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

Meeting Agenda

Wednesday, November 6, 2024

3:00 p.m. – 5:00 p.m.

Location:

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

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows. Note: Livestreaming for the public is listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 (323) 705-3950
    Phone Conference ID: 184 459 259#

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, November 5, 2024, to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to three minutes.
    b. In person, from an Alliance County office, during the meeting when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to three minutes.

1. **Call to Order by Chairperson Jimenez. 3:00 p.m.**
A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.

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

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

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

Consent Agenda Items: (5. – 9B.): 3:20 p.m.

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

Pages 5-01 to 5-09

6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the eighth month ending August 31, 2024.**
- Reference materials: Financial Statements as above.

Pages 6-01 to 6-10

Appointments: (7A.)

7A. **Approve appointment renewals of Ms. Doris Drost, Mr. Guadalupe Barajas-Iniguez, Mr. John Beleutz, Ms. Moncerat Politron, Ms. Rebekah Capron, and Mr. Michael Molesky to the Member Services Advisory Group.**
- Reference materials: Staff report and recommendation on above topic.

Page 7A-01

Minutes: (8A. – 8I.)

8A. **Approve Commission regular meeting minutes of September 25, 2024.**
- Reference materials: Minutes as above.

Pages 8A-01 to 8A-06

8B. **Accept Compliance Committee meeting minutes of July 17, 2024.**
- Reference materials: Minutes as above.

Pages 8B-01 to 8B-04

8C. **Accept Compliance Committee meeting minutes of August 21, 2024.**
- Reference materials: Minutes as above.

Pages 8C-01 to 8C-06

8D. **Accept Finance Committee meeting minutes of June 26, 2024.**
- Reference materials: Minutes as above.

Pages 8D-01 to 8D-04

8E. **Accept Member Services Advisory Group meeting minutes of February 8, 2024.**
- Reference materials: Minutes as above.

Pages 8E-01 to 8E-04

8F. **Accept Physician Advisory Group meeting minutes of May 30, 2024.**
- Reference materials: Minutes as above.

Pages 8F-01 to 8F-05

8G. **Accept Quality Improvement Health Equity Committee meeting minutes of June 27, 2024.**
- Reference materials: Minutes as above.

Pages 8G-01 to 8G-12

8H. **Accept Whole Child Model Clinical Advisory Committee meeting minutes of June 20, 2024.**
- Reference materials: Minutes as above.

Pages 8H-01 to 8H-04

8I. **Accept Whole Child Model Family Advisory Committee meeting minutes of March 11, 2024.**
- Reference materials: Minutes as above.

Pages 8I-01 to 8I-04

Reports: (9A. – 9B.)

9A. **Accept Member Appeals and Grievance Report – Q2 2024.**
- Reference materials: Report as above.

Page 9A-01

9B. **Accept Quality Improvement Health Equity Transformation Workplan – Q2 2024.**
- Reference materials: Staff report and recommendation on above topic; Q2 2024 QIPH Workplan.

Pages 9B-01 to 9B-27

Regular Agenda Items: (10. – 12.): 3:20 p.m.

10. **Election of Officers of the Commission. (3:20 – 3:30 pm.)**

A. Board will nominate and elect Chairperson and Vice Chairperson.
- Reference materials: Staff report and recommendation on above topic.

Page 10-01

11. **Consider and take action on request for Letter of Support for Program of All-Inclusive Care for the Elderly (PACE). (3:30 – 4:00pm)**
- Ms. Danita Carlson, Government Relations Director, will discuss, and the Board will review and consider taking action on a request for a letter of support from GoldenPACE Health to develop PACE to serve Santa Cruz, Monterey, and San Benito counties.
- Ms. Alicia Rodriguez, MBA, FACHE, Chief Executive Officer, GoldenPACE, will present to the Board a request for a letter of support for GoldenPACE Health to develop PACE to serve Santa Cruz, Monterey, and San Benito counties.
- Reference materials: Staff report on above topic; Staff report on above topic from May 22, 2024 Board meeting; Updated GoldenPACE Health Response to Criteria for Assessment of PACE Letter of Support received October 16, 2024,

Golden PACE Demographic Market Analysis received October 16, 2024; Attachment C. Community Support; Appendix 1A received on October 22, 2024

Pages 11-01 to 11-47

12. **Consider approving Medi-Cal Capacity Grant Program 2025 Annual Investment Plan. (4:00 – 5:00pm.)**

A. Ms. Jessica Finney, Community Grants Director will review and the Board will discuss 2024 MCGP Investment Plan.

- Reference materials: Staff report on above topic; and MCGP Current Funding Opportunities

Pages 12-01 to 12-08

Information Items: (13A. – 13B.)

A. Alliance Fact Sheet – Q4 2024 — Page 13A-01 to 13A-02

B. Membership Enrollment Report — Page 13B-01

Announcements:

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

- Finance Committee
  TBD
- Member Services Advisory Group
  Thursday, November 7, 2024; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, December 5, 2024; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Thursday, December 19, 2024; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  TBD

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

The next regular meeting of the Commission, after this November 6, 2024 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
  Wednesday, December 4, 2024; 3:00 – 5:00 p.m.

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

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

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

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

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

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

Members of the public interested in attending should call the Alliance at (831) 430-1429 to verify meeting date and location prior to the meeting.

The complete agenda packet is available for review on the Alliance website at https://thealliance.health/about-the-alliance/public-meetings/. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-1429. 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: November 6, 2024

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Chief Executive Officer (CEO) Report

Alliance Board Retreat. Thank you to Alliance Board Members for your in-person attendance with Senior Leadership and our outside speakers at the Alliance Board Retreat in Aptos on September 25, 2024. In the morning, I gave an overview of our Alliance six priority initiatives, financial reserves, and housing investments; Linnea Koopmans, CEO of the Local Health Plans of California (LHPC) gave an Environmental Scan of the Medi-Cal program, including to describe where things are headed for managed care plans; and Dr. Palav Babaria, DHCS Chief Quality Officer and Deputy Director of Quality and Population Health Management, described the state's goals for quality, health equity, and population health. In the afternoon, there was a session on workforce and provider supply with Dr. Margo Vener, the Director of Undergraduate Medical Education for the BS to MD program at UC Merced, and Dr. Walt Mills, the Director for the Dominican Hospital Family Medicine Residency program. Closing out the day, was a session on Proposition 35 with Dustin Corcoran, CEO of the California Medical Association, and our own Dr. Donaldo Hernandez, Immediate Past President of CMA and current Alliance Board member.

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

- Merced Health Fair. The Alliance hosted a Health Fair on Sunday October 6, 2025, in the parking lot of our Merced office, and it was a resounding success. The Fair was widely promoted ahead of time with a radio campaign of 300 ads in English and Spanish, social media ads, delivered flyers to schools, and website postings by our community partners. The result was a strong turnout of an estimated 1,000 attendees, including a line that wrapped around our building before the gates opened at 9:00am. The main stage featured a variety of entertainment, including a local radio station, Hmong dancers, Folklorico dancers, and raffle giveaways. Golden Valley Health Centers immunized more than 300 community members against the flu. Nearly 30 volunteers from the UCSF Fresno School of Medicine and UC Merced BS to MD program, administered COVID vaccines and childhood immunizations. The Alliance, with provisions from the Merced County Food Bank, assembled and distributed hundreds of food bags. Dignity Health participated with its new mobile van and street medicine unit. Our Health Fair was very much a community event, featuring booths staffed by Castle Family Health Centers, Community Health Centers of America, Merced County Rescue Mission, Merced Lao Family Community, CalPride Valley Central, Sierra Vista Children & Family Services, Merced County Health Services Agency, Boys & Girls Club, Valley Onward, Merced Police Department, Kids Discovery Station, All Dads Matter, ACE Overcomers, DHHS Deaf & Hard of Hearing, the California Highway Patrol, and Bryant Orthopedic. Thank you to the approximately 35 Alliance volunteers who helped organize and host the Health Fair.

- Community Outreach. In October, our Community Engagement team participated in over 20 outreach events across our five-county region, including the Mariposa Certified

Farmer's Market, Planada Annual Health Fair, the 14th Annual Salinas Valley Pride Celebration, Dia Del Trabajador Agricola honoring agricultural workers, and the Hollister Certified Farmer's Market. The purpose of these outreach events was to connect with members and the community, while promoting our Alliance texting campaign and vaccine reminders. Staff also gave community presentations at the Merced County Public Information Officer Roundtable, Merced County Homeless Court, Housing First Forum, and the Frank Paul Family Resource Center in Salinas. The purpose of these presentations was to develop and strengthen relationships, as well as to educate our communities on Alliance benefits and resources.

- Community Involvement. In the month of October, I participated in Alliance Health Fair in Merced; took part in a ribbon cutting for the Merced County Community Action Agency's new Enhance Care Management building; met with Dr. Timothy Johnston, who delivers approximately a third of the babies in Merced; attended the Board meeting of the Local Health Plans of California in Palm Desert; attended the Board meeting of the California Association of Health Plans in Palm Desert; held an in-person orientation for a resident from the Dominican Family Medicine Residency Program; participated in an Board Executive Committee meeting of the Health Improvement Partnership (HIP) of Santa Cruz County; joined the HIP Council meeting; and joined our Community Engagement Team at our booth at the Hollister Certified Farmer's Market.

Alliance Six Priority Initiatives.
Our environment has changed, staff are immersed in implementing CalAIM, and the organizational workload is heavy with state mandated initiatives, competing priorities, DHCS deadlines, and a focus on getting the work done over the next two years, including the priority initiatives described below.

- Medicare Dual Special Needs Plan (D-SNP)**.** Staff are preparing to launch a D-SNP product by January 1, 2026. This product will allow the Alliance to serve as the single plan for members eligible for both Medi-Cal and Medicare, streamlining their healthcare experience. The Alliance submitted our Notice of Intent to Apply (NOIA) for the Medicare D-SNP product to the Centers for Medicare and Medicaid Services (CMS) in October 2024.

  The Alliance team has been working towards a key milestone, which is the initial submission of our provider network to CMS in November 2024. A key accomplishment to date includes the execution of D-SNP amendments with nearly 65 percent of our current Medi-Cal provider network, as shown in the table below. As a supplement, we are pursuing non-binding Letters of Intent (LOIs) with key providers that need more time before signing D-SNP amendments. In addition to the existing Medi-Cal network, an additional fifty providers have been identified as needed for recruitment, and staff have begun to engage with them.

D-SNP Amendment	PCPs	Specialists	Hospitals
Sent to Providers	57	338	8

Fully Executed	38	218	4
Declined Amendment	3	4	0

Another milestone will be the submission of a Medicare D-SNP application and contracted provider network to CMS in February 2025.

- National Center for Quality Assurance (NCQA) Accreditation. The NCQA standards represent a commitment to quality, excellence, and health equity. Our efforts continue to obtain two separate accreditations from NCQA. We needed to complete work by October 2024, since the NCQA survey of the Alliance will take place on April 1, 2025, for which the lookback period is six months. Prior to October 2024, staff modified our policies and procedures to align Alliance operations with NCQA standards. Now, staff are implementing those modified policies and procedures in advance of our NCQA survey. For accreditation, a minimum of 80% of the NCQA standards must be achieved and all must-pass elements must be met.

- JIVA Care Management System. The Alliance went live on the new Jiva Care Management System in July and completed the remaining integration work through the end of October. The Jiva Care Management System is necessary for meeting operational requirements related to our future Medicare D-SNP program and NCQA accreditations. The system is used for prior authorizations, case management, and appeals and grievances.

- Behavioral Health Insourcing. In June 2025, the Alliance formally notified Carelon that we will not renew the contract when it expires on June 30, 2025. Effective July 1, 2025 the Alliance will internally manage the behavioral health benefit, including non-specialty mental health (i.e., mild to moderate mental health) and behavioral health therapy. Bringing Behavioral Health inhouse will give us direct control and better opportunity to improve access for members, support providers, and collaborate with counties and schools. The Alliance team has been working diligently to build relationships with behavioral health providers across our five counties, including reaching out to over 450 providers to begin the contracting process. One identified challenge is that many behavioral health providers are not enrolled with Medi-Cal, a DHCS requirement for our Alliance network, and staff have been supporting them with the enrollment process. Other work efforts include redesigning internal workflows and developing future workflows to ensure that the Alliance complies with regulatory requirements related to behavioral health. Staff also completed the initial regulatory filings to DHCS and DMHC.

- Enhanced Care Management and Community Supports. The purpose of this initiative is to connect our most vulnerable members to needed clinical and non-clinical support in the community. Our objectives have been multifactorial: to increase ECM enrollment, to ensure that our capitated ECM providers are delivering services and submitting complete and timely encounter data to the Alliance, and to show DHCS that the rate it pays to the Alliance is supported by the encounter data.

To increase ECM enrollment, the Alliance team has actively conducted outreach and education to enroll new ECM providers and generate referrals of members to ECM providers. The result has been that our ECM enrollment has increased from 2,600 to 7,600 members in a recent six-month period,

To ensure that our capitated ECM providers are delivering services to their assigned members and submitting complete and timely encounter data, the Alliance team has been actively conducting focused outreach. Staff have been educating ECM providers about the need to submit complete encounter data, as required per their Alliance contracts, and the various ways they can do so, as well as helping them overcome operational and technical challenges. The result of these focused efforts is that we've experienced a 160 percent increase in monthly ECM encounter submissions in August and September.

The Alliance team has also been sharing the encounter data with DHCS. We must demonstrate to DHCS that our ECM utilization, as reflected by the encounter data, supports the capitation rate that it pays the Alliance. Without sufficient encounter data, DHCS said it will lower the ECM capitation rate that it pays to the Alliance, from which the Alliance derives the capitation rate for our downstream ECM providers.

- Quality and Health Equity in Merced and Mariposa Counties. We want to close the geographic health disparity across our 5-county service area that disproportionally impacts children in Merced and Mariposa Counties. We are working with primary-care clinics to get more children in for preventative services like immunizations, lead screenings, and well child/adolescent visits. In addition, for eight weeks, we ran a paid media campaign targeting Merced families with messaging encouraging them to stay up to date on vaccines for their families. The campaign included print, mobile, radio and geofencing ads in English and Spanish. The geofencing ads allowed us to target members where they are, such as grocery stores, convenience stores, and dollar stores. Further, we created flyers and distributed them to parents at 72 schools in our service areas. As a result of these efforts, we are "moving the needle," and exceeding our 2024 goal to achieve a 5% improvement for each of the eight relevant HEDIS measures for which we were sanctioned by DHCS in 2023 for Measurement Year (MY) 2022. Nonetheless, more improvement is needed to achieve our ultimate goal to reach the 50th percentile or better for each measure, which is necessary to avoid annual sanctions from DHCS, as described in a below paragraph (DHCS Quality Sanction)

Notable Efforts. In addition to our Six Priority Initiatives, the Alliance has been pursuing other notable efforts to better serve our members and partner with providers.

- Doula Services as a Medi-Cal Benefit. DHCS added Doula services as a covered benefit on January 1, 2023. Services include personal support to individuals and families throughout pregnancy and one year postpartum. This includes emotional and physical support provided during pregnancy, labor, birth, and the postpartum period, as well as

support for and after miscarriage and abortion. Staff continue efforts to build our Doula provider network. As of October 2024, the Alliance is proud to share that there are 15 Doulas in the provider network supporting members in all our service areas. The recruitment effort prioritized Doulas who provide in-person support and advocacy for our members.

- Digital Member ID. We soft-launched digital ID for members in September. Members who call the Alliance Call Center to request a replacement ID will be offered the option of receiving a secure link to download a digital version of their ID if they have a cell phone. To date, we have provided 479 digital cards in English, 175 in Spanish and 1 request in Hmong. We are working on a few issues and will be promoting the digital ID card broadly later this year.

- Texting. We launched our internal texting program in September with a welcome text to new members. In late October, we sent text messages to members who have children, reminding them of the importance of well-care visits. The Alliance has developed a texting schedule for the rest of 2024 and has started a draft schedule for 2025. DHCS approved a batch of our text scripts for transportation, behavioral health, vaccines, health screenings, and selecting a doctor.

Regulatory Audits and Compliance. The Alliance has structured processes to ensure that we operate in an ethical and compliant manner, so that we protect our members' rights.

- Regulatory Affairs. In the third quarter of 2024, the Alliance executed the DHCS's Medi-Cal Contract Amendment (#23-30241), extending the agreement through December 31, 2025. All Plan Letters (APLs) are communications issued by DHCS and DMHC to Medi-Cal managed care plans to provide important information, guidance, and instructions on implementing changes in policy or procedure. In Q3, the Alliance received six APLs from DHCS and five from DMHC. Overall, we continue to significantly improve our success rate of timely implementations of APLs through increased interdepartmental collaboration – the timely implementation rate for Q3 was 94.5 percent.

- Regulatory Audits. Like all Medi-Cal Managed Care Plans, the Alliance is in a constant state of preparing for routine audits, experiencing them, or following up. Under follow up:
    - The Health Services Advisory Group (HSAG) on behalf of DHCS formally closed our 2024 Network Adequacy Validation (NAV) Audit, confirming that the Alliance resolved all identified issues.
    - DHCS issued a final audit report from its 2023 DHCS Focused Audit of Behavioral Health and Transportation, and the Alliance team is remediating the identified deficiencies.
    - DHCS notified the Alliance that our 2024 DHCS Medical Audit CAP was closed, reflecting that we sufficiently remediated identified deficiencies
    - We are awaiting DMHC's preliminary report from its 2024 Medical Survey of the Alliance that took place in March 2024.

  Under preparation, DMHC will conduct its routine triennial financial exam of the Alliance in January 2025.

- DHCS Quality Sanction. On October 25, 2024, DHCS issued the Alliance a Notice of Intent to Impose Monetary Sanctions for Failure to Meet or Exceed Minimum Performance Levels for Medi-Cal Managed Care Accountability Set Performance Measures. This 2024 sanction is based on our quality scores for Measurement Year (MY) 2023 in Merced County for six measures, including five in the children's domain and one in the Reproductive Health and Cancer Prevention domain.

  As described in an above paragraph (*Quality and Health Equity in Merced and Mariposa Counties*), DHCS will continue to sanction the Alliance on an annual basis for our quality performance in Merced County until we get the scores for all MCAS measures to meet or exceed the required minimum performance levels, or the 50th percentiles.

  The good news is that based on staff's work with clinics in Merced, the trend has been positive. Last year (reporting year 2023 for measurement year 2022) we were sanctioned for 8 measures, and this year (RY 2024 for MY 2023) we're being sanctioned for only six. This year's sanction amount is $25,000, the same as from last year.

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

- November 5th General Election. On November 5th voters will cast their votes for many consequential items including at the federal, state and local levels with election results having the potential to shape the future of health care. There will be a change in federal administration which may have long reaching impacts on health care funding and delivery at both the national and local levels. State ballot propositions such as Proposition 35 may impact funding for the Medi-Cal program and local initiatives such as Measure Z in the city of Santa Cruz have implications on public health. Staff will be prepared to adapt to any changes resulting from the election results and will develop plans to chart the course forward for the Alliance.

- 2024 Legislative Session. The 2023-24 Legislative Session adjourned at midnight on August 31, 2024, with the deadline for the Governor to sign or veto bills passed in the session on September 30th. Staff monitored one-hundred fourteen (114) bills this year in the Board's areas of legislative focus. Of those bills, twenty-nine (29) were enacted into law. Seventeen (17) of these bills have been identified as having implementation or operational impacts. The Alliance is currently reviewing these bills to develop implementation plans and will provide updates to the Board on issues rising to the level of needing board attention.

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

- All Staff and Town Hall meetings. The next Town Hall will be on November 12, 2024 via Zoom. We have quarterly All Staff meetings, two in-person and two via Zoom. The next All Staff meeting will be in-person at the Cocoanut Grove on the Santa Cruz Beach Boardwalk on December 12, 2024.

- Staffing Numbers. As of October 7, 2024, the Alliance has 638.7 budgeted positions, of which 584 are filled. Moreover, the Alliance has 38 temporary employees supporting our workforce needs. In total, the organization is 92.4 % staffed. Talent Acquisition is currently managing 73 regular and temporary recruitments.

- Biannual Performance Reviews. Supervisors delivered Check-ins to staff in August. The Alliance provides leadership and staff two formal opportunities a year to meet and discuss current performance, goal status, career development and other performance related topics.

- Open Enrollment. Annual benefits selection will commence in November. Health benefits are highly important to Alliance staff, and we work to ensure the plan offers options that suit diverse needs, while also working to keep them affordable. The goal is to provide a robust benefits package while managing the benefits budget for the organization. Open Enrollment will be held November 13 – November 27.

DHCS Incentive Programs. The Alliance team has worked to maximize state funding for our communities by taking full advantage of DHCS incentive programs for the benefit of our providers, Local Education Agencies (LEAs), and community organizations.

- CalAIM Incentive Payment Program (IPP) The CalAIM Incentive Payment Program supports the implementation and expansion of Enhanced Care Management (ECM), Community Supports by providing incentives to Medi-Cal Managed Care Plans (MCPs). The incentive program has been voluntary. MCPs have only been eligible to receive incentive payments by fulfilling all the requirements of the program. There were five required submissions between January 31, 2022, and September 1, 2024. The Alliance team has leveraged this program for significant community investment, having successfully executed 60 Letters of Agreement (LOAs) with providers and community organizations since program inception. Our Alliance focus for 2024 has been for ECM and Community Support providers to increase their capacity (see above paragraph titled "*Enhanced Care Management and Community Supports*"). Staff are currently awaiting information from DHCS for our last two Submissions 4 and 5, for the measurement periods July 1 - December 31, 2023, and January 1 - June 30, 2024, with the potential to earn $10.8M and $9.9M, respectively.

- Children and Youth Behavioral Health Initiative / Statewide Multi-Payer School-Linked Fee Schedule. DHCS is creating an opportunity to increase funding for school-based behavioral health services in public schools including K-12, colleges, and universities. As part of CYBHI, DHCS aims to expand access to school-linked behavioral health services by implementing a new and sustainable source of funding

DHCS established a statewide, multi-payor, school-linked fee schedule. This fee schedule defines the scope of services inclusive of outpatient mental health and substance use disorder services, identify billing codes and rates, and specify the provider types eligible to bill for the services. The intent of this fee schedule is to allow LEAs and their employed, contracted, or affiliated providers to obtain reimbursement from Medi-Cal Managed Care Plans (MCPs), Medi-Cal Fee For Service (FFS), commercial plans, and disability insurers.

DHCS selected Carelon as the third-party administrator for the fee schedule. Carelon will serve as a statewide clearinghouse for claims management and payment remittance, through which LEAs can submit claims to payors and receive reimbursement.

This program started with the first cohort on January 1, 2024 and the second cohort on July 1, 2024. The third cohort will begin in January 2025. In our 5 counties, Cohort 1 includes Pajaro Valley Unified, Cohort 2 includes the Santa cruz County Office of Education, and Cohort 3 includes 2 LEAs in Merced County, 27 in Monterey County, and 9 in Santa Cruz County.

- Equity and Practice Transformation (EPT):
  The DHCS EPT Program is for primary care practices to advance health equity and reduce disparities. The program incentivizes participating primary care practices to implement practice transformation and prepare for value-based contracting.

  The State Budget for Fiscal Year 2024/25 substantially reduced finding for the EPT program, restricted it to only Cohort 1 (there will not be any future cohorts), and scaled back the requirements for primary care practices in Cohort 1. As such, DHCS shortened the program duration from five to three years, cut down the total number of milestones from over 100 to 25, and reduced the amount earned per milestone. The Alliance is exploring ways to supplement practices to provide an opportunity to earn an amount close to their initial allocation.

  The Alliance is actively supporting 15 of our primary care practices in the EPT program. The Alliance will be hiring 3 practice coaches and a supervisor to support practices with deliverable/milestone completion. The supervisor position is currently posted.

  The initial EPT deliverable for participating primary care practices was the completion of an assessment (the PhmCAT), which was due on May 1, 2024. All 15 practices successfully achieved this milestone, thereby qualifying to receive their first payment by October 2024. However, due to a delay in the payment from DHCS to March 2025, the Alliance will advance the payment to providers.

  The next milestone submission deadline is November 1, 2024, during which practices may submit deliverables for various milestones. However, practices have until 2025 to fulfill these requirements; there are no mandatory deliverables for the November submission.

Alliance Housing Fund. To better support our housing partners, the Alliance took steps to simplify understanding and process by combining certain funding from our Housing and Homeless Incentive Program (HHIP) and Medi-Cal Capacity Grant Program (MCGP) into the Alliance Housing Fund.

- Purpose of Alliance Housing Fund. In May 2024, staff formally launched the Alliance Housing Fund, with the renewed purpose to provide capital funds to build, purchase, renovate and/or furnish permanent housing units, recuperative care facilities and short-term post-hospitalization housing units. The Alliance Housing Fund will help expand temporary and permanent housing opportunities for Medi-Cal members across the Alliance service area.

- June 2024 Funding Round, The Alliance awarded more than $30 million for 17 housing projects across the Alliance service area. Additional funds remain available in Monterey County, and a second round of funding is currently open through November 30, 2024. Round two Housing Fund awards will be announced by December 31, 2024.

- Cumulative Awards to Date. Since 2015, through a combination of MCGP and later HHIP funding, the Alliance has awarded these totals:
    - $34M for permanent supportive housing projects, totaling 824 units.
    - $5M for recuperative care projects, totaling 97 beds.
    - $3M for short-term post hospitalization housing projects, totaling 113 beds.
    - $3M for shelter projects, totaling 75 beds.

The Medi-Cal Capacity Grant Program (MCGP). The Alliance makes investments to health care and community organizations 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, as well as to address social drivers that influence health and wellness.

- Today's Board Packet. This Board packet contains a report on stakeholder inputs and emerging priorities for funding strategies in the MCGP 2025 Annual Investment Plan. This topic will be a Board discussion item in advance of the final plan recommendation to the Board in January 2025.

- Trends in the Number of Awards and Total Spend. Both MCGP grant awards and annual spending have increased in 2024. The October 23, 2024, round resulted in $19.2M in grant awards, some of which will get paid out in future years, such as for capital projects. Year to date 2024, MCGP has paid out $19M compared to $13M for all of 2023. In addition, there is one more round of Workforce Recruitment grant applications in 2024, for which there are currently 49 applications under review for the December 13, 2024, awards. Details of all awards in 2024 will be included in the end of year report in the January 2025 Board packet.

DATE: November 6, 2024

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, 2024

For the month ending August 31, 2024, the Alliance reported an Operating Loss of $31.0M. The Year-to-Date (YTD) Operating Income is $49.7M, with a Medical Loss Ratio (MLR) of 91.1% and an Administrative Loss Ratio (ALR) of 5.1%. The Net Income is $80.8M after accounting for Non-Operating Income/Expenses.

The budget expected a $39.6M Operating Income for YTD August. The actual result is favorable to budget by $10.1M or 25.6%, driven primarily by rate variance and membership favorability.

	Aug-24 MTD ($ In 000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*447,805*	*398,633*	*49,172*	*12.3%*
Revenue	$137,805	$135,548	$2,257	1.7%
Medical Expenses	159,769	124,050	(35,719)	-28.8%
Administrative Expenses	9,021	8,740	(281)	-3.2%
Operating Income	(30,986)	2,758	(33,743)	-100.0%
Net Income	($22,966)	$3,994	($26,960)	-100.0%
MLR %	115.9%	91.5%	-24.4%	
ALR %	6.5%	6.4%	-0.1%	
Operating Income %	-22.5%	2.0%	-24.5%	
Net Income %	-16.7%	2.9%	-19.6%	

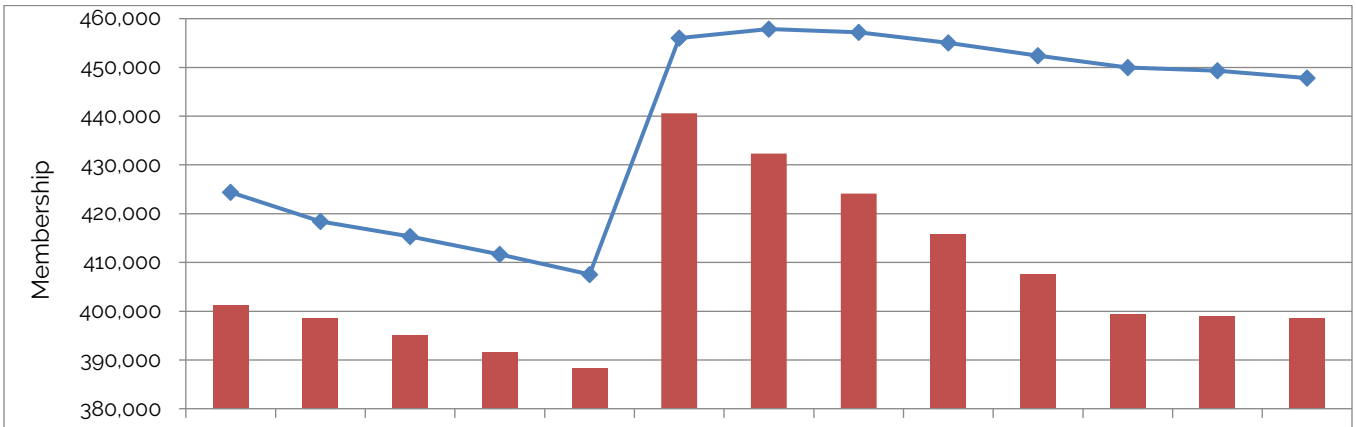
Aug-24 (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*3,625,576*	*3,317,663*	*307,913*	*9.3%*
Revenue	$1,304,796	$1,122,689	$182,108	16.2%
Medical Expenses	1,188,225	1,013,380	(174,845)	-17.3%
Administrative Expenses	66,901	69,750	2,849	4.1%
Operating Income/(Loss)	49,670	39,559	10,111	25.6%
Net Income/(Loss)	$80,753	$50,821	$29,932	58.9%
PMPM				
Revenue	$359.89	$338.40	$21.49	6.4%
Medical Expenses	327.73	305.45	(22.28)	-7.3%
Administrative Expenses	18.45	21.02	2.57	12.2%
Operating Income/(Loss)	$13.70	$11.92	$1.78	14.9%
MLR %	91.1%	90.3%	-0.8%	
ALR %	5.1%	6.2%	1.1%	
Operating Income %	3.8%	3.5%	0.3%	
Net Income %	6.2%	4.5%	1.7%	

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

At a PMPM level, YTD revenue is $359.89, which is favorable to budget by $21.49 or 6.4%. Medical cost PMPM is $327.73, which is unfavorable by $22.28 or 7.3%. Overall, this results in an unfavorable gross margin of $0.80 or 2.4% compared to the budget. The operating income PMPM is $13.70, which is favorable to the budget by $1.78 or 14.9%.

Membership: August 2024 membership is favorable to budget by 12.3%. The 2024 budget assumed a 17% decrease over the course of redetermination (July 2023 to June 2024) based on Mercer projections. Mercer later updated their projections to be less impactful than originally estimated and now only assumes an 11% decrease. The actual decrease during the unwinding period from July 2023 to June 2024, is approximately 7.6%, excluding the new counties / new Unsatisfactory Immigration Status (UIS) members. Redetermination losses continued in August and total loss between July 2023 and August 2024 is 8.5%.

Membership. Actual vs. Budget (based on actual enrollment trend for Aug-24 rolling 13 months)



	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Budget	401,191	398,530	395,036	391,611	388,255	440,590	432,354	424,119	415,884	407,648	399,413	399,023	398,633
Actual	424,399	418,442	415,304	411,670	407,542	456,002	457,871	457,197	455,001	452,430	449,959	449,311	447,805
Variance	23,208	19,912	20,268	20,059	19,287	15,412	25,517	33,078	39,117	44,782	50,546	50,288	49,172
Variance %	5.8%	5.0%	5.1%	5.1%	5.0%	3.5%	5.9%	7.8%	9.4%	11.0%	12.7%	12.6%	12.3%

Revenue: The 2024 revenue budget was based on the Department of Health Care Services (DHCS) 2024 draft rate package (dated 10/13/2023), which reflected a 0.4% rate increase, not including the Targeted Rate Increase (TRI). Furthermore, the budget assumed breakeven performances for the San Benito Region. The CY 2024 Prospective rates from DHCS (dated 12/5/2023, including Maternity) represented a 2.1% increase over CY 2023 Rates excluding TRI. Overall, actual revenue is favorable due to higher enrollment, a favorable category of aid (COA) mix, and an increase in prospective rates.

As of August MTD, actuals are favorable to budget by $2.3M or 1.7%. This positive variance is driven by favorable enrollment contributing $17.9M offsetting rate variances of $15.7M. The rate variance is mainly attributed to an $18.0M reduction due to UIS Adult and Adult Expansion Risk Corridor. To align with the risk corridor threshold, August is the first entry to reflect UIS payable based on January through April actual with 3 months of claims runout at 75% and going forward this will be reconciled monthly for the remainder year.

As of August 2024 YTD, operating revenue stands at $1,304.8M, surpassing the budget by $182.1M or 16.2%. This favorable variance includes $107.2M from increased enrollment and $74.9M from positive rate variances, state incentives, and prior year revenue. The rate variance of $74.9M comprises $30.1M from favorable prospective rates, $24.4M from State Incentive Programs, and $20.4M from prior year revenue due to MCO tax liability relief for CY 2021 and CY 2022.

The State Incentive Programs consist of $22.1M for HHIP, $1.4M for SBHIP, and $0.8M for EPT and are offset by the State Incentive Programs expense. These incentives are assumed to be budget neutral.

Beginning January 2024, the new general ledger structure is reported by region and immigration status. Central California (CEC) includes the counties of Santa Cruz, Monterey,

Merced, and Mariposa, and San Benito (SBN) includes San Benito. Immigration status is reported as UIS (Unsatisfactory Immigration Status) or SIS (Satisfactory Immigration Status).

Aug-24 YTD Capitation Revenue Summary (In $000s)

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	951,580	843,935	107,645	70,642	37,003
CEC UIS	248,554	235,392	13,161	29,705	(16,544)
SBN SIS	47,957	33,562	14,396	5,191	9,205
SBN UIS	8,394	7,047	1,347	1,125	222
Total*	**1,256,485**	**1,119,936**	**136,549**	**106,663**	**29,887**

*Excludes Aug-24 In-Home Supportive Services (IHSS) premiums revenue of $3.5M, State Incentive Programs revenue of $24.4M, and Prior Year Revenue of $20.4M.

Medical Expenses: The 2024 budget assumed a 3.7% increase in utilization over the base data that spanned from 2018 through June 2023 and 2.9% unit cost increase that included case mix and changes in fee schedules. 2024 incentives include a $15M Care-Based Incentive (CBI), $4M Data Sharing Incentives, $18M for the Hospital Quality Incentive Program (HQIP), and $10M for the Specialist Care Incentive (SCI).

August 2024 Medical Expenses of $159.8M are $35.7M or 28.8% unfavorable to budget. August 2024 YTD Medical Expenses of $1,188.2M are above budget by $174.8M or 17.3%. Of this amount, $93.8M is due to higher enrollment and $81.1M due to rate variances which include $24.4M for State Incentive Programs. YTD, we are seeing increases in spending on Inpatient Services, Physician Services, LTC, Outpatient Facility, and Other Medical.

The State Incentive Programs consist of $22.1M for HHIP, $1.4M for SBHIP, and $0.8M for EPT. These are also included under revenue and assumed to be budget-neutral.

Aug-24 YTD Medical Expense Summary ($ In 000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services - Hospital	371,221	370,865	(355)	(34,282)	33,927
Inpatient Services - LTC	138,648	87,029	(51,618)	(8,031)	(43,587)
Physician Services	273,589	215,598	(57,991)	(19,970)	(38,021)
Outpatient Facility	165,879	125,831	(40,048)	(11,636)	(28,412)
Other Medical*	214,497	214,056	(441)	(19,834)	19,393
State Incentive Programs	24,392	-	(24,392)	-	(24,392)
TOTAL COST	**1,188,225**	**1,013,380**	**(174,845)**	**(93,753)**	**(81,092)**

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

At a PMPM level, YTD Medical Expenses are $327.73, unfavorable by $22.28 or 7.3% compared to the budget.

Inpatient Services: Inpatient Services continues to be favorable to budget due to lower utilization than budgeted. Inpatient was budgeted to have a utilization of 344 days per 1,000 members but actual utilization is closer to 307 days per 1,000 members. Unit costs are comparable between budget and actuals which results in a 8.4% PMPM variance between budget and actual. This is expected to continue for the rest of the year.

Inpatient Services – LTC: LTC's unfavourability is primarily driven by unit cost. The budget underestimated the baseline cost and did not consider the continuation of the 10% COVID add-on for certain codes or the 3% annual fee schedule increase. The budget was based on a -96% free-standing SNF service mix for both regions; however, San Benito actual utilization is 95% hospital-based SNF, resulting in higher costs. As San Benito is a new country the risk corridor will assist in managing the higher cost hospital affiliated service mix. The unfavorable variance is expected to continue.

Outpatient Facility: Outpatient Facility consists of both Outpatient and Emergency Room. ER continues to significantly trend upwards for both utilization per 1k and unit cost and are unfavorable to budget for both utilization and unit cost by 9% and 12% respectively, partially offset by favorable other Outpatient to budget both in utilization and unit cost.

Physician Services: Utilization has risen by 14% to the previous year, across SIS and UIS populations, driven by increased utilization at Federally Qualified Health Center (FQHC) clinics, Primary Care Physicians (PCP) and as well as overall growth at ACA expansion and Whole child model enrollments, which utilize Specialty Clinics. The budget underestimated FFS unit cost in PCP and FQHC and we expect this unfavorable variance to continue. Further, the ECM provider capitation expense shows unfavorable to budget, as the budget was allocated to Other Medical. Move over, ECM enrollments have doubled since the beginning of the year as of Aug YTD and continues to grow at a rate of 11% month-over-month. As ECM is a newer program the risk corridor will assist in mitigating the increased expenses due to growth.

Other Medical: Other Medical costs are unfavorable to budget by $0.4M. This small variance is primarily due to Non-Claims Health Care Costs being significantly lower than budgeted by $6.0M and the ECM actuals only including FFS expense, while capitation is accounted for under Physician Services, resulting in ECM being favorable to budget by $9.2M. However, this is offset by unfavorable variances in Allied Health, Behavioral Health, and Durable Medical Equipment. Allied Health experienced a $5.4M unfavorable variance due to increased utilization of Physical Therapists and Chiropractors, and Behavioral Health saw a $6.2M unfavorable variance due to higher unit costs for Behavioral Analysts and Behavioral Neurology. In addition, DME and Supplies is unfavorable by $1.1M due to a significant increase in Unit Cost for Neonatal equipment. In summary, despite the unfavorable variances in Allied Health, Behavioral Health, and Durable Medical Equipment, the lower Non-Claim Health Care Costs and favorable ECM variance lead to an overall $0.4M unfavorable variance.

Aug-24 YTD Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	102.39	111.79	9.40	8.4%
Inpatient Services - LTC	38.24	26.23	(12.01)	-45.8%
Physician Services	75.46	64.98	(10.48)	-16.1%
Outpatient Facility	45.75	37.93	(7.82)	-20.6%
Other Medical	59.16	64.52	5.36	8.3%
State Incentive Programs	6.73	-	(6.73)	-100.0%
TOTAL MEDICAL COST	**327.73**	**305.45**	**(22.28)**	**-7.3%**

Administrative Expenses: August YTD Administrative Expenses are favorable to budget by $2.8M or 4.1% with a 5.1% ALR. Salaries are favorable by $2.0M, driven by savings from vacant positions, employment taxes, benefits, and PTO. Non-Salary Administrative Expenses are favorable by $0.8M or 3.7% due to savings and unspent budgets.

Non-Operating Revenue/Expenses: August YTD Net Non-Operating income is $31.1M, which is favorable to the budget. Total Non-Operating Revenue is favorable to budget by $19.3M, attributed to $13.6M in interest income and $5.8M unrealized investment gain offsetting lower other revenues of $0.1M. Non-Operating Expenses are favorable by $0.5M due to lower grant expenses.

Summary of Results: Overall, the Alliance generated a YTD Net Income of $80.8M, with an MLR of 91.1% and an ALR of 5.1%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Eighth Month Ending August 31, 2024
(In $000s)

Assets	
Cash	$200,657
Restricted Cash	300
Short Term Investments	1,033,049
Receivables	195,014
Prepaid Expenses	5,932
Other Current Assets	4,058
Total Current Assets	**$1,439,009**
Building, Land, Furniture & Equipment	
Capital Assets	$82,651
Accumulated Depreciation	(46,353)
CIP	162
Lease Receivable	3,084
Subscription Asset net Accum Depr	10,510
Total Non-Current Assets	**50,054**
Total Assets	**$1,489,063**
Liabilities	
Accounts Payable	$119,325
IBNR/Claims Payable	375,217
Provider Incentives Payable	30,636
Other Current Liabilities	8,026
Due to State	28,713
Total Current Liabilities	**$561,917**
Subscription Liabilities	8,687
Deferred Inflow of Resources	2,933
Total Long-Term Liabilities	**$11,620**
Fund Balance	
Fund Balance - Prior	$834,772
Retained Earnings - CY	80,753
Total Fund Balance	**915,525**
Total Liabilities & Fund Balance	**$1,489,063**
Additional Information	
Total Fund Balance	**$915,525**
Board Designated Reserves Target	453,461
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	155,247
Value Based Payments	46,100
Provider Supplemental Payments	152,410
Total Reserves	**863,918**
Total Operating Reserve	**$51,607**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Eighth Month Ending August 31, 2024
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*447,805*	*398,633*	*49,172*	*12.3%*	*3,625,576*	*3,317,663*	*307,913*	*9.3%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$137,308	$135,204	$2,105	1.6%	$1,256,485	$1,119,936	$136,549	12.2%
State Incentive Programs	-	-	-	0.0%	24,392	-	$24,392	100.0%
Prior Year Revenue*	-	-	-	0.0%	20,378	-	$20,378	100.0%
Premiums Commercial	496	344	152	44.2%	3,541	2,753	789	28.6%
Total Operating Revenue	**$137,805**	**$135,548**	**$2,257**	**1.7%**	**$1,304,796**	**$1,122,689**	**$182,108**	**16.2%**
Medical Expenses								
Inpatient Services (Hospital)	$44,438	$45,302	$864	1.9%	$371,221	$370,865	($355)	-0.1%
Inpatient Services (LTC)	19,962	10,630	(9,331)	-87.8%	138,648	87,029	(51,618)	-59.3%
Physician Services	37,543	26,337	(11,206)	-42.6%	273,589	215,598	(57,991)	-26.9%
Outpatient Facility	26,393	15,371	(11,022)	-71.7%	165,879	125,831	(40,048)	-31.8%
Other Medical**	31,433	26,410	(5,023)	-19.0%	214,497	214,056	(441)	-0.2%
State Incentive Programs	-	-	-	0.0%	24,392	-	(24,392)	-100.0%
Total Medical Expenses	**$159,769**	**$124,050**	**($35,719)**	**-28.8%**	**$1,188,225**	**$1,013,380**	**($174,845)**	**-17.3%**
Gross Margin	**($21,964)**	**$11,498**	**($33,462)**	**-100.0%**	**$116,571**	**$109,309**	**$7,262**	**6.6%**
Administrative Expenses								
Salaries	$5,949	$6,064	$116	1.9%	$45,895	$47,932	$2,038	4.3%
Professional Fees	426	323	(102)	-31.7%	2,442	2,429	(14)	-0.6%
Purchased Services	1,069	948	(121)	-12.8%	8,214	8,108	(106)	-1.3%
Supplies & Other	1,206	936	(270)	-28.8%	7,340	7,827	487	6.2%
Occupancy	96	134	38	28.2%	887	999	113	11.3%
Depreciation/Amortization	276	336	59	17.7%	2,124	2,455	331	13.5%
Total Administrative Expenses	**$9,021**	**$8,740**	**($281)**	**-3.2%**	**$66,901**	**$69,750**	**$2,849**	**4.1%**
Operating Income	**($30,986)**	**$2,758**	**($33,743)**	**-100.0%**	**$49,670**	**$39,559**	**$10,111**	**25.6%**
Non-Op Income/(Expense)								
Interest	$4,297	$2,188	$2,109	96.4%	$33,917	$20,279	$13,637	67.2%
Gain/(Loss) on Investments	5,157	350	4,807	100.0%	7,307	1,400	5,907	100.0%
Bank & Investment Fees	(31)	(36)	5	14.8%	(421)	(290)	(130)	-44.8%
Other Revenues	198	198	(0)	-0.1%	1,474	1,576	(102)	-6.5%
Grants	(1,601)	(1,463)	(138)	-9.4%	(11,195)	(11,703)	508	4.3%
Total Non-Op Income/(Expense)	**8,020**	**1,236**	**6,783**	**100.0%**	**$31,083**	**$11,262**	**$19,821**	**100.0%**
Net Income/(Loss)	**($22,966)**	**$3,994**	**($26,960)**	**-100.0%**	**$80,753**	**$50,821**	**$29,932**	**58.9%**
MLR	*115.9%*	*91.5%*			*91.1%*	*90.3%*		
ALR	*6.5%*	*6.4%*			*5.1%*	*6.2%*		
Operating Income	*-22.5%*	*2.0%*			*3.8%*	*3.5%*		
Net Income %	*-16.7%*	*2.9%*			*6.2%*	*4.5%*		

*Prior Year Revenue consist of revenue booked in the current calendar year for services rendered in prior years.

**Other Medical includes Pharmacy and IHSS.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Eighth Month Ending August 31, 2024
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*447,805*	*398,633*	*49,172*	*12.3%*	*3,625,576*	*3,317,663*	*307,913*	*9.3%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$306.63	$339.17	($32.54)	-9.6%	$346.56	$337.57	$8.99	2.7%
State Incentive Programs	-	-	-	0.0%	6.73	-	6.73	100.0%
Prior Year Revenue*	-	-	-	0.0%	5.62	-	5.62	100.0%
Premiums Commercial	1.11	0.86	0.24	28.4%	0.98	0.83	0.15	17.7%
Total Operating Revenue	**$307.73**	**$340.03**	**($32.30)**	**-9.5%**	**$359.89**	**$338.40**	**$21.49**	**6.4%**
Medical Expenses								
Inpatient Services (Hospital)	$99.24	$113.64	$14.41	12.7%	$102.39	$111.79	$9.40	8.4%
Inpatient Services (LTC)	44.58	26.67	(17.91)	-67.2%	38.24	26.23	(12.01)	-45.8%
Physician Services	83.84	66.07	(17.77)	-26.9%	75.46	64.98	(10.48)	-16.1%
Outpatient Facility	58.94	38.56	(20.38)	-52.9%	45.75	37.93	(7.82)	-20.6%
Other Medical**	70.19	66.25	(3.94)	-5.9%	59.16	64.52	5.36	8.3%
State Incentive Programs	-	-	-	0.0%	6.73	-	(6.73)	-100.0%
Total Medical Expenses	**$356.78**	**$311.19**	**($45.59)**	**-14.7%**	**$327.73**	**$305.45**	**($22.28)**	**-7.3%**
Gross Margin	**($49.05)**	**$28.84**	**($77.89)**	**-100.0%**	**$32.15**	**$32.95**	**($0.80)**	**-2.4%**
Administrative Expenses								
Salaries	$13.28	$15.21	$1.93	12.7%	$12.66	$14.45	$1.79	12.4%
Professional Fees	0.95	0.81	(0.14)	-17.2%	0.67	0.73	0.06	8.0%
Purchased Services	2.39	2.38	(0.01)	-0.4%	2.27	2.44	0.18	7.3%
Supplies & Other	2.69	2.35	(0.34)	-14.7%	2.02	2.36	0.33	14.2%
Occupancy	0.21	0.34	0.12	36.0%	0.24	0.30	0.06	18.8%
Depreciation/Amortization	0.62	0.84	0.23	26.7%	0.59	0.74	0.15	20.8%
Total Administrative Expenses	**$20.15**	**$21.93**	**$1.78**	**8.1%**	**$18.45**	**$21.02**	**$2.57**	**12.2%**
Operating Income	**($69.19)**	**$6.92**	**($76.11)**	**-100.0%**	**$13.70**	**$11.92**	**$1.78**	**14.9%**

*Prior Year Revenue consist of revenue booked in the current calendar year for services rendered in prior years.

**Other Medical includes Pharmacy and IHSS.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Eighth Month Ending August 31, 2024
(In $000s)

	MTD	YTD
Net Income	($22,966)	$80,753
Items not requiring the use of cash: Depreciation	297	2,144
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	3,053	296,574
Prepaid Expenses	(1,008)	(3,704)
Current Assets	758	1,548
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**2,803**	**294,418**
Changes to Payables:		
Accounts Payable	44,335	(286,550)
Other Current Liabilities	(2,061)	(1,166)
Incurred But Not Reported Claims/Claims Payable	(11,750)	86,844
Provider Incentives Payable	3,817	(9,364)
Due to State	18,012	18,012
Subscription Liabilities	0	0
Net Changes to Payables	**52,352**	**(192,224)**
Net Cash Provided by (Used in) Operating Activities	**32,486**	**185,092**
Change in Investments	(33,156)	(187,217)
Other Equipment Acquisitions	441	(2,302)
Net Cash Provided by (Used in) Investing Activities	**(32,715)**	**(189,519)**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**(229)**	**(4,427)**
Cash & Cash Equivalents at Beginning of Period	**200,885**	**205,083**
Cash & Cash Equivalents at August 31, 2024	**$200,657**	**$200,657**

DATE: November 6, 2024

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Services Advisory Group: Member Appointment

Recommendation. Staff recommend the Board approve the appointment renewal of the individuals listed below to the Member Services Advisory Group (MSAG).

Background. The Board established MSAG authorized in the Bylaws of the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission.

Discussion. The following individuals have indicated interest in participating on MSAG.

Name	Affiliation	County
Doris Drost	Member	Monterey
Guadalupe Barajas-Iniguez	Member Representative	Merced
John Beleutz	Community Partner	Santa Cruz
Moncerat Politron	Community Partner	Monterey
Rebekah Capron	Community Partner	Merced
Michael Molesky	Commissioner	Santa Cruz

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

Attachments. N/A

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

Meeting Minutes

Wednesday, September 25, 2024
9:30 a.m. – 3:30 p.m.

Seascape Golf Club
Monarch Room
610 Clubhouse Drive
Aptos, CA 95003

Commissioners Present:

Ms. Leslie Abasta-Cummings,	At Large Health Care Provider Representative
Ms. Anita Aguirre,	At Large Health Care Provider Representative
Dr. Ralph Armstrong,	At Large Health Care Provider Representative
Supervisor Wendy Root Askew,	County Board of Supervisors
Ms. Tracey Belton,	County Health and Human Services Agency Director
Ms. Dorothy Bizzini,	Public Representative
Ms. Janna Espinoza,	Public Representative
Supervisor Zach Friend,	County Board of Supervisors
Dr. Donaldo Hernandez,	Health Care Provider Representative
Ms. Elsa Jimenez,	County Director of Health Services
Mr. Michael Molesky,	Public Representative
Ms. Mónica Morales,	County Health Services Agency Director
Dr. Allen Radner,	At Large Health Care Provider Representative

Commissioners Absent:

Dr. Maximiliano Cuevas,	Health Care Provider Representative
Dr. Kristina Keheley,	Interim Health and Human Services Agency Director
Supervisor Josh Pedrozo,	County Board of Supervisors
Dr. James Rabago,	Health Care Provider Representative

Staff Present:

Mr. Michael Schrader,	Chief Executive Officer
Ms. Lisa Ba,	Chief Financial Officer
Mr. Scott Fortner,	Chief Administrative Officer
Dr. Omar Guzman,	Chief Health Equity 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. Danita Carlson,	Government Relations Director
Mr. Marwan Kanafani,	Health Services Officer
Ms. Kay Lor,	Payment Strategy Director
Mr. Dave McDonough,	Legal Services Director
Ms. Andrea Swan,	Quality Improvement and Population Health Director
Ms. Kristen Rolf.	Quality and Population Health Manager
Ms. Kristynn Sullivan.	Program Development Director
Ms. Ronita Margain,	Community Engagement Director
Ms. Jessica Finney,	Community Grants Director
Mr. Noah Ross,	Administrative Specialist
Ms. Dulcie San Paolo,	Administrative Specialist

1. Call to Order by Chair Jimenez.

Commission Chairperson Jimenez called the meeting to order at 9:30 a.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

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.

4. Comments and announcements by Chief Executive Officer.

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

Mr. Michael Schrader, Chief Executive Officer (CEO), welcomed the Commissioners to the retreat. He provided a rundown of the agenda and introduced guest speakers. He provided a reminder of Proposition 35, which is an upcoming Managed Care Organization (MCO) tax measure.

[Commissioner Belton arrived at this time: 9:34 a.m.]

Consent Agenda Items: (5. – 6.): 9:39 a.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 voting on this item.

Chair Jimenez opened the floor for approval of Consent Agenda items 5 through 6.

MOTION: Commissioner Friend moved to approve Consent Agenda items 5 through 6, seconded by Commissioner Molesky.

ACTION: The motion did not pass with the following vote:

Ayes: Commissioners Belton, Bizzini, Espinoza, Friend, Molesky

Noes: None.

Absent: Commissioners Abasta-Cummings, Askew, Cuevas, Keheley, Pedrozo, Rabago.

Abstain: Commissioners Aguirre, Armstrong, Hernandez, Jimenez, Morales, Radner

Chair Jimenez directed staff to conduct a second vote later in the meeting on this topic due to there being insufficient non-conflicted commissioners in attendance at the present time and eligible to vote.

[Commissioner Abasta-Cummings arrived at this time: 9:40 a.m.]

Consent Agenda Items: (7. – 8.): 9:43 a.m.

Chair Jimenez opened the floor for approval of Consent Agenda items 7 through 8.

MOTION: Commissioner Friend moved to approve Consent Agenda items 7 through 8, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Aguirre, Armstrong, Belton, Bizzini, Espinoza, Friend, Hernandez, Jimenez, Molesky, Morales, Radner

Noes: None.

Absent: Commissioners Askew, Cuevas, Keheley, Pedrozo, Rabago.

Abstain: None

Regular Agenda Items: (9. – 13.): 9:45 a.m.

9. Board Discussion: Overview of Alliance Priorities and Initiatives. (9:45 a.m. – 10:31 a.m.)

Mr. Schrader provided an overview of the Alliance's six priority initiatives in detail including Enhanced Care Management (ECM) Enrollment, D-SNP by 2026, NCQA Accreditation by 2026, Quality and Health Equity in Merced and Mariposa, Jiva Management System, and Behavioral Health Insourcing by 2025.

[Commissioner Askew arrived at this time: 9:59 a.m.]

Mr. Schrader discussed Alliance reserve funds and how they are being used to help members. He then spoke on the Alliance's housing investments across its five counties.

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

10. Board Discussion: Local Plans in the Evolving Medi-Cal Environment. (10:31 a.m. – 11:36 a.m.)

Local Health Plans of California (LHPC) Chief Executive Officer (CEO), Ms. Linnea Koopmans, provided a presentation on local plans in the evolving Medi-Cal Environment.

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

11. Board Discussion: Quality and Health Equity. (11:36 a.m. – 12:08 p.m.)

Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality and Population Health Management, California Department of Health Care Services, provided a presentation on quality and health equity at the state level.

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

Consent Agenda Items: (5. – 6.): 12:08 p.m.

Chair Jimenez opened the floor for reconsideration of approval of Consent Agenda items 5 through 6.

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 voting on this item.

MOTION: Commissioner Friend moved to reconsider the approval of Consent Agenda items 5 through 6, seconded by Commissioner Molesky.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Espinoza, Friend, Molesky

Noes: None.

Absent: Commissioners Cuevas, Keheley, Pedrozo, Rabago.

Abstain: Commissioners Abasta-Cummings Aguirre, Armstrong, Belton, Hernandez, Jimenez, Morales, Radner

[Commissioner Friend departed at this time: 12:35 p.m.]

[Commissioner Morales departed at this time: 12:40 p.m.]

12a. Board Discussion: Workforce and Provider Supply. (12:48 p.m. – 1:45 p.m.)

Dr. Margo Vener, Director of Undergraduate Medical Education at U.C. Merced, provided a presentation on workforce and provider supply in the Central Valley.

[Commissioner Radner departed at this time: 2:04 p.m.]

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

12b. Board Discussion: Workforce and Provider Supply. (1:45 p.m. – 2:16 p.m.)

Dr. Walt Mills, Family Medicine Residency Program Director at Dominican Hospital, reviewed the residency program and the benefits to workforce issues on the Central Coast.

12. Board Action: Proposition 35 – Managed Care Organization (MCO) Tax Initiative. (2:16 p.m. – 3:01 p.m.)

Chair Jimenez welcomed Mr. Dustin Corcoran, Chief Executive Officer of the California Medical Association CMA), and Dr. Donaldo Hernandez, Alliance Board Member/Immediate Past President of CMA. She advised that Dr. Donaldo Hernandez will present on this topic as a member of the public rather than as a Commissioner of the Board. Board members who perceived that they were at risk for conflict of interest were advised to abstain from voting on this item.

[Commissioner Bizzini departed at this time: 2:50 p.m.]

Chair Jimenez opened the floor for approval of the Board's position of support for Proposition 35.

MOTION:	Commissioner Askew moved to approve seconded by Commissioner Abasta-Cummings
ACTION:	The motion did not pass with the following vote:
Ayes:	Commissioners Abasta-Cummings, Askew, Aguirre, Armstrong, Belton, Espinoza, Jimenez, Molesky
Noes:	None.
Absent:	Commissioners Bizzini, Cuevas, Friend, Keheley, Morales, Pedrozo, Rabago, Radner
Abstain:	Commissioner Hernandez

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The Commission adjourned its regular meeting of September 25, 2024 at 3:05 p.m. to the regular meeting of November 6, 2024 at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa, unless otherwise noted.

Respectfully submitted,
Ms. Dulcie San Paolo, Administrative Specialist

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, July17, 2024
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Andrea Swan	Quality Improvement and Population Health Director
Anne Lee	Financial Planning and Analysis Director
Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Dennis Hseih	Deputy Chief Medical Officer
Dianna Myers	Medical Director
Elizabeth Leary	Care Management Director
Jenifer Mandella	Chief Compliance Officer (Chair)
Jessica Finney	Grants Director
Jimmy Ho	Accounting Director
Kate Knutson	Compliance Manager
Kay Lor	Payment Strategy Director
Krishan Patel	Data Analytics Services Director
Kristynn Sullivan	Program Development Director
Lilia Chagolla	Community Engagement Director
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Marwan Kanafani	Health Services Officer
Michael Schrader	Chief Executive Officer
Michael Wang	Medical Director
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Omar Guzman	Chief Health Equity Officer
Ronita Margain	Community Engagement Director, Merced County
Ryan Markley	Compliance Director
Scott Crawford	Medicare Program Executive Director
Shaina Zurlin	Behavioral Health Director
Shelly Papadopoulos	Operations Management Director
Tammy Hoeffel	Enhanced Health Services Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Fabian Licerio	Risk Adjustment Director

Committee Members Excused:

Adam Sharma	Operational Excellence Director
Arti Sinha	Application Services Director
Dave McDonough	Legal Services Director
Jessie Dybdahl	Provider Services Director
Maya Heinert	Medical Director
Ryan Inlow	Facilities & Administrative Services Director
Scott Fortner	Chief Administrative Officer
Tammy Brass	Utilization Management Director

Ad-Hoc Attendees:

Aaron McMurray	Information Security Analyst
Anita Guevin	Medicare Compliance Program Manager
Daisy Gomez	Compliance Specialist (Temp)
Ka Vang	Compliance Specialist
Margarita Shull	Program Integrity Specialist
Megan Sims	Health Services Operations Manager
Paige Harris	Regulatory Affairs Specialist
Rachel Siwajek	Program Integrity Specialist
Rebecca Seligman	Compliance Supervisor
Sara Halward	Compliance Specialist
Stephanie Vue	Regulatory Affairs Specialist

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

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

2. **Review and Approval of May 15, 2024 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of May 15, 2024 meeting.

3. **Consent Agenda.**
   1. **Policy Hub Approvals** – May and June
   2. **Quarterly Policy Monitoring**
   3. **Regulatory and All Plan Letter Updates** – May and June
   4. **NCQA Project Status Update**

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. Program Integrity Quarterly Report

Siwajek, Program Integrity Specialist III, presented the Q1 2024 Program Integrity Activity Report. Siwajek reported that 76 concerns were referred to Program Integrity in the quarter, 43 of which resulted in the opening of a MUI. There were 78 active MUIs in the quarter.

Siwajek reviewed referral trends for the period noting the following:

- 18 provider specific
- 4 member related
- 11 state Requests
- 1 waste referral
- 1 employee referral
- 8 categorized as other

Siwajek reported performance of the Program Integrity metrics from the Q1 2024 Alliance Dashboard noting that efficiency metrics failed to meet target performance and quality metrics met target performance.

Siwajek reviewed 1 exemplar case, highlighting investigative measures taken and next steps for completion of MUI investigation. This included investigation of an MUI related to a provider upcoding in their billing procedures.

Siwajek reviewed Q124 Program Integrity Financials reporting the total requested recoupment was $39,892 and completed recoupment was $95.20.

COMMITTEE ACTION: Committee reviewed and approved the Q1 2024 Program Integrity Report.

2. Delegate Oversight Process Changes for NCQA

Knutson, Compliance Manager, advised the Committee of planned revisions to the Delegate Oversight process as required to meet NCQA (National Committee for Quality Assurance) requirements. Process revisions will begin Q3 2024 and continue through Q2 2025.

Knutson highlighted the following planned areas of revision:

- Migration from C360 to SmartSheet
- Assessment criteria and documentation procedures
- Other opportunities for process improvement per NCQA requirements
- Oversight Attestation

3. CAPs Review and Discussion

Seligman, Compliance Supervisor, reported updates to new and previously reported Corrective Action Plans (CAPs) as follows:

DHCS 2024 Medical Survey CAP – Seligman updated the Committee on the status of this CAP as follows:

- Compliance staff coordinated with impacted departments and an initial response was submitted timely documenting the Plan's root cause analysis and actions taken or pending for mitigation of each deficiency.
- DHCS accepted 4 of the 5 actions and requested additional information on one. Additional information was provided to DHCS with the first monthly update, which was submitted 07/11/2024.
- Next update is due on 08/14/2024.

PCP to FTE Ratio CAP – Seligman reported that programming updates were identified. A quality check was conducted. The June 274 file was submitted timely and staff are confident that the June filing will remediate DHCS's concerns.

Enhanced Care Management (ECM) Justice Involved (JI) Population of Focus (pre-corrective: related to provider network capacity) – Seligman reported that DHCS has determined the Plan has made sufficient progress in priority areas and the Pre-CAP is officially closed with no formal CAP warranted. Seligman noted the DHCS requires continuous improvement in this area.

4. Record Retention

Knutson, Compliance Manager, reviewed the Plan's purpose for a Record Retention program and advised the Committee of changes to the retention process. These process changes are being implemented to aid in simplifying the process and improve efficiency, accuracy and accountability. The timeline for 2024 Record Retention is as follows:

- Kick-Off 08/01/2024
- Completion 12/15/2024

Compliance staff is available for consultation and support to all departments.

The meeting adjourned at 9:57 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, August 21, 2024
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
Anne Lee	Financial Planning and Analysis Director
Arti Sinha	Application Services Director
Bob Trinh	Technology Services Director
Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Dennis Hseih	Deputy Chief Medical Officer
Dianna Myers	Medical Director
Elizabeth Leary	Care Management Director
Fabian Licerio	Risk Adjustment Director
Jenifer Mandella	Chief Compliance Officer (Chair)
Jimmy Ho	Accounting Director
Kate Knutson	Compliance Manager
Kay Lor	Payment Strategy Director
Krishan Patel	Data Analytics Services Director
Kristynn Sullivan	Program Development Director
Lilia Chagolla	Community Engagement Director
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Marwan Kanafani	Health Services Officer
Michael Schrader	Chief Executive Officer
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Omar Guzman	Chief Health Equity Officer
Ronita Margain	Community Engagement Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Ryan Markley	Compliance Director
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Shelly Papadopoulos	Operations Management Director
Tammy Brass	Utilization Management Director
Tammy Hoeffel	Enhanced Health Services Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Jessica Finney	Community Grants Director
Michael Wang	Medical Director

Committee Members Excused:

Bryan Smith	Claims Director
Dave McDonough	Legal Services Director
Kate Knutson	Compliance Manager

Ad-Hoc Attendees:

Aaron McMurray	Information Security Analyst
Anita Guevin	Medicare Compliance Program Manager
Daisy Gomez	Compliance Specialist (Temp)
Ka Vang	Compliance Specialist
Margarita Shull	Program Integrity Specialist
Paige Harris	Regulatory Affairs Specialist
Rachel Siwajek	Program Integrity Specialist
Rebecca Seligman	Compliance Supervisor
Sara Halward	Compliance Specialist
Stephanie Vue	Regulatory Affairs Specialist
Vanessa Paz	Health Equity Program Manager

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

   Chairperson Ryan Markley called the meeting to order at 9:04 a.m.

2. **Review and Approval of July 17, 2024 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of July 17, 2024 meeting.

3. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Regulatory and All Plan Letter Updates**
   3. **Approve Revisions to Compliance Plan and Code of Conduct**

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. **Regular Agenda**

   1. **HIPAA Privacy and Security Quarterly Report**

   Mandella, Chief Compliance Officer, and McMurray, Information Security Analyst, presented the Q2 2024 HIPAA Privacy & Security Report. Mandella advised the Committee of an increase in security incidents impacting providers and vendors and updated information on the Change Healthcare cybersecurity incident.

Mandella reviewed HIPAA reporting trends for the quarter noting that of the 31 referrals received, 9 were determined to be incidents requiring report to the state, 5 were determined to be non-events, 16 were determined to be non-reportable, and 0 were determined to be breaches. 1 incident is still pending determination by DHCS. The highest ranking incident root causes for HIPAA disclosures in the quarter was incorrect selection/entry.

Mandella reviewed HIPAA program metrics included on the Alliance Dashboard reporting that the quality metric met the targeted performance threshold for the quarter while the efficiency metric did not. Mandella reminded the Committee to inform staff not to take time to investigate possible HIPAA incidents prior to reporting.

McMurray, Information Security Analyst, provided an update on the assessment of cybersecurity measures related to phishing attacks for Q224, noting steady trends in opened and failed phishing attempts and a decrease in reported attempts.

McMurray reported an update to the security remediation program highlighting vendor selection and Q3 implementation plans.

COMMITTEE ACTION: Committee reviewed and approved the Q2 2024 HIPAA Privacy & Security Quarterly Report.

2. Internal Audit & Monitoring Quarterly Report

Halward, Compliance Specialist III, presented the Q1 2024 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 3 internal audits were conducted, all of which received a passing score.

Halward reported Q1 2024 Targeted Audits Dashboard metrics related to internal audits noting that quality metrics met the targeted performance threshold for the quarter.

Halward reviewed one exemplar internal audit, the purpose of which is to ensure that correspondence generated for members who have chosen an alternative format is converted into the appropriate format and the correspondence is sent in a timely fashion.

Halward reviewed outcomes of the monitoring of 31 Alliance Dashboard metrics related to regulatory requirements, noting that all 31 metrics met their established thresholds during the review period of Q3 2023 – Q4 2023.

Halward reviewed the Q1 2024 Internal Audit Workplan identifying focus areas for medium and low risk levels and planned activities for corrective action plans.

Halward reported outcomes or updates of a number of 2023 and 2024 external audits and advised the Committee that DMHC plans to perform a Routine Financial Examination beginning January 6, 2025, which could potentially run concurrently with the annual DHCS Medical Audit.

Finally, Halward reviewed Corrective Action Plan (CAP) activities for Q1 2024 reporting closure of the CAP for Member Service Call Center Wait Times, and updated the

Committee on activities related to the internal CAPs for Provider Payment Accuracy and Provider Preventable Conditions.

COMMITTEE ACTION: Committee reviewed and approved the Q1 2024 Internal A&M Quarterly Report.

3. Delegate Oversight Quarterly Activity Report

Reddell, Compliance Specialist II, presented the Delegate Oversight Quarterly Activity Report, highlighting approved and pending reviews and additional oversight activities for Q1 2024, as well as annual review activities for 2024.

2024 Delegate Oversight Annual Review
Staff recommended approval of the following reports received from delegated health plans:

- AristaMD: Compliance
- Carelon: BC&DRP, Case Management, Claims Processing, Credentialing & Recredentialing, Cultural & Linguistics, HIPAA, Member Grievance, Provider Disputes, Quality Improvement and UM Behavioral Health
- CareNet: BC&DRP, Cultural & Linguistics, HIPAA and Member Grievance
- LPCH: Credentialing & Recredentialing
- MedImpact: BC&DRP, Claims Processing, Compliance, Cultural & Linguistics, Finance, HIPAA, Member Connections, Network Management, Program Integrity and Utilization Management
- PAMF: Compliance and Credentialing & Recredentialing
- SCVMC: Compliance
- Stanford Medical Group: Compliance
- VSP: BC&DRP, Claims, Credentialing & Recredentialing, HIPAA, Member Connections and Member Grievance

Staff recommended holding approval of the following reports receipt of documentation from delegates, review of received documents, and/or staff follow-up with delegates as described below:

- AristaMD: Credentialing & Recredentialing
- ChildNet: Credentialing & Recredentialing
- Dignity: Credentialing and Compliance
- MedImpact: Credentialing & Recredentialing
- SCVMC: Credentialing
- Stanford Medical Group: Credentialing
- UCSF: Compliance and Credentialing
- VSP: Cultural & Linguistics, Credentialing & Recredentialing, Finance, Network Management, Provider Disputes, Quality Improvement

COMMITTEE ACTION: Committee reviewed and approved the 2024 Annual Review of Health Plans and assigned the following action items:

- Staff to review requested documentation from AristaMD, ChildNet, Dignity, MedImpact, SCVMC, Stanford, UCSF and VSP and complete annual reviews.

Q3 2023 Quarterly Review
Staff recommended approval of the following reports received from delegated health providers:

- Carelon: Member Grievance, Network Management and Provider Services Credentialing & Recredentialing
- Dignity: Credentialing

COMMITTEE ACTION: Committee reviewed and approved the Q3 2023 Quarterly Review of delegated health plans and vendors.

Q4 2023 Quarterly Review
Staff recommended approval of the following reports received from delegated health providers:

- Carelon: Claims Processing, Credentialing & Recredentialing and Member Grievance
- ChildNet: Credentialing & Recredentialing
- Dignity: Credentialing
- LPCH: Credentialing
- MedImpact: Claims processing, Credentialing & Recredentialing, Member Connections and Member Grievance
- PAMF: Credentialing
- SCVMC: Credentialing
- Stanford Medical Group: Credentialing
- UCSF: Credentialing
- VSP: Claims and Credentialing

Staff recommended holding approval of the following reports receipt of documentation from delegates, review of received documents, and/or staff follow-up with delegates as described below:

- VSP: Member Grievances

COMMITTEE ACTION: Committee reviewed and approved the Q4 2023 Quarterly Review of delegated health plans and vendors and assigned the following action items:.

- Staff to review requested documentation from VSP and complete quarterly review

Q1 2024 Quarterly Review
Staff recommended approval of the following reports received from delegated health providers:

- Carelon: Claims Processing, Member Connections, Member Grievance, Network Management, Provider Disputes, Quality Improvement and Utilization Management
- ChildNet: Credentialing & Recredentialing
- LPCH: Credentialing & Recredentialing
- MedImpact: Claims Processing, Member Connections, Member Grievance, Network Management and Provider Disputes
- PAMF: Credentialing
- UCSF: Credentialing
- VSP: Claims, Credentialing, Member Connections and Quality Improvement

Staff recommended holding approval of the following reports received from delegated Providers:

- Arista MD: Credentialing & Recredentialing
- Carelon: Case Management and Credentialing & Recredentialing
- Dignity: Credentialing
- LPCH: Credentialing & Recredentialing
- SCVMC: Credentialing
- VSP: Member Grievances and Provider Disputes

COMMITTEE ACTION: Committee reviewed and approved the Q1 2024 Quarterly Review of delegated health plans and vendors and assigned the following action items:

- Staff to review requested documentation from Arista MD, Carelon, ChildNet, LPCH, MedImpact, PAMF, SCVMC, Stanford, UCSF and VSP and complete quarterly reviews.

Additional Oversight Activities

Vang and Seligman, Compliance Supervisor, provided an update on resolution of open CAPs on delegates, including:

- Carelon Credentialing – 2 of 3 deficiencies have been closed and additional documentation received from Carelon is under review
- Carelon Network Management CAP – 1 of 3 deficiencies have been closed and additional documentation received from Carelon is under review
- Call the Car – Required process changes were implemented. Deficiency is considered resolved
- MedImpact 2022 DMHC Audit Findings: MedImpact adjusted their letter content with Alliance staff conducting ongoing monitoring. Deficiency is considered resolved.

Finally, Reddell reviewed Carelon's performance against their contractual Performance Guarantees for Q1 2024, indicating that all performance guarantees were met during the quarter.

COMMITTEE ACTION: Committee reviewed and approved the Additional Oversight Activities of the Q1 2024 Quarterly Report.

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The meeting adjourned at 9:52 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

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

Meeting Minutes

Wednesday, June 26, 2024

Members Present:

Ms. Anita Aguirre	At Large Health Care Provider Representative
Ralph Armstrong, DO	At Large Health Care Provider Representative
Ms. Elsa Jiménez,	County Health Director
Supervisor Josh Pedrozo	County Board of Supervisors
Allen Radner, MD	At Large Health Care Provider Representative

Members Absent:

Mr. Michael Molesky	Public Representative

Staff Present:

Ms. Lisa Ba	Chief Financial Officer
Mr. Michael Schrader	Chief Executive Officer
Mr. Jimmy Ho	Accounting Director
Ms. Kay Lor	Provider Payment Strategy Director
Mr. Fabian Licerio	Risk Adjustment Director
Ms. Shannon Cotton	Finance Coordinator

1. Call to Order. (1:35 - 1:36 p.m.)

Commissioner Pedrozo called the meeting to order at 1:35 p.m. Roll call was taken. A quorum was present.

2. Oral Communications. (1:36 – 1:37 p.m.)

Commissioner Pedrozo 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 September 27, 2023 meeting of the Finance Committee. (1:37 – 1:38 p.m.)

FINANCE COMMITTEE ACTION: Commissioner Pedrozo opened the floor for approval of the minutes of the September 27, 2023 meeting.

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

ACTION: The motion passed with the following vote:

Ayes: Commissioners Armstrong, Jiménez, Pedrozo, Radner

Noes: None

Absent: Commissioners Aguirre, Molesky

Abstain: None

Regular Agenda Items:

4. April YTD Financial Results. (1:38 - 1:41 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), updated the commissioners on the Alliance's most recent financial performance for the four months ending on April 30, 2024. Year-to-Date (YTD) Operating Income was $79.7M, with a Medical Loss Ratio (MLR) of 83.9% and an Administrative Loss Ratio (ALR) of 4.7%.

5. Provider Supplemental Payment. (1:41 - 2:03 p.m.)

Next, Ms. Ba introduced Ms. Kay Lor, Director of Provider Payment Strategy. Ms. Lor presented the proposed payment methodology for a provider supplemental payment. She explained that the goals of the provider supplemental payment are to improve realized network access and advance health equity through increased collaboration with providers. The methodology would be based on various data points to identify where there are specialty access challenges. The commissioners were asked to provide comments and feedback.

[Commissioner Aguirre arrived at this time: 1:51 p.m.]

The commissioners discussed the difficulties in accessing healthcare and the shortage of healthcare providers in all five counties. They were particularly interested in identifying the specific areas where there is a lack of specialty services in each county. Ms. Ba mentioned that suggested data points are included in the proposed methodology to help identify access challenges, including out-of-network utilization, complaints, provider satisfaction surveys, the ratio of specialty providers to members,

and the number of days between the authorization date to member being seen date. The commissioners agreed that the data points outlined in the proposed methodology were appropriate.

6. 2025 Provider Incentives (HQIP, SCI, RA). (2:03 – 2:27 p.m.)

Ms. Ba introduced the topic and explained that the purpose of the discussion is to gather feedback from the committee regarding the proposed 2025 provider incentives before presenting them for Board approval in August 2024. She introduced Ms. Kay Lor, Provider Payment Strategy Director, who will give an overview of the proposed 2025 Hospital Quality Incentive Program (HQIP) and the 2025 Specialist Care Incentive (SCI) Program. Additionally, Mr. Fabian Licerio, Risk Adjustment Director, will present a newly proposed Risk Adjustment Incentive program for 2025, which will be important to have in place as we prepare for Medicare Dual Eligible Special Needs Plan (D-SNP) implementation in 2026.

First, Ms. Lor presented an overview of the proposed 2025 HQIP. She explained that the program is a carryover from the 2024 program with some modifications. The program would consist of two measures: Inpatient Transitional Care Services (TCS) and Emergency Visit Follow-up. An additional data exchange incentive is also proposed as a new measure for the 2025 program. The program objectives are to achieve better health outcomes for members, improve coordination of care, allow hospitals to earn additional revenue through collaboration with physicians, lower the total cost of care, and advance value-based payment. Staff will propose budgeting $20M for the calendar year 2025, with quarterly payouts. All contracted hospitals with 50 or more emergency or inpatient admissions would qualify to participate in the program.

Commissioner Radner mentioned that arranging post-discharge follow-up within 14 days can be complex. He noted that while every effort is made to coordinate the necessary follow-up care within that timeframe, it's not always feasible for the follow-up to be with the primary care physician. Ms. Lor confirmed that hospitals are still eligible to receive credit for post-discharge follow-up if it occurs within 14 days, even if it doesn't happen with the primary care provider.

Next, Ms. Lor presented an overview of the proposed 2025 Specialist Care Incentive program for the commissioners' consideration and feedback. She stated that the program aims to encourage physician actions that align with outcomes, improve member care by incentivizing referrals and coordinating care, reduce emergency department utilization, and enhance provider revenue through continuous advancement of value-based payment. Ms. Lor reviewed the proposed eight measures, the payment methodology, and the estimated funding for each. The proposed funding is approximately $12M and will be based on the number of participating providers.

Lastly, Mr. Fabian Licerio shared the proposed Provider Risk Adjustment Incentive program. He gave an overview of the risk adjustment model and explained the key elements of the proposed incentive program. The program would have a simple design and aim to align with providers' regular workflows. The incentives would be tied to completing and submitting attestations, completing annual health assessment (AHA) exams, and participating in provider education sessions.

7. Investment Update. (2:27 – 2:38 p.m.)

Ms. Ba introduced Mr. Jimmy Ho, Accounting Director, who provided an economic and investment update.

Mr. Ho noted that the Federal Fund Rate is at 5.33% as of March 2024. He explained that the last federal rate hike occurred in July 2023 and that the Fed has paused the rate hikes because the inflation trend is moving towards the 2.0% Fed target after peaking at 9.1% in June 2022. He explained that as a public agency, Alliance staff are required to manage the investments in accordance with the Board approved Investment Policy. This policy conforms to the California Government Code section 53600 et seq. (the Code) and customary standards of prudent investment management. Staff have utilized the Pooled Money Investment Account (PMIA) accounts to manage the majority of the investments. These accounts are designed for public agencies and have low fees and investment objectives aligned with our policy, with safety being the primary priority.

Mr. Ho presented information about Environmental, Social, and Governance (ESG) investing, which is a strategy that selects companies with high scores in environmental and societal responsibility metrics. ESG investing aims for positive outcomes and aligns with social and environmental values. However, he explained that ESG bonds have limited investment options, lower returns, and are subject to high volatility due to market fluctuations. Although the Alliance's policy and investment strategy does not include ESG investment, it does have positive screening requirements that support the criteria of ESG investing.

Finally, Mr. Ho provided an overview of the Alliance's investment portfolio as of March 2024. He explained that due to rising interest rates, there was an unrealized loss of $3.2M, representing a 0.1% decrease. The plan is to hold the bonds to maturity, and any negative fluctuations will not be recognized. Additionally, the higher interest rates have allowed for cash reinvestment at a rate of return that exceeds the pre-pandemic level. As of March 2024, the Alliance has generated $11.4M in interest income, resulting in a 3.72% annual rate of return.

The Commission adjourned its meeting of June 26, 2024, at 2:38 p.m.

Respectfully submitted,

Ms. Shannon Cotton
Finance Coordinator

Meeting Minutes

Thursday, February 8, 2024
10 – 11:30 a.m.
In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
Community Services & Workforce Development (CSWD) Building
1161 San Felipe Road, Building B, Hollister, California
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Members Present:

Alma Mandujano-Orta	Community Advocate
Doris Drost	Consumer
Guadalupe Barajas-Iniguez	Consumer Advocate
Janna Espinoza	Consumer, Commissioner
John Beleutz	Community Advocate
Michael Molesky	Consumer, Commissioner
Moncerat Politron	Community Advocate
Rebekah Capron	Community Advocate

Members Absent:

Candi Walker	Consumer
Carolina Meraz	Consumer
Humberto Carrillo	Consumer
Juana Chávez de Guízar	Consumer
Margaret O'Shea	Consumer
Mimi Park	Consumer

Staff Present:

Clarisa Gutierrez	Community Engagement Coordinator
Desirre Herrera	Quality and Health Programs Manager
Jessie Newton, RN	Continuum of Health Manager - Adult
Julie Norton	Behavioral Health Program Manager
Kayla Zoliniak	Administrative Specialist
Linda Gorman	Communications Director
Maria Colomer	Community Engagement Coordinator
Ronita Margain	Community Engagement Director
Stacie Simmons	Community Engagement Program Manager
Veronica Olivarria	Member Services Supervisor

1. Call to Order by Chairperson Beleutz.

Chairperson Beleutz called the meeting to order at 10:05 a.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

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

No members of the public addressed the Advisory Group.

3. Comments and announcements by Member Services Advisory Group members.

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

Commissioner Molesky stated the Master Plan on Aging was provided to Alliance staff to distribute to the senior population.

4. Comments and announcements by Alliance staff.

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

Ronita Margain requested Advisory Group members submit annual W-9 form required to receive compensation for attending Advisory Group meetings.

Ronita Margain requested Advisory Group members submit Member Services Advisory Group application form to ensure contact information is up to date and Alliance members are represented. Application form is being utilized but does not impact current Advisory Group membership.

Consent Agenda Items (5 – 14):

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

Action: Consent Agenda approved.

Regular Agenda Items (15 – 16):

15. Annual Election of Officers of the Advisory Group

Chairperson Beleutz opened the floor for nominations for Chairperson and Vice Chairperson.

Commissioner Molesky nominated Chairperson Beleutz for Chairperson. Chairperson Beleutz accepted the nomination.

Chairperson Beleutz nominated Commissioner Molesky for Vice Chairperson. Commissioner Molesky accepted the nomination.

Action: Nominations approved and Chairperson Beleutz was elected to serve as Chairperson and Commissioner Molesky was elected to serve as Vice Chairperson.

16. Behavioral Health Benefits

J. Norton, Behavioral Health Program Manager, provided an overview of the Alliance's Behavioral Health benefits, how to access services, and solicited thoughts and feedback from MSAG.

The California Medi-Cal behavioral health system is a continuum of care and members may get non-duplicated care in both the Non Specialty Mental Health (NSMH) system (the Alliance) and the Specialty Mental Health and Substance Use Disorder Services (SMHS) system (the County). In the State of California, there is a standard screening tool, if a member contacts Carelon, the Alliance, or the County, the member is screened to see which system is the best fit and the Alliance tracks members get connected to care using a closed loop referral system.

Providers and Members can both call Carelon at (855) 765-9700. Most Behavioral Health services do not require a referral.

J. Norton presented the utilization data based on ethnicity. Hispanic groups trend lower in usage of behavioral health services, however, the membership of the Alliance is 68% Hispanic. While the Alliance is meeting the State's goals, J. Norton asked how the Alliance can improve overall BH utilization and increase utilization in historically underserved populations.

MSAG member shared Monterey County partnered with school districts to be able to provide access to behavioral health services within schools. For example, Salinas Union High School District has Wellness Centers for students. J. Norton shared about the Department of Health Care Services' Children and Youth Behavioral Health Initiative.
MSAG member shared the Suicide and Crisis Lifeline: 988 is on the back of all California student school ID cards.

MSAG member stated there are resources available through other sources outside local county services and Carelon.

MSAG member recommended meeting people where they are and the idea of encouraging people to start talking about mental health. For example, creating peer groups where someone who has been through Substance Abuse issues can be an example to others. Another example provided was going to prisons.

MSAG member inquired about the time between calling Carelon and an appointment. J. Norton responded saying from the time a member is connected to Carelon for BH services, to time members are offered a first appointment with a provider it should be within 10 business days. The member may be provided the names and phone numbers for providers for them to reach out to the providers, receive appointment assistance, or receive case management services. MSAG member shared their experience of calling provider numbers supplied by Beacon, now Carelon, and being turned away because of availability which can be discouraging for members. J. Norton stated providers are supposed to notify the Alliance if they are no longer serving Alliance members.

J. Norton stated the presentation data is from Department of Health Care Services (DHCS) webpage for the CalAIM Behavioral Health Initiative.

MSAG member expressed interest in how parents and guardians of children who are members can access information, especially for children with special health care needs, and recommended awareness and education for daycares to be able to connect the parents and guardians with resources and information.

Adjourn:
The meeting adjourned at 11:18 a.m.

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

Physicians Advisory Group

Meeting Minutes

Thursday, May 30, 2024
12:00 - 1:30 p.m.

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

Group Members Present:

Dr. Cristina Mercado	Provider Representative
Dr. Shirley Dickinson	Provider Representative
Dr. Cheryl Scott	Provider Representative
Dr. Salvador Sandoval	Provider Representative
Dr. Casey KirkHart	Provider Representative
Dr. Mai-Khanh Bui-Duy	Provider Representative
Dr. Caroline Kennedy	Provider Representative
Dr, Mimi Carter	Provider Representative
Dr. Donaldo Hernandez	Board Member

Group Members Absent:

Dr. Jennifer Hastings	Provider Representative
Dr. Scott Prysi	Provider Representative
Dr. James Rabago	Provider Representative
Dr. Devon Francis	Provider Representative
Dr. Amy McEntee	Provider Representative
Dr. Charles Harris	Provider Representative
Dr. Misty Navarro	Provider Representative
Dr. Ralph Armstrong	Board Member

Staff Present:

Dr. Dennis Hsieh	Chief Medical Officer
Dr. Omar Guzman	Chief Health Equity Officer
Dr. Mike Wang	Medical Director
Dr. Dianna Diallo	Medical Director
Ms. Elizabeth Leary	Care Management Director
Ms. Andrea Swan	Quality Improvement Director
Ms. Kristynn Sullivan	Program Development Director

Back to agenda

Ms. Rebecca McMullen	Behavioral Health Program Manager
Ms. Sarina King	Quality & Performance Improvement Mgr.
Ms. Jessie Dybdahl	Provider Services Director
Mr. Jim Lyons	Provider Relations Manager
Ms. Kristen Rohlf	Quality & Population Health Manager
Ms. Lisa Ba	Chief Financial Officer
Ms. Kay Lor	Director of Payment Strategy
Ms. Tracy Neves	Clerk of the Advisory Group

Public Representatives Present:

Mr. Mike Molesky	Board Member
Dr. Sandrine Pirard	Carelon

1. Call to Order by Dr. Dennis Hsieh.

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

2. Oral Communications.
   Chairperson Hsieh opened the floor for any members of the public to address the Group on items not listed on the agenda.

   No members of the public addressed the Group.

   Consent Agenda Items:
   A. The Group reviewed the March 7, 2024 Physicians Advisory Group (PAG) minutes.

      Action: Minutes approved.

3. **Regular Agenda Items:**
   A. Provider Supplemental Payment
      Lisa Ba reviewed the reserve allocation, framework, and methodology for provider supplemental payments. Staff will ask the Board for approval of the reserve allocation for provider payments. Financial performance for the past 4 years was reviewed with the Group. In 2023, the Alliance's operating income was 135 million with a revenue of 32 million from investment income for a net of 168 million income. The Alliance fund balance for 2023 was also reviewed. The Board sets aside a 3 month capitation emergency fund and strategic reserve. Funds are also set aside for DSNP, Medi-Cal Capacity Grants and Value Based Payments. Staff will ask the Board to allocate 152 million for supplemental provider payments. The framework is aligned with the Alliance's strategic goals of Health Equity and Person-Centered System Transformation. In April, the Board reviewed network access and this will be incorporated into the framework. In addition, the provider appointment availability survey was shared with the Board, and currently the Alliance is at 54% compliance for specialists for urgent appointments and routine appointments 68%, this will provide the basis for the recommendation. Goals will be achieved by member and community support, provider support and data. In June, the Board recommendation will be to approve the framework to make a one-time supplemental payment to the contracted reimbursement rates to improve access and advance health equity.

Kay Lor asked the Group for feedback regarding specialty access and shared the supplemental payment goals. The program will be potentially for a maximum of 3 years. It was noted MCO funds will be available for providers in 2025. Also noted was the maximum of 3 years seems short term based on issues. It was suggested to have a two prong incentive for current specialists and another to increase providers to be able to provide that care. Also noted was having a deep understanding of the gaps is important.

Lisa noted the MCO tax has an impact on the delivery system and not the Alliance network, and specialists are already paid 100 percent of Medicare. The hope is that the state will bring providers (non-specialists) up to 87.5% of Medicare but the state is pausing the MCO tax. The Alliance will use reserves to bring providers to 87.5%.. There are continuous incentive programs including grants and Care Based Incentives (CBIs) for providers. If the Alliance continues to have additional profits, there is a possibility of continuing the supplemental payments for a multi-year effort. Several issues were noted including Medicare does not pay the cost of care provisions, and the cost to provide care across the state, and lack of providers taking fee for service.

Kay shared the methodology and next steps. The recommendation will be made to the Board in August 2024 with implementation in January 2025. A provider noted she loses money seeing patients which limits her ability to be a strong primary care provider. Also, she interviews multiple providers, and it is difficult to get physicians to move to the area. A provider noted, the data from the Alliance website is poor and broken for months at a time, the website needs to be up to date so it can be utilized. Kristynn noted there is comprehensive data work being done at the Alliance and the data optimization project is getting ready to launch and focused on how to receive and process the data and get it back to our partners. The quality received in not reliable and creates difficulty and is complicated by each entity on a different system.

A provider noted she has not received Quarter 1 data yet. Another provider noted it is not easy to survive on a capitated rate. There should be incentives and bonuses for primary care providers (PCPs). Jessie noted the importance of continuing to investigate in workforce recruitment and retention bonuses for providers. Kristynn noted Program Development is partnering with the public health departments and working on their processes. Grants has allocated an amount to each health department to further the work in all 5 counties.

B. Continuity & Coordination of Care: Behavioral Health & Primary Care
Andrea Swan reviewed Measure 1: Anti-Depressant Medication Management (AMM). This measure looks at the percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication. Reviewed was Effective Acute Phase Treatment and Effective Continuation Phase Treatment. Data for 2022 was reviewed in Merced, and the rate was 65.05% and Santa/Cruz/Monterey was 64.40% with an eligible population of 1.000 members. The goal for the counties was 75%, Continuation phase rates were 44.92% in Merced and 47.07% in Santa Cruz/Monterey. Sarina King asked the Group about barriers to care. Dr. Pirard noted patients are complex to manage with behavioral health and limited time. The recommendation is to start low and go slow, making certain to monitor side effects. Barriers noted included stigma and medication side effects. A provider noted medication is not right for everyone. Other barriers noted, patients sometimes do not pick up medications, lack of access, no follow-up in 2 weeks and patient falls off the schedule. It is difficult to follow up if the appointment is canceled.

A behavioral health navigator was suggested. Another suggestion was to invest more in the care team, Provider suggested education on screening and prescribing (possible webinar)..

Measure 2: Follow-up Care for Children Prescribed ADHD Medication (ADHD) – This measures the percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Measure looks at members prescribed and whether they remained on the medication. The initiation rate for Merced was 41.8% and Santa Cruz/Monterey 41.14%, the goal was met. continuation phase rate in Merced was 49.06% and Santa Cruz/Monterey 40.30%. Dr Pirard suggested working with the therapist, and telehealth. A provider noted some PCPs do not feel comfortable prescribing medication for ADHD and refer to psychiatry.

Also considered should be summer months and weekends when children do not take their medications. There was a question whether the data captures when kids' diagnosis changes. Kristen noted they are not removed from the measure if the diagnosis is changed. It was suggested understanding the criteria for diagnosis and other psychiatric conditions.

C. Care Management Referral Criteria
Elizabeth Leary asked the Group for feedback on referrals and noted Care Management is working on processes. Leadership has developed draft referral criteria and would like input. There are 2 divisions, Care Coordination and Complex Case Management. The Complex Care Management referral criteria is:

- Newly diagnosed life-limiting condition or disease
- Dual diagnosis of severe mental illness (SMI) or substance use disorder (SUD) and a physical health condition for those who are not eligible for Enhanced Care Management (ECM)
- Poorly controlled disease states

Care Coordination referral criteria:

- Alcohol and other Drugs (AOD) bridge
- Behavioral Health Bridge
- Resources for Social Determinants of Health Applications/Access to Public Benefits programs
- Skilled Nursing Faciality (SNF) Placement from the Community
- Health System Navigation/Appointment Assistance
- Assistance with durable medical equipment (DME), Home Health, other supports

A provider noted there could be a lack of understanding about the programs. Another provider noted she has only had her patients go through ECM services, and coordination has been helpful when patients are no shows. Elizabeth noted Care Management is working to bridge the gaps and looking at proactive strategies.. Board member noted the care team has been helpful with his health care needs.

Adjourn:

The meeting adjourned at 1:40 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Group

The Physicians Advisory Group is a public meeting governed by the provisions of the Ralph M. Brown Act. As such, items for discussion and/or action must be placed on the agenda prior to the meeting.

Quality Improvement Health Equity Committee

Date: June 27, 2024

Time: 12:00pm – 1:30pm

Location: MS Team Meeting

MINUTES

Chair: **Dennis Hsieh, MD, CMO**			**Minutes by:** **Jacqueline Van Voerkens**
	Members Present:	Dr. Eric Sanford, Family Medicine, Dr. Jessica Langenhan, Psychiatry, Carelon Medical Director, Dr Madhu Ragavan, Pediatrician, Dr. Minoo Sarkarati, Internal Medicine/Pediatrics, Dr. Stephanie Chang, Family Medicine, Stacey Kuzak, GVHC Director of Nursing, and Susan Harris, MFA COO,	
	Members Absent:	Dr. Caroline Kennedy, Family Medicine, Dr. Oguchi Nkwocha, Family Medicine, Dr. Sandrine Pirard, Psychiatrist, Dr. Stephanie Graziani, Pediatrics, Dr. Sanjay Vaswani, Carelon Medical Director	
	Central California Alliance for Health staff:	Ms. Andrea Swan — QI/ Population Health Director Ms. DeAnna Leamon — Clinical Safety Quality Manager Ms. Desirre Herrera — Quality and Health Programs Manager Dr. Dianna Myers — Medical Director Ms. Elizabeth Leary — Care Management Director Ms. Emily Kaufman — Clinical Safety Supervisor (RN) Ms. Jessie Dybdahl — Provider Services Director Ms. Kristen Rohlf — Quality Improvement Manager Dr. Kristynn Sullivan, PhD — Program Development Director Ms. Lilia Chagolla — Member Services Director Dr. Maya Heinert — Medical Director Dr. Michael Wang — Medical Director Ms. Navneet Sachdeva — Pharmacy Director Dr. Omar Guzman — Chief Health Equity Officer Ms. Ronita Margain — Community Engagement Dir., Merced Ms. Sarah Sanders — Grievance and Quality Manager Ms. Sarina King — Quality and Performance Improvement Manager Mr. Scott Fortner — Chief Administrative Officer	
Item No.	**Agenda Item**		
I.	**Call to Order**	Andrea Swan, QI/ Population Health Director, called the meeting to order at 12:05 PM and welcomed the members. Ms. Swan opened the floor for any announcements. No announcements were received from the Committee. Announcement: Ms. Swan introduced new members of the committee	

Quality Improvement Health Equity Committee

Date: June 27, 2024

Time: 12:00pm – 1:30pm

Location: MS Team Meeting

MINUTES

Items for Approval		Discussion	Action/Recommendation
II.	**Review & Approve Minutes**	**The Minutes from the April 25, 2024 QIHEC Meeting were reviewed.** * Navneet Sachdeva, PharmD, *motioned to approve the minutes from the QIHEC meeting.* * Dr. Minoo Sarkarati *2nd the motion for approval.* **Committee approved April 25, 2024 QIHEC as presented.*	*The QIHEC approved the April 25, 2024 QIHEC meeting minutes.*
Action Item Follow Up			
III.	2024 QIHETP Workplan Kickoff	*Action: U*pdate the workplan to have clear specific concrete deliverables/results/goals, versus processes in the quality plan. Action Complete.	Action Complete.
Items for Review/Approval		**Consent Agenda Items**	**Action/Recommendation**
IV.	**Review**	<u>Subcommittee/Workgroup Meeting Minutes</u>	
		• Pharmacy and Therapeutic (P&T) Committee Minutes Note: Dr. Sanford mentioned a typo in page 3 of the P&T minutes. Action: QIPH Admin will inform Pharmacy Admin of typo	*Approved at P&T*
		• Quality Improvement Health Equity Workgroup (QIHEW) Minutes	*Approved at QIHEW*
		• Utilization Management Workgroup (UMWG) Minutes	*Approved at UMWG*
		<u>Delegate Oversight Report</u>: The VSP Q3 2023 and the Carelon Q3 2023 quarterly delegate oversite summary included in consent agenda meeting packet.	
		<u>QIHEW Charter:</u> Annual review of the updated QIHEW charter.	*Approved at QIHEW*

Quality Improvement Health Equity Committee

Date: June 27, 2024

Time: 12:00pm – 1:30pm

Location: MS Team Meeting

MINUTES

Policies: Require QIHEC Approval		
Number/Title	**Significant Changes**	**Action/Recommendation**
401-1508 Facility Site Review Process	FSR policy updated to reflect APL 24-002, including the APL reference, and adding "Indian health care provider" to the PCP / Provider definitions	*Approved*
401-1510 Medical Record Review and Requirements	MRR policy updated to reflect APL 24-002, including the APL reference, and adding "Indian health care provider" to the PCP / Provider definitions	*Approved*
401-2001 Member Surveys	Annual review – no changes	*Approved*
Policies: Informational		
Number/Title	**Significant Changes**	**Action/Recommendation**
401-1518 Medical Assistants: Scope of Practice and Supervision	Added requirements for the MA policy and attachment.	*Approved at QIHEW*
404-1108 Monitoring of Over-Under Utilization of Services	None - annual review	*Approved at UMWG*
404-1109 Disclosure of Utilization Management Process to Providers Member and the Public	Section 8: Referrals & Authorizations: Deferrals & Denials, page 92	*Approved at UMWG*
404-1111 Utilization Management Assessment Process	QIHEC name/ wording for NCQA UM-2C: Factor 2	*Approved at UMWG*
404-1112 Medical Necessity The Definition and Application of Medical Necessity Provision to Authorization Requests	Wording updated for NCQA	*Approved at UMWG*
404-1113 External Independent Medical Review	NCQA: UM Element 4F	*Approved at UMWG*

MINUTES

404-1115 Terminal Illness		None - annual review	*Approved at UMWG*
404-1306 Extended and Standing Referral Authorizations		None - annual review	*Approved at UMWG*
404-1401 Sterilization Consent Protocol		None - annual review	*Approved at UMWG*
404-1714 Technology Assessment 2021 Medi-Cal Rx		NCQA UM 10A/B	*Approved at UMWG*
404-1719 Home Health Care		None - annual review	*Approved at UMWG*
404-1721 Antepartum Fetal Surveillance		None - annual review	*Approved at UMWG*
404-1723 Major Organ Transplant Authorization Process		None - annual review	*Approved at UMWG*
404-1726 Non-Emergency Medical Transportation		Clarification on PCS forms / requirements for PCS forms	*Approved at UMWG*
404-1727 Provision of Telehealth Services to Alliance Members		Changes made to reflect requirements per DHCS APL 23-001.	*Approved at UMWG*
404-1729 Pulmonary Rehabilitation		None - annual review	*Approved at UMWG*
404-1744 Systems Control Policy		Created due to new system (JIVA) & NCQA UM12: A-D	*Approved at UMWG*
		Regular Agenda	**Action/Recommendation**
IV.	NCQA QI3 & QI4	Andrea Swan, CCAH QIPH Director shared the presentation on Continuity and Coordination of Care. The areas of focus are Plan All-Cause Readmission, Prenatal and Postpartum Care, Opioid Use Disorder, Behavioral Health, and Primary Care. Sarina King, CCAH Quality and Performance Improvement Manager, opened the floor for discussion on reducing readmissions; how data sharing is working, and opportunities for further	Action: Dr. Wang will create a focus group with those who meet the definition of preventable readmissions Action Complete

MINUTES

		improvement. Susan Harris, MFA COO, indicated the issue is manually gathering of information. Information is either not coming into the system correctly or it is getting lost in other provider documents. Dr. Hsieh asked Ms. Harris how they are presently receiving their information. Ms. Harris responded information is received in a combination of ways, which makes it difficult because so much information is coming in automatically. Dr. Hsieh inquired of the best way to provide this information. Ms. Harris noted MFA is piloting a program to see if it can assist with getting the information faster and more direct. Dr. Sanford inquired if there is a process for collecting data which best represents a sample of patients who got readmitted , and if anything could have been done to prevent it, as well as asking the primaries, and the ER doctors who readmit them, to narrow down on the preventable readmissions. Dr. Sanford also indicated delays or lack in DME equipment is a cause for some readmissions. Something as simple as a walker would have kept a patient from falling, or bandages for the underserved. Help for patients who are unsure on how to get and take their medicine or are unable to get to the pharmacy could reduce preventable readmission rates. Dr. Hsieh responded CCAH Case managers connect with hospital discharge planners. To Dr. Sanford's point, this is part of the reason DHCS is pushing MCPs towards DSNP, a dual special needs plan for Medicare and Medi-Cal combined. Dr. Myers informed the committee about a program which collaborates with Central Avenue Pharmacy called Meds to Beds, which delivers medication to the members home or bedside. **Action:** Dr. Wang will create a focus group with those who meet the definition of preventable readmissions. Action Complete: Dr. Wang met with finance to create a survey, which will trigger the focus group. Ms. Swan presented the Prenatal and Postpartum Care data. Timeliness of Prenatal Care for MY 2023 goals were surpassed. Result for Merced County was 93.46%, (exceeded the 91.07% goal). Result for anta Cruz/Monterey was 91.24% (exceeded the 91.07 % goal.) Postpartum Care for MY 2023 goals were also surpassed. Results for Merced were 85% (exceeded the 84.59% goal.) Results for Santa Cruz/Monterey was 92.94% (exceeded the 84.59% goal.)	

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		Dr. Hsieh asked the group for feedback on ideas to getting some of these measures to 100%. Dr. Myers mentioned the discharge sheet has been used and is extremely useful. The biggest challenge is the mom baby identification. Dr. Myers suggested the possibility of scheduling multiple return appointments at once on the first visit; it would increase scores tremendously. Dr. Raghavan noted if mothers are aware they are medically eligible for health coverage, an increase in pre- and post-partum appointments can be expected, which will increase these scores. Dr. Myers inquired how much communication is taking place to ensure members are receiving prenatal visits, as some clinics may not have the bandwidth for this service. Dr. Sandford reiterated he thinks it is a measure of poverty, access, and a mix of some who are migrant workers. Dr. Sarkarati noted many children are receiving care at the facility their mother is receiving care at. Members are receiving sporadic care. Dr Sarkarati suggested facilitating clinic assignment matches. Dr. Hsieh indicated speaking to members to see what is modifiable would be best. Susan Harris, MFA COO, noted there is a shortage of OB providers in Merced, Fewer and fewer physicians are providing OB services. Dr. Hsieh acknowledge the lack of OB providers in Merced is at almost a crisis level. Dr. Hsieh informed the group Dr. Guzman, Chief Health Equity Officer, has been looking into this, as well as Provider Services. Ms. Lilia Chagolla, Member Services Director, respond Member Services tries to ensure families are linked to the same doctor if possible. Matching with a specialist is sometimes difficult, especially when there is a shortage. Dr. Wang asked the committee if the Pre and Postpartum Care data reported out appeared correct. Dr. Sanford suggested reaching out to the county for the true denominator of births. Navneet Sachdeva, Pharm D., Pharmacy Director presented on the DUR: Opioid Use Disorder. The role the Alliance can focus on is retrospective review, and review of trends, member and provider education, and targeted member and provider letters. The Alliance has also conducted a Naloxone distribution project, which is available at Alliance offices, all five locations.	

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		Dr. Hsieh mentioned Ms. Leary, Care Management Director, may have some interest in partnering with the hospitals to do inpatient MAT services. Dr. Sanford mentioned the Opioid Use crisis is a coordination of care opportunity. Many patients utilize the ER when they are going through withdrawal. Many patients unfortunately have physicians who retire, or change offices, and residents/new doctor is unfamiliar with the patient and hesitant to prescribe chronic pain medication. The question is how to create a structure within systems to build trust between doctors and members when the members move between doctors. The doctors need access to the members records. Dr. Hsieh acknowledged and agreed with Dr. Sanford Dr. Sachdeva requested ideas on how the health plan can assist with the coordination of care. Dr. Sanford provided an example of a patient who was referred to him, in which a case manager was able to assist connecting the patient to a pain specialist. The patient was able to be stabilized and tapered off the multiple pain medications. Dr. Sachdeva acknowledged and agreed case management or ECM is a valuable resource. Dr. Wang mentioned pain contracts with members, to have available for their new providers. Dr. Hsieh suggested reaching out to provider who are prescribing the high doses of pain medications who are not pain specialists. Dr. Sarkarati inquired about members who are incarcerated and are transitioning out and require prescriptions. The concern is if these individuals are aware they are eligible for Medi-Cal, and prescription coverage, and where to get their prescriptions. When they are released, they are in a very vulnerable and desperate. Dr. Hsieh responded state legislation requires all jails make sure individuals who are eligible, are sign up prior to release, although implementation of this may not have taken place in all facilities. Ms. Leary mentioned Vivitrol and Naltrexone injection are also being explored. It helps for 30 days and is not a narcotic. It treats both opioid and alcohol use disorders. The medications are expensive but are less expensive than multiple Ed visits and hospitalizations. Dr. Sachdeva mentioned the Alliance is exploring if a pharmacist might be able to furnish under collaborative practice agreement with a physician. The goal is when a member is discharged the Alliance connects the member to a pharmacy/ pharmacist, to continue the medication. Input from multiple parties is required, such as the Board of Pharmacy and MCP.	

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		Ms. Swan presented on Behavioral Health. Antidepressant medication management (the AMM measure) and follow up care for children prescribed ADHD medication was reviewed. AMM – Acute Phase 2022 goals were not met. Result for Merced County was 65.05%, (goal was 75%). Result for Santa Cruz/Monterey was 64.4% (goal was 75%.) AMM Continuation Phase goals were not met. Results for Merced were 44.92% (goal was 65%.) Results for Santa Cruz/Monterey was 47.07% (goal was 65%.) Scores for the ADD Initiation phase were successful. Results for Merced were 41.84% (exceeded goal of 31.67%.) Results for Santa Cruz/Monterey was 41.14% (exceeded goal of 31.67%.) ADD Continuation Phase goals were not met. Results for Merced were 49.06% (goal was 60.66%.) Results for Santa Cruz/Monterey was 40.3% (goal was 60.66%.) The barriers noted were around provider education, bandwidth, roles and responsibilities, and follow up screening stigma, awareness, and comorbidities. Ms. King indicated the biggest opportunities for improvement for both of the measures was around provider education and having a provider champion at a practice for each of the measures which could help support with follow up as needed. Dr. Myers requested clarification of the ADHD Continuation Phase. Ms. Swan responded the ADHD Continuation Phase data is a percentage of Members who are 6 to 12 who have a prescription for ADHD medication who remained on the medication for at least 210 days and who, in addition to a visit in the initiation phase, also had at least two follow up visits with a practitioner within 270 days or nine months after the initiation phase. Dr. Hsieh requested suggestions and insight from the committee. Dr. Sanford inquired about member who are prescribed an ADHD med which does not agree with them, or if a member decides they do not like the idea of taking the medication. The members choice will make the data look worse but may have been the right choice for the member. Dr. Jeesica Langenhan, Psychiatrist from Carelon, noted these factors could be a part of the treatment plan. Kristen Rohlf clarified the measure is essentially noting if the member is on the medication for a certain amount of time and then if they received follow up. If the member is on the medication longer in the continuation phase, it is then looking for additional visits beyond the first 30 days. NCQA typically does is, though they will allow for switches of medication. One of the barriers was knowing if the medication may not be a good fit within the first two weeks. Also to let the	

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		patient know about possibly needing to allocating time to adjust to their dosages/ change in the medication. Having the ability to have a conversation in advance with the patient may increase the rate. Another concern is to try to get the patient to stay on the medication for a longer period of time. There is some allowance for a change to a different type of prescription. There is a gap allowance within the medication time period. Dr. Myers inquired if the data is collected includes PCP prescribers, or only Psychiatrist prescribers. Ms. Rohlf indicated the data captures any prescriber to have the follow up. Any prescriber data received by the Health Plan, such as Pharmacy data, would trigger the member into the measure. Dr. Sanford suggested reviewing physicians who are over medicating, but he also acknowledged the population is under treated.	
	Q1 2024 QIPH Workplan Review	Andrea Swan, CCAH QIPH Director reviewed the Q1 2024 QIH Workplan with the committee. Ms. Swan noted the action item from the previous meeting was completed. The action was to update the goals. The updated goals were shared with the committee. Ms. Swan shared the goals the outcomes of Q1 2024. MCAS strategic goal is to improve pediatric measures in Merced County by a 5 percentile increase from 2022 through 2026 for each year. In addition, two Women's Health measures fell below the minimum performance level and those were Breast Cancer Screening (BCS) and Chlamydia Screening in Women (CHL-Tot). An intervention was launched with the Provider partnership program, and an MCAS workgroup was created which focuses particularly on all MCAS measures. Between 4 and 6% improvement for breast cancer screening has been noted. Well child visits show on minimal improvement. Well child visits looking at the 15 months and then also the W30 have shown improvement rates between 11 and 15%. For Care Based Incentives (CBI) the focus is on enhancing the provider portal, providing information to new practices on the CBI program, and working to be able to roll up clinics, and provide trainings. For Basic Population Health management, the goals here were to provide at least two health education services or member rewards presentations per quarter to different departments and to external partners to increase the number of incentives that are fulfilled over the measurement	*Action Complete. Q1 2024 QIPH WP approved via email vote.*

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		year 2023. In the first quarter, 4 presentations were conducted internally, and UC Merced Health and Wellness staff. The Health Education team also attended new hire department orientations to talk to different teams about the incentive program. The next goal was to inform members of the Health and Wellness programs and management tools which are available to manage their conditions. In the first quarter, this information was available in the Member newsletter. About 683 outreach calls were made by the Health Educators to members. Goal three was to launch survey to ask members how they feel about Alliance services, and suggestions for enhancement. About 44-member experience surveys were completed related to these programs and the quantum chronic disease management programs. About 88% of the members reported they were satisfied with these programs. The Wellness program: about 75% of the members reported satisfaction. The goal was to increase the number of member workshops available; this goal was met. In quarter one the team was able conduct about 9 workshops (telephonic, in person and virtual workshops.) The Facility Site Review goal was to ensure 80% of existing primary care provider sites with an FSR completed within three years of their last date (DHCS time frame.) The goal was met at 100%. The second goal was to ensure 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes. This goal was met in quarter one. Additional FSR staff was hired and recruiting two additional Nurses to be able to meet the workload and then all the upcoming reviews have been planned and scheduled. The Potential Quality Issues goal is to make sure 100% of member grievances received by the QI Team related to these PQI are completed within the regulatory timeframes. This goal was met. The second goal is for 80% of non-grievance related PQIs, are completed within 90 calendar days. This goal was met at 83%. Approximately 166 grievances were received in quarter one, equivalent to .12 grievances per thousand members. About 193 grievances were related to quality of care and access in quarter one, which is about a .1 for per thousand members. Transportation issues were down. Quality of care issues were also down then stabilized. Some of the reasons why members were filing grievances or issues were related to genetic testing and provider billing.	

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		Emerging trends include access challenges, provider availability, and timely access. NMT grievances decreased in Q1 2024. Members Satisfaction Survey item included launching a CAP survey. Member Services department's Telephone Access Goal is to make sure 80% of calls from the members are answered within 30 seconds. The rate for quarter one is 63%. The goal for Call Abandonment was to not exceed 5%. The rate for Q1 was at 6%. The goals were not met due increased call volume by 46% which is about 6000 additional calls monthly. An increase in walk-ins to Alliance locations by 264% also affected this goal. For Cultural and Linguistics, the goal is to ensure a total of two presentations of C&L services are conducted across the organization. The first intervention was to ensure the information was available in the Alliance website, and the member newsletter (March of 2024.) Feedback received was positive, including requests to continue to do member surveys to make sure Members are satisfied with their services, or to find how to improve services, and also continue to increase provider utilization of language assistance services. A 37% increase in provider utilization of interpreter services, was noted, face to face interpreting requests increased by 26.5%. Dr. Sanford inquired about the Alliance's interpreter services, and if they align with the population. Dr. Sanford noted the difficulty to find interpreters. Dr. Sanford inquire d if there is data on the primary languages of the Alliance members. Desiree Herrera, Quality and Health Programs Manager, responded there are barriers to accessing interpreters who speak Indigenous languages. The Alliance has vendors available, however, because there's limited access overall, this service requires to be a scheduled appointment because there's not enough interpreters available. The Alliance is looking into additional vendors. Action: Q1 2024 QIPH Workplan Review will be distributed to the committee for email approval.	
	Q1 2024 UM Workplan Review	Action: Q1 2024 UM Workplan Review will be distributed to the committee for email approval.	*Action Complete. Q1 2024 UMWP approved via email vote.*

Quality Improvement Health Equity Committee

Date: June 27, 2024

Time: 12:00pm – 1:30pm

Location: MS Team Meeting

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Action Items			
Agenda Item	**What is the action item**	**Due date**	**Responsible staff**
Consent	Dr. Sanford mentioned a typo in page 3 of the P&T minutes. **Action**: QIPH Admin will inform Pharmacy Admin of typo. Pharm. Admin will update the P&T Minutes. **Action complete.**		**QIPH Admin**
NCQA QI3 & QI4	**Action:** Dr. Wang will create a focus group with those who meet the definition of preventable readmissions. Action Complete: Dr. Wang met with finance to create a survey, which will trigger the focus group.		**Dr. Wang**
Q1 2024 QIPH Workplan Review	**Action:** Q1 2024 QIPH Workplan will be distributed for approval via email. **Action Complete.** Q1 2024 QIPH Workplan approved.		**QIPH Admin**
Q1 2024 UM Workplan Review	**Action:** Q1 2024 UM Workplan will be distributed for approval via email. **Action Complete:** Q1 2024 UM Workplan approved.		**QIPH Admin**
Meeting adjourned at 1:30 pm			
Next Meeting TBD			
Approved by QIHEC Date: 9/24/2024	***Signature:*** *Andrea Swan, RN, Quality Improvement Population Health Director*		**Date:** 9/24/2024

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, June 20, 2024
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

Cal Gordon, MD	Provider Representative
Salvador Sandoval, MD	Provider Representative
John Mark, MD	Provider Representative
Lena Malik, MD	Provider Representative
Hue Nguyen, MD	Provider Representative
Sarah Smith, MD	Provider Representative
James Rabago, MD	Board Representative
Ibraheem Al Shareef, MD	Provider Representative

Committee Members Absent:

Jennifer Yu, MD	Provider Representative
Devon Francis, MD	Provider Representative
Allyson Garcia, MD	Provider Representative
Nicole Shelton, PA	Provider Representative

Staff Present:

Dennis Hsieh, MD, JD	Chief Medical Officer
Kristynn Sullivan, PhD	Program Development Director
Elizabeth Leary	Care Management Director
Cynthia Bali	Provider Relations Supervisor
Kelsey Riggs, RN	Pediatric Complex Case Mgmt. Manager
Jenna Stromsoe, RN	Complex Case Management Supervisor
Ashley McEowen, RN	Complex Case Management Supervisor
Jacqueline Morales	Provider Relations Representative
Ronita Margain	Community Engagement Director
Shae Redwine	Behavioral Health Program Analyst
Sabryna Sherman	Utilization Management Manager
Rebecca McMullen	Behavioral Health Program Manager
Tracy Neves	Clerk of the Committee

Other Representatives Present:

Jill Young	Carelon
Erik Riera	Carelon
Sarah Acosta	Carelon
Christopher East	Carelon
Geneva Edwards	Carelon
Ignacio Santana, MD	Provider Representative
Laurie Soman	Provider Representative
Becky Shaw	Provider Representative

1. **Call to Order by Chairperson Hsieh.**
   Chairperson Dr. Dennis Hsieh called the meeting to order at 12:00 p.m.
   Roll call was taken.

2. **Oral Communications.**
   Chairperson Dr. Hsieh opened the floor for any members of the public to address the Committee on items not listed on the agenda.

   No members of the public addressed the Committee.

3. **Consent Agenda Items:**
   A. Approval of WCMCAC Minutes
      Minutes from the March 21, 2024 meeting were reviewed.
   B. Grievance Update
      Grievance data was reviewed and provided to the Committee.

   M/S/A Consent agenda items approved.

4. **Regular Agenda Items:**
   A Whole Child Model California Children's Services (CCS) Referral Updates
   Kelsey Riggs, RN provided an introduction and overview of the Pediatric Complex Case Management Team. Jenna Stromsoe, RN shared CCS referral data trends from January 2023 to May 2024, data was tracked by count pending, count denied, count approved, count other and count corrected. Total CCS referral approval rates by county for Q1 includes Merced – 78.6%, Monterey – 71.6% and Santa Cruz – 79%. Average approval rate is 75.5%.

   Q1 Alliance Referral Count Rates by County:
   Merced: 154
   Monterey: 194
   Santa Cruz: 81
   Total Referrals: 429

   As of May, total Whole Care Model (WCM) volume was 7,332 and WCM age-out count was 67. Dr. Hsien noted at a recent clinic visit, there were questions regarding eligible conditions, and general provider questions, Dr. Hsieh suggested the Alliance work on provider education and how to refer and eligible conditions. A provider noted, there has been a universal decrease in CCS eligible individuals since WCM occurred in Santa Cruz County and potential opportunity regarding how to engage with providers. In addition, there is a need in understanding the restraints around particular conditions. More interaction with community providers and specialists regarding CCS eligibility and educating providers on the value for patients would be a good idea. Another provider asked about the March 2023 increase being an outliner and if there is data by county and approval rates for each month. It was noted the first quarter for Merced, 22% of referrals were not approved, and provider asked for the reasons for the determinations. Jenna noted they work closely with the counties in regard to denials, but specific information would need to be researched. There were no updates regarding changes in conditions. Denials are taken back to the Alliance team for educational purposes. Sometimes there is back and forth between the county regarding additional documentation needed or pending labs or imaging. The Pediatric team continues to follow-up.

   It was also noted the decrease since WCM, is not exclusive to the Alliance, and others may think CCS has gone away. There was a question about what the Alliance is doing to notify providers in regard to referring members. Dr. Hsieh noted there is a need for provider education and how to do better loop closure when there is a CCS determination. A provider

noted there is a need in having providers know what the program is and what it is there for, It was noted providers are not always kept in the loop regarding the members. There was a question regarding CCS data for San Benito and Mariposa. There are 292 CCS eligible children in San Benito County and. 69 in Mariposa County. The Alliance expects the numbers to increase with more work on WCM and working closely with the counties. A provider noted targeted outreach and tools to make the process easier would be helpful. It was suggested to have available a list of common and uncommon conditions that are eligible for CCS referral.

Action items for the Alliance:

- Come back with a plan regarding how to better educate providers,
- CM team to work with Provider Services regarding a system for closing the loop with primary care providers (PCPs),
- For future meetings, Include referral numbers for San Benito and Mariposa counties.
- Pull data for eligible members and non-referring providers.

B. Discussion Regarding Concerns with Behavioral Health & ABA Services for Members Without Autism

Rebecca McMullen reviewed topics for discussion and informed the Committee Carelon was in attendance to answer questions.. Carelon staff members introduced themselves to the Committee. Rebecca noted that a presentation was given at the WCMFAC meeting on the array of behavioral services provided and how to obtain services.. A provider had question regarding eating disorders, and noted her patient was hospitalized for medical stabilization but upon discharge there were a number of items that needed to be completed and the process took 6 months. During the 6 months, the patient was readmitted to the hospital. The provider noted a need for a streamlined process and collaboration. The provider also noted there are multiple layers to the referral process, and it takes hours to figure out the member's care and coordination.

Rebecca acknowledged working with members with eating disorders has been challenging across all counties. There is an Alliance eating disorders workgroup that began this year and is working on the issues and solutions to ensure members get the care they need in a timely manner. It was noted the eating disorders workgroup is a collaborative effort across departments at the Alliance. There has been lots of communication with the counties regarding eating disorders, and those with eating disorders behavioral status is deemed specialty. It was noted resources in the smaller counties is also a challenge. Carelon provides the non-specialty benefit and has outpatient providers that specialize in eating disorders for those less severe. Members can be referred for specialty mental health services directly without the need to go to Carelon, there is no wrong door. The eating disorders workgroup is working on ways to better collaborate with providers.. **Action**: Rebecca will follow-up with Julie Norton that is part of the workgroup and provide specifics around collaboration efforts. The Care Management team contact information was shared with the Committee and the team is a resource for providers. The team can advocate for members and providers to help members get the care they need.

Rebecca asked the Committee if there were any questions related to the Applied Behavioral Analysis (ABA) benefit A provider mentioned they were not aware that ABA was offered for non-Autism diagnosis and asked about the criteria for the therapy. Rebecca noted this benefit has been a recent change from the state. Carelon noted there is an FAQ document for physicians to help with referrals for BHT services. A diagnosis is not required if the physician can make a referral for a full CDE evaluation or a referral for BHT. Some conditions are failure to meet milestones, behavioral concerns, lack of communication or organization. The FAQ was shared with the Committee:
https://thealliance.health/wp-content/uploads/Provider_FAQ_for_BHT_Services.pdf.

There are a large number of members that have a diagnosis of Autism, but it is no longer required. A provider asked if an MCHAT qualifies and Carelon stated that it does qualify. A provider noted for those not reaching milestones, he refers them to the Regional Center, and some are set-up as early as 24 months for ABA therapy. Carelon noted the process begins with an initial assessment followed with provider recommendations. Dr. Hsien suggested further discussion on this issue at the next meeting as it is an area of significant interest..

Adjourn:
Meeting adjourned at 1:00 p.m.

Respectfully submitted.

Ms. Tracy Neves
Clerk of the Advisory Committee

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

Meeting Minutes

Monday, March 11, 2024

Teleconference Meeting

Members Present:

Janna Espinoza	Monterey County – CCS WCM Family Member, WCMFAC Chair
Manuel López Mejia	Monterey County – CCS WCM Family Member
Michael Molesky	Santa Cruz County – Alliance Commissioner
Paloma Barraza	Monterey County – CCS WCM Family Member
Kevin Smith	Merced County – Local Consumer Advocate

Members Absent:

Frances Wong	Monterey County – CCS WCM Family Member
Heidi Boynton	Santa Cruz County – Local Consumer Advocate
Heloisa Junqueira, MD	Monterey County – Provider
Irma Espinoza	Merced County – CCS WCM Family Member
Kim Pierce	Monterey County – Local Consumer Advocate
Susan Skotzke	Santa Cruz County – CCS WCM Family Member

Staff Present:

Jenna Stromsoe, RN	Complex Case Management Supervisor - Pediatric
Kayla Zoliniak	Community Engagement Administrative Specialist
Ronita Margain	Community Engagement Director
Rebecca McMullen	Behavioral Health Program Manager

Guest:

Anna Rubalcava	Merced County
Denise Sanford	Santa Cruz County
Christine Betts	Monterey County

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

   WCMFAC Mission Statement read in English and Spanish.

   Committee introductions and roll call was taken.

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

   Consent Agenda Items:

3. **Accept WCMFAC Meeting Minutes from Previous Meeting**
   K. Zoliniak opened the floor for approval of the meeting minutes of the previous meeting on November 6, 2023. Minutes were approved with no further edits.

   Regular Agenda Items:

4. **CCS Advisory Group Representative Report**
   No update provided.

5. **Feedback, New Issues, and Impact on Members – Open Forum**
   Committee member shared they recently spoke with executive leadership at the Alliance regarding durable medical equipment especially for Whole Child Model members.

   Committee member shared the Santa Cruz Master Plan on Aging survey will be completed by the end of March.

   Committee member shared the Pajaro Valley Health Care District Measure N was approved supporting $116M in bonds which will be used to improve healthcare quality in Santa Cruz County.

   Committee member shared their concern regarding authorizations not being communicated between the Alliance the provider. The Alliance confirmed the WCMFAC committee member informed them of the situation prior to the meeting and the concern is being addressed.

   R. Margain welcomed Kevin Smith to the WCMFAC committee. Kevin Smith introduced himself and will be representing the Merced County community.

6. Whole Child Model Resource Sheet

Chairperson Espinoza opened the floor to feedback and ideas for the Whole Child Model (WCM) Resource Sheet.

Ideas submitted to the Alliance by Friday, March 15, 2024 will be considered for the next iteration of the published WCM Resource Sheet.

Feedback provided by the committee members and Alliance staff included All Dads Matter in Merced County, Denti-Cal, VSP, 2-1-1, and updating Beacon to Carelon to reflect the organization's name change. The recommendation was made to prepare Mariposa and San Benito resources for inclusion in the 2025 WCM Resource Sheet update.

Committee member recommended the WCM Resource Sheet be published the to the Alliance website.

Committee member expressed positive feedback for the WCM Resource guide citing how helpful the guide is for WCM families.

Chairperson Espinoza is working with Monterey County SELPA to include the WCM Resource Sheet in their onboarding packet and inquired about other education organizations including the WCM Resource Sheet in their onboarding packets too.

7. Behavioral Health Benefits

R. McMullen, Behavioral Health Manager, provided an overview of the Alliance's Behavioral Health benefits, how to access services, and solicited thoughts and feedback from WCMFAC.

R. McMullen stated in the State of California, there is a standard screening tool, if a member contacts Carelon, the Alliance, or the County, the member is screened to see which system is the best fit and the Alliance tracks members get connected to care using a closed loop referral system. The member may be provided the names and phone numbers for providers for them to reach out to the providers, receive appointment assistance, or receive case management services.

Committee member shared Monterey County partnered with school districts to be able to provide access to behavioral health services within schools. For example, Salinas Union High School District has Wellness Centers for students. Committee member inquired if other school districts provide this.

Committee member shared Monterey County partnered with school districts to be able to provide access to behavioral health services within schools. For example, Salinas Union High School District has Wellness Centers for students.

Committee member and Alliance staff expressed interest in mental health, behavioral health, and physical health being seen as integrated.

8. Review Action Items

K. Zoliniak reviewed the actions items.

9. Future Agenda Items

R. Margain shared the intention to align Whole Child Model Family Advisory Committee agendas with Member Services Advisory Group agendas.

Committee member requested Rx Carve-Out Impact and Updates.

Committee member requested Whole Child Model Clinical Advisory Committee minutes be included in the WCMFAC agenda packet as a consent agenda item.

Adjourn:

The meeting adjourned at 3:02 p.m.

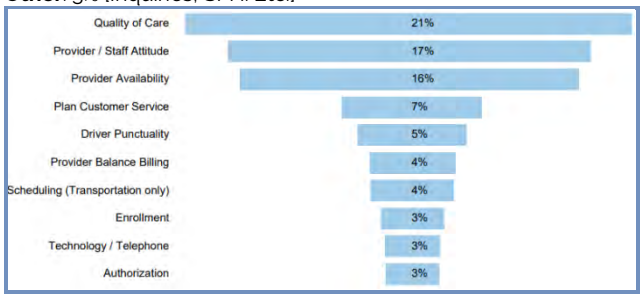
The meeting minutes are respectfully submitted by Kayla Zoliniak, Administrative Specialist

Next Meeting: Monday, May 13, 2024, at 1:30 p.m.

Member Appeals and Grievance Report
Q2, 2024

Q2 2024 Appeals and Grievances: 1206* including Carelon.

Appeals: 3% [81% in favor of Plan; 19% in favor of Member]
Exempt: 50%
Grievances: 44%
Other: 3% [Inquiries, SFH. Etc.]



Analysis and Trends

- Access issues regarding provider availability in MRY increased.

Highest Grievances Filed by County

1. **Monterey**: 36%
2. Merced: 33%
3. Santa Cruz: 23%
4. San Benito: 6%
5. Mariposa: 2%

Behavioral Health Carelon Grievances: #47

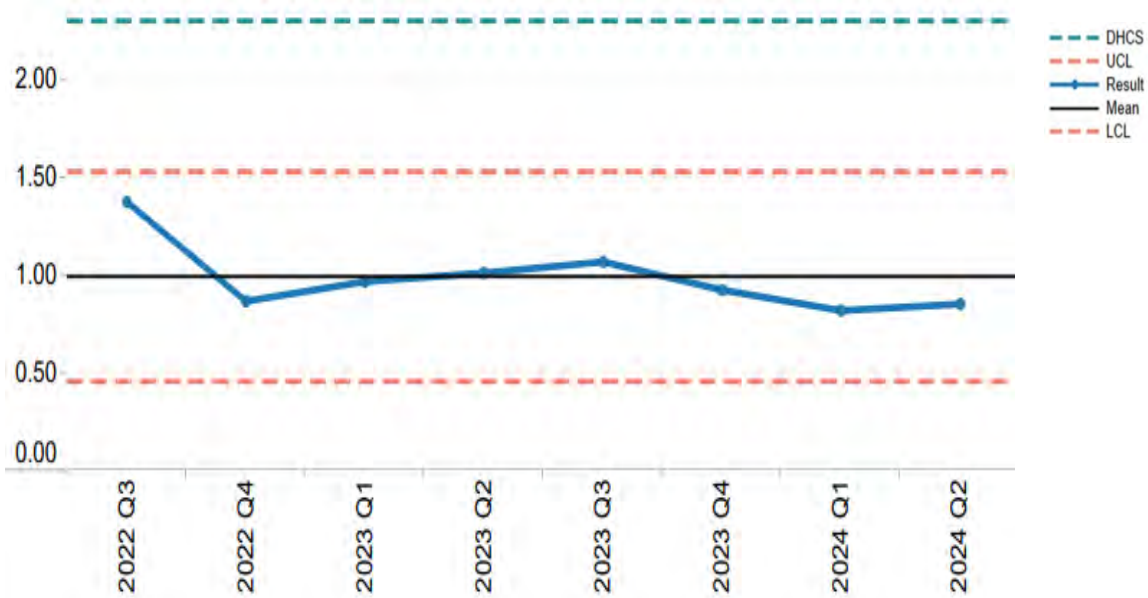
- **Monterey**: 17
- Santa Cruz: 14
- Merced: 14
- San Benito: 2

IHSS Summary: #8

- Member Grievances: 3
- Exempt Complaints: 5

☒ **In Control**
☐ **Not in Control**

A lower rate demonstrates a good or positive result when compared to Upper Control Limits (UCL) and Lower Control Limits (LCL). Control limits represent three (3) standard deviations from mean or average performance.



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	MemberMonths	420,218	421,740	423,191	426,109	427,751	428,849	427,117	425,602	419,724	415,693	411,409	407,617
	Case Count	321	425	480	376	488	436	448	459	455	479	369	295
	Case Count Per 1000 MM ..	0.76	1.01	1.13	0.88	1.14	1.02	1.05	1.08	1.08	1.15	0.90	0.72
2024	MemberMonths	458,075	456,814	456,605	454,985	452,014	450,067						
	Case Count	394	386	345	399	427	333						
	Case Count Per 1000 MM ..	0.86	0.84	0.76	0.88	0.94	0.74						

*Grievances Per 1,000 Member Month

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DATE: November 6, 2024

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

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

SUBJECT: Quality Improvement Health Equity Transformation Workplan – Q2 2024

Recommendation. Staff recommend the Board accept the Q2 2024 Quality Improvement Health Equity Transformation (QIHET) Workplan report.

Summary. This report provides pertinent highlights, trends, and activities from the Q2 2024 QIHET Workplan.

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

The 2024 QIHET Workplan was developed to align with the Alliance Strategic Plan of Member Wellness, Access to Care, and Promotion of Value.

Discussion:

QUALITY OF PROGRAM STRUCTURE

Annual Evaluation

Reporting purpose is to ensure all required sections of the workplan meet DHCS, and NCQA requirements,

No previously Identified Issues were reported.

Report Changes/Updates:
On track to meet all quarterly updates to QIHEC with appropriate approvals, and no barriers noted. Workplan structure with initial goals was approved by QIHEC 2/2024.

Program Description

Reporting purpose is to finalize the 2024 Program Description and develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS, and NCQA requirements.

Report Previously Identified Issues/Highlights

Program description completed in prior year was not sufficient to meet new DHCS and NCQA standards. Program description has been reviewed to meet all regulatory requirements.

Report Changes/Updates:

Program description was finalized 5/15/2024. but has not been presented to QIHEW as it is currently being reviewed by NCQA team to ensure all elements have been met.

Annual Workplan
Reporting purpose is to execute a QI program annual work plan that reflects ongoing activities throughout the year and addresses all required DHCS, and NCQA requirements.

Report Previously Identified Issues/Highlights:

1. Current workplan needed to be updated to meet DHCS and NCQA requirements which was successfully completed.

2. With the presentation of workplan goals within the QIPH committee feedback included in the need to establish clear baselines, and timeframes. The workplan was updated, and presented with changes, and approved.

Report Changes / Updates:
Quarter 1 updates presented and approved at QIHEW and QIHEC. Q2 updates completed pending update at QIHEW in August, and QIHEC in September.

QUALITY OF CLINICAL CARE
MCAS Intervention
Reporting purpose is to develop a comprehensive MCAS workgroup to capture, plan, and discuss quality improvement activities that will improve DHCS required MCAS measures, and NCQA HEDIS prioritized measures. Provider Partnership program established and launched.

Overall strategic goal is to improve Merced County Pediatric Measures by a 5 percentile increase over MY 22 each year through 2026. In addition to children's health measures sanctioned in Merced there were there are two women's health measures that also fell below the minimum performance level (MPL) held to the 50th percentile. Goal is to reach the following:

- Child and Adolescent Well-Care Visits (WCV) - 48.0% (45th percentile)
- Childhood Immunizations - Combo 10 (CIS-10) - 24.5% (14th percentile).
- Immunizations for Adolescents - Combo 2 (IMA–2) - 35.2% (50th percentile).
- Lead Screening in Children (LSC) - 53.2% (25th percentile).
- Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6)- (16th percentile)
- Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 60.8% (28th percentile)
- Breast Cancer Screening (BCS) - 52.6% (50th percentile).
- Chlamydia Screening in Women (CHL-Tot) - 56.04% (50th percentile).

Report Previously Identified Issues/Highlights:

In Q2 2024 five practices enrolled by April 2024, two focused measures selected per site, and project charters were completed for provider partnership. Monthly practice coaching sessions

and quarterly data review meetings began in April 2024. MCAS committee work included tracking projects and initiatives that may impact MCAS measures through interviewing key stakeholders across the organization.

Care Base Incentive
Reporting purpose is to enhance Provider Portal reports to streamline access to reports and increase availability of functions and measures monthly. Increase access to introductory CBI program information for network providers. Planned activities include:

Enhance monthly quality provider portal report data and functionality.

- Create business requirements for a roll-up function that allows multiple clinics sites to see a combined monthly rate for measures available monthly on the Provider Portal Quality Report.
- Develop workflow to extract and generate the additional column that notes members meeting continuous enrollment specifications to applicable monthly Provider Portal Quality reports.
- Create business requirements to add trending graphs to monthly quality reports.
- Create business requirements to add a Gaps in Care report.
- Create business requirements to generate email reminders for portal reports for providers.

Increase access to introductory CBI program information for network providers.

- Record a CBI 2024 introductory video inclusive of Provider Portal Data Submission Tool (DST), and Provider Portal Quality and CBI reports.
- Published video on the Alliance Webinars and Training website.
- Advertise video to network providers, with additional targeting for newly added Mariposa and San Benito County providers.
- Create and record coding training material for MCAS/CBI on available portal reports.

Report Changes/Updates:

Combined the training videos for the CBI introduction, Data Submission Tool (DST) and provider portal reports into one training video for ease of use by provider clinics. CBI Introduction video completed and released. Business requirements completed for continuous enrollment.

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

No previously identified issues/highlights were noted.

Report Changes/Updates:

Goal 1:
On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal department staff that interact with members to increase awareness of Health Education services and health rewards available for members. A minimum of 2 presentations will be conducted per quarter.

- Q2 progress: A total of 6 presentations on Health Education services and Member Health Rewards were coordinated and completed in Quarter 2. This included internal and external audiences.

Goal 2:
On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.

- Q2 progress: The project team included 1 article in the June 2024 Member Newsletter informing members of member incentive programs available to them. Additionally, the Health Educators completed 671 outreach calls to offer members health and wellness programs.

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

- Q2 progress: The project team completed a total of 44-member experience surveys.

Goal 4:
On a quarterly basis increase the number of member workshops provided by the Health Education Team in comparison to 2023 baseline. A minimum of 4 workshops will be offered per quarter.

- Q2 progress: A total of 5 member workshops were completed during the reporting period. Virtual and telephonic workshops were completed.

SAFETY OF CLINICAL CARE
Facility Site Review and Potential Quality Issues

Identified Issues: Staffing to perform site reviews. (2) Positions were approved and are awaiting HR posting.

Goal Results:

- 11/13 or 85% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.

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

Report Previously Identified Issues/Highlights:
Facility Site Review:
Identified Issues: Staffing to perform site reviews. (2) Positions were approved and are awaiting HR posting.

Goal Results:

1. 11/13 or 85% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.
2. 11/12 or 92% (goal: 100%) of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.

Report changes / Updates:

1. Preparation for hiring (2) FSR positions has taken longer than anticipated. However, having FSR-specific position descriptions outlining DHCS expectations and maintenance of certification and IRR participation, as outlined in APL 22-017, was critical for job requirements.
2. Goal (100%) not met: 92% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.
    - (1) The provider did not complete their DHCS CAP by the timeframes outlined in APL 22-017.
    - Provider interventions included email, letters, phone calls, Provider Services, and Medical Director involvement.
    - Review date: 1/11/2024.
    - CAP issued: 1/15/2024, membership frozen.
    - Incomplete CAP response received 1/23/2024.
    - Provider declared a family emergency in Mexico and would complete by 5/3/2024.
    - 5/6/2024 Letter signed by MD sent to provider.
    - 5/13/2024 Provider submitted CAP; CAP closed and verified.
    - 7/26/2024 DHCS made aware of failed CAP.
    - Follow-up: Focus Review due by 1/11/2025

Potential Quality Issues

Identified Issues:

1. Staffing to balance regulatory PQIs, internal PQI referrals, collaboration work, and quality studies focused on improving the quality of care for members.
2. Identification of LTSS members. We are implementing a retrospective review approach (vs. proactive identification) based on member IDs and claims reports for PQIs investigated that quarter for DHCS Critical Incident reporting.

Results:

1. 98/98 or 100% (goal: 100%) of member grievances received by QI related to the potential medical quality of care issues are completed within Member Grievance regulatory timeframes.
2. 20/30 or 67% (goal: 80%) of non-grievance related PQIs are completed within 90 calendar days.20/30 or 67% (goal: 80%) of non-grievance related PQIs are completed within 90 calendar days.

Report Changes/Updates:

1. Project work with Health Services Operations regarding LTSS implementation of APLs 23-004, 023, and 027.
2. QI RNs prioritize regulatory PQIs based on member complaints. This prioritization and current staffing have caused internal referral PQIs to go over their assigned 90-day due dates and have impacted collaboration work outside of regulatory PQIs, such as Academic Detailing in collaboration with Pharmacy and focused Quality Studies, such as

opioid/benzo co-prescribing and reports to isolate impacted members by inappropriate co-prescribing.

Grievance and Appeals
Reporting purpose is to provide an update and review of AG performance, trends, and activities for the Appeals and Grievance Program during Quarter 2 of 2024.

Previously identified issues/highlights:

Identified Issues:
1. Staffing deficiency emerged in June after two long-term AG employees transitioned out of the unit.
2. System testing for new CMSR system (Jiva), training and preparation for slowdowns due to learning curves.

Results:
1. Active recruitment underway to stabilize staffing resources and sustain regulatory performance. Regulatory performance met during Q2 2024.
2. AG staff prepared for new CMSR (Jiva) implementation with backup plans to ensure regulatory compliance.

CoC of Medical and Behavioral Health
Reporting purpose is to outline goals, activities, and target completion date for CoC of Medical and Behavioral Health care.

Previously identified issues / highlights:
1. Lack of accessible in person appointments within 10 business days for many BH providers/members not having first appointment within 10 business days
2. Discovery of pending BHT referrals through Carelon not linked to services in a timely manner.
3. BH team informed by BH providers of difficulty with credentialing timelines and referral questions.

Report changes / updates:
- BH Manager presented on BH benefits to MSAG group in 2/2024.
- BH Manager presented on BH benefits to WHM advisory committee in 3/2024.
- BH Manager and QI team presented at PAG in 5/2024 on current BH measures, including discussion from providers related to BH benefit.
- BH Manager attended outreach event in Merced County in 5/2024 on BH benefits.
- BH Managers invited to several of the hospital JOC meetings, where psychiatric hospitalizations (FUA FUM measures) were discussed.
- Weekly meetings with Carelon to review data on BHT referrals and linkage to care.
- BH Managers met with Monterey group of pediatricians, along with other alliance and Carelon staff, in 7/2025 to discuss BH services and referral process and barriers.
- Outreach events attended by BH manager in our 2 new counties.
- Workgroup started with Merced BHRS in 6/2024 on high utilizers and ED visits.

MEMBER EXPERIENCE

Member Satisfaction Survey – CAHPS
Reporting purpose is to update the group on the progress of CAHPS work.

Report Previously Identified Issues/Highlights:
- Team previously identified that CAHPS surveys were not fielded timely which led to delayed results.

Report Changes/ Updates:
- In Q2 2024 CAHPS Medicaid and IHSS surveys were fielded timely. We are waiting to receive results which are expected in Q4 2024.

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

Report Previously Identified Issues/Highlights:
- Goals met due to the addition of FTE's, SLA increased by 31% and abandonment rate decreased by 4.5%.
- Small decrease in Walk-ins, we assisted 1,510 Walkin members.

Report Changes / Updates:
- Addition of FTE/ Call Center Supervisors successful, working on a workforce Management Tool to increase efficiencies.

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

No previously identified issues/highlights were noted.

Report Changes / Updates:

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

Q2 progress: A total of 3 presentations on C&L services were completed in Quarter 2.

Goal 2:
On a quarterly basis, inform members of C&L Services available to them in 2024 utilizing at least 1 member informing modality.

Q2 progress: In April 2024 language assistance services was highlighted on the Alliance Facebook page.

Goal 3:

On a quarterly basis, collect member feedback on their experience with language assistance services in a clinical setting.

Q2 progress: The project team completed a total of 53-member experience surveys.

Goal 4:
Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2023 baseline utilization data.

Q2 progress:

- Phone interpreting services: There was a total of 6,904 total calls in Q2 by provider sites. This reflects an increase of 45% compared to Q2 in 2023.
- Face-to-Face (F2F) interpreting services: There was a total of 1,542 requests in all service counties for F2F. This reflects an increase of 18.65% compared to Q2 in 2023.
    - Santa Cruz County had 627 requests in Q2. This was a 35% increase compared to Q2 2023.
    - Merced County had 507 requests in Q2. This was a 20% increase compared to Q2 2023.
    - Monterey County had 404 requests in Q2. This was a 2% decrease compared to Q2 of 2023.
    - San Benito County had 4 requests in Q4. This is a new service county and there was no comparison for 2023.
    - Mariposa County had 0 requests in Q2. This is a new service county and there was no comparison for 2023.

Delegation Oversight

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

No previously identified issues were noted.

Report Changes / Updates:

All delegate reports for the quarter were received and reviewed with no gaps identified. No issues with delegate reports. QIPH working with Compliance to ensure all delegate reports meet NCQA requirements.

Conclusion: The QIHET Workplan does not have any critical areas of concern that require further intervention or follow-up. There is continued progress toward goals for the initiatives and operational metrics, including addressing any barriers to achieve outcomes. The pandemic continues to impact provider staffing and active engagement; however, there are efforts in participation and the team is providing support as needed.

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

Attachments.

1. Q2 2024 Quality Improvement and Population Health Transformation Program Workplan.

SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To develop a comprehensive evaluation of all Quality Improvement activities for 2024.	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements.	1/1/2024	Andrea Swan, Quality Improvement & Population Health Director	1st update- On track to meet all quarterly updates to QIHEC with appropriate approvals, and no barriers noted. Workplan structure with initial goals was approved by QIHEC 2/2024.	1: No identified issues or barriers.	1. Continue with action plan.	☑ Yes ☐ No	N/A
2.	2. Present for approval Quality Improvement workplan which contains all required sections for the evaluation.	3/31/2024 – 3/31/2024	Andrea Swan, Quality Improvement & Population Health Director				☐ Yes ☐ No	
3.	3. Ensure all quarterly updates are reviewed and approved by QIHEC.	3/31/24,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	2nd update	2:	2:	☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

PROGRAM DESCRIPTION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Finalize 2024 Program Description for presentation to QIHEC	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements.	1/31/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director	1st update: Program description was finalized 5/15/2024. but has not been presented to QIHEW as it is currently being reviewed by NCQA team to ensure all elements have been met.	1: Program description completed in prior year were not sufficient to meet new DHCS and NCQA standards. Program description has been reviewed to meet all regulatory requirements.	1 Present finalized program description to QIHEW by the end of June 2024.	☐ Yes ☑ No	N/A
2. Presentation of the Program Description to both the QIHEW, and QIHEC for approval by 3/31/2024	2. Submission of Program Description to QIHEW staff	2/1/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director				☐ Yes ☐ No	

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3. Develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS, and NCQA requirements.	3. Review all DHCS, and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2024-12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	2nd update:	2:	2:	☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

ANNUAL WORKPLAN (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To executes a QI program annual work plan that reflects ongoing activities throughout the year and addresses all required DHCS, and NCQA requirements	1. Create a workplan that captures yearly activities, time frame for each activity's completion, staff members responsible for each activity, monitoring of previously identified issues, and evaluation of QI program.	1/1/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1: Workplan successfully completed, and approved at QIHEW, and QIHEC in the 1st quarter of 2024. 1st quarter updates have been completed pending presentation to QIHEW and QIHEC. Qtr. 2 Quarter 1 updates presented and approved at QIHEW and QIHEC. Q2 updates completed pending update at QIHEW in August, and QIHEC in Sept.	1: Current workplan needed to be updated to meet DHCS and NCQA requirements which was successfully completed. 2: With the presentation of workplan goals within the QIPH committee feedback included in the need to establish clear baselines, and timeframes. The workplan was updated, and presented with changes, and approved.	1: Continue to work with business owners for timely submission, and ensuring work plan updates meet requirements and reflect progress towards goals.	☑ Yes ☐ No	N/A
2. Ensure all workplan elements are properly documented and reflect appropriate follow up by each business owner.	2. Regular quarterly check-ins to review workplan entries, with regular feedback provided to business owners when applicable.	3/31/204,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director				☑ Yes ☐ No	
3. Review and approval of workplan quarterly by QIHEC	3. Review of all workplan entries prior to each committee to ensure appropriate documentation.	3/31/204,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	Qtr. 3: Qtr. 4:	3:	2	☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

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SECTION 2: QUALITY OF CLINICAL CARE

MCAS INTERVENTION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Establish and launch Provider Partnership program	1. Sign up 4 providers by 3.31.24. 2. Do onsite meetings and observations by 4.31.24. 3. Develop and implement interventions for 1-2 MCAS measures at each site by 6.30.24. 4. Monitor and adjust interventions and MCAS rates 9.30.24	1/1/24-3/31/24 3/31/24-4/31/24 4/1/24-6/30/24 7/1/24-9/30/24	Alex Sanchez, Quality Improvement Advisor	Five practices enrolled by April 2024. 2 Focused measures selected per site, with project charters completed. Monthly practice coaching sessions and quarterly data review meetings began in April 2024.		Intervention planning underway	☑ Yes ☐ No	Overall, all roll-out goals have been met. Practices benefiting from constant collaboration with QIPA staff (2 liaisons per site). Education is an overwhelming gap identified and requested for CCAH assistance.
2. Develop a comprehensive MCAS committee to capture, plan, and discuss quality improvement activities that will improve DHCS required MCAS measures, and NCQA HEDIS prioritized measures. Overall strategic goal is to improve Merced County Pediatric Measures by a 5 percentile increase over MY 22 each year through 2026. In addition to children's health measures	1. Create project charter and project tracker. 2. Establish regular monthly check-in with committee to monitor activities. 3. Evaluation current intervention strategies against finalized audited measurement year (MY) MY2023 MCAS measure rates. 4. Request direction of interventions from.	1/1/2024-3/31/2024 3/1/2024-6/30/2024 6/17/23-8/31/2024 4/1/24-12/31/2024	Britta Vigurs, Quality Improvement Program Advisor	In Q1 2024 we drafted the MCAS Workgroup Meeting Charter and identified stakeholders across the Alliance to attend future meetings as core attendees or ad hoc. Topic tracker has been drafted to assist identifying standing agenda items and future topics based on priorities. MCAS Measurement Year (MY) 2023 rates (Report Year 2024) in Merced County show improvements in all measures but Immunizations for Adolescents (IMA-2). Child and Adolescent	The previous cross-departmental workgroup to address MCAS measures during the pandemic was structured more for reporting out, rather than allowing active work within the meeting to identify and flag barriers in projects.	This meeting will reoccur monthly.	☑ Yes ☐ No	This MCAS committee meeting is structured to be an interdisciplinary workgroup to review and approve interventions, as well as serve as working sessions to problem solve barriers. There were a number of new quality

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sanctioned in Merced there were there are two women's health measures that also fell below the minimum performance level (MPL) held to the 50th percentile. Goal is to reach the following: • Child and Adolescent Well-Care Visits (WCV) - 48.0% (45th percentile) • Childhood Immunizations - Combo 10 (CIS-10) - 24.5% (14th percentile). • Immunizations for Adolescents - Combo 2 (IMA–2) - 35.2% (50th percentile). • Lead Screening in Children (LSC) - 53.2% (25th percentile). • Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6)- (16th %ile) • Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 60.8% (28th %ile) • Breast Cancer Screening (BCS) - 52.6% (50th percentile). Chlamydia Screening in Women (CHL-Tot) - 56.04% (50th percentile).				Well-Care Visits (WCV), Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6+), Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30-2+), and Breast Cancer Screening met 2023 Target Goals. WCV, W30-6+ and BCS are on track for 2024.				improvement projects within the provider network last year in 2023, which would have helped drive improvements in targeted measures like BCS and W30-6+.

CARE BASE INCENTIVE (CBI) (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Enhance Provider Portal reports to streamline access to reports and increase availability of functions and measures monthly.	1. Create business requirements for a roll-up function that allows multiple clinics sites to see a combined monthly rate for measures available monthly on the Provider Portal Quality Report. 2. Develop workflow to extract and generate additional columns that note members meeting continuous enrollment specifications to applicable monthly Provider Portal Quality reports. 3. Create business requirements to add trending graphs to monthly quality reports. 4. Create business requirements to add a Gaps in Care report. 5. Create business requirements to generate email reminders for portal reports for providers.	1/1/2024-3/31/2024 1/1/2024-6/30/2024 6/30/2024-12/31/2024 4/1/2024-12/31/2024	Alex Sanchez, Quality Improvement Program Advisor, Magdalena Kowalska, Quality Improvement Program Advisor, Shannon Fletcher, Quality Improvement Program Advisor, Annecy Majoros, Quality Improvement Program Advisor	1. Roll-up function has been deployed on the Provider Portal Quality Reports in Q1 2024. 2. Work for business requirements completed in Q2 2024. 3. Business requirements completed and submitted to ITS in Q1 2023. 4. Work to start in Q2 2024. 5. Completed draft language in Q1 2024.	Competing priorities for staff, and limited staffing available to build and test reports. Limited visual and report functionalities of the provider portal.	1. No further action required. 2. Submission of portal tickets, development, and testing. 3. Development and testing. 4. Development of business requirements by QIPH, development of report by ITS, and QA by QIPH. 5. Continued discussions with staff from Provider Services and Quality Improvement and Population Health on portal feature development, then	☑ Yes ☐ No	Initial reports with target dates in Q1 were successfully completed with no issues after collaborating on the easiest technological solution. Anticipate potential bandwidth challenges for the rest of the report enhancements due to regulatory and non-regulatory alliance projects.

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		4/1/2024- 12/31/2024 1/31/2024- 3/31/2024				development and testing of the function.		
2. Increase access to introductory CBI program information for network providers.	1. Record a CBI 2024 introductory video. 2. Create survey for feedback on training content. 3. Published video on the Alliance Webinars and Training website. 4. Advertise video to network providers, with additional targeting for newly added Mariposa and San Benito County providers. 5. Create Data Submission Tool (DST) training video. 6. Create and record coding training material for MCAS/CBI.	4/1/2024- 5/30/2024. 4/1/2024- 5/30/2024. 6/1/2024- 6/30/2024 7/1/2024- 7/31/2024 6/1/2024- 8/31/2024 6/1/24-8/31/24	Annecy Majoros, Quality Improvement Program Advisor, Juan Velarde, Quality Improvement Program Advisor, Britta Vigurs, Quality Improvement Program Advisor, Tera Mendoza, Coding Resource Specialist	Work completed for CBI Introduction video in Q2 2024.	Bandwidth of staff to complete the training videos in competition with regulatory and other project obligations.	Development in Q2-Q3 coding training resources.	☑ Yes ☐ No	Planned activities were updated to combined the training videos for the CBI introduction, DST and provider portal reports into one training video for ease of use by provider clinics.

BASIC POPULATION HEALTH MANAGEMENT (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal department staff that interact with members to increase awareness of Health Education services and health rewards available for members. 2. A minimum of 2 presentations will be conducted per quarter.	1. The project team will reach out to internal departments that interact with members. Examples of teams: a. Health Education team b. Member Services team c. Care Coordination team d. Community Engagement team 2. Schedule presentations 3. Deliver Health Education and Member Health Rewards services presentation. 4. Request input regarding presentation content and any member needs that they have encountered regarding Health Education services.	3/31/2024, 6/30/2024 9/30/2024, 12/31/2024	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	A total of 6 presentations on Health Education services and Member Health Rewards were coordinated and completed in Quarter 1. Presentations were delivered to the following audiences: • Member Services Call Center representatives • Merced County Provider meeting • Provider Relations team new hire • Case Management teams • Community Engagement team new hires • Livingston Community Health Call Center staff	In Q1 we were training and onboarding new staff. As we entered Q2 were able to offer and schedule more presentations.	The project team will continue to coordinate presentations for internal departments and Alliance staff in Q3. A minimum of 2 presentations on Health Education Services and Member Incentives will be completed in Q3. Additionally, team members will explore offering the presentation to external audiences in Q3-Q4.	☑ Yes ☐ No	This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members. Additionally, in Q2 the project team presented to external audiences including Merced County provider representatives and at a Merced County site Livingston Community Health.

3. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.	1. The project team will conduct outreach and education activities to inform members of services available to them via: a. Member outreach calls b. Member workshops c. Member mailings d. Member newsletter articles e. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	The following activities were completed in Q2 to inform members of Health and Wellness programs: • <u>Member Newsletter:</u> The project team included 1 article in the June 2024 Member Newsletter informing members of member incentive programs available to them. • <u>Member outreach calls:</u> The Health Education team completed 671 outreach calls in Q2 to offer members.	No issues to report in Q2.	The project team will continue to conduct outreach calls each quarter. The project team will include health and wellness information in the September 2024 Member Newsletter.	☑ Yes ☐ No	The member newsletters result in higher calls to the Health Education Line regarding programs included in the newsletter. Health Education staff are aware of when notices are sent to members to ensure questions on program enrollment can be answered. In Q2 the Health Education Line received 903 incoming calls from members, providers and the community regarding Quality and Health Programs services.
4. On a quarterly basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact.	1. The project team will conduct satisfaction surveys with members to evaluate: a. Information about the overall program b. Usefulness of the information shared. c. Percentage of members indicating that the program helped them achieve health goals. 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	The member survey efforts are under review with NCQA Health Plan accreditation consultants. There were no additional surveys completed in Q2 after the in the last report. Once NCQA consultants approve the report and surveys submitted additional outreach be completed. This is anticipated for Q3 and Q4. In the previous report, member feedback surveys were completed in Q2 to evaluate services in Q1. These were included in the Q1 report. <u>Member Satisfaction Surveys completed in Q1-Q2:</u> The project team completed a total	In Q2 the member survey data collected was reported and shared with NCQA consultants. The approval for the report is in progress. Once approved, surveys will continue with members in Q3.	Once NCQA consultants approve the reporting metrics the project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.	☑ Yes ☐ No	Member feedback surveys were placed on hold in late Q2 in order to allow time for NCQA Health Plan accreditation consultants to review the data collected. Once approved surveys with members will continue.

				of 44-member experience surveys.				
4. On a quarterly basis increase the number of member workshops provided by the Health Education Team in comparison to 2023 baseline. In 2023 there were on average 2 workshops scheduled per quarter. In 2024 the team will double this number and offer at minimum 4 workshops per quarter.	1. The Health Educators will conduct a minimum of 4 member workshops per quarter. 2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs. 3. Health Educators will lead.	3/31/2024, 6/30/2024, 9/30/2024, 12/31/2024	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	A total of 5 member workshops were completed in Q2. The following workshop modalities and languages were completed: • 2 virtual Live Better with Diabetes (LBD) groups (1 English, 1 Spanish) • 1 telephonic Healthier Living Program (HLP) group in Spanish • 2 virtual Healthy Weight for Life (HWL) groups (1 English, 1 Spanish)	No issues to report in Q2.	The project team will continue to schedule workshops to meet the quarterly goal of a minimum of 4 workshops per quarter.	☑ Yes ☐ No	The project team continues to experience high interest in member workshops.

SECTION 3: SAFETY OF CLINICAL CARE

FACILITY SITE REVIEW (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.	1. Address current staffing to support provider scheduling by onboarding three additional QI RNs to perform facility site reviews. 2. Review upcoming reviews one quarter prior. 3. Schedule reviews by sending the provider sites multiple review dates to choose from two months before the review due date. 4. Continue communication with the provider site until a review date is confirmed.	01/01/2024 – 03/29/2024	Joana Castaneda, Quality Project Specialist, Tisha Criswell Senior Quality Improvement Nurse, Nicole Lyles, Senior Quality Improvement Nurse	1. Goal results: 11/13 or 85% 2. Worked with HR to develop FSR-specific position description and will post (2) FSR positions in Q3 2024. 3. Upcoming reviews for Q3 have been reviewed for planning in Q2. 4. Communications to providers for Q3 reviews have been initiated.	1. Staffing to perform site reviews. (2) Positions were approved and are awaiting HR posting.	1. Continued engagement with HR regarding (2) approved QI RN positions for FSR. 2. Communicate with providers with site reviews due in Q3 regarding date selection until a date is confirmed.	☑ Yes ☐ No	Preparation for hiring (2) FSR positions has taken longer than anticipated. However, having FSR-specific position descriptions outlining DHCS expectations and maintenance of certification and IRR participation, as outlined in APL 22-017, was critical for job requirements.
2. 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.	1. Address current staffing to support CAP management by onboarding three additional QI RNs to perform facility site review. 2. Send email reminders to provider sites with CAP due dates. 3. Address non-responsive providers with direct phone calls and PRR involvement.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Tisha Criswell Senior Quality Improvement Nurse, Nicole Lyles, Senior Quality Improvement Nurse	1. Goal results: 11/12 or 92% 2. Worked with HR to develop FSR-specific positions and will post (2) FSR positions in Q3 2024. 3. Communications were sent to providers with CAP to remind the site of due dates. 4. (1) provider was reported to DHCS for failed Medical Record Review (MRR) CAP in Q2. Emails, letters, phone calls, and PRR involvement were used as interventions.	1. Staffing to perform site reviews. (2) Positions were approved and are awaiting HR posting.	1. Continued engagement with HR regarding (2) approved QI RN positions for FSR. 2. Continue communication with providers regarding CAP due dates. 3. Address any non-responsive providers with direct phone	☐ Yes ☑ No	Failed CAP Timeline: 1. 1/11/24 MRR 62%, 1st failure. PRR was made aware of MRR results and CAP. 2. 1/15/24 MRR CAP issued due 2/26/24. 3. 1/16/24 key stakeholders in the organization were made aware of the provider's MRR results and to freeze membership. 4. 1/23/24: incomplete CAP response submitted by

						calls and PRR involvement.		the provider. 5. On 2/21/24, the provider was sent a letter (PRR cc'd) of the upcoming CAP due date for all XAP elements. 6. The provider states he is in Mexico for a family emergency and will complete it by 5/3/24. 7. 5/6/24: Letter sent by MD regarding CAP. 8. 5/13/24 CAP closed and verified. 9. On 7/26/24, DHCS was notified of the failed CAP submission outside of the due dates outlined in APL 22-017. 10. Focused Review is due by 1/11/25.
4.	4.						☐ Yes ☐ No	

POTENTIAL QUALITY ISSUES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 100% of member grievances received by QI related to the potential medical quality of care issues are completed within Member Grievance regulatory timeframes.	2. Create due dates in SharePoint for PQIs that provide enough time for investigation and translation needs (if applicable) and for the Grievance Coordinator to resolve the case. 3. If medical records are needed for the PQI investigation, request timely upon case assignment to QI RN. 4. Coordinate timely discussion if the case requires MD guidance or potential P2/P3 recommendation.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Emily Kaufman, Clinical Safety Supervisor, Eleni Pappazisis, Quality Improvement Program Advisor, Naomi Kawabata, Senior Quality Improvement Nurse Nurse, Katie Lutz, Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, and Bethany Fung, Quality Improvement Nurse	1. Goal results: 100%; 98/98 of cases closed timely. 2. Due dates were created in SharePoint and used to guide the closure of regulatory PQIs. 3. Medical records were requested timely for PQI investigations by QI RN. 4. Timely discussions were held with MD for P2/P3 cases.	1. Staffing to balance regulatory PQIs, internal PQI referrals, collaboration work, and/or quality studies focused on improving the quality of care for members. 2. Identification of LTSS members. We are implementing a retrospective review approach (vs. proactive identification) based on claims reports for PQIs investigated that quarter for DHCS Critical Incident reporting.	3. Continue creating due dates in SharePoint to prioritize promptly closing regulatory-based PQIs. 4. Continue requesting medical records when needed for investigation and timely case closure. 5. Continue weekly MD meetings to discuss potential P2/P3 cases requiring guidance not to inhibit timely case closure. 6. Continue retrospective review approach to capture LTSS members for DHCS Critical Incident reporting pending brainstorming with key departments to develop a "flag" in HSP or JIVA.	☑ Yes ☐ No	Project work with Health Services Operations regarding LTSS implementation of APLs 23-004, 023, and 027.
1. 80% of non-grievance related PQIs are completed within 90 calendar days.	2. Triage and prioritize incoming internal referrals for the following case types:	01/01/2024 – 03/29/2024	Eleni Pappazisis, Quality Improvement Program Advisor, Naomi Kawabata, Senior Quality Improvement Nurse, Emily Kaufman, Senior Quality Improvement Nurse, Katie Lutz, Quality Improvement	1. Goal results: 57%; 20/30 cases closed on time. 2. The team triaged and prioritized incoming internal	1. Staffing to balance regulatory PQIs, internal PQI referrals, collaboration work, and/or quality studies focused on	1. Continue to triage incoming 90-day referrals.	☐ Yes ☑ No	QI RNs prioritize regulatory PQIs based on member complaints. This prioritization and

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	a. Known provider to track and trend. b. Provider on a CAP or open Quality Study c. LTSS member 3. Consider revising the PQI policy to expand the due date to 120 days.	3/31/204,6/30/2024 9/30/2024,12/31/2024	Nurse, Sandy Clay Senior Quality Improvement Nurse, and Bethany Fung, Quality Improvement Nurse	referrals to the best of their ability for the following case types: a. Known provider to track and trend. b. Provider on a CAP or open Quality Study c. LTSS member	improving the quality of care for members.	2. Decline collaborative work and be selective regarding Quality Studies until the team can close regulatory and internal referral PQIs at 100% compliance. 3. Consider revising the PQI policy to expand the due date to 120 days.		current staffing have caused internal referral PQIs to go over their assigned 90-day due dates and have impacted collaboration work outside of regulatory PQIs, such as Academic Detailing in collaboration with Pharmacy and focused Quality Studies, such as opioid/benzo co-prescribing and reports to isolate impacted members by inappropriate co-prescribing.
3:	3.						☐ Yes ☐ No	

GRIEVANCE & APPEALS REVIEW (SARAH SANDERS)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide grievance updates to interdisciplinary groups including SGRC and QIHEW.	a. Monitor and process concerns within regulatory timeframes. b. Provide internal communications on appeal and grievances trends and outcomes. c. Track and trend grievance data by demographics including language to analyze disparities. d. Identify actionable opportunities for improvement	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q2 updates: SGRC for 2/15 & 4/11 QIHEW 2/29 & 5/29 Q2: June staffing deficiency & preparations for CMSR (Jiva) system replacement to ensure regulatory compliance.	Q2: n/a	Continue monitoring regulatory compliance and trends. Active staffing recruitment planned for Q3-24 to ensure appropriate staffing to support regulatory compliance.	☑ Yes ☐ No	Close monitoring, communications and tracking of AG occurred
2. Support Members by resolving issues of dissatisfaction with the Alliance.	a. Ensure that where appropriate, corrective action is implemented and effective in improving identified problems. b. Track grievance and appeals for access/QOC trends, system issues, and identify actionable corrections needed.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q2 updates: ROLT	ROLT Transport	QI action and monitoring for responsiveness	☑ Yes ☐ No	ROLT Transport CAP occurred in Q2
3. Quality Data: External Report requirements are met 100% of the time.	a. Monitor timely data and state submissions to ensure completeness.	01/01/2024 – 03/29/2024	Sarah Sanders, Grievance and Quality Manager	Q2: Accuracy achieved.	Q2: n/a	Monitor for when new benefit types are required for MCPD reporting.	☑ Yes ☐ No	New tableau reports created for NCQA & MCPD

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	b. Evaluate and identify opportunities to improve the data accuracy of AG information.	3/31/204,6/30/2024 9/30/2024,12/31/2024		*Note updates to MCPD to expand benefit types for AG proposed by DHCS for Q3 implementation				benefit additions planned for go-live in Q3-24.
4. Ongoing monitoring of AG results to support that appropriate action is taken when occurrences of poor performance are identified. Identify and track allegations of discrimination.	a. Identify and, when appropriate, act on substantiated issues in a timely manner. Monitor and report findings bi-monthly. Complete audits for allegations of discrimination to monitor, prevent and identify any discriminatory practices.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q2: Discrimination reviews completed	Q2: n/a	Monitor outliers	☑ Yes ☐ No	Results Achieved.

COC OF MEDICAL & BEHAVORIAL HEALTH (REBECCA MCMULLEN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase Utilization of BH benefit overall by 2.5% within the Behavioral health network in Merced County, from a baseline of 4.07% by 12/31/2024, by increasing provider and member education about BH benefits offered	-At minimum, annual BH team member attendance at PAG and QIHEC meetings to discuss BH services -At minimum, annual BH team member attendance at MSAG or other similar member forums to discuss BH services such as WCM advisory committee -Quarterly attendance at ER JOC meetings by BH team member to address questions related to BH benefit -increase in provider outreach and education via provider newsletters -Promotion of BH services at outreach activities (at least 3) in Merced County -Meet with Delegate (Carelon) monthly and MHPs at minimum quarterly to track and discuss appropriate referrals and transitions to the NSMHS benefit.	By 10/31/2024 Attended by 2/8/2024 Ongoing, started 5/1/2024 By 12/31/2024 Ongoing, started in 5/1/2024 Ongoing, started 1/1/2024	- Rebecca McMullen, BH Manager and/or Shae Redwine, BH Analyst - Communications department manager, Provider Services Manager, Member Services Manager	Q2 update: -BH Manager presented on BH benefits to MSAG group in 2/2024 -BH Manager presented on BH benefits to WHM advisory committee in 3/2024 -BH Manager and QI presented at PAG in 5/2024 on current BH measures, including discussion from providers related to BH benefit -BH Manager attended outreach event in Merced County in 5/2024 on BH benefits -BH Managers invited to several of the hospital JOC meetings, where psychiatric hospitalizations (FUA FUM measure) were discussed. -Weekly meetings with Carelon to review data on BHT referrals and linkage to care, specifically. - BH Managers met with Monterey group of pediatricians, along with other alliance and carelon staff, in 7/2025 to discuss BH services and referral process and barriers. -Carelon to provide the BH service until 6/30/25 -Workgroup started with Merced BHRS in 6/2024 on high utilizers and ED visits	-Lack of accessible in person appointments within 10 business days for many BH providers/members not having initial appointment occur within 10 business days - Discovery of pending BHT referrals through Carelon not linked to services in a timely manner -BH team informed by BH providers of difficulty with credentialing timelines and referral questions	-BH services will be insourced in 7/2025 with goal to increase utilization and member and provider experience. -By 1/1/25, BH, along other applicable departments, will coordinate around annual communication to members and providers to ensure they are aware of BH benefits -BH Manager working with Carelon to update BHT referral form for ease of use for providers to reduce incomplete referrals and members not being linked to services. -Weekly meetings to continue with Carelon at minimum through August and into September 2025 for ongoing monitoring of BHT data referrals. -BH Manager to meet with Monterey Pediatrician team again in 9/2025 for follow up on BH services.	☐ Yes X No	The reason why goal was not met is due to several factors related to lack of education of BH benefit to members and providers, lack of available providers in the BH space, difficulty referring members to the BH benefit and lack of follow through on referrals submitted incorrectly or with insufficient information.

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				-Outreach events attended by BH manager in our 2 new counties				
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	

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SECTION 4: MEMBER EXPERIENCE

MEMBER SATISFACTION SURVEY – CAHPS (SARINA KING)								
Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start& end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. CAHPS survey fielded timely, and results reported out to internal stakeholders within 8 weeks of receiving results	1. CAHPS workflows, processes, and timelines documented and reviewed in Q1 2024, and steps are taken to begin MY2023 surveys	2/8/24 – 3/31/24	Alex Sanchez, Quality Improvement Program Advisor	Medicaid fielding has been completed. IHSS fielding ended 8/5. Benchmark results are expected in Q4.	Previously fielding was not always completed in a timely manner which led to delayed results.	• Medicaid fielding stops – • CG CAHPS planning begins. • ECHO CAHPS planning for MY2024 begins. • Results will be received and shared in Q4/Q125	☑ Yes ☐ No	Creating the workflows and timelines and coordinating with all involved parties led to do timely fielding of the Medicaid and IHSS surveys.
2. Increase organizational awareness of what CAHPS is and current what current rates are	2. Present MY 2022 CAHPS rates to targeted and appropriate stakeholders 1. Begin outreach to chiefs/admins to present CAHPS overview and high-level rates to organization at all-staff or division meetings	3/1/2024 – 10/31/24 Same timeline as above	Sarina King, Quality Performance Improvement Manager	In Q2, meetings with Member Services and Provider Services Directors were held to discuss results and interventions.	Current issues that we are working through involve getting organizational involvement and alignment on CAHPS interventions based on previous MY results.	Work with the Project Management Office and the executive leadership team to get organizational support on MY 2023 CAHPS interventions.	☑ Yes ☐ No	We have continued to lay the groundwork for organizational support and alignment to focus on CAHPS interventions. Once we have MY23 results, we will be sure to add the interventions to the workplan and measure specific improvement efforts.

SECTION 4: QUALITY OF SERVICE

ACCESS & AVAILABILITY (AA) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with DMHC Timely Access Survey Requirements	1. Ensure 90% of After-hours triage compliance in Timely Access Survey. (Provider Appointment Availability Survey [PAAS]). 2. Ensure 75% Urgent and routine appointment access compliance, as well as next available follow up appointment for non-physician mental health care, within required time frames. 3. PAAS work begins in the summer with vendor engagement and finalization of the project plan and contact lists. The survey is launched from August to November/December. Results are available in Q1 of the subsequent year.	7/1/2024-12/31/2024	Jessie Dybdahl, Provider Service Director	None	None	None	☐ Yes ☐ No	none
2. Quarterly review of provider to member ratios for PCPs and High-volume/high-impact Specialties. To ensure all ratios meet regulatory requirements.	1. Ensure provider to member ratios are w/in compliance and mitigate if out of compliance on a quarterly basis. 2. Tableau report is monitored no less than quarterly to ensure provider to member ratios are met for each required provider type.	1/1/2024-3/31/2024	Jessie Dybdahl, Provider Service Director	None	None	None	☐ Yes ☐ No	none

3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with Time or Distance Standards set forth by DHCS	1. Ensure the network meets time or distance standards in compliance with DHCS requirements when a provider is available. 2. Monitor areas where no provider is available and ensure alternative access requests are in place on a quarterly basis. 3. Evaluate the non-contracted provider network to determine if recruitment might remedy access gaps. Launch recruitment efforts as applicable.	1/1/2024-3/31/2024 1/1/2024-3/31/2024	Jessie Dybdahl, Provider Service Director	none	none	none	☐ Yes ☐ No	none
2.	2.						☐ Yes ☐ No	
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provider Satisfaction Survey	1. Monitor Provider Satisfaction annually. Ensure no less than 5% decrease in overall satisfaction with the plan from prior year. 2. The Provider Satisfaction Survey (PSS) is launched in the summer with vendor engagement in spring. Contact lists are sent for primary care, specialty care, and non-physician mental health care. The survey is launched from July to August. Results are available in quarter 4.	7/1/2024 - 12/31/2024	Jessie Dybdahl, Provider Service Director	none	none	none	☐ Yes ☐ No	none
2.	2.						☐ Yes ☐ No	
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

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TELEPHONE ACCESS (VERONICA OLIVARRIA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of calls to Member Services answered within 30 seconds.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. Improvement efforts slated for 2024: • The adoption of a Workforce Management Tool to assist with call forecasting and representative scheduling, ensuring we have appropriate levels of staff supporting the queues at any given time/day. • Call Audit Optimization: We are developing formal call audit guidelines and defined audit methodology to ensure staff is adhering to Alliance updates and processes. This will ensure representatives are provided with the appropriate resources and are getting through calls, timely. • Developing additional call circles (queues) to: o Optimize resource availability. o Improve speed to answer. o Reduce representative training time. o Increase member satisfaction. • Leverage technology to reduce wait times for members where their inquiries can be filled by the system. Example: Interactive voice response to check eligibility or change PCP. • Computer Telephone Integration: • Enhance HSP/Finesse by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time on phone for the MSR and will make each call more efficient.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Olivarria, MS Call Center Manager Lilia Chagolla, Member Services Director	Goal not met (63%). The call center has hired additional staff to support the calls and member walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Assign staff to support offices to assist member walk-ins. Eliminate unnecessary meetings and focus meetings/training on business needs. Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules. Trainings coordinated in small teams to maximize service level.	Quarter 1 is the busiest time of the year in the Call center, the company was also in a Common Spirit negotiation that impacted 7600 members and the Call center was short staffed. Q2- we hired an additional 5 MSR's that helped maximize coverage and increase service level to 90% and higher monthly. Q3- We hired 2 Call Center Supervisors and a Call Center Manager.	The Call Center team will continue to ensure we are fully staffed by continuing to review the needs of our callers and ensure our staff have the most current resources and/or trainings. Additional FTEs and moving call quality auditing to MS Ops team, WFM tool to be implemented with new phone system.	☐ Yes ☑ No	This goal has been successful in increasing every month by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members. We are currently in the process of reviewing a new phone system and a Workforce management tool.

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2. Call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	2. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. (Same as above)	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Olivarria, MS Call Center Manager Lilia Chagolla, Member Services Director	Goal not met (63%) The call center has hired additional staff to support the calls and member walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Assign staff to support offices to assist member walk-ins. Eliminate unnecessary meetings and focus meetings/training on business needs. Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules. Trainings coordinated in small teams to maximize service level.	Q1 is the busiest time of the year in the Call center, the company was also in a Common Spirit negotiation that impacted 7600 members and the Call center was short staffed. Q2- we hired an additional 5 MSR's that helped maximize coverage and increase service level to 90% and higher monthly. Q3- We hired 2 Call Center Supervisors and a Call Center Manager.	Working on additional FTEs and moving call quality auditing to MS Ops team, WFM tool to be implemented with new phone system.	☐ Yes ☑ No	This goal has been successful in increasing every month by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members. We are currently in the process of reviewing a new phone system and a Workforce management tool.
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

CULTURE & LINGUISTICS (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide at least 1 C&L services presentations to Alliance internal department staff that interact with members to increase awareness of C&L services available for members.	1. The C&L team will reach out to internal departments that interact with members. Examples: a. QIPH new hire orientation b. Member Services team c. Care Coordination team d. Community Engagement team 2. Schedule C&L services presentation 3. Deliver C&L services presentation. 4. Request input regarding presentation content and any member needs that they have encountered regarding C&L services.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	A total of 3 presentations on C&L services were coordinated and completed in Quarter 2. Presentations were delivered to the following audiences: • Care Management teams • Provider Relations team new hire • Community Engagement team new hires	In Q1 we were training and onboarding new staff. As we entered Q2 were able to offer and schedule more presentations.	The project team will continue to coordinate presentations for internal departments and Alliance staff in Q3. A minimum of 1 presentation on C&L Services will be completed in Q3. Additionally, team members will explore offering the presentation to external audiences in Q3-Q4.	☑ Yes ☐ No	This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members. Increased awareness of C&L Services allows Alliance staff to share information on a broader scale with members they are working with in

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								day-to-day operations. In Q3-Q4 we will explore increasing awareness for network providers.
2. On a quarterly basis, inform members of C&L Services available to them in 2024 utilizing at least 1 member informing modality.	1. The C&L team will conduct outreach and education activities to inform members of services available to them via: a. Member newsletter articles b. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor	The following activities were completed in Q2 to inform members of C&L Services: <u>Social Media Post:</u> In April 2024 language assistance services were highlighted on the Alliance Facebook page.	No issues to report in Q2.	The project team will continue to collaborate with internal departments to ensure members are informed of language assistance services.	☑ Yes ☐ No	Social media posts allow members to be informed on a larger scale and when the social media post is clicked it leads members to our Alliance website for additional information.
3. On a quarterly basis, collect member feedback on their experience with language assistance services in a clinical setting with a goal of establishing a baseline for 2024 to target improvements in 2025.	1. The project team will conduct satisfaction surveys with members to evaluate: a. Individual ratings of access to language services. b. Overall rating of interpretation services. c. Access to language services at a health care encounter. d. Gather individual experiences with the services. 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	The member survey efforts are under review with NCQA Health Equity accreditation consultants. There were no additional surveys completed in Q2 after the in the last report. Once NCQA consultants approve the report and surveys submitted additional outreach be completed. This is anticipated for Q3 and Q4. In the previous report, member feedback surveys were completed in Q2 to evaluate services in Q1. These were included in the Q1 report. <u>Member Satisfaction Surveys completed in Q1-Q2:</u> The project team completed a total of 53 member experience surveys.	n Q2 the member survey data collected was reported and shared with NCQA consultants. The approval for the report is in progress. Once approved, surveys will continue with members in Q3.	Once NCQA consultants approve the reporting metrics the project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.	☐ Yes ☑ No	Member feedback surveys for C&L services was placed on hold in late Q2 in order to allow time for NCQA Health Equity accreditation consultants to review the data collected. Once approved surveys with members will continue.
4. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2023 baseline utilization data.	1. The project team will track utilization for the following services: • Phone interpreting services. • Face-to-Face (F2F) interpreting services. 2. Use quarterly utilization data to identify potential need to training of provider network on language assistance services.	3/31/2024 6/30/2024 9/30/2024 12/31/2024	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor	Provider Utilization for Q2 was as follows: <u>Phone interpreting services:</u> There was a total of 6,904 total calls in Q2 by provider sites. This reflects an **increase of 45%** compared to Q2 in 2023. <u>Face-to-Face (F2F) interpreting services:</u> There was a total of 1,542 requests in all service counties for	No issues to report in Q2.	The project team will review Q1-Q2 utilization data to identify potential need for training on language assistance services of providers in Q3-Q4.	☑ Yes ☐ No	There were significant increases in utilization of language assistance services by providers in Q1-Q2 2024 compared to Q1-Q2 of 2023. According to the data there is little

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5. Establish baseline rate, and demographic profile of members who utilize interpreter services to determine any disparity to help determine additional interventions.				F2F. This reflects an **increase of 18.65%** compared to Q2 in 2023. • Santa Cruz County had 627 requests in Q2. This was a 35% **increase** compared to Q2 2023. • Merced County had 507 requests in Q2. This was a 20% **increase** compared to Q2 2023. • Monterey County had 404 requests in Q2. This was a 2% **decrease** compared to Q2 of 2023. • San Benito County had 4 requests in Q4. This is a new service county and there was no comparison for 2023. • Mariposa County had 0 requests in Q2. This is a new service county and there was no comparison for 2023.				utilization in the new service counties. The C&L team will reach out to collaborate with the Provider Relations team to ensure the providers in the new service counties are familiar with the language assistance services for Alliance members.

DELEGATION OVERSIGHT (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations.	1. Quarterly review of delegate reports to ensure compliance, and identification of any issues.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	1. All delegate reports for the 1st quarter were received and reviewed with no gaps identified.	No previous issues identified	Continue with quarterly review	☑ Yes ☐ No	N/A
2. Ensure oversight of all delegated activities by governing board.	2. Present quarterly updates of all reviewed activities with identification of any issues to the governing board for review, and feedback.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	2. All delegate reports for the 1st quarter were received and reviewed with no gaps identified. 3. No issues with delegate reports. QIPH working with Compliance to ensure all delegate reports meet NCQA requirements.	No previous issues identified	Continue with quarterly review	☑ Yes ☐ No	
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

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DATE: November 6, 2024

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Annual Election of Officers of the Commission

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

Background. The SCMMSBMMMCC is due for its annual election of Chairperson and Vice Chairperson, pursuant to section 3.1 of the bylaws.

Discussion. The SCMMMMCC shall elect officers (Chairperson and Vice Chairperson) 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

DATE: November 6, 2024

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

FROM: Danita Carlson, Government Relations Director

SUBJECT: Request for Letter of Support for Program of All-Inclusive Care for the Elderly

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Recommendation. Staff recommend the Board review, consider and take action on the request for a Letter of Support from GoldenPACE Health to develop a Program of All-Inclusive Care for the Elderly (PACE) to serve Santa Cruz, Monterey and San Benito counties.

Background. At the board's May 22, 2024, meeting, your board reviewed, considered and took action on a request by Golden PACE Health for a Letter of Support from the Alliance to develop a PACE to serve Santa Cruz, Monterey and San Benito counties.

The staff report prepared for the May 22, 2024, meeting is attached for your board's reference which includes background on the PACE program and considerations regarding this request. At the May meeting, your board considered information provided by staff and GoldenPACE and received testimony from members of the public including representatives of GoldenPACE and representatives from local Community Based Adult Services (CBAS) providers. Your Board discussed and considered options with respect to this request and subsequently adopted a motion to not approve a letter of support for GoldenPACE Health to develop a PACE center to serve Santa Cruz, Monterey and San Benito counties at this time.

Discussion. In October, GoldenPACE requested an opportunity to return to your Board for reconsideration of its request for a letter of support. and has provided an updated Response to the Alliance's Criteria for Assessment of PACE Letter of Support which is included as Attachment B. In addition, GoldenPACE provided an updated Demographic Market Analysis and revised exhibit with letters of support.

Staff will provide the Board with an assessment of the updated materials provided by GoldenPACE at the Board's November 6, 2024, meeting to support the Board's evaluation of the request for a letter of support. In addition, a representative of GoldenPACE will be provided an opportunity to present this new information to your board and can respond to questions that the Board may have.

Fiscal Impact. While the Alliance would lose the revenue associated with the individuals that elect to enroll in GoldenPACE Health, the plan would also not incur the medical costs for these individuals.

Attachments.

1. Staff report and Attachments from the May 22, 2004 Board meeting regarding the Golden PACE request for a letter of support
2. Attachment A: GoldenPACE Health Response to Criteria for Assessment of PACE *(Updated – received October 16, 2024)*
3. Attachment B: GoldenPACE Demographic Market Analysis *(Updated - received October 16, 2024)*
4. Attachment C: GoldenPACE Letters of Support *(Updated – received October 22, 2024)*

5. Appendix 1A: GoldenPACE additional information *(received October 22, 2024)*

DATE: May 22, 2024

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

FROM: Marwan Kanafani, Health Services Officer

SUBJECT: Request for Letter of Support for Program of All-Inclusive Care for the Elderly

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Recommendation. Staff recommend the Board review, consider and take action on the request for a Letter of Support (LOS) from GoldenPACE Health to develop a Program of All-Inclusive Care for the Elderly (PACE) to serve Santa Cruz, Monterey and San Benito counties.

Background. The PACE model of care provides a comprehensive medical and social service delivery system, using an interdisciplinary team approach, within a PACE Center that provides and coordinates all needed preventive, primary, acute, and long-term care services. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model allows eligible individuals to remain independent and in their homes for as long as possible.

Many PACE enrollees are dually eligible for Medicare and Medi-Cal and the PACE program becomes the sole source of Medicare and Medi-Cal benefits for PACE participants. In a Medi-Cal managed care county, dually eligible Medicare/Medi-Cal PACE enrollees are disenrolled from the Medi-Cal managed care plan and are instead enrolled in the PACE program where they receive all necessary medical care.

To be eligible for PACE, participants must be at least 55 years old, reside in a service area or zip code served by a PACE program, and be determined to be eligible for nursing home level of care. The comprehensive service package of the PACE model of care enables individuals to remain living independently within their home and community, rather than receiving care in a nursing home.

In 2016, the California Legislature passed the PACE Modernization Act (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016), which included updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of PACE Organizations (POs) that could operate in the state, and allowed for-profit entities to become POs.

In late 2017, the Department of Health Care Services (DHCS) developed guidance regarding its review and approval of PACE for dually eligible Medicare/Medicaid beneficiaries. DHCS subsequently issued PACE Policy Letter (PL 19-01 – superseded by PL 23-01 issued April 14, 2023), documenting this guidance. The purpose of PACE PL 23-01 is to inform POs and potential applicant organizations of DHCS' application review process and timeline for new PO applications and PO Expansion applications. Among other things, this guidance requires that a PO seeking to commence or expand operations in a county served by a County Organized Health System (COHS) must obtain an LOS from the COHS which includes a statement that the COHS supports the establishment of the independent PO in the county, and verification of the COHS' concurrence with the applicant's proposed service area.

Full approval of a PO requires both State and Federal approvals through a defined application process, which begins with the POs submission of a Letter of Intent to DHCS. Based on the information provided by the PO, DHCS will decide whether to move forward with a non-COHS

PACE application in a COHS county. If DHCS approves operation of a non-COHS PO in a COHS county, the non-COHS PO must contract directly with DHCS and Centers for Medicare & Medicaid Services (CMS) as the PACE entity in a three-way program agreement. DHCS does not allow a COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement, whereby the COHS would delegate operation of the PO to a separate entity.

Discussion. Pursuant to Alliance policy, the Alliance's Board is required to consider and determine a request for an LOS which has either a potential or actual financial/business impact on the Alliance. The Alliance has been asked by representatives of GoldenPACE Health to provide an LOS for their development of a PACE organization to operate a PACE center in Salinas intended to serve eligible beneficiaries within its catchment area (i.e., 60 minute travel time) which includes zip codes in Santa Cruz, Monterey and San Benito counties. This report provides a review of relevant issues for the Board's consideration and determination regarding this request.

The Alliance's offer of support for a third-party PACE means that the Alliance would forego the exclusivity of its contracting authority for a defined set of Alliance eligible members, thereby having both a financial and business impact to the Alliance.

Staff previously identified criteria to inform the Board's consideration of such a request and shared this with GoldenPACE Health for response. See the full list of criteria in Attachment A of this report.

Staff corresponded with GoldenPACE Health representatives to obtain information responsive to the criteria. Key criteria and responsive information submitted by GoldenPACE Health are outlined in the attached letter dated April 12, 2024 from GoldenPACE Health requesting an LOS for operations of a PO within the Alliance's service area to include specified zip codes in Monterey, San Benito and Santa Cruz counties.

Since GoldenPACE Health is not yet operational, nor providing services to members, staff are unable to review areas such as fiscal viability, quality, program integrity, encounter and claims data submission, or contractual compliance which may affect the Board's decision related to the request for support. However, staff will provide the Board with an assessment of the materials provided by GoldenPACE Health at the Board's May 22, 2024 meeting to support the Board's evaluation of the request for a letter of support.

Notably, GoldenPACE Health proposes to begin operations, upon DHCS and CMS approval, on January 1, 2026, which coincides with the anticipated start of operations of the Alliance's Dual Eligible Special Needs Plans (D-SNP) which will also offer coordinated, integrated care for dually eligible Alliance members. Additionally, PACE offers adult day health care services to enrolled individuals. Thus, a PACE center operating in Salinas could conceivably have an impact on existing Community Based Adult Services (CBAS) centers currently operating in Salinas and Watsonville.

Fiscal Impact. While the Alliance would lose the revenue associated with the individuals that elect to enroll in GoldenPACE Health, the plan would also not incur the medical costs for these individuals.

1. Whether the requesting organization is local with established history of providing services to Alliance members and/or low-income residents of the community.

GoldenPACE Health, headquartered in Watsonville, is a mission-driven organization focused on addressing the health equity gap for low-income seniors in Monterey, Santa Cruz, and San Benito counties. While GoldenPACE is awaiting CCAH approval to begin operations, its leadership brings substantial experience in serving low-income, Medi-Cal eligible seniors, including launching and managing successful PACE programs in underserved communities.

A key strength of GoldenPACE is its trusted partner, Carmel Valley Manor (CVM), a not-for-profit 501(c)(3) organization that has been serving local residents in the community since 1963. CVM provides a full continuum of care to its residents which includes Medi-Cal eligible seniors. This partnership combines CVM's longstanding mission-driven focus with GoldenPACE's expertise in PACE programs, enhancing our ability to deliver high-quality care to the region's most vulnerable populations.

In addition to this partnership, our leadership team remains deeply engaged with the evolving healthcare needs of the region through active involvement in local boards and initiatives, such as the Santa Cruz County Seniors Commission and the Monterey County Area Agency on Aging. This involvement ensures that GoldenPACE stays attuned to the critical issues facing seniors and caregivers, aligning our services with community priorities.

GoldenPACE Health is further strengthened by the extensive expertise of its leadership team, which has spearheaded the launch and expansion of PACE programs nationwide. Our leaders possess deep knowledge of Medicaid and Medicare services, senior healthcare delivery, and regulatory compliance, with over 100 years of combined experience in senior care and integrated healthcare systems.

Key members of the team include CEO Alicia Rodriguez, who led the development of San Diego County's first FQHC-operated PACE program—now the largest in the area—and Jay Zimmer, whose decades of leadership in senior living and healthcare will ensure GoldenPACE's long-term sustainability. Dr. John Murphy and other leaders contribute invaluable clinical and operational experience from their work in healthcare systems, medical groups, and regulatory initiatives.

Beyond leadership expertise, GoldenPACE has a proven track record of building partnerships with community-based organizations and local governments, essential for successfully implementing PACE programs. With a deep understanding of the local service area and these robust partnerships, GoldenPACE is uniquely positioned to adapt the PACE model to meet the specific needs of seniors on the Central Coast.

Though newly formed, GoldenPACE is led by seasoned professionals who have collectively developed and overseen PACE programs for years. This combination of expertise and local knowledge makes GoldenPACE exceptionally qualified to serve the seniors of Monterey, Santa Cruz, and San Benito counties.

2. Whether the requesting organization has provided a description of the member experience for delivery of services including addressing the following, and any other relevant factors.

GoldenPACE Health is committed to delivering a seamless and personalized member experience, focused on minimizing travel time and enhancing access to care. The main PACE center will be located in Salinas, ensuring convenient access for participants throughout the tri-county area, including Monterey, Santa Cruz, and San Benito counties. To further support participants, particularly in more rural or underserved areas, GoldenPACE will establish Alternative Care Settings (ACS) in the communities throughout the service area. These ACSs will offer all PACE services except primary care, which will be provided through partnerships with local community-based providers to ensure primary care services are accessible within a 30-minute drive.

GoldenPACE will implement a hybrid transportation model, using both in-house transportation services and contracted local providers to ensure safe and efficient transport to the PACE center, ACS locations, and medical appointments. All transportation services will comply with CMS guidelines, ensuring that participant safety and comfort are prioritized at all times. Drivers will be fully integrated members of the participant's care team, ensuring coordination and communication regarding any changes in care.

With a focus on culturally sensitive care, GoldenPACE aims to partner with existing senior centers and community-based organizations to bring services closer to where participants live, further reducing travel time and creating a familiar, supportive environment for seniors. By leveraging both direct staff and subcontracted providers, including specialists, home health aides, and long-term care facilities, GoldenPACE will ensure comprehensive care that is accessible, coordinated, and tailored to meet the unique needs of each participant.

A comprehensive community outreach and education strategy will inform and engage eligible seniors, utilizing both digital and community-based methods to facilitate smooth enrollment into the program.

o Which services will be made available to members within the county in which the member resides and for which services members would be required to travel out of area for services (longer than a 30-minute drive).

The following services will be made available to participants within the county in which they reside:

- **Medical care**: Primary care, specialty care, prescription drugs, laboratory services, and more
- **Social services**: Case management, social work counseling, and recreational activities
- **In-home services**: Home care, respite care, and medical supplies
- **Transportation**: To and from PACE centers for medical appointments and activities
- **Adult day care**: Meals, nursing, social work, personal care, and physical, occupational, and recreational therapies
- **Other services**: Emergency services, dental, hearing, vision, and foot care

Participants will have the opportunity to receive services in both the main PACE center located in Monterey County, or in an Alternative Care Setting (ACS). To further reduce travel for participants, especially those residing in Santa Cruz and San Benito counties, GoldenPACE Health plans to utilize ACS locations that will offer all PACE services except for primary care, allowing participants to receive culturally sensitive care closer to home. For primary care, GoldenPACE will establish partnerships with community-based providers within the participants' local areas, ensuring that primary care is accessible within a 30-minute drive.

o A description of how transportation will be facilitated for members to services in the county in which the member resides and out of the area.

In a model similar to those used in neighboring counties, GoldenPACE Health will establish a hybrid model of directly providing transportation services and contracting with local transportation service providers. When possible GoldenPACE Health will utilize its own transportation vans and employ drivers to transport participants to and from their residences and appointments. Only when/if this demand cannot be met using GoldenPACE vans and drivers, will a locally contracted vendor be used to transport participants.

GoldenPACE Health's service area is designed to ensure that participants can reach the PACE Center within the travel time limits mandated by CMS and DHCS. As part of the approval process, DHCS conducts an extensive review of the proposed service area, including a detailed drive-time analysis based on various traffic patterns throughout the day. CMS and DHCS strictly regulate drive times for PACE participants, and if their analysis determines that adjustments are needed, GoldenPACE will be required to make the necessary changes.

CMS strictly regulates participant travel, including safety, accessibility, vehicle equipment and maintenance, driver communication with the PACE center, and training in managing participants' special needs and emergency situations. Additionally, any changes in care plans must be communicated to transportation personnel (staff and contractors) as part of the interdisciplinary team process. CMS requires that PACE drivers be included as essential members of the participant's interdisciplinary team, and any concerns regarding a participant's ability or comfort during travel must documented, discussed, and addressed in the daily IDT meeting.

All PACE organizations adhere to these guidelines. Unlike other types of managed care plans, which may face challenges with coordination and quality, PACE has an advantage due to its size and integrated model.

- o Identification of the physical site at which the PACE will operate and the defined service area.

Since March, we have been actively evaluating several potential properties in and around downtown Salinas for its main PACE center. However, we are currently unable to finalize a lease or purchase agreement until we receive the necessary letter of support from CCAH, which is a prerequisite for submitting our formal notice of intent to DHCS. Once CCAH approval is received, we will move forward with securing the property and providing the exact site address as part of the next phase in the application process.

Additionally, to promote culturally sensitive care in community settings, GoldenPACE Health plans to deliver services through alternative care settings within the service area and collaborate with existing senior centers whenever possible. This approach leverages the strengths of community-based organizations that already serve seniors, while also helping to reduce travel time for PACE participants.

The designated service area encompasses Monterey, San Benito, and Santa Cruz counties.

- o Whether services will be provided by subcontractors to the requesting organization, rather

than directly provided by the requesting organization itself.

Due to the complexity of the PACE model, most organizations experience gradual growth, typically enrolling 5 to 11 new participants per month, with growth as low as 0 to 5 participants per month during the first year. GoldenPACE Health will directly employ its Interdisciplinary Team and support staff, which may include current CVM staff, resulting in approximately 30 full-time employees within the first year of operation. Members of the Interdisciplinary Team include:

• Primary Care Physician	• Social Work (MSW)	• Personal Care Attendant
• Registered Nurse	• Physical Therapist	• Transportation Driver
• Home Health Coordinator	• Occupational Therapist	• Center Manager
• Registered Dietitian	• Activities Coordinator	• Clinical Pharmacist

Additionally, GoldenPACE Health may subcontract services such as in-home care aides (both skilled and unskilled), medical specialists, dentists, mental health specialists, and other routine specialists, as well as partner with skilled nursing facilities, assisted living facilities, ADHCs, and inpatient hospitals in the service area.

o A description of the marketing activities targeting members for enrollment.

GoldenPACE Health will implement a marketing strategy combining both digital and traditional methods to reach seniors eligible for the PACE program. Key activities will include social media campaigns, billboards, and dedicated websites to create awareness online. Additionally, GoldenPACE will participate in local community events and distribute printed informational materials to local resource centers who engage and support seniors and their family members. Branded signage on transportation vans will further increase visibility. Trained marketing and enrollment staff will follow up on all referrals, ensuring compliance with DHCS requirements and guiding eligible members through the enrollment process.

3. Whether the requesting organization, if contracted with the Alliance, is in good standing with the Alliance.

o This includes, but is not limited to, having no identified potential quality issues, no potential issues of fraud, waste or abuse, and no open quality or fraud waste and abuse investigations.

GoldenPACE Health has not had any contractual arrangements with the Alliance. CVM has not had any issues identified.

o Additionally, the organization must not currently be engaged in contract negotiations with the Alliance or pursuing litigation or arbitration against the Alliance at the time of application.

GoldenPACE Health has not had any contractual arrangements with the Alliance. CVM has not had any issues identified.

o The Alliance Chief Executive Officer or designee may determine that the requesting organization is not in good standing based on the considerations identified above or other business concerns including a record of not providing encounter data or claims submissions in a timely manner.

4. Whether the requesting organization has agreed to establish an MOU with the Alliance addressing:

o The transition of members out of the managed care plan into the PACE;

Yes, GoldenPACE intends to work closely with the CCAH to ensure that participants are smoothly transitioned into the program and that their families/caregivers are involved throughout the process.

o The transition of members back into managed care should the member determine they no longer want to be enrolled in the PACE; and,

Yes, participants can easily disenroll from PACE without any cause and at any time. PACE organizations are required to use the most expedient process and continue to furnish all services to the participant until the enrollment is terminated.

o A process to resolve and address any issues or conflicts between the PACE and the managed care organization.

Yes, GoldenPACE agrees to enter into an MOU with CCAH to address these points.

5. The requesting organization's provision of its Market Feasibility Study or other data or analyses indicating that entry of the PACE into the market will not disrupt existing delivery systems on which Medi-Cal members rely for community-based services.

GoldenPACE Health Market Feasibility and Impact on Existing Systems

The PACE model typically experiences gradual growth, enrolling an average of 5 to 11 new participants per month, with only 0 to 5 participants in the first year. Most programs reach around 300 participants over five years. Based on GoldenPACE Health's demographic market analysis (*Attachment B*), we project reaching a full census of approximately 300 participants across Monterey, Santa Cruz, and San Benito counties within five years. This slow, steady growth is unlikely to disrupt existing Medi-Cal delivery systems.

GoldenPACE Health's operations will strengthen, rather than disrupt, local community-based services in the following ways:

- **Collaborative Service Delivery**: By partnering with ADHCs, home health agencies, and transportation providers, GoldenPACE will increase patient referrals and financial sustainability for these organizations. For example, we will refer participants to local ADHCs for daytime care, creating a consistent stream of revenue.
- **Strengthening the Continuum of Care**: GoldenPACE will enhance local healthcare providers' capabilities by offering integrated medical, social, and long-term care services, improving health outcomes for seniors and reducing strain on hospitals and clinics.
- **Training and Workforce Development**: We will provide specialized training to local healthcare professionals, improving care coordination, geriatric expertise, and interdisciplinary collaboration across the community.
- **Economic Impact**: GoldenPACE will create local jobs in healthcare and caregiving, while contracting with local vendors and service providers, stimulating the local economy.
- **Supporting Local Health Initiatives**: We will collaborate with local organizations to align with community health goals, such as reducing hospital admissions and supporting aging-in-place

programs.

- **Access to Federal and State Resources**: By serving dual-eligible seniors, GoldenPACE will bring additional federal and state healthcare funding to the community, benefitting local organizations.
- **Enhancing Transportation Services**: GoldenPACE will improve transportation options for seniors by contracting with local providers, reducing isolation and increasing mobility.
- **Culturally Appropriate Care**: By partnering with culturally knowledgeable local organizations, GoldenPACE will provide tailored services that respect the cultural and social needs of diverse senior populations.
- **Housing Support for Seniors**: We are committed to addressing housing challenges by collaborating with developers and community partners to provide safe, affordable housing for at least 20% of our participants within five years, replicating successful initiatives from previous PACE programs.

In fact, GoldenPACE has received strong support from a wide range of community organizations and local leaders, including:

- City of Santa Cruz
- City of Monterey
- City of Salinas
- City of Seaside
- Monterey County Board of Supervisors
- Alliance on Aging
- Community Health Trust of Pajaro Valley
- United Way of Santa Cruz County
- Mayor of Carmel, Dave Potter
- Dientes Community Dental
- Salinas Valley Health
- Montage Health
- Alzheimer's Association
- Blind & Visually Impaired Center of Monterey
- Serving Communities of Health Information Organization (SCHIO)
- Monterey County Supervisor Alejo
- Central Coast Senior Services

We are grateful for the support provided by our community stakeholders, who are well-informed and highly respected in their fields. These endorsements reflect not only the understanding but also the confidence these organizations have in GoldenPACE Health's ability to complement, rather than disrupt, the existing community-based services for Medi-Cal members.

We acknowledge concerns expressed by two ADHCs in the region; however, we are confident that these concerns are unfounded. In fact, ADHCs often benefit from collaborating with PACE programs, as such partnerships can lead to increased ADHC enrollment and more favorable contract rates compared to traditional managed care organizations. This is supported by the included letter (*Attachment C*) from a prominent ADHC in San Diego County, which illustrates how GoldenPACE Health's CEO has successfully fostered such partnerships in the past.

In light of these points, we encourage CCAH to give greater weight to the broad support for GoldenPACE Health and recognize the potential benefits PACE programs offer to ADHCs, rather than viewing them as a threat to existing services.

Impact on CCAH

There is no significant financial impact on CCAH. While the CCAH may lose revenue from fewer than 0.1% of its members, it would also avoid the medical costs associated with these high-utilizer, high-cost, high-risk members. Even considering just the dual-eligible population (~38,000 members), this number remains under 1%.

Most PACE organizations take about 5 years to reach full capacity. In the first year, we estimate enrolling approximately 60 participants, and assuming all of these are current CCAH members, the financial impact to CCAH would be a small fraction of a percent. Additionally, DHCS projects an annual growth rate of 3% for newly eligible duals. Even if CCAH achieved only half of that growth in its first year, it would still far exceed the number of members enrolling in PACE.

It is important to also clarify that GoldenPACE Health's proposed PACE program does not conflict with CCAH's efforts to implement a D-SNP in the region. In fact, PACE and D-SNP programs serve distinct yet complementary roles in the healthcare landscape, and they successfully coexist in other counties across California, including those served by County Organized Health Systems.

The PACE program is specifically designed to provide comprehensive, integrated care to frail seniors who are eligible for nursing home-level care. Its focus is on helping these individuals remain in their homes and communities while receiving the medical, social, and supportive services they need. PACE is a voluntary, highly specialized program that serves a relatively small and distinct population—seniors who are both eligible for Medicaid and meet the clinical criteria for nursing home care. This is a population that is unlikely to be the primary target for CCAH's D-SNP, which generally serves a broader population of dual-eligible individuals who do not necessarily require the intensive, wraparound services provided by PACE.

In regions where PACE and D-SNPs co-exist, the two programs operate side by side, each serving their specific populations without competing for the same participants. The complementary nature of these programs allows for more tailored care, with PACE addressing the needs of those requiring higher levels of care, while D-SNPs focus on dual-eligible individuals who may need more general managed care services.

GoldenPACE Health is committed to collaborating with CCAH and other local stakeholders to ensure that seniors in the tri-county area have access to the appropriate level of care based on their individual needs. By working together, both programs can enhance the overall quality of care and provide more options for seniors, ultimately improving health outcomes across the region. Rather than viewing PACE as a competitor, we encourage CCAH to see it as an opportunity to strengthen the continuum of care for our most vulnerable seniors.

In summary, GoldenPACE Health's deep understanding of the local landscape and existing partnerships uniquely positions us to enhance community-based services while minimizing disruption. Our slow growth, community-centric approach, and strategic partnerships will ensure that our PACE program supports rather than competes with the existing Medi-Cal delivery system.

6. Copies of all necessary Letters of Support obtained, and an identification of any objection raised by a required supporter.

The letter sought from CCAH is the only letter that is required by DHCS to begin the application process.

However, GoldenPACE Health has received many letters of support from community stakeholders in anticipation of the application requirements, receiving well over the number that will be needed.

PACE DEMOGRAPHIC MARKET ANALYSIS

This analysis evaluates the potential for operating a PACE program to serve portions of Santa Cruz, Monterey and San Benito Counties. The map below represents the forty-three (43) zip codes contained within the service area (mapped below) that will be referred to in this report as the Golden PACE Service Area.

A PACE demographic market analysis estimates the number of PACE eligibles in a specific geographic service delivery area and focuses on three primary data sets in the Golden PACE Service Area:

(1) **Age:** total households age 65 and over,

(2) **Medi-Cal eligibility**: total households age 65 and over with household income less than $35,000, and,

(3) **Clinical eligibility:** an estimate of those persons aged 65 and over who would self-report at least one self-care limitation **and** at least one mobility limitation.

The **age** category focuses on those persons and households in the Golden PACE Service Area 65 years of age and older. While PACE eligibility begins at age 55, national PACE experience has demonstrated most persons enrolled in PACE are 65 years of age and over, primarily because 65 years of age is when Medicare eligibility is attained for most beneficiaries. Although **Medi-Cal financial eligibility** is not an eligibility requirement for enrollment in PACE, currently most PACE enrollees across the country are eligible for both Medicare and Medi-Cal/Medi-Cal ("dual eligible"). Those not eligible for Medi-Cal must pay the monthly Medi-Cal capitation and Medicare Part D cost-share privately, which potential enrollees view as cost prohibitive under most circumstances. Therefore, this demographic analysis focuses on a low-income population - those individuals who are currently Medi-Cal eligible or those who are likely to spend down quickly to meet financial eligibility criteria.

The **clinical eligibility** category is determined based on the self-reported health status of persons living in the defined PACE service area. U.S Census Bureau estimates for 2020 provide information on persons aged 65+ who self-report mobility and self-care limitations. Although such reporting does not ensure that these individuals will meet California Medi-Cal's criteria for nursing home placement, it does represent a reasonable proxy for nursing home eligibility. Because PACE most often enrolls a low-income population where the likelihood of poor health and functional impairment is greater than among the older population in general, an approach that uses these data points should result in a moderately conservative estimate of the actual number of frail elderlies in the targeted geographic area. The two categories used in the final analysis to calculate PACE eligible estimates are:

- Self-Reported, *Self-Care limitation*; this category results in a more conservative estimate for PACE eligibility in a service area;

- Self-Reported, *Independent Living Difficulty limitation*; this category results in a more aggressive estimate for PACE eligibility in a service area;

Estimated PACE Eligibles
Golden PACE Service Area
Conservative and Aggressive Estimates

	65+	65+ Households	65+ Households, less than $35,000 Annual Household Income	Estimated Clinically Eligible	Estimated PACE Eligible Households Range (Conservative – Aggressive)
Golden PACE Service Area	**109,784**	**64,986**	**15,946**	**8,079 – 13,519**	**2,132 – 3,528 ("mid-point" of 2,830)**

Golden PACE Service Area Zip Codes (43)

Zip Code		PACE Eligible Households (Mid-Point Estimate)
93901	Salinas	205
93905	Salinas	233
93906	Salinas	306
93907	Salinas	57
93908	Salinas	20
93921	Carmel by the Sea	16
93923	Carmel	86
93924	Carmel Valley	16
93925	Chualar	2
93926	Gonzales	15
93927	Greenfield	44
93930	King City	46
93933	Marina	108
93940	Monterey	119
93943	Monterey	0
93944	Monterey	0
93950	Pacific Grove	45
93953	Pebble Beach	8
93954	San Lucas	0
93955	Seaside	197
93960	Soledad	27
93962	Spreckels	0
95003	Aptos	75
95004	Aromas	1
95005	Ben Lomond	12
95007	Brookdale	0
95010	Capitola	56
95012	Castroville	19

95017	**Davenport**	**1**
95018	**Felton**	**13**
95019	**Freedom**	**70**
95023	**Hollister**	**167**
95039	**Moss Landing**	**2**
95041	**Mount Hermon**	**0**
95045	**San Juan Bautista**	**10**
95060	**Santa Cruz**	**180**
95062	**Santa Cruz**	**192**
95064	**Santa Cruz**	**0**
95065	**Santa Cruz**	**21**
95066	**Scotts Valley**	**52**
95073	**Soquel**	**16**
95075	**Tres Pinos**	**0**
95076	**Watsonville**	**395**
	TOTALS	**2,830**

Please refer to **Appendix 1** for detailed demographic PACE eligible tables for the Golden PACE Service Area.

Please refer to **Appendix 2** for the color-coded density map of PACE eligibles in the Golden PACE Area based on the mid-point estimate.

Market Penetration Analysis
Golden PACE Service Area
Based on the Mid-Point Clinical Eligibility Estimate

Estimated PACE Eligible Base (Clinically Eligible and Financially Eligible for Medi-Cal)	2,830
If the assumed demographic penetration is:	PACE enrollment:
4%	113
6%	170
8%	226
10%	283

General market conclusions:

- Based on the **conservative** clinical eligibility estimate, the Golden PACE Service Area is estimated to contain at least **2,132 PACE eligible households;** based on the **aggressive** clinical eligibility estimate alone the Golden PACE Service Area could contain as many as **3,528 PACE eligible households**;

- Based on estimated current market penetration rates for operational PACE programs, the number of projected PACE eligible households would appear to lie closer to the average of the conservative and aggressive estimates. For the Golden PACE Service Area, the average or mid-point of the conservative and aggressive estimate is **2,830 PACE eligible households**.

- The number of PACE eligibles in the service area would appear to necessitate an initial PACE Center of approximately 15,000 square feet with the ability to support a maximum census of 283 participants and a maximum average daily attendance of 110 participants.

- Assuming census growth and referral trends support program expansion, planning for additional PACE Center(s) would need to occur and there are possible secondary markets within in the service area that could support the expansion of PACE Centers or Alternative Care Settings.

Source: 2022 US Census Bureau

Golden PACE Demographic Market Assessment Map

PACE Eligibles by ZIP Code

Demographic Market Assessment by Zip Code for Golden PACE Service Area

Zip Code/ County		Clinical Eligibility Estimate				Income Eligibility Estimate			Estimated Clinically Eligible Population		Estimated Clinically and Financially Eligible Population		MidPoint for Projected PACE Eligibility
		Self-Care	%	Independent Living Difficulty	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Independent Living Difficulty	Self-Care	Independent Living Difficulty	
93901	4228	569	13.46%	705	16.67%	2584	832	32.20%	569	705	183	227	205
93905	3816	605	15.85%	638	16.72%	1721	645	37.48%	605	638	227	239	233
93906	7121	815	11.45%	1138	15.98%	3816	1197	31.37%	815	1138	256	357	306
93907	3904	143	3.66%	411	10.53%	2084	429	20.59%	143	411	29	85	57
93908	2414	141	5.84%	191	7.91%	1365	163	11.94%	141	191	17	23	20
93921	1218	56	4.60%	130	10.67%	862	150	17.40%	56	130	10	23	16
93923	5313	280	5.27%	626	11.78%	3279	622	18.97%	280	626	53	119	86
93924	2133	43	2.02%	118	5.53%	1245	241	19.36%	43	118	8	23	16
93925	110	0	0.00%	11	10.00%	57	20	35.09%	0	11	0	4	2
93926	634	19	3.00%	41	6.47%	335	173	51.64%	19	41	10	21	15
93927	1328	53	3.99%	148	11.14%	655	284	43.36%	53	148	23	64	44
93930	1555	175	11.25%	161	10.35%	758	206	27.18%	175	161	48	44	46
93933	3569	332	9.30%	525	14.71%	2092	526	25.14%	332	525	83	132	108
93940	6549	416	6.35%	687	10.49%	4193	902	21.51%	416	687	89	148	119
93943	0	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0
93944	0	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0
93950	4012	146	3.64%	299	7.45%	2713	543	20.01%	146	299	29	60	45
93953	1743	65	3.73%	125	7.17%	1148	95	8.28%	65	125	5	10	8
93954	28	0	0.00%	0	0.00%	10	10	100.00%	0	0	0	0	0
93955	4265	695	16.30%	857	20.09%	2438	619	25.39%	695	857	176	218	197
93960	1566	61	3.90%	97	6.19%	655	222	33.89%	61	97	21	33	27
93962	160	0	0.00%	0	0.00%	95	26	27.37%	0	0	0	0	0
95003	5685	243	4.27%	605	10.64%	3531	625	17.70%	243	605	43	107	75

Demographic Market Assessment by Zip Code for Golden PACE Service Area

Zip Code/ County		Clinical Eligibility Estimate				Income Eligibility Estimate			Estimated Clinically Eligible Population		Estimated Clinically and Financially Eligible Population		MidPoint for Projected PACE Eligibility
		Self-Care	%	Independent Living Difficulty	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Independent Living Difficulty	Self-Care	Independent Living Difficulty	
95004	650	0	0.00%	22	3.38%	334	20	5.99%	0	22	0	1	1
95005	1494	59	3.95%	90	6.02%	920	143	15.54%	59	90	9	14	12
95007	0	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0
95010	2127	221	10.39%	263	12.36%	1376	317	23.04%	221	263	51	61	56
95012	998	66	6.61%	132	13.23%	515	101	19.61%	66	132	13	26	19
95017	170	6	3.53%	6	3.53%	98	18	18.37%	6	6	1	1	1
95018	1215	66	5.43%	97	7.98%	825	128	15.52%	66	97	10	15	13
95019	924	20	2.16%	176	19.05%	608	436	71.71%	20	176	14	126	70
95023	6638	455	6.85%	945	14.24%	3777	899	23.80%	455	945	108	225	167
95039	381	41	10.76%	41	10.76%	116	7	6.03%	41	41	2	2	2
95041	138	0	0.00%	0	0.00%	72	8	11.11%	0	0	0	0	0
95045	830	30	3.61%	103	12.41%	453	70	15.45%	30	103	5	16	10
95060	7636	523	6.85%	892	11.68%	4814	1224	25.43%	523	892	133	227	180
95062	6811	440	6.46%	876	12.86%	4379	1279	29.21%	440	876	129	256	192
95064	39	10	25.64%	10	25.64%	12	0	0.00%	10	10	0	0	0
95065	1476	59	4.00%	159	10.77%	1020	195	19.12%	59	159	11	30	21
95066	3106	161	5.18%	345	11.11%	2070	422	20.39%	161	345	33	70	52
95073	2307	60	2.60%	92	3.99%	1543	322	20.87%	60	92	13	19	16
95075	127	0	0.00%	7	5.51%	68	6	8.82%	0	7	0	1	0
95076	11366	1005	8.84%	1750	15.40%	6350	1821	28.68%	1005	1750	288	502	395
TOTALS	**109784**	**8079**		**13519**		**64986**	**15946**		**8079**	**13519**	**2132**	**3528**	**2830**

Attachment C

Community Support

Thursday, March 28, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of the Alliance on Aging, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) in our region. We are the oldest non-profit in Monterey County serving the needs of seniors.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. As the Ombudsman for Monterey County, we encounter seniors every day who would have preferred to receive care in their own home if that was an option. Therefore, I strongly support bringing this PACE program to our region, and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at jmcpherson@allianceonaging.org.

Sincerely,

John McPherson
Executive Director

280 Dickman Avenue
Monterey, CA 93940
831-646-1458 Phone
831-646-1232 Fax

247 Main Street
Salinas, CA 93901
831-655-1334 or 831-758-4011 Phone
831-655-8781 Fax

Spirals Consignment & Benefit Shop
570 Lighthouse Avenue
Pacific Grove, CA 93950
831-383-5030 Phone

April 11, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of the Alzheimer's Association Northern California and Northern Nevada Chapter, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region. Since its founding in 1980, the Alzheimer's Association's Northern California and Northern Nevada Chapter has grown into one of the largest in an 80-chapter network serving more than 25,000 individuals through our 24/7 Helpline, one-on-one care consultations, community and caregiver education classes, and more than 150 support groups. Our vision of improving health equity, assess and care is paramount to the community, especially in the Monterey/Santa Cruz/San Benito region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. Accessing a timely and accurate diagnosis, as well as receiving high quality care continue to be drivers in the need for systems change for people living with dementia and their care partners.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter. If you have any questions, please feel free to contact me at 831.647.9890.

Sincerely,

Philip M. Geiger

Philip M Geiger
Regional Director
Greater Monterey Bay Region
2 Lower Ragsdale Dr., Ste. 150, Monterey, CA 93940

THE BLIND & VISUALLY IMPAIRED CENTER
OF MONTEREY COUNTY INC.

April 11, 2024

Ms. Michelle Baass
Director
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, California 95899

Re: Letter of Support for GoldenPACE Health

Dear Ms. Baass:

On behalf of The Blind and Visually Impaired Center of Monterey County, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

Incorporated in 1971, The Blind and Visually Impaired Center of Monterey County is a 501(c)(3) non-profit agency that has provided free services to Monterey County residents who are visually impaired. The mission of the Center is to empower these individuals toward independent living through education, support services and skills training. We are the only low vision clinic in Monterey County working directly with 400 clients on an annual basis.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at 831-649-3505 or via email at steven@blindandlowvision.org

Sincerely,

Steven Macias
Executive Director

cc: Alicia Rodriguez
Founder and CEO
GoldenPACE Health

CENTRAL COAST
SENIOR SERVICES INC.

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of Central Coast Senior Services, Inc., I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) in Monterey County. Since 1996 Central Coast Senior Services, Inc. has been providing Monterey County seniors with care management services to assist them to remain in their homes to include direct care Registered Home Care Aides and social services to overcome barriers to access services. In addition, we operate a licensed Assisted Living community and prior to COVID-19 operated a licensed Adult Day Care facility.

Since closing the Adult Day program in 2020 we have been looking for a suitable location to reopen the program and continue to have requests from desperate caregivers seeking an alternative Adult Day program for their loved ones.

As you know the Program of All-Inclusive Care for the Elderly (PACE) model has been an important and effective service Statewide to address the needs of caregivers and seniors alike. Through August 2024 there have been eight applications to expand the PACE program throughout the State. Monterey County has one adult day health care (ADHC) program LA CASA ADULT DAY HEALTH CENTER, INC which is filed with the State as a general stock entity and contracts with Central California Alliance for Health a Medi-Cal HMO health plan.

While La Casa provides the typical health care services of an ADHC, it does not provide the scope of services to fill the gaps in needs for many of our Monterey County seniors and their families.

I strongly support bringing the GoldenPACE program to our community. If you have any questions, please feel free to contact me at 831-649-3363 (jobrien@centralcoastseniorservices.com).

Sincerely,
John O'Brien, CEO
Central Coast Senior Services, Inc.

cc: Alicia Rodriguez, CEO of GoldenPACE Health; alicia@goldenpace.org

phone (831) 649-3363 fax (831) 372-2465
203 Calle Del Oaks, Suite B
Del Rey Oaks, CA 93940

Tuesday, April 16, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

As the Mayor of Carmel-by-the-Sea, I am writing to express my personal support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. I am personally aware of the challenges faced by our senior community. Given my family's personal experience with my wife's 102-year-old aunt and her 100-year-old mother, we are seeing first-hand the challenges and issues that PACE works with every day.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at *831-646-9053.*

Sincerely,

Dave Potter
Mayor of Carmel-by-the-Sea

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

April 11, 2023

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

RE: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley,

On behalf of the City of Monterey, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for Elderly (PACE) services in our region. Approximately 18% of Monterey's residents are over the age of 65 and would benefit from GoldenPACE Health's Program.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our county, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Monterey County, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at tyller@monterey.gov.

Sincerely,

Tyller Williamson
Mayor, City of Monterey

Cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

City of Salinas
OFFICE OF THE CITY MANAGER • 200 Lincoln Ave • Salinas, California
93901 (831) 758-7201 • (831) 758-7368 (Fax) • www.cityofsalinas.org

March 25, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of The City of Salinas, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at 831-758-7201.

Sincerely,

Jim Pia

Jim Pia
Interim City Manager

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

CITY OF SANTA CRUZ

MAYOR AND CITY COUNCIL

809 Center Street, Room 10, Santa Cruz, CA 95060 • (831) 420-5020 • Fax: (831) 420-5011 • citycouncil@cityofsantacruz.com

March 28, 2024

Mr. Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

RE: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

At its meeting on March 12, 2024, the Santa Cruz City Council passed a motion expressing support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) for Santa Cruz, San Benito, and Monterey Counties.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. It has the high level of cultural competency and PACE expertise that our communities need. PACE is renowned as a high-touch, team-based model of care and is considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. The City of Santa Cruz faces significant challenges in meeting the health care needs of its aging population, including access barriers, limited resources, and disparities in health outcomes among diverse communities. GoldenPACE Health's commitment to culturally competent care and its focus on traditionally underserved and rural areas aligns closely with our community's needs.

Studies have shown that PACE programs lead to improved health outcomes, reduced hospitalizations, and enhanced quality of life for participants. By bringing a PACE program to our region, GoldenPACE Health will not only address the immediate health care needs of our senior residents but also contribute to the overall well-being and vitality of our community.

We strongly support bringing this PACE program to our region and appreciate your consideration of this letter. If you have any questions, please feel free to contact me.

Sincerely,

Fred Keeley
Mayor

cc: Alicia Rodriguez, Founder and CEO of GoldenPACE Health (alicia@goldenpace.org)
City Clerk

OFFICE OF THE MAYOR
440 Harcourt Avenue
Seaside, CA 93955
www.ci.seaside.ca.us
Telephone 831-899-6701
Fax 831-624-5839

March 11, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of City of Seaside, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in Monterey County. Approximately, 15% of Seaside's residents are between the ages of 60-79 years old, and would benefit from a resident care facility, allowing them to remain in their homes that they've resided in for a majority of their lives.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our county, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Monterey County, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at ioglesby@ci.seaside.ca.us or (831) 899-6703.

Sincerely,

Ian N. Oglesby
Mayor

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

4/11/2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of the Community Health Trust of Pajaro Valley, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at *djames@pvhealthtrust.org*

Sincerely,

DeAndre James
Executive Director

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Dear Mr. Billingsley:

On behalf of Dientes Community Dental Care, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region. Dientes 30 plus years providing dental services to low-income residents of Santa Cruz County places us in an important role as partner to the PACE program and we highly recommend it be established in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. Dientes, in partnership with Salud Para La Gente, and Delta Dental Foundation, recently completed a survey of Seniors in our area which showed the significant need for services at home or in a nursing facility. We strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at laura@dientes.org or 831-252-0120.

Sincerely,

Laura Marcus, CEO
Dientes Community Dental

June 20, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of Montage Health, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at 831-625-4965.

Sincerely,

Matt Morgan, MBA, FACHE, FHFMA

Chief Financial Officer

Montage Health

831-625-4965

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

April 15, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

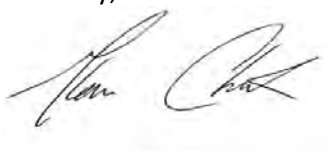
On behalf of the County of Monterey, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

For these reasons, the County of Monterey supports bringing this PACE program to our region. Thank you for your consideration.

Sincerely,



Glenn Church, Chair
Board of Supervisors

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

MONTEREY COUNTY

BOARD OF SUPERVISORS ▪ 168 West Alisal Street, 2nd Floor, Salinas, CA 93901
LUIS A. ALEJO, SUPERVISOR ▪ District One ▪ Chief of Staff, Linda J. Gonzalez
Telephone: (831) 755-5011 ▪ Fax: (831)755-5876 ▪ Email: district1@co.monterey.ca.us

April 12, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

As a Monterey County Supervisor for District 1 in Salinas and a former State Assemblymember in the Monterey Bay Region, I am writing in support of the GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. Monterey County's aging population continues to grow with an increase of 11% since 2016.

For these reasons, I support bringing this GoldenPACE Health Care program to our region. I thank you for your time and consideration, should you have any further questions, please do not hesitate to contact me at my district office at (831) 755-5511 or via email at District1@co.monterey.ca.us.

Sincerely,

Luis A. Alejo
Monterey County Supervisor, District 1
State Assemblymember, 30th District (Ret.)
Mayor, City of Watsonville (Ret.)

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

Salinas Valley HEALTH

April 5, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of Salinas Valley Health, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) in our region. Salinas Valley Health has served Monterey County since 1953 as a public-district hospital and comprehensive healthcare system providing quality care to everyone in our community.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. A significantly disproportionate percentage of our patient population, 75%, is government insured. In addition, Monterey County is widely recognized as one of the least affordable places to live in the country.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me.

Sincerely,

Allen Radner, MD
Interim CEO

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

October 18, 2023

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of the Serving Communities Health Information Organization (SCHIO), I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region. SCHIO, a CA QHIO, is the focused regional HIO in the community.

GoldenPACE Health will bring much needed, high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. SCHIO looks forward to supporting GoldenPACE in their important efforts with interoperability and whole person information.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at 831.610.4422or dchavez@schio.org.

Sincerely,

Daniel J. Chavez

Daniel J. Chavez
Executive Director

cc: Alicia Rodriguez, CEO of GoldenPACE Health; alicia@goldenpace.org

April 9, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of United Way of Santa Cruz County, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region. Since 1941, United Way of Santa Cruz County ignites our community to give, advocate and volunteer so that our youth succeed in school and life, our residents are healthy and our families are financially independent. We believe that we will create a healthy, thriving and safe Santa Cruz County for by focusing on the building blocks of an exceptional life – education, economic mobility, and health.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

We know that within 5 years, senior adults will be the largest demographic in Santa Cruz County. It is imperative that we have programs and services in place to address the needs of our senior adults to ensure their quality of life.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at *kbrowder@unitedwaysc.org*

Sincerely,

Keisha

Keisha Browder
Chief Executive Officer – United Way of Santa Cruz County

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

GEORGE G. GLENNER
ALZHEIMER'S FAMILY CENTERS, INC.®

Central California Alliance for Health (CCAH)
1600 Green Hills Road, Suite 101
Scotts Valley, CA

October 25, 2024

Dear CCAH Board of Directors:

I am writing today to express my support for GoldenPACE Health's efforts to establish a PACE program in the Central Coast region. As the Chief Executive Officer/Executive Director of the Glenner Centers, which operates Adult Day Health Care (ADHC) facilities in San Diego County, I have had the opportunity to collaborate with PACE programs in the past, including those led by Alicia Rodriguez. These partnerships under her leadership have proven to be highly beneficial for both our non-profit organization and the local community.

Our experience with PACE programs has resulted in increased enrollment at our centers and favorable contract agreements as an Alternative Care Site (ACS), contributing to the financial stability of our services. PACE programs not only provide opportunities to increase specialized referrals but also bring greater resources to the care of vulnerable seniors, enhancing the quality of care and offering vital support to Adult Day Health Care Centers like ours.

Based on my past experience with Alicia Rodriguez and her proven ability to collaborate effectively with community organizations, I am very confident that GoldenPACE Health will be a valuable partner for local ADHCs, contributing positively to the region's healthcare network.

Thank you for considering my perspective. Please feel free to reach out if you have any questions or would like any additional information.

Sincerely,

Scott J. Tarde
Chief Executive Officer/Executive Director

Support Office
2765 Main Street, Suite A, Chula Vista, CA, 91911
(619) 543-4700 / (800) 736-6674
Scott J. Tarde, L.N.H.A.
CEO/Executive Director

Hillcrest Adult Day Care Center
3686 Fourth Ave., San Diego, CA 92103
619-543-4704
Pam Givens
Hillcrest Program Director

Town Square® | Chula Vista Center
2765 Main Street, Suite A, Chula Vista, CA, 91911
619-420-1703
Kristyn Bojorquez, LCSW
Town Square® Program Director

Encinitas Adult Day Care Center
335 Saxony Rd., Encinitas, CA 92024
760-635-1895
Sheila Argeanton, BS
Encinitas Program Director

Back to agenda

Appendix 1A Contents:

1.0 GoldenPACE Health Overview

GoldenPACE Health is a mission-driven organization dedicated to delivering high-quality, comprehensive care to seniors through the Program of All-Inclusive Care for the Elderly (PACE). Founded by Alicia Rodriguez, a seasoned healthcare leader, GoldenPACE Health aims to serve frail and vulnerable seniors in Monterey, San Benito, and Santa Cruz counties, offering a unique model of integrated care that helps seniors age safely in their homes.

At its core, GoldenPACE Health is committed to promoting health equity, access, and dignity for all seniors. The organization's focus is on providing personalized, holistic care that integrates medical, social, and supportive services, ensuring that underserved seniors receive the care they need to thrive in their communities. GoldenPACE Health's values are rooted in its mission to prioritize the well-being of seniors above all else, ensuring that every participant receives the highest level of care regardless of financial status.

Partnership with Carmel Valley Manor (CVM)

GoldenPACE Health's partnership with Carmel Valley Manor (CVM), a respected non-profit life care community, adds even greater strength to our mission. With over 30 years of experience in senior living and healthcare, CVM brings a legacy of non-profit excellence that complements GoldenPACE's commitment to serving the region's most vulnerable seniors.

This partnership is built on shared values: both organizations are dedicated to delivering care that puts people before profit. While GoldenPACE Health is driven by its own mission to provide quality, community-centered care, CVM's non-profit status further reinforces these principles. The collaboration creates a public-private partnership that not only enhances operational capacity but also ensures that any financial gains are reinvested into improving services and expanding care for seniors.

Shared Commitment to Quality and Access

GoldenPACE Health and CVM are united in our mission to provide high-quality care to seniors in our region. Together, we will expand access to the PACE model by integrating medical, social, and supportive services that allow seniors to remain in their homes and communities. CVM's strengths—particularly in long-term care, housing management, and caregiver support—naturally align with GoldenPACE's mission, strengthening our expertise and enhancing the quality of care provided across all three counties.

2.0 GoldenPACE Health Team Summary of Biographies

Alicia Rodriguez, MBA, FACHE, brings hands-on experience from her role in starting and leading San Diego County's first FQHC-operated PACE program, now the largest in the area. Her success in navigating the complexities of Medicaid services for low-income seniors demonstrates her capability in establishing and scaling a PACE program, particularly in underserved communities.

Jay Zimmer, MBA, MA, brings over 30 years of executive leadership experience in senior living and healthcare, having led several Life Plan communities and large hospital systems. As President and CEO of Carmel Valley Manor, his operational and strategic expertise will support GoldenPACE Health in building a sustainable and high-quality PACE program in Monterey County.

Dr. John Murphy, MD, MBA, brings a wealth of experience to GoldenPACE Health through his extensive career in healthcare leadership, including roles as Chief Medical Officer and CEO of large integrated health systems. His clinical expertise, combined with his work in academic medicine and consulting, positions him as a valuable asset in guiding GoldenPACE Health's mission to provide comprehensive care to seniors. His experience across military, private, and academic sectors ensures that GoldenPACE will benefit from his deep understanding of complex healthcare delivery systems.

John Tucker, MHA, is a PACE industry veteran with over 25 years of experience. He has directly guided over 50 organizations through the PACE provider approval process and has specialized in all aspects of PACE start-up and development, including business planning and CMS fiscal compliance. His expertise ensures that GoldenPACE will meet all regulatory and financial requirements to operate a successful program.

Judy Baskins, a founding leader of the PACE model and the National PACE Association, has been involved in PACE since its inception. Her role in launching one of the first PACE programs, along with her decades of leadership in clinical integration and senior care, offers unparalleled insight and experience that will be pivotal to GoldenPACE's ability to create a high-quality, fully integrated program from the ground up.

Allison Ashley, BSN, RN, contributes her nine years of experience within PACE programs, focusing on intake, outreach, and participant care coordination. Her leadership in managing operations and her commitment to creating positive participant experiences will be essential in building strong relationships with participants and their families from the outset.

Rhett Clark, MHA, has been integral in helping PACE programs launch successfully for over 16 years. His deep knowledge of CMS application processes, financial benchmarking, and regulatory compliance will provide critical guidance to GoldenPACE as it navigates early stages of development and implementation.

Teresa Acosta, MBA, brings over 15 years of experience in building public-private partnerships and managing government relations for organizations throughout California. Teresa specializes in developing innovative solutions that drive positive community impact. Her deep knowledge of local government, combined with her strategic communication skills, will support GoldenPACE Health in navigating the complexities of regulatory environments and fostering strong community relationships to enhance the program's success.

Samantha Avina, BS, a Salinas native and UC Davis graduate, holds a degree in Managerial Economics with a minor in Technology Management. Her local roots and academic background equip her to engage effectively with the community and support GoldenPACE Health's mission of delivering high-quality, affordable healthcare to low-income seniors in Monterey County.

3.0 GoldenPACE Health Will Address Senior Needs in the Tri-County Region

GoldenPACE Health is uniquely positioned to address the pressing needs of seniors in the tri-county region, offering a model of care that ensures vulnerable older adults can age safely and with dignity in their communities. By providing comprehensive healthcare and support services, we will mitigate the challenges faced by seniors in Monterey, San Benito, and Santa Cruz counties.

Summary of Needs by County:

- **Monterey County** *(AAS All Programs PowerPoint Report to BOS, Monterey County DSS 2024)*:
    - Programs like Aging & Disability Resource Connection (ADRC) are in place to help seniors access services, but many still face challenges with housing, mental health, and transportation.
- **San Benito County** *(2024 San Benito County Fact Sheet, Seniors Council)*:
    - The senior population is growing rapidly, with a 67.2% increase in the 65-84 age group since 2010, making it critical to address issues like housing, healthcare, and caregiving.
- **Santa Cruz County** *(2024 Santa Cruz County Fact Sheet & Solutions Summit MPA Data)*:
    - The economic challenges faced by low-income seniors are compounded by high rates of disability and living alone, with many expressing concerns about their ability to age in place due to housing and healthcare costs.

GoldenPACE Health In Monterey County:

- **Economic Security**: Many seniors in Monterey County face financial strain due to high healthcare and housing costs. GoldenPACE will address these challenges by covering a wide range of healthcare and support services through its all-inclusive care model, eliminating out-of-pocket costs for participants and easing financial pressure on low-income seniors.
- **Housing and Homelessness**: GoldenPACE's commitment to keeping seniors in their homes through services like in-home care, home repairs, and case management aligns perfectly with the need for stable housing among seniors in Monterey County. By reducing the risk of institutionalization, GoldenPACE will help participants remain in their homes longer, providing the care and services they need. CVM's expertise in managing senior living environments will complement these efforts, ensuring that seniors have the support they need to age in place safely and with dignity.
- **Healthcare Access and Mental Health**: With long wait times for medical appointments being a major issue in Monterey County, GoldenPACE will offer immediate access to a team of healthcare professionals. GoldenPACE's integrated approach will ensure seniors receive timely primary care, mental health support, and specialty services, reducing the strain on overburdened local health systems.
- **Caregiving Support**: Many family caregivers in Monterey County report significant stress. GoldenPACE can step in to support family caregivers by offering respite care, adult day care services, and providing a dedicated care team for each participant.

GoldenPACE Health in San Benito County

- **Economic Security**: The rapid growth of the Medi-Cal eligible senior population in San Benito County demonstrates a clear need for affordable, high-quality care. GoldenPACE will provide all

necessary medical and support services under one umbrella, reducing the financial burden on seniors and ensuring they receive the care they need without worrying about costs.

- **Housing and Homelessness**: The growing homelessness among seniors in San Benito County requires targeted interventions. GoldenPACE will help prevent homelessness by providing in-home support services, coordinating housing assistance, and offering case management to keep seniors safely housed. CVM's experience in senior housing management will help ensure that seniors can remain securely housed with the support they need.
- **Mental Health and Isolation**: San Benito seniors are facing increased isolation, especially in rural areas. GoldenPACE will address this by offering transportation services to its day centers and organizing activities that foster social engagement. The program's focus on mental health will help reduce depression and anxiety among isolated seniors.
- **Caregiving**: Caregivers in San Benito County struggle with limited support. GoldenPACE's wrap-around services, including respite care, counseling, and access to a full care team, will relieve the burden on family caregivers and improve the quality-of-care seniors receive.

GoldenPACE Health In Santa Cruz County:

- **Economic Security**: With 31% of seniors in Santa Cruz County earning less than $50,000 and many reporting disabilities and unstable housing, GoldenPACE will provide economic relief by covering healthcare and long-term care services that would otherwise be financially out of reach for many seniors. This includes access to primary care, medications, and home-based services, ensuring comprehensive care without financial barriers.
- **Housing and Aging in Place**: Housing costs in Santa Cruz County are a significant barrier to aging in place. GoldenPACE will help seniors remain in their homes by offering in-home personal care services, home safety evaluations, and modifications that allow participants to live independently in a safe environment. CVM's expertise in managing life-care communities will further support GoldenPACE's goal of providing safe, stable environments for seniors to age in place.
- **Healthcare and Mental Health**: With many seniors in Santa Cruz County experiencing difficulties accessing healthcare and mental health services, GoldenPACE will provide a network of healthcare professionals, ensuring timely access to care. GoldenPACE's mental health services will help address the high rates of depression, anxiety, and isolation experienced by low-income seniors.
- **Social Engagement and Isolation**: To combat the loneliness and isolation prevalent among Santa Cruz County's seniors, GoldenPACE will provide social activities and community-building programs at its day centers, and existing community centers. Seniors will have regular opportunities for socialization, reducing isolation and enhancing their quality of life.
- **Caregiving**: GoldenPACE will alleviate the stress on family caregivers in Santa Cruz County by providing full-time care teams, access to adult day care, and support services that allow caregivers to take breaks, knowing their loved ones are well cared for.

GoldenPACE Health will be an essential resource for seniors in Monterey, San Benito, and Santa Cruz counties, addressing their unique needs through a holistic, integrated care model. By providing comprehensive medical, social, and supportive services, GoldenPACE will help seniors remain in their communities, live safely in their homes, and maintain their health and dignity as they age. Our focus on equity and access ensures that even the most vulnerable seniors will receive the care and support they need and deserve.

4.0 Senior Needs Data by County

Economic Security

- Monterey County:
    - Seniors in Poverty: Monterey County has a significant senior population with the greatest economic needs, including low-income, minority, limited English-speaking, and rural seniors.
    - Financial Assistance: Programs like the Supplemental Security Income (SSI) Advocacy help seniors obtain benefits, but the financial strain remains high, particularly for those relying solely on Social Security.
- San Benito County:
    - Medi-Cal Eligibility: The number of Medi-Cal-eligible seniors has doubled over the past decade, reflecting increasing financial insecurity.
    - Income Inequality: Rising costs of long-term care are a significant financial burden for many seniors, particularly those relying on fixed incomes.
- Santa Cruz County:
    - Low-Income Population: 31% of seniors have incomes under $50,000, with 60% of low-income seniors reporting disabilities and 57% living alone.
    - Retirement Status: 69% of low-income seniors are retired, and 13% are working part-time or full-time to make ends meet.

Housing and Homelessness

- Monterey County:
    - Affordable Housing: Housing affordability is a top concern, and programs like the Housing & Disability Advocacy Program (HDAP) and Home Safe assist seniors at risk of homelessness.
    - Home Repairs and Maintenance: Many seniors are unable to afford home repairs or maintenance, contributing to deteriorating living conditions.
- San Benito County:
    - Homelessness Growth: Homelessness among seniors is growing rapidly, particularly for those aged 50 and older.
    - Impact of Rural Living: Seniors in rural areas are particularly vulnerable to housing insecurity due to limited access to affordable housing options.
- Santa Cruz County:
    - Aging in Place: 38% of seniors are unsure whether they will be able to age in place due to rising housing costs.
    - Housing Cost Burden: More than half of older renters are cost-burdened, spending a significant portion of their income on rent.
    - Home Maintenance: 43% of seniors report needing help with home maintenance, repairs, and yard work. Seniors living alone or with disabilities are the most affected.

Health and Mental Health

- Monterey County:
    - Health Access: The long wait times for medical appointments (up to 4 months) are a significant challenge.
    - Mental Health Support: Programs like Age Wise aim to reduce mental health recidivism, but social isolation and anxiety remain prevalent among seniors.
- San Benito County:

    - Mental Health Crisis: Senior isolation has worsened due to COVID-19, leading to increased rates of depression and anxiety among the elderly.
- Santa Cruz County:
    - Mental Health Challenges: Low-income seniors are 4x more likely to experience neglect and 3x more likely to experience physical abuse. Mental health challenges such as depression and anxiety are common.
    - Access to Care: 30% of seniors report difficulty accessing mental health care, with barriers also present for dental and specialist care.

Caregiving and Support Services

- Monterey County:
    - Caregiver Stress: One-third of caregivers aged 60+ report feeling burdened by caregiving responsibilities.
    - Respite and Counseling: Caregivers need more access to respite services and mental health counseling to manage stress.
- San Benito County:
    - Caregiver Challenges: Caregivers face emotional and financial challenges, particularly those caring for individuals with Alzheimer's or dementia.
- Santa Cruz County:
    - Caregiver Burden: Caregivers report high levels of stress, anxiety, and emotional exhaustion. Many struggle to find affordable and reliable help.
    - Lack of Support: Caregivers express difficulty accessing support services, with a significant emotional toll placed on those caring for loved ones.

Social Engagement and Isolation

- Monterey County:
    - Social Isolation: 350 iPads were distributed to help seniors connect digitally and reduce isolation. Programs like Meals on Wheels also address isolation by providing social interaction.
- San Benito County:
    - Isolation in Rural Areas: Seniors in rural San Benito County are twice as likely to be isolated as their urban counterparts, with limited access to social services.
- Santa Cruz County:
    - Loneliness: 13% of low-income seniors report feeling lonely most or all of the time. Social isolation is prevalent, especially among those living alone or with disabilities.
    - Community Support: Seniors express a need for more community engagement and opportunities for social connection.

Transportation

- Monterey County:
    - Access to Transportation: Transportation barriers are a critical issue, with many seniors lacking access to reliable public transportation. Programs have distributed discounted bus passes, but more solutions are needed.
- San Benito County:
    - Limited Transportation Access: Transportation challenges exist, particularly for seniors in rural areas who may have limited access to healthcare and services.

- Santa Cruz County:
    - Healthcare Access: 28% of seniors report difficulty navigating the healthcare system, with many needing to travel outside the county for services
    - Transportation Barriers: Many seniors face challenges accessing transportation, which impacts their ability to attend medical appointments and participate in community activities.

Summary:

- Monterey County:
    - Programs like Aging & Disability Resource Connection (ADRC) are in place to help seniors access services, but many still face challenges with housing, mental health, and transportation.
- San Benito County:
    - The senior population is growing rapidly, with a 67.2% increase in the 65-84 age group since 2010, making it critical to address issues like housing, healthcare, and caregiving.
- Santa Cruz County:
    - The economic challenges faced by low-income seniors are compounded by high rates of disability and living alone, with many expressing concerns about their ability to age in place due to housing and healthcare costs.

Data Sources:

Monterey County: AAS All Programs PowerPoint Report to BOS, Monterey County DSS 2024
San Benito County: 2024 San Benito County Fact Sheet, Seniors Council
Santa Cruz County: 2024 Santa Cruz Solutions Summit Master Plan on Aging & 2024 Santa Cruz County Fact Sheet

DATE: November 6, 2024

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

FROM: Jessica Finney, Community Grants Director

SUBJECT: Medi-Cal Capacity Grant Program Annual Investment Plan: Inputs and Emerging Priorities

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Recommendation. This report outlines emerging priorities for Medi-Cal Capacity Grant Program (MCGP) investments in 2025 for the Board's consideration and discussion. On January 22, 2025, staff will return with a Board action recommendation on the 2025 MCGP Investment Plan.

Summary. This report provides background on the MCGP annual investment plan process and summarizes the key inputs gathered to date on the most critical needs and opportunities for the Alliance's MCGP investments in the upcoming year. It introduces emerging priorities for the 2025 MCGP Investment Plan and proposes how the MCGP budget could address these goals and strategies through new and existing funding opportunities.

Background. In February 2024, the Board approved an annual investment plan policy for the MCGP and in March 2024 approved an inaugural plan under the new policy. The Board-approved plan serves as a roadmap for MCGP investments, defining grantmaking priorities to address Medi-Cal capacity needs in the Alliance's service area and allocating funding to advance the goals under each focus area and strategy. The approval of an annual MCGP investment plan allows the Board to provide high-level strategic direction for the MCGP year over year and direct staff to manage program-level implementation and county budgets based on allocated funding to meet identified community needs.

The Board-approved grantmaking focus areas for the MCGP include: 1) Access to Care; 2) Healthy Beginnings; and 3) Healthy Communities. These focus areas, approved in 2022, address unmet and emerging Medi-Cal needs and opportunities, align with organizational and State priorities, and include upstream investments targeting root causes and prevention. As part of the annual investment plan process, staff review data and solicit stakeholder input to identify investment priorities that: 1) address community needs; 2) align with the Board-approved MCGP framework (including focus areas, strategies, goals, Medi-Cal purpose, and sustainability requirements); 3) support Alliance strategic objectives; and 4) invest resources outside of core health plan responsibility where alternative funding is not available.

Between January and October 2024, the Alliance awarded 180 grants totaling $40.4M to 117 organizations in the Alliance's five-county service area.

Discussion. To identify the priorities for the 2025 MCGP Investment Plan, staff conducted an environmental scan of the current health care landscape, interviewed key community leaders, surveyed grantees, and solicited input from both the Internal Grants Review

Committee and Executive team on community needs and service gaps. Staff are soliciting input from the Board on the emerging priorities at this meeting and will solicit feedback from the Member and Physician Advisory Committees before finalizing the investment plan recommendations. Key themes from the strategic inputs gathered to date are summarized below.

Environmental Scan: Medi-Cal Landscape and Alliance Priorities. At the September Board Retreat, Commissioners were oriented to the State's and the Alliance's major priorities over the next year. Several of these priorities align with existing Medi-Cal Capacity Grant Program (MCGP) investment areas and the needs identified by community stakeholders. Key organizational priorities where MCGP investments could help the Alliance advance its objectives in the near future include:

- CalAIM: Increasing enrollment in Enhanced Care Management (ECM) while continuing to expand Community Supports offerings.
- Quality Performance: Improving both quality metrics and health equity outcomes in Merced and Mariposa counties.
- Market Changes: Insourcing behavioral health services to enhance care integration and coordination.
- Service Diversification: Developing a Medicare Dual Eligible Special Needs Plan (D-SNP) to better serve the dual-eligible population.
- Workforce Development: Strengthening and expanding the provider workforce to address provider shortages and reflect the ethnic and cultural diversity of Medi-Cal members.

Environmental Scan: Community Health Needs and Priorities. A review of each county's most recent Community Health Needs Assessment (CHA) and Community Health Improvement Plan (CHIP) revealed similar health issues and priorities across all five counties in the Alliance service area. The CHAs and CHIPs are developed by local health departments using data and community participation to identify health needs and develop plans to improve health. The most pressing health issues across all counties include, access to care, housing, mental health and substance use disorders and nutrition/physical activity concerns. The CHIP priorities where there is the most alignment across the service area include addressing health care access, mental health and substance use disorders, social determinants of health, preventable chronic diseases, and support for families with young children.

Stakeholder Interviews. In July and August 2024, eleven community leaders from the Alliance's five-county service area participated in interviews about critical needs and opportunities for the Alliance's Medi-Cal Capacity Grant Program (MCGP) investments in 2025 and beyond. These leaders represented diverse organizations, including contracted primary and specialty care providers, FQHCs, hospitals, Enhanced Care Management (ECM) and Community Supports (CS) providers, behavioral health providers, and non-contracted community-based organizations. Through these interviews, stakeholders identified several critical needs for Medi-Cal members in their communities, including access to health services, housing and homelessness support, community education and awareness, addressing language and cultural barriers, affordable childcare, and other social determinants of health. Their recommendations for improving the health and well-being of Medi-Cal members focused on key themes such as: improving access to care, investing in workforce development, expanding behavioral health services, supporting community-

based outreach and education, ensuring cultural competence and language justice, and continuing investments in housing and other social determinants of health.
Please see Appendix A to read the full summary.

Grantee Survey. In July, Grant Program staff conducted a survey of active Alliance grantees with a 40% response rate (n=52). The survey provided insight into the grantee's perceptions regarding the Alliance's focus areas and funding priorities. The notable findings were that:

- 97% reported being familiar with MCGP focus areas, goals and priorities.
- 76% of grantees responded "to a great extent" that the MCGP funding priorities reflect a deep understanding of Medi-Cal member needs in their community.
- 84% reported the Alliance's grant program has a significant positive impact on their local community.

Grantees identified the following as areas for additional investment: improving access and availability of Medi-Cal services, addressing workforce recruitment and retention, expanding housing through capital grants, and increasing access to healthy food.

Critical Needs Identified by Stakeholders. Through the comprehensive environmental scan and extensive stakeholder engagement, the following emerged as the most frequently cited needs for Medi-Cal members across the Alliance service area.

- Access to Health Care Services
- Health Care Workforce
- Culturally and Linguistically Competent Care
- Community Education and Engagement
- Mental Health and SUD Treatment
- Social Determinants of Health
- Affordable Housing/Homelessness
- Chronic Disease Prevention
- Early Childhood Support
- Affordable Child Care Options

Emerging Priorities for MCGP Investments in 2025. Staff identified the proposed investment priorities for 2025 by evaluating critical stakeholder-identified needs, reviewing alignment with MCGP and Alliance priorities, and assessing available community investment funding. Based on this analysis, the following key priorities have emerged:

1. Workforce Development: Support initiatives to grow a diverse healthcare workforce that reflects the communities the Alliance serves.
2. Behavioral Health: Expand access to comprehensive behavioral health services.
3. Parent Support and Engagement: Invest in programs that empower parents and caregivers through education and support, ensuring access to timely prenatal and postnatal care, preventative health services, and community resources.
4. Community Education and Engagement: Invest in trusted, community-based organizations serving historically marginalized communities to educate members about Medi-Cal services, improve access to care, and promote the importance of preventative care and regular screenings.
5. Social Drivers of Health: Continue investing in social determinants of health, including access to nutritious food, safe spaces for recreation, and permanent supportive housing.

These priorities all align with existing MCGP focus areas and strategies.

2025 Priority	MCGP Focus Area	MCGP Strategy
Workforce Development	Access to Care	Healthcare Workforce
Behavioral Health	Access to Care	Healthcare Workforce Health Care System Infrastructure
	Healthy Beginnings	Parent Support & Engagement Parent/Child Health and Wellness
	Healthy Communities	Community Resources, Engagement & Empowerment
Parent Support and Engagement	Healthy Beginnings	Parent/Child Health & Wellness Parent Support & Engagement
Community Education and Engagement	Healthy Communities	Community Resources, Engagement & Empowerment
Social Drivers of Health	Healthy Communities	Community Resources, Engagement & Empowerment Social Drivers of Health

MCGP Fund Balance Available Funding for 2025 Investment Plan. The Alliance's August 30, 2024 Balance Sheet shows the MCGP fund balance at $155M. This figure is comprised of three classifications:

- $65M Awarded but not yet paid out (i.e., committed);
- $81.5 Allocated to specific strategies but not yet awarded (i.e., available for awards under existing and new funding opportunities); and
- $8.5M Unallocated remaining (i.e., not yet been Board-directed to a specific strategy or funding opportunity).

The next opportunity for a new allocation from the Alliance reserves to the MCGP for future investments is June 2025 when the Board considers staff recommendations for strategic use of reserves, per policy #700-2000 Board-Designated Reserve.

Based on available funding and identified priorities, staff will synthesize stakeholder and input to develop recommendations for the 2025 MCGP Investment Plan to best address identified priorities. Considerations will include streamlining existing funding opportunities, shifting allocated funds amongst existing strategies and adding new funds from the remaining unallocated budget.

Conclusion. After soliciting feedback from the Board and Advisory Committees on the emerging priorities, staff will return to the Board with a final 2025 MCGP Investment Plan for Board action in January 2025.

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

Attachments. MCGP Summary of Stakeholder Interviews (September 2024).

Central California Alliance for Health | Medi-Cal Capacity Grant Program
Summary of Stakeholder Interviews | September 2024

Introduction

In July and August 2024, eleven community leaders from the Alliance's five-county service area were interviewed to gather insights on critical needs and opportunities for the Alliance's Medi-Cal Capacity Grant Program (MCGP) investments in 2025 and beyond. Staff engaged Kathleen McCarthy Consulting to conduct interviews with stakeholders who represent a diverse range of organizations, including contracted primary and specialty care providers, FQHCs, hospitals, Enhanced Care Management (ECM) and Community Supports (CS) providers, behavioral health providers, and a County Administrative Officer. The individuals interviewed also included leaders from non-contracted community-based organizations that work closely with Alliance members or collaborate with the Alliance on community initiatives. The participants had varying degrees of familiarity with the grant program; several represented organizations that had received MCGP grants or were current applicants.

Feedback from these interviews will inform the development of the MCGP's 2025 Investment Plan. Below is a list of the 11 community leaders interviewed and additional staff who participated.

Community Stakeholder	Title	Organization	County
John Alexander	Director	MACT Health Board	Mariposa
Joe Lynch	CAO	Mariposa County	Mariposa
Robert Hypes	CEO	United Way of Merced County	Mariposa/ Merced
Claudia Corchado	Director	Cultiva Central Valley	Merced
David Quackenbush	President and CEO	Golden Valley Health Centers	Merced
Katy Castagna	CEO	United Way of Monterey County	Monterey
Katy Eckert & Lara Clayton	BH Bureau Chief/BH Director & BH Services Manager II	Monterey County Behavioral Health	Monterey
Mary Casillas & Amy Breen-Lema	CEO & VP of Clinics	Hazel Hawkins Hospital	San Benito
Rosa Vivian Fernández	President & CEO	San Benito Health Foundation	San Benito
Maria Elena De La Garza	Executive Director	Community Action Board of Santa Cruz County	Santa Cruz
Stephen Gray	CEO	Watsonville Community Hospital	Santa Cruz

Most Pressing Needs and Challenges

Community leaders shared their perspectives on the most pressing needs and challenges facing Medi-Cal members in their community. They also discussed the biggest obstacles in achieving meaningful change in the MCGP investment focus areas: Access to Care, Healthy Beginnings, and Healthy Communities. Their responses generally emphasized the following:

1. Access to Health Care Services:
    - Shortage of healthcare providers, especially in rural areas
    - Limited access to specialty care, behavioral health, and primary care services
    - Transportation barriers
    - Limited hospital services or concerns about small rural hospitals' future viability
2. Housing/Homelessness:
    - Lack of affordable housing
    - Rising costs of living, including rent
    - Increasing number of people experiencing homelessness
3. Community Education and Awareness:
    - Reaching vulnerable populations furthest from the system
    - Better education about available services/benefits and accessing care
    - Trust-building and culturally appropriate outreach
4. Language and Cultural Barriers:
    - Lack of bilingual services and culturally appropriate care
    - Need for "language justice"
    - Specific challenges faced by Indigenous communities
    - Mistrust of government services, especially among immigrant communities
5. Affordable Child Care
    - Lack of affordable, quality childcare options
6. Social Determinants of Health:
    - Lack of living wage jobs
    - Food insecurity and limited access to healthy food options
    - Need for safe spaces for physical activity
    - Limited broadband access in some areas

Opportunities to Improve the Health and Well-being of Medi-Cal Members

Stakeholders provided a range of ideas to improve the health and well-being of Medi-Cal members, along with some specific investment ideas the Alliance could consider. Many of these opportunities directly address the needs outlined above and are aligned with the existing MCGP framework. These themes reflect a diverse range of potential investments, focusing on both immediate healthcare needs and broader social determinants of health.

Key themes included:

1. Access to Care
    - Increase the number of healthcare providers, prioritizing primary care, specialty care, and behavioral health providers
    - Increase the number of healthcare access points and expand the capacity of existing sites
    - Improve access to primary care and early screenings
    - Expand services for specific populations (e.g., PACE-like programs for aging population)

    - Expand technology for improved access to care and data-sharing
2. Workforce Development
    - Attract and retain qualified healthcare professionals
    - Partner with educational institutions to develop healthcare career pathways/pipeline programs
    - Focus on "growing our own" healthcare professionals
    - Increase the integration of Community Health Workers and non-traditional providers
3. Behavioral Health
    - Address the shortage of behavioral health providers
    - Build up the non-MD behavioral health workforce
    - Create more options for mental health crisis care and support services
4. Community-Based Outreach and Education
    - Educate members about Medi-Cal services and accessing care
    - Focus on underserved populations and geographic areas
    - Conduct outreach and education through community channels (e.g., churches, grocery stores, and Spanish-language media
5. Cultural Competence and Language Justice
    - Increase the number of bilingual, bicultural providers
6. Housing/Homelessness:
    - Increase housing options
    - Leverage current state funding for housing
    - Expand awareness of new housing benefits
7. Social Determinants of Health (SDOH):
    - Continuing to recognize and address SDOH, focusing on housing, food security, and transportation
    - Expand broadband access
8. Other Opportunities:
    - Support for childcare and after-school programs
    - Capacity building for CBOs
    - Support for climate justice initiatives
    - Encourage collaboration between healthcare providers and community organizations

Health Care Provider Definition and Access to Care Investments

Community leaders' perspectives on the definition of "healthcare providers" and who is included in the delivery system were explored in the context of the MCGP's Access to Care focus area. Staff were interested in exploring whether community leaders had a more traditional definition of “provider” or whether that definition had shifted with the implementation of CalAIM and other new Medi-Cal services. Most respondents described a relatively traditional view, encompassing medical professionals, community health workers, and support staff. They emphasized the importance of whole-person care and the collaborative effort of the entire healthcare team. While the majority advocated for investments in the traditional medical delivery system, some leaders from community-based organizations presented a more expansive view. These individuals considered certain aspects of their work, such as navigation and case management, as integral components of healthcare delivery.

Current Funding Opportunities

While many community leaders expressed limited familiarity with the various MCGP funding

opportunities, the Provider Recruitment Program emerged as a frequently cited and highly valued program for the primary care and specialty care providers interviewed. Stakeholders consistently described it as both effective and essential, urging the Alliance to maintain this offering. However, this perspective was not unanimous; one behavioral health stakeholder advocated for a shift away from Provider Recruitment grants, suggesting instead a focus on developing the local healthcare workforce, which would have a more lasting impact. The Capital Grant Program was also identified as critical, with many stakeholders recognizing its importance for infrastructure development and its potential for long-term impact. The COVID Response Fund was highlighted by one stakeholder for its effectiveness, particularly praising its direct approach and flexibility. Additionally, grants supporting technology and capacity building for doulas were mentioned by another community leader.

Future Trends or Issues

When asked about any trends or issues the MCGP should be prepared to address in the next few years, stakeholders identified the following diverse range of areas focusing on both immediate healthcare needs and broader social determinants of health:

1. Economic Challenges: Stakeholders highlighted the growing economic disparities and increasing poverty levels across the service area. They also raised concerns about the rising high cost of living and the growing number of people experiencing homelessness.
2. Political Concerns: Several stakeholders expressed concern about the potential impacts of the upcoming federal election on healthcare policies and benefits and other policies affecting vulnerable populations.
3. Demographic Shifts: Stakeholders highlighted several demographic shifts. One was the aging population, and the other was related to the outmigration of youth from certain communities and declining school enrollment in other areas.
4. Healthcare Access and Delivery: Stakeholders expressed concern about worsening primary care access, the severe lack of behavioral health resources, and the potential impact of rural hospital closures or sales within their communities. The need for collaborative, innovative approaches to address workforce challenges was highlighted.
5. Environmental and Public Health Concerns: Other issues stakeholders identified included natural disasters or potential future pandemics, tobacco use, and violence prevention.

Guidance or Advice for the Alliance's Investment Strategy

Community leaders recognized the Alliance as a valuable partner and appreciated the opportunity to share their thoughts during the interview process. They viewed the MCGP positively, particularly for its investments in provider recruitment and addressing the social determinants of health. Their advice centered on several key themes:

- Strengthen partnerships with trusted community-based organizations to reach underserved populations.
- Prioritize investments with a long-term impact over short-term solutions.
- Improve clarity and accessibility of funding opportunities across the health plan.
- Continue to streamline application and reporting processes to reduce the administrative burden on applicants and grantees.
- Provide funding or capacity-building support to small community-based organizations interested in offering or expanding Medi-Cal services.
- Ensure equitable distribution of funding based on community needs.

END

Information Items: (13A. – 13B.)

Alliance Fact Sheet
Q4 2024

About the Alliance

The Central California Alliance for Health is an award-winning regional managed care health plan. The Alliance has provided trusted, no cost Medi-Cal health care from local teams to families since 1996. Using the State's County Organized Health System (COHS) model, we currently serve more than **442,007 members** in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We have a local presence in the communities we serve, so we understand the unique needs of these communities and our members. Together with our contracted providers, we work to promote prevention, early detection and effective treatment and to improve access to quality, equitable health care. The Alliance is governed with local representation from each county on our Board of Commissioners.

Quick Facts

1996
Year Established

598
Number of Employees

$1.66B[1]
Annual Revenue

6.3%[1]
Administrative Overhead

$23.5M[2]
Community Grants

VISION

HEALTHY PEOPLE.
HEALTHY COMMUNITIES.

MISSION

Accessible, quality health care guided by local innovation.

VALUES

Collaboration:
Working together toward solutions and results.

Equity:
Eliminating disparity through inclusion and justice.

Improvement:
Continuous pursuit of quality through learning and growth.

Integrity:
Telling the truth and doing what we say we will do.

What We Do

The Alliance is a local health ally for compassionate and trusted health care that supports the whole person. We ensure quality care for all ages and stages of life and for any health condition. We go beyond just providing health care, connecting our members to day-to-day resources.

Who We Serve

Our members represent 41%[3] of the population in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income parents and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled and low-income, childless adults ages 19–64.

Provider Partnerships

The Alliance partners with 100% of hospitals in our services areas and a network of approximately 13,400 providers (98% of primary care physicians and 98% of specialists within our service areas) to ensure members receive timely access to the right care, at the right time. The Alliance also partners with more than 4,600 providers to deliver behavioral health and vision services.

Back to agenda

Our Members[4]

1 out of every 3
Mariposa County residents.

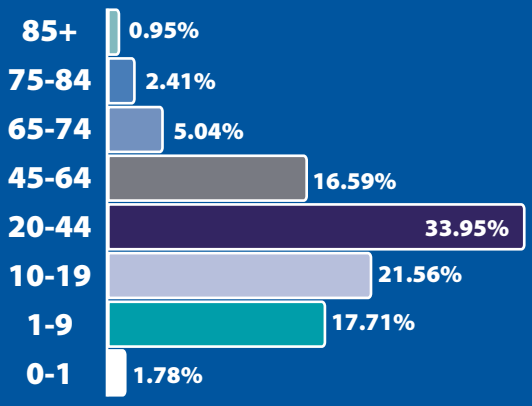
1 out of every 2
Merced County residents.

1 out of every 2
Monterey County residents.

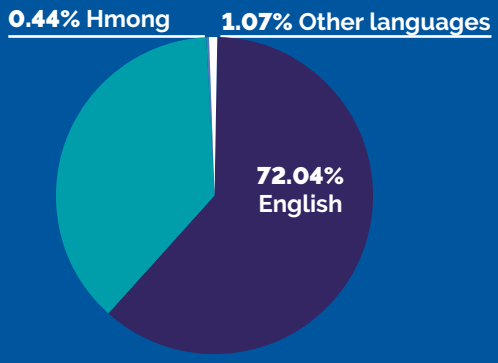
1 out of every 3
San Benito County residents.

1 out of every 3
Santa Cruz County residents.

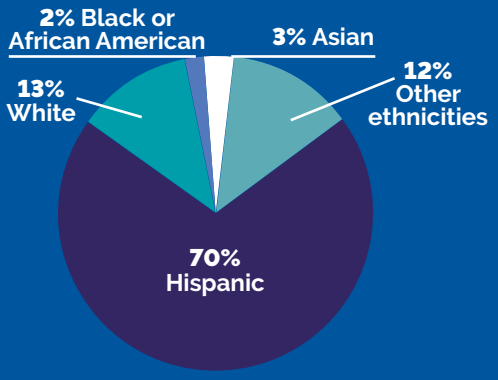
Membership by Age Group



Preferred Language



Race/Ethnicity



Executive Leadership

Michael Schrader
Chief Executive Officer

Dennis Hsieh, MD
Chief Medical Officer

Lisa Ba
Chief Financial Officer

Jenifer Mandella
Chief Compliance Officer

Scott Fortner
Chief Administrative Officer

Cecil Newton
Chief Information Officer

Omar Guzmán, MD
Chief Health Equity Officer

Van Wong
Chief Operating Officer

Governing Board

The Alliance's governing board, the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan.

In alphabetical order, current Board members are:

- **Leslie Abasta-Cummings,** Chief Executive Officer, Livingston Community Health, At Large Health Care Provider Representative
- **Anita Aguirre,** Chief Executive Officer, Santa Cruz Community Health, At Large Public Representative
- **Ralph Armstrong,** DO FACOG, Hollister Women's Health, At Large Health Care Provider Representative
- **Wendy Root Askew,** Supervisor, County of Monterey, County Board of Supervisors Representative
- **Tracey Belton,** Health and Human Services Agency Director, San Benito County, County Health Department Representative
- **Dorothy Bizzini,** Public Representative
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas, Health Care Provider Representative
- **Janna Espinoza,** Public Representative
- **Zach Friend,** Supervisor, County of Santa Cruz, County Board of Supervisors Representative
- **Donaldo Hernandez, MD,** Health Care Provider Representative
- **Elsa Jimenez,** Director of Health Services, Monterey County Health Department – Alliance Board Chairperson, County Health Department Representative
- **Kristina Keheley, PhD,** Interim Health and Human Services Agency Director, Mariposa County Health and Human Services Agency, County Health Department Representative
- **Michael Molesky,** Public Representative
- **Monica Morales,** Health Services Agency Director, County of Santa Cruz Health Services Agency, County Health Department Representative
- **Supervisor Josh Pedrozo,** County of Merced – Alliance Board Vice Chairperson, County Board of Supervisors Representative
- **James Rabago, MD,** Merced Faculty Associates Medical Group, Health Care Provider Representative
- **Allen Radner, MD,** President/CEO, Salinas Valley Health, At Large Health Care Provider Representative
- **Vacant,** County Health Department Representative

Unless otherwise stated, Fact Sheet data as of October 1, 2024.

[1]Amounts based on 2024 annual budget.

[2]Represents 2023 investments through the Alliance's Medi-Cal Capacity Grant Program.

[3]County population data source: U.S. Census Bureau 2023 population estimate (as of Jul. 1, 2023).

[4]Represents an approximate visual representation. Membership percentage by county: Mariposa (33 percent) Merced (51 percent); Monterey (44 percent); San Benito (30 percent); Santa Cruz (30 percent).

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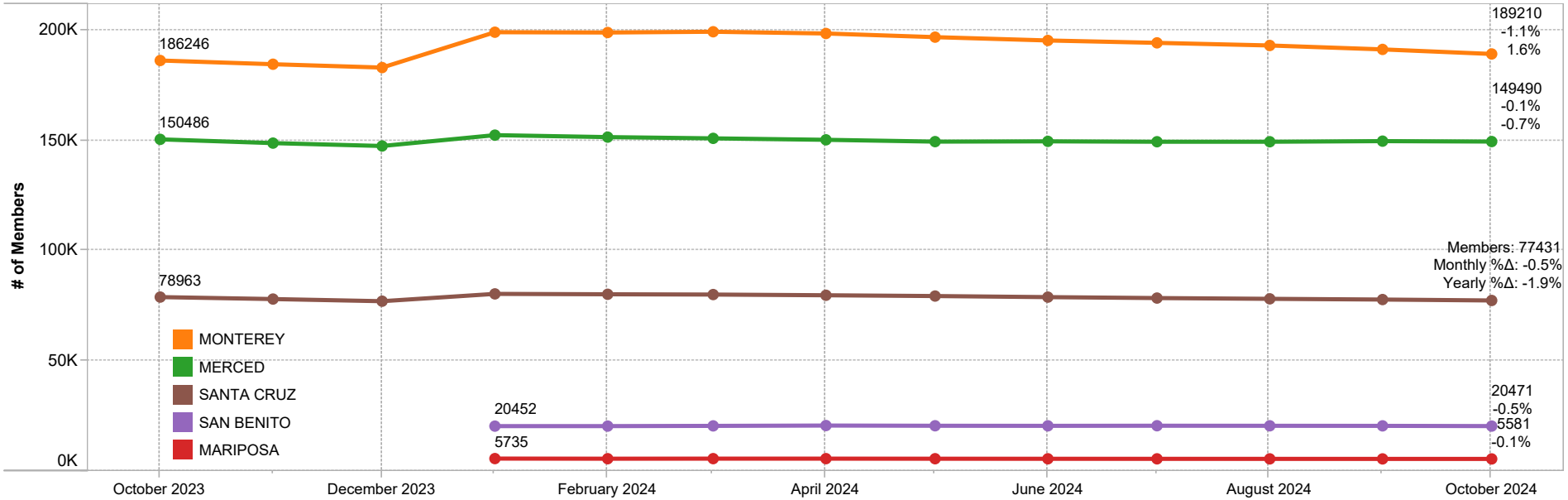
Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *10/8/2024 6:12:26 AM*

Enrollment Month
10/1/2023 to 10/31/2024

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



LOB	County	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024
Medi-Cal	SANTA CRUZ	78,963	78,072	77,097	80,418	80,239	80,112	79,790	79,437	78,946	78,521	78,173	77,850	77,431
	MONTEREY	185,565	183,867	182,347	198,373	198,235	198,578	197,776	196,108	194,596	193,519	192,333	190,560	188,501
	MERCED	150,486	148,785	147,479	152,401	151,503	150,940	150,281	149,460	149,585	149,409	149,408	149,676	149,490
	MARIPOSA				5,735	5,679	5,710	5,708	5,671	5,641	5,618	5,603	5,588	5,581
	SAN BENITO				20,452	20,460	20,562	20,714	20,617	20,582	20,632	20,603	20,572	20,471
IHSS	MONTEREY	681	689	695	698	698	704	719	725	731	729	723	717	709
Total Members		**415,695**	**411,413**	**407,618**	**458,077**	**456,814**	**456,606**	**454,988**	**452,018**	**450,081**	**448,428**	**446,843**	**444,963**	**442,183**