 4:52 p.m.)

Chair Jimenez advised the Board that this item carried potential conflict of interest. Board members who perceived that they were at risk for conflict of interest were advised to abstain from discussion and voting on this item.

Ms. Kay Lor, Payment Strategy Director, provided background on the Alliance payment strategy. The payment strategy would align provider payment rates with revenue rates, utilization trends and industry benchmarks and advance value-based payment.

[Commissioner Radner departed at this time: 4:23 p.m.]

The Hospital Quality Incentive Program offers financial incentives for hospitals and encourages partnership with Managed Care Plans by meeting operational efficiencies which will further improve transitional care services, facilitate reduction of unnecessary healthcare costs, and improve service delivery. with a focus on improving members access to comprehensive care based on member needs.

MOTION: Commissioner Cuevas moved to approve the proposed 2024 Hospital Quality Incentive Program for contracted hospitals, seconded by Commissioner Espinoza.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Cuevas, Espinoza, Hernandez, Jimenez, Kalantari-Johnson, Molesky, Morales and Nanyonjo.

Noes: None.

Absent: Commissioners Abasta-Cummings, Edgcomb, Friend, Pedrozo, Peterson, Rabago, Radner, Schuller and Smith.

Abstain: Commissioner Harris.

Adjourn to Closed Session

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

Chair Jimenez moved the Commission into Closed Session at 4:52 p.m. Council provided an update to the Board on active litigation. No action was taken by the Board, so there was nothing to report subsequently. The Board adjourned from Closed Session at 4:57 p.m.

The Commission adjourned its regular meeting of the three-County Commission on September 27, 2023 at 4:52 p.m. to the regular meeting of the five-County Commission on October 25, 2023 at 10:30 a.m. at Seacliff Inn in Aptos, unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

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

Meeting Minutes

Wednesday, August 23, 2023

Members Present:

Ms. Elsa Jiménez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Supervisor Josh Pedrozo	County Board of Supervisors
Allen Radner, MD	Provider Representative

Members Absent:

Staff Present:

Ms. Lisa Ba	Chief Financial Officer
Mr. Michael Schrader	Chief Executive Officer
Dennis Hsieh, MD, JD	Deputy Chief Medical Officer
Ms. Kay Lor	Payment Strategy Director
Ms. Dulcie San Paolo	Finance Administrative Specialist

1. Call to Order. (1:34 p.m.)

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

2. Oral Communications. (1:35 – 1:36 p.m.)

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

No members of the public addressed the Committee.

Consent Agenda Items:

3. Approve minutes of the June 28, 2023 meeting of the Finance Committee. (1:33–1:34 p.m.)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the June 28, 2023 meeting.

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

ACTION: The motion passed with the following vote:

Ayes: Commissioners Jiménez, Molesky, Radner

Noes: None

Absent: Commissioners Kalantari-Johnson, Pedrozo

Abstain: None

Regular Agenda Items:

4. June YTD financial results. (1:37 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioners on the Alliance's most recent financial performance for the six months ending on June 30, 2023. Year-to-Date (YTD) Operating Income was $65M, with a Medical Loss Ratio (MLR) of 87.3% and an Administrative Loss Ratio (ALR) of 5.2%.

Overall, medical cost was 9% unfavorable to the budget, due mainly to increased utilization in Inpatient, Behavioral Health, and Transportation services. To offer more insight, Ms. Ba went on to provide the commissioners with a detailed view of medical cost broken down by category of service.

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

The CFO explained that the Outpatient Facility category includes Emergency Department (ED) services. Medical cost in this category was 5% favorable compared to budget, Additional views of Emergency and Inpatient medical expense by Date-of-Service (DOS) were reviewed to illustrate a trended picture of utilization in those areas from 2019 to 2023 YTD. Ms. Ba clarified that, when examining utilization at the per 1,000 members per month level for ED services, it is below the 2019 levels. Therefore, she explained that increased utilization of emergency services is primarily attributed to the augmented enrollment from the Public Health Emergency (PHE). However, a similar analysis of Inpatient medical expense indicates that utilization in that category has increased compared to 2019 levels.

Ms. Ba reminded the commissioners that staff shared a preliminary forecast at the June 2023 Finance Committee meeting. She advised that the cost analysis will be refreshed, and an updated forecast will be provided for this committee's review in September.

Next, the CFO presented a view of membership projections by county-level detail. Overall, in June 2023, the Alliance enrollment peaked at 429,000. It is expected that the losses due to redetermination will be mitigated by the expansion into the new counties and the new undocumented adult coverage.

[Commissioner Kalantari-Johnson arrived at this time: 2:00 p.m.]

Ms. Ba explained that future membership losses to Kaiser will only occur in Santa Cruz and Mariposa counties and are expected to total approximately 4,000 members, representing less than 1% of the total membership.

The commissioners discussed the redetermination projections and how they have compared to actual reported numbers in the first two months of the redetermination process. Mr. Michael Schrader, Chief Executive Officer (CEO), explained that, so far, the number of disenrolled Alliance members appears to be below the Department of Health Care Services (DHCS) projections. He advised that it is possible that counties may have backlogs in processing renewals due to workforce and system restraints and that these numbers may change.

5. 2024 Hospital Quality Incentive Program (HQIP). (2:05 p.m.)

Ms. Ba introduced Ms. Kay Lor, Provider Payment Strategy Director, and Dennis Hsieh, M.D. J.D., Deputy Chief Medical Officer, to provide an overview of the proposed 2024 Hospital Quality Incentive Program (HQIP).

Ms. Lor outlined the program objectives, including better health outcomes for members, improving coordination of care, allowing hospitals to earn additional revenue through collaboration with physicians, reducing unnecessary use of expensive services, and advancing value-based payment.

The 2024 program would be based on two measures; Inpatient Transitional Care Services (TCS) and Emergency Visit Follow-Up: High Risk Outpatient ER Discharges. Payment will be based on completion of summary sheets per discharge. Payouts would occur quarterly, with participating hospitals having the opportunity to earn the maximum funds for each measurement.

Staff proposes $18M be budgeted for the HQIP in 2024. The program would be available to all contracted hospitals with 50 or more emergency or inpatient admissions in 2022.

The commissioners expressed appreciation for the adjusted design of the program to have an increased emphasis on process. Ms. Ba thanked Ms. Lor and Dr. Hsieh for their work in developing the proposed program.

The next steps will be to present the program for the Board's consideration and approval in September 2023.

6. Q2 2023 Investment Update. (2:21 p.m.)

Ms. Ba provided the commissioners with an economic update and an overview of the Alliance's investment portfolio as of June 30, 2023.

In March 2023, staff informed this committee about bank failures that occurred in the first quarter of 2023 and outlined the Alliance's proposed contingency plan. Ms. Ba shared that, although the bank failures were stabilized through intervention by the federal government, the Alliance's contingency plan was successfully implemented in the second quarter of 2023 to avoid potential operational payment disruptions.

Next, Ms. Ba presented the commissioners with a view of the Alliance's portfolio by institution and holdings. Investments are managed per the Board-approved Investment Policy. Ms. Ba advised that staff have utilized the Pooled Money Investment Account (PMIA), including CalTRUST and Local Agency Investment Fund (LAIF), to manage most of the funds. These accounts are designed for public agencies, and their investment objectives align with the Alliance's, with safety being the primary priority.

The commissioners expressed interest in learning whether there could be an opportunity for the Alliance to explore alternate types of investment opportunities, such as utilizing equity in healthcare projects and initiatives. Ms. Ba noted that consultation with the Alliance's Compliance and Legal teams would be required before this could be considered.

The Commission adjourned its meeting on August 23, 2023, at 2:35 p.m.

Respectfully submitted,

Ms. Dulcie San Paolo
Finance Administrative Specialist

Quality Improvement Health Equity Committee (QIHEC)

Meeting Minutes
Thursday, June 29, 2023
12:00 – 1:30 p.m.

Virtual Meeting / Web Conference

Committee Members Present

Dr. Caroline Kennedy, Family Med.	Physician Representative
Dr. Casey Kirkhart, Family Med.	Physician Representative
Dr. Minoo Sarkarati, Pediatrician	Physician Representative
Dr. Oguchi Nkwocha, Family Med.	Physician Representative
Ms. Cheri Collette	Provider Representative
Ms. Susan Harris	Provider Representative

Committee Members Absent:

Dr. Eric Sanford, Family Med.	Physician Representative
Dr. Madhu Raghavan, Pediatrician	Physician Representative
Dr. Stephanie Graziani, Pediatrician	Physician Representative
Ms. Stacey Kuzak	Provider Representative

Guests Present:

Myisha Reed	Provider Representative

Alliance Committee Members Present:

Dr. Dianna Diallo	Medical Director, Chair
Ms. Andrea Swan	QI/ Population Health Director
Ms. Carissa Grepo	UM Manager – Prior Authorizations
Ms. DeAnna Leamon	Clinical Safety Quality Manager
Ms. Debi McGrath	UM Manager - Authorizations and Transp. Coord.
Ms. Desirre Herrera	Quality and Health Programs Manager
Ms. Gisela Taboada	Member Services Call Center Manager
Ms. Jacqueline Van Voerkens	Administrative Specialist
Ms. Jennifer Mockus	Community Care Coordination Director
Ms. Jessie Dybdahl	Provider Services Director
Ms. Kristen Rohlf	Quality Improvement Manager
Dr. Kristynn Sullivan, PhD	Program Development Director
Ms. Lilia Chagolla	Community Engagement Dir., Monterrey
Dr. Maya Heinert	Medical Director
Ms. Navneet Sachdeva	Pharmacy Director
Ms. Rebecca McMullen	Behavioral Health Program Manager
Ms. Ronita Margain	Community Engagement Dir., Merced
Ms. Sarah Sanders	Grievance and Quality Manager
Ms. Tammy Brass	Utilization Management Director
Ms. Viki Doolittle	UM/Complex Case Management Manager

1. Call to Order by Dr. Dianna Diallo, Medical Director

Dr. Diallo called the meeting to order at 12:05 PM and welcomed the members. Dr. Diallo opened the floor for any announcements. No announcements were received from the Committee.

Announcement: Dr. Diallo announced that Michael Schrader joined the Alliance in April as the new Chief Executive Officer, and Dr. Dennis Hsieh joined the Alliance this week as the new Deputy Chief

Medical Officer, New members of the committee, Dr. Maya Heinert, MD, Medical Director, Ms. Rebecca McMullen, Behavioral Health Program Manager, and Kristynn Sullivan, Program Development Director, were introduced. Dr. Diallo announced the promotions of, and now permanent members of the committee, Desirre Herrera, Quality and Health Programs Manager, and Kristen Rohlf, Quality Improvement Manager.

2. Consent Agenda

Dr. Diallo introduced the consent agenda.

March 30, 2023 QIHEC Meeting Minutes

Dr. Diallo presented the March 30, 2023 QIHEC Minutes. Action items were reviewed.

Motion: Dr. Kennedy moved to approve the minutes, seconded by Dr. Kirkhart.
Committee Decision: Minutes were approved with edits.

Subcommittee/Workgroup Meeting Minutes

- Quality Improvement Health Equity Workgroup (QIHEW) Minutes
- Pharmacy and Therapeutic (P&T) Committee - Minutes
- Utilization Management Workgroup (UMWG) Minutes

Workplans:

- Q1 2023 Utilization Management Work Plan
- Q1 2023 Utilization Management Work Plan Executive Summary
- Q1 2023 Quality Improvement Health Equity Transformation (QIHET) Program Work plan (email approval)
- Q1 2023 QIHET Workplan Executive Summary

Policies Requiring QIHEC Approval:

Policy Number	Title	Significant Changes
401-1508	Facility Site Review Process	Significant changes were made to the policy based on APL 22-107 – Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review
		Changes were made to the policy based on MCQMD APL 22-023 – Street Medicine Provider: Definitions and Participation in Managed Care
401-1509	Timely Access to Care	Minor revision made to comply with 2024 Medi-Cal Contract and Operational Readiness Deliverable request R.0131. Added clarifying language to state that members may access emergency care from contracted and out-of-network providers without prior authorization.
		Minor revision made to comply with 2024 Medi-Cal Contract and Operational Readiness Deliverable request R.0186. Added that Alliance members will have timely access to Indian Health Service Programs within the provider network, where available.
		Revisions made to comply with DMHC APL 22-026 – Implementation Filing Requirements Related to the Amendments to the Timely Access and Network Reporting Statutes and Regulation and added Health and Safety Code 1367.03(e)(2) & Health and Safety Code 1367.03(e)(3) as references.

401-2001	Member Surveys	Policy updated in response to DMHC Comment Letter re: APL 22-026 TA P&Ps, noting The Alliance Quality Improvement System (QIS) reviews key Consumer Satisfaction Survey outcomes/findings compared to prior years.
		Two attachments added to policy: Enrollee Satisfaction Survey Tool (Spanish and English)

Delegate Oversight Report: The VSP Q4 2022 and the Carelon Q4 2022 quarterly delegate oversite summary included in consent agenda meeting packet.

QIHEW Charter: Annual update and review of the Quality Improvement Health Equity Workgroup Charter.

QIHEC Charter: Annual update and review of the Quality Improvement Health Equity Committee Charter.

Motion: Dr. Kennedy moved to approve the consent agenda, seconded by Dr. Sarkarati**.**
Committee Decision: Consent Agenda was approved as written.

Action:
a. UM Administrative Assistant will submit the UM Workplan and Executive Summary to the Executive Assistant for the July Board meeting packet.
b. QIPH Administrative Specialist will submit the QIHEC minutes, QIHET Workplan and Executive Summary to the Executive Assistant for the July Board meeting packet.
c. QIPH Administrative Assistant will submit the policies to Policy Hub for approval.

3. Regular Agenda

a. Care-Based Quality Improvement Program
Ms. Kristen Rohlf, Quality Improvement Manager presented the Care-Based Quality Improvement Program and application status.

Dr. Kennedy mentioned that there is a communications issue with the application process for the CBI Program, where applications are denied, but the reason is not specified. Ms. Rohlf acknowledged that there was a communication issue due to a directional change midway through the application process. Dr. Kennedy expressed that clearer communication would be beneficial. Dr. Diallo acknowledged Dr. Kennedy's feedback and will take it back to the appropriate group, and ensure communication is focused on in the future.

b. County Expansion Continuity of Care (COC) Process
Ms. Tammy Brass, Utilization Management Director, provided a brief update on the County Expansion Continuity of Care (COC) Process. Go Live is in January 2024, and expect to receive authorization data in November.

Dr. Diallo asked for clarification about what is COC. New members who have an established specialist for the past 12 months, regardless if the specialist is contracted with the Alliance (in network), will receive approval to continue receiving care from their specialist. Pending appointments to establish care will also be reviewed for approval, to reduce barriers to care.

c. Utilization Management Criteria:
Ms. Tammy Brass, Utilization Management Director, provided an update on the new 2023 Codes and UM Member Benefit Updates, which included the Street Medicine pilot.

Dr. Kennedy inquired if telemedicine would be a part of Street Medicine. Dr. Kennedy suggested the possibility of utilizing an iPad or a telephone during the Street Medicine services to provide physician /pharmacy services. Ms. Brass appreciated the feedback and will take it back for consideration.

Dr. Nkwocha inquired about the Durable Medical Equipment (DME) wheelchair request, and if it would be possible to change the present process of the repair requests requiring to come from the physician. Ms. Brass indicated that the Alliance contracts with a company that visits the patients home to evaluate the condition of the wheelchair, and home, and the appropriate need of repair/replacement. Dr. Nkwocha suggests receiving the request from the member, let the Alliance's vendor do the evaluation, then if the vendor approves, send the approval request to the physician. Ms. Brass indicated that the process can also be worked out with the Case Management team. Dr. Kennedy indicated that DME paperwork is very time consuming for the physician and not always straight forward, and sometimes rejected due to wrong codes.

Dr. Nkwocha mentioned that the Next Gen DME provider require paper scripts, and inquired if the Alliance is aware more DME providers.

d. Emerging Issues:
   - Dr. Nkwocha indicated:
     - that his organization began a telepsychiatry program, presently providing counseling services. Recruiting for bi-lingual providers.
     - Collaborating with a company that provides Blood pressure monitoring via a kit (cuff – batterie operated) **Action:** Provider Services and Pharmacy will connect with Dr. Nkwocha and provide blood pressure cuff resources/information to the group after the meeting.
       Action complete: Blood pressure cuffs are a Medi-Cal covered benefit. Information distributed to the committee after the meeting.
   - Dr. Kirkhart indicated:
     - Present challenges recruiting and hiring medical assistants.
     - Planning an EHR switch to Ocean Epic, projected go live in 2025
     - Planning for Family Medicine Residency clinic projected go live July 2024
       - Dr. Diallo offered the Alliance teams to meet with the residents to present on quality measures and MCAS
   - Dr. Kennedy indicated:
     - Present challenges include finding locations to expand to provide services, recruiting and hiring residents
     - One of the 16 clinics and in California in the DHCS pilot for changing to quality over quantity
     - Applied for a HRSA grant
   - Ms. Cheri Collett indicated:
     - Golden valley is working on the EMR for developmental screenings and ACES screenings,
     - Working on QI metrics and reinforcing some best practices and workflows internally to reflect the numbers
   - Dr. Sarkarati indicted:
     - Behavioral Health positions open/recruiting/evaluating resources
     - Developmental Behavioral Health services for children over 3 years of age
     - ACEs, conducting work around developmental screenings
     - Recruiting for provider and nursing positions

   Committee discussed the UC Irvine Train the Trainer program and available scholarships. Committee is interested in hearing from those who participated in the program and how they integrated the model with an FQHC.

Dr. Kennedy mentioned the possibility of having a topic around CBI reports, and where to find the most up-to-date data. The committee was informed that providers receive a mid-year performance report mid-July each year. The Alliance is still working on how to create month to month performance data/profile for those under the 50th percentile.

For CBI, if services are provided by a different provider, the linked PCP will continue to receive CBI credit.

Members can change their assigned PCP quickly if they prefer. If it is noticed that an assigned member is consistently receiving services by another PCP, a link can be provided to the member for them to easily complete: **use the online form**

Future Topics

- No future topics were recommended.

Committee members are encouraged to submit items for discussion, at any time, to Dr. Diallo or Tammy Brass.

Next Meeting: Thursday, September 28, 2023

The meeting adjourned at 1:20 p.m.

Minutes respectfully submitted by,

Jacqueline Van Voerkens
Administrative Specialist

DATE: October 25, 2023

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

FROM: Van Wong, Chief Operating Officer

SUBJECT: Medi-Cal Redetermination Live Member Outreach

Recommendation. Staff recommend the Board approve an unbudgeted expense not to exceed $250,000 for continuation of live member outreach related to the resumption of the full Medi-Cal eligibility redetermination process.

Summary. In 2023, the Alliance partnered with an external entity to conduct live outreach to members who received a Medi-Cal redetermination packet but had not yet responded. The goal is to educate members about the redetermination process and to remind them about the importance of returning their completed packet. While the cost for this outreach was included in the 2023 budget, the anticipated number of members not submitting their redetermination packet was underestimated. Live member outreach has a positive impact on preventing members from falling off Medi-Cal for administrative reasons and it would be valuable to continue the outreach.

Background. In 2022, the Department of Health Care Services (DHCS), released an All Plan Letter (APL) outlining specific activities Medi-Cal health plans were required to take to ensure members were aware of the resumption of the full Medi-Cal redetermination process. Per DHCS, activities included in person, text messaging, email, phone campaign, website banners, social media messages, flyers, and newsletters to conduct outreach and educate Medi-Cal beneficiaries. To align with these requirements, the Alliance implemented a comprehensive communication plan, including text messaging and live phone outreach processes using third party vendors.

The Alliance partnered with county staff to develop a process for the Alliance to obtain county data on members receiving a redetermination packet, including those who have not yet returned their packets. The Alliance used this data to conduct live outreach to members to remind them of the importance of looking out for the redetermination packet, completing it, and returning it timely.

The requested item is unbudgeted as staff used pre-pandemic historical data from the counties on the number of members who are disenrolled each month due to administrative reasons. Given the continuous coverage requirement, the number of members who are not receiving and returning their packet has been a lot higher.

Discussion. The APL requires the Alliance to conduct outreach and educate Medi-Cal members about the redetermination process. The Alliance has developed several educational materials for member awareness around this topic, as well as implemented the text message and live phone outreach campaigns to ensure broader awareness. Members have been very receptive to the live outreach campaign, as members have an opportunity to ask questions and ensure they understand what to do with the packet. The requested additional budget will be used to continue this key member touchpoint around the redetermination process.

Fiscal Impact. The requested $250,000 is less than 1% of the approved 2023 budget.

Attachments. N/A

DATE: October 25, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Local Agency Investment Fund Authorization Resolution Update

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Recommendation. Staff recommend the Board approve the updated Local Agency Investment Fund (LAIF) Authorization Resolution to update the organization's legal name to include San Benito and Mariposa counties. The legal name shall be changed from: Santa Cruz – Monterey – Merced Managed Medical Care Commission to Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission.

Existing Alliance staff as authorized users will remain unchanged:

1. Michael Schrader – Chief Executive Officer (CEO)
2. Lisa Ba – Chief Financial Officer (CFO)
3. Jimmy Ho – Accounting Director

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

Discussion. Staff seek approval from the Board to update the LAIF Authorization Resolution due to the legal name change to include county expansion into San Benito and Mariposa. The revised resolution allows for the CFO and authorized users, without disruption, to oversee the treasury function to manage Alliance investments under the new legal identity appropriately.

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

Attachments.

1. Resolution of Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Ste. B
Merced, CA 95240-4710
209-381-5300

RESOLUTION OF SANTA CRUZ-MONTEREY-MERCED-SAN BENITO-MARIPOSA MANAGED MEDICAL CARE COMMISSION

AUTHORIZING INVESTMENT OF MONIES IN THE LOCAL AGENCY INVESTMENT FUND

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

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

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

BE IT FURTHER RESOLVED, as follows:

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

MICHAEL SCHRADER – CHIEF EXECUTIVE OFFICER

LISA BA – CHIEF FINANCIAL OFFICER

JIMMY HO – ACCOUNTING DIRECTOR

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

PASSED AND ADOPTED, by the BOARD OF DIRECTORS of SANTA CRUZ-MONTEREY-MERCED-SAN BENITO-MARIPOSA MANAGED MEDICAL CARE COMMISSIONS of State of California on OCTOBER 25, 2023.

ATTEST:

_____

Kathy Stagnaro, Executive Assistant, Clerk to the Board

DATE: October 25, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services Medi-Cal Contract 08-85216 A-58

Recommendation. Staff recommend the Board authorize the Chairperson to sign Amendment 58 to Medi-Cal Contract 08-85216 to incorporate updated Capitation Payment rates for CY 2022.

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, and Merced counties. The Alliance entered into the primary Agreement 08-85216 with DHCS on January 1, 2009. The agreement has subsequently been amended via written amendments (A-1 through A-57).

Discussion. DHCS prepared A-58, an amendment to the Alliance's State Medi-Cal contract to incorporate Capitation Payment rates for CY 2022 that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into an SIS version and UIS version, as required by the Centers for Medicare and Medicaid Services. The amendment implements what is essentially a "bookkeeping change" and is revenue neutral to the Alliance.

Fiscal Impact. There is no financial impact. DHCS has indicated the change in rates is expected to be revenue neutral and staff have reviewed the rates and concur with this assessment.

Attachments. N/A

Medi-Cal Capacity Grant Program

PERFORMANCE DASHBOARD

October 2015 through September 2023

About the MCGP

Since 2015, the Alliance has awarded grants to local organizations through the Medi-Cal Capacity Grant Program to improve the availability, quality and access of health care and supportive resources for Medi-Cal members in Santa Cruz, Monterey and Merced counties.

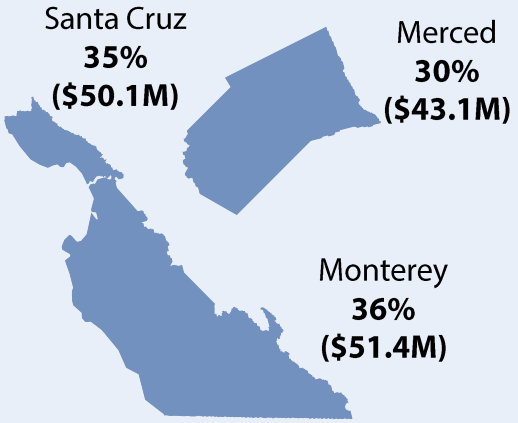
New funding opportunities were launched in Spring 2023 under three new focus areas: *Access to Care, Healthy Beginnings* and *Healthy Communities*. Funding priorities are responsive to the current health care landscape, align with organizational and State priorities, and address current and emerging needs of Alliance members and the social drivers that influence health and wellness.

Total Awarded:

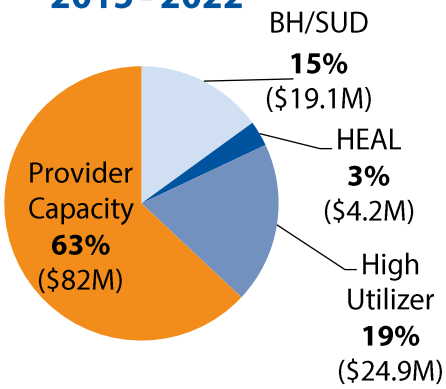
$144.7M

Number of Organizations Awarded:

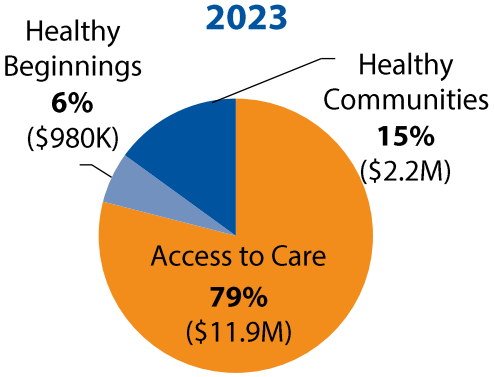
162



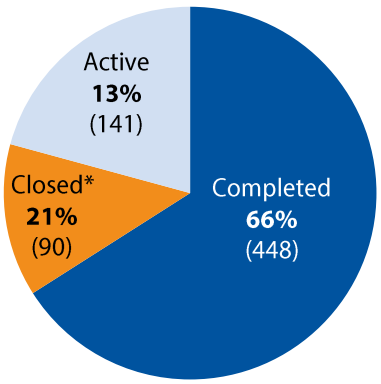
Awards by Focus Area 2015 - 2022



Awards by Focus Area 2023

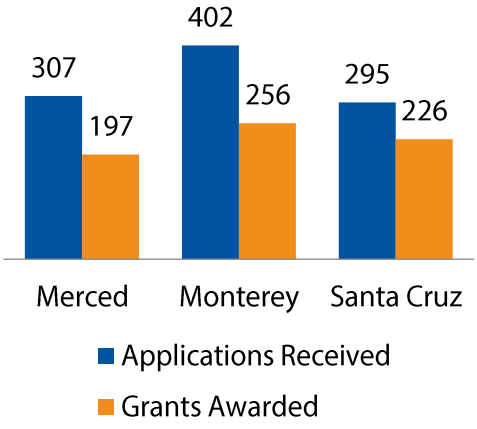


Award Status



* Withdrawn by grantee/terminated.

Total Grants Awarded: 679



HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Focus Area: Access to Care

Healthcare Technology

7 grants to support the purchase and implementation of specific types of technology and infrastructure that improves Medi-Cal member access to high quality health care.

Total Awarded:

$309K

Healthcare Technology investments in:

- **Mobile Health Platforms**
- **Enhancements and Optimization of Electronic Health Records**
- **Telehealth and eConsult**
- **General Technology to Support Member Access**

Workforce Recruitment Programs

Workforce Recruitment Programs provide funding to support health care and community organizations in their efforts to recruit and hire community health workers, medical assistants and licensed health care professionals to provide culturally and linguistically competent care to the Medi-Cal population in Merced, Monterey and Santa Cruz counties.

Community Health Worker (CHW) Recruitment

15 grants totaling $969.3K awarded to subsidize recruitment expenses for CHWs who become credentialed to provide the Medi-Cal CHW Benefit in the Alliance network.

Medical Assistant (MA) Recruitment

11 grants totaling $637.7K awarded to subsidize recruitment expenses for MAs to serve the Medi-Cal population in primary care practices in the Alliance network.

Focus Area: Access to Care

Provider Recruitment Program

329 grants totaling $39.9M* awarded to subsidize recruitment expenses for new health care professionals to serve the Medi-Cal population.
*Awards since 2015

211 new providers hired to date.

80% retention of new recruits.

25 recruited primary care physicians specialize in Pediatrics.

	Merced		Monterey		Santa Cruz		Total	% of Total
Type Recruited	Physician	Non-Physician	Physician	Non-Physician	Physician	Non-Physician		
Primary Care	29	18	21	20	11	6	105	50%
Specialty Care	5	4	30	2	13	2	56	27%
Allied		9				3	12	6%
Behavioral Health	2	3	3	1	8	8	25	12%
Dental	3				4		7	3%
Other				3		3	6	3%
Total Recruited	39	34	54	26	36	22	211	100%
	35% of total		38% of total		27% of total			

Specialties Recruited

Focus Area: Healthy Beginnings

Home Visiting

2 grants to support the implementation or expansion of home visiting programs with trained professionals that use evidence-based models and focus on health outcomes for pregnant women and parents of children up to age 5. Home visiting programs support maternal, infant and child health in the first five years of life and remove barriers to preventative health care for the Medi-Cal population.

Total Awarded:

$750K

Investing in early childhood development has proven benefits for children, families and society in the short and long term, and provides resources and support needed to thrive.

Focus Area: Healthy Communities

Partners for Active Living

4 grants totaling $994.6K to support community-based projects that provide children, adults and families opportunities to engage in physical activity and recreation programs in the community. Projects engage health care providers in partnering on program coordination and referral of Medi-Cal members to these resources.

Active Living Projects Include:

Physical Activity Programming

Partnership with Health Care Provider

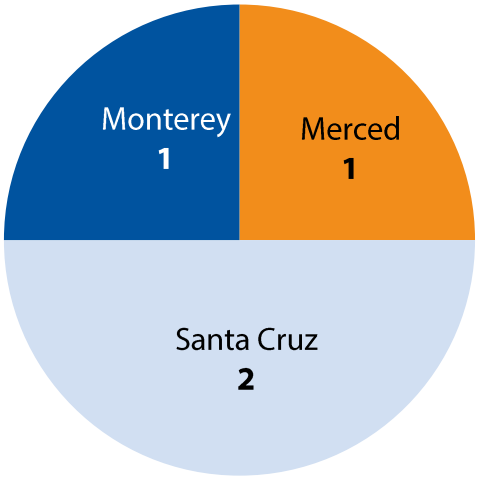
- Referral, coordination and promotion

Behavioral Education/Empowerment

- Component that communicates importance of physical activity for health and wellbeing

Member Engagement

- Culturally and linguistically competent programming
- Youth and other populations of focus

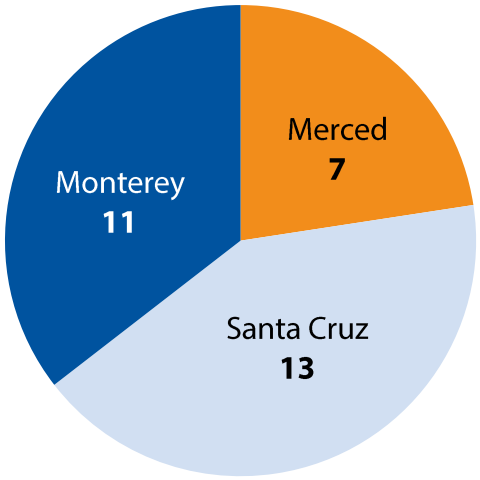


Total Number of Projects: 4

Focus Area: Healthy Communities

Partners for Healthy Food Access

31 grants totaling $4.6M* awarded to support a variety of innovative partnerships between health care providers, community-based organizations and/or government agencies implementing community-based nutritious and medically supportive food projects to improve Medi-Cal member health and food security.
*Awards since 2018; one grant terminated.



Total Number of Projects: 31

Food Access Projects Focus On:

Food Insecurity Screening

Chronic Disease Screening

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

Referrals to Supportive Services
- Cal-Fresh Enrollment

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

Grants to be Awarded in October 2023

The first round of awards for these new programs will be made in October 2023:

Equity Learning for Health Professionals

Grants to support training or consulting engagements that directly support Medi-Cal members in receiving equity-oriented care. (Focus Area: Access to Care)

Parent Education and Support

Grants awarded to increase access to childhood development education, parenting skills and supportive resources for parents of children up to age 5. (Focus Area: Healthy Beginnings)

Community Health Champions

Grants to support training or consulting engagements that directly support Medi-Cal members in receiving equity-oriented care. (Focus Area: Healthy Communities)

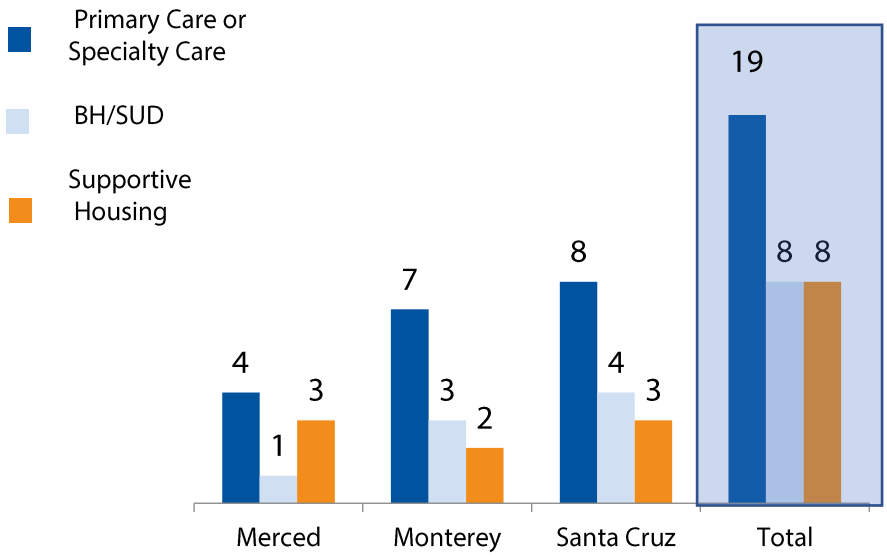
Not Accepting Applications

Capital Program

60 grants* totaling $78.4M awarded for the expansion, construction, renovation, and/or acquisition of health care facilities that will serve the Medi-Cal population in the Alliance service area. Capital grants are also available for projects that expand access to Medi-Cal services through transitional or permanent supportive housing for the Alliance's most medically fragile Medi-Cal members.

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

35 Capital Projects



172K

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

Not Accepting Applications

Children's Saving Account Pilot

1 grant totaling $230K awarded to support a 2 ½ year pilot program to build on existing children's savings account (CSA) program in Santa Cruz County for eligible Alliance members 0-2 years old who achieve preventative care milestones.

A CSA is a special savings account to save money for children's use for college or vocational education.

For each milestone achieved, $25 will be deposited into the Alliance member's CSA.

Preventative Care Milestones:

- Childhood Immunization Status Combo 10
- Well-Child Visits in the First 15 Months of Life (6 or More Visits)

It is estimated there will be a **5%** increase in the number of children achieving the milestones year over year from 2021 baseline. A program evaluation will inform potential for future expansion of CSA health milestone contributions to other counties.

Workforce Development Investments

3 grants totaling $1.1M awarded to support the development of new educational programs for health care professionals that will serve the Medi-Cal population.

- **58** Physician Assistant graduates to date (starting 2020).
- Master of Science - Physician Assistant Program, CSU Monterey Bay.
- Serves Monterey and Santa Cruz counties.

- **55** Family Nurse Practitioner graduates to date (starting 2019).
- Master of Nursing - Family Nurse Practitioner Program, CSU Stanislaus.
- Serves Merced County.

- **70 anticipated** Community Health Workers (CHW).
- Monterey County Workforce Development Board CHW Certificate Training Program.
- Serves Monterey County.

Retired Programs

COVID-19 Response Fund: 27 grants totaling $1M awarded to community-based organizations to meet the basic health-related needs of Medi-Cal members impacted by COVID-19, such as food, hygiene and sanitation supplies. Program was retired as of April 2021.

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

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

Intensive Case Management Program: 11 grants totaling $4.9M awarded to high-volume primary care practices to add staff to provide intensive case management services for medically complex Medi-Cal patients within the patient centered medical home. Three-year pilot launched 01/01/18 and was retired on 12/31/20.

Post-Discharge Meal Delivery Pilot: 3 grants totaling $651K awarded to fund the delivery of 12 weeks of ready-made, nutritious meals to Medi-Cal members recovering from an inpatient hospital stay. Two-year pilot launched 11/01/18. The Alliance Board approved the transition of the successful pilot to an Alliance-only Medi-Cal benefit, effective 01/01/21.

Practice Coaching Program: 23 grants totaling $619K awarded to practices for consultant engagements to adopt the Patient Centered Medical Home (PCMH) model of care. Program was retired as of October 2017.

Technical Assistance Program: 13 grants totaling $470K awarded to provide support for training or consulting engagements that directly result in increased access, coordination of care and integration of services. Program was retired as of April 2020.

Recuperative Care Pilot: 13 grants totaling $470K awarded to community-based organizations to support 30–60-day recuperative care stays for Medi-Cal members experiencing homelessness and recovering from an illness or injury. This short-term housing solution is an alternative to hospital care for individuals experiencing homelessness who no longer need hospital care but have medical needs that would worsen if living on the street or in a shelter. Funding also supported temporary bridge housing for members exiting recuperative care temporary housing while awaiting a more permanent housing placement. The pilot created the foundation for a successful transition to Community Support implementation under CalAIM. These services are now reimbursable through Medi-Cal as Recuperative Care and Short-Term Post-Hospitalization Housing.

Retired Focus Areas (2015 – 2022)
Provider Capacity
Behavioral Health/Substance Use Disorder (BH/SUD)
High Utilizer
Healthy Eating and Active Living (HEAL)

Grants in the Community

Home Visiting

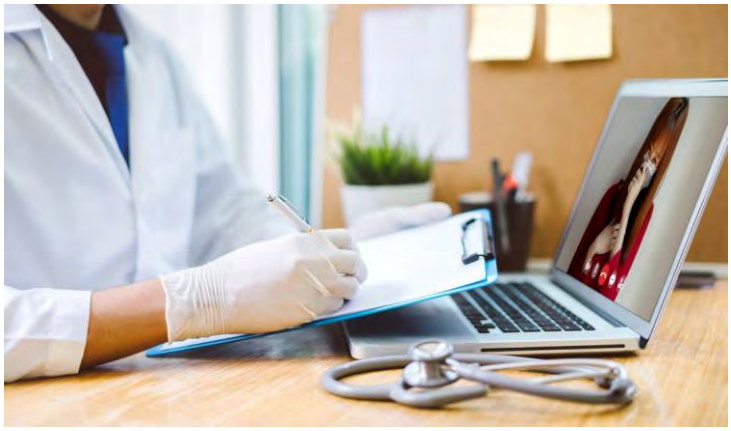
In the first round of Home Visiting grants, **Harmony at Home** and **First 5 Monterey County** (F5MC) were funded to expand their services using the evidence-based home visiting model *Parents as Teachers (PAT)*.

F5MC is leading a PAT Collaborative in Monterey County whose members include Door to Hope, GoKids, and North Monterey County Unified School District/Castroville Family Resource Center. F5MC coordinates best practices amongst the service providers to encourage reflective, healing and trauma-informed practices to ultimately eliminate health disparities, achieve optimal health outcomes for children, and improve the system of care for members with complex social needs.

Harmony At Home's *Family First* program is growing its current home visiting program by implementing PAT to increase parent knowledge, detect developmental delays and health issues, prevent child abuse, and increase self-sufficiency. The program serves families with children up to age three and supports young parents ages 13-25 to continue their education. Families are partnered with a Case Advocate and participate in family bonding activities and peer support groups.

Healthcare Technology

Doctors on Duty Medical Group, Inc., **Golden Valley Health Centers** and **Salinas Valley Medical Clinic** were each awarded a Healthcare Technology grant in June 2023 for patient check-in systems. These systems range from tablets to freestanding kiosks. Leveraging technology for the patient intake process improves clinic workflows and operational efficiencies allowing clinic staff to better support the provider team for direct patient care. The check-in systems also improve accuracy of data collection in patient records.



Patient experience is improved through patient check-in systems by streamlining various intake forms and health questionnaires in patients' preferred languages and by decreasing wait times during the check-in process.

DATE: October 25, 2023

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

FROM: Jessica Finney, Grants Director

SUBJECT: Medi-Cal Capacity Grant Award Recommendations (Group A)

Recommendation. Staff recommend the Board approve grant recommendations that total $2,324,973 for Group A of funding recommendations under Consent Agenda Item 9E.

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

Background. Since the launch of the MCGP in July 2015, the Alliance has awarded 679 grants totaling over $144.7 million to 162 organizations in the Alliance's service area to strengthen the local health care delivery system.

There are ten current funding opportunities currently accepting applications (see table below). These programs align with the MCGP Framework and funding goals under three focus areas to advance the Alliance's vision of *Healthy People. Healthy Communities.*

MCGP Focus Areas	Funding Opportunities
Access to Care	Workforce Recruitment: 1) Provider; 2) Community Health Worker (CHW) and 3) Medical Assistant (MA) 4) Equity Learning for Health Professionals 5) Healthcare Technology
Healthy Beginnings	6) Home Visiting 7) Parent Education and Support
Healthy Communities	8) Partners for Healthy Food Access 9) Partners for Active Living 10) Community Health Champions

The next application deadline for all funding opportunities is January 16, 2024. The award date for Workforce Recruitment applications will be March 15, 2024 and the award date for all other programs will be April 24, 2024.

Awards for Workforce Recruitment Programs. Grant applications for Provider Recruitment, CHW Recruitment and MA Recruitment are accepted and approved four times per year. The Board approved Chief Executive Officer (CEO) authority for individual grant award approvals, with an internal review committee recommending applications for approval. On September 15, 2023, the CEO approved 31 grant applications for Workforce Recruitment Programs out of a total of 32 eligible applications received from 26 organizations. The distribution of applications across programs and total awarded are as follows:

Grant Program	Number of Provider Recruitment Approvals	Number of CHW Recruitment Approvals	Number of MA Recruitment Approvals	Total Workforce Recruitment Award Amount
Merced	1	2	3	$443,000
Monterey	6	5	3	$1,245,297
Santa Cruz	5	1	5	$811,048
Total	**12**	**8**	**11**	**$2,499,345**

Discussion.

Grant Application Review and Recommendation Process. Grant applications in the current round of funding were due on July 18, 2023. This funding cycle, the Alliance received 54 eligible applications from 42 organizations for all programs (not including Workforce Recruitment, per above). Staff carefully reviewed each application to determine eligibility and is recommending approval of 40 applications out of the eligible applications received.

An internal committee reviewed and selected applications to recommend to the Board for approval based on the eligibility and program criteria previously approved by the Board. The internal review committee included: Michael Schrader, CEO; Dennis Hsieh, Chief Medical Officer; Lisa Ba, Chief Financial Officer; Van Wong, Chief Operating Officer; Jessie Dybdahl, Provider Services Director; Kristynn Sullivan, Program Development Director; and Jessica Finney, Grants Director. All applicants received a letter notifying them of award recommendations for approval in October 2023.

Of the 40 grant applications being recommended for approval, eight are from Merced County, 16 are from Monterey County and 16 are from Santa Cruz County. Of the 40 applications recommended for approval 14 are under the Access to Care focus area, 11 are under the Healthy Beginnings focus area and 15 are under the Healthy Communities focus area. The grant applications recommended for approval are distributed across seven programs as follows:

Grant Program	Number of Awards Recommended	Award Amount Recommended
Equity Learning	5	$198,750
Healthcare Technology	9	$381,999
Home Visiting	3	$499,733
Parent Education and Support	8	$779,200
Community Health Champions	7	$613,900
Partners for Active Living	5	$874,429
Partners for Healthy Food Access	3	$596,955
Total	**40**	**$3,944,966**

Grant Award Recommendations. Funding recommendations are grouped for two separate approval actions so that Board members with a conflict may abstain from voting where applicable. The two groups are included in the Consent Agenda as two separate items, as follows: Item 9E (Group A) includes applications not affiliated with Board members; and

Item 9F (Group B) includes applications affiliated with Board members.

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

County	Group A | Not Board Affiliated	Group B | Board Affiliated
Merced	$265,000	$190,000
Monterey	$1,075,833	$714,993
Santa Cruz	$984,140	$715,000
Total	**$2,324,973**	**$1,619,993**
Total Grant Award Recommendation: $3,944,966		

Fiscal Impact. Recommended grant awards totaling $3,944,966 would be funded by the MCGP budget, which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan's reserves to create the MCGP.

Attachments.

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

Medi-Cal Capacity Grant Program
Grant Recommendations
GROUP A: Not Affiliated with Alliance Board Members

Equity Learning for Health Professionals

County	Page*	Organization	Award**
Merced	2	Merced County Office of Education	$40,000
Santa Cruz	1	Dientes	$38,750
		Subtotal	**$78,750**

Healthcare Technology

County	Page*	Organization	Award**
Merced	5	Community Health Centers of America	$50,000
	10	Provident Primary Care Inc.	$50,000
Monterey	4	Acacia Family Medical Group	$50,000
	7	Montage Medical Group	$50,000
	8	Pacific Rehabilitation & Pain	$20,000
	13	Santa Lucia Medical Group, Inc.	$38,000
Santa Cruz	6	Encompass Community Services	$23,999
	11	Salud Para La Gente	$50,000
		Subtotal	**$331,999**

Home Visiting

County	Page*	Organization	Award**
Merced	16	Merced County Office of Education	$125,000
Monterey	14	Coastal Kids Home Care	$249,733
		Subtotal	**$374,733**

Parent Education and Support

County	Page*	Organization	Award**
Monterey	20	Merced County Office of Education	$100,000
	22	Positive Discipline Community Resources	$100,000
	24	The Parenting Connection of Monterey County	$79,200
Santa Cruz	18	First 5 Santa Cruz County	$100,000
		Subtotal	**$379,200**

Community Health Champions

County	Page*	Organization	Award**
Monterey	26	Centro Binacional para el Desarrollo Indígena Oaxaqueño	$100,000
	34	The Parenting Connection of Monterey County	$88,900
Santa Cruz	28	Community Health Trust of Pajaro Valley	$100,000
	30	FoodWhat?!	$100,000
	32	Raíces y Cariño	$100,000
		Subtotal	**$488,900**

Partners for Active Living

County	Page*	Organization	Award**
Santa Cruz	35	Community Health Trust of Pajaro Valley	$201,429
	36	Urban Works	$73,000
		Subtotal	**$274,429**

Medi-Cal Capacity Grant Program
Grant Recommendations
GROUP A: Not Affiliated with Alliance Board Members

Partners for Healthy Food Access

County	Page*	Organization	Award**
Monterey	40	MEarth	$200,000
Santa Cruz	38	Esperanza Community Farms	$196,962
		Subtotal	**$396,962**

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

**Final grant awards will depend on verification of actual expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Dientes**
County: **Santa Cruz**
Grant Award History: Yes

Equity Learning for Health Professionals Program

Project Name: Diversity, Equity & Inclusion Training
Proposed Start/End Dates: 9/15/2023 - 9/14/2024
Total Project Budget: $41,603
Request Amount: **$38,750**
***Recommended Award:** **$38,750**

Proposal Summary: Dientes will work with SEADE Coaching and Consulting to conduct extensive Diversity, Equity & Inclusion (DEI trainings for staff throughout the year. Trainings will be offered in person and virtually to approximately 108 staff covering a wide range of topics. The consultant will provide 24 training sessions, a half-day retreat, and 15 hours of implementation coaching over 12 months. The aim is to educate staff on diversity, equity, and inclusion and train them to consider this context when providing culturally competent care. Training curriculum topics include belonging, inclusive language, bias, allyship, psychological safety, allyship, systemic/structural racism, anti-racism and micro-aggression related to age, sexual orientation, gender religion, race and ability.

This project will improve the communication and cultural competency of providers and all patient-facing staff. The extensively DEI training will improve patient interaction in providing culturally responsive care and have ideas on how to improve clinical operations to consider and address health inequities that our patients face. Beyond the training, staff will hone into concrete actions that can be implemented to address health equity for our patients and DEI across the organization. The management team will work closely with SEADE to evaluate the organization and create a DEI implementation plan to improve equitable care.

Outcomes:

1. By September 30, 2024, DEI trained staff will increase from 21% to 100% to improve culturally responsive care as measured by trainings attended.
2. By September 30, 2024, a DEI implementation plan will be created with actionable items to improve organizational diversity, equity and inclusion for patients and staff as measured by the finalized plan.
3. By September 30, 2024, a total of 24 (60-minute) virtual sessions will be provided to management team, administrative staff, and clinical staff, including providers, back office, and front office support staff.
4. By September 30, 2024, a DEI focused (3 hour) management retreat will be offered to staff and providers including 15 hours of coaching made available after training.

Impact:

- Number to be reached by project: 15,000

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Merced County Office of Education**
County: **Merced**
Grant Award History: Yes

Equity Learning for Health Professionals Program

Project Name: Historical Trauma: Diversity, Equity & Inclusion
Proposed Start/End Dates: 11/01/2023 - 10/31/24
Total Project Budget: $41,737
Request Amount: **$40,000**
***Recommended Award:** **$40,000**

Proposal Summary: Merced County Office of Education will offer 48 hours of training for health professionals through the Family Resources Center (FRC). The FRC operates under the umbrella of the Merced County Office of Education and collaborates with other Medi-Cal partners such as Merced County Behavioral Health and Recovery Services. The FRC is known as "the hub of community building" with a network that includes more than 200 faith-based, community-based, educational, law enforcement, and government organizations.

The proposed training will be grounded in principals and information to facilitate equity in health care for people of all races, ethnicities, religious backgrounds, and cultural identities. Through a commitment to cultural humility, the training will strive to develop empathy and understanding, paving the way for trust-based relationships and improved communication between healthcare providers and the public. The curriculum will address build the capacity of health care providers to interact with clients and co-workers from a stress-reduction ideology with cultural competence, creating a professional workspace that values humanity, and identify internal policies to promote inclusion. The identified trainer, Ms. Iya Affo, founder of Heal Historical Trauma, will train staff of organizations that provide health care services to Medi-Cal members. The trainings will be conducted for 45 health care providers over six 8-hour sessions via Zoom platform and in-person at 632 W. 13th Street in Merced where there are several rooms designated for training.

The curriculum will focus on trauma-informed processes and practices that support providers in understanding the history of various disempowered groups, the impact of intersectionality, the formation of trauma, and ideology that supports the goal of not re-traumatizing, creating healing-centered engagement and developing a dynamic system of health equity. The series will address the impact of historical, collective, and intergenerational trauma across generations and trauma-informed processes and practices that support providers in understanding the history of various disempowered groups. Taught from a multicultural perspective, the trainer will include traditions and ideology from various cultures from around the world, weaving in current academic research with knowledge from Medicine Women\Men, traditional historians, and cultural leaders from various African, Native American, Aboriginal and Asian communities.

The FRC staff of four is committed to marketing and outreach to generate attendance, including e-mail and text communications, setting up staff meetings at health provider locations to describe the training, media campaigns, community events, and outreach to over 125 members of ACEs Informed

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Network of Care. FRC staff is committed to sustaining future trainings in the community. If the training is successful, First 5 Merced has expressed interest in ongoing funding for training.

Outcomes:

1. By October 31, 2024, 45 health professionals to attend a high quality and culturally competent training series to impact serving Medi-Cal members. A total of 48 hours of health equity training will be provided in six 8-hour sessions.
2. By October 31, 2024, Health professional who attended the trainings will have the knowledge and ability to promotes diversity and inclusion in the workplace, communicate in a culturally competent manner with Medi-Cal members and other clients, and create internal policies that promote health equity.

Impact:

- Number to be reached by project**:** TBD based on participating organizations.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Acacia Family Medical Group**
County: Monterey
Grant Award History: No

Healthcare Technology Program

Project Name: Acacia Family Medical Group
Proposed Start/End Dates: 11/01/2023- 10/30/2024
Total Project Budget: $80,000
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: Despite significant attention and investments over the years, the challenge of ensuring timely follow-up after emergency room visits or hospitalizations is especially acute for the Medi-Cal population due to lags in information from hospitals. There is an additional concern about infants, where lack of reminders during the distractions of the pandemic led to a drop in Well Child Checks and vaccinations. Additionally, the automated patient scheduling reminders and outreach are limited by a poor third-party module. It often does not send reminders for the day, and allows one button cancellation too easily, allowing many missed appointments at short notice without staff contact.

Proposal Summary: To improve patient access, Acacia Family Medical Group seeks to augment and improve the functionality of the existing electronic health records (EHR) system through consultation with Faber Consulting and Salinas Valley Health eMD Team improve the text reminder systems for appointments. Acacia currently has a patchwork of modules that send appointment reminders and provide freestanding telehealth services. After the project is complete, including data migration, this enhancement will support care after emergency use or hospital follow up, with improved ability to outreach to patients in their homes. These improvements will facilitate and enhance continuity of care.

Outcomes:

1. By November 2024, select modules and an integrated EHR system to improve accessibility via telehealth, improve the accessibility of appointments, create a more efficient workflow, and maintain the ability to provide responsive care.
2. By November 2024, staff will be trained in new modules that will be integrated into helehealth system.
3. By November 2024, increase of 750 more patients in a year and provide a 5% better metric based care quality.

Impact:

- Individuals Served Annually by Project: 3500
- Geographic Area/Target Population: Centered in and surrounding peninsula and South County. Patients come from Prundale, Castroville, Pajaro and Watsonville, Aromas, San Juan Bautista, North Salinas as well as Hollister.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Community Health Centers of America**
County: Merced
Grant Award History: No awards to date

Healthcare Technology Program

Project Name: UDS+
Proposed Start/End Dates: 11/1/2023 – 11/30/2024
Total Project Budget: $50,250
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: eCW has very limited "canned" reporting capability and charges for each report request. In addition, CHCA needs to prepare for UDS+ which will likely be required as early as 2024. Having reporting capabilities will help with performance on the care-base initiatives and can leverage real-time data in quality improvement and population health management efforts.

Proposal Summary: Community Health Centers of America (CHCA) seeks grant funding for a project that will increase their capacity to run reports from their electronic health records (EHR) system, which will be used in their population health management improvement efforts as well to be prepared for new requirements related to the Uniform Data System (UDS) Modernization Initiative (UDS+). They are seeing a solution that allows flexibility and creativity in generating reports that enable tracking of quality improvement efforts over time. The consultant utilized will be BridgeIT Solutions which has proven experience executing reporting solutions with another health care provider in the Alliance service area using the same EHR, eClinicalWorks (eCW).

By having the capacity to run their own reports, there will be better opportunities to improve on all of the five aims in the quintuple aim to improve beneficiary outcomes by optimizing coordination of care, decrease per beneficiary cost by becoming more efficient and coordinated, enhance the patient experience as well as clinic operations (staff satisfaction) through efficiencies and improve health equity by running reports that identify disparities. Becoming more efficient and coordinated will also improve patient safety.

Outcomes:

1. By January 31, identify which reports are needed for quality improvement strategy to be successful and to succeed with UDS+.
2. By January 31, 2024, staff will have the technical capacity to run and submit reports as per the UDS+ specification.
3. By March 31, 2024 , staff will be able to develop detailed training documents for QI teams on how to run reports, incorporate them into QI work, and prepare the reports to share data with staff.

Impact:

- Individuals Served Annually by Project: 2,220
- Geographic Area/Target Population: All central valley and rural health areas.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Encompass Community Services**
County: Santa Cruz
Grant Award History: Yes

Healthcare Technology Program

Project Name: Technology for Measurement-based Care
Proposed Start/End Dates: 09/01/23 - 08/31/24
Total Project Budget: $23,999
Request Amount: **$23,999**
***Recommended Award:** **$23,999**

Problem/Needs Statement: This project will address efficient and least error-prone method for entering client self-report measures is via portable devices such as iPads or Smart Phones. Clients lack consistent access to Smart Phones with data plans and to ensure consistent and reliable methodology. Encompass prefers use of iPads for in-person client data collection. They are implementing programs do not have enough iPads for every counselor/clinician who will initiate the practice with their clients in the next year. Currently, counselor/clinicians share iPads at every client session which is challenging unless paired counselors/clinicians have opposite schedules. Encompass aims to avoid scheduling sessions around iPad availability rather than client preference and avoid lengthy paper-based data collection procedures which reduce counselor/clinician time with clients. Lack of accessible iPads could result in reduced capacity to obtain client input on treatment progress and their therapeutic relationship which are essential for tailoring care to optimize outcomes. Inconsistency with gathering and responding to client input on care could result in lengthened treatment time, poorer outcomes, disruptions in care due to no-shows, and incomplete treatment.

Proposal Summary: This project will address an essential infrastructure gap by implementing use of iPads to support implementation of measurement-based care (MBC) across outpatient and residential behavioral health programs. Other funding has been secured to support software and training requirements for measurement-based care implementation, but it did not include client-facing iPads for data collection. MBC/feedback-informed treatment is an evidence-based practice that includes routine use of validated measures of client outcomes and therapeutic alliance during treatment.

Encompass based their projection of Medi-Cal members served on the number of outpatient and residential providers scheduled in their MBC training plan who do not have iPads, their typical caseloads, and client enrollments. For some of providers, their caseloads are small and do not turn over quickly. MBC will be implemented only with newly enrolled clients. Based on their MBC implementation training, Encompass was advised to implement slowly and gradually for better sustainability and that full implementation takes two to three years. Thus, they were conservative with estimated numbers of clients impacted during the funding period. It is their expectation that the number of clients benefiting from MBC would grow over the next several years as providers integrate MBC into their practice with all new enrollees.

Impact:

- Number to be Served by Project: 200
- Geographic Area/Target Population: Santa Cruz County youth and adult residents, predominantly Latino/Hispanic and white.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Montage Medical Group**
County: Monterey
Grant Award History: No

Healthcare Technology Program

Project Name: Artificial Intelligence for Clinical Care Gaps
Proposed Start/End Dates: 01/01/2024 - 12/31/2024
Total Project Budget: $390,000
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: Staying on top of a patient's current health status can be extremely challenging for providers. EHRs often only tell part of the overall health story and leave providers trying to piece together the bigger picture to determine what care has been provided outside of their health system. Providers spend hours determining which patients have open care gaps and weed through EHRs to find missing clinical information. With healthcare staff shortages, clinics lack staff or capacity to do this manual work, and therefore cannot prioritize the open gaps, leaving patients with no follow-up. Open care gaps can be detrimental to a patient's health (i.e., a missed colon cancer screening for high risk patient) and to the health system's ability to meet critical quality metrics. In 2022, Montage Medical Group (MMG) identified care gap closure as a priority area of opportunity. In a pilot that tested this AI/RPA technology with cervical cancer screening gaps, approximately 6,000 more patients with the open gap had charts 'scrubbed' than would have without the technology. Of those patients, 6% had evidence that the care gap closure had taken place outside of MMG, and therefore could be closed. 5% of the patients had evidence of HPV with their last pap smear, indicating a critical need for follow-up. 94% of patients with open care gaps were outreached via text messaging that invited them to self-schedule their appointment with MMG.

Proposal Summary: Montage Medical Group (MMG) is seeking support to deliver a proven technology-based solution that will optimize clinical care to the Medi-Cal population through the closure of care gaps while increasing access to care. This program will couple artificial intelligence and robotic process automation (AI/RPA) technology with a mobile platform to automate tasks currently being completed by staff, including the 'scrubbing' of electronic health records (EHR) charts to find lab results, patient outreach, and scheduling. This automation will improve clinical outcomes, efficiency, and accuracy.

MMG will be able to automate the care gap closure activities for five different disease areas: Colon Cancer, Cervical Cancer, Breast Cancer, Hypertension and Diabetic Eye Exams. The automation greatly reduces the manual workflows, allowing staff and providers to have more capacity and time with the patients in front of them. It also increases appointments through proactive outreach to patients who would otherwise not be contacted. This year, data indicates that 141 Medi-Cal patients have open breast cancer screening care gaps, 365 have open cervical cancer screening care gaps, 155 have open diabetic eye exam care gaps, and 168 have open hypertension care gaps. Automating the chart scrub and outreach process saves approximately 15 minutes per patient. With use of the AI/RPA technology, 829 Medi-Cal patients with open gaps, MMG staff and providers would save 207 hours that could be redirected to other patient-focused tasks.

Impact:

- Individuals Served Annually by Project: 2,250
- Geographic Area/Target Population: Linked Medi-Cal members in Monterey County

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Pacific Rehabilitation and Pain**
County: Monterey
Grant Award History: Yes

Healthcare Technology Program

Project Name: Rely Health Care Navigation System for Community Health Workers
Proposed Start/End Dates: 11/01/23 - 10/31/24
Total Project Budget: $20,000
Request Amount: **$20,000**
***Recommended Award:** **$20,000**

Proposal Summary: Pacific Rehabilitation and Pain (PRP) requests funding to implement Rely Health Care Navigation System (Rely) for Community Health Workers (CHWs). Rely is an artificial intelligence-based tool that will integrate with PRP's EHR system. Rely will enable CHWs to provide health care navigation and peer support more easily for patients with substance use disorder (SUD) by automating documentation, billing, intake data entry and other routine tasks. This increased capacity results in opening availability for direct service with patients.

Problem/Needs Statement PRP's physicians estimate that 25% of each patient encounter is spent on documentation; consistent with national trends, this often culminates in hours spent documenting at the end of every shift. This time commitment is particularly costly for CHWs. Ideally, the vast majority of a CHW's time is spent connecting with patients and providing care navigation. Their role is crucial in addiction medicine, where patients are frequently afraid to seek care due to financial concerns and stigma, are generally more difficult to contact and often struggle with negative secondary health outcomes. This highlights the need for comprehensive documentation to keep track of patients, making the CHW's role a difficult balancing act. Furthermore, high emergency department (ED) utilization for individuals with SUD further highlights the important role that CHW engagement and outpatient clinic management play in in addressing long-term health outcomes and reducing overall costs.

Rely's automated messaging will ensure 24/7 CHW service availability and encourage patient engagement. Rely lowers new appointment scheduling from a nationwide average of three weeks to 8.2 days for specialist care. Rely also has provisions to connect care navigators with services addressing social determinants of health and secondary health outcomes, integrating PRP more tightly in the local health system. On average, Rely reduces substance use-related visits to the ED by 53% following initial care navigation

Outcomes:

1. By October 31, 2024, reduce patient substance use-related ED visits by a minimum of 45% in the six months following implementation of Rely and supplant substance use-related ED visits with CHW services. This will be measured through ED data and patient surveys.
2. By October 31, 2024, increase average time spent on patient interactions to a minimum of 70% of CHW workday, as measured by regular team check-ins as well as EHR and scheduler tracking.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

3. By October 31, 2024, increase patient volume seen by CHW by 50% as measured through PRP's EHR.

Impact:

- Individuals Served Annually by Project: 300
- Geographic Area/Target Population: Monterey County, particularly the undeserved North and South County extremities.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Provident Primary Care Inc.**
County: Merced
Grant Award History: Yes

Healthcare Technology Program

Project Name: Operation Better System
Proposed Start/End Dates: 11/01/23 - 10/31/24
Total Project Budget: $91,500
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: PPC currently faces a long process checking in patients due to slow computers and internet. Additionally, the poor technology infrastructure does not support optimal functioning of their current electronic medical record (EMR) system.

Proposal Summary: Provident Primary Care (PPC) requests funds to purchase high-speed internet fiber, a new file server, cloud-based EMR optimization, computers, cameras and portable devices for telehealth and patient check-in. PPC notes that their practice will tremendously improve and increase productivity with these upgrades. Improved technology will allow PPC to efficiently coordinate care for patients and telehealth services. Overall, these improvements will help their providers monitor patients and improve patient quality of care measures.

Outcomes:

1. By April 30, 2024, purchase and implement new technologies (high-speed internet fiber, new file server, computers, cloud-based EMR optimization cameras, and portable devices for telehealth).
2. By October 31, 2024, increase quality measures above the 51% percentile.
3. By October 31, 2024, increase the number of patients served.

Impact:

- Individuals Served Annually by Project: 2,000
- Geographic Area/Target Population: Merced County patients and those from outside of the county on an emergency basis.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Salud Para La Gente**
County: Santa Cruz
Grant Award History: Yes

Healthcare Technology Program

Project Name: Pajaro Valley WOW/Telehealth
Proposed Start/End Dates: 11/1/2023 – 10/31/2024
Total Project Budget: $77,272
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: At least 6% (n=1,600) of Salud's patients speak indigenous languages (mainly Mixteco) and clinic staff are not able to utilize telephonic/contract interpretation as it is not a common language provided and requires advance notice. Salud currently only has three FTEs providing Mixteco interpretation in-person at their East Beach clinic. They schedule the majority of Mixteco-speaking patients at this site, however, this leaves their other sites without interpretation. Interpreters also impact space constraints in exam rooms. Due to the lack of local availability of bilingual, bicultural providers, all of Salud's psychiatrists and the majority of their behavioral health providers service patients via telehealth, however, not all patients have smart phones, unlimited data plans, or internet access. Challenges also arise with patient registration. All patients must complete multiple forms and answer various questions to get "checked in" for their appointments, creating inefficiency, adding time and stress to health visits. Additionally, through CalAIM, Medi-Cal eligibility will expand as of January 2024, and all income-eligible Californians can apply for Medi-Cal regardless of immigration status. Salud expects to add approximately 1,900 Medi-Cal patients, placing increased demands on their patient registration and interpretation services.

Proposal Summary: Salud Para La Gente (Salud) seeks grant funding for the Pajaro Valley Workstations on Wheels (WOW)/Telehealth project to expand their capacity and improve services by leveraging tablet technology. The proposed system will provide interpretation and telehealth services, collect consent, and gather more accurate data on social determinants of health (SDOH). This technology solution eliminates barriers to care, supports the delivery of coordinated and integrated care, and utilizes recognized effective practices.

Salud will employ iPad workstations on wheels (WOW) (n=20) to provide virtual interpretation at all clinic locations. Cellular-enabled tablets (n=24) will allow off-site community health outreach teams to access interpreters, schedule patient appointments from schools and community events, and enroll patients from homeless and Medi-Cal expansion outreach. Staff will also use the iPad Minis to access telehealth tools such as Doximity. The Surface Tablets' more robust operating system will allow staff to securely access patients' Electronic Health Records (EHR) and schedule appointments, look up past appointment and medical data, and update patient information from the field. Patients without WiFi or smart phones can use iPads (n=30) at Salud clinics for telehealth appointments with non-local providers. They can also access Salud's HealthiPass which allows self-check-in, including secure capture of demographic, contact and insurance information, co-pay processing and administration of screening tools (e.g., Staying Healthy, alcohol, depression, SDOH).

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Proposed Outcomes:

1. By January 31, 2024, launch use of WOWs and individual tablets at all clinics and off-site outreach sites. Progress will be measured through reports from Salud's IT department.
2. By October 31, 2024, increase the number of telehealth visits by 15% (from 38,370 to 44,000) as measured through internal visit data reports.
3. By October 31, 2024, increase the number of interpretation service events by 15% (from 3,824 to 4,388) as measured through internal visit data reports.
4. By October 31, 2024, 50% of patients will utilize the new HealthiPass registration system as measured through internal visit data reports.

Impact

- Individuals Served Annually by Project: 20,000
- Geographic Area/Target Population: Santa Cruz County, specifically serving the Pajaro Valley region. Low-income, Medi-Cal members, and uninsured residents of which 93% identify as Hispanic and nearly 50% are farmworkers.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Santa Lucia Medical Group, Inc.**
County: Monterey
Grant Award History: Yes

Healthcare Technology Program

Project Name: Phone System
Proposed Start/End Dates: 11/01/2023 - 10/31/2024
Total Project Budget: $38,000
Request Amount: **$38,000**
***Recommended Award:** **$38,000**

Problem/Needs Statement: The current phone system is limited to nine lines and patients have a difficult time getting through to front desk staff. The existing phone system is also limited to only one of their three locations. This makes it a difficult to communicate within the three offices when needing to assist patients that are at different sites. With the proposed phone system, SLMG would be able to have unlimited lines with all three locations merged onto this system.

Proposal Summary: Santa Lucia Medical Group (SLMG) requests funding to replace their existing phone system. They state that their growth necessitates a more robust system to meet the needs of their patients. They would purchase the new system and connection all three of their locations on the one system. The new phone system would be implemented with the assistance of Comcast and their IT consultant, DeVeera, who would install all wiring to connect all three locations to the system.
The new phone system would improve member experience. Patients would be able to get their appointments scheduled and other needs met. Having an upgraded phone system will increase SLMG's capacity to assist Alliance members and other patients when they call SLMG's offices.

Outcomes:

1. By October 31, 2024, replace existing phone system with a new system that allows unlimited incoming calls.
2. By October 31, 2024, improve patient experience for scheduling appointments to access care in a timely manner.

Impact:

- Individuals Served Annually by Project: 30,000
- Geographic Area/Target Population: Monterey County, specifically the underserved communities in Salinas.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Coastal Kids Home Care**
County: Monterey
Grant Award History: Yes

Home Visiting Program

Project Name: CKHV Home Visiting
Proposed Start/End Dates: 11/01/2023 - 10/31/2025
Total Project Budget: $297,300
Request Amount: **$249,733**
***Recommended Award:** **$249,733**

Proposal Summary: Coastal Kids Home Care's Home Visiting program will expand on the success of a prior home visiting program for mothers and infants by adding critical resources to support new parents in prioritizing their own health and wellbeing while also promoting infant and child health, fostering educational development and school readiness, and building a stronger foundation for family and economic stability. The Coastal Kids Home Care program is rooted in the proven successes of Nurse Family Partnership and Healthy Family Americas evidence-based models. This program partners with local NICUs to provide in-home nursing care for fragile infants coming home and will be building on the trusting relationships of nurses, case managers, and families. In 2022, the agency received referrals for NICU follow-up visits for 135 infants and already in 2023 our pediatric nurses have seen more than 75. Our clinicians estimate that greater than 50% of these patients would benefit from additional assistance in reaching their child's health and development goals. This program aims to achieve key outcomes of improved health and development outcomes for participating infants and their caregivers.

Recognizing that the success of home visiting models is rooted in the trusting relationships between case managers and families, all services will take place in the home and in the families' primary language when possible. For families who speak indigenous languages, case managers will coordinate with local partners, including community health workers, who have cultural and linguistic familiarity to build rapport with parents. Home Visiting Case Managers will continue to work with families throughout the child's early development. Every three months, they will reassess the needs of children and their family to measure progress toward personal goals while also determining ongoing eligibility for HV services.

Case Managers will be able to hold caseloads of 50 families at a time. This number will fluctuate as new referrals come in through our NICU program and other families meet their personal goals and graduate off the program. For some families this may be as the infant reaches six-months of age; others may require assistance throughout the entire course of the program. While we will prioritize families with medically fragile infants, if space allows, Coastal Kids Home Care will also conduct outreach to Mother and Infant Units (MIU) at local hospitals to identify additional families in need of case management services. Caregiver and physician referrals will be documented in electronic health records (EHR). Follow-up will be conducted at monthly home visits. We anticipate upwards of 85% of referrals (NICU and MIU) will be in Monterey County and the remaining 15% will be in Santa Cruz County.

Outcomes:

1. By October 31, 2025, 150 participating infants will have access to comprehensive home visiting services and enrolled with a primary care provider for well-baby check-ups through age 2 and to receive childhood vaccinations, documented in their EHR.
2. 2. By October 31, 2025, 150 participating families will create personal health, development and family stability goals and review these goals documented in their EHR every three months in partnership with their Home Visiting Program case manager.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

3. By October 31, 2025, 150 participating caregivers will be assessed for physical and mental health needs and approximately 50 will receive closed loop referrals to appropriate health and mental health care. Caregiver referrals will be documented in electronic health records, follow-up will be conducted at monthly home visits.
4. By October 31, 2025, 150 participating families will receive information on key early childhood development resources, including Head Start and other preschool resources available in their community.
5. By October 31, 2025, 150 participating families will access key economic support through a minimum of 450 closed loop referrals to community agencies assisting with housing, food, transportation, and other financial assistance.

Impact:

- Number to be Served by Project: 345
- Geographic Area/Target Population: Medi-Cal members primarily living in Salinas,

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Merced County Office of Education**
County: Merced
Grant Award History: Yes

Home Visiting Program

Project Name: Parents as Teachers (PAT)
Proposed Start/End Dates: 1/1/24 - 12/31/25
Total Project Budget: $1,000,000
Request Amount: **$249,966**
Recommended Award:** **$125,000*

***Funding awarded for one year; potential transition to Enhanced Care Management provider.*

Proposal Summary: The Parents as Teachers (PAT) program is housed within the Merced County Office of Education's Caring Kids program. The Caring Kids program has a longstanding history of providing prevention and early intervention services to thousands of children ages 0-5 in Merced County. Since 2019, the Caring Kids program has been a Parents as Teachers (PAT) Affiliate implementing the evidence-based PAT curriculum with eligible CalWORKs families throughout Merced County under the CalWORKs Home Visiting Program. In 2021 the MCOE Caring Kids program expanded its evidenced-based PAT home visiting services under the California Department of Public Health's California Home Visiting Program (CHVP) to focus on children with special needs, a service area gap identified in a countywide assessment of children's services.

The MCOE PAT Affiliate is currently designed to serve 150 families with children prenatal through kindergarten entry. Families served include those on CalWORKs Assistance, or have children with special health care needs, or any family at risk for adverse childhood experiences. Currently, they have the capacity to serve 30 families under the PAT Innovation team who work with families who have a child with special health care needs. The PAT program staff is multicultural and multilingual. Bilingual staff will provide services in a child or family's native language when needed or preferred. All written materials and videos will be provided in multiple languages.

Grant funds would be used to hire of an additional Home Visitor who will maintain a caseload of 15 additional families for two years, conducting 24 visits annually for enrolled families with each visit covering three key areas: parent-child interaction, development-centered parenting, and family well-being. The MCOE PAT program already has an established referral system that is used by medical providers, social service providers, and early childhood educators to connect children to this program. Families are connected to preschool and Head Start services.

The PAT model is designed to improve access to children's preventative health care services and behavioral health screening and referrals. Health and developmental screenings will be conducted annually for enrolled children and parents are screened for screening depression and intimate partner violence. Families will be connected to medically necessary services including behavioral and mental health support as warranted. It is also designed to improve emotional health and decrease behavioral challenges commonly experienced in childhood by screening with the ASQ:SE in order to increase the chances for early detection of delays and concerns. Families are encouraged to establish a medical home and track all children's well-child visits, vaccinations and preventative dental visits. They will also be reminded Alliance member incentives to promote preventative and routine health care. MCOE Home Visitors will collaborate with the Merced County Department of Public Health to connect children with high-risk nursing and California Children's Services as needed. The specialized PAT training and curriculum is called Interactions Across Abilities: Supporting Families of Children With Special Needs.

The Parents as Teachers model is framed around four components to serve the entire family: personal visits, group connections, child screenings, and resource networks. Home-visiting professionals meet families where they are comfortable, typically in their homes. Parent educators assess family needs and partner with parents to set family

goals. Home visitors provide necessary information and resources to ensure that parents are confident in the emotional, behavioral, and physical development of their children. Parent educators use partnering, facilitating, and reflecting in their work with families to promote parental resilience; knowledge of parenting and child development; and social and emotional competence of children to strengthen protective factors.

Outcomes:

1. By December 31, 2024, a home visitor will have maintained a caseload of 15 families and provided comprehensive evidenced-based services using the PAT curriculum with children birth through five.
2. By December 31, 2024, track well-child visits for participating children in order to improve access to health services for families and will measure this outcome by child health screening records.
3. By December 31, 2024, conduct array of developmental and health screenings for participating children and parents and make referrals to medical and behavioral health providers as indicated.
4. By December 31, 2024, all screening results and referrals for additional services will be tracked in client records to monitor and improve access to physical, behavioral, and social supports.

Impact:

- Number to be Served by Project: 15
- Geographic Area/Target Population: Medi-Cal members ages 0-5 with special health care needs and their families

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **First 5 Santa County**
County: Santa Cruz
Grant Award History: Yes

Parent Education and Support

Project Name: Positive Parenting for Healthy Beginnings
Proposed Start/End Dates: 11/01/23 – 10/31/25
Total Project Budget: $250,000
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: First 5 Santa Cruz County (First 5) requests funding to expand the number of trained practitioners and partner organizations implementing the Positive Parenting Program (Triple P) for Medi-Cal members with children ages 0-5. Grant funding would support: 1) Training up to 20 Community Health Workers (CHWs), promotores/parent leaders, and other providers in Level 3 Primary Care Triple P; and 2) Providing Level 3 Triple P brief services (workshops; one-on-one sessions) to 100-150 parents, with a focus on serving Spanish-speaking and Latine parents by training practitioners who are reflective of the geographic, language, and racial/ethnic communities being served. The first year of the proposed grant-funded activities would focus on planning, capacity-building, and training. Year two would focus on service delivery, implementation support and evaluation.

Triple P is an evidence-based program, offering practical, effective parenting strategies. Triple P's population health approach increases parents' knowledge of infant/child development and parenting skills, strengthens parent-child relationships, and improves child and parental socioemotional well-being. First 3 has successfully scaled all five Triple P services levels with multiple countywide partnerships. Additionally, the Alliance adopted Lifestyle Triple P for its Healthy Weight for Life program. In Santa Cruz County, First 5 has led the countywide implementation of Triple P since 2009, providing the backbone organizational support to ensure services are available in English and Spanish for families raising children of all ages and abilities, In FY 21/22, 850 parents participated in Triple P, benefiting nearly 700 children ages 0-5 (900 children ages 6+).

Through this grant, First 5 would provide programmatic support for CHWs and promotores/ parent leaders to provide Level 3 Triple P Workshops and short-term, one-on-one sessions to Medi-Cal members and other families. They will work with host organizations to identify, recruit, enroll participants to enroll in the Triple P classes. First 5 will also provide ongoing support and coaching to newly accredited practitioners and supervisors/managers to ensure services are accessible, culturally responsive, and effective. First 5 will provide technical assistance on adapting referral, intake, service delivery, and data collection workflows.
Partners/host organziations include:

- Cradle to Career Santa Cruz County (C2C) whiich has built a cohort of promotores— local parents trained as Community Health Workers that provide peer-to-peer support, health education, and systems navigation on behalf of neighbors and school families.
- Salud Para La Gente (SPLG) and Santa Cruz Community Health (SCCH): the two largest Federally Qualified Health Centers in the county, each with plans to offer Triple P in their clinics. Both FQHCs

already employ CHWs and/or support volunteer promotores/parent leaders. SCCH leads the support and training of Live Oak C2C Promotores.
- Community Bridges – Family Resource Collective (CB-FRC): primary provider of Triple P, serving thousands of families since 2010.

Once accredited, Triple P practitioners (with the support of First 5 and their host organizations) will provide brief Level 3 Primary Care Triple P services as workshops or four one-on-one sessions on specific topics to Medi-Cal members and other parents with children ages 0-5, and collect and submit client data to First 5 for the countywide evaluation of Triple P. The individuals who become accredited Triple P practitioners under this project will be CHWs, promotores/parent leaders, and staff in FRCs and other agencies who are trained to connect families to other health and social services. As practitioners become aware of other health and social services needs in the course of providing Triple P services, they will make referrals and ensure a warm hand-off to other community resources. If they are not doing so already, host organizations will be strongly encouraged to train and support practitioners to use Unite Us, the bi-directional, closed-loop referrals used by Alliance and growing number of nonprofit and public agencies serving the Medi-Cal population.

Outcomes:

1. By October 31, 2024, up to 20 bilingual or monolingual Spanish-speaking CHWs, promotores/parent leaders, and other providers will be accredited in Level 3 Primary Care Triple P (0-12, or Core Triple P curriculum).
2. By October 31, 2025, 75% or more of the parents who participated in Level 3 Triple P Workshops are likely to use the parenting strategies taught in the classes using participant responses of 4 or 5 on a 5-point scale to the statement,
3. By October 31, 2025, 75% or more of parents who completed Level 3 Primary Care Triple P services (3-4 brief sessions) reported improvements in one or more of these domains: Parental Confidence; Children's Behaviors; Positive Experiences with Parenting; Partner support.

Impact:

- Number to be Served by Project: 112 parents of children ages 0-5 enrolled in Medi-Cal
- Target Population/ Geographic Location: Spanish-speaking and Latine parents in Santa Cruz County (51% South County. 23% Mid County, 16% Santa Cruz/Scotts Valley/San Lorenzo Valley

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Merced County Office of Education**
County: Merced
Grant Award History: No

Parent Education and Support

Project Name: Triple-P Curriculum
Proposed Start/End Dates: 11/01/23 – 10/31/25
Total Project Budget: $134,668
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: Merced County Office of Education seeks funding to implement the Positive Parenting Program (Triple-P) curriculum at the Family Resource Center (FRC) in Merced County for parents with children ages 0-5 within the Medi-Cal population.

The Positive Parenting Program (Triple P) is an evidence-based that provides parents with simple, practical strategies to build strong, healthy relationships, confidently manage children's behavior and prevent problems from developing. Practitioners must be trained in the Triple P curriculum to achieve program fidelity in the five-level system. Levels 2-4 provide direct support to parents at increasing levels of intensity and in different formats, including additional childhood programs to help parents manage their children's anxiety. FRC staff and community partners would be trained in Triple P's Level 3 and 4 and meet current service gaps to meet Merced County families' needs. Because of the large Hispanic population in Merced County, a Spanish version of the Triple-P curriculum will be used.

The FRC operates under the umbrella of the Merced County Office of Education that collaborates with other Medi-Cal Partner(s) (e.g., Behavioral Health and Recovery Services and Merced County Human Services Agency). The FRC provides prevention and early intervention services to families with children ages 0-18 and those who care for them including parents, guardians, child-care providers, and teachers throughout Merced County. The FRC has maintained an effective information network for service providers in Merced County by linking programs and improving access to potential partnerships communitywide via referral system Unite Us funded by the ACE Aware Initiative in 2021. FRC will continue to partner with local health care providers, clinics, and community organizations that offer physical and behavioral health care services for children. These partnerships will allow facilitators to easily refer Triple P program participants to appropriate providers.

Grant funds would support recruitment and training of up to 20 Triple P facilitators (six Spanish speaking. The principal trainer(s) are employees of MCOE and Independent Contractors who specialize in facilitating parenting curricula through the FRC. One of the FRC trainers is certified as Master Trainer for the Nurturing Parenting Program, Positive Discipline, and Healing Historical Trauma. The FRC will maintain the number and diversity of trainers needed to support the training schedule.

MCOE would implement 12 eight-session series (50% in Spanish) with a maximum of 10 participants per cohort. Parents will be reached through Social Workers, pre-schools, school districts, medical clinics, the faith-based community, law enforcement, and non-profit organizations. We will collaborate with pediatricians and healthcare providers by distributing program brochures, providing program information

in waiting areas, and establishing referral mechanisms to ensure that families are aware of our services and can easily enroll in our program.

Outcomes:

1. By October 31, 2025, twelve (12) Triple P evidence-based educational series will be provided in English and Spanish for 120 parents of children ages 0-5 in Merced County.
2. By October 31, 2025, the number of parents who have access to parenting support and resources will increase as measured by pre/post assessment data and client satisfaction questionnaires.
3. By October 31, 2025, parents will identify strengths and weaknesses in their parenting role models to enhance their own parenting skills using the Family Adjustment Scale Self-assessment (PAFAS).

Impact:

- Number to be Served by Project: 108
- Target Population/ Geographic Location: Parents of children ages 0-5 of 5 enrolled in Medi-Cal in Merced County, 70% non-white and 40% have a language other than English as their primary language.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Positive Discipline Community Resources**
County: Monterey
Grant Award History: No

Parent Education and Support

Project Name: Central Coast Positive Discipline Parent Education
Proposed Start/End Dates: 11/01/23 – 0 6/30/2025
Total Project Budget: $502,239
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: Positive Discipline Community Resources (PDCR) utilizes the Positive Discipline Parent Education model, an evidence-based model, to support Santa Cruz and Monterey Counties community of families, schools, and service providers to benefit children's social-emotional development. The power of this model has been demonstrated in studies showing improvements in children's social, emotional, and behavioral wellbeing. In 2022-23 their program reach grew from 600 to now serving 1,193+ families; 46% Spanish, 40% English, 14% Mixteco. PDCR supported 231+ Pajaro flood impacted pregnant and postpartum families with children 0-5. Through the Parent Education and Support grant, PDCR would focus their reach to better serve the 0-5 community.

Since 2009, Positive Discipline Community Resources (PDCR)'s has supported the Santa Cruz and Monterey counties' communities of families, schools, and service providers to strengthen child and parent/caregiver relationships through positive parenting practices with a focus on promoting a sense of belonging and significance among both children and their caretakers. Through the Positive Discipline (PD) model ("connection before correction"), PDCR strengthens child and parent/caregiver relationships through positive parenting practices with a focus on promoting a sense of belonging and significance among both children and their caretakers. They have a pool of 975+ PD Certified Educators and 4 PD Certified Trainers. Since the pandemic, PDCR made all services free for all families, as well as increasing our cultural responsively to this region in offering in-person and virtual programs for families available in English, Spanish and Mixteco (Indigenous language to Oaxaca).

PDRC would use Alliance grant funds to support a Program Manager position, which has also been written into the Child Youth and Family Well-being State Block Grant for additional support. PDRC will establish formal relationships with at least five (5) partner organizations that identify a key staff point of contact for integrating PD, with the goal of integrating facilitators on-site at partner organizations. Progress has been made with early education partner Raices y Cariño Family Resource Collaborative, and First 5 Monterey County funded partners who have in the past invested in getting their staff trained in PD and will now be serving Pajaro with greater intention.

PDRC and its partners will provide a robust program inclusive of two rounds of 40+ classes/ workshops and 2+ certification trainings for parents/caregivers/educators/service providers. PDRC seeks to implement a tiered system of support that features mentorship through cohort groups, co-teaching opportunities, and one-on-one coaching and mentorship toward Advanced Candidate training for parents/caregivers and educators. Objective 5: Establish data collection and reporting

systems that value qualitative and quantitative measures of impact and report on expansion efforts and lessons learned.

Referral pathways will be co-developed with key partners. Progress has been made to ensure programming aligns with goals for expanding service to parents of children ages 0-5. The program will recruit and enroll participants both organically through access and awareness activities in the community to the public to engage hard to reach subsect of the population and through embedded partnerships. Current outreach and engagement strategies include text, phone, and social media platforms, word-of-mouth, tabling, presentations, warm hand-off referrals, and emails to a growing database of more than 975 practitioners and 5,000 families. Our partnerships specifically within the Pajaro Valley have led to providing coordinated care to families with infants and children in the hard-to-reach areas of Pajaro/Las Lomas.

PDCR has the support of First 5 Monterey County (F5MC) who selected Positive Discipline as one of their preferred programs, requiring their funded partners, including PDCR, to become certified in the program and encouraging integration of the curriculum in schools/resource centers/childcare centers. Through their new Strong Start Partnership, PDCR is supported to design/provide cohesive coordinated care to families, develop connections among early childhood providers and participate in F5MC capacity-building and policy efforts to align with their early childhood development agenda.

Outcomes:

1. By June 30, 2025, conduct two rounds of 40+ classes/workshops for parents of children ages 0-5.
2. By June 30, 2025, establish eight (8) key partnerships within the early in Monterey County to Increase the number of Medi-Cal eligible participating families from 35% to 75%, as measured through partner intake and referral information.
3. By June 30, 2025, conduct two (2) Positive Discipline certification trainings for 20+ educators and provide mentorship activities to support professional development.
4. By June 30, 2025,, 80% of the families served will self-report reduced parental stress, increased access and awareness of community resources and increased knowledge about how to practice effective parenting, as measured by participant surveys and evaluation instruments.

Impact:

- Number to be Served by Project: 750
- Target Population/ Geographic Location: Parents of children 0-5 in Monterey and Santa Cruz counties, including farmworker and migrant status families.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant:	**The Parenting Connection of Monterey County**
County:	Monterey
Grant Award History:	No

Parent Education and Support

Project Name:	Family Circles
Proposed Start/End Dates:	11/01/23 – 10/31/25
Total Project Budget:	$79,200
Request Amount:	**$79,200**
***Recommended Award:**	**$79,200**

Proposal Summary: The Parenting Connection of Monterey County (PCMC) is requesting grant funding to expand its capacity to offer circles at all three of the Alisal Unified School District Family Resource Centers as well as into the city of Pajaro, a section of Monterey County that has been historically underserved and, in light of recent climate disasters, has never been more in need of support. PCMC will be subcontracting with Raices y Cariño Family Center (RC) which has served as a point of contact and resource distribution center for Pajaro since its inception and thus is uniquely positioned to facilitate the services in that community.

Family Circles are facilitated in Mixteco/Triqui and those attending will be from that identified community in Wellness Living, PCMC's booking system. Family Circles build a space designed to create community, provide mental health support, and connect families to additional community resources. PCMC has been facilitating these spaces throughout the county since Summer 2021 and will be starting a circle at The Alisal Family Resource Center, one of three centers belonging to Alisal Union School District (AUSD). PCMC is seeking to expand their capacity to offer circles at all three of the AUSD Family Resource Centers as well as into the city of Pajaro. PCMC will be subcontracting with Raices y Cariño Family Center (RC) which has served as a point of contact and resource distribution center for Pajaro since its inception and thus is uniquely positioned to facilitate the services in that community.

Referrals from the Family Circles for Indigenous Families will be tracked by the Peer Navigation Specialist. The Family Circles program is the preexisting referral structure that PCMC has developed and grown since Summer 2022. Their referral workflow facilitates access to services and resources that support the health and well-being of young children and their parents/ caregivers and provides follow up support once the referral has been made. Over the years that PCMC has been in existence and specifically in the last 18 months where they have been focusing their work on the Latinx community, they have created a robust referral directory in the areas of mental health, childcare, housing assistance, food security, and many other important areas. Families will be invited to participate through the connection they already have with AUSD and RC, and their extensive networks. Word of mouth will also be a way in which the community will learn about the circles es which is why it is so important that PCMC is partnering with AUSD and Raices y Cariño who are already embedded in the community.

The grant will also allow cultural competency training and Diversity Equity and Inclusion work to be done at all levels of the organization which increases our commitment and alignment to our mission and vision

Outcomes:

1. By December 30, 2025, a minimum of six (6) trained Mixteco and/or Triqui speaking facilitators will facilitate Family Circles in 3 locations in East Salinas and Pajaro.
2. By December 30, 2025, a total of 200 Indigenous-identifying families will have attended the Family Circles.
3. By December 30, 2025, a minimum of 100 referrals will be made to other community services through the Family Circles in East Salinas and Pajaro.

Impact:

- Number to be Served by Project: 450
- Target Population/ Geographic Location: Families with children enrolled in Medi-Cal in East Salinas and Pajaro Valley, primarily indigenous farmworkers who are Spanish speaking or speak Indigenous languages Mixteco and/or Triqui.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Centro Binacional para el Desarrollo Indígena Oaxaqueño**
County: Monterey
Grant Award History: No

Community Health Champions

Project Name: Indigenous Health Initiative
Project Partners: N/A
Proposed Start/End Dates: 10/15/23-10/14/25
Total Project Budget: $ 255,458
Request Amount: **$ 100,000**
***Recommended Award:** **$ 100,000**

Proposal Summary: Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO, or Binational Center for Indigenous Oaxacan Development) seeks funding for the Indigenous Health Initiative to facilitate cultural and linguistic access to health care and social services programs, like Medi-Cal, for Indigenous communities in Monterey County, such as the Mixteco, Triqui, Chatino, and Zapotec communities. The Indigenous Health Initiative would support CBDIO's community workers, who they define as their community health champions, to engage in community outreach, education, and organizing around health justice for Indigenous families in South County, with the project's team members being primarily based in CBDIO's Greenfield office.

After the COVID-19 pandemic, health justice and education garnered more attention, especially for migrant and farm working communities in rural areas of California. CBDIO became heavily involved in several initiatives at the time on health education and outreach, focusing on efforts to reach Indigenous communities with culturally and linguistically appropriate resources and services. But as COVID-19 related grants and initiatives came to a close, so did much of the funding for CBDIO's health-related services and outreach. Even while the funding dwindled though, CBDIO's community workers have continued to provide health-related support services and community outreach and education.

The Indigenous Health Initiative would allow CBDIO to build the infrastructure to best facilitate access to our application assistance services, and help to better coordinate our community education, outreach, and organizing efforts around mental health and health justice. The funding from this grant would provide supportive funding to our Program Coordinator and Monterey County Programs Director who can then dedicate time to support CBDIO's community workers in their Medi-Cal and social services direct assistance work and to coordinate CBDIO's health justice education and outreach efforts. These direct assistance and community outreach and education efforts are much needed with the upcoming Medi-Cal expansion for ages 26 to 49, regardless of immigration status.

The project aims is to reach 1,000 individuals in South County in order to increase their awareness and knowledge of Medi-Cal benefits, community resources and how to access care through community outreach and education; increase the number of community resource access points by expanding CBDIO's capacity to directly assist Indigenous community members; and engage youth and adult Medi-Cal members in advocacy that positively impacts individual and community health and reduces stigma and barriers to care through community organizing. All data will be tracked maintained in CBDIO's current case management systems.

Currently, CBDIO's community workers all engage in community education and direct assistance efforts. CBDIO community workers assist community members who walk-in for assistance with Medi-Cal and other public benefits applications, and they engage in community outreach and education about Medi-Cal and other social services programs. Unfortunately, much of this work is unfunded and spread out amongst all of our team members who already have ongoing grants or projects that they are dedicated to. CBDIO's community workers primarily come from

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

the Indigenous communities that they serve though and are committed to responding to the needs of the community.

Through this coordinated and supported direct services and community education and outreach, CBDIO's community workers will be able to provide individualized direct assistance to Indigenous community members, and train community members on Medi-Cal eligibility and services and the availability of other community resources and health care access points. By encouraging and promoting the use of these health care and social services, CBDIO's community workers can help to alleviate concerns and distrust of these programs, dispel misconceptions about ineligibility based on immigration status, ensure that they know their right to request an interpreter when using services, and empower community members to understand their overall rights in health care and social services settings.

Outcomes:

1. By October 31, 2024, assist 20 people per month who speak indigenous languages with navigating health care resources in the community
2. By October 31, 2024, reach at least 75 people per month in community education and outreach, specifically focused on health justice, social services programs, housing, mental health, health rights, and labor rights.
3. By October 31, 2024, hold two community meetings every six months to discuss health justice topics under the Indigenous Health Initiative.

Impact:

- Estimated number to be served by project: 1,000
- Geographic location: Greenfield, Soledad, King City.
- Target Population: Indigenous communities who speak Mixteco, Triqui, Chatino, Zapotec, or Spanish.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Community Health Trust of Pajaro Valley**
County: Santa Cruz
Grant Award History: Yes

Community Health Champions

Project Name: Los Triunfadores de la Salud
Project Partners: Pajaro Unified School District
Wastonville High School
WIC Watsonville
Watsonville Family YMCA
Proposed Start/End Dates: 10/15/23-10/14/25
Total Project Budget: $ 120,744
Request Amount: **$ 100,000**
***Recommended Award:** **$ 100,000**

Proposal Summary: Los Triunfadores de la Salud (health advocates) is a program under The Community Health Trust of Pajaro Valley (CHT). The organization has focused on health equity in the Pajaro Valley since 1998 when an overwhelming number of patients were seeking emergency care for uncontrolled diabetes. Today, CHT's services focus on health equity and wellness through the promotion of activities and choices that prevent illness and improve quality of life.

Los Triunfadores de la Salud is a two-year project whose objective is to foster and strengthen the relationship between community members in Pajaro Valley and healthcare resources, particularly among residents who are enrolled in or eligible for Medi-Cal. Program staff will organize, train, and support youth and adults to both educate their peers and families on specific health topics and to promote available health care services and resources and health literacy among peers and families. Furthermore, Los Triunfadores de la Salud will serve as a valuable source of feedback for CHT, strengthening the organization's services for the Medi-Cal members. Los Triunfadores de la Salud advocates will be more accessible and approachable to individuals who may feel intimidated or uncomfortable seeking health information from professionals or in more formal settings. They will also deliver the information in a culturally and linguistically competent format as they are peers with workshop attendees. This accessibility facilitates better engagement and understanding of health education.

The program recruit 20 adult and high-school aged residents who are currently Medi-Cal members to act as Los Triunfadores de la Salud. They will recruit adult advocates from their own program participants as well as WIC and YMCA. Young adult advocates will be recruited by CHT's community health worker (who will make presentations at the Wellness Center at the Pajaro Unified School District (PVUSD) and Watsonville High School's Health Academy. These advocates will undergo training conducted by CHT and cover various health-related topics such as nutrition and healthy eating, resources available in the community for low-income families and individuals, how to engage people and the importance of community health. After the training, the 20 advocates will actively lead 10 educational workshops, sharing their knowledge with friends, family members, colleagues, and other familiar connections. The training sessions will be held at accessible community locations, namely CHT's Diabetes Health Center, Callaghan Park, and PVUSD's Wellness Center. These sites have been selected to ensure convenience and easy accessibility for community residents.

Outcomes:

1. By July 31, 2025, 10 adults and 10 youth will be recruited and trained to be advocates for the Los Triunfadores de la Salud program.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

2. After six months of training and based on pre/post survey responses, 20 advocates will indicate greater understanding of nutrition education and heightened comfort level in encouraging others to make healthier lifestyle choices.
3. By October 31, 2025, 20 advocates will each present three healthy lifestyles educational presentation to at least 10 individuals, reaching a total audience of 600+ people.

Impact:

- Number of estimated to be served: 600
- Percentage of Medi-Cal population: 81%
- Geographic Location: Pajaro Valley
- Target/focus Population: Majority Latinx facing poverty and high rates of chronic illness, including obesity.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **FoodWhat?!**
County: Santa Cruz
Grant Award History: Yes

Community Health Champions

Project Name: Youth Empowerment, Healthy Food Access & Loving Community
Project Partners: Pajaro Valley Unified School District
Proposed Start/End Dates: 2/1/2024 - 10/31/2024
Total Project Budget: $641,113
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: The Youth Empowerment, Healthy Food Access & Loving community, is a project dedicated to empowering marginalized youth through a lens of youth empowerment, food justice, and health equity. The project focuses on fostering the well-being, agency, and liberation of disadvantaged youth by engaging them in various activities such as organic farming, improving food access, addressing food justice concerns, creating healthy meals, accessing nutritional education, emphasizing mental health support, and cultivating a supportive community environment.

Funds from this grant will be instrumental in the expansion of participation from 70 to over 90 youth per year. The growth is facilitated by the addition of new staff positions, which enhances the capacity to meet the increased demand for FoodWhat?! (FW) programming. The expansion allows for improved, deepened, and expanded farm, culinary, and wellness activities, enriching the youth experience and promoting wellness to contribute to greater health equity in the Pajaro Valley community.

Part of FW youth's overall work focuses on operating and leading the affordable farm stand that takes place at E.A Hyde Middle School in partnership with Pajaro Valley Unified School District's (PVUSD) Wellness Center. PVUSD's Wellness Center is a community resource center where local students and families access behavioral health services and utilize food access points (of which FW is one). By being an important services provider offered through this resource center, FW youth help draw local students and families into the center in ways that make it more likely that they will access the other community resources, particularly the behavioral health services.

Key to the success of the FW program is that it operates using a graduated leadership model that encompasses three key phases: Spring Internship, Summer Job Training, and Fall Project Management. These programs offer paid positions and cater to the unique cultural contexts of the marginalized youth participants. This model supports sustaining youth over time and contributes to local health equity efforts by enhancing healthy food access in areas where residents face income insecurity, high rates of food insecurity and diet-related health concerns.

The effectiveness of FW's approach is underpinned by the fact that both youth participants and staff share cultural backgrounds, languages, and lived experiences with the communities they support. This shared understanding facilitates effective engagement and empowers these communities. The program is deeply rooted in the community, aligning with a youth empowerment perspective that prioritizes the voices and agency of young people. The approach emphasizes youth empowerment, which challenges existing definitions of success set by inequitable systems and empowers marginalized individuals to take charge of solution-building processes. This approach results in youth becoming culture shapers, advocating for healthy food access, and addressing the societal issues that hinder community well-being.

Outcomes

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

1. By November 2024, 80% of FW youth will experience increased wellness as exemplified by radical diet change which can be brought about by developing new and/or deepened relationships with healthy food, measured by administering three program surveys after each core program.
2. By November 2024, FW youth will distribute 5,000 lbs. of healthy food they helped grow through our family produce box project and our affordable farm stand project that takes place at E.A.
3. By November 2024, create and consume a total of approximately 1,700 healthy meals. This outcome will be measured using "load lists" which is a tool farmers use to track how much produce is distributed through a food access point by weighing produce amounts before and after distribution.

Impact

- Number to be reached by project: 90
- Geographic Location: Pajaro Valley
- Target Population: Majority low-income, Latinx youth.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Raíces y Cariño**
County: Santa Cruz
Grant Award History: Yes

Community Health Champions

Project Name: Building a Healthy Community
Project Partners: Campesina Womb Justice
Center for Farmworker Families
National Alliance on Mental Illness Santa Cruz County
Pajaro Valley Pride
Salud Para La Gente
San Andreas Regional Center
Special Parents Information Network
TransFamilies
Proposed Start/End Dates: 11/01/2023-10/31/2025
Total Project Budget: $150,000
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: Raíces y Cariño (RC) seeks grant funding for Building a Healthy Community, which aims to provide essential support and resources to underserved communities within the Pajaro Valley. Recognizing the unique needs of families with neurodiverse children and those identifying under the LGBTQ+ umbrella, the proposal focuses on offering mental/behavioral health support, enrichment activities, and a safe gathering space for these families. The project's overall goal of providing essential support to families in need, focusing on cultural competence, accessibility, and creating a safe and supportive environment for healing and growth. Grant funds would allow RC to hire and train Community Health Workers within the Pajaro Valley community to provide mental/behavioral health support, expanded programs tailored to LGBTQ+ and neurodiverse and/or disabled families and enrichment activities, as well as maintaining a safe hub for these families to gather, learn, and heal together in Spanish and the Indigenous Oaxacan languages.

Currently, families in these groups often lack accessible and culturally competent support services in their local area. Many must travel long distances to larger cities to access the necessary resources. This project seeks to bridge this gap by hiring and training community health workers from within the community itself. The workers will provide peer-to-peer support, facilitate enriching activities, and create a supportive environment for families to connect, learn, and heal together. RC will train facilitators in the Peer-to-Peer framework, best practices for group facilitation, data tracking systems, and utilizing the Unite Us platform for referrals and resource access managed by Peer Navigation Specialists, connects families with individualized resources and provides ongoing follow-ups to help navigate any potential barriers. The peer-to-peer structure ensures that support is provided at no cost, in comfortable locations (including participants' homes), and with a focus on accessibility.

Their current partners include San Andreas Regional Center (SARC), Special Parents Information Network (SPIN), Pajaro Valley Pride (PV Pride), TransFamilies, Salud Para La Gente (SPLG), Campesina Womb Justice, Center for Farmworker Families, and the local chapter of National Alliance on Mental Illness (NAMI), among others. Of these local agencies and organizations, all have expressed our mutual client's need for cultural and linguistic support for the unique needs of their families. The project's success is rooted in its collaborative nature, uniting organizations, providers, and agencies that work in maternal/perinatal mental health and general community health. The partnership with various local organizations helps identify potential champions, and the Unite Us platform facilitates efficient referral and follow-up processes.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Outcomes:

1. By October 15, 2025, RC will train 5 Peer Support Specialists (facilitators).
2. By October 15, 2025, RC will establish ten peer led perinatal, LGBTQ+, and Neuro-Diverse support groups in underserved communities Watsonville center and Pajaro location to reach 250 families through peer led support groups and play groups.
3. By October 15, 2025, RC will make 100 referrals to community partners through the Peer-to-Peer Support led groups.

Impact:

- Number to be reached by project: 790
- Geographic Locations: residing in the Pajaro Valley
- Target Population: the majority of whom will be Medi-Cal members/Medi-Cal eligible and Latinx.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **The Parenting Connection of Monterey County**
County: Monterey
Grant Award History: Yes

Community Health Champions

Project Name: Peer to Peer Support Network
Project Partners: Las Mamas
Proposed Start/End Dates: 10/15/23-10/14/25
Total Project Budget: $ 88,900
Request Amount: **$ 88,900**
***Recommended Award:** **$ 88,900**

Proposal Summary: The Parenting Connection of Monterey County (PCMC) initiated its efforts to establish a Peer-to-Peer support network in the spring of 2023, focusing on maternal mental health. Two cohorts were trained on the Mothers and Babies framework, an evidence-based intervention developed by Northwestern University that addresses Perinatal Mood and Anxiety Disorders (PMAD). This framework, based on principles of Cognitive Behavioral Therapy, equips individuals with stress management techniques, mindfulness, understanding the connection between thoughts and feelings, and building a support system. The trained cohorts, one English-speaking and one Spanish-speaking, are working to establish Peer-to-Peer support groups within their communities, aiming to support new families and prevent instances of PMAD.

PCMC proposes using grant funds to expand the reach of this network by training new cohorts in specific communities where maternal mental health support is insufficient. Collaborating with grassroots organization Las Mamas Abogan, which advocates for early childhood development and supports parents to become leaders and advocates within educational systems, PCMC seeks to leverage their community ties and expertise to extend the impact of their work. This collaboration will effectively extend the reach of the maternal mental health support network to communities that may be underserved. Las Mamas Abogan will subcontract with PCMC to assist in the expansion efforts.

PCMC will utilize a train-the-trainer model for the expansion. Experienced PCMC staff will be the primary trainers for coordinators selected from the communities. These coordinators will then train facilitators from their own communities. This approach ensures that the training is tailored to the linguistic, cultural, and logistical needs of each community. Regular reflective practice circles will be established to foster a supportive environment for coordinators and facilitators. These circles will provide a platform for sharing experiences, receiving guidance, and addressing challenges related to supporting family mental health during the perinatal year. Coordinators and facilitators will participate in follow-up training sessions to further enhance their skills and understanding of maternal mental health support. This continuous learning approach aims to equip them with comprehensive tools to effectively assist families.

Outcomes:
1. By October 15, 2025, train five Peer Support Specialists (facilitators).
2. By October 15, 2025, establish ten peer led postpartum support circles in underserved communities in Monterey County that will serve 250 families through peer led support groups.
3. By October 15, 2025, make 100 referrals to community partners through the Peer-to-Peer Support led circles.

Impact:
- Number to be reached by project: 790
- Target Population: Latinx birth-giving community and their families.
- Geographic Location: Salinas, with special focus on the East Salinas community.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Community Health Trust of Pajaro Valley**
County: Santa Cruz
Grant Award History: Yes

Partners for Active Living

Project Name: Active Wellness
Project Partners: Diabetes Health Center
Proposed Start/End Dates: 11/01/23 - 10/31/25
Total Project Budget: $296,822
Request Amount: **$201,429**
***Recommended Award:** **$201,429**

Proposal Summary: The Community Health Trust of Pajaro Valley's (CHT) strategic plan charted a new course in 2020 that focuses on health equity and wellness. One aspect of the new direction is a plan to convert the Diabetes Health Center (DHC) into a wellness center, which would expand services to include primary care, physical therapy, and physical activity classes.

CHT will launch the Active Wellness project as part its expansion which will offer weekly physical activity classes offer free of charge to Medi-Cal members, including balance and mobility work to yoga and Zumba. CHT will also conduct enhanced healthy lifestyle classes that integrates physical activity education content with the organization's existing 5 Steps to Prevent Diabetes course. In the first year, DHC will offer eight six-part courses; sixteen courses will be offered in year two. The goal of the Active Wellness project will be to weave physical activity classes and healthy lifestyle courses, thus making a cognitive connection with the physical benefits of the patient's increased activity.

Patients of the Diabetes Health Center will be referred to classes as part of their treatment plan. Upon their initial assessment, existing DHC patients will have the opportunity to enroll in physical activity classes, and their ongoing participation will be encouraged during follow-up visits. Beyond DHC, such as for patients of Salud para la Gente, their provider can recommend their participation in the Active Wellness programs. The patients can then visit the website to explore class options, complete the registration process, or seek guidance from DHC for registration. A $10 coupon for fresh produce will be given as an incentive to anyone who participates in 10 physical activity classes.. To facilitate access and provide class details, the CHT website will host a calendar of offerings, allowing online sign-ups.

All classes will take place at the City of Watsonville's Callaghan Park, close to downtown Watsonville. Callaghan Park is a 2.64-acre neighborhood park, with basketball courts, an indoor cultural center, children's playground, and tennis courts. This location is ideal for reaching the primary audience as the rate of sedentary adults in this census tract is 30.7%, one of highest in the Pajaro Valley. Any Medi-Cal member, whether they are affiliated with DHC or not, will be eligible to join the classes at no cost.

Outcomes:

1. By October 31, 2025, six physical activity classes will be offered once a week for 46 weeks at Callaghan Park in Watsonville.
2. By 31, 2025, a total of twenty four, six-part healthy lifestyle courses will be offered that combines the existing 5 Steps to Prevent Diabetes course with physical activity education content at Callaghan Park in Watsonville.
3. By October 31, 2025 at least 880 individuals (686 of whom are Medi-Cal members) will attend 10 or more Active Wellness program classes.

Impact:

- Number to be served by project: 880
- Percentage of Medi-cal Members to be Served 78%
- Geographic Area: Pajaro Valley
- Population of Focus: Primarily Latino residents who suffer high rates of chronic illness, such as diabetes and obesity.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Urban Works**
County: **Santa Cruz**
Grant Award History: No

Partners for Active Living Program

Project Name: Re-creation through Recreation
Project Partners: Living Evolution;The Camp Recovery Center; New Life Recovery Center; Hope Services; Hospice of Santa Cruz; County of Santa Cruz IHSS
Proposed Start/End Dates: 11/01/23 - 10/31/25
Total Project Budget: $ 144,000
Request Amount: **$ 73,000**
***Recommended Award:** **$ 73,000**

Proposal Summary: Urban Works is a nonprofit with the mission to embrace art and recreation as tools to overcome the faith, social and economic barriers that inhibit the cultivation of a more healthy and cohesive community in partnership with the County's Supportive Services Department, addiction rehabilitation centers and a variety of nonprofit agencies. They have been providing recreational programs for individuals living with disabilities and/or recovering from substance use disorders for over ten years, primary Medi-Cal members. Their diverse program offerings include:

- Inclusive dance offering, www.worldanz.com, offers accessible free dance classes throughout the county (Watsonville to Santa Cruz) every day of the week.
- 'Worries to the Wind' adaptive sailing program (www.saltysheep.org) features a wheelchair accessible 25 passenger catamaran and hosts two free outings per week leaving from the Santa Cruz Harbor.
- Experiential therapy program (www.livingevolution.org) utilizes outdoor activity as a means of exploring the personal and social mental health needs of the community.
- Adventure therapy program, which unites all of our interdependent, independent initiatives for weeklong recreational retreats to Lake Tahoe twice per year.

The Urban Works collective leadership team features several licensed therapists whose practices cover Medi-Cal. This allows for in-house referrals while fostering a safe, empowering and inclusive environment. By partnering with other agencies to offer healthy recreational and nutritional programing to their clients, they are able to utilize their medical/behavioral staff while complimenting their unique missions.

The Re-creation through Recreation project will provide free recreational programming for all ages & ability levels through adaptive sailing initiative, daily dance classes (also offered virtually) and therapeutic retreats. The seasonal retreats act as stepping stones into an active lifestyle by offering a healing week of healthy eating and nutritional coaching, constructive conversations led by a team of experiential therapists, and a spectrum of accessible recreation. As a way of bringing together all of their offerings, Urban Works will launch a "Park Takeover" initiative in which they partners with County Parks and Recreation to offer free dance, yoga, sport and healthy food to the community at a different site every month.

Grants would support an Americorps volunteer to oversee Medi-Cal engagement in program, a fleet of tandem kayaks and wheelchair ramp, and further development of their dance program to be self-sustaining. Urban works would expand their water sports programming through tandem kayaking which provides a workout as well as a safe median for behavioral intervention and counseling. They are able to purchase Advanced Element Kayaking equipment at cost and would purchase a trailer through other funding source to transport kayaks and participants between Santa Cruz Harbor and Moss Landing in Watsonville. Their recreational therapist and Marriage and Family therapist are each certified river guides would be hosting monthly trips down the American River in addition to our offerings on Monterey Bay.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

This project will support Urban Works in building their model for sustainability. They are currently working with the Department of Rehabilitation and the San Andreas Regional Center to monetize their program for sustainability. The state has funding set aside ranging from $30-$60/hour for recreational programs for disabled populations. By becoming a vendor for the County, they would be able to earn income for each participant without charging the actual participant to participate.

Objectives:

1. By November 30,2025, expand programs by adding 12 new teachers and two weekly classes specifically for Medi-Cal population to teach kayaking/river rafting, yoga, and dance.
2. By November 30,2025, recruit and manage participation of Medi-Cal participants for all expanded class offerings.
3. By November 30,2025, offer Adventure Therapy Retreat (in partnership with Zephyr Camp) twice per year.
4. By November 30,2025, host monthly Health & Recreation County Park Takeover series at parks throughout the county.

Impact:

- Individuals served annually by project: 750
- Percentage of Medi-Cal Members to be Served: 33%
- Geographic Area/ Target Population: Santa Cruz and Watsonville
- Population of Focus: Primarily people with disabilities and in recovery for substance use disorder

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Esperanza Community Farms**
County: Santa Cruz
Grant Award History: Yes

Partners for Health Food Access

Project Name: Activating CSA Member Power
Proposed Start/End Dates: 11/01/23 – 10/31/25
Total Project Budget: $405,952
Request Amount: **$196,962**
***Recommended Award:** **$196,962**

Proposal Summary: Esperanza Community Farms (ECF) was previously awarded a Healthy Food Access grant in 2020 for their Receta Vegetal program to establish a community supported agriculture (CSA) home delivery program. Esperanza Community Farms operates a three-acre community farm located near Highway 1 in Watsonville in Santa Cruz County and partners directly with local Latinx farmers who cultivate organic produce on 74 acres across three counties. The CSA program has expanded since it was established from 30 to 175 member families. ECF collaborates with the 9 Organic Farmer Co-op, a local farmers-of-color co-op, to cultivate pesticide-free, culturally preferred produce for the CSA Program and build their economic development capacity and change systems to ensure farmer's access to stable and profitable markets. ECF also operates a Farm-to-Cafeteria program in two high schools in Pajaro and Salinas Valley which reaches 600+ majority underserved students in two high schools with seasonal produce and train student leaders to prepare and serve salads and spread awareness about healthy eating.

The proposed grant project will deepen Esperanza Community Farms (ECF) engagement with existing CSA member families and increase participation in the program, offering expanded access to fresh, organic, subsidized produce in Watsonville. ECF and the 9 Organic Farmers Co-op will cultivate produce including planting, harvesting, packing, and transporting baskets from the farm to members' doors. They will establish a member-operated local farm stand that serves the Pajaro Valley public, with a goal of serving 70% Medi-Cal members. In partnership with The Diabetes Health Center at Community Health Trust (CHT), ECF will deploy a promoatora and a registered dietician to conduct food insecurity and BMI screenings with Medi-Cal members over the duration of the project and enroll members in two series of six-session nutrition education workshops held on the farm, covering a range of topics, including healthy and nutritious eating, physical activity, and overcoming barriers to health. CHT will support enrollment for WIC and CalFresh-eligible families.

ECF will act as a hub to connect CSA members to local food-related community resources to supplement the CSA food delivery, farm stand and workshops. ECF will establish streamlined methods of referral and communication with members to establish networks of support that address different aspects of health, including dietary education, medical services, local advocacy, and social services. Community resources will be promoted through materials at the farm stand, fliers in CSA boxes, and quarterly text or Whatsapp links. These activities include promotion of CHT's farmers market at Ramsay Park (also Alliance grant-funded) and partner-sponsored health fairs offered in Downtown Watsonville's historic plaza. ECF will Invite up to 10 community partners that offer Medi-Cal, WIC, CalFresh, and other resource enrollment and CSA members to a resource fair at ECF farm site once per project year. ECF will also be a lead organizer and will facilitate a total of four collaborating organizations serving residents in Watsonville and the Pajaro Valley towards improving community health in Medi-Cal recipients and mitigating and preventing chronic diseases through healthy food access and choices.

Outcomes:

1. By 10/31/25, ECF will engage CSA and food stand customers with 30+ BMI in workshops and accessing fresh produce.

Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

2. By 10/31/25, 122 Medi-Cal recipients will have access to at-door delivery of medically supportive food for five months each for two seasons.
3. By 10/31/25, ECF will conduct pre- and post-surveys with all 275 CSA members with the goal of receiving a 60% program satisfaction rate and reported increased confidence among CSA members to manage their health and advocate for community change.

Impact:

- Individuals Served Annually by Project: 275
- Population Focus: 95% Latinx and Indigenous from Mexico, speaking monolingual Spanish or bilingual Spanish-English farmworkers and their families.
- Geographic Area: Watsonville

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **MEarth**
County: Monterey
Grant Award History: No

Partners for Health Food Access

Project Name: Organic Produce as Medicine for the Community of Big Sur
Proposed Start/End Dates: 12/01/23 – 1/30/25
Total Project Budget: $279,928
Request Amount: **$200,000**
***Recommended Award:** **$200,000**

Proposal Summary: MEarth manages a hands-on organic produce farm and education site at the nationally recognized Hilton Bialek Habitat, a 10.5-acre watershed microenvironment in Monterey County where their staff and volunteers handle the care and upkeep of the native habitats, edible garden, culinary herb garden, heirloom fruit tree orchard, and solar greenhouse. Last year, MEarth contributed multiple thousands of pounds of fresh, organic produce, reaching hundreds of our most vulnerable community members. MEarth also provides community education to share the power of environmental stewardship and sustainable practices as well as healthy lifestyle choices that improve wellness.

MEarth's proposed program, Organic Produce as Medicine, would specifically addresses the lack of consistent access to nutritious food in the Big Sur community in south Monterey County, an area that lacks community resources to support residents who may have challenges accessing healthy food. The vast majority of these are families with adult family members working multiple jobs in the hospitality industry. A majority also belong to indigenous communities or have indigenous heritage from Mexico with unique dietary needs and challenges.

In partnership with the Big Sur Health Center, the project would identify Medi-Cal members who are food insecure through a validated screening tool and assess their chronic disease indicators through checkups, health risk assessments and screening tools. Members indicating need for the program will be referred to MEarth's food distribution sessions and educational activities. The project's outcomes will be measured through tracking Big Sur Health Center's Medi-Cal members' program participation, monitoring food security status and chronic disease indicators in their electronic health record and conducting patient surveys.

Outcomes:

1. By November 30, 2025, increase access to organic produce for at least 400 participants annually.
2. By November 30, 2025, 170 households with Medi-Cal members will participate in food distribution sessions and health education activities.
3. By November 30, 2025, at least 25-35% of program participants will have adopted healthier eating habits, increasing organic fruit and vegetable intake by at least one daily serving.

Impact:

- Individuals Served Annually by Project: 1,100
- Population Focus: All ages and stages of persons residing or working in the Big Sur community, with a focus on Medi-CAL beneficiaries (or those who qualify to become Medi-CAL beneficiaries) who may have challenges accessing healthy organic food.
- Geographic Area: Big Sur

Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program

CURRENT FUNDING OPPORTUNITIES

PURPOSE

The Alliance makes investments to health care and community organizations in Merced, Monterey and Santa Cruz counties through the Medi-Cal Capacity Grant Program to realize the Alliance's vision of heathy people, healthy communities.

These investments focus on increasing the availability, quality and access of health care and supportive resources for Medi-Cal members and address social drivers that influence health and wellness in our communities.

FUNDING PRIORITIES

The Alliance invests in developing Medi-Cal capacity in three priority funding focus areas:

1) Access to Care
2) Healthy Beginnings
3) Healthy Communities

CURRENT FUNDING OPPORTUNITIES

Focus Area: *Access to Care*

Workforce Recruitment Programs provide funding to support health care and community organizations in their efforts to recruit and hire personnel to provide culturally and linguistically competent care to the Medi-Cal population in Merced, Monterey and Santa Cruz counties.

Provider Recruitment
Grants for high need priority provider types including allied, behavioral health, primary care and specialty care.

Medical Assistant (MA) Recruitment
Grants for MAs in primary care practices.

Community Health Worker (CHW) Recruitment
Grants for CHWs who become credentialed to provide the Medi-Cal CHW Benefit.

The Alliance offers an additional Linguistic Competence Provider Incentive for grantees who hire bilingual providers.

Equity Learning for Health Professionals
Grants to support training or consulting engagements that directly support Medi-Cal members in receiving equity-oriented care.

Healthcare Technology
Grants to support the purchase and implementation of specific types of technology and infrastructure that improves Medi-Cal member access to high quality health care.

Focus Area: *Healthy Beginnings*

Home Visiting
Grants to support the implementation or expansion of home visiting programs that use evidence-based models with trained professionals for pregnant women and parents of children up to age 5.

Parent Education and Support
Grants to increase access to childhood development education, parenting skills and supportive resources for parents of children up to age 5.

Focus Area: *Healthy Communities*

Community Health Champions
Grants for organizing, training and supporting youth and adults to promote individual and community health and wellness and to advocate for equity in health care access.

Partners for Healthy Food Access
Grants to support community-based projects that align with a food prescription model, including medically supportive food distribution coupled with an education and/or skill-building intervention, to improve member health and nutritious food security.

Partners for Active Living
Grants to support community-based projects that provide children, adults and families opportunities to engage in physical activity and recreation programs in the community and engage health care providers in partnering on program coordination and referral of Medi-Cal members to these resources.

APPLICATION PROCESS

- Visit our website for program descriptions, eligibility criteria and link to the online application process.
- Grant applications for Workforce Recruitment grants will be considered four times per year.
- Grant applications for all other funding opportunities will be considered by the Alliance Board two times per year.
- Applications will be accepted on a rolling basis if funds are still available. Visit the website for upcoming application deadlines and award dates.

FOR MORE INFORMATION

For questions, email **grants@ccah-alliance.org** or contact staff at **(831) 430-5784**.

For more information about the Medi-Cal Capacity Grant Program, please visit
www.thealliance.health/grants

DATE: October 25, 2023

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

FROM: Jessica Finney, Grants Director

SUBJECT: Medi-Cal Capacity Grant Award Recommendations (Group B)

Recommendation. Staff recommend the Board approve grant recommendations that total $1,619,993 for Group B of funding recommendations under Consent Agenda Item 9F, voted upon separately due to potential conflicts of interest.

Summary. See report at Item 9E for content, background, and process for this agenda item. This is the second of two recommendations to allow a separate vote on those items for which Board members may have a conflict.

Discussion.

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

County	Group A | Not Board Affiliated	Group B | Board Affiliated
Merced	$265,000	$190,000
Monterey	$1,075,833	$714,993
Santa Cruz	$984,140	$715,000
Total	**$2,324,973**	**$1,619,993**
Total Grant Award Recommendation: $3,944,966		

Fiscal Impact. Recommended grant awards totaling $3,944,966 would be funded by the MCGP budget, which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan's reserves to create the MCGP.

Attachments.

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

Medi-Cal Capacity Grant Program
Grant Recommendations
GROUP B: Affiliated with Alliance Board Members

Equity Learning for Health Professionals

County	Page*	Organization	Award**
Merced	3	Merced County Behavioral Health and Recovery Services	$40,000
Monterey	1	County of Monterey Health Department - Public Health Bureau	$40,000
Santa Cruz	4	Santa Cruz Community Health Centers	$40,000
		Subtotal	**$120,000**

Healthcare Technology

County	Page*	Organization	Award**
Merced	6	Merced County Behavioral Health and Recovery Services	$50,000
		Subtotal	**$50,000**

Home Visiting

County	Page*	Organization	Award**
Santa Cruz	7	Santa Cruz Co., Health Services Agency, Public Health Division	$125,000
		Subtotal	**$125,000**

Parent Education and Support

County	Page*	Organization	Award**
Merced	9	ACE Overcomers of Merced County	$100,000
Monterey	11	Read to Me Project	$100,000
Santa Cruz	13	Santa Cruz Community Health Centers	$100,000
	15	The Circle Family Center	$100,000
		Subtotal	**$400,000**

Community Health Champions

County	Page*	Organization	Award**
Monterey	19	The Boys and Girls Clubs of Monterey County	$25,000
Santa Cruz	17	Cradle to Career	$100,000
		Subtotal	**$125,000**

Partners for Active Living

County	Page*	Organization	Award**
Monterey	23	Boys and Girls Clubs of Monterey County	$100,000
	24	Ventana Wildlife Society	$250,000
Santa Cruz	21	Boys & Girls Clubs of Santa Cruz County	$250,000
		Subtotal	**$600,000**

Partners for Healthy Food Access

County	Page*	Organization	Award**
Monterey	26	North County Recreation & Park District	$199,993
		Subtotal	**$199,993**

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

**Final grant awards will depend on verification of actual expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **County of Monterey Health Department - Public Health Bureau**
County: Monterey
Grant Award History: Yes

Equity Learning for Health Professionals Program

Project Name: Be a Goldfish
Proposed Start/End Dates: 12/01/23 - 11/30/24
Total Project Budget: $40,000
Request Amount: **$40,000**
***Recommended Award:** **$40,000**

Proposal Summary: The proposed project is to assist Monterey County Health Department - Public Health Bureau staff in acknowledging and addressing health disparities and inequalities related to social determinants of health affecting Monterey County residents. Given the diverse background and needs of the Medi-Cal population, it is imperative that staff are culturally responsive to their clients. The project goal is to expand staff knowledge of reflective practice and, where appropriate, reflective supervision including addressing secondary trauma. The goal of this project is to increase the number of public health professionals trained in cultural competence and humility, trauma-informed care, reflective practice/supervision, and equity in the health care delivery system. Training will include focus on respecting and incorporating a client's cultural background and experience into the plan of care and interventions. Training will also include clinical interventions on trauma-informed care, social determinants of health, and secondary traumatic stress.

Training consultant selection was based on professional experience, relevance to the Medi-Cal Capacity Grant Program goals and adherence to project requirements, current needs of the Public Health Bureau, and input from Behavioral Health Bureau staff who had used training consultants. The two facilitators selected are Dr. Matthew Mock, PhD, and Al Killen-Harvey, LCSW, both recognized experts in the field. Trainers will provide sessions over 12 months in-person and virtually.

- 5 in-person trainings focused on Trauma, Secondary Traumatic Stress and Reflective Supervision for leadership and supervisory personnel.
- 8 mentoring/coaching calls delivered via video conferencing for supervisors to reinforce the learning skills related to Reflective Supervision; and
- 1 in-person full day Cultural Competency Training (with CE).
- 3 consultation group sessions on Cultural Competency.

Sessions will be designed specifically for the Community Based Nursing, Communicable Disease Prevention and Control, and Children's Medical Services divisions that encompass both field-based services and case management for clients in the County of Monterey Health Department Public Health Bureau. Prevention programs, including but not limited to Youth Violence Prevention and Healthy Aging will also participate. The trainings will translate the health equity concepts in a way that staff, including executive leadership, can operationalize for themselves and their work with their peers and clients. The Public Health Bureau will look for opportunities to embed learned concepts into workflows and protocols.

Outcomes:

1. December 31, 2024, 40 staff members will be trained in secondary trauma and reflective practice via in-person trainings, followed by virtual or in-person coaching.
2. By December 31, 2024, 40 staff members will increase knowledge on various concepts related to cultural humility and ability to demonstrate concepts through culturally appropriate case management, such as correct use of interpreters and using destigmatizing language.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

3. By December 31, 2024, 40 staff members will report an increase in knowledge on how trauma and inequity are impactful in their daily work with clients, as measured by identifying signs and symptoms of secondary trauma, and able to create a plan for themselves on prevention of burn out and compassion fatigue.
4. By December 31, 2024, 40 supervisors will increase their leadership knowledge of secondary trauma and reflective supervision including formulating a plan to support front line staff.

Impact:

- Number to be reached by project: 4,500

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Merced County Behavioral Health and Recovery Services**
County: **Merced**
Grant Award History: Yes

Equity Learning for Health Professionals Program

Project Name: Merced Ahead; Addressing Health Disparities
Proposed Start/End Dates: 11/01/2023 - 10/31/2024
Total Project Budget: $40,000
Request Amount: **$40,000**
***Recommended Award:** **$40,000**

Proposal Summary: The Equity Learning grant will fund a cross-cultural conference organized by Merced County Behavioral Health and Recovery Services (BHRS) for Merced County behavioral health care providers. The goal of the conference is to expand provider knowledge base and capacity to understand and address patient experiences, needs, and barriers with culturally sensitive and culturally responsive practices. The conference will increase the number of providers trained in cultural competence and cultural humility, trauma-informed care and equity in the health care delivery system and advance health equity in organizations that serve Medi-Cal members. Behavioral health practitioners will have an opportunity to engage and participate in culturally comprehensive workshops to further dialogue and emphasize on the marginalized experiences and disparities related to health equity, diversity, stigma, humility, and inclusion. A keynote speaker will be recruited to speak on behalf of health equity and disparities in underserved communities.

This learning collaboration will engage community stakeholders throughout the planning of the conference. A team of volunteers will be recruited within BHRS to plan and organize for the conference under the direction of Program Manager, May-Ci Xiong, MSW, LCSW. Ms. Xiong was a committee member of the Hmong Women Initiative (multi-agency collaborative effort primarily led through Merced County Human Services Agency) and provided mental health presentations at their biannual Hmong Conference in Merced that attracted 350-400 attendees from around the state of California. The team will consist of varying levels of leadership and direct face to face providers. The team will also include identifying community partners and inviting them to participate in the monthly planning meetings.

Outcomes:

1. By January 31, 2024, identify keynote speakers and obtain Alliance approval on qualifications and selection.
2. By August .30, 2024, a Cross-Cultural Conference for 100-120 behavioral practitioners in Merced County will be held at the MCBHRS Conference Center.
3. By October 31, 2024, staff will increase to 70% satisfaction rate in participating providers' commitment to actively work to eliminate health disparities and achieve health equity for all Medi-Cal recipients in Merced County.

Impact:

- Number to be reached by project**:** TBD based on participating organizations.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Santa Cruz Community Health Centers**
County: **Santa Cruz**
Grant Award History: Yes

Equity Learning for Health Professionals Program

Project Name: Diversity, Equity & Inclusion in Health Care
Proposed Start/End Dates: 11/01/2023 - 10/31/24
Total Project Budget: $78,600
Request Amount: **$40,000**
***Recommended Award:** **$40,000**

Proposal Summary: Santa Cruz Community Health Centers' (SCCHC's) Justice, Equity, Diversity & Inclusion (JEDI) team, in collaboration with consultants from the Health Improvement Partnership of Santa Cruz County (HIP), will develop and implement a three-part DEI training for all staff on trauma-informed care, cultural competence and humility, and health equity and literacy. This three-part virtual series will include identified experts in the field. Sessions will be part of all-staff gatherings and each one-hour training will have an informal test that follows, in addition to pre/post surveys. Staff will receive learning materials and meals to encourage participation. Sessions will be recorded, and video series will be used to train new staff. The JEDI team will purchase educational resources for ongoing learning and revise policies to improve culturally responsive patient-provider communication.

SCCHC's 2023-24 JEDI work plan aligns with the agency's strategic plan and focuses on four pillars that promote and advance DEI: 1) policies and procedures; 2) staff development and training; 3) staff engagement; and 4) patient/community engagement. All staff including management teams (chiefs, directors, managers, supervisors, and leads) will participate in the Equity Learning project. This includes all team members from the call center, billing, IT, HR, clinicians, medical assistants, front office, and support staff, The SCCHC board will also be invited to attend.

The DEI training aims to break down barriers in healthcare that are rooted in white privilege and oppression and will impact the SCCH team, patients, community, and system by cultivating an environment that addresses injustices and creates a diverse, equitable work environment. The training will also increase patient-provider trust and comfort, leading to more active patient participation and advocacy. Staff will be able to model cultural humility, competence, and communication for others in the medical field.

Outcomes:
1. By October 31, 2024, the number of staff newly trained under JEDI series will increase from 0% to 80% based on pre-post survey results.
2. By October 31, 2024, the patient pre/postsurvey will be administered to compare baseline data to post-training that measures indicators of health literacy, health education, cultural competency, and cultural humility.
3. By October 31, 2024, two policies around Health Literacy & Health Education will be developed to improve patient-provider communication.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

4. By October 31, 2024, add training materials and additional educational resources to existing resource libraries for staff in all SCCHC sites as ongoing training opportunities.

Impact

- Number to be reached by project**:** 11,600

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Merced County Behavioral Health and Recovery Services**
County: Merced
Grant Award History: Yes

Healthcare Technology Program

Project Name: Mobile Crisis Response Deployment Equipment
Proposed Start/End Dates: 01/01/2024 - 12/31/2024
Total Project Budget: $50,000
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: Expanding service coverage through the 24/7/365 MCRT is anticipated to place added demands on staff to work swiftly and efficiently to provide quality services within the community. Merced County is geographically large, and many outlying rural neighborhoods lack access to reliable internet connectivity. To ensure high quality and responsive care when responding to a mental health crisis, MCBHRS staff will need to be adequately equipped with necessary technology. MCBHRS staff will require a complete toolbox to address community needs and the capacity to meet that need when, where, and how it is needed. Without the necessary tools, MCBHRS staff will struggle to connect Medi-Cal members to services along the care continuum, creating obstacles for allocating emergency services and diverting those with less intensive needs to an appropriate resource.

Proposal Summary: Merced County Behavioral Health and Recovery Services (MCBHRS) is working to develop a 24/7/365 Mobile Crisis Response Team (MCRT) that will respond to behavioral health and substance use crisis across the county. The team is designed to evaluate community member's needs early and determine the least restrictive environment safe enough to place or refer one to when struggling with a crisis. Staff will respond to mental health crises in the community with the goals of stabilizing crisis, reducing law enforcement involvement, and reducing impact on local emergency resources.

MCBHRS is proposing equipping this team with laptops, headsets, and hotspots to ensure staff work effectively in the field. The primary technology for this proposal is 15 Surface Pro laptops, phones, and associated accessories. These will be allocated to the 24/7/365 team, allowing them to provide services wherever they are stationed, when responding into field, and when they are on-call. Creation of a tight-knit interconnected team to interface via this technology to the electronic health record system and telehealth software is expected to reduce response times, create better linkage coordination, and greater flexibility for clients requiring aftercare services.

Impact:
- Number to be Served by Project: 779

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **County of Santa Cruz, Health Services Agency, Public Health Division**
County: Santa Cruz
Grant Award History: Yes

Home Visiting Program

Project Name: Trauma Informed Approach (TIA) Public Health Nursing (PHN)
Proposed Start/End Dates: 11/01/2023 - 10/31/2025
Total Project Budget: $1,218,000
Request Amount: **$250,000**
Recommended Award:** **$125,000*

***Funding awarded for one year; potential transition to Enhanced Care Management provider.*

Proposal Summary: The County of Santa Cruz Health Services Agency (HSA) Public Health Division will pilot the Trauma Informed Approach Public Health Nursing (TIA PHN) home visiting model. The Children and Family Health Unit within the Public Health Division provides specialty services and builds strong partnerships to address disparities and improve access to quality health services for children, families, and communities in Santa Cruz County. The unit currently provides targeted case management to Medi-Cal members through two Public Health Nursing Home Visiting Programs: Nurse-Family Partnership for first-time parent and Field Nursing for families with children under the age of 5. Funding under the Home Visiting grant would enable expansion of home visiting services for Medi-Cal eligible pregnant and parenting people with children under the age of 5 and pilot test a new evidence-informed model.

The HSA Public Health Division is looking to test a new model as the landscape for home visiting programs has changed. Their Public Health Field Nursing Program has been funded largely through Targeted Case Management and Medi-Cal Administrative Activities. As CalAIM is currently rolling out, they are learning more about Enhanced Care Management and future restrictions on concurrent ECM and TCM enrollment. In the coming year, HSA will work with the Alliance and state partners to decipher which funding streams are the best fit for the programs doing home visiting with the perinatal population. They have also contracted with Santa Cruz County First Five to conduct a fiscal assessment of programming for the 0-5 population in the county to ensure effective and efficient utilization of available funding streams to keep perinatal home visiting programs strong in Santa Cruz County to improve equity, access, and maternal child well-being for all.

TIA PHN is currently being implemented and funded by the California Department of Public Health California Home Visiting Program (CHVP) as an innovative approach by Sonoma, Napa, and San Francisco Counties. There is a strong program evaluation component, and UCSF is currently assisting this collaborative in their pursuit of evidence-based status. Santa Cruz County has been receiving ongoing training and support from Sonoma County in preparation to pilot this model outside of those funded counties.

The TIA PHN model incorporates trauma-informed principles in all client and staff interactions, and conversations about Adverse Childhood Experiences (ACEs) while also implementing case management components employed in most evidence-based models. These components include voluntary participation, development of an individual service plan, mental health screenings and referrals for adult caregivers, and developmental screenings and referrals for children. The TIA model suggests a 6-month commitment, while historically the field nursing team would work with a client for 3-4 months. The home visiting nurse will also provide education to clients on the lasting positive effects on the health of the parent and child of remaining engaged for the entire six months.
An integral component of the TIA PHN model is the use of a multidisciplinary team consisting of a public health nurse (PHN) and a community health worker (CHW). Using such a team has been shown to improve participants' perception of the help and education they receive and to increase participants' reports of improved self-confidence and feeling that they have someone who listens and cares. To address historical and evolving traumas experienced

by enrolled families, the TIA PHN model incorporates a curriculum aimed at providing trauma-informed health education. The TIA PHN model acknowledges the need for nursing expertise outside of the clinic setting to identify and support families with complex medical needs (e.g., low birthweight, preeclampsia) and to provide and reinforce education surrounding medical risks associated with pregnancy and the postpartum period (e.g., sepsis, postpartum hemorrhage). The model also recognizes the need for CHWs to help support enrolled families with culturally competent health and safety education, demonstration of the use of social and medical services, and provision of assistance such as transportation to medical appointments, and interpretation in client's native language, if needed.

The TIA PHN program will track and manage data being collected for this project utilizing the Persimmony system which has been used for the Field Nursing Program, The creators of the TIA Guidelines designed the TIA home visiting program using Persimmony as their client data program. Public Health Division staff plan to work closely with Sonoma County partners and Persimmony team to effectively document client data and utilize reports required to evaluate fidelity of program.

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Outcomes:

1. By October 2024, TIA PHN will serve a minimum of 80 unique families, utilizing Persimmony database for tracking.
2. By October 2024, TIA PHN will connect at least 80% of families to their medical and/or dental home, utilizing Persimmony for data tracking.
3. By October 2024, 80% of families will receive education on Adverse Childhood Experiences (ACEs) and how to mitigate the impacts of toxic stress.
4. By October 2024, 80% of families will receive a screening for mental and/or developmental milestones, utilizing Persimmony for data tracking.

Impact:

- Number to be Served by Project: 271
- Geographic Area/Target Population: Medi-Cal eligible Pregnant and Parenting people with children under the age of 5 in Santa Cruz County

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **ACE Overcomers of Merced County**
County: Merced
Grant Award History: No

Parent Education and Support

Project Name: Building Healthy Skills & Creating Successful Families
Proposed Start/End Dates: 11/01/23 - 10/31/25
Total Project Budget: $100,000
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: The Parent Education and Support Program is specifically designed to increase knowledge of ACEs access to childhood development education, parenting skills, and supportive resources for parents of children up to age 5 within the Medi-Cal population in Merced County. ACEs Overcomers of Merced County plans to expand their current Parent Education and Support Program over the next two years, in collaboration with Valley Children's Hospital Olivewood Pediatrics Clinic. In March of 2022, ACEsINC, ACE Overcomers, the Alliance, and Valley Children's hospital (VCH) partnered on the Preventing and Responding to Adverse Childhood Experiences (PRACTICE) grant which was awarded in September 2022. The outcome of this grant was the creation of two educational programs: Building Healthy Life Skills (BHLS) and Creating Successful Families (CSF). The foundation of both classes was formed on the evidence-based ACE Overcomers curriculum.

The BHLS sessions focus on ACEs and toxic stress, providing essential knowledge and skills to pregnant mothers and their support persons (open to all parents, support persons, and guardians of children 0-5). The CSF class builds on the principles of Help Me Grow, incorporating evidence-based strategies to support parenting and child development for ages 0-5 to foster strong parent-child relationships and enhance socio-emotional well-being. To date, BHLS and CSF have been taught two cohorts in Merced in English and are scheduled for three more cohorts: two in Los Banos (one in English and one in Spanish), and a final class delivered in Spanish in Merced. The Parent Education and Support Program grant would support an additional series of 8 BHLS and 8 CSF classes targeting the underserved Medi-Cal population in smaller, remote rural communities, The 16 cohorts would have 15 attendees each, resulting in a total of 240 attendees of the course of the grant period. Of the 16 two-hour sessions, eight will be conducted in Spanish and eight in English. Alliance grant funds will be used for teaching staff, gift cards, breakfast snacks, mileage, class materials and supplies, indirect costs and a consultant for data reporting and evaluation.

The PRACTICE grant funded a Care Navigator position which would be leveraged to support participants in the proposed 16 sessions. The Care Navigator supports access to appropriate community resources and services and works with a multidisciplinary team to develop and implement individualized care plans. They manage referrals to healthcare providers and community resources and is a liaison between individuals with ACEs, Valley Children's Hospital's Olivewood Clinic and Merced County's Trauma-Informed Network of Care (ACEsINC). The recruitment and enrollment process will be facilitated through partnership with local agencies, community outreach, collaboration with pediatricians and healthcare providers, digital/online, and culturally relevant messaging and materials.

Outcomes:

1. By October 31, 2025, conduct 8 Building Healthy Life Skills (BHLS) interactive, evidence-based educational sessions to all parents, and guardians of children aged 0-5 in English and in Spanish.
2. By October 31, 2025, ACE Overcomers and VCH will conduct 8 Creating Successful Families (CSF) classes that incorporate evidence-based educational sessions to all parents, support persons, and guardians of children aged 0-5 in English and in Spanish.
3. By October 31,2025, ACE Overcomers and VCH will utilize data from participant surveys and anecdotal data from BHLS/CHF classes to drive program improvement using the Plan, Do, Check, Act (PDCA) continuous improvement cycle system for future educational series.

Impact:

- Number to be Served by Project: 216
- Target Population/ Geographic Location: Families with children up to 5 years old within the Medi-Cal population in Merced County.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Read to Me Project**
County: Monterey
Grant Award History: No

Parent Education and Support

Project Name: **Projecto Leeme**
Proposed Start/End Dates: 11/01/23 – 10/31/25
Total Project Budget: $131,415
Request Amount: $**100,000**
***Recommended Award:** **$100,000**

Proposal Summary: The Read to Me Project focuses on increasing the proportion of children who are developmentally ready for school, recognizing the critical role of education in improving health outcomes. and provides resources to families by addressing the social determinants of health including educational opportunities. The health literacy parent workshops proposed for grant funding will promote positive health outcomes and a brighter future for children in Monterey County.

Read to Me Project will integrate the evidence-based Abriendo Puertas curriculum within comprehensive Projecto Leeme sessions on health and well-being, equipping parents with health literacy skills and the knowledge of healthcare rights and access to services. By demystifying the complex healthcare landscape and providing information on available resources, the program empowers parents to make informed decisions, seek appropriate care, and effectively advocate for their family's health. Through the program's emphasis on cultural relevance, plain language instruction, and safe group discussions, parents gain the skills and confidence to navigate healthcare systems successfully. Parent education staff will be fully trained in the Abriendo Puertas curriculum.

The Projecto Leeme workshops, will be offered at community centers and clinics, targeting Medi-Cal beneficiaries in Monterey County. There will be four 10-week sessions conducted over the two-year grant period. On 10-week session will be interpreted from Spanish into an indigenous language. Natividad Hospital and Clinica de Salud will identify eligible parents who meet the participation criteria and have active Medi-Cal status. These parents will be referred to the Read to Me Project for enrollment in the parent education classes. The referrals will be made based on the health providers' assessment of the parent's need for additional support and education. Criteria includes active Medi-Cal status and experience with Pediatric, Prenatal, or Family Planning Services.

The parent support and education program educators within the Read to Me Project will collaborate closely with Natividad Hospital and Clinica de Salud of the Salinas Valley to connect participants and their family members to health care providers for physical and behavioral health care, including childhood immunizations and well-child visits. Program educators will leverage these connections to help families access community resources such as parenting support groups, mental health services, nutrition programs, and educational programs, which complement the healthcare services provided by Clinica de Salud and Natividad Hospital.

The Read to Me Project recognizes that addressing the social determinants of health, including access to healthcare and health education, is crucial for promoting overall well-being. By empowering parents

to effectively advocate for their own and their children's health needs, the program contributes to reducing health disparities and promoting equitable access to healthcare services among Medi-Cal beneficiaries in Monterey County.

Outcomes:

1. By June 30, 2025, parent education staff will be trained on the Abriendo Program curriculum.
2. By June 30, 2025, incorporate Abriendo Program curriculum into existing comprehensive Project Read To Me programming.
3. By October 31, 2025, four 10-week Project Leemo sessions will be conducted in Monterey County. one of which will be interpreted from Spanish into an indigenous language.
4. October 31, 2025 participants will demonstrate increased knowledge and confidence in navigating healthcare systems and advocating for their family's health, as measured through pre/post validated measurement tools.

Impact:

- Number to be Served by Project: 100
- Target Population/ Geographic Location: Medi-Cal members receiving Comprehensive Prenatal Service Program (CPSP) services at CSVS or maternity-related services at Natividad Hospital

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Santa Cruz Community Health Centers**
County: Santa Cruz
Grant Award History: Yes

Parent Education and Support

Project Name: HealthySteps
Proposed Start/End Dates: 11/01/23 – 10/31/25
Total Project Budget: $116,317
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: Santa Cruz Community Health (SCCHC) requests funds to implement key portions of the nationally recognized HealthySteps program focused on parent education to serve Medi-Cal families at their Santa Cruz Mountain Health Center (MHC) in the San Lorenzo Valley (SLV). HealthySteps (HS) is an evidence-based, team-based, interdisciplinary pediatric primary care model that promotes the health, well-being, and school readiness of all babies and toddlers, particularly in areas where there are persistent inequities for families of color or with low incomes.

For this project, SCCH will focus on implementing portions of the HealthySteps Program as a pilot that: 1) offers services and resources supporting the health and well-being of young children and their parents/ caregivers; 2) increases parents' knowledge of infant and child development, parenting skills and children's health needs; and 3) strengthens parent/caregiver-child relationships and improve child and maternal socio-emotional well-being. Grant funding would be used to develop and implement a site plan for piloting key aspects of HealthySteps Pilot Program at MHC. SCCHC would hire one .4 FTE Childhood Development Specialist/HealthySteps Specialist to provide services at MHC two days/week, including evidence-based classes related to Triple P and/or Circle of Security. Based on interest, the goal is to provide at least two classes per month (6 per quarter). Parent participation would be incentivized (food, transportation, and childcare). Medi-Cal families in San Lorenzo Valley will also have access to resources and support through fully implemented HealthySteps program at the Live Oak Health Center or Women's Health Center which serves 1,650 Medi-Cal members through this program.

The Specialist conducts community partner outreach about HealthySteps to support referrals, warm handoffs, and ensure appropriate referral criteria are met (e.g., participating in community-wide early childhood and/or mental health meetings). Referrals to healthcare providers and community resources will be managed by the Specialist who also maintains a community resource directory/database. The Specialist provides referrals and tracks follow-up, as appropriate, to help families make successful connections to key resources within the community.

The HealthSteps Pilot will be a universal offering. Every SLV family in the age range will be offered the services, classes, and resources. Recently, several healthcare facilities have closed in SLV. Prior to the opening of the new MHC in 2022, patients drove 30 or more minutes to access a health care provider. In 2022, they served nearly 200 patients. MHC remains the only Medi-Cal primary care provider in Ben Lomond or Felton.

Outcomes:

1. By February 28, 2024, hire a Childhood Development Specialist/ HealthySteps Specialist available two days per week to support program activities.
2. October 31, 2025, deliver two evidence-based parenting classes per month (in the second year of pilot) to families in the San Lorenzo Valley to improve positive parenting skills, measured through class attendance and class evaluations.
3. By February 2024, serve 25% of SLV patient families with kids aged 0-5 through the support line and 10% of SLV families through drop-in hours with parenting guidance and support families to improve uptake of all medical home services, as measures by adherence to regularly scheduled WCC visits and increasing referrals sent for wrap-around services.

Impact:

- Number to be Served by Project: 264
- Geographic Location: San Lorenzo Valley (SLV), a remote mountainous region in Santa Cruz County that includes Ben Lomond, Boulder Creek, Brookdale, Felton.
- Target Population: Primarily households with incomes below 200% FPL. 58.9% of those below 200% FPL did not utilize a Health Center Program.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **The Circle Family Center**
County: Santa Cruz
Grant Award History: No

Parent Education and Support

Project Name: Parenting Together
Proposed Start/End Dates: 11/01/23 – 10/31/25
Total Project Budget: $109,000
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: The Circle Family Center currently operates the Parenting Together program which supports all families with parenting education and emotional support starting immediately postpartum and continuing for the first five years of parenting. They seek funding to expand services offered under this program and to expand access to these services for Medi-Cal members.

The Circle Family Center opened in 2021 with the main goal of supporting families in pregnancy and through the first 5 years of parenting. Their offerings build upon the belief that no parent should feel isolated or unsupported during this challenging and vulnerable stage of life. The Circle supports parents by offering hands-on support from the very beginning to improv physical and mental health outcomes and create family systems that thrive. With in-home postpartum visits, weekly check-ins with qualified providers (both virtually and in-person), parenting classes, and mental health support groups for both mothers and fathers. The program will ensure that no family in the Parenting Together program feels supported and has clear access to necessary resources. Parenting Together will follow parents throughout their parenting journeys to give them a sense of belonging, support, and community while teaching them valuable parenting skills. The Parenting Together Program would offer an array of components including infant care and breastfeeding workshops, infant/child CPR, Positive Discipline workshop, and facilitated support groups (including dad's group and onsite support circle at Pajaro Valley Shelter Services),

The program will ensure that providers regularly refer program participants to obstetricians, midwives, lactation consultants, pediatricians, pediatric dentists, occupational therapists, speech language pathologists, therapists, and more. Currently there is not a formal tracking system, instead the program typically checks in with participants when they visit The Circle space to see if the provider referral was a good match or if they need further resources. This program will be open to all families with priority going to parents who are enrolled in Medi-Cal. Recruitment will happen through existing partnerships with Dignity Health, Kaiser, PAMF, and Santa Cruz County's Nurse Family Partnership. This is an ongoing project that will begin on a rolling basis as families enroll. They are already offering each of the outlined support groups/classes, with the exception of in-home postpartum visits and on-location support at Pajaro Valley Shelter Services. They have already trained providers who are eager to begin these offerings as soon as funding is secured.

Outcomes:

1. By October 31, 2024, enroll 360 Medi-Cal members in the Parenting Together program and provide the array of services, as appropriate, as measured by attendance records and client record.

2. By October 31, 2024, refer participating Medi-Cal members to supportive community resources, as measures by referral tracking system.

Impact:

- Number to be Served by Project: 360
- Target Population/ Geographic Location: Target/Focus Population: low-income families who are Medi-Cal eligible. Pregnant mothers and families with children 0-5 years in Santa Cruz and Monterey counties.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Cradle to Career**
County: Santa Cruz
Grant Award History: Yes/No

Community Health Champions Program

Project Name: Promotores Program
Project Partners: Santa Cruz Community Health
Santa Cruz County Health Services Agency
Second Harvest Food Bank Santa Cruz County
Proposed Start/End Dates: 11/1/23-10/31/25
Total Project Budget: $619,435
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: Cradle to Career (C2C) is seeking funding to support their Promotores program in Santa Cruz County. This initiative addresses health disparities in children from marginalized backgrounds, particularly low-income, immigrant, and BIPOC communities. The Promotores program trains parent leaders, primarily of Latinx background, to provide health-related information to families and how they can advocate for policy changes that impact their families' well-being. The program aims to address health disparities, improve access to resources, and promote equity and trust within marginalized communities in Santa Cruz County. The grant funds would be used to improve the Promotores program in several ways, including refining the curriculum, providing ongoing support through a Lead C2C Community Organizer, and offering volunteer gift cards to acknowledge the expertise and time of Promotores.

The program plans to expand its impact to school districts and local health centers by building a countywide network of community health parent leaders who provide; peer-to-peer health education, resource referrals, and co-designed advocacy strategies. This project is motivated by significant health disparities observed in marginalized communities, particularly among BIPOC populations, which face higher rates of COVID-19 infection, mortality, mental health challenges, and chronic conditions like diabetes. The goal is to equip Promotores with updated health and wellness information that is culturally sensitive, allowing them to connect effectively with a diverse range of families.

This C2C proposal is focusing on the continuing education and ongoing coordination and support necessary for Promotores success in the broader community (e.g. via schools, community events, and advocacy spaces), as well as on the development of a mutually-supportive countywide Promotores network. Promotores are parent volunteers who receive stipends for their work. Community Organizers are paid Cradle to Career staff.

The C2C Promotores program will provide monthly continuing education workshops for Promotores over the course of 24 months. Continuing education workshops will be provided by experts in the field and will include topics such as: Medi-Cal resources and information, ACEs, mental and behavioral health, nutrition, active living, health equity, preventive care, disease prevention, and communication and outreach skills. Ongoing training is not limited to these topics and will evolve with Promotores and Community Organizers' input. The trainings will result in 25-32 trained trusted community health champions who will reach approximately 1400 Medi-Cal enrolled or eligible community members through individual and community event outreach efforts over the course of 24 months.

Outcomes

1. By September 30, 2025, monthly continuing education workshops will be provided for 10-12 new Promotores (currently being recruited), 10-16 existing Promotores, and five C2C Community Organizers over the course of 24 months.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

2. By September 30, 2025, 90% of participants will increase their knowledge in key topics as demonstrated by post-training surveys.
3. By September 30, 2025, 80% participants will increase in confidence in their ability to provide health education to other community members as demonstrated by post-training surveys.

Impact

- The project will result in 25-32 trained trusted community health champions.
- Estimated number served: 1,400 Medi-Cal enrolled or eligible community members.
- Target Population: Medi-Cal members/eligible), BIPOC
- Geographic Location: Santa Cruz County including San Lorenzo Valley, Live Oak, and Soquel as well as the City of Santa Cruz.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **The Boys and Girls Clubs of Monterey County**
County: Monterey
Grant Award History: Yes

Community Health Champions

Project Name: SMART Girls
Project Partners: CalFresh Healthy Living
Montage Medical Group
Ohana Center for Child and Adolescent Behavioral Health
Proposed Start/End Dates: 11/01/2023 - 11/31/2024
Total Project Budget: $ 343,250
Request Amount: **$ 25,000**
***Recommended Award:** **$ 25,000**

Proposal Summary: The SMART Girls program will empower 5th-8th grade to promote health education, well-being, and social empowerment. They will build upon their SMART (Skills Mastery and Resistance Training) curriculum will cover a range of important topics, including physical and emotional changes during puberty, self-esteem, healthy eating, physical fitness, health exams, personal values, social interaction, healthy relationships, and responsible use of social media. The project targets underserved and underrepresented communities in South County and seeks to address the need for accurate information and support during the crucial stage of puberty and aims to have a lasting impact on the girls' overall well-being and health advocacy skills.

The program defines a community health champion as a girl who has the increased knowledge to make informed decisions to advocate for her own health and share information and resources with her peers to advocate for others. The SMART Girls curriculum will be delivered through sessions offered in collaboration with schools during the school day or after-school programs. These sessions will cover essential topics related to physical and emotional development, self-esteem, nutrition, fitness, health exams, and responsible use of social media. The curriculum will be age-appropriate and tailored to the needs of 4th-8th-grade girls, a critical time period when puberty begins and exposure to social media increases. BGCMC will partner with elementary and middle schools to identify students who could benefit from the program. Recommendations from schools and community partners will guide the selection of locations for program delivery. Girls will register for the program through intake forms that collect relevant data.

The project will include Family Nights that engage both parents and children in discussions about health, wellness, and managing screen time. Parents will learn about the importance of health advocacy, managing social media usage, and addressing body image messaging in social media. This engagement aims to create a supportive environment at home that reinforces the lessons learned in the curriculum. Health care providers, including Montage Medical Group, Ohana Center for Child and Adolescent Behavioral Health, and CalFresh Healthy Living, will collaborate with the project by training SMART Girls facilitators in delivering relevant health education content. This includes training facilitators to deliver lessons on nutrition, cooking skills, meal planning, label reading, media literacy, and more. Health care providers will also directly engage with program participants, delivering lessons and interactive demonstrations to enhance health literacy.

Outcomes:
1. By October 31, 2025, 85% of participants will have improved knowledge of emotional and physical changes that occur during puberty through SMART Girls lessons.
2. By October 31, 2025, 585 participants will build skills to learn how to make informed decisions and advocate for their nutritional health by participating in nutritional education lessons.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

3. By October 31, 2025, 585 participants will create strategies to avoid overuse and negative effects of social media by identifying harmful content and reducing screen time SMART Girls lessons and education provided by healthcare partners/evidenced based curriculum.

Impact:

- The project will expand its reach from 214 to 585 girls served annually, approximately 92% Medi-Cal.
- Geographic Location: focusing on the Greenfield, Salinas, Seaside and Soledad.
- Target Population: Girls ages 6-18, 75% Latina.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Boys & Girls Clubs of Santa Cruz County**
County: Santa Cruz
Grant Award History: No

Partners for Active Living

Project Name: Healthy Habits and Physical Fun
Project Partners: Santa Cruz Community Health
Proposed Start/End Dates: 11/01/2023 - 10/31/2025
Total Project Budget: $ 897,701
Request Amount: **$ 250,000**
***Recommended Award:** **$ 250,000**

Proposal Summary: The Healthy Habits and Physical Fun project (HHPFP) will feature a suite of physical activity offerings for Santa Cruz County, with a focus on increasing participation among Medi-Cal members. The core elements of this project include daily physical activity offerings for youth ages 5-14 provided via afterschool and summer programs, as well as swim lessons, a basketball league, and additional seasonal activities as determined by our youth participants. All Medi-Cal member activity will be tracked via MyClubHub membership management system. Grant funds will be used to provide scholarships for youth participants, program staffing, sports equipment and jerseys, CATCH curriculum/materials, volunteer recognition, awards for youth participants, and facility maintenance.

HHPFP will be offered at three Clubhouse locations throughout Santa Cruz County: Downtown Santa Cruz, Live Oak, and Scotts Valley. Each location features a range of amenities to support physical activity, including an indoor swimming pool, full-size gymnasium, turf sports fields, basketball hoops and playgrounds. In addition to offering free play, each day at Boys & Girls Clubs includes at least one hour of structured physical activities based on BGCA's Triple Play curriculum, as well as the evidence-based CATCH physical activity program (delivered in partnership with the Santa Cruz County Public Health Department).

In partnership with Santa Cruz Community Health Centers (SCCHC), this project will increase access to opportunities for physical activity and recreation to Medi-Cal eligible members via direct referrals, especially for those pediatric patients experiencing obesity and whose parents are struggling to reduce their children's screen time and can't afford camps. Participants will have access to all programs free of charge including sports equipment, jerseys, CATCH curriculum/materials, volunteer recognition, awards for participants, and facilities.

As a result of the project, 1,420 youth will be introduced to new physical activities, sports, and healthy habits, increasing the percentage of all participants who are Medi-Cal members from 20% to 25%. Boys and Girls Clubs anticipates that youth participants will discover new games and activities that they enjoy, will have the opportunity to practice goal setting and build confidence, and will develop an understanding that physical activity and teamwork are concrete tools to support physical and mental health.

Outcomes:

1. By October 31,2025, increase percentage of participants from 40% in 2023 to 45% in 2025 who engage in 60+ minutes of daily physical activity. The National Youth Outcome Initiative (NYOI) survey will be utilized.
2. By October 31,2025, member registration data will increase percentage of Medi-Cal members from 20% in 2023 to 25%+ in 2025 who participate in our programs.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

3. By October 31,2025, 1,000 youth participants (ages 5-14) will be offered physical activity 5x per week for via afterschool and summer programs.
4. By October 31,2025, 150 youth participants will be enrolled in swim lessons per year. 75 youth members pass the swim test, demonstrating the ability to swim safely in the deep end of the pool.
5. By October 31,2025, 270 youth participants will engage in basketball league twice per week, and games once per week.

Impact:

- Number to be served by project**:** 1,420
- Percentage of Medi-Cal Members to be Served**:** 25%
- Geographic Area: Santa Cruz, Live Oak, and Scotts Valley
- Population of Focus: Santa Cruz County youth ages 5-14

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **The Boys and Girls Club of Monterey County**
County: **Monterey**
Grant Award History: Yes

Partners for Active Living Program

Project Name: Mind, Body, & Soul
Project Partners: Salinas Valley Health
Proposed Start/End Dates: 11/01/2023 - 10/31/2025
Total Project Budget: $ 1,142,756
Request Amount: **$100,000**
***Recommended Award:** **$100,000**

Proposal Summary: The Boys and Girls Club of Monterey County's (BGCMC's) Healthy Lifestyles initiative utilizes Triple Play as their flagship recreational and wellness program. Appropriately fitted with modules and lessons plans focused on the Mind, Body, and Soul the program was intentionally designed to build the skills, attitudes, knowledge, and behaviors essential to an overall healthy lifestyle. Grant funds will be used to expand their existing program to four elementary schools in Greenfield and three elementary schools in Soledad. The program is anticipated to serve over 1,350 youth annually, an increase of over 50%.

Triple Play will be offered at minimum one hour per week for varying 8-, 10- or 12-week periods. At the Clubhouse elementary age groups will rotate during the after-school program to receive Triple Play programming. For the school site expansion, we will likely have one class period to work with the students. The program focus will be to increase the number of days participants have 60 minutes or more of physical activity, becoming physically literate in a core movement category, and engage parents through the Triple Play at home manual, to foster additional opportunities for physical activity at home. Quarterly family nights will have a physical activity and recreation theme. A healthy meal is provided, and the entire family is engaged in an evening focused on wellness and physical activity.

Partnerships includes engaging Salinas Valley Health for family nights in Salinas, Greenfield, and Soledad. The health care provider will provide a topic such as avoiding sugary drinks and host a table to connect attendees with possible services. The Montage Health Foundation and auxiliary health care facilities/partners are committed to assisting with the nutrition program and nutrition education through the Triple Play Health Habits lessons.

Outcomes:
1. By October 31, 2025 a total of 1,355 youth will increase their daily activity of 60 minutes per week by 20%.
2. By October 31, 2025 a total of 85% of participants will demonstrate competency in one or more areas of late childhood physical literacy.
3. By October 31, 2025 a total of 200 parent/guardians will be engaged in the Triple Play programming, including training on the Triple Play parent guide.

Impact:
- Individuals served annually by Project: 1,355
- Percentage of Medi-cal Members to be Served: 85%
- Geographic Area: Monterey County youth and families, focusing on the Greenfield, Salinas, Seaside, and Soledad communities
- Population of Focus: Primarily Latino, school age children 4th-6th grade, who are eligible for free/reduced lunch and Medi-Cal eligible.

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Ventana Wildlife Society**
County: **Monterey**
Grant Award History: No awards to date

Partners for Active Living Program

Project Name: Wellness Through Nature and Active Outdoor Living
Project Partners: Soledad Medical Clinic
Proposed Start/End Dates: 11/01/23 - 10/31/25
Total Project Budget: $ 698,443
Request Amount: **$ 250,000**
***Recommended Award:** **$ 250,000**

Proposal Summary: The Wellness Through Nature and Active Outdoor Living project would expand existing programs that provide children and families with opportunities to engage in physical activity and recreation. The hub model includes a deep breadth of programming with weekly youth sessions during the school year, bi-monthly single-day family excursions, overnight family camping twice per year, and a monthly club for planning and leadership opportunities). Youth may launch into programming at any age 4 through 24—with a school or community-based organization, with multi-generational family members, or as an individual. Ventana Wildlife Society currently operates Hubs in East Salinas and in the neighborhood surrounding La Paz Middle School.

The Wellness Through Nature and Active Outdoor Living project offers meaningful outdoor experiences. Program delivery meets youth where they are geographically, economically, emotionally, academically, and culturally, in order to decrease any perceived and real barriers as well as to increase meaningful, active participation. Ventana Wildlife Society leverages long-term partnerships to reach families directly within their neighborhoods where trust is established. They have a fleet of passenger vans, so participation can take place while parents work or at no transportation expense for the family. Programs are led by bilingual instructors trained in best practices in trauma-informed teaching and cultural competencies.

Grant funds would support Ventana Wildlife Society to continue and to expand existing programs that provide children and families with opportunities to engage in physical activity and recreation. Specifically, the funds will be used to establish hub models in Castroville and Soledad, continue their Teen & Teacher Exploration Program (integrated into the school day through weekly classes, field trips, and curriculum assistance), and purchase replacement transportation vehicles for two vans that need to be retired, ensuring safe and reliable participant access to programs.

Based on prior nature prescription pilot program, Ventana Wildlife Society has well-developed referral relationships with partner organizations such as North Monterey County Recreation and Park District, Soledad Medical Clinic, Alisal Health Center as well as developing new partnerships such as Clinica de Salud del Valle de Salinas in Castroville.

Objectives:

1. By October 31, 2025, 80% of participants will report increased favorable attitude toward the outdoors; knowledge of local outdoor environments; and improved feelings of wellness (such as enhanced mood, reduced anxiety).
2. By October 31, 2025, conduct weekly 2-hour classes for youth residing in Castroville and Soledad to access and engage actively in nature.
3. By October 31, 2025, conduct bi-monthly single day outdoor adventures and twice per year host overnight family camping experiences for families residing in Castroville and Soledad,

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Impact:

- Individuals served annually by Project: 500
- Percentage of Medi-Cal Members to be Served: 98%
- Geographic Area: East Salinas, Salinas Valley, and North County.
- Population of Focus: Primarily Latino, 4–24-year-olds who are enrolled in the National School Lunch Program—with family incomes at or below 130% of the Federal Poverty

*Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount.

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **North County Recreation & Park District**
County: Monterey
Grant Award History: No

Partners for Health Food Access

Project Name: Fresh Horizons
Proposed Start/End Dates: 11/01/23 – 10/31/25
Total Project Budget: $210,353
Request Amount: **$199,993**
***Recommended Award:** **$199,993**

Proposal Summary: North County Recreation & Park District is the hub of the North County Community in Castroville, offering youth, family, and senior activities, including a weekly outdoor market that sells hot prepared food. They recently established a partnership with the Blue Zones Project which focuses on nutrition education and gardening initiatives to educate individuals about healthy eating habits and provide them with the resources and knowledge needed to cultivate their own fresh produce. Castroville ranks high in food insecurity within Monterey County and the US (with an index of 58.1). The absence of a farmers' market with nutrition incentives aggravates the lack of accessible fresh and nutritious food options for Medi-Cal members in the area.

The Fresh Horizons project aims to establish a certified farmer's market with Everyone's Harvest at the Recreation Center in Castroville, offering locally grown nutritious, culturally valued produce to residents of North Monterey County. The market will operate from 3 to 7pm every Thursday evening. To address the specific needs of the Medi-Cal population, a partnership has been formed with the Castroville Clinic of Clinica de Salud del Valle de Salinas (CSVS). They plan to engage Medi-Cal members in participatory action research methods (leading focus groups, interviews, and surveys) to collect valuable insights and feedback to help inform the project's design and implementation. Once the farmers' market is established, North County Recreation & Park District will seek ongoing funding through the Ecology Center's Market Match program.

CSVS' role will be to engage Medi-Cal members linked to their Castroville clinic and referring members to the farmers' market via text messages and emails. CSVS will invite members who respond "yes" to either of the food insecurity questions to connect with the Community Health team directly by phone for further assessment and enrollment in the program. Medi-Cal members can self-report any existing chronic diseases during their phone screenings with the Community Health Services Team who will be able to validate it. CSVS will refer food-insecure patients at risk of diet-related chronic diseases to the market. They will provide a one-time $25 produce prescription, which can be redeemed at the farmer's market. The market and nutrition incentives will be available year-round for 50 weeks. At the farmers markets, two dedicated community health workers or promotoras will be available to assess and discuss risk factors for chronic diseases.

Each Medi-Cal member who attends the market to redeem their produce prescription will receive support in applying for WIC and CalFresh benefits, facilitated by two community health workers present at the market. For those already enrolled in CalFresh, support will be provided for EBT transactions and Market Match, a nutrition incentive program that matches CalFresh spending up to $15 per visit. For WIC enrollees, staff will be on-site at market to support families in using their benefits for free produce. At the market, Salinas Valley Health will share resources to promote healthy eating and build knowledge on prevention and management of chronic diseases. Blue Zones Project Monterey County will provide support in developing marketing tools that can be utilized by all partners to promote the program effectively. North County Recreation & Park District will offer monthly cooking and nutrition education activities in collaboration with various partners. Blue Zones Project provides free nutrition classes with bilingual chefs, bridging language and cultural barriers. Everyone's Harvest will offer Edible

Education sessions led by Spanish-speaking chefs. CalFresh Healthy Living will host nutritional tastings for participants to experience healthier options.

Outcomes:

1. By March 31, 2024, establish weekly farmers' market with Everyone's Harvest and referral process with CSVS.
2. By October 31, 2025, increase the number of Medi-Cal members enrolled in CalFresh and using Market Match.
3. By October 31, 2025, offer monthly Edible Education workshops and cooking classes with Spanish-speaking chefs utilizing fresh seasonal produce available at the markets.
4. By October 31, 2025, three focus groups will be conducted (Spanish/English) with at least 10 Medi-Cal members at the Recreation Center to identify and address participants' needs.

Impact:

- Individuals Served Annually by Project: 570
- Population Focus: Medium to low-income families
- Geographic Area: Castroville, North Monterey County

DATE: October 25, 2023

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

FROM: Jessica Finney, Grants Director

SUBJECT: Medi-Cal Capacity Grant Program Funding Recommendations

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Recommendation. Staff recommend the Board approve changes and budget allocations for Medi-Cal Capacity Grant Program (MCGP) funding opportunities, including the retirement of the Partners for Healthy Food Access program.

Summary. This report provides a brief background on current MCGP funding opportunities and outlines a forthcoming change to Community Supports - Medically Tailored Meals/ Medically Supportive Food services that impacts the Food Access grant program. The report includes staff recommendations related to programmatic changes and funding allocations for current funding opportunities.

This set of recommendations was presented to the Board on September 27, 2023; however, there were not enough Board members without conflicts of interest present to vote during the meeting. Staff are returning with these recommendations for Board action on the October 25, 2023 consent agenda.

Background. The Alliance established the MCGP in July 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act. Through investment of a portion of the Alliance's reserves, the MCGP provides grants to local health care and community organizations in Merced, Monterey, and Santa Cruz counties to increase the availability, quality and access of health care and supportive services for Medi-Cal members, and to address social drivers that influence health and wellness in our communities. The MCGP serves as a vehicle for the Alliance to invest in areas outside of core health plan responsibility and where other funds are not available. It also serves as a tool to build capacity for the provider network to provide timely access to high quality care and implement new Medi-Cal benefits. Since 2015, the Alliance has awarded 648 grants totaling $144.7M to 162 organizations in the Alliance's service area.

There are ten funding opportunities approved by the Alliance Board in early 2023 which are currently accepting applications (see table below). These programs align with the MCGP Framework and funding goals under three focus areas to advance the Alliance's vision of *Healthy People, Healthy Communities.*

MCGP Focus Areas	Funding Opportunities
Access to Care	Workforce Recruitment: 1) Provider; 2) Community Health Worker and 3) Medical Assistant 4) Equity Learning for Health Professionals 5) Healthcare Technology
Healthy Beginnings	6) Home Visiting 7) Parent Education and Support
Healthy Communities	8) Partners for Healthy Food Access 9) Partners for Active Living 10) Community Health Champions

Discussion. Interest has been very high from providers and community-based organizations in the new MCGP funding opportunities launched in 2023. In the three application rounds in 2023, a total of 165 applications were submitted by 92 entities across the 10 programs. In 2023, $6.5M has been awarded to Workforce Recruitment programs, in part to support 15 Community Health Workers (CHWs) joining the Alliance network to deliver the new Medi-Cal CHW Benefit. The total awarded to date in 2023 for all other programs (non-Workforce Recruitment) is $8M, and $3.9M is pending recommendation for October 25, 2023 Board approval.

Having established Board approval on September 27, 2023 to maintain MCGP grantmaking under the health plan and to not establish a 501(c)(3) foundation, staff recommend replenishing the current program budgets to continue funding qualified applications responsive to the funding priorities set forth by the Board and to spend down MCGP allocated reserves to normalize the health plan's Tangible Net Equity status. The original budgets proposed for the new programs in early 2023 had been conservative due to uncertainty at that time about the future of MCGP governance. The additional allocation amounts recommended below are based on an estimation of 2024 application volume and aligned with current development of a 2024 MCGP investment plan for Board consideration in December 2023.

Allocations for Current Funding Opportunities. The proposed amounts below for each of the funding opportunities are recommended to be allocated from each county's MCGP unallocated budget. Total program allocations are proportional to Medi-Cal membership volume in each county as of August 2023.

Recommended additional allocations to Access to Care programs:

County	Provider Recruitment	CHW Recruitment	MA Recruitment	Equity Learning	Healthcare Technology
Merced	$1,080,000	$360,000	$360,000	$43,200	$540,000
Monterey	$1,350,000	$450,000	$450,000	$54,000	$675,000
Santa Cruz	$570,000	$190,000	$190,000	$22,800	$285,000
Total Additional Allocations	**$3,000,000**	**$1,000,000**	**$1,000,000**	**$120,000**	**$1,500,000**
Remaining after pending 10/2023 Awards	**$12,192,843** (49 providers)	**$1,830,644** (24 CHWs)	**$1,712,234** (23 MAs)	**$761,250** (19 grants)	**$1,408,660** (28 grants)

Recommended additional Allocations to Healthy Beginnings programs:

County	Home Visiting	Parenting Education & Support
Merced	$540,000	$216,000
Monterey	$675,000	$270,000
Santa Cruz	$285,000	$114,000
Total Additional Allocations	**$1,500,000**	**$600,000**
Remaining after pending 10/2023 Awards	**$1,750,301** (7 grants)	**$1,620,800** (16 grants)

Recommended additional allocations to Healthy Communities programs:

County	Partners for Active Living	Community Health Champions
Merced	$720,000	$180,000
Monterey	$900,000	$225,000
Santa Cruz	$380,000	$95,000
Total Additional Allocations	**$2,000,000**	**$500,000**
Remaining after pending 10/2023 Awards	**$2,130,939** (8 grants)	**$1,386,100** (14 grants)

Changes to Provider Recruitment Program. The above recommendation for additional allocation to the Provider Recruitment Program budget accounts for recommended changes to the maximum grant award amount and eligible expenses. The Provider Recruitment grants offer support to contracted Medi-Cal providers to be competitive in the job market. Since the Provider Recruitment Program started in 2015, the cost of living and workforce recruitment costs have risen dramatically in the Alliance's service area. Staff recommend increasing the maximum award amount from $150K to $250K effective January 2024. Staff also recommend allowing a housing stipend/bonus as an eligible recruitment expense under the grant. Eligible expenses are documented by the grantee as paid or incurred when the recruit is hired.

Retirement of Food Access Program. Staff recommend retiring the Food Access Program after the October 25, 2023 awards and returning the unspent funds in the Food Access budget to the MCGP unallocated budget for future program development. In July 2023, the Department of Health Care Services (DHCS) updated the Community Supports (CS) policy guidance, instructing Medi-Cal managed care plans (MCPs) that by January 1, 2024 MCPs must adhere to the full DHCS-established CS service definitions without modifications or limitations. Since January 1, 2022, the Alliance had been limiting the CS services under Medically Tailored Meals/Medically-Supportive Food to solely home-delivered medically tailored meals for eligible members. The other components under this CS have not yet been operationalized: 1) medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies; and 2) behavioral, cooking, and/or nutrition education when paired with direct food assistance under the CS service. Staff will identify best practices from the past five years of Food Access program experience to inform the service model and effective operationalization for the two additional components. Staff will also identify Food Access grantee partners who have the capacity and interest to become CS providers and will support bridging their efforts from a grant-funded project to the reimbursable Medi-Cal service model. Staff will assess

where gaps remain after CS is implemented to support those community partners who would not contract as CS providers and who fill the gap through other food access programing.

County	Total Proposed Additional Allocations to Current Programs	Total Funds Remaining in Current Program Budgets for Future Awards (if proposed allocations approved)	Remaining MCGP Unallocated Budget* (for future program development)
Merced	$4,039,200	$11,223,332	$45,809,940
Monterey	$5,049,000	$9,063,078	$42,956,711
Santa Cruz	$2,131,800	$4,507,361	$17,345,760
Total	**$11,220,000**	**$24,793,771**	**$106,112,412**

* Total Remaining MCGP Unallocated Budget after approval of October 25, 2023 funding recommendation for Workforce Support for Care Gaps Closure: $105,632,412.

Next Steps. If approved, staff will take immediate steps to implement the approved changes, including updating public information about current funding opportunities on the Alliance's website. Staff would notify Food Access grantees of forthcoming operationalization of new Community Supports service components and support transitioning from active grant-funded project to reimbursement for Medi-Cal service delivery where feasible.

Fiscal Impact. This recommendation would: 1) return $1,838,595 of unused funds from the Food Access budget to the MCGP unallocated budget; and 2) allocate $11,220,000 from the MCGP unallocated budget to current program budgets. Amounts remaining in the MCGP unallocated budget per county after recommended allocations (and assuming approval of Agenda Item 9D) are as follows: Merced County $45.3M; Monterey County $42.9M; and Santa Cruz County $17.3M.

Attachments. N/A

DATE: October 25, 2023

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

FROM: Jessica Finney, Grants Director

SUBJECT: Medi-Cal Capacity Grant Program Funding Recommendation: Workforce Support for Care Gaps Closure

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Recommendation. Staff recommend the Board approve $480,000 from Merced County's Medi-Cal Capacity Grant Program (MCGP) unallocated budget to fund a limited pilot in Merced County which supports primary care clinics to close care gaps for Medi-Cal members.

Summary. This report provides a brief background on the current need to support primary care providers in Merced County to achieve the mutual goals of increasing health care quality scores and improving the overall health of Medi-Cal members in Merced County. The report includes a staff recommendation for a pilot intervention to achieve these goals.

Background. To promote better health outcomes and preventive services, the Department of Health Care Services (DHCS) requires Medi-Cal managed care plans to report annually on a set of quality measures, known as the Medi-Cal Managed Care Accountability Set (MCAS) performance measures. This set of quality measures represents children's preventive services, women's health preventive services, chronic medical conditions, and behavioral health conditions. DHCS establishes a Minimum Performance Level (MPL) on qualifying performance measures based on the National Committee for Quality Assurance's (NCQA) national Medicaid 50th percentile. The MPL represents a quality standard that MCPs contracting with DHCS are required to meet or exceed, while the High Performance Level (HPL), set at the 90th percentile, is the ultimate quality goal for all contracted MCPs. The Alliance is currently below the 50th percentile on some MCAS measures in Merced County and has identified specific care gaps that, if closed, would improve quality performance.

Discussion. The aim of the workforce support for care gaps closure pilot is to test the effectiveness of financial support for a targeted workforce intervention at primary care clinics in order to close specific care gaps and improve quality scores to between the 50th and 90th percentile. If effective, this intervention would be considered for inclusion in the Care Based Improvement Program in 2024.

The pilot would fund participating primary care organizations to either hire full-time locum tenens providers (MD, PA or NP) or to allocate additional hours for existing providers to augment clinic hours and/or days. The additional workforce will assist with scheduling members for appointments and delivering services that would result in closing the remaining MCAS care gaps through the end of 2023. Participating organizations will ensure additional workforce are scheduled at strategic locations to maximize the number of member visits and build the schedule to account for no-shows. Intervention activities would occur October 2023 through December 2023.

Participating Organizations. There are three primary care provider organizations with the highest volume of linked Alliance members in Merced County who have agreed to participate in the pilot, if funding is approved: 1) Castle Family Health Centers; 2) Golden Valley Health Centers, and 3) Livingston Community Health. Staff are currently in discussion with two other practices that may participate.

Participating organizations will report to the Alliance monthly: 1) the number of appointments kept; 2) type of visit; and 3) preventive health visits completed. It is estimated that approximately 20-22 members could be seen per provider per 8-hour day. The estimated target across all participating organizations for visits and care gaps closure is 1,155 members.

The following care gaps will be closed through this intervention:

1. Cervical cancer screening
2. Breast Cancer Screening
3. Chlamydia screening
4. Post-partum care
5. Well child visits ages 15-30 months
6. Well child visits ages 3 to 21 years and immunizations
7. Annual wellness exams and Immunizations for adolescents
8. Immunizations ages 0-to-2-years
9. Depression screening and follow-up, if applicable
10. HbA1c testing for patients diagnosed with diabetes
11. Controlling Blood Pressure for patients diagnosed with hypertension
12. ACE screening, when applicable

Funding Amount. Grant funding would be a one-time payment based on expenses incurred during the pilot period (estimated at $180/hour), not to exceed $120,000 per clinic and not to exceed $600,000 total for the pilot. Final grant awards will depend on verification of actual program expenses but will not exceed the recommended amount. Unused funds allocated to this pilot would be returned to the MCGP unallocated budget.

Next Steps. If approved, staff will take immediate steps to implement the pilot with primary care clinics and establish the reporting process, including timely encounter data and expense documentation for grant payment.

Fiscal Impact. This recommendation would fund $600,000 from Merced County's MCGP unallocated budget. Amounts remaining in the MCGP unallocated budget per county after recommended allocations (and assuming approval of Agenda Item 9C) are as follows: Merced County $45.2M; Monterey County $42.9M; and Santa Cruz County $17.3M.

Attachments. N/A

DATE: October 25, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Commission Bylaws

Recommendation. Staff recommend the Board approve the Bylaws of the Commission and direct staff to submit to the County Boards of Supervisors for final approval.

Background. Welfare and Institutions Code §14087.54 provides that County Board(s) of Supervisors (BOS) may, by ordinance, establish a commission with the authority to contract and arrange for the provision of health care services and may enter into contracts for the provision of health care services to persons who are eligible to receive medical benefits under a publicly supported program.

The BOS of Santa Cruz, Monterey, Merced, San Benito and Mariposa counties adopted mirrored ordinances establishing the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission for the purpose of contracting with the Department of Health Care Services and to arrange for the provision of health care services to qualifying individuals in the respective counties who lack sufficient annual income to meet the cost of health care and whose other assets are so limited that their application toward the cost of health care would jeopardize future minimum self-maintenance and security.

The county ordinances set forth certain requirements and standards of conduct for the Commission. Further, the ordinances require the Commission to adopt Bylaws outlining procedures for the conduct of business not otherwise specified in the ordinance, including the provision for the creation of standing committees of the Commission. Upon adoption by the Commission, the Bylaws are to be submitted to the BOS of each county for final approval.

Discussion. Staff reviewed the Bylaws adopted by the predecessor Commission, the Santa Cruz – Monterey – Merced Managed Medical Care Commission and updated them to reflect the addition of two new counties and other revisions necessary to properly reflect the Board's conduct of business.

The draft Bylaws were submitted to the Department of Managed Health Care and were approved as part of the required Notice of Material Modification to the Alliance's Knox-Keene license.

The Bylaws include provisions governing the following areas:

Article I.	Authority and Purpose
Article II.	Commissioners
Article III.	Officers
Article IV.	Meetings
Article V.	Committees
Article VI.	Advisory Groups
Article VII.	Execution of Documents
Article VIII.	Conflict of Interest Policy
Article IX.	Chief Executive Officer
Article X.	Miscellaneous Procedures, Practices and Policies, Insurance, Bonds
Article XI.	Amendment of Bylaws

The Bylaws are included as an attachment to this staff report and staff recommends the Board approve the Bylaws as drafted. Staff will submit the approved Bylaws to each County's Board of Supervisors for final approval.

Attachments.

1. Draft Bylaws of the Commission

BYLAWS
OF THE SANTA CRUZ-MONTEREY-MERCED-SAN BENITO-MARIPOSA MANAGED MEDICAL CARE COMMISSION

ARTICLE I. AUTHORITY AND PURPOSE

These Bylaws are adopted by the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, hereinafter referred to as the "Commission" to establish rules, policies and procedures for its proceedings. The purpose of the Commission is to negotiate exclusive contracts with the California Department of Health Care Services, to arrange for the provision of health care services to qualifying individuals, as well as those other purposes set forth in the enabling ordinances enacted by the respective counties. The Commission was established by the Board of Supervisors of Santa Cruz County, the Board of Supervisors of Monterey County, the Board of Supervisors of Merced County, the Board of Supervisors of San Benito County, and the Board of Supervisors of Mariposa County, under the statutory authority of California Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.8, entitled "County Health Systems," Section 14087.54. These Bylaws and any amendments to these Bylaws must be approved by the Santa Cruz County Board of Supervisors, the Monterey County Board of Supervisors, the Merced County Board of Supervisors, the San Benito County Board of Supervisors, and the Mariposa County Board of Supervisors, as specified in Chapter 7.61 of the Santa Cruz County Code, Chapter 2.46 of the Monterey County Code, Chapter 9.43 of the Merced County Code, Chapter 11.17 of the

San Benito County Code, and Chapter 2.114 of the Mariposa County Code.

ARTICLE II. COMMISSIONERS

2.1 Number. The Commission shall consist of a maximum of twenty-five (25) voting members.

2.2 Appointment. Members shall be appointed by the Santa Cruz County Board of Supervisors, hereinafter referred to as the Santa Cruz Board, the Monterey County Board of Supervisors, hereinafter referred to as the Monterey Board, the Merced County Board of Supervisors, hereinafter referred to as the Merced Board, the San Benito County Board of Supervisors, hereinafter referred to as the San Benito Board, and the Mariposa County Board of Supervisors, hereinafter referred to as the Mariposa Board. The number of appointed members is established by formula, based upon the number of Medi-Cal beneficiaries within each county, and including a maximum of five (5) members within a county. Each Commission member shall serve at the pleasure of the Board appointing them.

2.3 Qualifications.

2.3.1 Each member of the Commission shall be committed to a health care system which seeks to improve access to quality health care for all persons, regardless of their economic circumstances. Members of the Commission shall have an abiding commitment to, and interest in, a quality publicly-assisted health care delivery system.

2.3.2 Each member of the Commission shall be a legal resident of the county whose Board of Supervisors made the appointment.

2.3.3 The number of voting members of the Commission shall be based upon the number of Medi-Cal beneficiaries within each county and includes a maximum of five (5) members within a county, and with the number of Commissioners within a county and Commission representation categories determined according to the following formula:

2.3.3.1 Zero (0) to fifteen thousand (15,000) Medi-Cal beneficiaries within the county equals one (1) commission seat to be filled by the Director of the County Health Department (or Health Services Agency) or their designee;

2.3.3.2 Fifteen thousand (15,000) to thirty thousand (30,000) Medi-Cal beneficiaries within the county equals two (2) commission seats to be filled as follows:

2.3.3.2.1 The Director of the County Health Department (or Health Services Agency) or their designee; and

2.3.3.2.2 One (1) at-large representative of either the health care provider population or the population of beneficiaries to be served by the Commission.

2.3.3.3 Thirty thousand (30,000) to forty-five thousand (45,000) Medi-Cal beneficiaries within the county equals three (3) commission seats to be filled as follows:

2.3.3.3.1 The Director of the County Health Department (or Health Services Agency) or their designee;

2.3.3.3.2 One person representing health care providers; and

2.3.3.3.3 One person from the public representing the population of beneficiaries to be served by the Commission.

2.3.3.4 Forty-five thousand (45,000) to sixty-thousand (60,000) Medi-Cal beneficiaries within the county equals four (4) commission seats to be filled as follows:

2.3.3.4.1 The Director of the County Health Department (or Health Services Agency) or their designee;

2.3.3.4.2 One member of the Board of Supervisors;

2.3.3.4.3 One person representing health care providers; and

2.3.3.4.4 One person from the public representing the population of beneficiaries to be served by the Commission.

2.3.3.5 Sixty-thousand (60,000) or more Medi-Cal beneficiaries within the county equals five (5) commission seats to be filled as follows:

2.3.3.5.1 The Director of the County Health Department (or Health Services Agency) or their designee;

2.3.3.5.2 One member of the Board of Supervisors;

2.3.3.5.3 One person representing health care providers;

2.3.3.5.4 One person from the public representing the population of beneficiaries to be served by the Commission; and

2.3.3.5.5 One at large representative of either the public representing the population of beneficiaries to be served by the Commission or one person representing health care providers.

2.3.4 If a Commissioner no longer qualifies for their prescribed position on the Commission, the position shall be vacant and the Board of Supervisors shall appoint a replacement.

2.3.5 Any deletion of commissioners based upon a change in the population of Medi-Cal beneficiaries within a county will be achieved through attrition, with a maximum of two (2) years to come into compliance with qualifications provisions in this Section.

2.4 Term. Except for the initial staggered terms as specified in Chapter 7.61 (Santa Cruz County), Chapter 2.46 (Monterey County), Chapter 9.43 (Merced County), Chapter 11.17 (San Benito County), and Chapter 2.114 (Mariposa County), all Commissioners appointed by the Board shall serve four (4) year terms of office. At the end of the term, a member may be re-appointed to a subsequent four (4) year term or terms.

2.5 Resignation. A Commissioner may resign effective upon the date of giving written notice to the Clerk of the Commission, unless the notice specifies a later date for their resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and the Board of Supervisors of the County appointing the Commissioner.. The acceptance of a resignation shall not be necessary to make it effective.

2.6 Removal. Any Commissioner may be removed from office at any time by a four-fifths vote of the Board of Supervisors of the County appointing the Commissioner favoring such removal.

2.7 Vacancies. Any vacancy on the Commission shall be filled by the Board of Supervisors of the County appointing the Commissioner. The individual must be appropriately qualified for the position in accordance with Section 2.3.

2.8 Compensation. Compensation as established by the Commission in accordance with the provisions of these bylaws may be claimed by any member of the Commission who does

not receive compensation from any public agency in connection with the position which qualifies them for service on the Commission.

2.8.1 Amount of Compensation. Total compensation for each Commissioner who qualifies shall not exceed $400 per month. Commissioners may choose one or both of the following options:

2.8.1.1. $300 for each Commission meeting attended for which Commissioners must travel outside of the Commissioner's respective county of representation, to meet in a single location, or $100 each for all other Commission meetings attended.

2.8.1.2. $50 for each committee or Advisory Group meeting attended.

2.8.2 Reimbursement. Commissioners may be reimbursed for their actual expenses incurred in attending Commission meetings in categories of expenses and at such rates as are payable to Commission staff in accordance with policies and procedures applicable to staff employed by the Commission. .

ARTICLE III. OFFICERS

3.1 Designation. Officers of the Commission shall be:

3.1.1 A chairperson who shall be a Commissioner and preside over all meetings.

3.1.2 A Vice-Chairperson who shall be a Commissioner and who in the absence of the Chairperson shall preside at the meetings of the Commission. If both Chairperson and Vice-Chairperson are absent, the Commissioners present will select one Commissioner to act as Chairperson pro tempore who will have all the authority of the Chairperson.

3.1.3 A Clerk, or designee, who shall attend all the Commission meetings, keep the minutes, witness signatures on all documents executed on behalf of Commission, keep the seal of the Commission, if one is adopted, shall give notice of all meetings of the Commission and committees of the Commission, as required by law, and shall have other duties as resolved by the Commission. The Clerk shall not be a member of the Commission.

3.2 ~~Election~~. The Commission shall elect officers for one (1) year terms, at the first meeting in October of each year. For the first election of the Commission, officers shall serve a term which begins on the day of the election and ends at the first meeting in October of the following calendar year.

3.2.1 Commissioners may be nominated by other Commissioners or may nominate themselves for offices.

3.3 Resignation. An officer may resign effective on the date of giving written notice to the Clerk of the Commission, unless the notice specifies a later date for their resignation to become effective. Upon receipt of such notice, the Clerk shall notify the. The acceptance of a resignation shall not be necessary to make it effective.

3.4 Vacancies. A vacancy in any office shall be filled by resolution or motion of the Commission at a regular or special meeting of the Commission.

ARTICLE IV. MEETINGS

4.1 Regular and Special Meetings. The date, time and place of regular meetings shall be established by resolution or motion of the Commission. The Commission shall hold at least four (4) regular meetings per calendar year. Special meetings can be held by call of the Chairperson or a majority of appointed members of the Commission.

4.2 Open and public. All meetings of the Commission shall be open and public, and the Commission shall comply with the provisions of the Ralph M. Brown Act. Anyone shall be permitted to attend meetings of the Commission, except for closed sessions as permitted by applicable law.

4.3 Notice. At least seventy-two (72) hours prior to each regular meeting, an agenda for the regular meeting shall be mailed or

sent by other electronic means to each Commission member, and to each representative of the news media and to each other person who has submitted a written request to the Commission for notification of meetings, and shall be posted at least seventy-two (72) hours prior to the regular meeting at a location that is freely accessible to the public. The agenda shall contain a brief general description of each item of business to be transacted or discussed at the meeting. No action or discussion shall be undertaken on any item not appearing on the posted agenda, except that members of the Commission may briefly respond to statements made or questions posed by persons exercising their public testimony rights or ask a question for clarification, refer the matter to staff or to other resources for factual information, or request staff to report back at a subsequent meeting concerning any matter. Notwithstanding the foregoing, action may be taken on an item of business not appearing on the posted agenda upon a determination by two-thirds vote of the appointed membership of the Commission, or if less than two-thirds of the members are present, by unanimous vote of those members present, that there is a need to take immediate action and that the need for action came to the attention of the Commission subsequent to the agenda being posted.

4.4 Attendance and Participation. Commissioners must attend the regular meetings of the Commission and of committees to which they are appointed. If a Commissioner is unable to attend a meeting, they must notify the Clerk of the Commission of the reason and the Clerk, in turn, will notify the Chairperson.

Except in the case of an emergency, if a Commissioner fails to attend a meeting without first notifying the Clerk, the absence will be considered unexcused. Two unexcused absences during a six-month period may be grounds for the Board of Supervisors of the County appointing the Commissioner to consider removing the Commissioner.

4.5 Quorum. A majority of the appointed members of the commission (excluding any positions that are vacant) shall constitute a quorum, and no act of the commission shall be valid unless a majority of those members appointed and not disqualified from voting due to a conflict of interest concur therein. Any act of the Commission shall be accomplished by a roll call vote when such a vote is requested by any member in attendance.

4.6 Special Meeting. At least twenty-four (24) hours prior to each special meeting, an agenda for the special meeting shall be mailed or by other electronic means to each Commission member and to each representative of the news media and to each other person who has submitted a written request to the Commission for notification of meetings; and shall be posted at least twenty-four (24) hours prior to the special meeting at a location that is freely accessible to members of the public. No business other than that listed on the agenda shall be considered at a special meeting. However, the commission may hold an emergency meeting without complying with the twenty-four (24) hour

notice and posting requirements if an emergency situation exists as defined by California Government Code Section 54956.5.

4.7 Conduct of Business.

4.7.1 Items on the agenda will be considered in order unless the Chairperson announces a change in the order of consideration.

4.7.2 Unless an agenda item identifies a particular source for a report, (such as the Chairperson, Commissioners, Advisory Groups or Chief Executive Officer), the Chief Executive Officer, the Commissioners, the Commission staff and consultants shall report first on the item. The item will then be open to public comment upon recognition of the speaker by the Chairperson.

4.7.3 Confidential information shall not be subject to disclosure at meetings of the Commission unless required by law.

4.8 Resolutions or Motions. All official acts of the Commission shall be taken either by resolution or a motion, duly made, seconded and adopted by vote of the Commissioners.

4.9 Voting. All actions of the Commission shall be adopted by an affirmative vote of a majority of the Commissioners eligible to vote: those appointed and who are not disqualified from voting under Section 4.10. Thus, if 25 Commissioners are appointed

and 2 are disqualified pursuant to Section 4.10, then a positive vote of 12 is required to adopt the motion or resolution (25 appointed - 2 disqualifications = 23 eligible to vote, requiring 12 positive votes for a majority).

4.10 Disqualification from Voting. A Commissioner shall be disqualified from voting on any contract in which they have a financial interest as required by law and the Conflict of Interest Policy of the Commission. Commissioners will not be disqualified from continuing to serve on the Commission merely because they have a financial interest in a contract, and such contracts may not be avoided for the sole purpose of avoiding the conflict of financial interest, where neither the law nor the Conflict of Interest Policy of the Commission has been violated

4.11 Minutes. The Clerk of the Commission shall prepare the minutes of each meeting of the Commission. The minutes shall be an accurate summary of the Commission's or committee's consideration of each item on the agenda and an accurate record of each action taken by the Commission. At a subsequent meeting, the Clerk shall submit the minutes to the Commission for approval by a majority vote of the Commissioners in attendance at the meeting covered by the minutes. .

4.11.1 The official minutes, as approved by the Commission, recording any motions or actions taken by the Commission

shall be prepared and submitted to the Board of Supervisors and the County Administrative Offices of each County.

4.12 Closed Sessions. The Commission may meet in closed sessions as permitted by applicable law. The Commission shall report actions taken at a closed session to the public as required by applicable law. As required by applicable law, minutes for closed sessions shall be kept in a closed session minute book and will contain only those topics discussed and decisions made at the closed meeting. The closed session minute book shall be maintained as confidential and not be a public record. Access to the closed session minute book shall be limited to Commissioners, the Chief Executive Officer, and the Commission's legal counsel, except as otherwise required by applicable law.

4.13 Public Records. All documents and records of the Commission which are not exempt from disclosure by law shall be public records under California's Public Records Act (California Government Code Section 7920.000 et seq.).

4.14 Adjournment. The Commission may adjourn any meeting to a time and place specified in the resolution or motion of adjournment, notwithstanding less than a quorum may be present and voting. If no members of the Commission are present at regular or adjourned meeting, the Clerk may declare the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided for special meetings, unless such notice is waived as

provided in Section 4.3 of these Bylaws for special meetings. A copy of the order or notice of adjournment shall be posted as required by applicable law.

4.15 Reports. The Commission shall submit an annual report to the Board of Supervisors and to the County Administrative Offices of each County on or before January 31st of each year. The report shall state the activities, accomplishments, and future goals of the Commission.

4.16 Progress Reports. The Board of Supervisors from any County may direct the Commission at any time to submit progress reports and recommendations.

4.17 Communications with the Public. Public participation in Commission meetings shall be allowed as follows:

4.17.1 An opportunity for members of the public to directly address the Commission on any item on the agenda of interest to the public shall be provided before or during the Commission's consideration of the item.

4.17.2 In addition, the agenda will provide for public oral communications on items not on the agenda which are within the subject matter jurisdiction of the Commission at the beginning of each regular meeting agenda.

4.17.3 The Chairperson of the Commission may establish reasonable limits on the amount of time allotted to each

speaker on a particular item, and the Commission may establish reasonable limits on the total amount of time allotted for public testimony on a particular item or the total amount of time allotted for community oral communications. When further discussion is required, the Commission may vote to allot time in the agenda of the following meeting.

ARTICLE V. COMMITTEES

5.1 Appointment. The Commission may create standing and ad hoc committees and appoint members to those committees. Only Commissioners may serve on the committees, but all committees must be composed of less than a quorum of voting Commissioners. The Commission may designate one (1) or more alternates for the committees to serve during any absences.

5.2 Authority. All committees are advisory only.

5.3 Meetings. Regular meetings of committees shall be held at times and places determined by resolution or motion of the Commission. Special meetings may be held at any time and place as designated by Chairperson, Chief Executive Officer or a majority of members on the committee. A majority of the appointed members of a committee shall constitute a quorum.

5.4 Notice and Agenda. All committees shall comply with the notice and agenda requirements otherwise applicable to the

Commission in these bylaws, except for committees composed solely of less than a quorum of the members of the Commission which are not standing committees of the Commission with either a continuing subject matter jurisdiction or a meeting schedule fixed by resolution or other formal action of the Commission.

5.5 Minutes. The Clerk of the Commission or designated individual shall prepare the minutes of each meeting of the committees of the Commission. The minutes shall be an accurate summary of the committee's consideration of each item on the agenda and an accurate record of each action taken by the committee. At a subsequent meeting, the Clerk or designated individual shall submit the minutes to the Commission for approval by a majority vote of the Commissioners in attendance at the meeting covered by the minutes. Once approved, copies of minutes shall be forwarded to the Commissioners and to the Chief Executive Officer.

5.6 Open and Public. Meetings of standing committees shall be open and public.

ARTICLE VI. ADVISORY GROUPS

6.1 Purpose. The Commission may establish Advisory Groups and committees of Advisory Groups composed of at least one Commissioner and beneficiaries, representatives of beneficiaries, and/or providers. The Advisory group provides

review and recommendations on policies and procedures considered by the Commission, and to the extent deemed appropriate by the Commission, shall participate in the Commission's consideration of policies and procedures prior to their adoption.

6.2 Member Services Advisory Group.

6.2.1 The Commission shall establish a Member Services Advisory Group consistent with the criteria set forth in this Article.

6.2.2 The Member Services Advisory Group shall serve as an avenue for public policy participation and shall meet at least quarterly.

6.2.3 The Member Services Advisory Group shall include representatives from the population for whom the Commission is responsible for the provision of health care services as describe in Article I.

6.3 Authority. Advisory groups shall be considered advisory by nature.

6.4 Composition. Advisory Group categories shall be decided by the Commission.

6.5 Selection.

6.5.1 The number of members to an Advisory Group shall be limited to a specific number as deemed appropriate by the Commission.

6.5.2 The Commission shall consider all nominations to Advisory Groups from members of the public and from Commissioners.

6.5.3 Members to an Advisory Group shall be appointed by a majority vote of the Commission.

6.6 Appointment. Advisory Group members shall serve one (1) year terms at the end of which the Commission shall vote on Advisory Group membership.

6.7 Officers. The Advisory Group members shall select a Chairperson and a Vice-Chairperson.

6.8 Conduct of Proceedings. The provisions of Article IV of these Bylaws pertaining to regular and special meetings of the Commission shall apply equally to such meetings of the Advisory Groups, all references to the "Commission", "Commissioners" and "Clerk" shall be deemed to mean the "Advisory Groups", the "members of the Advisory Groups" and the "secretary of the Advisory Groups", respectively.

ARTICLE VII. EXECUTION OF DOCUMENTS

7.1 Contracts and Instruments. The Commission may either by motion or by resolution authorize any officer(s), agent(s) or

employee(s) to enter into or execute any contract in the name of and on behalf of the Commission. The authority given may be general or confined to specific instances. And unless authorized or ratified by the Commission, no officer, agent or employee shall have the power or authority to bind the Commission by any contract or to render it liable for any purpose or for any amount.

7.2 Checks, Drafts, Evidence of Indebtedness. All checks, drafts or other orders for payment of money on behalf of or payment to the Commission shall be signed or endorsed by such persons as determined by either motion or resolution of the Commission.

ARTICLE VIII. CONFLICT OF INTEREST POLICY

8.1 Adoption. The Commission shall by resolution or motion adopt and may amend a Conflict of Interest Code for the Commission as required by applicable law.

8.2 Definition. A member of the Commission shall not be deemed to be financially interested in a contract entered into by the Commission (within the meaning of Government Code Section 1090 et seq.) if all the following apply, as specified in Welfare and Institutions Code section 14087.57:

1) The Board appointed the member to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

2) The contract authorizes the Commissioner or the organization the Commissioner represents to provide services to Medi-Cal beneficiaries under the Commission's program.

3) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the Commissioner was appointed to represent.

4) The Commissioner does not influence or attempt to influence the Commission or other Commissioners to enter into a contract in which the Commissioner is interested.

5) The member discloses the interest to the Commission and abstains from voting on the contract.

6) The Commission notes the Commissioner's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of the majority of the Commission without counting the vote of the interested member.

ARTICLE IX. CHIEF EXECUTIVE OFFICER

9.1 Appointment and Tenure. The Chief Executive Officer shall be the Commission's direct executive representative in managing the affairs and activities of the Commission. The Chief

Executive Officer shall serve at the pleasure of the Commission subject to any provisions in an employment contract between the Chief Executive Officer and Commission.

9.2 Duties.

9.2.1 The Chief Executive Officer shall be responsible for, and have the necessary authority to, carry out the policies, procedures and practices of the Commission.

9.2.2 The Chief Executive Officer shall act as representative of the Commission in all matters that the Commission has not authorized someone else to do.

9.2.3 The Chief Executive Officer shall appoint a Chief Financial Officer who shall be an employee of the Commission. The Chief Executive Officer may also appoint other employees in executive, administrative and management positions for the Commission. All personnel shall serve at the pleasure of the Chief Executive Officer subject to any personnel policies adopted by the Commission.

ARTICLE X. MISCELLANEOUS PROCEDURES, PRACTICES AND POLICIES, INSURANCE, BONDS

10.1 Purchasing, Hiring, Personnel. The Commission shall adopt either by motion or by resolution, and may amend procedures, practices and policies for purchasing and acquiring the use of

equipment and supplies, acquiring, constructing and leasing real property, and improvements, hiring employees, managing personnel, and for all other matters as deemed appropriate. These policies shall be kept with the minutes of the proceedings of the Commission.

10.2 Enforcement. Subject to authority of Commission, the Chief Executive Officer shall implement all procedures, practices and policies adopted by the Commission.

ARTICLE XI. AMENDMENT OF BYLAWS

These Bylaws may be amended only by a motion or resolution of the Commission at any meeting of the Commission, with subsequent approval by the Board of Supervisors of each respective County. Notice of such proposed amendment shall be given in the manner prescribed in Section 4.3 for notices of special meetings of the Commission.

CERTIFICATE OF CHAIRPERSON

I, the undersigned, do hereby certify:

That I am the duly elected and acting Chairperson of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, a local public agency and political subdivision of the State of California; and

That the foregoing Bylaws, comprising 24 pages, including this page, constitute the Bylaws of the Commission, as duly adopted by the Commission at a regular meeting, duly called and held on the _____ day of _____, 2023, at _____, California.

_____

Chairperson of the Commission

BYLAWS
OF THE SANTA CRUZ-MONTEREY-MERCED-SAN BENITO-MARIPOSA
MANAGED MEDICAL CARE COMMISSION

TABLE OF CONTENTS

DATE: October 25, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Committees, Advisory Groups, Board Delegation and Policies

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Recommendation. The following staff recommendations are presented for the Board's approval:

1. Create Finance Committee, Physician and Member Services Advisory Groups, Whole Child Model Advisory Committees and appoint members to each;
2. Schedule of Board Meetings, Committees and Advisory Groups; and
3. Delegate authority to staff and/or Alliance committees as described in this staff report and approve referenced policies.

Summary. As part of the Alliance's expansion into San Benito and Mariposa counties, a new 5-county Board, the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission was established by County Ordinance and replaces the previous 3-county Board. The 5-county Board is a new legal entity, which requires that the new Board approve the creation of Committees and Advisory Groups of the Board and approve the delegation of Board authority and responsibilities to ensure proper authorities have been granted. The recommendations included in this report are a continuation of the long-standing practices which were in place under the 3-county Board.

Background.

Board Committees. Article V. Committees of the Bylaws of the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission allow for the creation of standing committees of the Board. Only Commissioners may serve on the committees and committees must be composed of less than a quorum of voting Commissioners. The Commission may also designate one (1) or more alternatives for the committees to serve during any absences. All committees are advisory only.

Regular meetings of committees are held at times and places determined by resolution or motion of the Commission, are subject to noticing and agenda requirements applicable to the Commission and are open to the public.

Advisory Groups. Article VI. Advisory Groups of the Bylaws of the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission allow for establishing standing advisory groups of the Board composed of at least one Commissioner and beneficiaries, representatives of beneficiaries, and/or providers. The Advisory Group provides review and recommendations on policies and procedures considered by the Commission, and to the extent deemed appropriate by the Commission, shall participate in the Commissions' consideration of policies and procedures prior to their adoption. All Advisory Groups are advisory only.

Whole Child Model Advisory Committees. SB 586 (Statutes 2015) established the Whole Child Model (WCM) program under which County Organized Health System (COHS) Medi-Cal managed care plans in designated counties would provide California Children's Services (CCS) program services to Medi-Cal eligible CCS children and youth. In addition, SB 586 required COHS plans operating a WCM program to maintain a clinical advisory committee and a family advisory group to provide input to the plan. *Note: Pursuant to W&I Code §14094.5(b) the WCM may be implemented in San Benito and Mariposa counties no sooner than January 1, 2025.*

Board Oversight/Delegation of Committees. The Alliance's contract with the Department of Health Care Services (DHCS) requires that the Alliance Board maintain oversight responsibility for various plan functions, including the Quality Improvement and Health Equity Transformation Program, credentialing, and the Compliance Program. Historically, the Board delegates oversight and performance responsibilities for these functions to Alliance staff and committees.

Delegation of Authority for Plan Functions. Board bylaws state that the Board retains responsibility for certain plan functions and that the Chief Executive Officer (CEO) has the responsibility and authority to carry out policies, procedures and practices of the Commission and act as representative for the Commission in matters on which the Commission has not authorized someone else to do so. The Board may adopt procedures, practices, and policies for purchasing and acquiring the use of equipment and supplies, acquiring, constructing and leasing real property, and improvements, hiring employees, managing personnel, and for all other matters as deemed appropriate.

Discussion.

Finance Committee

The Finance Committee of the Board provides advisory support to the Alliance Board to assist in ensuring the Alliance fulfills its commitment to prudent use of taxpayer dollars by providing oversight of, and performing detailed review of, the Alliance's financial operations.

The committee Charter which provides an overview of the Committee, including structure and process, objectives, meeting standards and frequency, and Committee composition, is included as an attachment to this report for the Board's review.

The following Commissioners have indicated an interest in serving on the Finance Committee with a meeting schedule as indicated below:

Name	Affiliation	County
Michael Molesky, Chair	Commissioner	Santa Cruz
Elsa Jimenez	Commissioner	Monterey
Supervisor Josh Pedrozo	Commissioner	Merced
Allen Radner, MD	Commissioner	Monterey

- Wednesday, March 27, 2024; 1:30 – 2:45 p.m.
- Wednesday, June 26, 2024; 1:30 – 2:45 p.m.
- Wednesday, August 28, 2024; 1:30 – 2:45 p.m.
- Wednesday, November 6, 2024; 1:30 – 2:45 p.m.

Member Services Advisory Group (MSAG)

Section 6.2 Members Services Advisory Group states that the Commission shall establish a Member Services Advisory Group consistent with criteria set forth in Article VI.

The Board bylaws further state that MSAG shall serve as an avenue for public policy participation and shall meet at least quarterly (6.2.2) and shall include representatives from the population for whom the Commission is responsible for the provision of health care services (6.2.2).

Included as an attachment to this report is the proposed Charter for MSAG and sets forth the vision, mission, composition, responsibility and authority and meeting parameters. Regular meetings of Advisory Groups are held at times and places determined by motion of the Commission and are subject to noticing and agenda requirements applicable to the Commission and are open to the public.

The following individuals have indicated interest in participating on MSAG with a meeting schedule as indicated below:

Name	Affiliation	County
Carolina Meraz	Consumer Community Partner	Merced
Debby Perez	Consumer	Monterey
Doris Drost	Consumer	Monterey
Guadalupe Barajas-Iniguez	Consumer Parent/Guardian	Merced
Humberto Carrillo	Consumer	Monterey
John Beleutz	Community Partner	Santa Cruz
Leo Demushkane	Consumer	Monterey
Linda Jenkins	Consumer	Santa Cruz
Lupe Chavez	Consumer	Merced
Margaret O'Shea	Consumer	Santa Cruz
Martha Rubbo	Consumer	Santa Cruz
Melissa Raya	Community Partner	Monterey
Michael Molesky	Consumer Alliance Commissioner	Santa Cruz

Mimi Park	Consumer	Monterey
Moncerat Politron	Community Partner	Monterey
Rebekah Capron	Community Partner	Merced
Vivian Pitman	Consumer	Merced
Janna Espinoza	Consumer Alliance Commissioner	Monterey

Note that Alliance staff will recruit representation from San Benito and Mariposa counties for MSAG upon expansion into these counties and will return to the Board for appointment of interested individuals.

- Thursday, November 9, 2023; 10:00 – 11:30 a.m.
- Thursday, February 8, 2024; 10:00 – 11:30 a.m.
- Thursday, May 9, 2024; 10:00 – 11:30 a.m.
- Thursday, August 8, 2024; 10:00 – 11:30 a.m.
- Thursday, November 7, 2024; 10:00 – 11:30 a.m.

Physicians Advisory Group (PAG)

Included as an attachment to this report is the proposed Charter for PAG which sets forth the goals of PAG, including advising the Commission and staff on issues, concerns, policies, making policy recommendations, advocating on behalf of members and providers, working to ensure the Alliance is user-friendly and focused on the needs of members and providers, providing a communication channel for providers, and educating physicians, members, and the community about the Alliance.

The following individuals have indicated interest in participating on PAG with a meeting schedule as indicated below:

Name	Affiliation	County
Amy McEntee, MD	Provider Representative	Santa Cruz
Casey KirkHart, DO	Provider Representative	Santa Cruz
Jennifer Hastings, MD	Provider Representative	Santa Cruz
Devon Francis, MD	Provider Representative	Santa Cruz
Mai-Khanh Bui-Duy, MD	Provider Representative	Santa Cruz
Patrick Clyne, MD	Provider Representative	Santa Cruz
Scott Prysi, MD	Provider Representative	Monterey
Caroline Kennedy, MD	Provider Representative	Monterey
Shirley Dickinson, MD	Provider Representative	Monterey
Misty Navarro, MD	Provider Representative	Monterey
Charles Harris, MD	Provider Representative	Monterey

Cristina Mercado, MD	Provider Representative	Monterey
James Rabago, MD	Provider Representative	Merced
Salvador Sandoval, MD	Provider Representative	Merced
Cheryl Scott, MD	Provider Representative	San Benito
Ralph Armstrong, DO	Provider Representative	San Benito
Eric Sergienko, MD	Provider Representative	Mariposa
Mimi Carter, MD	Provider Representative	Mariposa

Note that Alliance staff will continue to recruit representation from San Benito and Mariposa counties for PAG upon expansion into these counties and return to the Board for appointment of interested individuals.

- Thursday, December 7, 2023; 12:00 – 1:30 p.m.
- Thursday, March 7, 2024; 12:00 – 1:30 p.m.
- Thursday, June 6, 2024; 12:00 – 1:30 p.m.
- Thursday, September 5, 2024; 12:00 – 1:30 p.m.
- Thursday, December 5, 2024; 12:00 - 1:30 p.m.

Whole Child Model Clinical Advisory Committee (WCMCAC)

Welfare and Institutions Code §14094.17(a) mandates that Medi-Cal managed care plans participating in the Whole Child Program create and maintain a clinical advisory committee composed of the managed care contractor's Chief Medical Officer or the equivalent, the county CCS Medical Director, and at least four CCS-paneled providers, to advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and to serve as clinical advisers on other clinical issues relating to CCS conditions.

The proposed Charter for the WCMCAC which sets forth the purpose, authority and responsibilities, membership and meeting standards for the WCMCAC is included as an attachment to this report.

The following individuals have indicated interest in participating on WCMCAC with a meeting schedule as indicated below:

Name	Affiliation	County
Jennifer Yu, MD	Physician	Santa Cruz
Camille Guzel, MD	Physician	Santa Cruz
John Mark, MD	Physician	Santa Cruz
Cal Gordon, MD	Physician	Santa Cruz
Devon Francis, MD	Physician	Santa Cruz
Patrick Clyne, MD	Physician	Santa Cruz
Allyson Garcia, MD	Physician	Monterey

Sarah Smith, MD	Physician	Monterey
Lena Malik, MD	Physician	Monterey
Salvador Sandoval, MD	Physician	Merced
James Rabago, MD	Physician	Merced
Ibraheem Al Shareef, MD	Physician	Merced

Note that Alliance staff will recruit representation from San Benito and Mariposa counties for the WCMCAC upon expansion of the WCM into these counties which is slated to occur "no sooner than January 1, 2025".

- Wednesday, December 13, 2023; 12:00 – 1:00 p.m.
- Thursday, March 21, 2024; 12:00 – 1:00 p.m.
- Thursday, June 20, 2024; 12:00 – 1:00 p.m.
- Thursday, September 19, 2024; 12:00 – 1:00 p.m.
- Thursday, December 19, 2024; 12:00 to 1:00 p.m.

Whole Child Model Family Advisory Committee (WCMFAC)

Welfare and Institutions Code §14094.17(b) requires each Medi-Cal managed care plan participating in the Whole Child Model program establish a family advisory group for CCS families.

The proposed Charter for the WCMFAC which describes structure and process, objectives, duties, meeting standards and composition, the purpose, authority and responsibilities, as well as membership and meeting standards for the WCMFAC is included as an attachment to this report.

The following individuals have indicated interest in participating on WCMFAC with a meeting schedule as indicated below.

Name	Affiliation	County
Paloma Barraza	CCS WCM Family Member	Monterey
Irma Espinoza	CCS WCM Family Member	Merced
Janna Espinoza	CCS WCM Family Member	Monterey
Frances Wong	CCS WCM Family Member	Monterey
Manuel Lopez Mejia	CCS WCM Family Member	Monterey
Kim Pierce	Local Consumer Advocate	Monterey
Heloisa Junqueira, MD	CCS Provider Representative	Monterey
Susan Skotzke	CCS WCM Family Member	Santa Cruz
Heidi Boynton	Local Consumer Advocate	Santa Cruz

Note that Alliance staff will recruit representation from San Benito and Mariposa counties for the WCMFAC upon expansion of the WCM into these counties which is slated to occur "no sooner than January 1, 2025".

- Monday, November 6, 2023; 1:30 – 3:00 p.m.
- Monday, January 8, 2024; 1:30 – 3:00 p.m.
- Monday, March 11, 2024; 1:30 – 3:00 p.m.
- Monday, May 13, 2024; 1:30 – 3:00 p.m.
- Monday, July 8, 2024; 1:30 – 3:00 p.m.
- Monday, September 9, 2024; 1:30 – 3:00 p.m.
- Monday, November 4, 2024; 1:30 – 3:00 p.m.

Schedule of Board Meetings

Board meetings are held from 3:00 to 5:00 p.m. (fourth Wednesdays) at the following locations via videoconference unless otherwise noticed and are open to the public.

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 East 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 1161 San Felipe Road, Building B, Hollister, CA
In Mariposa County:	Mariposa County Health and Human Services Agency 5362 Lemee Lane, Mariposa, CA

To ensure compliance with Brown Act provisions governing public meetings, staff propose the following.

- Board meetings will be held via videoconferencing at each of the five county locations in Scotts Valley, Salinas, Merced, Hollister and Mariposa.
- Board members must attend the meetings in person at one of the five locations.
- Members of the public will be allowed access to each meeting location and to provide public comment from each location.
- Members of the public wishing to observe the meeting via video/audio livestream may do so. However, to provide comment during the meeting the public must be at one of the on-site locations.

Schedule of Alliance Board Meetings.

November 2023	No meeting scheduled
December 6, 2023	In-person Alliance/County offices
January 24, 2024	In-person Alliance/County offices
February 28, 2024	In-person Alliance/County offices
March 27, 2024	In-person Alliance/County offices
April 24, 2024	In-person Merced County; 10:00 a.m. – 2:30 p.m.

May 22, 2024	In-person Alliance/County offices
June 26, 2024	In-person Alliance/County offices
July 2024	No meeting scheduled
August 28, 2024	In-person Alliance/County offices
September 25, 2024	Retreat; 9:00 a.m. – 4:00 p.m.; Location: TBD
October 2024	No meeting scheduled
November 6, 2024	In-person Alliance/County offices
December 4, 2024	In-person Alliance/County offices

Board Oversight/Delegation of Committees

DHCS requires the Alliance Board to oversee and maintain accountability for various plan programs, which is accomplished by delegating this oversight responsibility to plan Committees and by receiving routine reports from the delegated Committees as described below:

- The Board is responsible for oversight of the Compliance Program and has delegated authority for overseeing the effectiveness of the Compliance Program to the Compliance Committee, as documented in the Alliance's Compliance Plan.
- The Board is accountable for all credentialing activities and has delegated the authority to oversee the Alliance's credentialing function to the Peer Review and Credentialing Committee (PRCC), as documented in Alliance Policy 300-4020 – PRCC – Authority, Roles and Responsibilities.
- The Board has delegated oversight and performance responsibility of the Quality Improvement and Health Equity Transformation program (QIHETP) to the Quality Improvement Health Equity Committee, as described in Policy 401-1101 – QIHETP.
- The Alliance's Utilization Management Program is a component of the QIHETP; therefore, the Board remains accountable for the performance of the Program and has delegated oversight and performance responsibility of the program to the QIHETP as described in Alliance Policy 404-1101 – Utilization Management Program.

Delegation of Authority for Plan Functions

The following policies reflect the Board's delegation of authority for Board responsibilities to the CEO or specified Alliance staff and require approval by the new 5-county Board:

- Policy 700-1000 – Investments sets forth the investment guidelines for all operating funds and Board-designated reserve funds to ensure the Alliance's funds are invested according to the Board's objectives to preserve capital, provide necessary liquidity, and to achieve a market-average return on investments.
- Policy 800-0012 – Administrative Decision-Making Controls describes Board delegation of certain functions, including representation in advocacy matters, authority to enter into legal settlements, and decision-making regarding the management and hiring of personnel.
- Policy 800-0013 – Expenditure Authority describes the delegation of authority to implement Board-approved administrative and medical budgets to the CEO.

- Policy 800-0014 – Contract Signature Authority describes the delegation of authority to enter into certain contracts from the Alliance Board to designated staff.
- Policy 800-0018 – Government Claims sets forth the Alliance's procedure for addressing claims for money or damages. The Alliance Board has delegated the authority to approve, allow, deny, or settle certain Government Claims, to a Government Claims Committee comprised of Alliance staff.

Updates and changes were made to several of the existing policies, as follows.

- Policy 800-0012 – Administrative Decision-Making Controls was revised to clarify that the CEO may proactively activate the Executive Line of Succession, in whole or in part, when they anticipate being unavailable.

- Policy 800-0013 – Expenditure Authority was revised to implement an internal control to ensure that unanticipated medical expenses which do not impact the overall Medical Budget are reviewed and approved by Finance staff.

- Policy 800-0014 – Contract Signature Authority was revised to better reflect the process for entering into contracts, and to clarify that all contracts must be in writing and signed by a designated Alliance staff member or Board member. The purpose of this revision is to protect the Alliance from claims that other entities had implied in fact contracts with the Alliance.

Additional Policies Requiring Board Approval

Finally, there are a suite of Alliance policies that require Board approval either because review and approval from the governing Board is required by DHCS or because the policies document prior Board decisions that will carry forward under the new 5-county Board.

These policies are as follows:

- Alliance Code of Conduct is a component of the Compliance Program, which provides guidelines to Board members, employees, and contractors on appropriate ethical and legal standards. The Alliance's DHCS Medi-Cal contract requires annual Board review and approval of this document.
- Policy 100-0001 – Alliance Donations and Sponsorship of Events and Organizations documents the Board-approved policy for financial donations to non-profit 501(c)(3) community organizations and sponsorship of such organizations' events within the Alliance service area.
- Policy 110-0003 – Letters of Support documents the Board-approved policy for responding to requests for letters of support from external entities.
- Policy 700-2000 – Board Designated Reserve ("Reserve") documents the Board approved reserve requirements, which ensure the Alliance's long-term financial viability.

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

Attachments.

1. Finance Committee Charter
2. Member Services Advisory Group Charter
3. Physicians Advisory Group Charter

4. Whole Child Model Clinical Advisory Committee Charter
5. Whole Child Model Family Advisory Committee Charter
6. Alliance Compliance Plan
7. Policy 300-4020 – PRCC – Authority, Roles and Responsibilities
8. Policy 401-1101 – Quality Improvement & Health Equity Transformation Program
9. Policy 404-1101 – Utilization Management Program
10. Policy 700-1000 – Investments
11. Policy 800-0012 – Administrative Decision-Making Controls
12. Policy 800-0013 – Expenditure Authority
13. Policy 800-0014 – Contract Signature Authority
14. Policy 800-0018 – Government Claims Presentation and Delegation of Authority to Approve, Deny and/or Settle Certain Government Claims
15. Alliance Code of Conduct
16. Policy 100-0001 – Alliance Donations and Sponsorship of Events and Organizations
17. Policy 110-0003 – Letters of Support
18. Policy 700-2000 – Board Designated Reserve ("Reserve")

Finance Committee

Meeting Charter

Original Date: October 2023	**Last Revision Date:** 10/02/2023
Approved by: Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission	

Overview	As a public agency, the Alliance is responsible for the prudent use of taxpayer dollars. The Finance Committee helps to ensure that the Alliance fulfills that commitment by providing oversight of, and performing detailed reviews of the Alliance's financial operations, and advises the Commission of findings.
Structure and Process	• Standing Committees of the Commission may be created by the Board. • The Finance Committee is comprised of only Commissioners. • The Finance Committee must be comprised of less than a quorum of appointed Board members. • The Finance Committee is advisory to the Board. • Meeting schedules are determined and approved by the Board. • A majority of appointed Committee members constitutes a quorum. • The Finance Committee must comply with Brown Act noticing and agenda posting requirements and be open to the public.
Objectives	The Finance Committee will provide advisory input to the full Board and may include: • Annual medical and administrative budget proposals • Investment plan • Review any independent audit issues • Mid-year budget variances and adjustments
Frequency	The Finance Committee shall meet at least quarterly with a minimum of three meetings per year. The meeting calendar and schedule of Committee participation shall be approved by the Board annually.
Open and Public Meetings	Finance Committee meetings are open to the public. Meetings will take place in-person via videoconference from each of the five county offices. Livestreaming may be available for the public to listen/view the meeting.
Composition	Finance Committee members are appointed by the Alliance Board. There are a maximum of nine Committee members.

	Committee members will be appointed to a one-year term. At the end of the term the member may be reappointed to a subsequent one-year term or terms. Finance Committee members may receive a stipend to cover travel expenses and other costs associated with in-person meeting attendance. Support staff to the Finance Committee includes, but is not limited to: • Alliance Staff: Chief Financial Officer, Administrative Specialist
Minutes and Reporting	Alliance staff will work in collaboration with the Chair to develop the agenda for each meeting. Alliance staff are responsible for agenda and meeting material production and distribution. Agendas and meeting materials will be published and distributed to Finance Committee members and posted publicly at least 72 hours prior to each meeting. Alliance staff will record minutes of meetings which will be approved by Finance Committee members at each subsequent meeting.
References	

Revision History:

Date	Changes Made By	Approved By
xx/xx/xx	Lisa Ba, Chief Financial Officer	Alliance Board

Member Services Advisory Group (MSAG)

Meeting Charter

Original Date: October 2023	**Last Revision Date:** 10/10/2023
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission	

Vision	The vision of the Member Services Advisory Group is two-way communication between Alliance members and the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission.
Mission	In conjunction with the Commission, the goal is to facilitate effective, efficient, patient-friendly, high-quality medical care for members of Central California Alliance for Health (the Alliance). • In the course of our service, we will: o Advise the Commission on issues and concerns of members and the community as they relate to the Alliance. o Make policy recommendations to the Commission, based on member and community input and feedback. o Advocate on behalf of Alliance members and bring their concerns and ideas to the Advisory Group meetings for discussion and possible action. o Be a place to hear and collect the voices of those Alliance members who, otherwise, might not be heard. o Work to ensure that the Alliance is user-friendly and stays focused on members' needs. o Educate members and the community about the Alliance by disseminating information from the meetings to members and to the community.
Membership	• **Chairperson:** Elected committee member • **Liaison:** Alliance Director • **Staff:** Alliance Administrative Staff • **Members:** o 51% Central California Alliance for Health members o 49% Community partners o Appointed by the Alliance Board o One-year, renewable, term • **Commissioner:** o Assigned by Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission

Member Services Advisory Group (MSAG)

Meeting Charter

Responsibilities and Authority	• Attend at least 50% of meetings per calendar year.
	• Approve meeting minutes.
	• Vote on recommendations.
	  o Requires quorum and commissioner presence.
	• Quorum requires one more than half the total voting membership.
	• Voting membership is committee members.
	  o Excludes Chairperson, Alliance liaison, Alliance staff, and commissioner.

Meetings	• MSAG shall meet at least quarterly with a minimum of three (3) meetings per year. • The proposed meeting calendar shall be shared annually at the November meeting. Appointed members may receive a stipend to cover travel expenses and other costs associated with in-person meeting attendance.

Open & Public Meetings	• Meetings are subject to the Brown Act, thus are open to the public.
	• Agendas and meeting materials will be published and distributed to MSAG members and posted publicly at least seventy-two (72) hours prior to each meeting.
	• Staff will record minutes of meetings which will be approved by MSAG members at each subsequent meeting.
	• Meetings will take place in the Alliance offices listed below and joined together via videoconferencing.
	  o Mariposa County: Cathey's Valley Room
	  Mariposa County Health and Human Services
	  5362 Lemee Lane, Mariposa, CA 95338
	  o Merced County: Board Room
	  530 West 16th Street, Suite B, Merced, CA 95340
	  o Monterey County: Board Room
	  950 East Blanco Road, Suite 101, Salinas CA 93901
	  o San Benito County: Conference Room
	  Community Services & Workforce Development (CSWD)
	  1161 San Felipe Road, Building B, Hollister, CA 95023
	  o Santa Cruz County: Board Room
	  1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066

Translation and Interpreter Services / Assistive Devices	Requests for translation and interpreter services, including sign-language interpretation or other assistive devices such as real-time captioning, note takers, reading or writing assistance and conversion of meeting materials into Braille, large print or computer flash drive can be made available if requested at least ten (10) business days prior to the meeting.
Review of Charter	MSAG shall review this charter at least annually. Any proposed changes shall be submitted to the Board for approval.
References	

Revision History:

Date	Changes Made By	Approved By
10/10/23	Kayla Zoliniak, Administrative Specialist	

	Physicians Advisory Group (PAG) **Meeting Charter**
Original Date: October 2023	**Last Revision Date:** October 13, 2023
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission	

Purpose	The primary responsibilities of the Physicians Advisory Group (PAG) are to advise and provide perspective to the Chief Medical Officer and staff regarding Alliance policies, programs, and initiatives.
Meetings	Meetings are held quarterly with a minimum of three (3) meetings per year. Meetings fall within the Ralph M. Brown Act (Brown Act). An opportunity for public comment will be offered and agendas and meeting materials will be published and distributed to PAG members and posted publicly at least 72 hours prior to each meeting.
Structure and Process	The Chief Medical Officer will serve as Chair and PAG is a non-voting advisory group and does not require a quorum.
Committee Membership	PAG consists of between ten and twenty contracted Alliance Primary Care Providers, Chief Medical Officer, Medical Directors, Utilization Management Director, Quality Improvement and Population Health Director, Provider Services Director, Member Services Director, and other staff may attend depending upon agenda items. The specific number of participating physicians shall be determined by the group annually as needed. Membership will reflect demographic representation within practical limits, including geographic distribution, Primary Care and Specialists, as well as structurally distinct practice types (clinics, independent office practice, etc.). Members serve a one-year term, renewable by the

	Commission. Physicians unable to attend at least half of meetings will be encouraged to yield their seats to others with more compliant schedules.
Minutes and Reporting	PAG reports to the Board of Commissioners, through Committee Minutes as well as recommendations for policy revisions and innovations.
Review of Charter	The PAG Charter will be reviewed annually. Any proposed changes shall be submitted to the Board for approval.

Revision History

Review Date	Revised Date	Changes Made By	Approved By
10/13/2023	10/13/2023	Tracy Neves Administrative Specialist	

	Whole Child Model Clinical Advisory Committee (WCMCAC) Meeting Charter
Original Date: October 2023	**Last Revision Date:** October 13, 2023
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission	

Purpose	The Whole Child Clinical Advisory Committee (WCMCAC) is an advisory committee providing input and recommendations to the health plan on important strategic issues that impact California Children's Services (CCS) members, families, and providers. The WCMCAC will provide feedback to assist in meeting the six (6) goals of the WCM: • Support Patient and Family-Centered Approaches to Care • Improve Care Coordination through an Organized Delivery System • Maintain Quality of Services • Streamline Care Delivery • Build on Lessons Learned • Provide Quality, Cost Effective Services
Authority and Responsibility	The primary responsibility of the WCMCAC is to advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, and serve as clinical advisers on other clinical issues relating to CCS conditions. The WCMCAC will provide perspective on issues relating to diagnosis and treatment of Alliance members with conditions that have been traditionally covered through the California Children's Services (CCS) program. In addition, the WCMCAC will review and offer advice about policies, programs and initiatives relating to care of members with CCS eligible diagnoses enrolled in the Whole Child Program.
Membership	WCMCAC members are appointed by the Alliance Board. Membership includes:

	• Alliance Chief Medical Officer • Alliance Medical Directors • Each County's CCS Medical Director At least four (4) CCS paneled providers with representation from each of the Alliance counties served. Membership will reflect demographic representation within practical limits, including geographic distribution, primary care, and specialists. Members are recruited several ways including, but not limited to: 1. Recommendation of CCS staff representing each County. 2. Volunteer by individual physician. 3. Physicians with specific expertise may be invited to assist with the committee's work. WCMCAC members will be appointed by the Alliance Board. Alliance staff, including, but not limited to the, Utilization Management/CCM Director, Quality Improvement & Population Health Director, Community Care Coordination Director, Provider Services Director, Member Services Director, and other staff may attend depending upon agenda items.
Terms	Members will be appointed to a one-year term. At the end of the term the member may be reappointed to a subsequent one-year term or terms. Physicians unable to attend at least half of meetings will be encouraged to yield their seats to others with more compliant schedules.
Meetings	The Alliance Medical Director will serve as Chair. The WCMCAC will meet quarterly, with a minimum of three (3) meetings per year. WCMCAC meetings are open to the public. WCMCAC members may receive a stipend for participation in the WCMCAC.

	Meetings will be held via teleconference utilizing Microsoft Teams. Meeting participants may also participate telephonically.
Agenda, Minutes, Reports	Alliance staff will work in collaboration with the Chair to develop the agenda for each meeting. Alliance staff are responsible for agenda and meeting material production and distribution. Agendas and meeting materials will be published and distributed to WCMCAC members and posted publicly at least seventy-two (72) hours prior to each meeting. Alliance staff will record minutes of meetings which will be approved by the WCMCAC at each subsequent meeting.
Translation and Interpreter Services/Assistive Devices	Requests for translation and interpreter services, including sign-language interpretation or other assistive devices such as real-time captioning, note takers, reading or writing assistance and conversion of meeting materials into Braille, large print or computer flash drive can be made available if requested at least ten (10) business days prior to the meeting.
Review of Charter	The WCMCAC Charter shall be reviewed annually. Any proposed changes shall be submitted to the Board for approval.

Revision History

Review Date	Revised Date	Changes Made By	Approved By
10/13/2023	10/13/2023	Tracy Neves Administrative Specialist	

Whole Child Model Family Advisory Committee (WCMFAC)

Meeting Charter

Original Date: October 2023	**Last Revision Date:** 10/6/2023
Approved by: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission	

Overview	The WCMFAC is an advisory committee to the Alliance providing input, review and recommendations on policies and issues that affect children and their families served through the Alliance's WCM program.
Structure and Process	The WCMFAC shall select a Chair and Vice Chair. The Chair and Vice Chair shall be a CCS Member or family representative selected by the voting members of the WCMFAC. The role of the Chair is to provide meeting facilitation and direct the meeting process through the agenda. The Chair will guide and lead discussion to ensure all participants are provided equal opportunity for participation. The role of the Vice Chair is to preside at the meetings of the WCMFAC in the absence of the Chair. If both Chair and Vice Chair are absent, the WCMFAC members present will select one member to act as Chair for the meeting. The WCMFAC shall elect a Chair and Vice Chair for a one-year term each December. Members will be appointed to a one-year term. At the end of the term the member may be reappointed to a subsequent one-year term or terms.
Objectives	The WCMFAC is intended to promote open communication between families with children who have special health care needs, Alliance leadership, and local family support providers and will serve as a mutual learning forum for committee members and Alliance staff to make a positive difference in the care the health plan provides to California Children's Services (CCS) beneficiaries.
Duties	The WCMFAC will provide advisory input to assist in meeting the six goals of the WCM which include: • Implement Patient and Family-Centered Approaches to Care • Improve Care Coordination through an Organized Delivery System • Maintain Quality of Services • Streamline Care Delivery • Build on Lessons Learned

	• Provide Quality, Cost Effective Services
Frequency	The WCMFAC shall meet at least quarterly with a minimum of three (3) meetings per year. The meeting calendar shall be established annually at the WCMFAC's December meeting. Meetings will take place by videoconference using Microsoft Teams.
Open and Public Meetings	WCMFAC Meetings are open to the public. Translation and Interpreter Services/ Assistive Devices: Requests for translation and interpreter services, including sign-language interpretation or other assistive devices such as real-time captioning, note takers, reading or writing assistance and conversion of meeting materials into Braille, large print or computer flash drive can be made available if requested at least ten (10) business days prior to the meeting.
Composition	Members are appointed by the Alliance Board. There are a maximum of nineteen (19) members. Membership includes: • CCS WCM member and/or family member – maximum of four (4) family representatives in each Alliance county. An Alliance member and/or family representative constitutes one (1) representative. • Local Consumer Advocate – maximum of one (1) local consumer advocate representing CCS families in each Alliance county. • CCS Provider Representative –maximum of one (1) provider in each Alliance county that providers services to CCS children. • One (1) Alliance Board member Members will be appointed to a one-year term. At the end of the term the member may be reappointed to a subsequent one-year term or terms. WCMFAC appointed Members may receive a stipend to cover travel expenses and other costs associated with in-person meeting attendance. Support staff to the WCMFAC includes: • Alliance Staff – Community Engagement Director, Community Care Coordination Director, Member Services Director. • County CCS Representative – County CCS Medical Director or designee • Ad Hoc Staff from either Alliance or County CCS as needed. Alliance staff will serve as staff to the WCMFAC.
Minutes and Reporting	Alliance staff will work in collaboration with the Chair to develop the agenda for each meeting. Alliance staff are responsible for agenda and meeting material production and distribution. Agendas and meeting materials will be published and distributed to WCMFAC members and posted publicly at least seventy-two (72) hours prior to each meeting.

	Alliance staff will record minutes of meetings which will be approved by the WCMFAC members at each subsequent meeting.
References	

Revision History:

Date	Changes Made By	Approved By
10/6/23	Kayla Zoliniak, Administrative Specialist	Lilia Chagolla, Community Engagement Director
10/25/23		

Alliance Compliance Plan

PURPOSE

The Central California Alliance for Health's (the Alliance's) Compliance Program ensures that the organization and its staff operate in compliance with contractual, regulatory and statutory requirements. Through its Compliance Program, the Alliance maintains its business operations to ensure alignment with these requirements. The Alliance exercises due diligence to prevent and detect criminal conduct, and when necessary, takes corrective action to ensure that its business operations are compliant with governing requirements. The Alliance promotes an organizational culture that encourages ethical conduct and a commitment to compliance with the law. The Alliance takes appropriate steps to ensure that its staff members are knowledgeable of requirements and that they consistently work towards meeting them. To maintain its independence, the Alliance's Compliance Program acts independently of operational and program areas without fear of repercussions for identifying non-compliance.

Following is a description of how the Alliance aligns with the Effective Compliance and Ethics Program guidance published by the United States Sentencing Commission.

WRITTEN POLICIES, PROCEDURES, AND STANDARDS OF CONDUCT

Policies and procedures ensure that Board members, employees, and contractors, including Network Providers, Subcontractors and Downstream Subcontractors, understand and perform their responsibilities in compliance with regulatory and contractual obligations and applicable law. The Alliance maintains policies and procedures that demonstrate compliance with relevant requirements and updates are made as needed to reflect alignment with changing operations and requirements. Compliance Department staff regularly reviews proposed changes to policies and procedures and responds to needs identified through program monitoring. Policies and procedures are developed within the applicable departments, are reviewed and approved through the Policy Hub process. Compliance staff leverage compliance's management software to ensure that all Alliance policies are reviewed and/or revised at least annually. Policies and Procedures are available to all staff through the Alliance's Policy Library located on its Intranet. .

The Compliance Department maintains a suite of policies that implement this Compliance Plan, including, but not limited to the following:

- Policies describing the obligations of plan Board members, employees, and contractors to maintain the confidentiality of protected health information (PHI) in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and HIPAA Program Operations;
- Policies describing the Alliance's Program Integrity Program, including procedures in place to prevent, detect, investigate, and resolve fraud, waste, and abuse (FWA);
- Policies related to reporting, investigation, and resolution of non-compliance;
- Policies related to the oversight of delegated entities, including Subcontractors and Downstream Subcontractors, and the operations of the Delegate Oversight Program; and
- Policies regarding regulatory audits and the operations of the Internal Audit and Monitoring Program

A full listing of Compliance Department policies can be found in Appendix A.

In addition, the Compliance Plan includes a Code of Conduct, included in a separate document, which guides Alliance Board members, employees, and contractors in conducting their business activities in a professional, ethical, and legal manner. The Human Resources Department also reflects these expectations in its Employee Handbook. In addition to being made available to Alliance staff, this Compliance Plan and Code of Conduct are publicly posted on the Alliance's website.

STRUCTURE AND OVERSIGHT

Alliance Governing Board – The Alliance Governing Board (Board) is responsible for oversight of the Compliance Program. The Board receives and approves a report from the Compliance Program annually and receives, at minimum, quarterly reports on compliance activities. These reports include a review of activities of the Compliance Program, results of internal and external audits, and reporting of other compliance-related issues. To ensure that the Board is aware of the content and operation of the Alliance's Compliance Program, the Board receives training regarding the content and operations of the Alliance's Compliance Program, which includes FWA prevention training on appointment and annually thereafter. The Board is also responsible for review and approval of revisions to the Alliance's Compliance Plan and Code of Conduct, which are made at minimum biennially.

Chief Executive Officer – The Chief Executive Officer (CEO) oversees the Compliance Program and attends Compliance Committee. The Chief Compliance Officer (CCO) reports directly to the CEO.

Compliance Committee – The Compliance Committee is comprised of Director and Chief level representatives from each department and is chaired by the CCO. The Compliance Committee directs the CCO and assists in the implementation of the Compliance Program. The Compliance Committee meets at least quarterly and reports to the Board. Additional responsibilities of the Compliance Committee include, but are not limited to:

- Reviewing information regarding new requirements or changes to existing requirements that are brought before it by the CCO, Compliance Department staff, or Government Relations Department staff, and determining necessary steps for implementation, operations, and compliance with requirements;
- Reviewing and approving an annual Compliance Risk Assessment developed by Compliance staff and overseeing the outcomes of auditing and monitoring activities identified in the Internal Audit and Monitoring Workplan;
- Reviewing monitoring and evaluation reports based upon ongoing review of existing policies and procedures and operations;
- Biennially reviewing and, as necessary, updating the Code of Conduct and Compliance Plan;
- Ensuring that Compliance training and education are effective and appropriately completed;
- Reviewing areas of non-compliance and developing appropriate corrective and preventive action to prevent or mitigate compliance concerns;
- Reviewing delegated entities, including the Alliance's Subcontractors and Downstream Subcontractors, to ensure their performance on delegated functions meets contractual, legal, and regulatory obligations, and Alliance standards;
- Overseeing the Alliance's Program Integrity activity to ensure that the organization deters, identifies, investigates and resolves potential and/or actual FWA, both internally and externally; and,
- Ensuring the Alliance implements appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of PHI and ensure compliance with HIPAA requirements.

In addition to the Compliance Committee, the Alliance has other committees that oversee its contractual, legal, and regulatory obligations, including the following:

Continuous Quality Improvement Committee

The Continuous Quality Improvement Committee (CQIC) monitors progress on the Quality Improvement work plan, oversees Utilization Management activities, and receives reports from the Pharmacy and Therapeutics Committee. In addition, the Committee oversees various plan activities including: care-based incentives, HEDIS results, analysis and suggested interventions, disease management and educational

programs, cultural and linguistic initiatives, grievances and potential quality issues, emergency department utilization projects, and the annual review of Alliance's preventive health guidelines. The CQIC reports its activities to the Board on a regular basis.

Staff Grievance Review Committee

The Staff Grievance Review Committee (SGRC) monitors the timeliness and appropriateness of the research for and resolution to member complaints and provider disputes. In addition, the SGRC monitors the processing of all Grievance cases for statutory, regulatory and contractual compliance and to manage continuous quality improvement. SGRC reports its activities to the Interdisciplinary Clinical Quality Improvement Workgroup and Board on a regular basis.

Chief Compliance Officer – The CCO, under the guidance of the CEO, directs the Compliance Program in support of Alliance goals, provides executive leadership in developing, implementing, and monitoring the Alliance's Compliance Program, and serves as the HIPAA Privacy Officer and Fraud Prevention Officer. The CCO maintains a direct reporting relationship to the Board, providing routine reports and updates to the Board on Compliance Program activities. The CCO is responsible for overseeing the implementation of the Compliance Program, including defining the program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations of all staff and contractors. In the event the CCO is unavailable, the Compliance Director serves as the backup Compliance Officer, Privacy Officer, and Fraud Prevention Officer.

The CCO, in coordination with the Compliance Committee and staff, ensures the following activities are performed:

- Ensuring that updates from the Compliance Program are presented to the CEO and the Board on a periodic basis;
- Ensuring that the Alliance's Compliance Programs, including the Delegate Oversight Program, HIPAA Program, Internal Audit and Monitoring Program, and Program Integrity Program adhere to relevant state and federal requirements, are responsive to the Alliance's needs, and are effective in identifying and mitigating compliance risk;
- Ensuring processes and reporting mechanisms are in place that encourage staff to report noncompliance, suspected FWA, or other misconduct without fear of retaliation;

- Ensuring that effective compliance training is in place and that staff are aware of the Alliance's Compliance Program, Code of Conduct, and all applicable statutory and regulatory requirements;
- Ensuring effective processes are in place to allow two-way communication between the Compliance Division and Alliance staff such that staff are aware of new and changing requirements and are knowledgeable about how to report noncompliance, suspected FWA, or other misconduct without fear of retaliation; and
- Ensuring corrective action plans (CAPs) are implemented when non-compliance is identified and that the CAPs effectively address the identified root cause.

Compliance Director – The Compliance Director, under the guidance of the CCO, executes and oversees the Compliance Program in support of Alliance goals, directs the Alliance's Compliance function, and chairs the Compliance Committee. The Compliance Director is responsible for implementing Compliance Program, including ensuring that the Compliance Plan is implemented, maintaining reporting and complaint mechanisms, directing response and correction procedures, and recommending revisions to the Compliance Program to meet organizational need. The Compliance Director, in coordination with the Compliance Committee and staff, ensures the following activities are performed:

- Directing and overseeing the Alliance's Compliance Programs, including the Delegate Oversight Program, HIPAA Program, Internal Audit and Monitoring Program, and Program Integrity Program to ensure alignment with the CCO's stated objectives;
- Interacting with the operational units of the company and being involved in and aware of the daily business activities;
- Maintaining processes that encourage staff to report potential compliance concerns without fear of retaliation;
- Ensuring reports of potential instances of FWA, disclosures of PHI, and noncompliance are resolved, including overseeing internal investigations and developing corrective or disciplinary actions, if necessary;
- Maintaining documentation for each report of potential noncompliance or FWA received;
- In partnership with the Alliance's Training & Development Department, developing training programs to ensure that staff are aware of the Alliance's Compliance Program, Code of Conduct, and all applicable statutory and regulatory requirements;
- Maintaining the compliance reporting mechanism and initiating audits through the Internal Audit and Monitoring Program, operational departments, and the Program Integrity function, where applicable;
- Ensuring that the Alliance does not employ or contract with individuals excluded from participation in federal programs. This function has been delegated to the

Alliance's Human Resources Department, Provider Services Department, and Administrative Contracts Unit; and,
- Overseeing development and implementation of CAPs.

Compliance Manager – The Compliance Manager reports to the Compliance Director and is responsible for managing the day-to-day activities of the core Compliance Program functions, including the HIPAA Program, Internal Audit and Monitoring Program, Program Integrity Program, and Delegate Oversight Program.

Compliance Specialists – Compliance Specialists are responsible for conducting day-to-day operational work related to implementation of the Alliance's HIPAA Program, Program Integrity Program, Delegate Oversight Program, and Internal Audit and Monitoring Program. Compliance Specialists are also responsible for managing regulatory audits, including pre-onsite and onsite document requests and logistics, and coordinating any required CAPs. Other duties may be assigned as appropriate.

Regulatory Affairs Manager– The Regulatory Affairs Manager reports to the Compliance Director and is responsible for managing the day-to-day activities of the Alliance's regulatory affairs function, which includes analyzing and monitoring state and federal policy, legislation and regulations affecting the Alliance; maintaining systems and procedures to intake, assess and implement regulatory policies and legislative information; and ensuring the submission of timely and accurate program reporting to regulators.

Regulatory Affairs Specialists – Regulatory Affairs Specialists are responsible for conducting day-to-day operational work related to implementation of new requirements, policy development and maintenance, regulatory reporting, and regulatory filings. Other duties may be assigned as appropriate.

Government Relations Director – The GRD is the health plan contact with external regulatory and government agencies. The GRD monitors legislative, regulatory, and contractual requirements to identify new or changing, policies, standards, laws and regulations that may impact plan operations and ensures that these are brought to the relevant departments for review and implementation.

EDUCATION AND TRAINING

As part of their orientation and training, Alliance staff are informed of the Alliance's commitment to compliance with contractual, regulatory and legal standards. New employees receive general compliance training and receive a copy of the Compliance Plan, Code of Conduct, and policies and procedures pertinent to that individual's job responsibilities, where applicable.

General compliance trainings are conducted via the Alliance Learning Center (ALC), a web-based training module, for all employees upon initial hiring. The Training & Development Department ensures that all employees are trained on the Alliance's Code of Conduct and Compliance Plan within 90 days of the date of hire and annually thereafter.

Staff are trained on the Alliance's Code of Conduct and Compliance Plan, including but not limited to:

- Policies and procedures relevant to their job functions to ensure compliance with requirements;
- The Alliance's Program Integrity function, including information regarding the False Claims Act and the Anti-kickback Statute;
- HIPAA compliance training, with emphasis on confidentiality of PHI; and,
- An overview of compliance issues and how to report potential non-compliance or FWA.

To gauge the effectiveness of this training, staff are required to take a pre-test prior to the specific training module and a post-test after the completion of the training. The results of these tests indicate enhanced understanding of the Alliance's Compliance Program through effective training. Staff must attain a passing score of 80% in the post-test to complete the training module.

Board members receive a copy of the Compliance Plan, Code of Conduct, and policies and procedures pertinent to their appointment as part of their orientation. In addition, Board members receive general compliance training, including FWA prevention training, as part of their orientation and on an annual basis thereafter.

Compliance staff also monitor reports on an ongoing basis to ensure the following required training is occurring:

- For Member Services staff, training must cover Alliance policies and procedures; contractually required services for all members; how to utilize services in the Medi-Cal program; how to access carved out services; how to obtain referrals to

community resources; how to assist members with disabilities and chronic conditions; and diversity, equity and inclusion (DEI) training.
- For staff carrying out obligations under MOUs, training must cover how complaints can be raised and how to resolve disputes between the parties in the MOU.
- For Network Providers, training includes an overview of the Medi-Cal Managed Care program; covered services, policies and procedures for clinical protocols governing prior authorization and utilization management; how to refer to and coordinate care for carved out services; preventive healthcare services including Early Periodic Screening, Diagnosis and Testing (EPSDT); medical record and coding requirements; Population Health Management program requirements; member access, including appointment wait time standards, telephone access, translation and language access services; secure data sharing methods; member rights; DEI training; and advanced health care directives.

EFFECTIVE LINES OF COMMUNICATION

The Alliance has formal and routine mechanisms of communication available to staff, contractors, and members. The Alliance promotes communication through a variety of meetings and processes, including Board meetings, Compliance Committee meetings, Operations Committee, the Administrative Contract Review Process, the Policy Hub process, all-staff assemblies, regular departmental meetings, internal committee meetings, and ad-hoc provider and member communications. Additionally, information is communicated to Board members, employees, contractors, and members by email distributions, internal and external websites, reports, newsletters, and handbooks.

Policies and procedures ensure that staff members understand and perform their responsibilities in compliance with their positions and applicable law. Staff members are responsible for complying with the policies and procedures relevant to job descriptions and contractors are responsible for complying with their contractual obligations.

The Alliance expects that all Board members, employees, and contractors report compliance issues including noncompliant, unethical and/or illegal behavior. Reports of non-compliance with standards are investigated by supervisors, the GRD, and/or Compliance Department staff and leadership, as appropriate, and are referred to the Compliance Committee as needed. The Compliance Committee reviews these reports and ensures corrective actions are implemented and monitored for effectiveness.

The Alliance encourages staff to discuss issues directly with their supervisor or manager, Compliance Department staff, the Human Resources Director, or the Chief Administrative Officer. Should staff not feel comfortable reporting concerns directly, they may do so anonymously through the Confidential Disclosure Hotline. Staff can be assured that they may report compliance issues or concerns without risk of retaliation. The Alliance has a zero-tolerance policy for retaliation or retribution against any employee who in good faith reports suspected misconduct.

The Alliance's Confidential Disclosure Hotline is accessible 24 hours a day to report violations, or suspected violations of the law and/or the Compliance Program as well as concerns with Alliance personnel practices, such as allegations of discrimination, harassment or poor treatment. Additionally, staff may use the Alliance's Confidential Disclosure website.

TOLL FREE CONFIDENTIAL DISCLOSURE HOTLINE

844-910-4228

CONFIDENTIAL DISCLOSURE WEBSITE

https://ccah.ethicspoint.com

Additional reporting information is located on the Compliance Intranet page. The Alliance takes all reports of violations, or suspected violations, seriously and is committed to investigating all reported concerns promptly and confidentially to the extent possible.

The Alliance also maintains a reporting mechanism on its public website that allows employees, members, Network Providers, Subcontractors, or any other person or entity to submit reports of non-compliance, including anonymous reports if desired.

MONITORING AND AUDITING TO IDENTIFY COMPLIANCE RISK

The Alliance conducts monitoring and auditing activities to test and confirm the effectiveness of the Compliance Program, to ensure that plan operations align with contractual, legal, and regulatory requirements, and to identify the Alliance's organizational risk areas. This includes the evaluation of delegated entities – Subcontractors and Downstream Subcontractors – for compliance with standards, in alignment with the Delegation Reporting and Compliance Plan.

To comply with regulatory and contractual requirements, the Alliance conducts routine internal auditing in identified risk areas and routinely monitors plan performance through the Alliance Dashboard. The Alliance is also subject to external audits by federal and state agencies in connection with the Medi-Cal Program and its IHSS line of business.

Annually, Compliance Department staff conducts a Compliance Risk Assessment and develops an Internal Audit and Monitoring Work Plan outlining identified risk areas selected for internal audit. The Compliance Manager oversees the Internal Audit and Monitoring Work Plan, ensuring that internal audits are conducted, deficiencies are identified, reports are developed, and corrective action is taken, as needed.

DISCIPLINARY STANDARDS

The Alliance does not condone any conduct that negatively affects the operation, mission, or image of the Alliance. The Alliance ensures that standards and policies and procedures are consistently enforced through disciplinary mechanisms. Any employee or contractor engaging in a violation of laws or regulations (depending on the magnitude of the violation) will be disciplined up to, and including, termination from employment or their contract.

In the event of discovery of such activity, the Alliance will implement prompt action to correct the problem and may institute appropriate disciplinary action given the facts and circumstances.

RESPONSE TO COMPLIANCE ISSUES

Upon verification of non-compliance of a particular standard or requirement, the Alliance will take appropriate action steps to correct and prevent repeat non-compliance. These steps may include disclosing the incident to applicable regulatory agencies, retraining staff, and amending Alliance policies and procedures in an effort to avoid future recurrence. Compliance staff will initiate and document oversight of corrective action to ensure the instance of noncompliance has been effectively mitigated. Matters may be brought to the Compliance Committee for discussion, and Compliance Committee maintains responsibility for ensuring that issues are corrected.

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
	8/24/2021	Jenifer Mandella, Compliance Officer	Alliance Board
	8/19/2022	Jenifer Mandella, Compliance Officer	Alliance Board
	8/10/2023, with changes effective 1/1/2024	Jenifer Mandella, Chief Compliance Officer	

APPENDIX A – COMPLIANCE POLICIES AND PROCEDURES

Policy No.	Policy Title
105-0001	Policy Development, Maintenance, Review and Submission
105-0002	External Records Request
105-0004	Delegate Oversight
105-0005	Federal Funding Suspension and Debarment
105-0006	Physician and Pharmacist Stipends for Participation in Advisory Group and Committee Meetings
105-0008	Record Retention
105-0009	Identifying and Reporting Suspected Abuse and Neglect of Members
105-0011	Internal Audit and Monitoring
150-0012	Administrative Decision-Making Controls
105-0013	Expenditure Authority
105-0014	Sanctions
105-0015	Conflict of Interest Policy
105-0016	Management of Legal Work
105-0017	Requests for Electronic Communications
105-0018	Government Claims
105-0500	External Audits
105-2502	Contract Signature Authority
105-3001	Program Integrity: Fraud, Waste and Abuse Prevention Program
105-3002	Program Integrity: Special Investigations Unit Operations
105-3003	Suspended or Ineligible Providers
105-3004	Verification of Billed Services by Network Providers
105-4001	Notice of Privacy Practices
105-4002	Accounting of Disclosures
105-4003	No Retaliation or Waiver
105-4004	Privacy Officer Designation and Responsibilities
105-4007	Safeguarding Protected Health Information
105-4008	Uses and Disclosures of Limited Data Sets
105-4009	Minimum Necessary Use and Disclosure
105-4010	Verification of Requester Authority Prior to Release of PHI
105-4011	De-identification and Re-identification of PHI
105-4012	Use and Disclosure of PHI Including Member Authorization to Disclose
105-4013	Request to Access Records
105-4014	Requests for Amendment of PHI
105-4017	Permission to Leave Messages with PHI
105-4018	Personal Representative
105-4019	Disclosures to Family, Caregivers, and Friends

105-4020	Disclosure to Law Enforcement and Government Officials
105-4021	Use and Disclosures About Decedents
105-4022	Uses and Disclosure for Disaster Relief
105-4023	Uses and Disclosures for Public Health Activities
105-4024	Uses and Disclosures for Treatment, Payment, and Health Care Operations
105-4025	Uses and Disclosures for Health Oversight Activities
105-4026	Communication with Minors
105-4027	Disclosures of Protected Health Information of Members with Mental Incapacities
105-4028	Uses and Disclosures for Marketing
105-4029	Breach Risk Assessment and Response
105-4030	Internal Reporting
105-4031	Facility Access Controls
105-4037	Tracking and Monitoring of ePHI Systems
105-4039	Access to and Confidentiality of ePHI
105-4043	HIPAA Privacy and Security Training
105-4044	Disclosing Sensitive Protected Health Information
105-4045	Confidential Communications and Restrictions on Uses and Disclosures

	POLICIES AND PROCEDURES
Policy #: 300-4020	**Lead Department:** Provider Services
Title: Peer Review and Credentialing Committee – Authority, Roles and Responsibilities	
Original Date: 10/01/2007	**Policy Hub Approval Date:** 06/30/2023
Approved by: Peer Review and Credentialing Committee	

Purpose:
To clarify the specific authority, roles and responsibilities of the Peer Review and Credentialing Committee (PRCC).

Policy:
The Santa Cruz-Monterey-Merced Managed Medical Care Commission (the Board) is accountable for all 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). The PRCC makes recommendations to approve, defer, or deny network participation for new and existing providers based on established credentialing criteria. The PRCC also conducts peer review of network providers and offers advice and expertise when making credentialing decisions.

Definitions:

Network: PCPs, Specialists, hospitals, ancillary Providers, Facilities, and any other Providers with whom Contractor enters into a Network Provider Agreement.

Network Provider Agreement: Means a written agreement between a Network Provider and Contractor or Subcontractor.

Service Area: The Alliance service area is Santa Cruz, Monterey, and Merced Counties; however, the service area may vary by line of business.

Procedures:

1. Role of PRCC

    1.a. Provide oversight of the credentialing program ensuring compliance with Alliance requirements.

1.b. Approve, defer, or deny provider network participation based on the peer review of credentialing criteria for the initial credentialing of new providers and the recredentialing of existing providers as defined in Alliance Policies 300-4040 – Professional Providers Credentialing Guidelines and 300-4110 – Organizational Providers Credentialing Guidelines.

1.c. Review and monitor providers who have issues identified through the credentialing verification processes or through the ongoing monitoring of sanctions, complaints, and quality of care issues as defined in Alliance Policies 300-4030 – Credentialing Criteria and Identified Issues and 300-4090 – Ongoing Monitoring of Provider Credentials and Issues.

1.d. Approve credentialing program policies and procedures.

1.e. Review, analyze and recommend changes to credentialing policies and procedures on an annual basis or as deemed necessary.

1.f. Review and monitor potential quality of care concerns and recommend corrective action when necessary.

2. Committee Chair
The Chair of the PRCC will be a designated Alliance Medical Director. The Chair has the authority and responsibility to:

2.a. Oversee and coordinate with credentialing staff on credentialing related activities and follow-up.

2.b. Maintain knowledge of and adherence to policies related to the oversight of the credentialing process.

2.c. Oversee process for review of provider clinical quality of care issues, member complaints and grievances, as described in Alliance Policy 300-4090 – Ongoing Monitoring of Provider Credentials and Issues, and make recommendations for

review and final decision by the PRCC.

2.d. Coordinate follow-up with providers on recommendations made by the PRCC.

2.e. Approve clean credentialing files for new and existing providers, as described in Alliance Policy 300-4030 – Credentialing Criteria and Identified Issues.

2.f. Review and sign clean credentialing files processed for credentialing or recredentialing.

3. Meetings

3.a. Frequency

i. The PRCC will meet at a minimum every quarter, and may, at the discretion of the Chair, meet more frequently.

ii. Ad hoc meetings may be scheduled to review urgent quality of care issues when directed by the Chief Medical Officer or Medical Director.

iii. If an item with an urgent turnaround time is needed and a meeting cannot be scheduled, the PRCC chair may request that a vote and/or discussion take place through ad-hoc phone or webinar meetings, per NCQA guidelines, if necessary.

iv. Meetings may take place in-person or virtually.

3.b. Minutes

i. The proceedings of each PRCC meeting will be documented in minutes. Summary reports of the PRCC meetings will be submitted to the Board on a quarterly basis.

ii. PRCC minutes will be in a standardized format and identify or include the

following elements:

a. Committee members in attendance;
b. Providers recommended for network participation, not recommended for participation, and those not acted upon (due to need for additional information);
c. For each provider reviewed, the minutes and/or their corresponding attachments will identify the specialty and office location for the provider, the Committee's recommendation, and the rationale for recommendation.

iii. Minutes are maintained in a secured file cabinet with access limited to authorized Provider Services personnel.

4. Membership

4.a. Membership is composed of a minimum of seven (7) physicians with representation from each county in the Service Area.

4.b. The physician members of the PRCC must be contracted and credentialed with the Alliance and include providers with high-volume specialty practices reflective of the Alliance network. The PRCC may consult with other credentialed Alliance physicians in a specialty not represented by the PRCC members for related issues as needed.

4.c. Physician members of the PRCC must be physicians in good standing with the Alliance defined as not being under active investigation by the Special Investigations Unit nor having an open Corrective Action Plan for Quality Issues.

4.d. Committee members must attend a minimum of two (2) of four (4) annual meetings in order to remain in good standing. If a committee member is on a leave of absence from work or is unable to attend the minimum number of meetings, continuing membership is at the discretion of the PRCC chair.

4.e. The full term for a PRCC voting member is two (2) years, with replacements selected from the Alliance network. The determination of extending terms for members is at the discretion of the PRCC Chair.

4.f. Alliance staff participating in the PRCC consists of the Chief Medical Officer, Medical Director(s), Provider Services Director, Quality Improvement Director, Credentialing Manager, and other Alliance staff as necessary.

5. Membership Requirements

5.a. Annual review and approval of changes to the credentialing policies and procedures.

5.b. Upon membership and each year thereafter, each PRCC member must sign a "Conflict of Interest" and "Confidentiality" Agreement whereby the PRCC member agrees to refrain from participating in activities which may present a conflict of interest and to maintain the confidentiality of credentialing activities.

5.c. Each PRCC member will be immune, to the fullest extent provided by law, from liability to an applicant or provider for damages or other relief for any actions taken or statements or recommendations made within the scope of the PRCC duties exercised within the standards of good faith peer review.

5.d. PRCC members will participate in an annual training which includes a summary review of credentialing policies and procedures, including an update of any changes that may have occurred during the past year.

6. Voting

6.a. Voting rights are restricted to the contracted physician members of the Committee.

6.b. Decisions are based upon a majority of the committee members in attendance as long as a quorum has been established. A quorum is a minimum of half or three (3) voting Committee members.

6.c. A Committee member with a conflict of interest shall refrain from casting a vote where the subject matter presents a conflict of interest.

7. Non-Discriminatory Peer Review

The PRCC will perform its duties in an objective manner and within the standards of good faith peer review. The PRCC will not make credentialing or recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, sexual orientation, the types of procedures (e.g. abortions) or types of patients in which the practitioner specializes. The Alliance monitors and prevents discriminatory credentialing through the following processes:

7.a. Periodic audits of provider grievances to determine if there are disputes alleging discrimination.

7.b. The presence of a non-discrimination statement on the "Statement of Confidentiality" to be signed by Committee members, staff and guests of the PRCC on an annual basis.

7.c. The presence of a non-discrimination statement on the Attendance Sign-In form for each PRCC meeting.

7.d. Documents and/or information submitted to the PRCC for approval, denial or termination will not designate a practitioner's race, ethnic/national identity, gender, age, sexual orientation, or types of procedures performed.

References:

Alliance Policies:

300-4030 – Credentialing Criteria and Identified Issues
300-4040 – Professional Providers Credentialing Guidelines
300-4110 – Organizational Providers Credentialing Guidelines
300-4090 – Ongoing Monitoring of Provider Credentials and Issues

Impacted Departments:

Regulatory:

42 CFR section 438.214
42 CRF Section 438.608 (a)(5)

Legislative:

Contractual (Previous Contract):

Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12;
Exhibit A, Attachment 9, Provision 11;
Exhibit A, Attachment 18, Provision 4.h;
Exhibit A, Attachment 18, Provision 20.E
Exhibit E, Attachment 2, Provision 27.B.5.;

Contractual (2024 Contract):

Medi-Cal Contract, Exhibit A, Attachment 3, Provision 1; 3.2.C
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2; 2.12
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.10
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.1

DHCS All Plan Letter:

DHCS APL 22-013 - Provider Credentialing/Re-Credentialing and Screening/Enrollment
Policy Letter 02-03

NCQA:

Supersedes:

Alliance Policy 300-4021 – Medical Director Participation in the Credentialing Program

Other References:

Attachments:

Lines of Business This Policy Applies To	**LOB Effective Dates**
☒ Medi-Cal	(01/01/1996 – present)

	**POLICIES AND PROCEDURES**
Policy #: 300-4020	**Lead Department:** Provider Services
Title: Peer Review and Credentialing Committee – Authority, Roles and Responsibilities	
Original Date: 10/01/2007	**Policy Hub Approval Date:** 06/30/2023
Approved by: Peer Review and Credentialing Committee	

☒ Alliance Care IHSS (07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
06/26/2018	06/26/2018	Jessie Dybdahl, Credentialing Manager	PRCC
03/13/2019	03/13/2019	Jessie Dybdahl, Credentialing Manager	PRCC
12/11/2019	12/11/2019	Jessie Dybdahl, Credentialing Manager	PRCC
12/09/2021	12/09/2021	Jessie Dybdahl, Credentialing Manager	PRCC
12/13/2023	12/13/2023	Crystal Kerr, Credentialing Supervisor	PRCC
06/21/2023	06/21/2023	Carmen Duran, Provider Network Analyst	PRCC

	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	**Policy Hub Approval Date:**
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]. 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" - 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.

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:
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 QIHECo;
- 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 and is co-chaired by a 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, 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 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 200-1007 – *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, and 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.

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.

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.

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.

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, Potential Quality Issue investigative process, Facility Site Review audit process, 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 regarding all quality issues.

1.g.8. 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.9. 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.10. 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.11. 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.12. 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.13. 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.

1.g.14. 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.

1.g.15. 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.

1.g.16. 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.

1.g.17. 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.18. 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.19. 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.20. 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.21. 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.22. 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.23. Utilization Management Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of Utilization Management Program staff.

1.g.24. Community Care Coordination (CCC) Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of CCC Program staff.

1.g.25. Pharmacy Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of Pharmacy Program staff.

1.g.26. 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.27. 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.28. Other staff: The Alliance encourages active involvement of all Alliance staff in the design and implementation of the QIHETP.

1.g. QIHETP Alliance Board Reports

1.g.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.g.2. Committee Minutes: QIHEC and 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.g.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. 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.g.29. 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.

   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 401-1509 – *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 – *Annual 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 Needs Assessment (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]

2.m. 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 401-3104 – *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.n. 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.o. Technical assistance: The Alliance implements EQRO's technical guidance in conducting mandatory and optional activities described in 42 CFR 438.358[55]

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

2.q. 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.r. Behavioral Health Services Monitoring: The Alliance incorporates behavioral health services monitoring requirements into the QIHETP as described in Alliance Policy 405-1305 – *Behavioral Health Services for Medi-Cal*. Oversight and monitoring of any delegated portions of mental health services are outlined in Policy 105-0004 – *Delegate Oversight*.

2.s. 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.t. 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.u. 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.v. Long Term Care Services: The Alliance will implement quality monitoring, assurance, and improvement efforts for Long Term Care services at institutional settings once further guidance is received.

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. 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.
         3.a.3.a. Adult preventive care guidelines include[63]:
            a. The United States Preventive Services Task Force (USPSTF) guidelines;
            b. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (CDC ACIP); and
            c. 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]:
            a. The provision of the Early and Periodic Screening, Diagnostic, and Treatment Services for members under the age of 21 years old in accordance with the American Academy of Pediatrics (AAP) Bright Future guidelines (All Plan Letter 19-010);
            b. CDC ACIP;
            c. Child Health and Disability Prevention Program (CHDP); and
            d. 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 subcontractors 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.

Develop Interventions

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.

Performance Improvement Project (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.

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). 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 401-3104 – *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 Promotion 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
300-3092 – Annual 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 – Continuous Quality Improvement 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
401-1509 – Timely Access to Care
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 Promotion Program
401-3104 – 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
408-1107 – Behavioral Health Services

Impacted Departments:
Behavioral Health
Community Care Coordination
Community Engagement

Compliance
Member Services
Pharmacy Services
Provider Services
Utilization Management /Complex Case 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:

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

DHCS All Plan or Policy 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 19-010 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

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	**LOB Effective Dates**
☒ Medi-Cal	(01/01/1996 – present)
☒ Alliance Care IHSS	(07/01/2005 – present)

	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	**Policy Hub Approval Date:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
12/01/1998	12/01/1998	Barbara Flynn, RN	Barbara Flynn, RN
02/01/2000	02/01/2000	Barbara Flynn, RN	Barbara Flynn, RN
02/01/2003	02/01/2003	Barbara Flynn, RN	Barbara Palla, MD
02/01/2004	02/01/2004	Barbara Flynn, RN	Barbara Palla, MD
03/01/2005	03/01/2005	Barbara Flynn, RN	Barbara Palla, MD
04/01/2006	04/01/2006	Barbara Flynn, RN	Barbara Palla, MD
04/01/2007	04/01/2007	Barbara Flynn, RN	Barbara Palla, MD
01/01/2008	01/01/2008	Richard Helmer, MD	CQIC
10/01/2008	10/01/2008	Andres Aguirre	Richard Helmer, MD
11/01/2008	11/01/2008	Andres Aguirre	Richard Helmer, MD
01/01/2010	01/01/2010	Barbara Flynn, RN	CQIC
07/01/2010	07/01/2010	Barbara Flynn, RN	CQIC
11/14/2011	11/14/2011	David Altman, MD	CQIC
09/21/2012	09/21/2012	David Altman, MD	David Altman, MD, AMDQI
02/08/2013	02/08/2013	Herschel Leland, Sr. Compliance Specialist	David Altman, MD, AMDQI
08/15/2013	08/15/2013	Peg Behan, RRT, QI Manager	CQIW
09/16/2014	09/16/2014	Kelly Salazar, RN, QI Nurse	CQIW
01/22/2015	01/22/2015	Peg Behan, RRT, QI Manager	CQIW
01/20/2016	01/20/2016	Julio Porro, MD, Medical Director for QI	CQIW
03/21/2017	03/21/2017	Chris Morris, Accreditation Manager	CQIW
08/15/2016	08/15/2016	Sitara Cavanagh, Accreditation Specialist	CQIW
01/26/2017	01/26/2017	Sitara Cavanagh, Accreditation Specialist	CQIC
05/17/2017	05/17/2017	Chris Morris, Quality & Performance Improvement Manager	CQIW
06/07/2017	06/07/2017	Chris Morris, Quality & Performance Improvement Manager	CQIC
01/2/2018	01/2/2018	Chris Morris, Quality & Performance Improvement Manager	CQIW
01/19/2018	01/19/2018	Chris Morris,	CQIC

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Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
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Original Date: 02/01/1996	**Policy Hub Approval Date:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Reviewed Date	Revised Date	Changes Made By	Approved By
		Quality & Performance Improvement Manager	
01/16/2019	01/16/2019	Amit Karkhanis, Quality and Performance Improvement Manager	CQIW
01/24/2019	01/24/2019	Amit Karkhanis, Quality and Performance Improvement Manager	CQIC
07/17/2019	07/17/2019	Michelle Stott, RN, Quality Improvement Director	CQIW
07/25/2019	07/25/2019	Michelle Stott, RN, Quality Improvement Director	CQIC
09/18/2019	09/18/2019	Michelle Stott, RN, Quality Improvement Director	CQIW
10/24/2019	10/24/2019	Michelle Stott, RN, Quality Improvement Director	CQIC
01/15/2020	01/15/2020	Oscar Sanchez, Quality Improvement Administrative Assistant	CQIW
01/23/2020	01/23/2020	Michelle Stott, RN, Quality Improvement Director	CQIC
02/14/2020	02/14/2020	Amit Karkhanis, Quality and Performance Improvement Manager	Michelle Stott, RN, Quality Improvement Director
03/25/2021	03/25/2021	Amit Karkhanis, Quality and Performance Improvement Manager	CQIW-I
04/29/2021	04/29/2021	Amit Karkhanis, Quality and Performance Improvement Manager	CQIC
4/28/2022	4/28/2022	Amit Karkhanis, Quality and Performance Improvement Manager	CQIC
06/24/2022	06/24/2022	Michelle Stott, RN, Quality Improvement and Population Health Director	CQIC
2/2/2023	2/2/2023	Michelle Stott, RN, MSN, Quality Improvement and Population Health Director	QIHEW
03/30/2023		Dale Bishop, MD, Chief Medical Officer	

[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
[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

	POLICIES AND PROCEDURES
Policy #: 404-1101	**Lead Department:** UM
Title: Utilization Management Program	
Original Date: 02/01/1996	**Policy Hub Approval Date**:
Approved by: Quality Improvement and Health Equity Committee (QIHEC)	

PURPOSE

To describe Central California Alliance for Health's (the Alliance) Utilization Management Program (the Program) which serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and actively pursues identified opportunities for improvement. The program serves to accomplish the following:

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

The Program provides a reliable mechanism to review, monitor, evaluate, and address utilization-related concerns as well as recommend and implement interventions to improve appropriate utilization and resource allocation.

The Alliance recognizes the potential for over-and underutilization and takes appropriate steps and actions to monitor for this[3]. The processes utilized for decision-making are based solely on the clinical appropriateness of care and services. Practitioners are rewarded for providing appropriate quality of care and ensuring appropriate utilization of services.

The Health Services Division (HS) oversees the Program. The Division consists of Utilization Management (UM), Community Care Coordination (CCC), Pharmacy, Behavioral Health and the Quality Improvement and Population Health (QIPH) Departments.

The Alliance service area includes Santa Cruz, Monterey and Merced counties, with offices located in Scotts Valley, Salinas and Merced. As of January 1, 2024, Alliance service areas will also include Mariposa and San Benito Counties. Utilization management processes described in the Program are followed at all locations throughout the organization.

UM PROGRAM OBJECTIVES

The 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 current, relevant medical review of criteria and expert clinical opinion when needed. The utilization management process provides a system that ensures equitable access to high-quality health care across the network of providers for all eligible members.

1. Coordinate thorough and timely investigations and responses to member complaints and provider disputes associated with utilization issues.
2. Conduct operational revisions to prevent problematic issues from reoccurring.

3. Ensure that services are medically needed and consistent with the diagnosis and level of care required for each individual. This determination should take into account any co-morbid condition that exists and the ability of the local delivery system to meet the individual's needs.
4. Educate members, practitioners, providers and internal staff about the Alliance's goals for providing quality, cost-effective managed health care.
5. Define the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review.
6. Promote and ensure the integration of utilization management with: quality monitoring and improvement[4]; Program Integrity monitoring and reporting; risk management; and, disease and case management activities.
7. Ensure a process for critical review and assessment of the Program on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates practitioner and member input along with any regulatory changes, changes to current standards of care, and technological advances.
8. Ensure authorized Medi-Cal services are covered per the plan contract with the State of California Department of Health Care Services (DHCS) and conform to the California Code of Regulations Title 22.
9. Ensure that medical services are consistent with the benefit design of each plan.
10. Evaluate the ability of delegates to perform utilization management activities and to monitor performance.
11. Promote high level of satisfaction across members, practitioners, stakeholders and partner organizations.
12. Ensure compliance with all applicable regulatory and accrediting rules, regulations and standards, and applicable state and federal laws that govern the utilization management process.
13. Ensure processes are developed to protect the confidentiality of member protected health information and other personal/provider information.
14. Ensure that no staff member uses a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified, or registered professional described in Section 4999.2 of the Business and Professions Code unless the staff member is a licensed, certified, or registered professional.
15. Identify and resolve problem issues that result in over or under utilization and the inefficient or inappropriate delivery of health care services.
16. Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs via case management.
17. In partnership with Provider Services, educate practitioners and providers on the Alliance's UM policies, procedures and program requirements to ensure compliance with the goals and objectives of the UM program.

UTILIZATION MANAGEMENT PROGRAM SCOPE

Utilization management activities are developed, implemented and conducted by the HS Division under the direction of the Chief Medical Officer or designee. Behavioral Health Utilization Management is delegated to a Managed Behavioral Health Organization (MHBO).

The UM staff members perform specific activities. In accordance with Health and Safety Code section 1367.01, all staff responsible for the UM program are qualified, experienced, licensed nurses, practitioners and other health care professionals[5].

Specific functions performed include:

1. Prospective, concurrent and post-service utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a daily basis. This review is performed cooperatively with the personnel at the facility, attending physician(s) and any associated health care personnel that can provide information that will substantiate medical necessity and level of care.
2. Discharge planning in coordination with discharge planning personnel or appropriate case management personnel at the facility providing care for the member.
3. Care transitions activities include coordination with the member / member's representative and Primary Care Provider (PCP) following inpatient discharge for members at high risk for readmission.
4. Review inpatient and outpatient utilization data to determine appropriateness of member and provider utilization patterns, including inappropriate over- and under-utilization[6].
5. Use of evidence-based guidelines, such as Medi-Cal guidelines, MCG care guidelines, California Children Services (CCS) Numbered Letters, and other Alliance utilization criteria as developed and approved by the Quality Improvement and Health Equity Committee (QIHEC) for authorization decisions.
6. Use of California Department of Health and Welfare Code of Regulations Title 22 for Medi-Cal members.
7. Review authorization requests for skilled nursing care, home health care, durable medical equipment, ambulatory surgery, and ambulatory diagnostic and treatment procedures such as Physical, Occupational and Speech Therapy.

The Program encompasses monitoring and evaluation for the following services:

1. Acute hospital services
2. Ambulatory care
3. Ancillary care services, including but not limited to home health care, long-term care, skilled nursing care, subacute care, pharmacy, laboratory and radiology services
4. Emergency and urgent care services
5. Durable Medical Equipment and supplies
6. Non-Emergency Medical Transportation
7. Palliative Care
8. Pharmacy services

BEHAVIORAL HEALTH

A PCP is responsible to care for mental health conditions that are responsive to physical health care-based treatment, mild to moderate mental health conditions (e.g. anxiety and depression) and may elect to offer care for members with severe mental illness (SMI) that the

PCP deems are within their scope of practice. (See Alliance policy 404-1313 - *Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home).*

Medically Necessary Treatment of a Mental Health or Substance Disorder: Section 1374.72(a)(3)(A) of the CA Health and Safety Code (HSC) describes this to mean a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

i. In accordance with the generally accepted standards of mental health and substance use disorder care.
ii. Clinically appropriate in terms of type, frequency, extent, site, and duration.
iii. Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

In accordance with W&I Code sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the Early Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in Section 1396d(r)(5) of Title 42 of the USC. A service is considered medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

Covered Services do not include California Children's Services (CCS), pursuant to Exhibit A, Attachment III, Section 4.3.15 (California Children's Services (CCS), or Specialty Mental Health Services (SMHS), pursuant to Exhibit A, Attachment III Section 4.3.13 (Mental Health Services).

The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that could be covered under a Medicaid State Plan (as described in 42 USC Section 1396d(a) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state's Medicaid State Plan.

The Alliance will ensure referral to case management for Medically Necessary services authorized by CCS, county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System Plans under this Paragraph is equivalent to that provided by The Alliance for Covered Services for Members less than 21 years of age under this Contract and must, if indicated or upon the Member's request, provide additional Care Coordination and case management services as necessary to meet the Member's medical and behavioral health needs.

Consistent with federal guidance from CMS, behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition

are considered to ameliorate the condition and are thus medically necessary and are covered as EPSDT services.

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) to provide mild to moderate mental health services from licensed mental health care providers for Medi-Cal members. Severe conditions requiring Specialty Mental Health Services will be referred to the local County Mental Health Plan (MHP). See Alliance policy 408-*1305 – Behavioral Health Services* for details on Alliance Behavioral Health coverage for IHSS members. There is an expectation that Primary Care Providers and Mental Health Practitioners will coordinate care and services according to the Alliance/County Mental Health Memorandum of Understanding (MOU) executed with each County Mental Health Department.

The Alliance provides coverage for the physical health components of eating disorder treatment and non-specialty mental health services for Medi-Cal members, specifically:

- Inpatient hospitalization for members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and do not meet criteria for psychiatric hospitalization, as well as for NSMHS for members requiring these services.
- Medically necessary physical health components of partial hospitalization and residential eating disorder programs.

The Alliance also arranges for the provision of NSMHS for Medi-Cal members (through referral to the MBHO, as appropriate), including:

- Mental health evaluation and treatment, including individual, group, and family psychotherapy;
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purposes of monitoring drug therapy;
- Psychiatric consultation; and,
- Outpatient laboratory, drugs, supplies, and supplements.

For the IHSS Line of Business (LOB), the Alliance will not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program. For Medi-Cal members, the Alliance coordinates with the County in provision of hospital, medical, or surgical coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child. For additional details, see Alliance policy 408-*1305 – Behavioral Health Services*.

Behavioral Health: Behavioral Health refers to both mental health and substance use disorders.

- "Mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the

International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

- "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment.

The Alliance contracts with the MBHO to provide all behavioral health services (mental health and SUD) for Alliance Care IHSS members. Coverage of mental health medications is an Alliance benefit for the Alliance Care IHSS LOB.

The Alliance provides coverage for medically necessary treatment of mental health and substance use disorders (MHSUD) under the same terms and conditions applied to other medical conditions, for both the Medi-Cal and IHSS lines of business. If the Alliance cannot provide a medically necessary treatment of a MHSUD to a plan enrollee using the Alliance's contracted providers, within required geographic and timely access standards, the Alliance coordinates to arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services. If medically necessary services are not available within the Alliance's network, the Alliance arranges for the provision of covered services from providers outside the Alliance's network. Additionally, if medically necessary MHSUD services are not available in network within the geographic and timely access standards, the Alliance coordinates internally to arrange coverage outside the Alliance's network in accordance with Health and Safety Code (HSC) section 1374.72.

The Alliance provides covered SUD services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, and illicit drug screening in accordance with American Academy of Pediatrics Bright Futures for Children recommendations and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. Further, the Alliance arranges for the provision of:

- Medications for Addiction Treatment (also known as Medication-Assisted Treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.

Upon implementation effective, 01/01/2022, pharmacy services billed as pharmacy claims are carved out to fee-for-service (FFS) under Medi-Cal Rx for Alliance Medi-Cal members. Medi-Cal Rx is responsible for formulary management, prior authorization, and claims processing. The Alliance will retain responsibility for overseeing and maintaining care coordination activities for Medi-Cal enrollees, and providing oversight of all clinical aspects of pharmacy adherence, including providing disease and medication management.

Behavioral Health Treatment (BHT) is covered when medically necessary as part of the Early Periodic Screening, Diagnostic and Treatment services (EPSDT) for members under 21 years of age. BHT services covered must be evidence-based and prevent or minimize behavioral conditions. They must also promote, to the maximum extent practicable, the functioning of a member.

BHT services are provided as part of a behavioral treatment plan that has measurable goals over a specific timeline and that has been developed by a BHT Service Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

Covered BHT services must be provided in accordance with treatment plan and continuity of care requirements outlined in APL 18-008. For more details, please refer to Alliance policy 408-1305 – *Behavioral Health Services*.

The Alliance ensures that, consistent with state law, clinically appropriate and covered NSMHS are covered (through the MBHO, as appropriate), even when:

- Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
- Services are not included in an individual treatment plan;
- The member has a co-occurring mental health condition and substance use disorder; or,
- NSMHS and SMHS are provided concurrently, if those services are coordinated and not duplicated.

PROGRAM STRUCTURE, AUTHORITY AND RESPONSIBLITY

Committee Functions

Governance
The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board) promotes, supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated Program[7]. The Alliance Board has delegated oversight and performance responsibility of the program to the QIHEC.

Quality Improvement and Health Equity Committee (QIHEC)[8]
The QIHEC is the contractually required quality improvement committee with oversight and performance responsibility[9] of the Quality and Performance Improvement Program (QPIP) – excluding credentialing/recredentialing[10] activities, which are directed by the Peer Review and Credentialing Committee (PRCC) – as described in Alliance policy *401-1201 – Continuous Quality Improvement Committee*.

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee operates under the authority of the QIHEC and participates in the UM Program as described in Alliance policy *403-1104 – Mission, Composition and Functions of the Pharmacy & Therapeutics Committee*.

Utilization Management Work Group (UMWG)
The UMWG operates under the authority of the QIHEC. UMWG is co-chaired by an Alliance Medical Director and the UM Director. UMWG membership includes representatives from all major areas of Health Services (HS), including the CMO, Medical Directors, UM Managers, and Supervisors, QIPH Director, Pharmacy Director, and CCC Director, and other staff or delegates as needed. The UMWG meets, at a minimum, 12 times a year and once a quarter, and as needed. UMWG activities and recommendations are reported to the QIHEC quarterly. The UMWG provides guidance and direction to the Program. UMWG activities include, but are not limited to:

1. Reviewing and making recommendations to the Program policy annually.
2. Reviewing and approving the UM Work Plan and Evaluation quarterly.
3. Approving and ensuring implementation of utilization management criteria and UM policies.
4. Analyzing summary data and making recommendations for action.
5. Recommending medical policy, protocol, and clinical practice guidelines.
6. Monitoring delegated utilization management activities through regular reports as described in Alliance policy *105-0004 – Delegate Oversight*.

Program Staff
Alliance staff participating in Program activities are described below.

Chief Medical Officer
The Chief Medical Officer (CMO) ensures that medical decisions are made by qualified personnel that are not duly influenced by fiscal or administrative management considerations[11]. The CMO, in collaboration with the Medical Director(s), is responsible for providing professional judgment regarding matters of resource utilization. The CMO is responsible for providing executive management and leadership to all of the departments under the HS Division: CCC, Pharmacy, Behavioral Health, QIPH, and UM.

Medical Director
The Medical Director(s) has significant involvement in all UM activities and provides support to the UM Director in the oversight and implementation responsibility for the Program on a day-to-day basis. Specific functions include:

1. Supports the UM Director in assuring that the Program fulfills its purpose and goals and complies with regulatory agencies and accreditation bodies.
2. Participates in developing and coordinating policies and procedures.
3. Serving as committee co-chair of the UMWG.
4. Guiding and assisting in the development and revision of clinical criteria, clinical practice guidelines, and performance standards for UMWG review and approval.

5. Reviewing and evaluating new technology assessments, including referral to UMWG for benefit determinations.
6. Plays an active role in developing and implementing utilization management strategies.
7. Communicating utilization management activities to the QIHEC.
8. Presenting updates on utilization management activities to the QIHEC and the Alliance Board in collaboration with the UM Director.

Utilization Management Director
Under the direction of the CMO, the UM Director is responsible for directing all aspects of utilization management. In collaboration with the Medical Director, the QIPH Director, the CCC Director, Behavioral Health Program Director and other Health Plan Directors, the UM Director's duties include the development, implementation, maintenance, and evaluation of an efficient, effective and systematic Program. The UM Director promotes efficient resource utilization throughout the organization, providing the leadership, team building, and direction needed to ensure attainment of UM goals. The UM Director is responsible for overall Program management, with duties including, but not limited to:

1. Reviewing and submitting issues, updates, and recommendations to governing forums.
2. Coordinating completion of activities.
3. Presenting work plan status reports and updates to the QIHEC
4. Monitoring compliance with standards.
5. Making recommendations for interventions to improve utilization management issues.
6. Coordinating implementation of interventions.
7. Developing UM policies and procedures for QIHEC approval.
8. Coordinating development and documentation of UM activities.

UM Managers
Responsible for the direct supervision of the concurrent review, or prior authorization staff. Ensures that reviews are accurate and timely and use nationally recognized approved standards such as the MCG care guidelines. Participate in Performance Improvement Projects, DHCS mandated study of specific health issues, as needed, and assist the UM Director and CMO in preparation for audits. Duties include:

1. Coordinate concurrent review/prior authorization/authorization coordination activities.
2. Ensure that criteria adopted by the Alliance are applied consistently and correctly to reviews.
3. Work with the UM Director, and the Medical Director(s) to evaluate and improve the departmental review processes.
4. Coordinate with other departments as appropriate.
5. Investigate and follow up on complaints, grievances, and quality issues.

UM Regulatory Reporting Supervisor

Responsible for research and analytical work related to the development of regulatory reports and audit responses, supervises the UM department State reporting function, and drafts policies and procedures to ensure regulatory compliance. Duties include:

1. Oversee and perform administrative functions and manage special projects and initiatives in support of the UM Director and Managers
2. Supervise, mentor and train assigned staff
3. Review All Plan Letters to ensure that UM policies comply with current state and Federal policies and directives
4. Draft, revise, recommend, process and assist with the implementation of administrative policies and procedures related to department operations.
5. Work with department managers and subject matter experts to implement reporting requirements, and work as a liaison with the Information Technology Services team.

UM Project Specialist
Responsible for coordinating, leading, supporting, and participating in UM departmental projects and serves as a liaison for interdepartmental and company-wide initiatives, with duties including but not limited to:

1. Providing input on project content and collaborating with relevant stakeholders at various levels throughout the organization to gather project requirements and define project deliverables
2. Assisting the UM leadership with planning and implementing training, education and awareness activities for internal and external audiences;
3. Coordinates, leads, develops and implements departmental communications activities through collaboration with UM leadership and other staff;
4. Supports departmental activities related to routine data analysis and reporting by conducting basic analysis of relevant business and health care information and data, formulating conclusions, developing recommendations and compiling results.

Utilization Management Supervisor – Concurrent Review
Responsible for direct supervision of Concurrent Review staff including Concurrent Review Nurses, Medical Social Workers, and other staff as assigned, performs duties as a Concurrent Review Nurse as needed, participates in UM projects, oversees Notice of Action (NOA) processes, and assists UM Manager - Concurrent Review and department Director in preparation for audits and other regulatory activities. Coordinates and implements effective and efficient UM processes.

Utilization Management Supervisor – Prior Authorizations
Responsible for direct supervision of Prior Authorization staff, including Prior Authorization Nurses, and other staff as assigned. Performs duties as a Prior Authorizations Nurse as needed, participates in UM projects, oversees Notice of Action (NOA) processes, and assists UM Manager and department Director in preparation for audits and other regulatory activities.

Health Services Authorization Supervisor
Responsible for the direct supervision of Health Services Authorization Coordinators, processing authorizations and referrals, preparing various departmental reports, and inputting data regarding utilization of services.

Health Services Transportation Supervisor
Responsible for the direct supervision of Non-Emergency Medical Transportation (NEMT) Coordinators, processing NEMT authorizations and preparing various departmental reports.

Concurrent Review Nurse / Prior Authorization Nurse
Work collaboratively with the UM Managers, UM Director, the CMO/ Medical Director(s), and other Alliance staff to develop, implement, and evaluate health outcomes, practitioner and provider performance and other performance indicators pertinent to quality of care within their scope of practice. Duties include:

1. Provide oversight of the work completed by the Licensed Vocational Nurse (LVN) (as assigned)
2. Review and authorization of DME, Ancillary and Medical authorizations based on established guidelines.
3. Review and authorization of Skilled Nursing authorizations based on established guidelines.
4. Review and authorization of Inpatient hospital authorizations based on established guidelines on site and remotely (Concurrent Review only).
5. Post-service review of services to determine medical necessity.
6. Refer cases to the CMO/ Medical Director(s) for requests that may not meet medical necessity criteria.
7. Determine if requested services are part of the member's benefit package.
8. Work collaboratively with the CCC, QIPH staff on UM issues.
9. Review each patient admission for quality management issues per the Alliance's QM guidelines (with special attention to Health Care-Acquired Conditions (HCACs), including Provider-Preventable Conditions (PPCs) and Other Provider-Preventable Conditions (OPPCs)) and report any areas of concern to the Medical Director by completing a Potential Quality Issue (PQI) form.

Concurrent Review Nurse LVN / Prior Authorization Nurse LVN
Under the direction of a licensed professional nurse, the LVNs work collaboratively with the UM Managers, UM Director, the CMO/ Medical Director(s), and other Alliance staff to develop, implement, and evaluate health outcomes, practitioner and provider performance and other performance indicators pertinent to quality of care within their scope of practice.

Per BRN guidelines (Vocational Nursing Practice Act, CA Business & Professions Code 2, Section 2518.5), the licensed vocational nurse performs services requiring technical and manual skills which include the following: Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.

Duties include:

1. Review of authorization requests based on established guidelines.
2. Retrospective review of services to determine medical necessity
3. Refer cases to Medical Director(s) for requests that may not meet medical necessity criteria
4. Determine if requested services are part of the members benefit plan
5. Work collaboratively with the CCC, Pharmacy, and QIPH staff on UM issues

Utilization Management Medical Social Worker
Participates in the UM interdisciplinary team in the psychosocial management of high-risk members and participates in Quality Improvement studies. Works directly with members and educates providers, external agencies and internal departments on utilization management programs, and provides assistance as needed.

Health Services Authorization Coordinator
Responsible for the accurate and timely handling, distribution, and processing of Authorization Requests and Provider Referrals, including processing of non-emergency medical transportation.

Community Care Coordination (CCC) Director
Under the direction of the CMO, the CCC Director is responsible for the strategic direction, planning, and management of the Alliance CCC Programs, to include development and implementation of new programs and services as they relate to Care Coordination; collaborates with UM Director and other staff on special projects as required; provides direct supervision to CCC and ECM Managers, and other staff in department as required. Duties include:

1. Designing, developing, implementing and managing Care Management Programs.
2. Collaborating with UM/CCM on coordinating CCC activities to improve health outcomes and promote appropriate use of resources.

Care Coordination Manager
The Community Care Coordination Manager is responsible for providing operational leadership including oversight development, implementation, and evaluation of the Alliance's clinical CCC Program. The Manager has day-to-day direction and management responsibility for the implementation of the CCC Program and reviews and submits issues, updates, recommendations, and information to the CCC Director.

Complex Case Management Supervisor (Pediatric):
Responsible for direct supervision of Complex Case Management staff, including Nurses, Medical Social Workers, Coordinators, and other staff as assigned. Performs duties as a Complex Case Management nurse or coordinator as needed, participates in CC projects, and

assists CC Manager and department Director in preparation for audits and other regulatory activities.

Care Coordination Supervisor (RN or LCSW)
Supervises the daily activities of the clinical nursing, social work and care coordinator staff. Assists in the development, implementation, and evaluation of department programs and processes; and coordinates, and participates in staff training and development opportunities.

Complex Case Manager (RN) – Adult Members
Develops and manages an individualized comprehensive plan of care for members referred into the Complex Case Management Program with the goal of promoting optimal, achievable outcomes in the most cost effective and appropriate manner. Duties include:

1. Performing comprehensive assessment of physical and psychosocial needs of the member via telephonic means and/or through face-to-face interaction or review of relevant and available medical records and developing a plan of care with member centric goals that are implemented, evaluated, and closed upon completion of member's goals
2. Recognizing barriers to compliance and alterations in member's condition in a timely manner and planning and executing appropriate interventions, evaluating outcomes and adjusting the plan as needed
3. Maintaining regular member contact. Documenting and managing the development and implementation of a member-specific care plan in a timely and accurate manner with consideration of benefit coverage and regulatory program policies
4. Facilitating completion of member goals through a multidisciplinary approach of collaboration with internal and external resources and family members, and making recommendations and authorizing services to appropriate agencies
5. Advocating appropriately based on the scope of the health plan on member's behalf to ensure quality of care and attainment of appropriate goals
6. Preparing and sending member correspondence that meets contractual requirements;

Care Coordination Nurse Case Manager
Responsible for managing a plan of care for members referred into the CCC Program with the goal of promoting optimal, achievable health outcomes. They also work with and educate members, providers, external agencies on the community care coordination program, and provide assistance as needed. The Nurse Case Manager is responsible for the assessment, planning, facilitation, and advocacy for options and services to meet the member's health care needs.

Complex Case Manager (RN) – Pediatric Members
Develops and manages an individualized comprehensive plan of care for members referred into the Pediatric Complex Case Management Program with the goal of promoting optimal, achievable outcomes in the most cost effective and appropriate manner. Duties include:

1. Performing comprehensive assessment of physical and psychosocial needs of the member via telephonic means and/or through face to face interaction or

review of relevant and available medical records and developing a plan of care with member centric goals that are implemented, evaluated, and closed upon completion of member's goals

2. Recognizing barriers to compliance and alterations in member's condition in a timely manner and planning and executing appropriate interventions, evaluating outcomes and adjusting the plan as needed
3. Maintaining regular member contact. Documenting and managing the development and implementation of a member-specific care plan in a timely and accurate manner with consideration of benefit coverage and regulatory program policies
4. Facilitating completion of member goals through a multidisciplinary approach of collaboration with internal and external resources and family members, and making recommendations and authorizing services to appropriate agencies
5. Advocating appropriately based on the scope of the health plan on member's behalf to ensure quality of care and attainment of appropriate goals
6. Preparing and sending member correspondence that meets contractual requirements;
7. Supporting the established pre-authorization review process for outpatient and inpatient services
8. Making utilization recommendations based upon evidence-based guidelines adopted by the Alliance, such as CCS numbered letters and MCG care guidelines
9. Communicating with physicians, ancillary providers and county service agencies to coordinate member care

Care Coordination Medical Social Worker
The Medical Social Worker ensures effective psychosocial intervention, impacting the member's ability to manage illness using available community, government, and/or community resources as needed.

Care Coordinator
Responsible for assisting the UM and CCC teams with non-clinical care coordination activities for Alliance members involved in our utilization management and CCC programs; establish and maintain effective working relationships with Provider offices, County and other various community agencies on care coordination for members.

Enhanced Care Management Manager
Manages and leads the Enhanced Care Management (ECM)/Community Supports (CS) Uni. Acting as a subject matter expert, for both programs and provides guidance related to the implementation and management of the ECM and CS benefit. Provides management oversight related to ECM/CS Unit and departmental operation.

Senior Enhanced Care Management Advisor, RN
Acts as a liaison between the Enhanced Care Management (ECM)/Community Supports (CS) Program and providers and community agencies to promote effective implementation of program objectives and requirements. Performs ECM/CS Program oversight and support activities internally and externally. Supports Complex Case nurses as needed to develop and

manage an individualized comprehensive plan of care for members referred into the assigned Case Management Program with the goal of promoting optimal, achievable outcomes in the most cost effective and appropriate manner, as needed

Behavioral Health Program Director
Under the direction of the CMO, the Behavioral Health Director is responsible for providing strategic leadership for the Behavioral Health program and for management of the behavioral health benefits for Alliance members. Oversees coordination of behavioral health services between the Alliance, the delegated MBHO, Regional Centers, and County BH departments.

Behavioral Health Program Manager
Manages day-to-day operational issues related to Behavioral Health (BH) activities and provides oversight on the referral and monitoring of members with BH needs into appropriate internal and external care coordination and case management programs with the goal of promoting optimal, achievable outcomes for members. They also oversee coordination of behavioral health services between the Alliance, the delegated MBHO, Regional Centers, and County BH departments.

Pharmacy Director
Under the direction of the CMO, the Pharmacy Director is responsible providing strategic leadership for the Pharmacy program and for management of the pharmacy benefit for Alliance members which includes the development of pharmacy authorization criteria and evaluations of new drug information for Pharmacy and Therapeutics Committee review. Serves as the primary clinical contact for the Pharmacy Benefits Manager (PBM) and Alliance practitioners.

Pharmacy Clinical Manager
Responsible for providing day-to-day operational leadership for the pharmacy department and prior authorization process. Assists the Pharmacy Director in the management of the department which includes staff training, supervision, and project management. Investigates and follows up on clinical appeals and clinical grievances/complaints. Monitors compliance with authorization processing turnaround times, clinical quality and all regulatory compliance items.

Clinical Pharmacist
Responsible for the implementation of the Alliance pharmacy authorization criteria, performs pharmacy utilization review, and develops cost-effective pharmacy measures. The clinical pharmacist also serves as a resource to internal and external contacts including pharmaceutical and medical communities relative to prescription of medications. Ensures the timely delivery of provider noticing for authorizations.

Pharmacy Services Supervisor
Responsible for supervising the Pharmacy Technicians and managing daily operations of technician-related Pharmacy services, including developing, updating, and reviewing Standard Operating Procedures (SOP) for all technician duties. Assists the Pharmacy Manager

with regards to any issues impacting timeliness of authorizations and other performance metrics. The Pharmacy Services Supervisor investigates and follows up on operationally related grievances and quality issues related to the prior authorization process.

Pharmacy Technician
Working under the direction of the Pharmacy Services Supervisor, responsible for processing, triaging and monitoring prior authorization requests. Follows established protocol for initial Authorization Request review and approval. Assists the department with internal and external issue resolution and communications requiring specialized pharmacy technical ability and expertise. Responds to calls received from providers through the ACD line and provides telephonic assistance to providers regarding claims processing and other requests for information. Coordinates and ensures the timely mailing of member notice of action correspondence.

Registered Dietitian (RD)
The RD reviews medical necessity of authorization requests for enteral and parenteral nutrition products in collaboration with the Pharmacy Department, reviews authorization requests for Medical Nutrition Therapy (MNT), performs Quality Improvement and evaluation of the Alliance's health education interventions to assess and seek need for effective change, and participates in collaborative meetings within the Alliance's tri-county service area to identify additional resources for the Alliance's members.

Other Staff
The Alliance encourages active involvement of staff plan-wide in the design and implementation of the Program. This includes, but is not limited to, support from Information Technology Services (ITS), the Provider Services Director, and the Member Services Director (or designees) participating in the development and review of Alliance policies and ensuring compliance with regulatory requirements. In addition, non- Alliance personnel may be contracted, as needed, to fulfill Program requirements.

COMMUNICATION SERVICES
The Alliance provides access to staff for members and practitioners seeking information about the UM processes and the authorization of care in the following ways:
Health Services staff accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday-Friday 8AM-5PM).

After normal business hours, members and providers may contact the Alliance and a message can be left that will be given to the appropriate staff person on the next business day.

Available on the Alliance Website:

1. Alliance policy information is featured on the Provider Website in the Provider Manual, and in Provider Bulletins as needed
2. Member Handbook, newsletters and requests for member ID cards are available on the Member Website

SPECIFIC UTILIZATION MANAGEMENT ACTIVITIES

The Alliance uses a variety of sources to assist in making determinations for care. These are described in detail in the UM policies and procedures. Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

1. Input from the treating practitioner
2. Age of member
3. Existence of medical co-morbidities and mental health conditions
4. Psychosocial situation
5. Home environment
6. Availability of service being considered
7. Benefit coverage

Referrals and requests for prior authorization of services are to be submitted by the provider of the service to the Alliance UM department by mail, fax or e-portal. The following information is to be provided on all requests. If information is missing or incomplete, the request will be returned to the requester.

1. Member demographic information
2. Practitioner demographic information
3. Requested service/procedure to include specific CPT/HCPCS code(s)
4. Member diagnosis (specific current version of ICD Code/Description)
5. Clinical indications requiring service or referral
6. Pertinent medical history, treatment or clinical data
7. Location of service to be provided
8. Requested length of stay for all inpatient requests
9. Proposed date of procedure for all outpatient surgical requests

Pertinent data and information are required to enable a thorough assessment of medical necessity.

Elective Admission Prior Authorization

The Alliance evaluates prior authorization requests for elective admissions considering factors such as the proposed treatment plan, member benefit and coverage, contract status of facility, suitability of location, and the level of care. Utilizing criteria that has been approved annually by the QIHEC, professional staff of the HS Division may review and approve appropriate authorization requests from practitioners or providers. Requests are reviewed utilizing evidence-based medical necessity criteria as described in Alliance Policy *404-1112 – Medical Necessity – The Definition and Application of Medical Necessity Provision to Authorization Requests*. Only the CMO or Medical Director/Physician designee has the authority to deny a request for service based on lack of medical necessity. The Alliance

offers the practitioner the opportunity to discuss any denial determination based on lack of clinical justification with the physician reviewer.

Referral Management[12]
Referrals are generated by the primary care provider or specialist, and are entered, monitored, reviewed (when appropriate) and tracked within the Alliance software system allowing for the identification of referrals requiring follow up, authorization and/or redirection. Out-of-network referrals are monitored to determine if the service(s) can be provided by a network practitioner/provider and to redirect the member within network as appropriate. Data gathered from out-of-network referrals assists in determining the network adequacy for providing services in meeting the members' needs and identifying the need for network enhancement. Referrals are also monitored to screen and redirect requests for "carved out" benefits and non-covered benefits. The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.

Second Opinions[13]
Obtaining second opinions are guided by Alliance policy *404-1307 – Medical Second Opinions*. Second opinions may be requested by the member or health care professional with whom the member is under care. Second opinions may be rendered outside the Alliance's provider network or service area with prior authorization in instances where a qualified specialist is not available within the network or service area; this includes Centers of Excellence such as academic tertiary centers. The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.

Referral to Out of Network Providers
Referrals to out of network providers are guided by Alliance policy *404-1310 – Authorization Process for Referrals to Out of NetworkProviders*. Indications for referrals to an Out of NetworkProvider include continuity of care, complexity of member's medical needs, or service or consultation expertise not available through a provider in the Service Area.

Continued Stay/Concurrent Review
The Alliance reviews hospitalized members for whom the Alliance is the primary payer source. Concurrent review is conducted to ensure the medical necessity of the admission and of the continued hospital stay, and that the correct level of care is being provided. This is conducted either on site or telephonically using evidence-based medical necessity criteria as described in Alliance policy *404-1102 – Inpatient Review*. All members are reviewed within two business days of admission and of notification by the facility. The Alliance provides coordination support with discharge planning including care transitions, case management, and social services referral as appropriate. Only the CMO or Medical Director/Physician designee has the authority to deny a request for service based on lack of medical necessity. The Alliance offers the practitioner the opportunity to discuss any denial determination based on lack of clinical justification with the physician reviewer. Care shall not be discontinued until the member's treating provider has been notified of the Alliance decision and a care plan has

been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

Skilled Nursing/Rehabilitation Facility Review
Review of short or long-term placement needs using Alliance criteria, MCG care guidelines, Medi-Cal criteria and/or other evidence-based guidelines for both initial placement and continued care.

Post-Service Review
Care that has not been prior authorized and requires authorization will be retrospectively reviewed for medical necessity, appropriateness of setting, and length of stay. Review of these factors may result in an adverse determination. This may also occur when a member is granted Medi-Cal benefits post-service by the State of California, when services are not authorized prior to member's receipt, when services rendered do not match those authorized, and when delivery of services is beyond the specified time frame. All reviews will be completed within 30 days of receipt of pertinent medical information.

Emergency Care
Emergency room visits needed to screen and stabilize members DO NOT require prior authorization in cases where a prudent layperson, acting reasonably, would believe that an emergency condition exists.

Discharge Planning
Discharge planning is a critical component of the utilization management process that begins at the time of admission with an assessment of the patient's potential discharge needs. It includes preparation of the family and the patient for these continuing care needs and initiation of arrangements for services or placement needed after acute care discharge. Health Services staff work with the hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.

In conjunction with the hospital discharge plan, CCC and UM/CCM staff provide support to members upon discharge and continuing into the post discharge period. CCC and UM/CCM team members consist of Registered Nurses (RNs), and Medical Social Workers (MSWs) who ensure that necessary care, services, and supports are in place after discharge from the hospital.

Pharmaceutical Management
The Alliance regularly develops, reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence in conjunction with Alliance P&T Committee for Physician-Administered Drugs. Prior authorization requests for medications are evaluated using evidence-based medical necessity criteria and procedures as described in Alliance policy *403-1103 – Pharmacy Authorization Request Review Process*.

For Alliance Care IHSS Line of Business, pharmacy services billed as pharmacy claims are delegated to MedImpact. MedImpact is responsible for formulary management, prior

authorizations, and claims processing. The Alliance contracts with MedImpact to maintain a drug formulary that:

1. Has been developed in conjunction with actively practicing pharmacists and practitioners from the MedImpact P&T Committee
2. Is reviewed and updated on an ongoing basis
3. Based on evidence based clinical necessity criteria
4. Has an exceptions policy that applies to drugs not included in the formulary
5. Is available to practitioners on the Alliance website and mailed upon request
6. Is available to members upon request.

Effective 01/01/2022, pharmacy services billed as pharmacy claims are carved out to fee-for-service (FFS) under Medi-Cal Rx for Medi-Cal Line of Business. Medi-Cal Rx is responsible for formulary management, prior authorization, and claims processing.

The Alliance has a patient safety process in place for Class I or II drug recalls or voluntary withdrawals from the market (see Alliance policy *403-1124 – Drug Recall Procedure* for more details).

Complex Case Management
Case Management is the focused arrangement of the sequence of services and resources necessary to respond to the member's overall care requirements in catastrophic or complicated cases. Cases are identified by diagnosis using high risk screening criteria. A team approach which includes the physician, primary care physician, and may include the specialist practitioner, home health agencies, discharge planners, physical therapists, social workers, and other practitioners as appropriate, is initiated by the nurse coordinating care. A collaborative approach is used to meet the health care and community service needs of the patient on a short or long term basis. The Program ensures that the highest quality of care is provided to the patient in the most cost-effective manner through complex case management utilization of all available health care resources.

Community Supports
Community Supports are services or settings offered by the Alliance, 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 Alliance's option and an enrollee cannot be required to use them.

The Alliance will monitor the utilization of and/or outcomes resulting from the provision of Community Supports, including activities, reports, and analyses to understand the impact of delivery services through available data sources (i.e., claims, enrollment files, surveys, etc.) and as required by the DHCS.

For more information about Community Supports and Enhanced Case Management, please refer to Alliance Policies 405-1310 Community Supports Overview, and 405-1308 Enhanced Care Management Overview

Denial Determinations

Denial determinations may occur at any time in the course of the review process. Only the CMO or the Medical Director/Physician designee or the Pharmacist can make a denial. There are a variety of reasons that a request may be denied, including but not limited to, lack of medical necessity or the service not being a covered benefit. The Alliance offers the practitioner the opportunity to discuss any denial determination based on lack of clinical justification with the CMO or Medical Director/Physician designee or the Pharmacist.

1. A denial determination may occur at the time of prior authorization. The process allows for informal discussion of such determinations between the Medical Director/CMO or the Pharmacist and the treating practitioner.
2. A denial determination may occur at the time of continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the CMO or Medical Director/Physician designee or the Pharmacist will occur. The Alliance will provide verbal/written notification of such determination to the facility, attending physician, patient or parents, significant other or guardian.
3. A denial determination may occur at the time of post-service review of claims for non-authorized care, medically unnecessary services, inappropriate level of care, or inappropriate care.
4. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the certification was erroneous.

Appeals Process

Members and providers have the right to appeal service authorization determinations. Pre-service appeals must be filed by the member or the member's authorized representative within sixty (60) days of the Notice of Action[14]. Providers have 365 days in which to file a post-service appeal.

Effective 01/01/2022, Medi-Cal Rx is responsible for appeals on service authorization determinations made by Medi-Cal Rx for pharmacy services billed as pharmacy claims for the Medi-Cal LOB. For Alliance Care IHSS LOB, MedImpact is responsible for appeals on service authorization determinations made by MedImpact for pharmacy services billed as pharmacy claims.

Requesting Expedited Appeal of a Denial Determination

If a member or provider reasonably believes that the Alliance's determination poses an imminent or serious threat to the member's health, they may request an expedited appeal of that determination. As a precondition to requesting such expedited appeal, the provider must:

1. Have received a determination from the CMO or Medical Director/Physician designee or the Pharmacist that the Alliance has denied the service; and
2. Establish that this determination will effectively preclude the patient from obtaining the desired services if the request for reconsideration is evaluated according to the process set out above.

Nurse Advice Line[15]
A Nurse Advice Line is available twenty-four hours/day, seven days/week to all Alliance members. Members access this service by calling a toll-free number. All threshold languages are represented.

REVIEW CRITERIA
The Alliance utilizes evidence based medical necessity criteria as described in Alliance policy *404-1112 - Medical Necessity – The Definition and Application of Medical Necessity Provision to Authorization Requests*. Criteria include Title 22 criteria, Medi-Cal guidelines (when available), California Children's Services (CCS) guidelines (where available), internally developed Alliance guidelines and policies approved by the QIHEC, MCG care guidelines, Medicare (CMS) guidelines, consensus statements and nationally recognized standards of practice, guidelines developed by other health plans, and expert opinions (such as clinical advisors serving on Alliance Committees and outside independent medical review) to determine the appropriateness of services. Medical necessity determinations take into consideration the needs of individual patients and characteristics of the local delivery system. Criteria are developed in conjunction with actively practicing practitioners and non-staff network practitioners and updated and evaluated on an annual basis and in Quality Improvement and Health Equity Committee (QIHEC) routinely. The Alliance utilizes the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. Relevant clinical information is obtained when making a determination based on medical appropriateness and the treating practitioner is consulted when appropriate. Information collected to support decision-making is documented.

Inter Rater Reliability (IRR)
A mechanism exists for evaluation of the consistency with which Alliance health care professionals make authorization determinations. This evaluation is conducted on an annual basis. If opportunities for improvement are identified during this process, corrective action will be implemented, and monitoring may occur more frequently.

The Alliance requires all new UM staff complete IRR evaluation with scores at or above 90% prior to conducting utilization review without supervision. Alliance staff with IRR testing results below 90% require immediate remediation, inclusive of retraining and repeat IRR evaluation before they can conduct utilization review without supervision.

DATA SOURCES
Sources for data may include, but are not limited to:

1. prospective/concurrent/post-service utilization management activities
2. claim/encounter (administrative) data
3. medical records
4. readmission statistics
5. member appeals

6. provider appeals
7. internally developed databases
8. pharmacy utilization data
9. other administrative or clinical data

Data Collection, Analysis, and Reporting
Data collection activities are coordinated by the HS Division. At the data gathering/performance measurement phase, participants in the process includes programmers and analysts in the ITS and HS Division staff nurses, and any other personnel required for the collection and validation of data. Data is reported in the UM Work Plan as appropriate.

EVALUATION OF NEW MEDICAL TECHNOLOGY
New technologies are handled on a case-by-case basis that includes obtaining information regarding the safety, efficacy, and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded research protocol. The CMO/ Medical Director(s) work closely with the requesting physician and specialists as needed in researching these cases. For more information on new technology, please see Alliance policy *404-1714 - Technology Assessment*.

DELEGATION OF UTILIZATION MANAGEMENT ACTIVITIES[16]
The Alliance may delegate UM activities to subcontracting entities. Oversight and performance responsibility of the Alliance's delegated utilization management functions are maintained and monitored by the QIHEC, in collaboration with the Compliance Committee, as described in Alliance policy *105-0004 – Delegate Oversight*.

PROTECTED HEALTH INFORMATION
The Alliance complies with all applicable requirements governing protected health information, as outlined in Alliance Health Insurance Privacy and Accountability Act (HIPAA) policies:

- 105-4001 **–** *Notice of Privacy Practice*; 105-4002 **–** *Accounting of Disclosures*;
- 105-4003 **–** *No Retaliation or Waiver*; 105-4004 **–** *Privacy Officer Designation and Responsibilities*; 105-4005 **–** *HIPAA Security Officer Designation and Responsibilities*;
- 105-4006 **–** *Required and Permissible Uses and Disclosures*; 105-4007 **–** *Safeguarding Protected Health Information*; 105-4008 **–** *Uses and Disclosures of Limited Data Sets*; and 105-4009 **–** *Minimum Necessary Use and Disclosure*.

CONFIDENTIALITY AND CONFLICT OF INTEREST
The QIHEC ensures confidentiality and avoidance of conflict of interest as described in Alliance policy *401-1201 – Continuous Quality Improvement Committee*.

ONGOING PROGRAM EVALUATION
The UM Program will be evaluated by the QIHEC. The evaluation includes, at a minimum:

1. Evaluation of select UM policies and procedures.
2. Development and implementation of an annual Utilization Management Work Plan.
3. Evaluation of the UM Work Plan that includes a description of completed and ongoing UM activities and an assessment of barriers and/or limitations.
4. Trending of utilization management indicators to assess performance.
5. An evaluation of delegated activities.

A summary of the Program evaluation, including a description of the Program, is provided to members or practitioners upon request.

ANNUAL WORK PLAN DEVELOPMENT

The annual Work Plan will be developed with input from the staff and findings of the Annual Program Evaluation. It is presented and approved at the QIHEC. It includes but is not limited to:

1. Summary of important goals for the Program during the year.
2. Measurable benchmarks for process and utilization.
3. Ability to track performance, assess goals and capture agreed upon strategies and interventions to meet goals.
4. The number and type of appeals, denials, deferrals, and modifications[17].
5. Identified under- and over-utilization activities[18].

References:

Alliance Policies:

105-0004 – Delegate Oversight
105-4001 – Notice of Privacy Practice
105-4002 – Accounting of Disclosures
105-4003 – No Retaliation or Waiver
105-4004 – Privacy Officer Designation and Responsibilities
105-4005 – HIPAA Security Officer Designation and Responsibilities
105-4006 – Required and Permissible Uses and Disclosures
105-4007 – Safeguarding Protected Health Information
105-4008 – Uses and Disclosures of Limited Data Sets
105-4009 – Minimum Necessary Use and Disclosure.
401-1101 – Quality and Performance Improvement Program
401-1201 – Continuous Quality Improvement Committee
401-1301 – Potential Quality Issue Review Process
401-1505 – Childhood Preventive Care
401-1509 – Timely Access to Care
403-1101 – Pharmacy Operations Management
403-1103 – Pharmacy Authorization Request Review Process
403-1104 – Mission, Composition and Functions of the Pharmacy & Therapeutics Committee
403-1124 – Drug Recall Procedure
404-1102 – Inpatient Review
404-1108 – Monitoring of Over/Under Utilization of Services

404-1112 – Medical Necessity – The Definition and Application of Medical Necessity Provision to Authorization Requests
404-1201 – Authorization Request Process
404-1303 – Referral Consultation Request Process
404-1307 – Medical Second Opinions
404-1310 – Authorization Process for Referrals to Out of NetworkProviders
404-1313 – Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home
404-1314 - Children with Special Health Care Needs
404-1315 - Identification and Monitoring of Members for the Hight Risk Infant Follow-up Program
404-1316 – Early Intervention Services
404-1528 – Adult Complex Case Management
404-1530 – Pediatric Complex Case Management
404-1714 – Technology Assessment
404-1732 – Meals and Lodging (Maintenance) for Members with CCS Eligibility
405-1105 – Care Coordination for Members in Foster Care
405-1112 – Care Management of Seniors and Persons with Disabilities for Medi-Cal Members
405-1303 – Identification of and Coordination of Care for Medi-Cal Members with Developmental Disabilities
405-1304 – Developmental Disabilities – Services to Members
408-1305 – Behavioral Health Services
405-1308 – Enhanced Care Management Overview
405-1310 – Community Supports Overview

Impacted Departments:

Claims
Compliance
Communications
Community Care Coordination
Information Technology Services
Member Services
Pharmacy
Provider Services
Quality Improvement and Population Health

Regulatory:

45 Code of Federal Regulations Parts 160 and 164-HIPAA Privacy Rule
Health and Safety Code Section 1363.5
Health and Safety Code Sections 1374.72(a)(3)(A); Section 1374.721(f)(1); Section 1374.721(b); Section 1374.72(h)
California Department of Health and Welfare Code of Regulations Title 22
Industry: MCG care guidelines

Legislative:

Senate Bill SB-855 Health Coverage for Mental Health and Substance Use Disorders

Contractual (Previous Contract):

Medi-Cal Contract Exhibit A, Attachment 1, Provision 5

Medi-Cal Contract Exhibit A, Attachment 4
Medi-Cal Contract Exhibit A, Attachment 5, Provision 1
Medi-Cal Contract Exhibit A, Attachment 18, Provision 5A
Medi-Cal Contract Exhibit A, Attachment 18, Provision 5B
Medi-Cal Contract Exhibit A, Attachment 18, Provision 10A
Medi-Cal Contract Exhibit A, Attachment 18, Provision 11E
Medi-Cal Contract Exhibit E, Attachment 3, Provision 5

Contractual (2024 Contract):

DHCS All Plan or Policy Letter:

Medi-Cal Contract 2024, Exhibit A, Attachment 3, Provision 1.1.5
Medi-Cal Contract 2024, Exhibit A, Attachment 5
Medi-Cal Contract 2024, Exhibit A, Attachment 3, Provision 2.3
MMCD All Plan Letter 17-014
MMCD All Plan Letter 18-008
MMCD All Plan Letter 20-020
DHCS All Plan Letter 22-003 – Plan Responsibility to Provide Services to Members with Eating Disorders DHCS All Plan Letter 22-006 – Plan Responsibilities for Non-Specialty Mental Health Services

NCQA:

NCQA UM 2: Element A: Factor 4 & 5

Supersedes:

Other References:

Board of Vocational Nursing & Psychiatric Technicians: Vocational Nursing Practice Act, CA Business & Professions Code 2, Section 2518.5
https://bvnpt.ca.gov/pdf/vnregs.pdf
Strategic Plan 2022-2026 – Central California Alliance for Health: PERSON-CENTERED DELIVERY SYSTEM TRANSFORMATION

Attachments:

Lines of Business This Policy Applies To
☒ Medi-Cal
☒ Alliance Care IHSS

LOB Effective Dates
(01/01/1996 – present)
(07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By

	POLICIES AND PROCEDURES
Policy #: 404-1101	**Lead Department:** UM
Title: Utilization Management Program	
Original Date: 02/01/1996	**Policy Hub Approval Date**:
Approved by: Quality Improvement and Health Equity Committee (QIHEC)	

Reviewed Date	Revised Date	Changes Made By	Approved By
10/28/2021	10/12/2021	Tammy Brass, RN UM/CCM Manager	QIHEC
06/07/2022	06/07/2022	Paige Harris UM Regulatory Reporting Supervisor	QIHEC
02/01/2023	02/01/2023	Paige Harris, Regulatory Reporting Supervisor	UMWG
5/11/2023	6/23/2023	Tammy Brass, RN UM Director	
8/4/2023	8/4/2023	Carissa Grepo, RN UM Manager – Prior Auth	UMWG
9/22/2023	9/22/2023	Danah Hernandez, UM Regulatory Reporting Supervisor	UMWG

[1] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.B
[2] Medi-Cal Contract [Final Rule] Exhibit A, Attachment 5, Provision 1.B
[3] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 4
[4] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.G
[5] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.A
[6] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 4
[7] DHCS State Medi-Cal Contract Exhibit A, Attachment 5, Provision 1.G
[8] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4

[9] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 2
[10] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12
[11] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.B
[12] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.F
[13] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.C
[14] Medi-Cal Contract [Final Rule] Exhibit A, Attachment 14, Provision 4.C.1
[15] Medi-Cal Contract, Exhibit A, Attachment 7, Provision 7.A
[16] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 5
[17] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.G
[18] Medi-Cal Contract, Exhibit A, Attachment 5, Provision 4

	POLICIES AND PROCEDURES
Policy #: 700-1000	**Lead Department:** Accounting
Title: Investments	
Original Date: 10/27/2004	**Policy Hub Approval Date:** 08/29/2023
Approved by: Lisa Ba, Chief Financial Officer	

Purpose:

This Investment Policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of the Central California Alliance for Health (the Alliance). The objective of this Investment Policy is to ensure the Alliance's funds are prudently invested according to the Board of Commissioners' objectives to preserve capital, provide necessary liquidity and to achieve a market-average rate of return through economic cycles.

Policy:

Investments may only be made as authorized by this Investment Policy. The Alliance Investment Policy conforms to the California Government Code section 53600 et seq. (the Code) as well as customary standards of prudent investment management. Irrespective of these policy provisions, should the provisions of the Code be or become more restrictive than those contained herein, such provisions will be considered immediately incorporated into the Investment Policy and adhered to. It is also the Alliance's intent to comply with investment requirements contained within contracts that the Alliance may have with any government funding agencies and will not invest in anything that is inconsistent with its direct mission.

The Alliance's investment objectives, in order of priority, are as follows:

A. Safety of Principal – Safety of principal is the foremost objective of the Alliance. Each investment transaction shall seek to ensure that capital losses are avoided, whether from institutional default, broker-dealer default, or erosion of market value of securities.

B. Liquidity – Liquidity is the second most important objective of the Alliance. It is important that the portfolio contain investments for which there is a secondary market and which offer the flexibility to be easily sold at any time with minimal risk of loss of either the principal or interest based upon then prevailing rates.

C. Social Responsibility – Investment decisions will be screened based on SRI heavy criteria outlined in Exhibit A.

D. Total Return – The Alliance's portfolio shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk.

Procedures:

I. OBJECTIVES

Safety of principal is the primary objective of the Alliance. Each investment transaction shall seek to ensure that large capital losses are avoided from securities or broker-dealer default. The Alliance shall seek to ensure that capital losses are minimized from the erosion of market value. The Alliance shall seek to preserve principal by mitigating the two types of risk, credit risk and market risk.

Credit risk, the risk of loss due to failure of the issuer of a security, shall be mitigated by investing in only permitted investments and by diversifying the investment portfolio according to this Investment Policy.

Market risk, the risk of market value fluctuations due to overall changes in the general level of interest rates, shall be mitigated by matching maturity dates, to the extent possible, with the Alliance's expected cash flow draws. It is explicitly recognized herein, however, that in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

II. PRUDENCE

The Alliance's Board of Commissioners or persons authorized to make investment decisions on behalf of the Alliance are trustees and fiduciaries subject to the prudent investor standard.

The standard of prudence to be used by investment officials shall be the "prudent person" standard as defined in Code Section 53600.3 and shall be applied in the context of managing an overall portfolio. Investment officers acting in accordance with written procedures and the Investment Policy and exercising due diligence shall be relieved of personal responsibility for an individual security's credit risk or market price changes, provided deviations from expectations are reported in a timely fashion and appropriate action is taken to control developments.

THE PRUDENT PERSON STANDARD: When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the Alliance, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency.

III. ETHICS AND CONFLICTS OF INTEREST

The Alliance's officers and employees involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions. The Alliance's officers and

employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with the Alliance, and they are not permitted to have any personal financial or investment holdings that could be materially related to the performance of the Alliance's investments.

IV. DELEGATION OF AUTHORITY

Authority to manage the Alliance's investment program is derived from an order of the Board of Commissioners. Management responsibility for the investment program is hereby delegated to the Alliance's Chief Financial Officer (CFO).

The CFO shall be responsible for all actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials.

A. Financial Benchmarks

The Alliance's portfolio shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk. The performance benchmark for the investment portfolio will be based upon the market indices for short-term investments of comparable risk and duration. These performance benchmarks will be determined by the Alliance's CFO and will be reviewed by the Finance Committee semi-annually.

B. Safekeeping

The investments purchased by the Alliance shall be held by a Board approved bank or trust company acting as the agent of the Alliance under the terms of a custody agreement in compliance with Code Section 53608.

C. Periodic Review of the Investment Policy

The CFO is responsible for providing the Finance Committee with a recommended Investment Policy. The Finance Committee is responsible for recommending the Investment Policy to the Board of Commissioners for final approval. This Investment Policy shall be reviewed by the Board of Commissioners at a public meeting pursuant to Section 53646 (a) of the California Government Code

The CFO is responsible for directing the Alliance's investment program and for compliance with this policy pursuant to the delegation of authority to invest funds or to sell or exchange securities. The CFO shall make a semi-annual report to the Finance Committee.

D. Procedures

The following procedures will be performed by the CFO:

1. The Operating Funds and Board-Designated Reserve Funds targeted average maturities will be established and reviewed periodically.

2. Investment diversification and portfolio performance will be reviewed semi-annually to ensure that risk levels and returns are reasonable and that investments are diversified in accordance with this policy.

E. Duties and Responsibilities of the Finance Committee:

The CFO and staff are responsible for the day-to-day management of the Alliance's investment portfolio. The Board of Commissioners is responsible for the Alliance's Investment Policy. The Finance Committee shall not make or direct the Alliance staff to make any particular investment, purchase any particular investment product, or do business with any particular investment companies or brokers. It shall not be the purpose of the Finance Committee to advise on particular investment decisions of the Alliance.

The duties and responsibilities of the Finance Committee shall consist of the following:

1. Review any changes to the Alliance's Investment Policy before its consideration by the Board of Commissioners and recommend revisions, as necessary.

2. To review semi-annually the Alliance's investment portfolio for conformance to the Alliance's Investment Policy diversification and maturity guidelines, and make recommendations as appropriate.

3. Perform such additional duties and responsibilities as may be required from time to time by specific action and direction of the Board of Commissioners.

V. PERMITTED INVESTMENTS

Alliance policy is to invest only in high quality instruments as permitted by the Code, subject to the limitations of this Annual Investment Policy.

A. U.S. Treasuries

These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

U.S. Government securities include:

1. Treasury Bills: Securities issued and traded at a discount.

2. Treasury Notes and Bonds: interest bearing instruments issued with maturities of 2 to 30 years.

3. Treasury STRIPS: U. S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system.

U. S. Treasury coupon and principal STRIPS are not considered to be derivatives for the purpose of this Annual Investment Policy and are, therefore, permitted investments pursuant to the Annual Investment Policy.

Maximum Term: Operating Funds – five years (Code 5 years)
Board Designated Reserve Funds – five years (Code 5 years)

B. Federal Agencies and U.S. Government Sponsored Enterprises

These investments represent obligations, participations, or other instruments of, or issued by, a federal agency or a United States government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (housing, agriculture). Often simply referred to as "Agencies", they include:

1. Federal Home Loan Banks (FHLB)
2. Federal Home Loan Mortgage Corporation (FHLMC)
3. Federal National Mortgage Association (FNMA)
4. Federal Farm Credit Banks (FFCB)
5. Student Loan Marketing Association (SLMA)
6. Government National Mortgage Association (GNMA)
7. Small Business Administration (SBA)
8. Export-Import Bank of the United States
9. U.S. Maritime Administration

10. Washington Metro Area Transit
11. U.S. Department of Housing & Urban Development
12. Tennessee Valley Authority

Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

Maximum Term: Operating Funds – five years (Code 5 years)
Board Designated Reserve Funds – five years (Code 5 years)

C. State of California and Local Agency Obligations

Registered state warrants, treasury notes or bonds of the State of California and bonds, notes, warrants or other evidences of indebtedness of any local agency of the State, including bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency or by a department, board, agency or authority of the State or local agency. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's and A-1 by Standard & Poor's or equivalent or better for short-term obligations, or A by Moody's or A by Standard & Poor's or better for long-term debt. Public agency bonds issued for private purposes (industrial development bonds) are specifically excluded as allowable investments.

Maximum Term: Operating Funds – five years (Code 5 years)
Board Designated Reserve Funds – five years (Code 5 years)

D. Bankers Acceptances

Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the bankers acceptance (BA) upon maturity if the drawer does not. Eligible bankers acceptances:

1. are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated C or better by Thomson BankWatch or IBCA, or are rated A-I for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

2. may not exceed the five percent (5%) limit of any one commercial bank and may not exceed the five percent limit for any security of any bank.

Maximum Term: Operating Funds – 180 days (Code)
Board Designated Reserve Funds – 180 days (Code)

E. Commercial Paper

Commercial paper (CP) is unsecured promissory notes issued by companies and government entities at a discount. Commercial paper is negotiable (marketable or transferable), although it is typically held to maturity. The maximum maturity is 270 days, with most CP issued for terms of less than 30 days. Commercial paper must be:

1. rated P-1 by Moody's and A-1 or better by Standard & Poor's, and
2. have an A or higher rating for the issuer's debt, other than commercial paper, if any, as provided for by Moody's and Standard & Poor's, and
3. issued by corporations organized and operating within the United States and having total assets in excess of five hundred million dollars ($500,000,000), and
4. may not represent more than ten percent (10%) of the outstanding commercial paper of the issuing corporation.

Maximum Term: Operating Funds – 270 days (Code)
Board Designated Reserve Funds – 270 days (Code)

F. Negotiable Certificates of Deposit

A negotiable (marketable or transferable) receipt for a time deposit at a bank or other financial institution for a fixed time and interest rate. Negotiable Certificates of Deposit must be issued by a nationally or state-chartered bank or state or federal association or by a state licensed branch of a foreign bank, which have been rated as C or better by Thomson BankWatch or IBCA, or are rated A-l for short-term or long-term deposits by Standard & Poor's and P-1 for short-term or long-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

Maximum Term: Operating Funds – 5 years (Code)
Board Designated Reserve Funds – 5 years (Code)

G. Repurchase Agreements

A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.

Repurchase agreements collateralized by U. S. Treasuries, GNMAs, FNMAs or FHLMCs with any registered broker-dealer subject to the Securities Investors Protection Act or any commercial banks insured by the FDIC so long as at the time of the investment such primary dealer (or its parent) has an uninsured, unsecured and unguaranteed obligation rated P-1 short-term or A-2 long-term or better by Moody's, and A-1 short-term or A long-term or better by Standard & Poor's, provided:

1. a Public Securities Association (PSA) master repurchase agreement signed by CCAH which governs the transaction and a subcustodial undertaking in connection with a master repurchase agreement signed by CCAH, when applicable; and

2. the securities are held free and clear of any lien by CCAH's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined capital, surplus and undivided profits of not less than $50 million and the custodian shall have received written confirmation from such third party that it holds such securities, free and clear of any lien, as agent for CCAH's custodian; and

3. a perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at 31 C.F.R. 306.1 et seq. or 31 C.F.R. 350.0 et seq. in such securities is created for the benefit of CCAH's custodian and CCAH; and

4. the Agent provides CCAH's custodian and CCAH with valuation of the collateral securities no less frequently than weekly and will liquidate the collateral securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within two business days of such valuation.

Maximum Term: Operating Funds – 1 year (Code 1 year)
Board Designated Reserve Funds – 1 year (Code 1 year)

Reverse repurchase agreements are not allowed.

H. Medium Term Maturity Corporate Securities

Notes issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States.

Medium term maturity corporate securities:

1. For the purpose of this Annual Investment Policy, corporate securities that are rated A, or better by Moody's or Standard & Poor's or a comparable rating by a nationally recognized rating service on longer term debt, and

2. Issued by corporations organized and operating within the United States or by depository institutions licensed by the United States or any state and operating within the United States and have total assets in excess of five hundred million dollars ($500,000,000), and

3. May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to commercial paper, i.e. medium term notes ("MTNs"). Under no circumstance can the MTNs or any other corporate security of any one corporate issuer represent more than 5% of the portfolio.

Maximum Term: Operating Funds – five years (Code 5 years)
Board Designated Reserve Funds – five years (Code 5 years)

I. Money Market Funds

Shares of beneficial interest issued by diversified management companies (commonly called money market funds):

1. Which are rated AAA (or equivalent highest ranking) by two of the three largest nationally recognized rating services, and have an investment adviser registered with the Securities and Exchange Commission with not less than five years' experience investing in fixed income securities and the money market fund shall have assets under management in excess of five hundred million dollars ($500,000,000) and

2. Such investment may not represent more than ten percent (10%) of the money market fund's assets.

J. Mortgage or Asset-backed Securities

Pass-through securities are instruments by which the cash flow from the mortgages, receivables or other assets underlying the security is passed-through as principal and interest payments to the investor.

Though these securities may contain a third party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt instruments have assets (such as leases or consumer receivables) pledged to support the debt service.

Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which

1. Rated AAA (Code AA) by a nationally recognized rating service, and

2. Issued by an issuer having an A (Code) or better rating by a nationally recognized rating service for its long-term debt.

Maximum Term: Operating Funds – one year (Code 5 years)
Board Designated Reserve Funds – five years stated final maturity with a maximum average life of three years (Code 5 years)

K. Variable and Floating Rate Securities

Variable and floating rate securities are appropriate investments when used to enhance yield and reduce risk. They should have the same stability, liquidity and quality as traditional money market securities. A variable rate security provides for the automatic establishment of a new interest rate on set dates. For the purposes of this Annual Investment Policy, a Variable Rate Security where the variable rate of interest is readjusted no less frequently than every 762 calendar days shall be deemed to have a maturity equal to the period remaining until the next readjustment of the interest. A Floating Rate Security shall be deemed to have a remaining maturity of one day.

Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, with a final maturity of not to exceed one year as described above, must utilize traditional money market reset indices such as U. S. Treasury bills, Federal Funds, commercial paper or LIBOR. Investments in floating rate securities whose reset is calculated using more than one of the above indices are not permitted, i.e. dual index notes.

Maximum Term: Operating Funds – five years (Code 5 years)
Board Designated Reserve Funds – five years (Code 5 years)

L. The Local Agency Investment Fund (LAIF)

LAIF, is a voluntary program created by statute, began in 1977 as an investment alternative for California's local governments and special districts. This program offers local agencies the opportunity to participate in a major portfolio which invests hundreds of millions of dollars, using the investment expertise of the Treasurer's Office investment staff. The LAIF is part of the Pooled Money Investment Account (PMIA). The PMIA has oversight provided by the Pooled Money Investment Board (PMIB) and an in-house Investment Committee. The PMIB members are the State Treasurer, Director of Finance, and State Controller.

The LAIF has oversight by the Local Agency Investment Advisory Board. The board consists of five members as designated by statute. The Chairman is the State Treasurer or his designated representative. Two members qualified by training and experience in the field of investment or finance, and two members who are Treasurers, finance or fiscal officers or business managers employed by any County, City or local district or municipal corporation of this state, are appointed by the State Treasurer. The term of each appointment is two years or at the pleasure of the appointing authority.

The State Treasurer's Office takes deliver of all securities purchased on a delivery versus payment basis using a third party custodian. All investments are purchased at market, and market valuation is conducted monthly.

Maximum Term: NA

M. Investment Trust of California (CalTRUST)

The Alliance also invests in a CalTRUST, which is a Joint Powers Authority created by public agencies to provide convenient consolidation method for public agencies to pool their assets for investment activities. The purpose of the organization is to reduce duplication, achieve economies of scale and carry out coherent investment strategies that are beneficial for their participants.

CalTRUST is governed by a board of seven Trustees, at least seventy-five percent of whom are members of the governing body, officers, or personnel of its Members. The CalTRUST Board sets overall policies for the program, selects, and supervises the activities of the Investment Administrators, Custodians, and Investment Advisors.

VI. POLICIES

A. Securities Lending

Investment securities shall not be lent to an Investment Manager or broker.

B. Leverage

The investment portfolio, or investment portfolios, cannot be used as collateral to obtain additional investable funds.

C. Other Investments

Any investment not specifically referred to herein will be considered a prohibited investment.

D. Underlying Nature of Investments

The Alliance shall not make investments in organizations which have a line of business that is visibly in conflict with the interests of public health (which shall be defined by the Alliance Board of Commissioners). Furthermore, the Alliance shall not make investments in organizations with which it has a business relationship through contracting, purchasing or other arrangements.

E. Derivatives

Investments in derivative securities are not allowed, except as to U.S. Treasury STRIPS.

F. Rating Downgrades

The Alliance may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this investment policy. A decision to retain a downgraded security shall be approved by the CFO or designee within five (5) business days of becoming aware of the downgrade.

References:
Alliance Policies:
Impacted Departments:
Regulatory:
Legislative:
Contractual:
DHCS All Plan Letter:
NCQA:
Supersedes:
Other References:

	POLICIES AND PROCEDURES
Policy #: 700-1000	**Lead Department:** Accounting
Title: Investments	
Original Date: 10/27/2004	**Policy Hub Approval Date:** 08/29/2023
Approved by: Lisa Ba, Chief Financial Officer	

Investment of Surplus: California Government Code Section §§53600-53610
Deposit of Funds: California Government Code Section §§53630-53686

Attachments:

Exhibit A – Socially Responsible Investing Screens

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

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
05/11/2017	05/11/20/17	Eugenia Tsuei, Finance Policy & Process Analyst	Barry Staton, Chief Financial Officer
10/01/2018	10/01/2018	Eugenia Tsuei, Finance Policy & Process Analyst	Lisa Ba, Chief Financial Officer
10/02/2019	10/02/2019	Eugenia Tsuei, Finance Policy & Process Analyst	Lisa Ba, Chief Financial Officer
09/27/2021	09/28/2021	Jimmy Ho, Finance Manager	Lisa Ba, Chief Financial Officer
08/10/2023	08/10/2023	Jimmy Ho, Accounting Director	Lisa Ba, Chief Financial Officer

	POLICIES AND PROCEDURES
Policy #: 800-0012	**Lead Department:** Legal Services
Title: Administrative Decision-Making Controls	
Original Date: 03/14/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

Purpose:
To outline Central California Alliance for Health's (the Alliance's) policy on administrative decision-making controls, as approved by the Board of Commissioners (the Board).

Policy:
Alliance Bylaws of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Bylaws) provide that the Chief Executive Officer (CEO) has the authority to carry out the policies, procedures and practices of the Board, and act as the representative of the Commission in all matters that the Commission has not authorized someone else to do.[i] Any authority not specifically addressed by the Board, the Bylaws, or this policy is reserved to the CEO or designee.

Definitions:
Administrative Controls – Procedures necessary to ensure decisions are made in compliance with requirements governing Alliance operations.

Unavailable – Absent and unreachable due to vacation, illness, injury, or other circumstance inhibiting decision-making abilities essential to support business operations.

Procedures:

1. Advocacy
    a. The Board delegates authority to staff for representation in advocacy matters relating to federal and state legislation.
        i. With the exception of lobbying, the Alliance is prohibited from partisan advocacy as a public agency. As such, Board advocacy shall focus on policy and legislative issues, including, but not limited to, member eligibility and/or benefits, Medi-Cal provider payments, Medi-Cal health plan revenue, and Medi-Cal managed care policies and initiatives.[ii]
    b. The CEO, or designee, maintains authority to represent the Alliance in professional or industry associations, including but not limited to, the Association for Community Affiliated Plans (ACAP), the California Association of Health Plans (CAHP), and the Local Health Plans of California (LHPC).

2. Legal Settlements
    a. The CEO maintains authority to approve legal settlements related to actions against the Plan, subject to expenditure authority outlined in policy 800-0003 – Expenditure Authority. The CEO will keep the Board apprised of any issue of pending or potential litigation up to the limits of the CEO's expenditure authority.[iii]

3. Signature Stamps
    a. The CEO maintains authority to approve use of their signature stamp.

4. Alliance Staff
    a. The CEO will submit to the Board, annually, for approval, an administrative budget that provides for necessary personnel, equipment, supplies, and other necessary expenditures to ensure that the work of the Commission can be carried out effectively and efficiently.
    b. The Board delegates to the CEO the responsibility for the management and hiring of personnel subject to personnel policies which are the responsibility of the CEO to establish and carry out. In doing so, the CEO will ensure all applicable laws, regulations and rules regarding personnel are followed and documented in personnel policies.
    c. Only the CEO has authority to approve involuntary staff terminations. In these instances, the Human Resources Director (HRD) recommends separation to the Chief Administrative Officer (CAO). If approved, the CAO forwards the separation request to the CEO for final approval.
    d. The CFO maintains authority to approve and sign the payroll register.

5. Executive Line of Succession
    a. Specific authorities may be delegated in accordance with this policy if the CEO is Unavailable, as defined in this policy.
    b. The CEO may proactively activate the Executive Line of Succession if they anticipate being Unavailable. In the event that the CEO activates the Executive Line of Succession, the CEO may opt to wholesale delegate responsibilities in accordance with the Executive Line of Succession or may choose to delegate specific functions to individuals listed in the Executive Line of Succession.

i. Should the CEO choose to delegate specific functions to certain individuals, this will be documented via memorandum and distributed to the Board and Alliance Chiefs.

c. In the event that the Executive Line of Succession is activated on behalf of the CEO, Alliance staff members listed in the table below may act in the CEO's absence, in accordance with this policy, beginning with the First Alternate and progressing thorough each alternate, as necessary.

Primary	CEO
First Alternate	Chief Operating Officer
Second Alternate	CFO
Third Alternate	CAO

i. Only the Officers named above are included in the Executive Line of Succession. The Board assumes authority when all named individuals are Unavailable.

d. Individuals acting in accordance with the Executive Line of Succession shall retain such authorities until:
   i. Authority is resumed by the Primary; or
   ii. Authority is assumed by the Board.

e. The acting CEO must notify the Board, Alliance Chiefs, and Department Directors in the event the Executive Line of Succession is activated based on CEO Unavailability due to incapacity, as determined by the acting CEO.

f. For any action in which two Officers' signatures or approvals are required, and in the event the authorized Officer is Unavailable to provide approval, the Executive Line of Succession may be used to obtain the signature or approval of the next alternate in the Executive Line of Succession.

References:

Alliance Policies:

101-1028 – Paid Time Off
101-1032 – Recruitment and Selection
101-1043 – Job Changes - Promotion – Reclassification
101-1051 – Bilingual Compensation Program
800-0013 – Expenditure Authority

	**POLICIES AND PROCEDURES**
Policy #: 800-0012	**Lead Department:** Legal Services
Title: Administrative Decision-Making Controls	
Original Date: 03/14/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

106-1044 – Tuition Reimbursement
500-3053 - Remote Access to Alliance Systems
701-1400 – Accounts Payable
701-1500 – Expense Reimbursement
701-4400 – Purchase Orders

Impacted Departments:
Executive
Finance Division
Government Relations
Human Resources

Regulatory:
Legislative:
Contractual (Previous Contract)
Contractual (2024 Contract):
DHCS All Plan Letter:
NCQA:
Supersedes:
Policy 105-0012 –Administrative Decision-Making Controls
Other References:
By-Laws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission
2023 Policy Priorities presented to the Commission February 22, 2023
Alliance Compliance Plan
Attachments:

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

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
			Jenifer Mandella
04/16/2019	05/13/2019	Ilsa Branch, Compliance Manager	Jenifer Mandella, Compliance Officer
03/04/2021	03/04/2021	Jenifer Mandella, Compliance Officer	Alliance Board

	**POLICIES AND PROCEDURES**
Policy #: 800-0012	**Lead Department:** Legal Services
Title: Administrative Decision-Making Controls	
Original Date: 03/14/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

12/20/2022			Jenifer Mandella, Chief Compliance Officer
08/23/2023	08/23/2023	Dave McDonough, Legal Services Director	

[i] SC-M-MMC Bylaws, Article IX, Provisions 9.2.1 and 9.2.2
[ii] 2023 Policy Priorities presented to the Commission February 22, 2023
[iii] Alliance Expenditure and Signature Authority Policy, adopted by the Board on 6/28/2000, and revised 9/26/2012 and 3/28/2018

	POLICIES AND PROCEDURES
Policy #: 800-0013	**Lead Department:** Legal Services
Title: Expenditure Authority	
Original Date: 03/12/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

Purpose:
To outline Central California Alliance for Health's (the Alliance's) policy on expenditure authority, as approved by the Board of Commissioners (Board).

Policy:
Alliance Bylaws of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Bylaws) provide that the Alliance Board may authorize officers, agents or employees to authorize expenditures on behalf of the Commission.[i]

Expenditures authorized pursuant to the Board's authority, as identified in this policy, may only be authorized by the person expressly authorized to approve. An Alliance officer, agent, or employee may not expend funds unless the Board has authorized such expenditure or delegated its power to that office, agent, or employee, subject to express general or specific standards.

The Chief Executive Officer (CEO) has the authority to carry out the policies, procedures and practices of the Board, and acts as the representative of the Commission in all matters that the Commission has not authorized someone else to do.[ii]

Definitions:
Budgeted expenditures – All items that are included within the Administrative and Medical Budgets, as approved by the Board.

Non-operating budget expenditures – Budgeted expenditures for non-operating items, such as investments and Alliance Medi-Cal Capacity Grant Program.

Expenditure Authority – Authority, as given by the Board, to approve expenditures.

Expenditure – The act of spending money for goods or services to attain new assets, improve existing ones, or reduce a liability.

Non-budgeted expenditures – All items that are not approved by the Board within the Administrative or Medical Budgets.

Unavailable – Absent and unreachable due to vacation, illness, injury, or other circumstance inhibiting decision-making abilities essential to support business operations.

Procedures:
1. Budget:
    a. The Board maintains authority to approve the annual Alliance Medical budget, including, but not limited to, provider payment rates, incentives and new payment models, and conceptual design pilot programs.

i. The Chief Financial Officer (CFO) is responsible for managing medical spend within each category in the Medical budget. Any variances from the original categorization must be approved by the CFO or designee through submission of a Medical Budget Allocation Approval Form.

b. The Board maintains authority to approve the annual Alliance Administrative budget.
   i. The Board maintains authority to approve Non-budgeted expenditures of $150,000 and over.
   ii. For non-budgeted expenditures, Division Chiefs can approve up to $9,999.99, the Chief Financial Officer (CFO) can approve up to $49,999.99, and the CEO can approve up to $149,999.99, as outlined in the grid below.

c. Medi-Cal Capacity Grant Program budgets are approved by the Board and implemented via Alliance policy numbers 107-0001 through 107-0004.

d. DHCS incentives programs are approved by the Board and implemented via Alliance policy number 450-0001.

e. The CEO maintains authority to implement both the Administrative and Medical budgets.[iii]
   i. The CFO is responsible for appropriate internal controls, financial oversight and monitoring, identifying controls deficiencies, ensuring necessary corrections related to provider payments, and effective management of medical cost and budget.
   ii. The Chief Operating Officer (COO) is responsible for accuracy and timeliness of claims processing in compliance with the provider contracts and ensuring appropriate system and process controls over authorization of claims payment.
   iii. Managers and above approve staff reimbursement requests, as outlined in Alliance policy 701-1500 – Expense Reimbursement.
      1. The CFO has authority to approve the reimbursement of expenses incurred by the CEO.
   iv. Authority for approval of all other expenditures subject to Purchase Order or invoice requirements is outlined in the grid below.

Expenditure Approval Authority							
Expenditure	Budget Status	Department Managers	Department Directors	Division Chiefs	CFO	CEO	Alliance Board
$0 - $2,499.99	Budgeted expenditures	X					
	Non-budgeted expenditures			X			
$2,500 - $9,999.99	Budgeted expenditures		X				

	Non-budgeted expenditures			X			
$10,000 - $49,999.99	Budgeted expenditures			X			
	Non-budgeted expenditures				X		
$50,000 - $149,999.99	Budgeted expenditures				X		
	Non-budgeted expenditures					X	
> $150,000	Budgeted expenditures					X	
	Non-budgeted expenditures						X
Notes: 1) Grid reflects minimum approval level required 2) Grid excludes claims payments and PAFs							

2. Executive Line of Succession:
   a. Expenditure authority may be delegated in accordance with this policy if the CEO is Unavailable as defined in this policy. Alliance Policy 105-0012 - Administrative Decision-Making Controls contains the Executive Line of Succession.

References:
Alliance Policies:
800-0002 – Administrative Decision-Making Controls
701-1500 – Expense Reimbursement
Impacted Departments:
Administration (CEO)
Finance Division
Regulatory:
Legislative:
Contractual (Previous Contract):
Contractual (2024 Contract):
DHCS All Plan Letter:
NCQA:
Supersedes:

	POLICIES AND PROCEDURES
Policy #: 800-0013	**Lead Department:** Legal Services
Title: Expenditure Authority	
Original Date: 03/12/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

105-0013 – Expenditure Authority
Policy 105-0003 - Contract Signature Authority, Expenditure Authority, and Decision-Making Administrative Controls

Other References:

By-Laws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission
Alliance Expenditure and Signature Authority Policy adopted by the Commission 6/28/2000, and revised 9/26/2012 and 3/28/2018

Attachments:

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

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
04/20/2020	04/20/2020	Kat Reddell, Compliance Specialist	Luis Somoza, Interim Compliance Officer
06/27/2022	06/27/2022	Jenifer Mandella, Compliance Officer	Jenifer Mandella, Compliance Officer
08/23/2023	08/23/2023	Dave McDonough, Legal Services Director	

[i] SC-M-MMC Bylaws, Article X, Provision 10.1
[ii] SC-M-MMC Bylaws, Article IX, Provision 9.2.1
[iii] SC-M-MMC Bylaws, Article IX, Provision 9.2.1

	POLICIES AND PROCEDURES
Policy #: 800-0014	**Lead Department:** Legal Services
Title: Contract Signature Authority	
Original Date: 03/09/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

Purpose:
To outline Central California Alliance for Health's (the Alliance's) policy on contracts signature authority, as approved by the Board of Commissioners (the Board), as well as to define the requirements under which the Board delegates authority to the Chief Executive Officer or designee to enter into contracts on behalf of the Board.

Policy:
Alliance Bylaws of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Bylaws) provide that the Board may authorize officers, agents or employees to enter into contracts on behalf of the Commission.[i] All contracts and/or agreements of any kind must be (1) in writing, (2) approved as to form and legality by the Legal Services Director or designee, and (3) executed pursuant to this policy, in order to be binding on the Alliance or the Board.

Contracts entered into pursuant to the Board's authority, as set forth in this policy, may only be executed by the person expressly provided with Signature Authority. An Alliance officer, agent, or employee may not enter into contracts on behalf of the Alliance or the Board, unless the Board has authorized such action, or delegated its power to that office, agent, or employee, subject to express general or specific standards.

Amendments or other changes to any document binding the Alliance must be executed in the same manner as the original document, as identified in this policy.

The Chief Executive Officer (CEO) has the authority to carry out the policies, procedures and practices of the Board, and acts as the representative of the Commission in all matters that the Commission has not reserved for itself or authorized someone else to do.[ii] The CEO may delegate signature authority to the Chief Financial Officer or Chief Operating Officer to sign agreement as specified in writing (such as an email or memorandum). The writing must specify the duration of the delegation, the delegatee, and the types of agreements for which the delegatee is authorized to sign.

Definitions:

Administrative Contracts – Contracts, including, but not limited to, agreements of any kind, such as memoranda of understanding, non-disclosure agreements, arrangements, and amendments, other than Payor Contracts or Provider Contracts.

Budgeted Expenditures – All items that are included within the Administrative and Medical Budget, as approved by the Board. This includes the Alliance's Medical Budget and all Alliance Department Administrative Budgets and items.

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Approved by: Alliance Board	

Provider Letters of Agreement – Written agreements with a provider regarding services involving a single member, for a single procedure or stay. Letters of Agreement are sometimes referred to as single case agreements (see Alliance policy 300-7030).

Non-Budgeted Expenditures – All items that are neither accounted for within Department Administrative Budgets, nor approved by the Board within the Administrative/Medical Budget.

Payor Contracts – Contracts, including, but not limited to, agreements of any kind, such as memoranda of understanding, non-disclosure agreements, agreements, and amendments, with payors of public health coverage programs, such as the California Department of Health Care Services, and the Centers for Medicare and Medicaid Services.

Provider Contracts – Contracts, including agreements of any kind, such as memoranda of understanding, non-disclosure agreements, arrangements, and amendments, with providers of medical services, including, but not limited to, facilities, physicians, practitioners, durable medical equipment suppliers, and pharmacies, that allow Alliance members to access health care services.

Signature Authority – Authority, as delegated by the Board pursuant to this policy, to enter into and sign Provider Contracts, Medi-Cal Capacity Grant Program agreements, Administrative Contracts, and leases of property owned by the Alliance.

Unavailable – Absent and unreachable due to vacation, illness, injury, or other circumstance inhibiting decision-making abilities essential to support business operations.

Procedures:

1. Provider Contracts and Provider Letters of Agreement:
    a. The CEO has the authority to enter into and sign Provider Contracts and Provider Letters of Agreement.
    b. Any changes to provider payment policies require the Board's approval before being implemented into contracts.[iii]

2. Payor Contracts:
    a. The Board approves and the Board Chair has authority to sign Payor Contracts.[iv]

3. Medi-Cal Capacity Grant Program Agreements
    a. The CEO has the authority to enter into and sign grant agreements., as discussed in Alliance policies 107-0001 through 107-0004.[v]

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4. Administrative Contracts:
    a. The CEO has authority to enter into and sign Administrative Contracts for all Budgeted expenditures, and for all Non-Budgeted Expenditures under $150,000.
    b. The Board maintains authority to approve, and the Board Chair maintains authority to sign, contracts for all Non-Budgeted Expenditures of $150,000 and over. In a Board meeting, the Board may delegate signature authority to the CEO, of a Board-approved Non-Budgeted Expenditure of $150,000 and over.[vi]

5. Leases of property owned by the Alliance:
    a. The CEO has the authority to enter into and sign any and all leases and related documents for the lease of real property owned by the Alliance to tenants.[vii]

Contract Signature Authority				
Primary Authority – X **Delegated Signature Authority - DSA**		Board	Board Chair	CEO
Provider Contracts	Provider Contracts	X		DSA
	Provider Contract Amendments	X		DSA
Payor Contracts	Payor Contracts		X*	
	Payor Contract Amendments		X*	
Administrative Contracts	Budgeted, or Non-Budgeted <$150,000	X		DSA
	Administrative Contracts	X		DSA
	Administrative Contracts Renewals	X		DSA
	Administrative Contracts Amendments	X		DSA
	Non-budgeted >$150,000			
	Administrative Contracts		X*	DSA
	Administrative Contracts Renewals		X*	DSA
	Administrative Contracts Amendments		X*	DSA
Medi-Cal Capacity Grant Program Agreements	Grant Agreements			X*
Leases	Leases of real property owned by the Alliance to tenants			X
* When prior Board approval has been obtained				

	**POLICIES AND PROCEDURES**
Policy #: 800-0014	**Lead Department:** Legal Services
Title: Contract Signature Authority	
Original Date: 03/09/2018	**Policy Hub Approval Date:**
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1. Executive Line of Succession
    a. Signature Authority may be delegated in accordance with this policy if the CEO is Unavailable as defined in this policy. Please refer to Alliance Policy 105-0012 - Administrative Decision-Making Controls, for the "Executive Line of Succession".

References:
Alliance Policies:
800-0002 – Administrative Decision-Making Controls
Impacted Departments:
Administration
Facilities and Administrative Services
Finance
Government Relations
Strategic Development
Regulatory:
Legislative:
Contractual (Previous Contract):
Contractual (2024 Contract):
DHCS All Plan Letter:
NCQA:
Supersedes:
Policy 800-2502 - Contract Signature Authority
Other References:
By-Laws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission
Alliance Expenditure and Signature Authority Policy adopted by the Commission 6/28/2000, and revised 9/26/2012 and 3/28/2018
Medi-Cal Capacity Grant Program: Framework and Governance Evolution adopted by the Commission 8/24/2022
Alliance Lease Execution Authority Policy adopted by the Commission 6/27/2018
Attachments:

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

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
	6/28/2018	Jenifer Mandella	Jenifer Mandella

	**POLICIES AND PROCEDURES**
Policy #: 800-0014	**Lead Department:** Legal Services
Title: Contract Signature Authority	
Original Date: 03/09/2018	**Policy Hub Approval Date:**
Approved by: Alliance Board	

	09/02/2020	Luis Somoza, Compliance Manager	Jenifer Mandella, Compliance Officer
07/25/2022	07/25/2022	Jenifer Mandella, Compliance Officer	Jenifer Mandella, Compliance Officer
08/23/2023	08/23/2023	Dave McDonough, Legal Services Director	

[i] SC-M-MMC Bylaws, Article X, Provision 7.1
[ii] SC-M-MMC Bylaws, Article X, Provision 9.2.1
[iii] Alliance Expenditure and Signature Authority Policy adopted by the Commission 6/28/2000, and revised 9/26/12 and 3/28/2018.
[iv] Alliance Expenditure and Signature Authority Policy adopted by the Commission 6/28/2000, and revised 9/26/12 and 3/28/2018.
[v] Medi-Cal Capacity Grant Program: Framework and Governance Evolution adopted by the Commission 8/24/2022
[vi] Alliance Expenditure and Signature Authority Policy adopted by the Commission 6/28/2000, and revised 9/26/2012 and 3/28/2018
[vii] Alliance Lease Execution Authority Policy adopted by the Commission 6/27/2018

	**POLICIES AND PROCEDURES**
Policy #: 800-0018	**Lead Department:** Legal Services
Title: Government Claims Presentation and Delegation of Authority to Approve, Deny and/or Settle Certain Government Claims	
Original Date: 10/12/2021	**Policy Hub Approval Date:** 10/06/2022
Approved by: Dave McDonough, Legal Services Director	

Purpose:

To set forth the Central California Alliance for Health's (the Alliance's) procedure for addressing claims for money or damages, including those which are excepted from the claim presentation requirements in Section 905 of the Government Code, or any successor law, and which are not governed by any other statutes or regulations expressly relating thereto, except Government Claims by health care providers for payment for medical and hospital services and supplies provided to Alliance Health Plan Members received by the Alliance from a single provider on any single day which individually or collectively do not exceed $5,000, as authorized by Section 935 of the Government Code or any successor law.

Policy:

Prior to commencing any lawsuit, legal action, arbitration or any other proceeding against the Alliance that is based on any claim for money or damages, including, but not limited to, those claims that are excepted from the claim presentation requirements of the Government Claims Act by Section 905 of the Government Code and which are not governed by any other statutes or regulations expressly relating thereto, except Government Claims by health care providers for payment for medical and hospital services and supplies provided to Alliance Health Plan Members received by the Alliance from a single provider on any day single day which individually or collectively do not exceed $5,000, persons or entities submitting claims must first present a claim to the Alliance and exhaust the procedure outlined in this policy.

The Alliance delegates authority of the Alliance Board to a Government Claims Committee to approve, allow, deny, compromise, or settle certain Government Claims, as described herein.

Definitions:

Alliance Board: The Santa Cruz-Monterey-Merced Managed Medical Care Commission.

Alliance Health Plan Member: An individual who is enrolled in the Alliance's Medi-Cal or Alliance Care IHSS line of business.

Government Claims Act: The Government Claims Act codified in California Government Code Sections 810 through 996.6. The Government Claims Act sets forth administrative claim requirements that must be satisfied before commencing most actions seeking money or damages against a public agency, like the Alliance, or a public employee acting within the scope of his/her employment. The Government Claims Act further sets forth the requirements that need to be included in the administrative claim (also known as the Government Claim) as well as the timing periods for filing and responding to such claims. The Government Claims Act expressly authorizes public agencies, like the Alliance, to establish its own claims presentation procedures (like this policy) to include certain types

of claims for money or damages that would otherwise be excepted from the requirements of the Government Claims Act. Additionally, the Government Claims Act expressly permits a public agency to delegate authority to approve, allow, deny, compromise, or settle certain Government Claims, as set forth in this policy.

Government Claim: Any claim that is subject to the Government Claims Act and/or this policy.

Procedures:

1. In accordance with Government Code Sections 935(b) and 945.4, or any successor law, before commencing, filing or initiating any lawsuit, legal action, arbitration or any other legal proceeding against the Alliance based on a claim for money or damages otherwise excepted from the requirements of the Government Claims Act by Section 905 of the Government Code, except Government Claims by health care providers for payment for medical and hospital services and supplies provided to Alliance Health Plan Members from a single provider on any single day which individually or collectively do not exceed $5,000, a Government Claim must be presented and acted upon, as provided in this Policy. The Alliance will use the sum of the dollar amounts of any Government Claims submitted by individual providers on any single day for purposes of determining whether the provider's claim exceeds the $5,000 threshold that would make such claims subject to the requirements of this Policy. In this context, the term dollar amount means the damage(s) sustained as described by the claimant.

2. Notwithstanding the exemptions set forth in Section 905 of the Government Code, or any successor law, but subject to exceptions listed in Section 7 below, all claims against the Alliance for money or damages, which are not otherwise governed by any other applicable statute or regulation or are claims by health care providers for payment for medical and hospital services and supplies provided to Alliance Health Plan Members received by the Alliance from a single provider on any single day which individually or collectively do not exceed $5,000, shall be presented and acted upon within the time limitations and in the manner prescribed by Chapter 2, commencing with Section 910 of Part 3 (Claims Against Public Entities) of Division 3.6 of Title 1 of the Government Code, or as these provisions may be amended from time to time. However, claims by Alliance employees for fees, salaries, wages, mileage, or other employee expenses and allowances, shall not be subject to this Policy and may be subject to other requirements including those established under the California Fair Employment and Housing Act.

a. A claim must be submitted in writing and include the name and address of the claimant, the date and place of the incident out which the claim arose, a general description of the damage sustained, the names of the public employees involved and the dollar amount of

the claim if the amount is less than $10,000. Claimants will also be required to submit the claim using any form specifying the information to be contained in the notice of claim that the Alliance may adopt, or the Alliance may reject the claim on that basis.

b. If the Alliance or its designee determines that the claim fails to substantially comply with the requirements of Sections 910 and 910.2 of the Government Code, the Alliance shall give written notice of the insufficiency to the Claimant, stating with particularity the defects or omissions therein, within twenty (20) days of receiving the Claim. The notice of insufficiency may be sent by U.S. Postal Service to the address given on the claim. The Alliance shall not take action on the claim for fifteen (15) days following the date such notice of insufficiency is mailed to the Claimant. The Claimant may amend the Claim at any time before the Alliance takes action on the Claim.

c. A claimant must provide written notice of the claim in accordance with this Policy within one year of the date of the incident or occurrence on which the claim is based, or, if the claim is for injury or death to a person, or damage to personal property, the claim must be presented to the Alliance within six (6) months of the date the incident on which the claim is based occurred. Except as is provided in Government Code Sections 946.4 and 946.6, no suit for money or damages may be brought against the Alliance on a cause of action that is subject to this Policy until a written claim has been presented to the Alliance, the Alliance has acted on the claim in accordance with this Policy, or the claim is deemed to have been rejected by the Alliance because it did not act on the claim within forty-five (45) days from the receipt by the Alliance. When a claim for death or injury to person, or to personal property is not presented to the Alliance under this Policy within six months after the event or occurrence on which the claim is based, the Alliance shall give written notice to the claimant at the address provided in the notice of claim that the notice of claim was not timely and is being returned without further action. The notice shall be in substantially the following form:

"The claim you presented to the Alliance on [insert date] is being returned because it was not presented within six months after the event or occurrence as required by law. See Sections 901 and 911.2 of the Government Code. Because the claim was not presented within the time allowed by law, no action was taken on the claim.

Your only recourse at this time it to apply without delay to the Alliance for leave to present a late claim. See Sections 911.4 to 912.2, inclusive, and Section 946.6 of the Government Code. Under some circumstances, leave to present a late claim will be granted. See Section 911.6 of the Government Code.

You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately."

d. The Alliance shall grant or deny the application to file a late claim within forty-five (45) days after it is received. The Alliance will grant the application where (1) the failure to present the claim was through mistake, inadvertence, surprise or excusable neglect and the Alliance was not prejudiced in its defense of the claim, (2) the person who sustained the alleged injury, damage or loss was a minor at the time of the occurrence on which the claim is based, (3) the person who sustained the alleged injury, damage or loss was physically or mentally incapacitated during all the time specified in Government Code Section 911.2 for the presentation of the claim, or (4) the person who sustained the injury, damage or loss died before the expiration of the time specified in Section 911.2 for the presentation of the claim. If the Alliance fails to take action on the application to file a late claim within forty-five (45) days of receipt of the application, the application will be deemed to have been denied. If the application to file a late claim is denied, the Alliance will send a written notice of the action to the applicant by U.S. Postal Service at the address given on the claim or application. The notice shall include a warning as follows:

"WARNING

If you wish to file a court action on this matter, you must first petition the appropriate court for an order relieving you from the provisions of Government Code Section 945.4 (claim presentation requirement). See Government Code Section 946.6. Such petition must be filed with the court within six months from the date your application for leave to present a late claim was denied.

You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately."

3. The Alliance may act on a Government Claim in one of the following ways:

e. If the Alliance finds the claim is not a proper charge against it, it shall reject the claim.

f. If the Alliance finds the claim is a proper charge against it and is for an amount that is justly due, it shall allow the claim.

g. If the Alliance finds the claim is a proper charge against the public entity but is for an amount greater than is justly due, it shall either reject the claim or allow it in an amount that is justly due and reject it as to the balance.

h. If the Alliance disputes whether it has liability or the amount is justly disputed, the Alliance may reject the claim or it may compromise the claim.

If the Alliance allows the claim in whole or in part or compromises the claim, it may require the claimant, if the claimant accepts the amount allowed or offered to settle the claim, to accept it in settlement of the entire claim. Any compromise accepted by the claimant shall be documented in a written settlement and release agreement with terms acceptable to the Alliance

4. The written notice of the Alliance's action on the claim or the inaction is deemed to be a rejection under Section 912.4, may be in substantially the following form:

"Notice is hereby given that the claim you presented to the Alliance on [insert date] was (indicate whether rejected, allowed, allowed in the amount of $____ and rejected as to the balance, rejected by operation of law on [insert date of rejection of the claim].

WARNING

Subject to certain exception, you have only six months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim. See Government Code Section 945.6.

You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately."

5. Establishment of and Delegation to the Alliance's Government Claims Committee:

i. Pursuant to the authority under Government Code Section 935.2, a Government Claims Committee is hereby established within the Alliance, which shall be comprised of at least three (3) of the follow members, or their respective designees: the Chief Executive Officer, the Chief Operating Officer, the Chief Administrative Officer and/or the Chief Financial Officer.

j. Pursuant to the same authority, the Government Claims Committee is hereby authorized to allow, compromise, negotiate or settle any Government Claim for money or damages for any budgeted expenses or unbudgeted expenses within the expenditure authority of any of the individuals serving on the Government Claims Committee.

k. Upon written order or authorization of the Government Claims Committee, the Chief Financial Officer (or his/her designee) shall cause payment to be issued in the amount for which a Government Claim has been allowed, negotiated, compromised or settled under this Section.

l. The Government Claims Committee, at its discretion, may refer the consideration of a Government Claim under this Section to the Alliance Board of Governors, as the Government Claims Committee deems appropriate.

m. In the event of conflict of interests with members of the Government Claims Committee, the members with the conflicts of interest shall appoint a designee without a conflict to serve on the Government Claims Committee for consideration of the claim.

6. Any Government Claim for an unbudgeted expense which exceeds $149,999.99 shall be first considered by the Government Claims Committee which shall make a recommendation on the claim decision to the Alliance's Board of Governors for its consideration of the claim.

7. This Government Claims Presentation Policy applies to Government Claims and does not affect or supersede any other applicable policies and practices for internal review and/or appeal of provider claims payment disputes or Alliance Health Plan Member appeals and grievances.

References:

Alliance Policies:
- 105-0012 – Administrative Decision-Making Controls
- 105-0013 – Expenditure Authority
- 701-1500 – Expense Reimbursement

Impacted Departments:
- Claims
- Human Resources
- Finance Division

Regulatory:

Legislative:
- Cal. Government Code §§ 810-996.6;
- Gov. Code §§ 905, 935, 935.2, 935.4, 945.6 and 946.
- Cal. Welfare & Institutions Code § 14087.54

Contractual (Previous Contract):

Contractual (2024 Contract):

DHCS All Plan Letter:

NCQA:

Supersedes:

Other References:

Attachments:

Lines of Business This Policy Applies To **LOB Effective Dates**

	**POLICIES AND PROCEDURES**
Policy #: 800-0018	**Lead Department:** Legal Services
Title: Government Claims Presentation and Delegation of Authority to Approve, Deny and/or Settle Certain Government Claims	
Original Date: 10/12/2021	**Policy Hub Approval Date:** 10/06/2022
Approved by: Dave McDonough, Legal Services Director	

☐ Medi-Cal (01/01/1996 – present)
☐ Alliance Care IHSS (07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
09/26/2022	09/27/2022	Jenifer Mandella, Chief Compliance Officer	Jenifer Mandella, Chief Compliance Officer

Alliance Code of Conduct

The Alliance's values are standards that guide our conduct. These values are represented in the Alliance's Code of Conduct.

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.

The Code of Conduct provides guidelines to Board members, employees, and contractors, including subcontractors, downstream subcontractors, and network providers, on appropriate ethical and legal standards. The Code of Conduct is an important component of the Compliance Program and reflects the Alliance's commitment to comply with all applicable Federal and State laws, regulations, and contractual obligations. Compliance is everyone's responsibility, thus it is the Alliance's expectation that all Board members, employees, and contractors be familiar and comply with all requirements of the Code of Conduct, avoid actions and relationships that may violate these standards, and seek guidance from appropriate staff when necessary.

The information contained in the Alliance Code of Conduct is not all inclusive or encompassing. The Alliance reserves the right to evaluate any and all situations pertaining to an actual or perceived ethical or legal conflict or misconduct, and then make a determination as to appropriate disciplinary action, policy and procedures, etc., given the facts and circumstances.

This Code of Conduct must be approved by the Alliance Board annually and is made available to Alliance staff and Board members, and is publicly posted on the Alliance's website.

COMPLIANCE WITH LAW

The Alliance is committed to conducting all activities and operations in compliance with applicable laws.

Fraud Waste & Abuse

With oversight from the Compliance Committee, the Alliance's Program Integrity function prevents, detects, evaluates, investigates, reports and resolves all potential/actual fraud, waste and abuse issues. Board members, employees, and contractors shall obey laws that prohibit direct or indirect payments in exchange for the referral of patients or services, which are paid by Federal and/or State health care programs.

Political Activities

The Alliance's political participation is limited by the Political Reform Act. Alliance funds, property, and resources are not to be used to contribute to political campaigns, political parties, or organizations. Board members, employees, and contractors may participate in the political process on their own time and at their own expense but are not to give the impression that they are speaking on behalf of or representing the Alliance during these activities.

Anti-Trust

All Board members, employees, and contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. The types of activities that involve antitrust laws include agreements to fix prices, bid rigging, and related activities; boycotts, exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors that determine prices at trade association meetings.

MEMBER RIGHTS

The Alliance is committed to meeting the health care needs of its members by providing access to quality health care services.

Access

Alliance policies and procedures have been developed to be consistent with applicable laws governing member choice and access to health care services. Employees and contractors shall comply with all requirements for coordination of medical and support services for Alliance members. Employees and contractors shall provide culturally,

linguistically, and culturally appropriate services to plan members to ensure effective communication regarding diagnosis, medical history and treatment, and health education.

Complaint Process

Alliance employees and contractors shall inform members of their grievance and appeal rights through member handbooks and other communications in accordance with Alliance procedures and applicable laws. Alliance member grievances and appeals shall be investigated in a prompt and nondiscriminatory manner in accordance with Alliance policies and applicable laws.

BUSINESS ETHICS

The Alliance is committed to the highest standards of business ethics. Employees and contractors shall accurately and honestly represent the Alliance and not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

Candor and Honesty

Board members, employees, and contractors shall be candid and honest in the performance of their responsibilities and in all communications.

Financial Reporting

All financial reports, accounting records, research reports, expense accounts, timesheets and other documents are to accurately and clearly represent the relevant facts or the true nature of a transaction. The Alliance maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets.

Regulatory Agencies and Accrediting Bodies

Alliance employees and contractors shall deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner.

Alliance Code of Conduct

PUBLIC INTEGRITY

The Alliance and its Board members and employees shall comply with laws and regulations governing public agencies.

Public Records

The Alliance shall provide access to records to any person, corporation, partnership, firm or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq., the Health Insurance Portability and Accountability Act (HIPAA), and Alliance policies.

Public Funds

The Alliance, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration that they serve a purpose within the authority of the Alliance.

Public Meetings

The Alliance, and its Board members and employees, shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act.

CONFIDENTIALITY

Board members, employees, and contractors shall maintain the confidentiality of all confidential information in accordance with applicable laws and shall not disclose confidential information except as specifically authorized by Alliance policies, procedures, and applicable law.

No Personal Benefit

Board members, employees, and contractors shall not use confidential or proprietary Alliance information for their own personal benefit or for the benefit of any other person or entity, while employed at or engaged by the Alliance, or at any time thereafter.

Duty to Safeguard Member and Medical Confidential Information

Board members, employees, and contractors shall safeguard Alliance member protected health information, identity, eligibility, and medical information, peer review, and other confidential information in accordance with HIPAA regulations, California law, and the Alliance's policies and procedures.

Personnel Files

Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable law.

Proprietary Information

Alliance Board members, employees, and contractors shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with, and to the extent required by, contract or law. The Alliance shall safeguard provider identification numbers including: medical licenses, Medicare numbers, social security numbers, and other identifying numbers.

CONFLICTS OF INTEREST

Board members and employees have a duty to be loyal to the Alliance.

Conflict of Interest Code

Designated employees as identified in the Conflict of Interest Code, including Board members, shall comply with the requirements of Alliance Conflict of Interest policies to avoid impropriety or the perception of impropriety, which might arise from their influence on business decisions or disclosure of Alliance business operations.

Outside Services and Interests

Employees shall not perform work or render services for any contractor, association of Contractors, or other organizations with which the Alliance does business or which seek to do business with the Alliance without prior Chief Executive Officer approval (See Outside Employment section in Employee Handbook). Employees shall not permit their names to be used in any fashion that would indicate a business connection with any contractor or association of contractors, including vendors. All employees shall report all Board-level

volunteer activities to the Alliance's Human Resources Department upon consideration and on an annual basis thereafter.

BUSINESS RELATIONSHIPS

Business transactions with vendors, contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements, and in accordance with applicable law and ethical standards.

Business Inducements

Board members, employees, contractors, and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, the Alliance, or Alliance members.

Gifts to the Alliance

Board members and employees shall not solicit or accept personal gratuities, gifts, favors, services, entertainment or any other things of value from any person or entity that furnishes items or services to the Alliance unless specifically permitted under Alliance Policies. Please see Alliance Policy 105-0015 – Conflict of Interest for specific guidance on acceptance of gifts by Alliance staff members.

Provision of Gifts by the Alliance

Employees may provide gifts, entertainment or meals of nominal value to the Alliance's current and prospective business partners and other persons when these activities have a legitimate business purpose, are reasonable, and are consistent with applicable law and Alliance policy. In addition to complying with statutory and regulatory requirements, it is important to avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with the Alliance.

Third-Party Sponsored Events

The Alliance will not participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, the Alliance or its operations. Employees' attendance at contractor, vendor or other third- party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose subject to prior approval by the

Department Manager or Director. To align with California Fair Political Practices Commission requirements, third party sponsorship of events or travel is not permitted, unless the meeting attendee is a speaker or honoree at the event. Additionally, employees will not participate in raffles at third party sponsored events.

Provision of Gifts to Government Agencies

Board members, employees, and contractors shall not offer or provide money, gifts or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws.

PROTECTION OF ALLIANCE ASSETS

Board members, employees, and contractors shall strive to preserve and protect Alliance assets by making prudent and effective use of Alliance resources and properly and accurately reporting its financial condition.

Personal Use of Alliance Assets

The assets of the Alliance are not for personal use. Board members, employees, and contractors are prohibited from the unauthorized use or taking of Alliance equipment, supplies, materials or services.

Communications

All communication systems, electronic mail, internet access, or voicemail are the property of the Alliance. Employees should assume that the communications are not private. Board members, employees, and contractors shall adhere to the highest standards of professional conduct and personal courtesy in the type, tone, and content of all written, verbal and electronic communications and messages.

Electronic Mail and Social Media

Employees may not use internal communication channels or access to the internet at work to post, store, transmit, download, or distribute any information or material which is threatening, knowingly, recklessly, or maliciously false, obscene, or which constitutes or encourages criminal offenses, gives rise to civil liability or otherwise violates any laws or Alliance policies. The internal communication channels or access to the internet may not be used to send spam mail, or copyrighted documents that are not authorized for

reproduction. Board members, employees, and contractors must adhere to the Alliance's Code-of-Conduct and policy 640-0005 – Social Media Policy when using social media in reference to the Alliance.

DISCRIMINATION

The Alliance acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.

No Discrimination

Board members, employees, and contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age or perceived age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, family care leave status, veteran status, marital status, genetic information, pregnancy, political affiliation, or any other legally protected status. The Alliance is committed to providing a work environment free from discrimination and harassment based on any classification noted above.

PARTICIPATION STATUS

The Alliance requires that network providers have valid and current licenses, certificates, and/or registration, as applicable, and that employees, contractors, and members of the Alliance Board of Commissioners are able to participate in Federal and State-funded programs.

Participation Status

The Alliance has policies that ensure network providers, employees, contractors, and members of the Alliance Board of Commissioners are not currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program.

Disclosure of Participation Status

Contractors shall disclose to the Alliance whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program; if they have ever been excluded from participation in Federal and/or

State health care programs based on a Mandatory Exclusion; and/or have met the Alliance's Felony Conviction status requirements as set forth in Alliance policy, as applicable.

Delegated Third Party Administrator Review

The Alliance requires that its contractors review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes.

Licensure

The Alliance requires that all employees and contractors who are required to be licensed, credentialed, certified or registered in order to furnish items or services to the Alliance and its Members have valid and current licensure, credentials, certification or registration as applicable.

GOVERNMENT INQUIRIES

Employees shall notify the Alliance upon receipt of government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

Notification of Government Inquiry

Employees are to notify the Government Relations Director immediately upon the receipt of a formal government inquiry for information regarding Alliance business practices.

No Destruction of Documents

Employees shall not conceal, destroy or alter Alliance information or documents in anticipation of, or in response to, a request for documents by any governmental agency or court.

Alliance Code of Conduct

COMPLIANCE PROGRAM REPORTING

Board members, employees, and contractors have a duty to comply with the Alliance Compliance Program. Compliance is a condition of appointment, employment, and/or engagement.

Seeking Guidance

Board members, employees, and contractors may seek additional guidance and clarity on any requirements outlined in this Code of Conduct by contacting the Alliance's Chief Compliance Officer, Compliance Director, or any Compliance Department staff.

Reporting Requirements

All Board members, employees, and contractors must report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or Alliance policies. Staff can be assured that they may report suspected and actual compliance or fraud issues or concerns without retaliation or retribution. Such reports may be made to a supervisor or manager, the Chief Compliance Officer, the Chief Administrative Officer, Human Resources Director, Compliance staff, or anonymously to the Confidential Disclosure Hotline.

Employees can call the Alliance's toll-free Confidential Disclosure Hotline at **1-844-910-4228**, or use the Alliance Confidential Disclosure website: **https://ccah.ethicspoint.com**. Additional reporting information is located on the Compliance Intranet page.

Contractors may report compliance concerns by contacting their designated Alliance contact person, contacting Compliance Department staff directly, or through the Compliance Concern Report form on the Alliance's website.

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
	3/20/2018	Jenifer Mandella, Compliance Officer	Alliance Board
	12/18/2019		Alliance Board

	1/13/2021	Jenifer Mandella, Compliance Officer	Alliance Board
	3/23/2022	Jenifer Mandella, Compliance Officer	Alliance Board
	9/20/2023	Jenifer Mandella, Compliance Officer	Alliance Board
	8/310/2023, with changes effective 1/1/2024	Jenifer Mandella, Chief Compliance Officer	

	POLICIES AND PROCEDURES
Policy #: 100-0001	**Lead Department:** Administration
Title: Alliance Donations and Sponsorship of Events and Organizations	
Original Date: 11/07/2021	**Policy Hub Approval Date:** 07/13/2023
Approved by: Michael Schrader, Chief Executive Officer	

Purpose:
To describe the Central California Alliance for Health's (the Alliance) policy and procedure for financial donations to non-profit 501c3 community organizations and sponsorship of such organizations' events within the Alliance's service area.

Policy:
It is the policy of the Central California Alliance for Health to be responsible stewards of public funds. The Alliance, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons or entities. Donations to a non-profit 501c3 organization or sponsorship of such organization's event must serve a direct and substantial public purpose and make appropriate use of public funds and Alliance staff time.

As such, the Alliance may donate to non-profit 501c3 organizations and/or sponsor their events which further a Medi-Cal purpose, the Alliance's strategic priorities, align with the Alliance's mission, vision, and values, and comply with the Alliance's Code of Conduct. Sponsorships and donations may only be awarded to the extent funds budgeted for such donations/sponsorships are available, and there is no guarantee of Alliance sponsorships or donations.

Alliance funds will not be used responsive to specific employee personal volunteer interests, including specific employee family and friend volunteer or associated non-profit organizations or their events (i.e. children's school fundraisers, etc.).

Definitions:

1. Donation: Financial contributions by the Alliance to support a non-profit 501c3 organization that serves a public purpose that is aligned with the Alliance's vision, mission, values and strategic priorities. Donations support the organization and are not restricted to a specific purpose nor are they subject to specific terms and conditions beyond the general requirement that they used by a 501c3 for a public purpose, aligned with the Alliance's Vision/Mission/Values. Donations may also include time provided by Alliance staff during business hours.

2. Sponsorship: Financial contributions by the Alliance, to a non-profit 501c3 organization for an event hosted by the organization which serves a public purpose, and that is aligned with the Alliance's vision, mission, values and strategic priorities. Sponsorship can also include contribution of goods or tangible items in support of an event and may also include time provided by Alliance staff to support the event during Alliance business hours.

Procedures:

	POLICIES AND PROCEDURES
Policy #: 100-0001	**Lead Department:** Administration
Title: Alliance Donations and Sponsorship of Events and Organizations	
Original Date: 11/07/2021	**Policy Hub Approval Date:** 07/13/2023
Approved by: Michael Schrader, Chief Executive Officer	

1. Budget.
    a. Annually, the CEO will propose a budget to be included in the annual Alliance administrative budget proposal acted on by the Alliance's board. The budget will be adequate to provide sponsorships and/or donations aligned with this policy in each of the counties in which the Alliance operates.

2. Requests.
    a. An organization requesting donation or sponsorship shall submit a request and any applicable supporting documents utilizing the mandatory Alliance request form, detailing how the requested funds are intended to be used, outlining the scope and purpose of the organizational donation or event sponsorship, and agreeing to the Alliance's requirements around benefits and recognition for any event sponsorship.

3. Action on Requests.
    a. For documentation purposes, the Executive Assistant/Clerk of the Board (EA/COB) will track all requests, with data including but not limited to: organization, date of event, type of request, staffing information, amount of request, and ultimate disposition of the request. The EA/COB will forward all requests to the Community Engagement Directors (CED) for review and recommendation.
    b. Requests for donation/sponsorship shall be reviewed by the CED for the county in which the organization operates for confirmation of alignment with this policy, verification of adequate budget for the requested sponsorship/donation, and recommendation for action to the Alliance's CEO. The CED will consult with Finance to determine whether funding the donation or sponsorship would constitute a medical expense attributable to the Alliance medical budget or whether it is an administrative expense, attributable to the donation/sponsorship budget in the administrative budget.
    c. If the request is aligned with criteria and there is adequate budget available, the CED will submit requests for recommended approval to the CEO. The CEO has the authority to approve or deny all requests.
    d. The CEO will notify the CED, the Executive Assistant and Finance of any approval. Finance will prepare the check for the approved sponsorship/donation. The Executive Assistant will prepare a letter indicating approval of the request and enclosing the sponsorship/donation.

e. The CEO will notify the CED and the Executive Assistant of any denial. The Executive Assistant will prepare a letter for the organization notifying the organization of the denial.

4. Benefits and recognition.
   a. Event sponsorship may be promoted by the Alliance in communications channels as deemed appropriate, including the web site, social media, press releases, print and electronic newsletters and other collateral.
   b. The non-profit will assume the responsibility of securing signed photo releases from any individuals included in photos or other visual material provided to the Alliance by the non-profit.
   c. As a benefit of sponsorship, the non-profit agrees to promote the sponsorship on the non-profit's and/or event promotional material, including website, press releases, public event recognition, social media, newsletters and other collateral
   d. The non-profit agrees to include the Alliance's name and approved logo in such promotional materials as deemed appropriate and agreed upon via the sponsorship terms and with advance approval from the Alliance's Communications Department.
   e. In the event the organization is identifying the Alliance as a donator to the organization, the organization will also only utilize the Alliance's approved logo and with advance approval from the Alliance's Communications Department.

5. Reporting.
   a. On an annual basis, the Alliance will report all donation and sponsorship activities to the Board of Commissioners to assure compliance and consistency with the criteria set forth in this policy.

References:

Alliance Policies:
Policy 101-1038 - Solicitation
Impacted Departments:
Administration
Regional Operations
Communications
Finance
Regulatory:
Legislative:
Contractual (Previous Contract):
Contractual (2024 Contract):

	**POLICIES AND PROCEDURES**
Policy #: 100-0001	**Lead Department:** Administration
Title: Alliance Donations and Sponsorship of Events and Organizations	
Original Date: 11/07/2021	**Policy Hub Approval Date:** 07/13/2023
Approved by: Michael Schrader, Chief Executive Officer	

DHCS All Plan Letter:
NCQA:
Supersedes:
Other References:
Attachments:

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

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
06/07/2023	06/22/2023	Kathy Stagnaro, Clerk of the Board	Michael Schrader, Chief Executive Officer

	POLICIES AND PROCEDURES
Policy #: 110-0003	**Lead Department:** Government Relations
Title: Letters of Support	
Original Date: 08/27/2019	**Policy Hub Approval Date:** 08/29/2023
Approved by: Danita Carlson, Government Relations Director	

Purpose:

To establish guidelines for responding to a request for a Letter of Support from external entities.

Policy:

I. Letter(s) of support (LOS) may be requested from Central California Alliance for Health (the Alliance) by or on behalf of external entities within the Alliance Service Area for things including, but not limited to, grant applications, community initiatives or general endorsement. As a public agency, the Alliance must protect and preserve its name and reputation by ensuring that any endorsement by or support from the Alliance is consistent with the Alliance's mission, vision and values (VMV) and/or aligned with the plan's priority activities. Therefore, requests must be carefully reviewed and considered to ensure such letters of support are in alignment with VMV and priority activities. This policy outlines the processes and guidelines related to requests for LOS.

II. The Alliance may consider requests for LOS from the following types of external entities: community based, non-profit organizations, governmental entities, or not-for-profit health care providers or partners that serve Alliance members or provide services in support of the Alliance VMV or priority activities.

III. The Alliance shall not provide LOS to endorse any commercial product or service, any religion or religious activity, any ballot measure or any candidate for public office.

IV. LOS for any state or federal legislation or policy initiatives must be aligned with board approved Policy Priorities reviewed and approved by the Alliance board. LOS related to legislation or policies in areas not contemplated under the Board's Policy Priorities must be approved by the Board.

V. Requests for LOS meeting the above requirements should be considered based on:

   a. The potential for the LOS to create positive visibility for the Alliance.
   b. Whether the LOS promotes or advocates for positions consistent with the Alliance's VMV and/or board adopted policy priorities.
   c. Whether the LOS conflicts with any Alliance policies, contractual obligations, regulations or laws.
   d. Whether the LOS constitutes any conflict(s) of interest for the Alliance whether real or perceived.

e. Whether the LOS has a potential or actual financial or business impact on the Alliance.

VI. Requests for LOS from external entities meeting the criteria stated above require approval of the Chief Executive Officer (CEO) after consideration of the above.

VII. The CEO shall report any LOS that have been provided meeting the above criteria and standards to the Alliance Board in writing via CEO Report to the Board at the next regularly scheduled board meeting.

VIII. Requests for LOS not meeting the above criteria and requirements can only be approved by the Alliance board.

Definitions:

I. Alliance Service Area: The Alliance Service Area consists of Santa Cruz, Monterey and Merced counties.

II. Letter(s) of Support**:** A LOS is a letter from a partner organization, legislative representative, or other key stakeholder that details a compelling reason why an organization or project is credible and of value to the community or a particular initiative. A LOS may be written from the perspective of a partner who is collaborating on a project, or as a separate entity offering support as a community leader or advisor.
   a. A LOS conveys how the partner will support the project (as applicable), describes the convergence of work between the organizations, and lends credibility to the organization requesting support. It is often submitted with an application for grant funds.
   b. A LOS as defined in this policy is different than a formal partnership agreement, interagency agreement, or memorandum of agreement, which explain each partner's specific responsibilities and use of funds in implementing a project. Therefore, a LOS is not considered a contractual or legal obligation or a monetary pledge. A LOS is also not a letter of commitment, which promises a gift-in-kind to support a project. However, specific commitments may be made in a LOS as deemed appropriate by the CEO. Generally, Alliance LOS are considered a reference in support of an organization or effort, without a promise or offer of any action, compensation, or committal to any plan, project or initiative, unless specifically noted.

Procedures:

The following procedure outlines the process for request, review and fulfillment of a LOS.

	POLICIES AND PROCEDURES
Policy #: 110-0003	**Lead Department:** Government Relations
Title: Letters of Support	
Original Date: 08/27/2019	**Policy Hub Approval Date:** 08/29/2023
Approved by: Danita Carlson, Government Relations Director	

1. All requests for LOS should be forwarded to the Executive Assistant – Clerk of the Board (EA-COB) who is the designated lead for tracking and maintaining LOS requests.
2. The LOS request must be approved by the relevant department director (if applicable) prior to being submitted to the EA-COB.
3. The staff member requesting the LOS on behalf of the external organization is responsible for providing all pertinent information including, but not limited to:
    a. The name of the organization seeking a LOS and their contact information;
    b. The reason for the request (e.g., funding application);
    c. The date the LOS is due to the organization;
    d. A template letter provided by the organization, if any; and
    e. Description of the relationship between the organization's work and the Alliance Service Area, programs/lines of business, vision, mission, values and/or scope of services.
4. Requests should be emailed by the department director to the EA-COB with copy to the Government Relations Director (GRD).
5. If approved by the CEO, a final letter will be drafted by the EA-COB or GRD for the CEO's signature.
    a. The EA-COB will prepare the LOS for inclusion in the next month's Board packet.
6. If approval is deemed required by the Board, the GRD will prepare a report for the Board.
7. A portable document format (PDF) copy and hard copy (if needed) of the LOS will be sent to the staff member who submitted the request, unless instructed to be sent directly to the requesting organization's contact.
8. If the request is denied, the EA-COB will prepare a letter for the requestor advising of the denial of the request.

Tracking

1. All LOS are tracked by the EA-COB in the Alliance LOS Tracking document located in the EA-COB's LOS folder.
2. Commitments agreed to by the Alliance, such as provision of data or collaborative participation, are carefully and specifically documented in the LOS Tracking document. Staff requesting LOS are responsible for fulfillment of stated commitment(s).

References:
Alliance Policies:
Impacted Departments:
All Departments

	**POLICIES AND PROCEDURES**
Policy #: 110-0003	**Lead Department:** Government Relations
Title: Letters of Support	
Original Date: 08/27/2019	**Policy Hub Approval Date:** 08/29/2023
Approved by: Danita Carlson, Government Relations Director	

Regulatory:
Legislative:
Contractual (Previous Contract):
Contractual (2024 Contract)
DHCS All Plan Letter:
NCQA:
Supersedes:
Policy 104-0004 – Letters of Support
Other References:
Attachments:

Lines of Business (LOB) This Policy Applies To	**LOB Effective Dates**
☐ Medi-Cal	(01/01/1996 – present)
☐ Alliance Care In-Home Supportive Services (IHSS)	(07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
09/02/2021	09/02/2021	Danita Carlson, Government Relations Director	Ilsa Branch, Government Relations Manager
08/15/2023	08/15/2023	Evan Eurs, Government Relations Specialist	Danita Carlson, Government Relations Director

	POLICIES AND PROCEDURES
Policy #: 700-2000	**Lead Department:** Finance
Title: Board-Designated Reserve ("Reserve")	
Original Date: 8/1/2022	**Policy Hub Approval Date:** 09/08/2022
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 net income which, if reserved would result in a fund balance that exceeds the Reserve Target, to:

a. Enable implementation of future program requirements, with such funds remaining in Alliance reserves until expended.
b. 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	**Policy Hub Approval Date:** 09/08/2022
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.

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.

4. 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 may recommend that the Board allocate the excess amount above the Reserve Target to the Medi-Cal Capacity Grant Program. The recommendation shall consider any short-term or long-term capital needs for future program requirements.

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

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

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By

Peter Roan

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Overview

Health care plans and organizations threatened by daunting litigation and regulatory challenges rely on Peter Roan to find creative solutions and achieve victories. His clients include managed care organizations at the forefront of the industry, and over three decades Peter has accumulated a particularly deep understanding of managed care businesses and the challenging regulatory environments they face.

Peter's clients include managed care organizations, health benefit plans, and Medicare Advantage organizations; Medicaid managed care plans; insurers, plan administrators, and plan sponsors; physician organizations; other health care providers and suppliers; ambulatory surgical, skilled nursing, and other health care facilities; and trade associations in various litigation and regulatory matters. His litigation experience includes payer/provider disputes and commercial litigation as well as defending consumer class actions, managed care liability, bad faith, wrongful death, ERISA, unfair business practices, False Claims Act, and RICO cases. Peter represents health care payers that offer or administer group and individual insurance as well as organizations participating in government-sponsored or subsidized health programs, including Medicare Advantage, Medicaid, TRICARE, and FEHBP. He counsels clients on regulatory and business matters and defends regulatory enforcement actions both in court and before the agencies as well as in physician peer review proceedings and related litigation.

Career & Education

Education

University of Iowa, B.B.A., 1982

Marquette University Law School, J.D., 1985

Admissions

California

Representative Matters

- Defeated arbitration claims by a durable medical equipment supplier against a Medicaid managed care plan and obtained judgment for damages and attorney's fees on the plan's counterclaim based on the supplier's fraud.
- Secured judgment for a Medicare Advantage plan of a bad faith lawsuit brought by a plan member because the member had not exhausted administrative remedies and because the claims were preempted by the Medicare Act.
- Obtained reinstatement of a specialty pharmacy following an appeal of the pharmacy's disenrollment by the state Medicaid agency.
- Won additional reimbursement for a Medicaid managed care plan dispute with a state Medicaid agency concerning the actuarial soundness of capitation payments made by the agency.
- Represented a health plan in an arbitration by a group of hospitals alleging the plan systemically underpaid thousands of hospital claims worth tens of millions of dollars and established through sampling and audit work that the claims were grossly overstated, resulting in a favorable settlement.

Insights

Publications

Ninth Circuit Bars Providers from Enforcing ERISA Protections on ERISA Plan Administrators | 04.07.17
American Health Lawyers Association Payers, Plans, and Managed Care Newsletter

CMS Proposes Significant Changes Impacting Medicare Appeals Processes | 07.18.16
American Health Lawyers Association Payers, Plans, and Managed Care Newsletter

CMS Proposed Rule On Affordable Care Act Standards For Essential Health Benefits, Actuarial Value, And Accreditation | 12.14.12
Health Lawyers Weekly, Vol. 10, Issue 49

Affirming the Right to Rescind In California | 02.01.10
Law360

"Application of Medical Billing Standards to Claims Submitted by Non-Contracted Providers" AHLA HMOs and Health Plans Practice Group, Vol. 11, Issue 1 | 02.01.08

Transfer of Financial Risk by HMOs to Health Care Providers: May HMOs Escape Liability When Their Contractors Fail to Pay? | 10.01.03
9 BNA Health Plan & Provider Report Rep. 1137

Speaking Engagements

"Recent Shifts and Lessons Learned in DOJ False Claims Act Enforcement," Los Angeles County Bar Association, Los Angeles, CA | 01.09.19

"Where is All of the Expected Enrollee and Provider Litigation from the Affordable Care Act?" Blue National Summit, Phoenix, AZ | 04.20.15

"Hot Issues in Payor/Provider Litigation," Crowell & Moring's Healthcare Ounce Of Prevention Seminar (HOOPS), Washington, D.C. | 10.27.14

"Narrow Networks – Now or Never," Blue National Summit, Orlando, FL | 05.19.14

"Coordinated Care Initiative: Are We Really Ready?" Crowell & Moring's Healthcare Ounce Of Prevention Seminar (HOOPS), Los Angeles, CA | 05.13.14

"Narrow Networks – Now or Never," Crowell & Moring's Healthcare Ounce Of Prevention Seminar (HOOPS), Los Angeles, CA | 05.13.14

"Litigation Update," California Association of Health Plans, Legal and Regulatory Affairs Meeting, San Francisco, CA | 04.24.14

Plan-Provider Managed Care Contracting Webinar Mini-Series: Current Compensation/Reimbursement Issues in Plan Provider Contracting," American Health Lawyers Association Webinar | 01.09.14

"Litigation Issues Affecting Health Plans in 2012," California Association of Health Plans Annual Meeting | 10.15.13

"Current Legal Issues in Managed Care," Health Care Financial Management Association Fall Conference | 09.01.09

Firm News

Crowell & Moring Releases Third Annual Litigation Forecast Report and Inaugural Regulatory Forecast | 01.13.15

Crowell & Moring's Insurance/Reinsurance Group Nominated for Chambers USA "Award of Excellence" | 05.27.14

Crowell & Moring Strengthens National Health Care Practice with West Coast Partner Trio | 10.09.12

Client Alerts

Supreme Court Clarifies that the Arbitrator, and Not the Court, Determines when Arbitration Is Required Under the Federal Arbitration Act | 01.10.19

Managed Care Lawsuit Watch - September 2017 | 09.06.17

Managed Care Lawsuit Watch - February 2017 | 02.02.17

New California Law to Curb Surprise Medical Bills Will Impact Relationships Between Health Plans and Non-Contracted Professionals | 10.18.16

Managed Care Lawsuit Watch - August 2016 | 09.06.16

Managed Care Lawsuit Watch - March 2016 | 03.29.16

Managed Care Lawsuit Watch - November 2015 | 11.04.15

Managed Care Lawsuit Watch - June 2015 | 06.08.15

Managed Care Lawsuit Watch - March 2015 | 03.05.15

California Department of Insurance's Emergency Regulations on Provider Networks Go Into Effect | 02.03.15

Blog Posts

California Supreme Court Prohibits Waiver of Public Injunctive Relief in Arbitration Agreements | 04.12.17
Crowell & Moring's Health Law Blog

New California Law To Target Surprise Bills Impacts Payor Relationships With Non-Contracted Professionals | 10.18.16
Crowell & Moring's Health Law Blog

Sequestration Extended to 2025 in Federal Budget Deal | 12.10.15
Crowell & Moring's Health Law Blog

CMS Proposes To Modify 'Two-Midnight Benchmark' To Broaden Exceptions for Part A Payments for Short Inpatient Stays | 07.16.15
Crowell & Moring's Health Law Blog

What Insurers Should Know About Emergency Regulations from the California Dept. of Insurance | 02.04.15
Crowell & Moring's Health Law Blog

Practices

Litigation and Trial

Class Actions

Administrative Law

False Claims Act Defense

Industries

Health Care

Government Health Care Programs

Health Care Litigation

Managed Care

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Languages Spanish

Overview

Given his background as a former federal prosecutor, clients trust Agustin Orozco to lead complex white collar cases and investigations, handle contentious and sophisticated pretrial litigation, and successfully prove highly difficult cases at trial. Agustin's experience as a federal prosecutor and government contracts attorney leaves him uniquely situated to help clients where government contracts and white collar intersect.

Agustin represents clients in criminal and civil government investigations and enforcement actions. He also represents and counsels clients on matters involving federal, state, and local government contracts. Agustin has litigated civil False Claims Act matters and other government contracts issues, such as disputes, claims, and terminations, as well as suspension and debarment matters. He is also experienced in matters involving the Foreign Corrupt Practices Act, including conducting investigations abroad and counseling clients on compliance issues.

Prior to rejoining the firm as a partner, Agustin was an assistant U.S. attorney in the Public Corruption & Civil Rights Section of the U.S. Attorney's Office for the Central District of California. While serving in this role, Agustin represented the United States in criminal investigations, prosecutions, and/or appeals of public corruption, bribery (both domestic and abroad), conflicts of interest, honest services fraud, procurement fraud, wire fraud, mail fraud, obstruction of justice, money laundering, tax, and civil rights crimes. He worked on hundreds of criminal cases, served as lead counsel in federal trials, examined dozens of witnesses on direct and cross-

examination, delivered opening and closing arguments, and briefed and argued multiple cases before the U.S. Court of Appeals for the Ninth Circuit.

During law school, Agustin was an extern for the Hon. Barry Russell at the U.S. Bankruptcy Court in the Central District of California and interned at the National Immigration Law Center in Los Angeles. He also served as the co-chair of La Raza de Loyola and as chief justice of the Scott Moot Court Honors Board.

Agustin is active in the community and serves as a commissioner on the Judicial Nominees Evaluation Commission of the State Bar of California; on the steering committee of Just the Beginning, Los Angeles; and as a board member of For People of Color Inc. He is also a board member of the Federal Bar Association-Los Angeles and on the Executive Committee of the Los Angeles County Bar Association's Privacy & Cybersecurity Section. Agustin previously served on Project LEAD, where he helped teach elementary school children about the criminal justice system, and as vice chair of the LACBA's Diversity in the Profession Committee. Agustin was selected to the Pathfinder Program of the Leadership Council on Legal Diversity in 2016.

Career & Education

Government Experience

Department of Justice: United States Attorney's Office
Central District of California, Criminal Division, Public Corruption & Civil Rights Section: Assistant U.S. Attorney, 2016-2022

Professional Experience

- Commissioner, State Bar of California's Commission on Judicial Nominees Evaluation (JNE), Jan. 2020 – Present
- Executive Committee, Just the Beginning–Los Angeles, 2019 – Present
- Board Member, For People of Color, Inc., 2014 – Present

Education

University of California, San Diego, B.A., economics

Loyola Law School, Los Angeles, J.D.

Admissions

California

U.S. District Court for the Central District of California

U.S. Court of Appeals for the Ninth Circuit

Insights

Publications

Forced Labor: Avoiding Traps from America's Latest Legal Weapon in the Geo-Political Struggle with China | 08.01.23
General Motors' July 2023 Legal Brief

Supreme Court Reins in Government's Fraud Theories…Again | 05.23.23
Daily Journal

A Practical Guide to Biometric Information Laws | 03.27.23

Supreme Court To Review Corruption Cases | 09.27.22
Daily Journal (subscription required)

Speaking Engagements

"Pre-Trial Matters," 19th Annual Federal Court Boot Camp: The Nuts and Bolts. | 05.25.23

"Procurement Fraud and Civil False Claims Act," 39th Annual Ounce of Prevention Seminar (OOPS 2023), Washington, D.C. | 05.09.23 - 05.10.23

"The End Game: Government and Stakeholder Expectations," 2023 Government Contracts Investigations Seminar, Washington, D.C. | 05.10.23

"Caught in the Crosshairs: Former Prosecutors Discuss Navigating False Claims Act Investigations and Litigation," Crowell & Moring Webinar, 2023. | 04.19.23

"Los Angeles Federal Bar Association Panel: Careers in Federal Practice," Los Angeles, California. | 04.11.23

"How to Avoid Criminal Prosecution for a Cyber Breach," ACC SoCal In-House Counsel Program | 01.25.23

"Paycheck Protection Program Enforcement Efforts," Crowell & Moring Webinar. | 11.02.22

"Effective Witness Prep at the ABA Professional Success Summit," American Bar Association, Webinar, 2022. | 10.27.22

“Procurement Fraud and Enforcement,” GC 101: Back to Basics, Washington, D.C. | 09.21.22

"The Intersection of Biometric Technology Privacy and Enforcement Actions," ACC Webinar, 2022. | 08.24.22

Podcasts

Let’s Talk FCA: Pandemic Relief Fraud | 08.29.23

Let's Talk FCA: Supreme Court Upholds DOJ's Broad Dismissal Authority | 07.05.23

Let's Talk FCA: FCA's Knowledge Element Gets Its Day In Court | 05.09.23

Firm News

Crowell & Moring Named to "GIR 100" for Eighth Consecutive Year | 02.27.23

Former DOJ Trial Attorney Jason Crawford Returns to Crowell & Moring | 01.25.23

Partner Agustin Orozco Elected to Federal Bar Association of Los Angeles Board of Directors | 09.12.22

The Daily Journal Names Crowell & Moring’s Agustin Orozco to “Top Forty Under 40 2022” List | 08.04.22

Senior Federal Corruption Prosecutor Agustin D. Orozco Returns to Crowell & Moring | 01.19.22

Press Coverage

Girardi’s Criminal Risk In Balance At Resumed Competency Hearing | 09.11.23
Bloomberg Law

Battle Begins In Los Angeles Federal Court Over Tom Girardi's Competence | 07.06.23
The Recorder

Supreme Court Once Again Strikes Blow To DOJ's Fraud Theories | 05.30.23
Compliance Week

Critical Mass with Law.com's Amanda Bronstad: Is Tom Girardi Competent to Stand Trial?
3M Now Faces Dismissal of Its Earplug Bankruptcy | 02.08.23
Law.com

California Cases to Watch in 2023 | 01.02.23
Law360

Elizabeth Holmes' Judge Proposes Minimum-Security Prison With Family Visitation | 11.23.22
Yahoo Finance

Holmes Faces Uphill Battle Fighting 11-Year Prison Term | 11.21.22
Law360

Interview on Elizabeth Holmes Sentencing | 11.18.22
KNX News Radio, Los Angeles

Top Forty Under 40 2022: Agustin Orozco | 08.03.22
Daily Journal

Dechert And Crowell Add White-Collar Expertise | 01.25.22
Commercial Dispute Resolution

Client Alerts

In Control: Supreme Court Reigns-In Second Circuit Fraud Theories | 05.15.23

New Jersey Firm Pays $2.2M to Settle FCA Allegations it Received Improper PPP Loan | 04.14.23

New Voluntary Self-Disclosure Policy for All United States Attorney's Offices | 02.24.23

Procurement Collusion Strike Force Nabs Another Military Contractor in Bid Rigging Scheme | 06.27.22

The ISDC Issues Annual Report on Federal Suspension and Debarment Activities and Trends | 04.19.22

Department of Justice Settles First False Claims Act Case Under its Civil Cyber-Fraud Initiative | 03.14.22

Largest South Korean Telecom Company Agrees to Pay $6.3 Million to Settle FCPA Allegations | 02.24.22

Practices

White Collar and Regulatory Enforcement

Government Contracts

False Claims Act Defense

Litigation and Trial

Investigations

Industries

Technology

Transportation

Financial Services Regulatory and Enforcement

Life Sciences