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

Meeting Agenda

Wednesday, December 6, 2023

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: 632 576 714#

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, December 5, 2023 to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to three minutes.
    b. In person, 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. – 10F.): 3:20 p.m.

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

Pages 5-01 to 5-12

6. **Accept Alliance Dashboard for Q3 2023.**
- Reference materials: Alliance Dashboard – Q3 2023.

Pages 6-01 to 6-02

7. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the ninth month ending September 30, 2023.**
- Reference materials: Financial Statements as above.

Pages 7-01 to 7-09

Appointments: (8A.)

8A. **Approve appointment of Ms. Juana Chávez de Guízar, Ms. Keota Xiong and Ms. Alma Mandujano to the Member Services Advisory Group.**
- Reference materials: Staff report and recommendation on above topic.

Page 8A-01

Minutes: (9A. – 9C.)

9A. **Approve Commission meeting minutes of October 25, 2023.**
- Reference materials: Minutes as above.

Pages 9A-01 to 9A-06

9B. **Accept Compliance Committee meeting minutes of July 19, 2023 and September 20, 2023.**
- Reference materials: Minutes as above.

Pages 9B-01 to 9B-09

9C. **Accept Whole Child Model Family Advisory Committee meeting minutes of September 11, 2023.**
- Reference materials: Minutes as above.

Pages 9C-01 to 9C-03

Reports: (10A. – 10F.)

10A. Approve revised Bylaws of the Commission for submittal to Santa Cruz, Monterey, Merced, San Benito and Mariposa County Board of Supervisors for final approval.

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

Pages 10A-01 to 10A-28

10B. Authorize the Chairperson to sign contracts with the Department of Health Care Services implementing the 2024 Medi-Cal Managed Care Plan contract provisions and adding San Benito and Mariposa counties to the Alliance Service area.

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

Pages 10B-01 to 10B-02

10C. Approve revised Member Services Advisory Group (MSAG) Charter.

- Reference materials: Staff report and recommendation on above topic; revised MSAG Charter.

Pages 10C-01 to 10C-05

10D. Accept report on 2023 Legislative Session Wrap-Up.

- Reference materials: Staff report on above topic; and 2023 Legislation - Final.

Pages 10D-01 to 10D-34

10E. Accept Alliance Donations and Sponsorship of Events and Organizations 2023 Annual Report.

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

Pages 10E-01 to 10E-02

10F. Accept Quality Improvement Health Equity Transformation (QIHET) Workplan – Q2 2023.

- Reference materials: Staff report and recommendation on above topic; and Q2 2023 QIHET Workplan.

Pages 10F-01 to 10F-22

Regular Agenda Items: (11. – 15.): 3:25 p.m.

11. Board Discussion: Conflict of Interest. (3:25 – 4:10 p.m.)

A. Mr. Michael Schrader, CEO, will review and Board will discuss Conflict of Interest as follow-up from October 25, 2023 Board meeting discussion.

12. Consider approving: 1) Medical Budget and 2) Administrative Budget for Alliance Calendar Year (CY) 2024. (4:10 – 4:30 p.m.)

A. Ms. Lisa Ba, Chief Financial Officer (CFO), will review and Board will consider approving proposed Medical Budget for CY 2024.
B. Ms. Ba, CFO, will review and Board will consider approving proposed Administrative Budget for CY 2024.

- Reference materials: Staff report and recommendation on above topic; Proposed Medical and Administrative Budget for CY 2024; and Capital Budget and Depreciation Expense for CY 2024.

Pages 12-01 to 12-07

13. **Consider approving proposed 2024 Provider Payment Policy on Enhanced Care Management (ECM). (4:30 – 4:40 p.m.)**

A. Ms. Lisa Ba, CFO, will review and Board will consider approving proposed 2024 provider payment policy on ECM.

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

Pages 13-01 to 13-02

14. **Consider approving proposed Incentive Program Funding for Calendar Year (CY) 2023. (4:40 – 4:50 p.m.)**

A. Ms. Lisa Ba, CFO, will review and Board will consider approving $40M incentive payments for provider performance in year 2023.

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

Pages 14-01 to 14-02

15. **Consider approving Care-Based Incentive (CBI) Program for 2024. (4:50 – 5:00 p.m.)**

A. Dr. Dianna Diallo, Medical Director, will review and Board will consider approving structural program changes to CBI 2024.

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

Pages 15-01 to 15-02

Information Items: (16A. – 16E.)

Announcements:

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

- Finance Committee
  Wednesday, March 27, 2024; 1:30 – 2:45 p.m.
- Member Services Advisory Group
  Thursday, February 8, 2024; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, December 7, 2023; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Thursday, March 21, 2024; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, January 8, 2024; 1:30 – 3:00 p.m.

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

The next regular meeting of the Commission, after this December 6, 2023 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
  Wednesday, January 24, 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) 430-5523 to verify meeting dates and locations prior to the meetings. Audio livestreaming will be available to listen/view the meeting. Note: Livestreaming for the public is listening/viewing only.

The complete agenda packet is available for review on the Alliance website at 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) 430-5523. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.

DATE: December 6, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

County Expansion. Expansion of the Alliance's service area to San Benito and Mariposa counties effective January 1, 2024 is on track. Deliverables demonstrating readiness are complete, provider network development continues, and community and member outreach is ongoing. In-person "Meet and Greets" were held in each county in November with good turnout. Final 30-day notices will be sent to transitioning members by the Department of Health Care Services (DHCS) on December 1, 2023. Alliance call center staff are available to take calls from new members, and offices in both counties are staffed with Member Services Representatives who are available to meet with members in person.

2023 Legislative Session. The 2023 Legislative Session came to a close on October 14, 2023, with the deadline for Governor Newsom to sign or veto bills remaining on his desk. Outcomes of bills for which the Board approved an official position of support are provided within the 2023 Legislative Wrap-Up report included as agenda item 10D. Additionally, staff provide the full final 2023 Bill List for the Board's information. As previously reported, staff maintain a list of bills impacting the Alliance and work with health plan trade associations to advocate on bills affecting the health care industry in general, as well as those which affect Medi-Cal specifically. Staff have reviewed the outcomes of these bills and are developing implementation steps as required.

Community Involvement. On November 9, 2023, I attended the Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting and attended the HIPSCC Annual Board meeting on November 16, 2023. I plan to attend the California Association of Health Plans Board meeting on December 13, 2023 and the HIPSCC Council meeting on December 14, 2023. On December 21, 2023, I plan to attend the HIPSCC Executive Committee meeting.

Health Services

The Health Services team is working in lockstep with the rest of the organization on County Expansion and Essette Replacement in addition to preparing for 2024. Both Pharmacy and Utilization Management (UM) are working to ensure proper member noticing and continuity of care for members from our two new counties. Through its transition of care work and partnership with the other hospitals, UM has seen decreased utilization rates as well as movement of long stay members. Pharmacy has focused on cost containment through its site of care program while improving care through partnering on efforts around opiate reduction and naloxone distribution. Quality Improvement has been busy across the department, including efforts to close Care-Based Incentive (CBI) care gaps while continuing to ensure access to culturally and linguistically appropriate services. Community Care Coordination continues to expand both Enhanced Care Management (ECM) and Community Supports (CS) while also working on continuity of care for new

members from our two new counties. Behavioral Health continues to work on the dual goals of Carelon quality improvement while increasing organizational behavioral health literacy. Program Development successfully wrapped up the equity practice transformation (EPT) application cycle and continues to move forward on all DHCS incentive programs. Overall, this activity has positioned Health Services and the Alliance for a good start in 2024.

Quality Improvement and Population Health (QIPH)

Health Education Services. The Health Educators provided 10 member workshops during 2023 in various modalities including virtual, telephonic, and in-person workshops. Members continue to respond positively to having a variety of options to attend health education programs. The Health Education team has also participated in planning and preparation for implementation of the Basic Population Health Management Program for the Alliance. The Health Educators have made outreach calls throughout 2023 informing members of services available to them and signing them up for workshops.

Cultural & Linguistics (C&L) Services. C&L staff successfully expanded services in 2023 to include translation services for all Notice of Action letters sent to members. Additionally, C&L staff have successfully coordinated face-to-face (F2F), in-person, interpreting services throughout the year for network providers. Utilization of F2F services continues to increase. Q3 ended with a total of 1,230 F2F requests processed, with each month within the quarter averaging 410 requests received. In October 2023, C&L staff processed 479 F2F requests, the highest so far in this quarter. C&L staff was also able to coordinate that an American Sign Language interpreter be present for the Mariposa County Expansion Meet & Greet event held on November 9, 2023.

Member Rewards Program. Quality Health Population (QHP) staff successfully partnered with internal departments to launch new member rewards in 2023. The "Healthy Start" program rewards members ages 0-21 for completing well-child and well-care visits. QHP staff provided informational presentations on the new rewards to internal departments and external partners including Community Based Organizations and at Joint Operations Committee meetings to increase awareness of the new rewards. QHP staff also worked with our internal Communications department to launch a paid media campaign to promote the "Healthy Start" program to our members and community, the campaign ran from May 2023 through July 2023 in all of our three servicing counties. The media campaign included: bus ads, mobile push ads, Facebook posts, and promotional flyer.

Care-Based Incentives, Managed Care Accountability Set, and Provider Engagement. QIPH staff in support with the provider relations team and other departments, worked with providers on multiple projects this year to improve the DHCS Managed Care Accountability Set (MCAS) quality performance measures. The CBI Improvement Pilot Program from April to June collaborated with Health Improvement Partnership of Santa Cruz County to work with three Merced providers on two measures for rapid cycle Plan, Do, Study, Act based practice coaching, focusing in particular on missed opportunities. The Care-Based Quality Improvement Program (CB QIP) concluded in October with the second cohort meeting, showcasing provider presentations of quality improvement activities they engaged on from July to October. Piloting of provider office hours for providers engaged in CB QIP occurred in November, with another scheduled for December. DHCS's Strength, Weakness, Opportunity, and Threat projects from January to September for pediatric and women's health, worked with specific providers on projects like standing orders for breast cancer screening, conducted member outreach for feedback on well-child visit scheduling, and collaborated with a network clinician for a pediatrics webinar. Discussions on piloting locum

provider and service expansion hours began in October for Merced providers with the largest linkage to our members. The Healthcare Effectiveness Data and Information Set/MCAS team has also begun project planning discussions to track the new DHCS scoring criteria for health plans based on the DHCS Bold Goals: 50x2025 and regional grouping.

Utilization Management

Inpatient and Emergency Department (ED). The Alliance has achieved significant advancements in the ongoing development of Transitional Care Services (TCS), involving more than 484 interdisciplinary team meetings with external stakeholders across three counties. Through collaborative hospital case conferences and the dedicated efforts to enhance Residential Care for the Elderly discharge processes, three highly complex individuals were successfully transitioned from Natividad to lower levels of care. These particular members had collectively spent 1,752 days in the hospital (922, 438, 392), and all previous discharge coordination attempts had been unsuccessful. Insights gained from these TCS case studies will inform future program and process enhancements. Alongside the emphasis on alternative discharge strategies, the continuous implementation of transitional care member-specific interventions has contributed to sustained year-long reductions in the average length of stay. Q3 data indicates a noteworthy decrease of 0.5 days, marking a significant improvement throughout the year.

The overall 30-day readmission rates for Q3 2023 stand at 10%, indicating a 2% decrease from the overall readmission rates observed in 2022. Significant 30-day readmission reduction improvements are evident in both Seniors and Persons with Disabilities (SPD) 30-day readmissions, declining from 21% in Q1 to 12% in Q3, and in the expansion population, which decreased from 14% in Q1 to 10% in Q3.

Despite a quarter-to-quarter increase in total ED visits, data for total avoidable visits reflects consistent reductions, with Q3 demonstrating a noteworthy 4% decrease in Merced (17% in Q1 compared to 13% in Q3). Medi-Cal Child and Family and SPD population groupings both separately reflect a 3% reduction in avoidable ED, with a pattern of progressive reductions when compared to Q1-Q2 data.

Long term care (LTC) admissions appear to have dropped dramatically for Q3 (n=96 vs 234), possibly due to a claims lag and staff will continue to monitor for newly emerging trends. Reductions in LTC may also be due in part to TCS program development, with increased focus on placing members in the least restrictive environment.

Skilled Nursing Facilities (SNF) bed days has shown a progressive decline from Q1 data, with a 10% reduction in overall SNF bed days in Q3. The SPD SNF bed days experienced a 15% decrease in 2023, while there was a simultaneous 12% increase in the total number of members placed in short-term rehab this year.

Prior Authorization. Prior Authorization turnaround times remain near goal of 100% (n=99.8), with a slight decrease in authorization volumes noted in Q3. Overall utilization is on par with prior quarters. Denial activity remains low at 1% with most appeals upheld in favor of the plan (74%) and only 10% denials resulting in appeal.

Jiva/ZeOmega work continues with the Essette system platform replacement on track for March 2024. Temporary staff are in recruitment and training to support the next steps of wide scale sandbox testing of new workflows and training in the Jiva system. As the team prepares for

integration of the new platform, authorization framework enhancements continue, with exploration underway for further streamlining of ECM authorizations to both widen member access and reduce provider administrative burden. The PA team is additionally engaged in redirecting members where possible at the authorization level to in-network specialty providers. This process enhancement better supports timely access and member connection to local care.

County expansion work continues, as integrated cross-departmental Continuity of Care (CoC) workflows are now in flight with the integration of data received from exiting health plans in the two counties. Historical authorization data sets are under analysis and system configurations in process to support both CoC processes and member outreach. Special population members have additionally been identified for outreach and coordination of care.

Pharmacy

Site of Care Program. The Alliance initiated the Site of Care Program in December 2022. The goal of the program is to transition members from hospital-based outpatient infusion to home-based infusion. The member and prescribing provider can opt in or out of the Site of Care Program depending on the member's clinical and social needs. Currently, we are focusing on members who are on infliximab (Remicade), its biosimilars, vedolizumab (Entyvio), intravenous immune globulin (IVIG), and ocrelizumab (Ocrevus). We also recently investigated members who are on ustekinumab (Stelara), pegloticase (Krystexxa), alpha-1-proteinase Inhibitor (Glassia), and alpha-1-proteinase Inhibitor (Zemaira). None of the members on these medications were eligible for our Site of Care program.

So far, we have identified 67 members who are candidates for this program.

- Eleven members have accepted the program:
    - Five members received provider approval and have started receiving their infusion medication at home.
    - Five members did not transition to home-based infusion because their provider did not respond after multiple attempts.
    - One member could not transition to home-based infusion because they no longer had Alliance coverage after the member and provider opted into the program.
- The members who have declined the program have done so for multiple reasons, including not wanting anyone in their home or prefer to continue at their current site of care because they receive other services from that site at the same time.

A barrier to the program has been that many members do not answer their phones and do not respond to voicemails left by the infusion pharmacy. Another barrier to this program has been the time it takes for prescribers to send clinical information and medication orders to the infusion pharmacy. The infusion pharmacy must follow up with the provider multiple times to obtain all the necessary information from the prescriber and sometime the provider simply does not respond at all.

We have completed training for all the Alliance Pharmacy Department staff on the Site of Care program. In the upcoming year we will focus on the same target medications as well as exploring ways to increase provider's program acceptance and identify any newly eligible members.

Drug Utilization Review (DUR) Program

Drug Disease Interaction in Older Adults: This report assesses adults 65 years of age and older who have a specific disease or condition (chronic kidney disease, dementia, history of falls) and were dispensed a prescription for a medication that could exacerbate the condition. The Alliance pharmacist reviewed all members 65 years and older with chronic kidney disease (CKD) who were prescribed a prescription strength non-steroidal anti-inflammatory drug (NSAID) during the year 2022. About 11% of our older adults with CKD were prescribed at least one prescription strength NSAID during the year 2022. Utilization was analyzed based on provider prescribing patterns and those providers who had prescribed to three or more members. Most providers had prescribed prescription strength NSAID only once post procedures. Only three providers had prescribed to three or more members, and they were prescribed in doses or quantities that seem appropriate for their condition. No concerns were found.

Persistence of Beta-Blocker Treatment after Heart Attack: Drug utilization review was performed on Alliance members who were greater than or equal to 18 years of age and had a heart attack and were treated at a hospital in 2022. We excluded members with other healthcare coverage and In-Home Supportive Services members. This resulted in 252 adult members (or 0.062% of all adults at the Alliance) who had a heart attack and were treated at a hospital in 2022. When comparing the prevalence of heart attacks between counties, Merced County had the highest rate of heart attacks at 0.084%. Monterey and Santa Cruz County had similar rates of heart attack at 0.051% and 0.048% respectively. We then looked at the percentage of members with a heart attack who also received beta-blocker therapy in 2022 because clinical guidelines recommend taking a beta-blocker after a heart attack to prevent another heart attack from occurring. At the Alliance overall, 74% of adult members who had a heart attack in 2022 also had a claim for a beta-blocker that year. The county breakdown showed that Monterey County had the highest rates of beta-blocker utilization after heart attack at 79%, followed by Merced County at 73% and Santa Cruz County at 65%. We also compared prevalence of beta-blocker use after heart attack broken down by spoken language and gender which were both unremarkable. A provider bulletin on "Beta-Blocker Use After Heart Attack" will be published soon to educate providers that most patients should be taking a beta-blocker after a heart attack.

Naloxone to Members at High Risk: California state law requires naloxone to be provided to patients who are at risk for an overdose. Additionally, as part of SUPPORT Act, states are required to identify members at high risk of opioid overdose who should be co-prescribed or co-dispensed naloxone. To ensure compliance with above, drug utilization review was performed on Alliance members who received ED or inpatient treatment for nonfatal opioid overdose during 2022. Members with other health coverage were excluded. Additionally, members who passed away prior to ER/hospital arrival were excluded as well. A total of 411 members met the above criteria. Six members died during admission, leaving 405 members being discharged status post opioid overdose. Of the 35 members who died after discharge, 31 died within one year, six members died within one month and two members died within two days. Cause of death was not evaluated, which presents a limitation to the above analysis. Out of 405 members, only 87 received naloxone after discharge and only 103 members received buprenorphine after discharge. Only 46 members received both naloxone and buprenorphine after the discharge. The results of this analysis were presented to the Utilization Management Work Group with a goal to collaborate with other departments and combine efforts to help our members. As a result, QI and pharmacy teams are developing a workflow to collaborate in helping our members.

Pharmacist-Led Academic Detailing (PLAD)

Asthma: Currently there are three providers from two clinics that are participating in the PLAD Asthma program. Providers are divided into two groups to ensure a small group environment. Two providers have completed one out of the two sessions, and one provider's first session is scheduled for the second week of November.

Diabetes: Two out of four clinics finished the 10 diabetes PLAD sessions in October 2023. To assess knowledge gain, post-training assessments were performed for each clinic and compared to pre-test. For both clinics, the post-test results were significantly improved compared to pre-test. Additionally, providers completed a post-program survey in which they strongly agreed that the educational program was useful to them, enhanced their knowledge and that they are likely to recommend the program to their colleagues. Moreover, after completing the program, providers from both clinics were motivated to participate in the Asthma PLAD sessions, which further indicates that they found the diabetes PLAD sessions valuable. Two remaining clinics (four providers) are scheduled to complete their PLAD sessions by November 16, 2023. The same analysis will be performed for them.

To evaluate member impact, baseline A1C data was collected prior to program start for each clinic. Patients whose A1C was nine or above at the start of program will be reassessed in April-May 2024 (six months after PLAD session completion) to obtain an indirect objective measure of PLAD program on member outcomes.

Community Care Coordination

Enhanced Care Management (ECM)/Community Supports (CS). There is a large focus on increasing enrollment in ECM services with ongoing work towards expanding the ECM and CS provider network capacity across all service areas. Continued efforts have been placed on engaging hospital and medical providers, County partners, as well as local Community Based Organizations that have experience serving the existing populations of focus and community supports services. Additional providers continue to be added to the network of ECM/CS providers to support expansion of services and increased enrollment. Collaborations have been ongoing with the exiting MCPs in San Benito and Mariposa to establish transition of services for ECM and CS services for county expansion. The ECM team continues to have collaborative working relationships across multiple sectors to support increased awareness and referral volume into the program. Provider network support remains a priority to encourage capacity expansion as well as quality provision of services for members.

Engagement of new providers and current contracted providers who have experience serving the two new populations of focus that will go-live in January include individuals transitioning from incarceration and those providers that serve the birth equity population of focus have been prioritized. Ongoing meetings are occurring with the justice involved County departments, as well as those medical and behavioral providers that serve members in the incarcerated settings. Post-release workflows have been shared with these providers to initiate proactive referrals and encourage early collaboration despite the difference in pre-release and post-release service timelines. This focus is intended to support with helping members have a congruent transition from incarceration into the community.

Complex Care Management (CCM). CCM staff continue to work on CalAIM Population Health Management Program (PHMP) project work. Last quarter CCM staff collaborated with the UM

team to complete the workflow for TCS to meet PHMP requirements. We have now implemented a pilot program using the new workflow. In this pilot we have focused on high-risk members with a diagnosis of diabetes. To-date we have found the pilot to be successful and look forward to implementing it with all high-risk members soon.

We are gearing up for the county expansion implementation in January 2024. CCM staff collaborated with UM staff on meeting requirements for our CoC for all new members. We are also focusing on our SPD members to meet regulatory requirements.

Lastly there has been a lot of training and preparation for Essette system replacement. This will go live in March of 2024. We have been doing a lot of testing and reviewing of all workflows to ensure that we are able to meet our members' needs in a more streamlined approach.

Whole Child Model/Pediatric Complex Care Management. The Pediatric CCM team continues work with the Essette system platform. Work in the Jiva platform is in full swing across all teams with the current discovery, and gap analysis phase. Optimization for both California Children's Services (CCS) and case management and other key health services functions is under full exploration as the new platform is developed to best align with National Committee for Quality Assurance standards as well as other requirements. We recently transitioned from the discovery, gap analysis (DGA) Phase to the elaboration and design (EAD) phase of planning. This phase includes review of solution requirements, specifications, and baseline.

Pediatric CCM staff is preparing for the implementation of the two new counties in January 2024. Unlike the existing Whole Child Model (WCM) counties, the new counties will be continuing the provision of the classic dependent county CCS service model, in alignment with County CCS programs, as well as DHCS. Meetings are ongoing for this implementation with both County CCS teams, as well as the Regional Centers. Though this is the short-term plan, we are concurrently working towards the transition of the two new counties into WCM in January 2025. The counties and both DHCS are eager to begin the planning for the implementation of WCM in 2025. The Pediatric team recently attended an on-site in-person event in Mariposa County to meet our members and continue relationship building, as well as share information about CCS and Pediatric CCM.

Behavioral Health

The Behavioral Health (BH) Department has maintained ongoing efforts to engage with our delegate Carelon to improve their performance in regard to compliance, communication, member experience and provider experience. This includes the regular updating of oversight trackers for legislation, All Plan Letters compliance and provider issues, as well as provision of regular feedback on routine operations verbally in weekly leadership meetings and in writing daily via email. We submitted redline edits of the proposed contract amendment to Carelon which included language to comply with the 2024 DHCS contract requirements and an amended contract termination date and are awaiting feedback.

Concurrently, BH began active engagement in operational readiness activities towards preparing for an insourced model should Carelon be unable to deliver substantial improvements. This included meetings with key department Directors from legal, compliance, finance, and provider services to identify milestones in a high-level project plan. To support these activities, Project Management Office support for the project began.

The department continued efforts to build a higher level of BH literacy across the Alliance with the delivery of the second webinar in the monthly learning session series. The focus was on understanding the profile of members who access non-specialty BH care and considering utilization trends. The voluntary session was attended by staff from a variety of departments with feedback that the webinar was informative and helpful.

Supporting county relationships, the BH Director provided a presentation to the Santa Cruz County Youth BH Continuum workgroup. The presentation highlighted the work delivered by the Alliance to support BH treatment and prevention with youth and families. The BH Director also met with the consultant assigned to lead the continuum assessment to conduct a deeper discussion on non-specialty mental health services.

Program Development

CalAIM Incentive Payment Program (IPP). The Alliance anticipates learning the allocation earned for IPP Payment on December 3, 2023. Staff continue to execute LOAs for the newly contracted ECM/CS providers serving Populations of Focus (PoF) that went live July 1, 2023, and for the new PoF that will go live January 2024. Additionally, staff continue to have discussions with Anthem Blue Cross (exiting Medi-Cal plan in Mariposa and San Benito Counties) and California Health and Wellness (exiting Medi-Cal plan in Mariposa County) to prepare and submit Needs Assessments and Gap Filling Plans to DHCS and assume responsibility for IPP in Mariposa and San Benito Counties beginning in 2024.

Housing and Homelessness Incentive Program (HHIP). The final HHIP Submission 2 is due from the Alliance to DHCS on December 29, 2023. The Alliance can earn up to 50% of the total HHIP funding allocation by performing and reporting on both qualitative and quantitative measures related to: a) partnerships and capacity to support referrals for services, b) infrastructure to coordinate and meet member housing needs, and c) delivery of services and member engagement. Additionally, staff anticipate receiving further information from DHCS on the HHIP Reinvestment Fund Option, through which The Alliance will have the opportunity to earn back additional funds withheld from Submission 1. These metrics will be due for submission to DHCS by December 29, 2023, concurrently with Submission 2.

Student Behavioral Health Incentive Program (SBHIP). Local Education Agency partners are preparing reports for the second reporting period (July 1, 2023 through December 31, 2023), which will be submitted to DHCS by the Alliance by December 31, 2023. The Alliance can earn up to 12.5% of the total SBHIP funding allocation through these reports, which report on the 11 targeted interventions being implemented across Merced, Monterey and Santa Cruz Counties. Regular meetings are underway with San Benito and Mariposa SBHIP partners, for successful transition of the SBHIP project in 2024.

Equity and Practice Transformation. Applications for EPT were due from primary care practices on October 23, 2023 at 11:59 pm. The Alliance received a total of 25 applications from Santa Cruz, Monterey, Merced, and San Benito. Staff will review applications and submit those applications recommended for approval to DHCS by November 27, 2023. DHCS will then review Alliance staff recommendations and practice applications and will announce selected practices on December 11, 2023. DHCS will prioritize practices from zip codes with Healthy Places Index quartile of 1 or 2.

Employee Services and Communications

Human Resources

Alliance Workforce. As of October 23, 2023, the Alliance had 573.4 budgeted positions of which our active workforce number is 539.9 (active FTE and temporary workers). There are 58 regular and temporary positions in active recruitment, and we are 94.2% staffed. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets. Human Resources partners with Finance to ensure alignment in this area and provides a bi-weekly workforce dashboard to all Directors and Chiefs for transparency regarding our workforce statistics.

Competencies and Career Development. Human Resources presented on our new 2024 Competency Redesign Work at the November 14, 2023 Leadership Forum. The focus of the meeting was the philosophy and framework of how we will use competencies going forward. In addition, a new ALC course went live on November 20, 2023 as a follow-up to the course, for introduction and training to the new platform, CompetencyCore. Next, there are two information sessions planned for the week of November 27, 2023 to provide the introduction and platform for all staff. Our new competencies will go live on January 1, 2024.

Annual FTE Request Process. This body of work closed with the completion of the 2024 budget. Approved FTEs are available for Directors to view but are pending final approval at the December Board meeting. Human Resources is supporting departmental changes for the coming new year.

Workforce Strategy Updates. Human Resources has commenced work as we update policies and process documents related to our workforce strategy. As we adapt to the post-pandemic work environment, policies and procedures have been communicated to staff as it relates to our new work environment and Human Resources is actively working on implementation and updates for a January 1, 2024 effective date. This includes creating new fields within our HRIS and adding content to the Employee Handbook.

Open Enrollment. Human Resources has provided two Open Enrollment meetings, facilitated by our benefits broker for staff education. Open Enrollment took place November 8 through November 22, 2023. Staff were encouraged to review all benefits, ask questions, and select their options no later than November 22, 2023 for January through December 2024 benefits.

Facilities and Administrative Services

Service Area Expansion. Facilities has actively worked with the counties of Mariposa and San Benito to coordinate sub-leasing space with an occupancy of November 13, 2023, in both service areas. Lease negotiations have been executed.

Alliance Footprint Reduction. The Facilities Department has cleared out employee workstations/offices in the areas targeted for footprint reduction. The team is proceeding with an 80,000 square foot reduction of Alliance occupied square footage and an increase of potential space for leasing which was included in the annual Facilities Management report. Several tenants are currently interested in the available space in Salinas and Merced and lease negotiations are occurring. The Salinas and Merced offices are expected to be fully occupied in Q1 2024.

Communications

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

County Expansion Media Campaign. For county expansion, we have launched a targeted media campaign to reach new members with messaging "We are the Alliance, your new Medi-Cal provider." Messaging also stresses that we are local, experienced, and trusted. Communication tactics include website content, flyers, and newsletter articles for providers, members, and community partners. Ads vary by county but include a combination of social media, closed circuit tv, streaming radio, YouTube, mobile, grocery carts, grocery store stuffers, transit shelters, and newspapers. We distributed a press release on November 1, 2023 and will reach out to local media to coordinate an OpEd for Michael Schrader, CEO. In addition, staff will be spending the next 60 days updating corporate materials and channels to reflect the new counties and membership figures.

Medi-Cal for All Campaign. Staff have developed a communications plan to support Medi-Cal for All, which expands full-scope Medi-Cal to 26–49-year-olds beginning January 1, 2024. The communication campaign includes flyers, website copy, member and provider bulletin articles, The Beat (community newsletter) content and social media posts.

CommonSpirit. In conjunction with CommonSpirit negotiations, staff have developed a communications plan which includes various tactics by audience. The communications plan largely leverages the messaging tactics created to support the 2021 negotiations.

Sit-Down with the Chief Executive Officer (CEO). Earlier this month, Sit-Down with the CEO content series was launched. This series includes a rotation of monthly emails and videos from Mr. Schrader, discussing a variety of topics to keep staff in the know. This communications tool provides a structured and focused opportunity for Mr. Schrader to reach and engage with all staff on a regular basis. The topic for the first video in the series highlighted learnings and observations during his first six months as CEO. In November, we pivoted to an email message, where he provided an update on County Expansion efforts. Communications staff are supporting the development and execution of these messages.

Operations

County Expansion. On November 4, 2023, the Alliance hosted a community meet and greet at the Community Foundation of San Benito County. There were over 15 Alliance staff in attendance representing each of our member facing departments. Current San Benito County Medi-Cal recipients were able to meet with staff and ask questions around services and benefits. There were around 350 attendees, most of whom were Medi-Cal beneficiaries. Provider trainings have also begun in San Benito County including in-person training with San Benito Health Foundation staff and Hazel Hawkins Healthcare District staff, respectively.

On November 9, 2023, the Alliance hosted another community meet and greet in Mariposa County at the Creekside Terrace Community Center. Alliance staff provided participants with information about services and benefits including care management, transportation and behavioral health.

Staff also answered questions regarding the provider network and continuity of care. Additionally, in-person provider trainings took place at Yosemite Medical Clinic.

The Alliance continues to partner with county office staff in both counties to support the continued development of the provider network.

Dual Eligible Special Needs Plan (D-SNP) Implementation. The Alliance executed the second scope of work with our implementation partner, Change Healthcare (CHC) which engages CHC through implementation into 2026. Medicare 101 training was conducted with select staff. Additionally, Medicare Administration is working to engage a resource to help us start building our D-SNP network and train our staff on Medicare contracting. We will be initiating workstream level work January 2024 once a comprehensive assessment is completed.

Network Development. The Provider Services Department continues to partner with local Community Based Organizations to gain insight on how best to support a strong doula and Community Health Worker (CHW) network. The CHW workforce recruitment grants have been supplementing the network build as well as supporting communication within the community about the newer benefits. With the October Board approval for doula workforce recruitment grants and doula technical assistant grants, the team is anticipating more community engagement to support growing the doula network.

The Enhanced Care Management (ECM) and Community Supports network continues to grow as we prepare for new populations of focus on January 1, 2024. Three new ECM providers are onboarding this November with ten more slated for a January 1, 2024 effective date.

Operational Efficiency.

Claims: Enhanced tableau reporting allows fast and efficient visibility into claim types worked the prior day for each claim technician, along with the technician's specific focus on aged claims.

Compliance: The 2024 Alliance/DHCS Medi-Cal Contract requires annual review of Policies and Procedures (P&Ps), marking a significant increase from the current biannual review cycle. The Virtual Policy Hub was replaced with a new change management process. Evolving the Alliance's P&P management process will make it easier for organizational departments to manage their own P&Ps, more accurately determine interdepartmental impacts, implement necessary changes to their P&Ps, and facilitate compliance with the 2024 Alliance/DHCS Medi-Cal Contract.

Software Development: There was an identified problem to standardize processes. A comprehensive end-to-end vision across various stakeholders for software development was established. Standardized processes and workflow were assessed and developed across the various stakeholders, ensuring consistency, efficiency, and software product quality.

Q3 2023 Organizational Dashboard Results. The Q3 2023 Alliance Dashboard is comprised of 149 metrics monitoring 65 health plan core, support, and managerial processes. These 65 health plan processes are rolled-up to 13 top-level (Level 1) processes for Board monitoring using a composite methodology.

Results for nine of 13 Level 1 processes met or exceeded 95% of target. Key exceptions to the 95% standard and other notable performance are as follows:

Level 1 Process	Q3 Results	Qtr over Qtr Change	Key Drivers
Manage Data	86.3%	-0.2 percentage points	Low performance can be attributed to a failed reporting measure across all three counties due to the Pharmacy Carveout. DHCS has not yet completed refinements to remove Pharmacy from their algorithm, and MCPs will not be penalized by DHCS for the failed measure. Additionally, performance is lower due to *resource constraints* during high-volume times for timely service request responses. The team is working on improvements.
Manage Alliance Compliance Commitments	91.2%	+0.3 percentage points	Late reported *Fraud, Waste & Abuse cases* as well as a late reported *PHI disclosure* were the reason for the lower performance. Even though the result for Q3 2023 is higher than the previous quarter's result, it is not yet meeting or exceeding 95% of target.
Manage Organizational Communications and Branding performance	77.9%	-21.6 percentage points	Performance of this process decreased considerably over the last quarter. The main reason is lower engagement rates on the average *Facebook page* than previously seen, even though the reach went up significantly due to an increased budget. The Communications team reviews goals around the metric to reflect a more realistic target.
Enhance Operational Effectiveness	92.9%	-3.0 percentage points	Lower performance this last quarter can be attributed to *resource constraints and competing project priorities*. Project teams are aware and escalate where necessary. The Operational Excellence team is also working on a better way to capture process performance across the organization.

Alliance Dashboard

Quarter 3, 2023

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

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

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

Core Processes

Deliver value to our members, providers and community

Engage & Support Members

96.2% Of Target

SUBPROCESSES
- 88.6 Help Members Engage
- 100 Help Members Navigate
- 100 Member Experience

Manage & Improve Care

98.2% Of Target

SUBPROCESSES
- 96.4 Manage Care Use
- 100 Improve Care

Develop & Maintain the Provider Network

99.2% Of Target

SUBPROCESSES
- 99.6 Develop the Network
- 98.9 Maintain the Network

Pay Providers

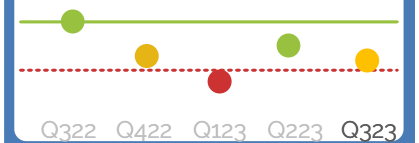
99.8% Of Target

SUBPROCESSES
- 100 Payment Models and Rates
- 100 Provider Payments
- 99.3 Payment Integrity

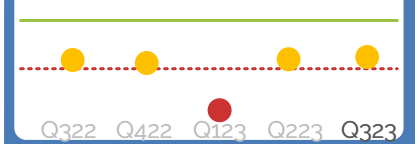
Managerial Processes

Guide the organization

92.9 Enhance Operational Effectiveness

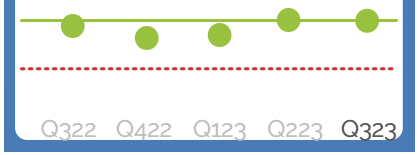


91.2 Manage Compliance Commitments



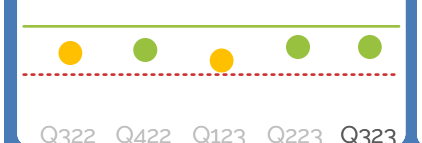
100 Manage Finances

100 Manage Governmental & Community Relations

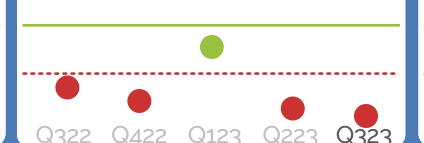


Support Processes *Enable organizational operations*

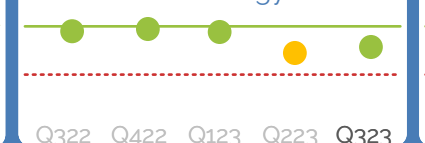
97.1 Optimize Alliance Workforce



86.3 Manage Data



96.2 Manage Technology



100 Provide Administrative Services

77.9 Communications & Organizational Branding

Alliance Dashboard – Board Metrics

Quarter 3, 2023

No.	Metric	Period	Target	Performance
1	Calls to Member Services answered within 30 seconds	Q323	80.0%	97.0%
2	New Member Welcome Call Completion Rate	Q223	30.0%	34.0%
3	Timely Resolution of Member Complaints	Q323	100.0%	100.0%
4	Members' Favorable Rating of Health Plan (CAHPS) (Medi-Cal)	2022	Child: 86.0% | Adult: 73.0%	Child: 87.8% | Adult: 76.8%
5	Members' Favorable Rating of Health Care (CAHPS) (Medi-Cal)	2022	Child: 84.5% | Adult: 70.5%	Child: 88.6% | Adult: 75.6%
6	Routine PCP Facility Site Reviews Completed Timely	Q323	100.0%	100.0%
7	Facility Sites Reviewed in Good Health	Q323	100.0%	100.0%
8	In Area PCP Market Share (all counties)	Q323	80.0%	86.9%
9	In Area Specialist Market Share (all counties)	Q323	80.0%	85.1%
10	Contracted PCP Open % (all counties)	Q323		60.4%
11	Overall Provider Satisfaction Rate	2022	88.0%	87.0%
12	Inpatient Bed Days/ 1,000 members/Year (Medi-Cal)	Q223	292.0	272.0
13	Admissions/1,000 Members/Year (Medi-Cal)	Q223	63.0	58.0
14	Total 30 Day All-Cause Readmissions %	Q223	11.0%	9.0%
15	Ambulatory Care Sensitive Admissions (Medi-Cal)	Q223	8.0%	6.0%
16	Average Length of Stay (Medi-Cal)	Q223	4.5	4.2
17	Emergency Department visits/1,000 members/year (all LOBs)	Q223	590.0	499.0
18	Avoidable Emergency Department visits (all LOBs)	Q223	18.0%	16.3%
19	Behavioral Health Utilization Rate by County (All Ages)	Q223	3.6%	SC: 10.9% | Mont: 5.9% | Merced: 5.1%
20	Routine Medical/Surgical Prior Authorizations Adjudicated Timely	Q323	100.0%	99.8%
21	Clean Claims Processed and Paid Within 30 Calendar Days	Q323	90.0%	92.6%
22	Employee Turnover Rate	Q422-Q323	10.0%	5.0%
23	Total Staffed Workforce	Q323	90.0%	93.7%
24	Board Designated Reserves Percentage	Q323	100.0%	120.6%
25	Net Income Percentage	Q323	1.0%	7.4%
26	Medical Loss Ratio	Q323	92.0%	88.5%
27	Administrative Loss Ratio	Q323	6.0%	5.5%

DATE: December 6, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Ninth Month Ending September 30, 2023

For the month ending September 30, 2023, the Alliance reported an Operating Income of $10.0M. The Year-to-Date (YTD) Operating Income is $89.7M, with a Medical Loss Ratio (MLR) of 87.7% and an Administrative Loss Ratio (ALR) of 5.3%. The Net Income is $104.4M after accounting for Non-Operating Income/Expenses.

The budget expected a $64.4M Operating Income for YTD September. The actual result is favorable to budget by $25.2M or 39.2%, driven primarily by rate variance and membership favorability.

	Sep-23 ($ In 000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*418,442*	*398,530*	*19,912*	*5.0%*
Revenue	135,724	126,122	9,602	7.6%
Medical Expenses	118,224	117,796	(428)	-0.4%
Administrative Expenses	7,539	8,075	536	6.6%
Operating Income	9,961	251	9,710	100.0%
Net Income	10,113	2,244	7,869	100.0%
MLR %	*87.1%*	*93.4%*	*6.3%*	
ALR %	*5.6%*	*6.4%*	*0.8%*	
Operating Income %	*7.3%*	*0.2%*	*7.1%*	
Net Income %	*7.5%*	*1.8%*	*5.7%*	

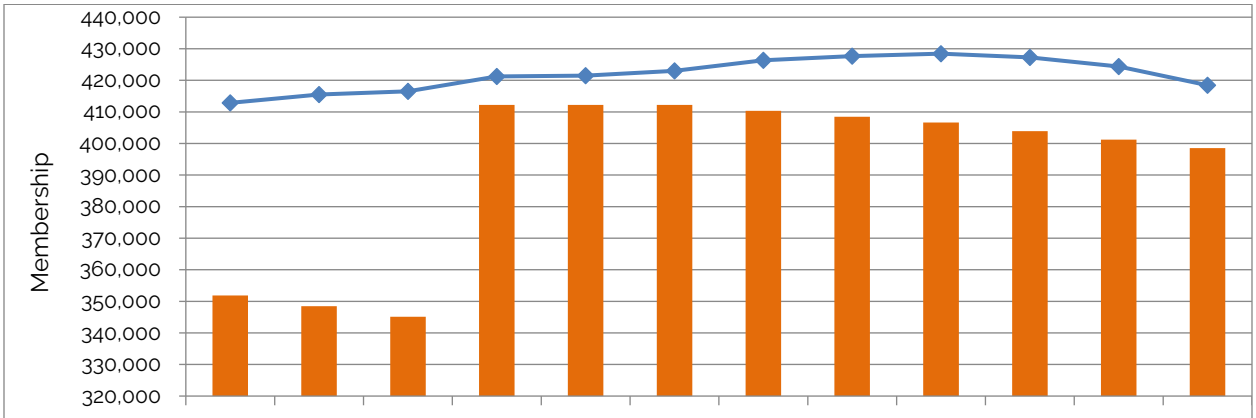
Sep-23 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*3,818,240*	*3,665,770*	*152,470*	*4.2%*
Revenue	1,280,700	1,163,626	117,074	10.1%
Medical Expenses	1,123,302	1,027,110	(96,192)	-9.4%
Administrative Expenses	67,739	72,090	4,351	6.0%
Operating Income/(Loss)	89,660	64,427	25,233	39.2%
Net Income/(Loss)	104,386	57,807	46,579	80.6%
PMPM				
Revenue	335.42	317.43	17.99	5.7%
Medical Expenses	294.19	280.19	(14.00)	-5.0%
Administrative Expenses	17.74	19.67	1.92	9.8%
Operating Income/(Loss)	23.48	17.58	5.91	33.6%
MLR %	*87.7%*	*88.3%*	*0.6%*	
ALR %	*5.3%*	*6.2%*	*0.9%*	
Operating Income %	*7.0%*	*5.5%*	*1.5%*	
Net Income %	*8.2%*	*5.0%*	*3.2%*	

Per Member Per Month (PMPM). 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 $335.42, which is favorable to budget by $17.99 or 5.7%. Medical cost PMPM is $294.19, which is unfavorable by $14.00 or 5.0%. Overall, this results in a favorable gross margin of $3.98 or 10.7% compared to budget. The resulting operating income PMPM is $23.48, which is favorable by $5.91 or 33.6% compared to the budget comprising a $3.98 gross margin and $1.92 favorable admin spend.

Membership. September 2023 membership is favorable to budget by 5.0%. Please note that the 2023 budget assumed the Public Health Emergency (PHE) would end in January 2023, with membership beginning to decline in April 2023. The Health and Human Services Department announced that the PHE ended on May 11, 2023. The Department of Health Care Services (DHCS) began the redetermination process in April 2023 for the June 2023 renewal month, with the actual enrollment loss starting in July 2023.

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



	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Budget	351,849	348,456	345,117	412,231	412,231	412,231	410,347	408,481	406,635	403,892	401,191	398,530
Actual	412,859	415,506	416,529	421,212	421,478	423,002	426,328	427,656	428,448	427,275	424,399	418,442
Variance	61,010	67,050	71,412	8,981	9,247	10,771	15,981	19,175	21,813	23,383	23,208	19,912
Variance %	17.3%	19.2%	20.7%	2.2%	2.2%	2.6%	3.9%	4.7%	5.4%	5.8%	5.8%	5.0%

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

September 2023 capitation revenue of $135.3M is favorable to budget by $9.6M or 7.6%, mainly attributed to higher enrollment of $6.3M and rate variances of $3.3M.

September 2023 YTD capitation revenue of $1,248.6M is favorable to budget by $88.1M or 7.6%. Of this amount, $43.5M is from boosted enrollment, and $44.6M is due to rate variance. Rate variances include prior year revenue of $12.0M for DHCS 2013-2016 Managed Care Organization Tax Reconciliation and $2.2M for the July 2019 through December 2020 Prop 56 adjustment.

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

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

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	256,373	247,815	8,558	5,972	2,587
Monterey	535,269	497,935	37,333	21,885	15,449
Merced	456,982	414,779	42,203	15,594	26,609
Total*	**1,248,624**	**1,160,529**	**88,095**	**43,451**	**44,644**

*Excludes Sep-23 YTD In-Home Supportive Services (IHSS) premiums revenue of $3.4M and State Incentive Programs revenue of $28.7M.

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

September 2023 Medical Expenses of $118.2M are $0.4M or 0.4% unfavorable to budget. September 2023 YTD Medical Expenses of $1,123.3M are above budget by $96.2M or 9.4%. Of this amount, $42.7M is due to higher enrollment, and $53.5M is due to rate variances, which include $28.7M for State Incentive Programs. YTD Inpatient Services (Hospital) is unfavorable to budget by $22.5M or 5.9%. $16.0M is attributed to enrollment, and $6.6M is attributed to increased spending primarily due to higher utilization. We are seeing similar increases in spending on Physician Services and Other Medical Services. Other Medical expenses include Allied Health, Lab, Durable Medical Equipment, Behavioral Health, and Transportation.

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

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	406,674	384,135	(22,540)	(15,977)	(6,562)
Inpatient Services (LTC)	133,286	137,580	4,294	(5,722)	10,016
Physician Services	238,485	214,732	(23,752)	(8,931)	(14,821)
Outpatient Facility	143,560	142,231	(1,328)	(5,916)	4,588
Other Medical*	172,590	148,431	(24,159)	(6,174)	(17,985)
State Incentives Programs	28,707	-	(28,707)	-	(28,707)
Total	**1,123,302**	**1,027,110**	**(96,192)**	**(42,721)**	**(53,471)**

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

At a PMPM level, YTD Medical Expenses are $294.19, unfavorable by $14.00 or 5.0% compared to the budget. Half of this negative variance is due to budget-neutral State Incentive Programs. The remaining variance is primarily due to unfavourability in Inpatient Services (Hospital), Physician Services, and Other Medical. Unfavorable trends in Inpatient Services (Hospitals) are driven by higher utilization. Allied Health, Behavioral Health, Transportation, and Lab drive the Other Medical cost unfavorable of 11.6%.

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

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	106.51	104.79	(1.72)	-1.6%
Inpatient Services (LTC)	34.91	37.53	2.62	7.0%
Physician Services	62.46	58.58	(3.88)	-6.6%
Outpatient Facility	37.60	38.80	1.20	3.1%
Other Medical	45.20	40.49	(4.71)	-11.6%
State Incentive Programs	7.52	-	(7.52)	-100.0%
Total	**294.19**	**280.19**	**(14.00)**	**-5.0%**

Administrative Expenses. September YTD Administrative Expenses are favorable to budget by $4.4M or 6.0% with a 5.3% ALR. Salaries are slightly favorable by $1.6M, driven by savings from vacant positions, benefits, and PTO, which offsets temporary services and the staff bonus accrual. Non-Salary Administrative Expenses are favorable by $2.8M or 12.3% due to savings and unspent budgets.

Non-Operating Revenue/Expenses. September YTD Net Non-Operating income is $21.3M, which is favorable to the budget. Total Non-Operating Revenue is favorable to budget by $15.9M, attributed to $16.0M interest income, and offsets the unfavorable variance of $97k in unrealized gain on investments. Non-Operating Expenses are favorable by $5.4M due to the timing of grant expenses.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $104.4M, with an MLR of 87.7% and an ALR of 5.3%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Ninth Month Ending September 30, 2023
(In $000s)

Assets	
Cash	$394,056
Restricted Cash	300
Short Term Investments	748,794
Receivables	103,604
Prepaid Expenses	4,216
Other Current Assets	5,030
Total Current Assets	**$1,256,000**
Building, Land, Furniture & Equipment	
Capital Assets	$82,441
Accumulated Depreciation	(46,871)
CIP	674
Lease Receivable	2,539
Total Non-Current Assets	**38,784**
Total Assets	**$1,294,784**
Liabilities	
Accounts Payable	$26,251
IBNR/Claims Payable	458,356
Provider Incentives Payable	17,992
Other Current Liabilities	7,997
Due to State	10,637
Total Current Liabilities	**$521,233**
Deferred Inflow of Resources	2,437
Total Long-Term Liabilities	**$2,437**
Fund Balance	
Fund Balance - Prior	$666,727
Retained Earnings - CY	104,386
Total Fund Balance	**771,113**
Total Liabilities & Fund Balance	**$1,294,784**
Additional Information	
Total Fund Balance	**$771,113**
Board Designated Reserves Target	411,966
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	171,561
Value Based Payments	46,100
Total Reserves	**686,327**
Total Operating Reserve	**$84,786**

* MCGP includes Additional Contribution of $48.6M

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Ninth Month Ending September 30, 2023
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*418,442*	*398,530*	*19,912*	*5.0%*	*3,818,240*	*3,665,770*	*152,470*	*4.2%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$135,335	$125,778	$9,557	7.6%	$1,248,624	$1,160,529	$88,095	7.6%
State Incentive Programs	-	-	$0	0.0%	28,707	-	$28,707	100.0%
Premiums Commercial	389	344	44	12.9%	3,369	3,097	272	8.8%
Total Operating Revenue	**$135,724**	**$126,122**	**$9,602**	**7.6%**	**$1,280,700**	**$1,163,626**	**$117,074**	**10.1%**
Medical Expenses								
Inpatient Services (Hospital)	$34,139	$44,056	$9,917	22.5%	$406,674	$384,135	($22,540)	-5.9%
Inpatient Services (LTC)	19,327	15,779	(3,548)	-22.5%	133,286	137,580	4,294	3.1%
Physician Services	26,460	24,627	(1,833)	-7.4%	238,485	214,732	(23,752)	-11.1%
Outpatient Facility	16,585	16,312	(273)	-1.7%	143,560	142,231	(1,328)	-0.9%
Other Medical*	21,713	17,022	(4,691)	-27.6%	172,590	148,431	(24,159)	-16.3%
State Incentive Programs	-	-	-	0.0%	28,707	-	(28,707)	-100.0%
Total Medical Expenses	**$118,224**	**$117,796**	**($428)**	**-0.4%**	**$1,123,302**	**$1,027,110**	**($96,192)**	**-9.4%**
Gross Margin	**$17,500**	**$8,326**	**$9,174**	**100.0%**	**$157,398**	**$136,516**	**$20,882**	**15.3%**
Administrative Expenses								
Salaries	$5,263	$5,439	$176	3.2%	$48,085	$49,686	$1,600	3.2%
Professional Fees	346	400	54	13.5%	2,041	2,694	653	24.2%
Purchased Services	833	856	22	2.6%	8,079	8,024	(55)	-0.7%
Supplies & Other	784	971	187	19.3%	6,276	8,169	1,893	23.2%
Occupancy	54	123	70	56.4%	929	1,005	76	7.6%
Depreciation/Amortization	259	286	28	9.6%	2,328	2,511	184	7.3%
Total Administrative Expenses	**$7,539**	**$8,075**	**$536**	**6.6%**	**$67,739**	**$72,090**	**$4,351**	**6.0%**
Operating Income	**$9,961**	**$251**	**$9,710**	**100.0%**	**$89,660**	**$64,427**	**$25,233**	**39.2%**
Non-Op Income/(Expense)								
Interest	$3,131	$1,025	$2,106	100.0%	$25,235	$9,223	$16,013	100.0%
Gain/(Loss) on Investments	(2,791)	2,312	(5,103)	-100.0%	(3,840)	(3,743)	(97)	-2.6%
Other Revenues	155	156	(0)	-0.1%	1,393	1,397	(3)	-0.2%
Grants	(344)	(1,500)	1,156	77.1%	(8,063)	(13,496)	5,434	40.3%
Total Non-Op Income/(Expense)	**$152**	**$1,993**	**($1,841)**	**-92.4%**	**$14,726**	**($6,620)**	**$21,346**	**100.0%**
Net Income/(Loss)	**$10,113**	**$2,244**	**$7,869**	**100.0%**	**$104,386**	**$57,807**	**$46,579**	**80.6%**
MLR	*87.1%*	*93.4%*			*87.7%*	*88.3%*		
ALR	*5.6%*	*6.4%*			*5.3%*	*6.2%*		
Operating Income	*7.3%*	*0.2%*			*7.0%*	*5.5%*		
Net Income %	*7.5%*	*1.8%*			*8.2%*	*5.0%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Ninth Month Ending September 30, 2023
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*418,442*	*398,530*	*19,912*	*5.0%*	*3,818,240*	*3,665,770*	*152,470*	*4.2%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$323.43	$315.60	$7.82	2.5%	$327.02	$316.59	$10.43	3.3%
State Incentive Programs	-	-	-	0.0%	7.52	-	7.52	100.0%
Premiums Commercial	0.93	0.86	0.07	7.6%	0.88	0.84	0.04	4.4%
Total Operating Revenue	**$324.36**	**$316.47**	**$7.89**	**2.5%**	**$335.42**	**$317.43**	**$17.99**	**5.7%**
Medical Expenses								
Inpatient Services (Hospital)	$81.59	$110.55	$28.96	26.2%	$106.51	$104.79	($1.72)	-1.6%
Inpatient Services (LTC)	46.19	39.59	(6.60)	-16.7%	34.91	37.53	2.62	7.0%
Physician Services	63.23	61.79	(1.44)	-2.3%	62.46	58.58	(3.88)	-6.6%
Outpatient Facility	39.64	40.93	1.30	3.2%	37.60	38.80	1.20	3.1%
Other Medical*	51.89	42.71	(9.18)	-21.5%	45.20	40.49	(4.71)	-11.6%
State Incentive Programs	-	-	-	0.0%	7.52	-	(7.52)	-100.0%
Total Medical Expenses	**$282.53**	**$295.58**	**$13.04**	**4.4%**	**$294.19**	**$280.19**	**($14.00)**	**-5.0%**
Gross Margin	**$41.82**	**$20.89**	**$20.93**	**100.0%**	**$41.22**	**$37.24**	**$3.98**	**10.7%**
Administrative Expenses								
Salaries	$12.58	$13.65	$1.07	7.8%	$12.59	$13.55	$0.96	7.1%
Professional Fees	0.83	1.00	0.18	17.6%	0.53	0.73	0.20	27.3%
Purchased Services	1.99	2.15	0.16	7.2%	2.12	2.19	0.07	3.3%
Supplies & Other	1.87	2.44	0.56	23.1%	1.64	2.23	0.58	26.2%
Occupancy	0.13	0.31	0.18	58.5%	0.24	0.27	0.03	11.2%
Depreciation/Amortization	0.62	0.72	0.10	13.9%	0.61	0.69	0.08	11.0%
Total Administrative Expenses	**$18.02**	**$20.26**	**$2.25**	**11.1%**	**$17.74**	**$19.67**	**$1.92**	**9.8%**
Operating Income	**$23.80**	**$0.63**	**$23.18**	**100.0%**	**$23.48**	**$17.58**	**$5.91**	**33.6%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Ninth Month Ending September 30, 2023
(In $000s)

	MTD	YTD
Net Income	$10,113	$104,386
Items not requiring the use of cash: Depreciation	259	2,289
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	184,342	67,176
Prepaid Expenses	363	(167)
Current Assets	59	8,385
Net Changes to Assets	**184,765**	**75,394**
Changes to Payables:		
Accounts Payable	(134)	(44,423)
Other Current Liabilities	426	289
Incurred But Not Reported Claims/Claims Payable	158,775	175,988
Provider Incentives Payable	1,973	7,992
Due to State	204	5,591
Net Changes to Payables	**161,244**	**145,436**
Net Cash Provided by (Used in) Operating Activities	**356,380**	**327,505**
Change in Investments	695	(72,798)
Other Equipment Acquisitions	(305)	1,010
Net Cash Provided by (Used in) Investing Activities	**390**	**(71,788)**
Lease Interest Income	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**356,770**	**255,717**
Cash & Cash Equivalents at Beginning of Period	**37,286**	**138,338**
Cash & Cash Equivalents at September 30, 2023	**$394,056**	**$394,056**

DATE: December 6, 2023

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 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
Juana Chávez de Guízar	Consumer	Merced
Keota Xiong	Safety Net Provider Representative	Merced
Alma Mandujano	Traditional Provider Representative	Monterey

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

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

Meeting Minutes

Wednesday, October 25, 2023
10:30 a.m. – 2:00 p.m.

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

Commissioners Present:

Ms. Leslie Abasta-Cummings	At Large Health Care Provider Representative
Dr. Ralph Armstrong	At Large Health Care Provider Representative
Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	At Large Health Care Provider Representative
Dr. Maximiliano Cuevas	Health Care Provider 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
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. Allen Radner	At Large Health Care Provider Representative
Dr. Eric Sergienko	County Public Health Officer

Commissioners Absent:

Ms. Tracey Belton	County Health and Human Services Agency Director
Ms. Rebecca Nanyonjo	County Public Health Director
Dr. James Rabago	Health Care Provider Representative

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Ms. Lisa Ba	Chief Financial 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. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Mr. Michael Schrader, Chief Executive Officer (CEO).

Mr. Schrader, CEO, called the meeting to order at 10:35 a.m. Commissioners were welcomed to the inaugural meeting of the new five-county Commission and provided an overview of the day.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

The Consent Agenda was moved to the end of the agenda so that items for approval could be informed by the presentation on conflicts of interest.

Mr. Schrader provided an update on the hospital contract with CommonSpirit for Dominican Hospital in Santa Cruz County and Mercy Medical Center in Merced County. In the last two weeks both parties have exchanged initial proposals for a three year engagement. The CommonSpirit proposal included a notice of termination effective on January 31, 2024, with the intent to reach an agreement prior to that date. The notice of termination included both hospitals, physician groups, Mercy Home Care and University Surgery Center. The goal of the Alliance is to reach an agreement prior to having to send 30-day advance member notices on January 1, 2024. The Alliance's constraint in negotiations is to operate within Board policy so provider rates do not exceed revenue from the state, with a focus to create opportunities for increases through value based payment models that are tied to quality measures. Status updates will continue to be provided to the Board.

2. Election of Officers of the Commission. (10:46 – 10:50 a.m.)

The Bylaws of the Santa Cruz – Monterey – Merced – San Benito - Mariposa Managed Medical Care Commission require an annual election of the Chairperson and Vice Chairperson each year in October. Immediately following the election, the newly elected Chairperson facilitates the remainder of the October meeting.

Mr. Schrader opened the floor for nominations of Chairperson and Vice Chairperson. Commissioner Conner nominated Commissioner Jimenez and Commissioner Pedrozo to serve as Chairperson and Vice Chairperson respectively for a successive year.

MOTION: Commissioner Friend moved to approve the nomination of Commissioner Jimenez as the Chairperson of the Commission and Commissioner Pedrozo as the Vice Chairperson of the Commission, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Armstrong, Askew, Bizzini, Conner, Cuevas, Espinoza, Friend, Hernandez, Jimenez, Molesky, Morales, Pedrozo, Radner and Sergienko.

Noes: None.

Absent: Commissioners Belton, Nanyonjo and Rabago.

Abstain: None.

Chairperson Jimenez presided over the meeting.

3. Oral Communications.

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

Mr. DeAndre James from Community Health Trust of Pajaro Valley, spoke in support of the Medi-Cal Capacity Grant Program and the opportunities provided by the grant funding.

4. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

No comments or announcements from Commissioners at this time.

5. Board Activity: Vision and Values. (10:50 – 11:47 a.m.)

Ms. Claire Laughlin, Claire Laughlin Consulting, facilitated a vision and values activity using visual imagery and explored with the Board some of the shared values of the Alliance's integrated five-county region.

Regular Agenda Item: (10. - 12.): 12:13 p.m.

10. Consider approving draft Bylaws of the Commission. (12:13 – 12:45 p.m.)

Mr. Schrader, CEO, reviewed the draft bylaws of the five-county Commission. Welfare and Institutions Code Section 14087.54 provides statutory authority authorizing the establishment of the Commission. The Board of Supervisors from each of the counties adopted mirrored ordinances establishing the five-county Commission. The bylaws of the Commission outline the procedures for conduct of business. The contents of the bylaws and conduct of meetings were reviewed and discussed.

The Board directed staff to revise the bylaws under 2.3 Qualifications, Section 2.3.3 with language that includes, "at least one person from the public shall be either a past or present Medi-Cal beneficiary or the parent/guardian of a past or present Medi-Cal beneficiary" and return to the Board at the December meeting for final approval.

MOTION: Commissioner Askew moved to approve the draft Bylaws of the Commission for submittal to Santa Cruz, Monterey, Merced, San Benito and Mariposa County Board of Supervisors for approval, with recommended revisions for final Board approval, seconded by Commissioner Conner.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Armstrong, Askew, Bizzini, Conner, Cuevas, Espinoza, Friend, Hernandez, Jimenez, Morales, Pedrozo, Radner and Sergienko.

Noes: None.

Absent: Commissioners Belton, Nanyonjo and Rabago.

Abstain: Commissioner Molesky.

11. Consider approving creation of Board Committees and Advisory Groups and appoint members, Board meeting schedule, and Board delegation and policies. (12:45 – 1:01 p.m.)

Mr. Schrader, CEO, proposed for the purpose of continuity, the establishment of the Finance Committee, Physicians Advisory Group, Member Services Advisory Group, Whole Child Model Clinical Advisory Committee and Whole Child Model Family Advisory Committee that existed under the tri-county Commission and appoint those members currently on each roster.

In addition, Commissioner Molesky requested participation on the Whole Child Model Family Advisory Committee and Commissioner Hernandez requested participation on the Physicians Advisory Group.

Mr. Schrader reviewed the Board, Committee and Advisory Group meeting schedules for the remainder of 2023 and 2024.

Ms. Jenifer Mandella, Chief Compliance Officer, reviewed Board oversight of plan programs to meet Department of Health Care Services contract requirements, delegation of authority for operational functions, and additional policies requiring Board approval.

MOTION: Commissioner Hernandez moved to approve the creation of Board Finance Committee, Physicians and Member Services Advisory Groups, Whole Child Model Advisory Committees and appoint members to each; approve schedule of Board meetings, Committees and Advisory Groups; and approve delegation of authority to staff and/or Alliance Committees and policies that reflect delegation of Board authority, seconded by Commissioner Molesky.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Armstrong, Askew, Bizzini, Conner, Cuevas, Espinoza, Friend, Hernandez, Jimenez, Molesky, Morales, Pedrozo, Radner and Sergienko.

Noes: None.

Absent: Commissioners Belton, Nanyonjo and Rabago.

Abstain: None.

12. Board Discussion and Education: Conflicts of Interest. (1:01 – 1:48 p.m.)

Mr. Peter Roan and Mr. Agustin Orozco from Crowell & Moring LLP provided an overview on the application of conflicts of interest rules governing Board members of a public health plan. Section 1090 prohibits Alliance Board members from participating in the making of a contract in which they have a financial interest. The Political Reform Act (PRA) places restrictions on whether or not a Board member may participate in any government decision-making if the Board member has certain economic interests. Certain exceptions apply and one or more Board member may recuse themselves without precluding decision-making by the rest of the Board.

[Vice Chair Pedrozo departed at this time: 1:26 p.m.)

Recusal procedures vary depending on whether Section 1090 or the PRA are implicated, but in general include publicly identifying all financial interests giving rise to the conflict of interest and refraining from any discussion and participation in the decision.

Key takeaways from the discussion included that making a contract may implicate Section 1090; Board discussion regarding financial interest may implicate the PRA; and if conflicted, follow recusal procedures and refrain from influencing the decision in any way. Commissioners may consult the Fair Political Practices Commission advisory opinions or request an opinion through Alliance legal counsel and contact Alliance legal counsel with any questions.

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

Consent Agenda Items: (6. – 9H.): 1:48 p.m.

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

Chair Jimenez reminded the Board that in order to manage any risk of conflict, consent will be taken in four separate motions due to potential conflicts of interest on Items 9F, 9G and 9H. Items 6-9E, which all Board members may discuss and vote on; and Items 9F, 9G and 9H that are affiliated with Board members which may have a conflict. Items 9F, 9G and 9H should be voted on separately from items 6-9E to facilitate four separate approval actions so that the Board may have separate votes and Board members with a conflict may abstain and leave the room prior to discussion and voting on items 9F, 9G and 9H.

MOTION: Commissioner Molesky moved to approve Consent Agenda items 6-9E, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Armstrong, Askew, Bizzini, Conner, Cuevas, Espinoza, Friend, Hernandez, Jimenez, Molesky, Morales, Radner and Sergienko.

Noes: None.

Absent: Commissioners Belton, Nanyonjo, Pedrozo and Rabago.

Abstain: None.

Due to potential conflicts of interest, Commissioners Abasta-Cummings, Conner, Cuevas, Hernandez, Jimenez, Morales and Radner abstained from discussion and voting on item 9F and left the room.

Mr. Schrader presided over the meeting for discussion and voting on consent items 9F and 9G.

MOTION: Commissioner Askew moved to approve Consent Agenda item 9F: Medi-Cal Capacity Grant Award Recommendations (Group B), seconded by Commissioner Armstrong.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Armstrong, Bizzini, Espinoza, Friend, Molesky and Sergienko.

Noes: None.

Absent: Commissioners Belton, Nanyonjo, Pedrozo and Rabago.

Abstain: Commissioners Abasta-Cummings, Conner, Cuevas, Hernandez, Jimenez, Morales and Radner.

Due to potential conflicts of interest, Commissioners Abasta-Cummings, Conner, Cuevas, Hernandez, Jimenez, Morales, and Radner abstained from discussion and voting on item 9G and did not return to the room.

MOTION: Commissioner Espinoza moved to approve Consent Agenda item 9G: Medi-Cal Capacity Grant Program Funding Recommendations, seconded by Commissioner Sergienko.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Armstrong, Askew, Bizzini, Espinoza, Friend, Molesky and Sergienko.

Noes: None.

Absent: Commissioners Belton, Nanyonjo, Pedrozo and Rabago.

Abstain: Commissioners Abasta-Cummings, Conner, Cuevas, Hernandez, Jimenez, Morales and Radner.

Chair Jimenez returned and presided over the remainder of the meeting.

Due to potential conflicts of interest, Commissioner Abasta-Cummings abstained from discussion and voting on item 9H and did not return to the room.

MOTION: Commissioner Molesky moved to approve Consent Agenda item 9H: Medi-Cal Capacity Grant Program Funding Recommendation: Workforce Support for Care Gaps Closure, seconded by Commissioner Askew.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Armstrong, Askew, Cuevas, Espinoza, Friend, Hernandez, Jimenez, Molesky and Sergienko.

Noes: None.

Absent: Commissioners Belton, Bizzini, Conner, Morales, Nanyonjo, Pedrozo, Rabago and Radner.

Abstain: Commissioner Abasta-Cummings.

The Commission adjourned its regular meeting of October 25, 2023 at 1:55 p.m. to the regular meeting of December 6, 2023 at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, July 19, 2023
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Dave McDonough	Legal Services Director
Dennis Hseih	Deputy Chief Medical Officer
Jenifer Mandella	Chief Compliance Officer
Jennifer Mockus	Community Care Coordination Director
Jessica Finney	Grants Director
Jessie Dybdahl	Provider Services Director
Jimmy Ho	Accounting Director
Kay Lor	Payment Strategy Director
Kristynn Sullivan	Program Development Director
Lilia Chagolla	Community Engagement Director
Linda Gorman	Communications Director
Lisa Ba	Chief Financial Officer
Lisa Artana	Human Resources Director
Luis Somoza	Member Services Director
Marwan Kanafani	Health Services Officer
Maya Heinert	Medical Director
Michael Schrader	Chief Executive Officer
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Ronita Margain	Community Engagement Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Ryan Markley	Compliance Director (Chair)
Scott Fortner	Chief Administrative Officer
Shaina Zurlin	Behavioral Health Director
Tammy Brass	Utilization Management Director
Van Wong	Chief Operating Officer
Veronica David	Financial Planning & Analysis Director

Committee Members Absent:

Committee Members Excused:

Arti Sinha	Application Services Director
Dale Bishop	Chief Medical Officer
Dianna Diallo	Medical Director
Kate Knutson	Compliance Manager

Ad-Hoc Attendees:

Kat Reddell	Compliance Specialist II
Ka Vang	Compliance Specialist II
Rachel Siwajek	Program Integrity Specialist
Rebecca Seligman	Compliance Supervisor
Stephanie Vue	Regulatory Affairs Specialist

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 April 19, 2023 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of June 21, 2023 meeting.

3. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Quarterly Policy Monitoring**
   3. **Regulatory and All Plan Letter Updates**
   4. **2024 Contract Gap Analysis**

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. **Regular Agenda**

   1. **Delegate Oversight Quarterly Report**

   Reddell, Compliance Specialist, presented the Delegate Oversight Quarterly Report, which includes a review of 2023 Annual Review progress, Ongoing Monitoring of Q123 Activity and Additional Oversight activities.

   2023 Delegate Oversight Annual Review
   Staff recommended approval of the following reports received from delegated health plans:
   - Carelon (Beacon): Claims Processing, Compliance and Member Grievances
   - MedImpact: Claims Processing, Finance, Member Connections, and Utilization Management and Behavioral Health

- VSP: Claims Processing, Member Connections and Credentialing

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

- Carelon (Beacon): Network Management
- MedImpact: Network Management and Cultural & Linguistics
- VSP: HIPAA, Program Integrity, Finance, Member Grievances, Network Management, Cultural & Linguistics and Quality Improvement

COMMITTEE ACTION: Committee reviewed and approved the 2023 Annual Review of Health Plans and assigned the following action items:

- Staff to review Carelon Network Management documentation and complete annual review.
- Staff to review MedImpact Network Management documentation received and follow up on outstanding concerns related to Cultural & Linguistics documentation received and complete annual review.
- Staff to review VSP HIPAA, Program Integrity, Finance, Network Management documentation received and follow up on outstanding concerns related to Member Grievance, Cultural & Linguistics and Quality Improvement documentation and complete annual review

Staff recommended approval of the following documents received from delegated Vendors:

- CareNet: Compliance, Member Connections and Member Grievances

Staff recommended holding approval of the following reports from delegated vendors pending staff follow-up review of documentation as described below:

- CareNet: Cultural & Linguistics

COMMITTEE ACTION: Committee reviewed and approved the 2023 Annual Review of Vendors and assigned the following action items:

- Staff to follow-up with CareNet to resolve concerns identified with Cultural & Linguistics documentation and complete annual review.

Staff recommended approval of the following reports received from delegated providers:

- PAMF: Credentialing
- UCSF: Credentialing

COMMITTEE ACTION: Committee reviewed and approved the 2023 Annual Review of Providers:

Q1 2023 Continuous Oversight Activities

Staff recommended approval of the following reports received from delegated health plans:

- Carelon (Beacon): Network Management
- MedImpact: Credentialing and Network Management
- VSP: Credentialing

Staff recommended holding approval of the following reports pending staff review of documentation as described below:

- Carelon (Beacon): Credentialing, and Member Connections
- VSP: Provider Disputes, Member Connections and Quality Improvement

COMMITTEE ACTION: Committee reviewed and approved the Q1 2023 Quarterly Review of delegated Health plans and assigned the following action items:

- Staff to review Carelon (Beacon) Credentialing and Member Connections documentation and complete quarterly review.
- Staff to follow up with VSP to resolve concerns with Provider Disputes, Member Connections and Quality Improvement documentation and complete quarterly review.

Q3 and Q4 2022 Continuous Oversight Activities

Staff recommended approval of the following reports received from delegated health plans:

- Carelon (Beacon): Q3 and Q4 2022 Member Grievances and Q4 2022 Credentialing
- MedImpact: Q4 2022 Credentialing and Network Management
- VSP: Q4 2022 Credentialing

COMMITTEE ACTION: Committee reviewed and approved the Q3 and Q4 2022 Quarterly Review of delegated health plans.

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

- ChildNet: Q4 2022 Credentialing
- LPCH: Q4 2022 Credentialing
- PAMF: Q4 Credentialing
- SCVMC: Q4 2022 Credentialing
- Stanford: Q4 2022 Credentialing
- UCSF: Q4 2022 Credentialing

COMMITTEE ACTION: Committee reviewed and approved the Q3 and Q4 2022 Quarterly Review of delegated health plans.

Additional Oversight Activities

Reddell reviewed the Q1 2023 Additional Oversight Activities highlighting the following Carelon Performance Guarantees:

- 3 of 3 Claims performance guarantees were met
- 1 of 2 Members Services performance guarantees were met
- 2 of 2 Network and Reporting performance guarantees were met

COMMITTEE ACTION: Committee reviewed and approved the Additional Oversight Activities of the Q1 2023 Quarterly Report.

Seligman, Interim Compliance Manager, presented the plan for modifications to the Delegate Oversight Program, highlighting 2024 Revised Model Agreement requirements, current status and Delegation Plan development and next steps.

Seligman provided a summary of the changes to delegation requirements in the 2024 contract and outlined two Operational Readiness deliverables related to the new requirements.

Seligman reviewed the current status of development of Delegation Plan components in response to 2024 contract requirements and outlined next steps for continued development and implementation.

2. CA State Budget Trailer Bill

Carlson, Government Relations Director, presented a summary of the 2023-24 State Budget Trailer Bill SB-118, highlighting key components that will impact the plan's operations and require implementation in the upcoming years. Carlson requested that Committee members review the document included in the packet and begin preparing to implement the new requirements. Carlson also requested that any edits to assignments be communicated to Government Relations staff.

3. Generative AI Policy Update

Markley, Compliance Director, presented the Generative Artificial Intelligence (Generative AI) policy which outlines the plan's risks and procedures for prohibited use of Generative AI for Alliance staff and third-party providers. Markley requested that Committee members communicate the requirements of the policy to their staff and that they inform Compliance if any Generative AI is currently being used or contemplated.

4. Policy Revisions and 2024 Contract

Seligman, Compliance Supervisor, reminded the Committee of changes to the plan's policy revision process and reiterated expectations of requiring all policy revisions to undergo a review of the 2024 contract and referencing new contract exhibits and attachments in policies. Markley reminded the Committee that policy review and revision will be required on an annual basis, effective January 1, 2024.

The meeting adjourned at 9:54 a.m.

Respectfully submitted,

Robin Sihler
Compliance Administrative and Data Reporting Assistant

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, September 20, 2023
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
Arti Sinha	Application Services Director
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Dave McDonough	Legal Services Director
Dianna Diallo	Medical Director
Jenifer Mandella	Chief Compliance Officer
Jennifer Mockus	Community Care Coordination Director
Jessie Dybdahl	Provider Services Director
Jimmy Ho	Accounting Director
Kay Lor	Payment Strategy 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
Luis Somoza	Member Services Director
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Ronita Margain	Community Engagement Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Ryan Markley	Compliance Director (Chair)
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Shaina Zurlin	Behavioral Health Director
Tammy Brass	Utilization Management Director
Van Wong	Chief Operating Officer
Veronica David	Financial Planning & Analysis Director

Committee Members Absent:

Bob Trinh	Technology Services Director
Jessica Finney	Grants Director
Marwan Kanafani	Health Services Officer

Committee Members Excused:

Dale Bishop	Chief Medical Officer
Danita Carlson	Government Relations Director
Dennis Hseih	Deputy Chief Medical Officer
Kate Knutson	Compliance Manager
Maya Heinert	Medical Director
Michael Schrader	Chief Executive Officer

Ad-Hoc Attendees:

Aaron McMurray	Information Security Analyst
Kat Reddell	Compliance Specialist II
Ka Vang	Compliance Specialist II
Rebecca Seligman	Compliance Manager
Rachel Siwajek	Program Integrity Specialist
Stephanie Vue	Regulatory Affairs Specialist

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 April 19, 2023 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of June 21, 2023 meeting.

3. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Regulatory and All Plan Letter Updates**
   3. **2024 Contract Gap Analysis**

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. **Regular Agenda**

   1. **HIPAA Quarterly Privacy & Security Update**

      Mandella, Chief Compliance Officer, and McMurray, Information Security Analyst, presented the Q2 2023 HIPAA Privacy & Security Report. Mandella reported on recent updates to the HIPAA Program reporting process noting that policy updates to align with 2024 contract have been completed. In addition, Mandella reported that a department survey to confirm awareness of external record request process was conducted and that education reiterating expectation of timely incident report was performed.

Mandella reviewed HIPAA disclosure notifications received in Q223, noting that of the 22 referrals received, 6 were determined to be incidents with 4 requiring state reporting, and 0 were determined to be breaches. 244 members were impacted as a result of the incidents in Q223. Root cause for HIPAA disclosures in the quarter was fairly evenly split between incorrect selection/entry, Other, and verbal disclosure.

Mandella reviewed HIPAA program metrics included on the Alliance Dashboard for Q223 reporting that quality metrics met the target performance, while efficiency metrics did not. Mandella indicated that targeted training had been done for department in response to not meeting efficiency metrics, and that Compliance staff began inquiring as to why reports are not made timely, to provide insight and opportunities for correction.

McMurray reported assessment of cybersecurity measures related to phishing attacks for the quarter noting an increase in delivered messages and a lowering trend of the overall Phish Prone Percentage (PPP) from 1.8% to 0.9% and a decrease in reporting messages from the phishing campaign from 60.1% to 51.6%.

McMurray provided an update on mitigation of gaps identified during the security assessments conducted in 2023. McMurray also informed the Committee that the preparation of the Active Directory infrastructure was completed in the quarter which will help to prevent the use of weak passwords and mitigate common password-related issues. McMurray advised that results of this work will be available by end of Q4 2023.

COMMITTEE ACTION: Committee reviewed and approved the Q2 2023 HIPAA Privacy & Security Quarterly Report.

2. Program Integrity Quarterly Report

Siwajek, Program Integrity Specialist III, presented the Q2 2023 Program Integrity Activity Report and reviewed select Matters Under Investigation (MUIs). Siwajek reported that 36 concerns were referred to Program Integrity in Q223, 22 of which resulted in the opening of a MUI. There were 64 active MUIs in the quarter.

Siwajek reviewed referral trends for the period noting that 11 were Provider specific, 2 were member related, 1 was a State Request and 8 were categorized as Other.

Siwajek reviewed performance of the Program Integrity metrics from the Q2 Alliance Dashboard noting that quality metric met target performance while the efficiency metric did not. Program Integrity staff determined that the source of the late report was a delegate and followed up to reiterate timely reporting expectations.

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 physical therapy provider billing a higher rate than their peers. A review of the provider's billing practices after the 9-month monitoring period showed that the provider has amended their billing practices, indicating that plan processes to address suspected fraud, waste, and abuse are effective.

Siwajek reviewed Q223 Program Integrity Financial Reporting noting the total requested recoupment was $7,946.17 and completed recoupment was $3,373.46, which included both Alliance-initiated and delegate-initiated recoveries.

COMMITTEE ACTION: Committee reviewed and approved the Q2 2023 Program Integrity Report.

3. NCQA and 2024 Contract Project Update

Mandella, Chief Compliance Officer, put forth the issue of the lack of traction being gained on two Compliance-led projects: 2024 Contract Implementation and NCQA Accreditation. Dave McDonough, Legal Services Director, reported low engagement – approximately 50% - from impacted departments and noted that the implementation date of 01/01/2024 is quickly approaching with little time left to align with contract requirements.

Markley, Compliance Director reported that the Plan has not met any NCQA Standard since the Gap Analysis performed in April and that organizational engagement has been very low. Markley informed the Committee that Compliance and Project Management staff are available resources to help move the project forward.

The meeting adjourned at 9:59 a.m.

Respectfully submitted,

Robin Sihler
Compliance Administrative and Data Reporting Assistant

Meeting Minutes

Monday, September 11, 2023

Teleconference Meeting

Members Present:

Frances Wong	Monterey County – CCS WCM Family Member
Janna Espinoza	Monterey County – CCS WCM Family Member, WCMFAC Chair
Kim Pierce	Monterey County – Local Consumer Advocate
Paloma Barraza	Monterey County – CCS WCM Family Member
Susan Skotzke	Santa Cruz County – CCS WCM Family Member

Members Absent:

Heidi Boynton	Santa Cruz County – Local Consumer Advocate
Heloisa Junqueira, MD	Monterey County – Provider
Irma Espinoza	Merced County – CCS WCM Family Member
Manuel López Mejia	Monterey County – CCS WCM Family Member

Staff Present:

Dianna Diallo, MD	Medical Director
Gabina Villanueva	Member Services Supervisor
Kayla Zoliniak	Community Engagement Administrative Specialist
Kelsey Riggs, RN	Complex Case Management Supervisor
Kevin Lopez	Member Services Supervisor
Lilia Chagolla	Community Engagement Director
Linda Gorman	Communications Director
Ronita Margain	Community Engagement Director

Guest:

Anna Rubalcava	Merced County
Denise Sanford	Santa Cruz County
Kevin Low	Monterey County

1. **Call to Order by Chairperson Espinoza.**
   Lilia Chagolla welcomed the group. Chairperson Espinoza called the meeting to order.

   WCMFAC Mission Statement read in English.

   Committee introductions and roll call was taken.

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

Consent Agenda Items:

3. **Accept WCMFAC Meeting Minutes from Previous Meeting**
   Chairperson Espinoza opened the floor for approval of the meeting minutes of the previous meeting on July 10, 2023. Minutes were approved with no further edits.

Regular Agenda Items:

4. **CCS Advisory Group Representative Report**
   S. Skotzke provided an update from the July 12, 2023 meeting. The meeting discussed the Whole Child Model expansion into Mariposa and San Benito counties in 2025, reviewed standards for CCS, reviewed the Whole Child Model report, reported challenges such as the pandemic and staffing, announced Kaiser is opening to CCS members with effective dates beginning January 1, 2024 in certain counties, and announced the new Quality Advisory Committee.

   Alliance staff provided additional information regarding the Kaiser enrollment including the enrollment being capped to a limited number of people and limited to people who have had a previous relationship with Kaiser within the previous twelve months. There was discussion around Kaiser facilities in existing counties and expansion counites. There was discussion around ensuring Kaiser provides appropriate care.

5. **Feedback, New Issues, and Impact on Members – Open Forum**
   S. Skotzke advocated for extending the age limit for CCS from 21 years of age to 26 years of age.

   S. Skotzke proposed a post-visit member feedback survey to inquire if needs were met. K. Riggs stated the Pediatric Complex Case Management team is developing a survey and will consider the example questions for future iterations of the survey.

   P. Barraza expressed concern around language and transportation barriers for members.

   L. Chagolla shared the Alliance has an internal Member Support and Engagement Committee focused on collecting member feedback from across the organization and taking action when possible.

   L. Gorman reported the Alliance is utilizing a text campaign for redetermination and is pursuing a permanent texting program for next year.

   Chairperson Espinoza recommended updating the WCMFAC Resource Sheet. The Resource Sheet will be reviewed at the next meeting.

L. Chagolla announced the Mariposa County and San Benito County expansion will go live January 1, 2024 and Whole Child Model will go live in 2025. The Community Engagement team is identifying and building relationships with community partners.

Chairperson Espinoza expressed concern of Durable Medical Equipment (DME) providers not servicing San Benito and Mariposa counties. L. Chagolla stated the Alliance is aware of and looking into the issue but does not know the exact cause. S. Skotzke advocated for online services such as purchasing items online. L. Chagolla stated the Alliance's Member Support and Engagement Committee will be reviewing the feedback to allow online DME purchases at the next meeting.

The committee confirmed the proposed 2024 meeting schedule. The dates will be proposed to the Alliance Board for approval at the October Board meeting.

The Alliance will continue mailing agenda packets to CCS WCM Family Member committee members.

P. Barraza shared about the San Andreas Regional Centers 4th Annual Holiday Craft Fair.

Chairperson Espinoza will be attending the Merced County 2023 Children Summit.

6. **Pediatric Clinic Outreach**

Chairperson Espinoza reported that the pediatric clinic outreach has not started. L. Chagolla will schedule a meeting for Chairperson Espinoza and Dr. Diallo to connect around pediatric clinic outreach.

7. **SELPA Connections**

Chairperson Espinoza reported SELPA connections are in progress. Monterey County Office of Education has agreed to include materials in their onboarding package. Pajaro Valley Office of Education has been reached out to and will be followed up with in the next weeks. Merced County Office of Education will be reached out to in next weeks.

8. **Review Action Items**

K. Zoliniak reviewed the actions items.

9. **Future Agenda Items**

Review and Update Whole Child Model Family Advisory Committee Roadmap
Determine Legislative News Process
Draft 2024 Fact Sheet
Draft 2024 Resource Sheet

Adjourn:

The meeting adjourned at 3:02p.m.

The meeting minutes are respectfully submitted by Kayla Zoliniak, Administrative Specialist
Next Meeting: Monday, November 6, 2023, at 1:30p.m.

DATE: December 6, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Commission Bylaws

Recommendation. Staff recommend the Board approve the revisions to the Bylaws of the Commission and direct staff to submit approved Bylaws to each County Boards of Supervisors for final approval.

Background. At the Board's, October 25, 2023 meeting, the Board adopted bylaws of the Commission outlining the conduct of business of the Board. Further, the Board directed staff to return to the Board with revisions to the bylaws to reflect concerns expressed by the Board regarding the provisions outlining the qualifications of the Board seat(s) designated for public representation. The Board stated its desire that the bylaws require that at least one of the individuals from the public representing the population of beneficiaries to be served by the Alliance be either a past or present Medi-Cal beneficiary or the parent or guardian of a past or present Medi-Cal beneficiary.

Discussion. Staff reviewed the bylaws in light of the expressed concerns and recommend a revision to the provision 2.3.3. as follows:

> 2.3.3 The number of voting members of the Commission shall be based upon the number of Medi-Cal beneficiaries within each county and includes a maximum of five (5) members within a county, and with the number of Commissioners within a county and Commission representation categories determined according to the following formula. At least one of the person(s) from the public representing the population of beneficiaries to be served by the Commission listed in 2.3.3.3.3, 2.3.3.4.4, or 2.3.3.5.4 shall be either a past or present Medi-Cal beneficiary or the parent/guardian of a past or present Medi-Cal beneficiary:

The recommended revision codifies the Board's commitment to having a public representative seat on the Commission specifically dedicated for a past or present Medi-Cal beneficiary or parent/guardian and remains consistent with the composition of the current Board.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

In addition, staff propose a second revision to the bylaws section 2.8 Composition. The suggested revision can be found at 2.8.1.1 and is intended to ensure compensation reflects Board members' time when attending meetings that extend longer than three hours in length (e.g., retreats). To this end, staff recommend a revision to the provision 2.8.1.1. as follows

> 2.8.1.1. $300 for each Commission meeting attended for which Commissioners must travel outside of the Commissioner's respective county of representation, to meet in a single location or for meetings beyond three-hours in length, or $100 each for all other Commission meetings attended.

The Bylaws are included as an attachment to this staff report and staff recommend the Board approve the Bylaws as amended. Staff will submit the approved Bylaws to each County's Board of Supervisors for final approval.

Attachments.

1. Bylaws of the Commission

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

ARTICLE I. AUTHORITY AND PURPOSE

These Bylaws are adopted by the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, hereinafter referred to as the "Commission" to establish rules, policies and procedures for its proceedings. The purpose of the Commission is to negotiate exclusive contracts with the California Department of Health Care Services, to arrange for the provision of health care services to qualifying individuals, as well as those other purposes set forth in the enabling ordinances enacted by the respective counties. The Commission was established by the Board of Supervisors of Santa Cruz County, the Board of Supervisors of Monterey County, the Board of Supervisors of Merced County, the Board of Supervisors of San Benito County, and the Board of Supervisors of Mariposa County, under the statutory authority of California Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.8, entitled "County Health Systems," Section 14087.54. These Bylaws and any amendments to these Bylaws must be approved by the Santa Cruz County Board of Supervisors, the Monterey County Board of Supervisors, the Merced County Board of Supervisors, the San Benito County Board of Supervisors, and the Mariposa County Board of Supervisors, as specified in Chapter 7.61 of the Santa Cruz County Code, Chapter 2.46 of the Monterey County Code, Chapter 9.43 of the Merced County Code, Chapter 11.17 of the

San Benito County Code, and Chapter 2.114 of the Mariposa County Code.

ARTICLE II. COMMISSIONERS

2.1 Number. The Commission shall consist of a maximum of twenty-five (25) voting members.

2.2 Appointment. Members shall be appointed by the Santa Cruz County Board of Supervisors, hereinafter referred to as the Santa Cruz Board, the Monterey County Board of Supervisors, hereinafter referred to as the Monterey Board, the Merced County Board of Supervisors, hereinafter referred to as the Merced Board, the San Benito County Board of Supervisors, hereinafter referred to as the San Benito Board, and the Mariposa County Board of Supervisors, hereinafter referred to as the Mariposa Board. The number of appointed members is established by formula, based upon the number of Medi-Cal beneficiaries within each county, and including a maximum of five (5) members within a county. Each Commission member shall serve at the pleasure of the Board appointing them.

2.3 Qualifications.

2.3.1 Each member of the Commission shall be committed to a health care system which seeks to improve access to quality health care for all persons, regardless of their economic circumstances. Members of the Commission shall have an abiding commitment to, and interest in, a quality publicly-assisted health care delivery system.

2.3.2 Each member of the Commission shall be a legal resident of the county whose Board of Supervisors made the appointment.

2.3.3 The number of voting members of the Commission shall be based upon the number of Medi-Cal beneficiaries within each county and includes a maximum of five (5) members within a county, and with the number of Commissioners within a county and Commission representation categories determined according to the following formula. At least one of the person(s) from the public representing the population of beneficiaries to be served by the Commission listed in 2.3.3.3.3, 2.3.3.4.4, or 2.3.3.5.4 shall be either a past or present Medi-Cal beneficiary or the parent/guardian of a past or present Medi-Cal beneficiary:

2.3.3.1 Zero (0) to fifteen thousand (15,000) Medi-Cal beneficiaries within the county equals one (1) commission seat to be filled by the Director of the County Health Department (or Health Services Agency) or their designee;

2.3.3.2 Fifteen thousand (15,000) to thirty thousand (30,000) Medi-Cal beneficiaries within the county equals two (2) commission seats to be filled as follows:

2.3.3.2.1 The Director of the County Health Department (or Health Services Agency) or their designee; and

2.3.3.2.2 One (1) at-large representative of either the health care provider population or the

population of beneficiaries to be served by the Commission.

2.3.3.3 Thirty thousand (30,000) to forty-five thousand (45,000) Medi-Cal beneficiaries within the county equals three (3) commission seats to be filled as follows:

2.3.3.3.1 The Director of the County Health Department (or Health Services Agency) or their designee;

2.3.3.3.2 One person representing health care providers; and

2.3.3.3.3 One person from the public representing the population of beneficiaries to be served by the Commission.

2.3.3.4 Forty-five thousand (45,000) to sixty-thousand (60,000) Medi-Cal beneficiaries within the county equals four (4) commission seats to be filled as follows:

2.3.3.4.1 The Director of the County Health Department (or Health Services Agency) or their designee;

2.3.3.4.2 One member of the Board of Supervisors;

2.3.3.4.3 One person representing health care providers; and

2.3.3.4.4 One person from the public representing the population of beneficiaries to be served by the Commission.

2.3.3.5 Sixty-thousand (60,000) or more Medi-Cal beneficiaries within the county equals five (5) commission seats to be filled as follows:

2.3.3.5.1 The Director of the County Health Department (or Health Services Agency) or their designee;

2.3.3.5.2 One member of the Board of Supervisors;

2.3.3.5.3 One person representing health care providers;

2.3.3.5.4 One person from the public representing the population of beneficiaries to be served by the Commission; and

2.3.3.5.5 One at large representative of either the public representing the population of beneficiaries to be served by the Commission or one person representing health care providers.

2.3.4 If a Commissioner no longer qualifies for their prescribed position on the Commission, the position shall be vacant and the Board of Supervisors shall appoint a replacement.

2.3.5 Any deletion of commissioners based upon a change in the population of Medi-Cal beneficiaries within a county will

be achieved through attrition, with a maximum of two (2) years to come into compliance with qualifications provisions in this Section.

2.4 Term. Except for the initial staggered terms as specified in Chapter 7.61 (Santa Cruz County), Chapter 2.46 (Monterey County), Chapter 9.43 (Merced County), Chapter 11.17 (San Benito County), and Chapter 2.114 (Mariposa County), all Commissioners appointed by the Board shall serve four (4) year terms of office. At the end of the term, a member may be re-appointed to a subsequent four (4) year term or terms.

2.5 Resignation. A Commissioner may resign effective upon the date of giving written notice to the Clerk of the Commission, unless the notice specifies a later date for their resignation to become effective. Upon receipt of such notice, the Clerk shall notify the Chairperson and the Board of Supervisors of the County appointing the Commissioner.. The acceptance of a resignation shall not be necessary to make it effective.

2.6 Removal. Any Commissioner may be removed from office at any time by a four-fifths vote of the Board of Supervisors of the County appointing the Commissioner favoring such removal.

2.7 Vacancies. Any vacancy on the Commission shall be filled by the Board of Supervisors of the County appointing the Commissioner. The individual must be appropriately qualified for the position in accordance with Section 2.3.

2.8 Compensation. Compensation as established by the Commission in accordance with the provisions of these bylaws may be claimed by any member of the Commission who does not receive compensation from any public agency in connection with the position which qualifies them for service on the Commission.

2.8.1 Amount of Compensation. Total compensation for each Commissioner who qualifies shall not exceed $400 per month. Commissioners may choose one or both of the following options:

2.8.1.1. $300 for each Commission meeting attended for which Commissioners must travel outside of the Commissioner's respective county of representation, to meet in a single location or for meetings beyond three-hours in length, or $100 each for all other Commission meetings attended.

2.8.1.2. $50 for each committee or Advisory Group meeting attended.

2.8.2 Reimbursement. Commissioners may be reimbursed for their actual expenses incurred in attending Commission meetings in categories of expenses and at such rates as are payable to Commission staff in accordance with policies and procedures applicable to staff employed by the Commission.

ARTICLE III. OFFICERS

3.1 Designation. Officers of the Commission shall be:

3.1.1 A chairperson who shall be a Commissioner and preside over all meetings.

3.1.2 A Vice-Chairperson who shall be a Commissioner and who in the absence of the Chairperson shall preside at the meetings of the Commission. If both Chairperson and Vice-Chairperson are absent, the Commissioners present will select one Commissioner to act as Chairperson pro tempore who will have all the authority of the Chairperson.

3.1.3 A Clerk, or designee, who shall attend all the Commission meetings, keep the minutes, witness signatures on all documents executed on behalf of Commission, keep the seal of the Commission, if one is adopted, shall give notice of all meetings of the Commission and committees of the Commission, as required by law, and shall have other duties as resolved by the Commission. The Clerk shall not be a member of the Commission.

3.1 Election. The Commission shall elect officers for one (1) year terms, at the first meeting in October of each year. For the first election of the Commission, officers shall serve a term which begins on the day of the election and ends at the first meeting in October of the following calendar year.

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

3.3 Resignation. An officer may resign effective on the date of giving written notice to the Clerk of the Commission, unless the notice specifies a later date for their resignation to become effective. Upon receipt of such notice, the Clerk shall notify the. The acceptance of a resignation shall not be necessary to make it effective.

3.4 Vacancies. A vacancy in any office shall be filled by resolution or motion of the Commission at a regular or special meeting of the Commission.

ARTICLE IV. MEETINGS

4.1 Regular and Special Meetings. The date, time and place of regular meetings shall be established by resolution or motion of the Commission. The Commission shall hold at least four (4) regular meetings per calendar year. Special meetings can be held by call of the Chairperson or a majority of appointed members of the Commission.

4.2 Open and public. All meetings of the Commission shall be open and public, and the Commission shall comply with the provisions of the Ralph M. Brown Act. Anyone shall be

permitted to attend meetings of the Commission, except for closed sessions as permitted by applicable law.

4.3 Notice. At least seventy-two (72) hours prior to each regular meeting, an agenda for the regular meeting shall be mailed or sent by other electronic means to each Commission member, and to each representative of the news media and to each other person who has submitted a written request to the Commission for notification of meetings, and shall be posted at least seventy-two (72) hours prior to the regular meeting at a location that is freely accessible to the public. The agenda shall contain a brief general description of each item of business to be transacted or discussed at the meeting. No action or discussion shall be undertaken on any item not appearing on the posted agenda, except that members of the Commission may briefly respond to statements made or questions posed by persons exercising their public testimony rights or ask a question for clarification, refer the matter to staff or to other resources for factual information, or request staff to report back at a subsequent meeting concerning any matter. Notwithstanding the foregoing, action may be taken on an item of business not appearing on the posted agenda upon a determination by two-thirds vote of the appointed membership of the Commission, or if less than two-thirds of the members are present, by unanimous vote of those members present, that there is a need to take immediate action and that the need for action came to the attention of the Commission subsequent to the agenda being posted.

4.4 Attendance and Participation. Commissioners must attend the regular meetings of the Commission and of committees to which they are appointed. If a Commissioner is unable to attend a meeting, they must notify the Clerk of the Commission of the reason and the Clerk, in turn, will notify the Chairperson. Except in the case of an emergency, if a Commissioner fails to attend a meeting without first notifying the Clerk, the absence will be considered unexcused. Two unexcused absences during a six-month period may be grounds for the Board of Supervisors of the County appointing the Commissioner to consider removing the Commissioner.

4.5 Quorum. A majority of the appointed members of the commission (excluding any positions that are vacant) shall constitute a quorum, and no act of the commission shall be valid unless a majority of those members appointed and not disqualified from voting due to a conflict of interest concur therein. Any act of the Commission shall be accomplished by a roll call vote when such a vote is requested by any member in attendance.

4.6 Special Meeting. At least twenty-four (24) hours prior to each special meeting, an agenda for the special meeting shall be mailed or by other electronic means to each Commission member and to each representative of the news media and to each other person who has submitted a written request to the Commission for notification of meetings; and shall be posted at least twenty-four (24) hours prior to the special meeting at a location that is freely accessible to members of the public. No

business other than that listed on the agenda shall be considered at a special meeting. However, the commission may hold an emergency meeting without complying with the twenty-four (24) hour
notice and posting requirements if an emergency situation exists as defined by California Government Code Section 54956.5.

4.7 Conduct of Business.

4.7.1 Items on the agenda will be considered in order unless the Chairperson announces a change in the order of consideration.

4.7.2 Unless an agenda item identifies a particular source for a report, (such as the Chairperson, Commissioners, Advisory Groups or Chief Executive Officer), the Chief Executive Officer, the Commissioners, the Commission staff and consultants shall report first on the item. The item will then be open to public comment upon recognition of the speaker by the Chairperson.

4.7.3 Confidential information shall not be subject to disclosure at meetings of the Commission unless required by law.

4.8 Resolutions or Motions. All official acts of the Commission shall be taken either by resolution or a motion, duly made, seconded and adopted by vote of the Commissioners.

4.9 Voting. All actions of the Commission shall be adopted by an affirmative vote of a majority of the Commissioners eligible to vote: those appointed and who are not disqualified from voting under Section 4.10. Thus, if 25 Commissioners are appointed and 2 are disqualified pursuant to Section 4.10, then a positive vote of 12 is required to adopt the motion or resolution (25 appointed - 2 disqualifications = 23 eligible to vote, requiring 12 positive votes for a majority).

4.10 Disqualification from Voting. A Commissioner shall be disqualified from voting on any contract in which they have a financial interest as required by law and the Conflict of Interest Policy of the Commission. Commissioners will not be disqualified from continuing to serve on the Commission merely because they have a financial interest in a contract, and such contracts may not be avoided for the sole purpose of avoiding the conflict of financial interest, where neither the law nor the Conflict of Interest Policy of the Commission has been violated

4.11 Minutes. The Clerk of the Commission shall prepare the minutes of each meeting of the Commission. The minutes shall be an accurate summary of the Commission's or committee's consideration of each item on the agenda and an accurate record of each action taken by the Commission. At a subsequent meeting, the Clerk shall submit the minutes to the Commission for approval by a majority vote of the Commissioners in attendance at the meeting covered by the minutes. .

4.11.1 The official minutes, as approved by the Commission, recording any motions or actions taken by the Commission shall be prepared and submitted to the Board of Supervisors and the County Administrative Offices of each County.

4.12 Closed Sessions. The Commission may meet in closed sessions as permitted by applicable law. The Commission shall report actions taken at a closed session to the public as required by applicable law. As required by applicable law, minutes for closed sessions shall be kept in a closed session minute book and will contain only those topics discussed and decisions made at the closed meeting. The closed session minute book shall be maintained as confidential and not be a public record. Access to the closed session minute book shall be limited to Commissioners, the Chief Executive Officer, and the Commission's legal counsel, except as otherwise required by applicable law.

4.13 Public Records. All documents and records of the Commission which are not exempt from disclosure by law shall be public records under California's Public Records Act (California Government Code Section 7920.000 et seq.).

4.14 Adjournment. The Commission may adjourn any meeting to a time and place specified in the resolution or motion of adjournment, notwithstanding less than a quorum may be present and voting. If no members of the Commission are present at regular or adjourned meeting, the Clerk may declare

the meeting adjourned to a stated time and place and shall cause written notice to be given in the same manner as provided for special meetings, unless such notice is waived as provided in Section 4.3 of these Bylaws for special meetings. A copy of the order or notice of adjournment shall be posted as required by applicable law.

4.15 Reports. The Commission shall submit an annual report to the Board of Supervisors and to the County Administrative Offices of each County on or before January 31st of each year. The report shall state the activities, accomplishments, and future goals of the Commission.

4.16 Progress Reports. The Board of Supervisors from any County may direct the Commission at any time to submit progress reports and recommendations.

4.17 Communications with the Public. Public participation in Commission meetings shall be allowed as follows:

4.17.1 An opportunity for members of the public to directly address the Commission on any item on the agenda of interest to the public shall be provided before or during the Commission's consideration of the item.

4.17.2 In addition, the agenda will provide for public oral communications on items not on the agenda which are within the subject matter jurisdiction of the Commission at the beginning of each regular meeting agenda.

4.17.3 The Chairperson of the Commission may establish reasonable limits on the amount of time allotted to each speaker on a particular item, and the Commission may establish reasonable limits on the total amount of time allotted for public testimony on a particular item or the total amount of time allotted for community oral communications. When further discussion is required, the Commission may vote to allot time in the agenda of the following meeting.

ARTICLE V. COMMITTEES

5.1 Appointment. The Commission may create standing and ad hoc committees and appoint members to those committees. Only Commissioners may serve on the committees, but all committees must be composed of less than a quorum of voting Commissioners. The Commission may designate one (1) or more alternates for the committees to serve during any absences.

5.2 Authority. All committees are advisory only.

5.3 Meetings. Regular meetings of committees shall be held at times and places determined by resolution or motion of the Commission. Special meetings may be held at any time and place as designated by Chairperson, Chief Executive Officer or a majority of members on the committee. A majority of the appointed members of a committee shall constitute a quorum.

5.4 Notice and Agenda. All committees shall comply with the notice and agenda requirements otherwise applicable to the Commission in these bylaws, except for committees composed solely of less than a quorum of the members of the Commission which are not standing committees of the Commission with either a continuing subject matter jurisdiction or a meeting schedule fixed by resolution or other formal action of the Commission.

5.5 Minutes. The Clerk of the Commission or designated individual shall prepare the minutes of each meeting of the committees of the Commission. The minutes shall be an accurate summary of the committee's consideration of each item on the agenda and an accurate record of each action taken by the committee. At a subsequent meeting, the Clerk or designated individual shall submit the minutes to the Commission for approval by a majority vote of the Commissioners in attendance at the meeting covered by the minutes. Once approved, copies of minutes shall be forwarded to the Commissioners and to the Chief Executive Officer.

5.6 Open and Public. Meetings of standing committees shall be open and public.

ARTICLE VI. ADVISORY GROUPS

6.1 Purpose. The Commission may establish Advisory Groups and committees of Advisory Groups composed of at least one Commissioner and beneficiaries, representatives of beneficiaries, and/or providers. The Advisory group provides review and recommendations on policies and procedures considered by the Commission, and to the extent deemed appropriate by the Commission, shall participate in the Commission's consideration of policies and procedures prior to their adoption.

6.2 Member Services Advisory Group.

6.2.1 The Commission shall establish a Member Services Advisory Group consistent with the criteria set forth in this Article.

6.2.2 The Member Services Advisory Group shall serve as an avenue for public policy participation and shall meet at least quarterly.

6.2.3 The Member Services Advisory Group shall include representatives from the population for whom the Commission is responsible for the provision of health care services as describe in Article I.

6.3 Authority. Advisory groups shall be considered advisory by nature.

6.4 Composition. Advisory Group categories shall be decided by

the Commission.

6.5 Selection.

6.5.1 The number of members to an Advisory Group shall be limited to a specific number as deemed appropriate by the Commission.

6.5.2 The Commission shall consider all nominations to Advisory Groups from members of the public and from Commissioners.

6.5.3 Members to an Advisory Group shall be appointed by a majority vote of the Commission.

6.6 Appointment. Advisory Group members shall serve one (1) year terms at the end of which the Commission shall vote on Advisory Group membership.

6.7 Officers. The Advisory Group members shall select a Chairperson and a Vice-Chairperson.

6.8 Conduct of Proceedings. The provisions of Article IV of these Bylaws pertaining to regular and special meetings of the Commission shall apply equally to such meetings of the Advisory Groups, all references to the "Commission", "Commissioners" and "Clerk" shall be deemed to mean the "Advisory Groups", the "members of the Advisory Groups" and the "secretary of the Advisory Groups", respectively.

ARTICLE VII. EXECUTION OF DOCUMENTS

7.1 Contracts and Instruments. The Commission may either by motion or by resolution authorize any officer(s), agent(s) or employee(s) to enter into or execute any contract in the name of and on behalf of the Commission. The authority given may be general or confined to specific instances. And unless authorized or ratified by the Commission, no officer, agent or employee shall have the power or authority to bind the Commission by any contract or to render it liable for any purpose or for any amount.

7.2 Checks, Drafts, Evidence of Indebtedness. All checks, drafts or other orders for payment of money on behalf of or payment to the Commission shall be signed or endorsed by such persons as determined by either motion or resolution of the Commission.

ARTICLE VIII. CONFLICT OF INTEREST POLICY

8.1 Adoption. The Commission shall by resolution or motion adopt and may amend a Conflict of Interest Code for the Commission as required by applicable law.

8.2 Definition. A member of the Commission shall not be deemed to be financially interested in a contract entered into by the Commission (within the meaning of Government Code Section 1090 et seq.) if all the following apply, as specified in Welfare and Institutions Code section 14087.57:

1) The Board appointed the member to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

2) The contract authorizes the Commissioner or the organization the Commissioner represents to provide services to Medi-Cal beneficiaries under the Commission's program.

3) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the Commissioner was appointed to represent.

4) The Commissioner does not influence or attempt to influence the Commission or other Commissioners to enter into a contract in which the Commissioner is interested.

5) The member discloses the interest to the Commission and abstains from voting on the contract.

6) The Commission notes the Commissioner's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of the majority of the Commission without counting the vote of the interested member.

ARTICLE IX. CHIEF EXECUTIVE OFFICER

9.1 Appointment and Tenure. The Chief Executive Officer shall be the Commission's direct executive representative in managing the affairs and activities of the Commission. The Chief Executive Officer shall serve at the pleasure of the Commission subject to any provisions in an employment contract between the Chief Executive Officer and Commission.

9.2 Duties.

9.2.1 The Chief Executive Officer shall be responsible for, and have the necessary authority to, carry out the policies, procedures and practices of the Commission.

9.2.2 The Chief Executive Officer shall act as representative of the Commission in all matters that the Commission has not authorized someone else to do.

9.2.3 The Chief Executive Officer shall appoint a Chief Financial Officer who shall be an employee of the Commission. The Chief Executive Officer may also appoint other employees in executive, administrative and management positions for the Commission. All personnel shall serve at the pleasure of the Chief Executive Officer subject to any personnel policies adopted by the Commission.

ARTICLE X. MISCELLANEOUS PROCEDURES, PRACTICES AND POLICIES, INSURANCE, BONDS

10.1 Purchasing, Hiring, Personnel. The Commission shall adopt either by motion or by resolution, and may amend procedures, practices and policies for purchasing and acquiring the use of equipment and supplies, acquiring, constructing and leasing real property, and improvements, hiring employees, managing personnel, and for all other matters as deemed appropriate. These policies shall be kept with the minutes of the proceedings of the Commission.

10.2 Enforcement. Subject to authority of Commission, the Chief Executive Officer shall implement all procedures, practices and policies adopted by the Commission.

ARTICLE XI. AMENDMENT OF BYLAWS

These Bylaws may be amended only by a motion or resolution of the Commission at any meeting of the Commission, with subsequent approval by the Board of Supervisors of each respective County. Notice of such proposed amendment shall be given in the manner prescribed in Section 4.3 for notices of special meetings of the Commission.

CERTIFICATE OF CHAIRPERSON

I, the undersigned, do hereby certify:

That I am the duly elected and acting Chairperson of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, a local public agency and political subdivision of the State of California; and

That the foregoing Bylaws, comprising 24 pages, including this page, constitute the Bylaws of the Commission, as duly adopted by the Commission at a regular meeting, duly called and held on the _____ day of _____, 2023, at _____, California.

_____

Chairperson of the Commission

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

TABLE OF CONTENTS

DATE: December 6, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: 2024 Department of Health Care Services Medi-Cal Contracts: CCAH 23-30273 and CCAH 23-30241

Recommendation. Staff recommend the Board authorize the Chairperson to sign Contracts with the Department of Health Care Services (DHCS) implementing the 2024 Medi-Cal Managed Care Plan contract provisions and adding San Benito and Mariposa counties to the Alliance Service area.

Background. As a component of DHCS' 2024 Medi-Cal Managed Care Plan contract procurement and county model change process, DHCS developed a new model contract for Medi-Cal Plans (MCPs). DHCS' stated goal of the new contract language is to advance health equity, quality, access, accountability, and transparency to improve the Medi-Cal health care delivery system. DHCS has developed a new model contract to be effective January 1, 2024 for the Alliance to incorporate new requirements for all MCPs and to expand the Alliance services to eligible beneficiaries residing in San Benito and Mariposa counties.

Discussion. The Alliance contracts with DHCS to provide health care services to eligible Medi-Cal beneficiaries within the scope of the Medi-Cal benefits as defined. DHCS prepares both a Primary and Secondary contract. The Primary Contract contains all 2024 MCP contract requirements. The Secondary Contract is a companion to the Primary Contract and covers specific Medi-Cal State Supported Services (i.e., services for which no federal matching funds are available) include services to members with Unsatisfactory Immigration Status and Private Services as defined within the contract.

The 2024 contract includes requirements and standards of care for MCPs towards the provision of quality, equitable and comprehensive coverage for Medi-Cal managed care members. The contracts require partnerships with local health departments, local educational and governmental agencies, and other local programs and services, including social services, child welfare departments, and justice departments, to ensure member care is coordinated and members have access to community-based resources, including Community Supports. Further, the contracts focus on increased transparency and oversight, including reporting on access, quality, health equity and community investments.

Alliance staff have initiated a project through the Project Management Office with oversight by the plans' Legal Services Director towards ensuring operational readiness and compliance with the new contract requirements effective January 1, 2024.

In addition, the Alliance's Compliance Department has overseen an Operational Readiness Deliverables process which includes submission of approximately 250 contract deliverables to DHCS for review and approval.

Staff have reviewed the final contract prepared by DHCS to effectuate this agreement and recommend the Board authorize the Chairperson to execute the contract to enable the ongoing provision of services and the expansion of the Alliance service area to include eligible beneficiaries in San Benito and Mariposa counties.

Fiscal Impact. Staff project an operating income of $66.6M, 89.5% medical loss ratio and 6.1% administrative loss ratio.

Attachments. N/A

DATE: December 6, 2023

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Services Advisory Group Charter

Recommendation. Staff recommend the Board approve the revised Member Services Advisory Group (MSAG) Charter.

Summary. The Member Services Advisory Group (MSAG) Charter has been revised to reflect changes due to the 2024 Department of Health Care Services (DHCS) contract effective January 1, 2024.

Background. MSAG ensures community and member participation in establishing the Alliance's public policy in quality, health equity, disparities, population health, children services, and other ongoing plan functions.

Discussion. The Board reviewed and approved the initial MSAG charter at the October 25, 2023 meeting. The 2024 DHCS contract includes new requirements of MSAG. The revised charter reflects the new requirements which will take effect on January 1, 2024. MSAG reviewed the revised charter at the November 9, 2023 meeting. MSAG had no comments or objections to the revised charter and is being submitted to the Board for approval.

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

Attachments.

1. Member Services Advisory Group Charter.

Member Services Advisory Group (MSAG)
Meeting Charter

Original Date: October 2023	**Last Revision Date:** October 26, 2023
Approved by: Alliance Board of Commissioners	

Overview	The Member Services Advisory Group (MSAG) serves as the Alliance's Community Advisory Committee. The MSAG ensures community and member participation in establishing the Alliance's public policy in quality, health equity, disparities, population health, children services, and other ongoing plan functions.
Duties	**Responsibilities of Members During MSAG Meetings** • Provide feedback to inform the development of the provider manual clarify new and revised policies and procedures contained therein. • Provide input, advice, and recommendations on the Population Needs Assessment (PNA). • Review PNA findings and discuss improvement opportunities with an emphasis on Health Equity and Social Drivers of Health. • Provide input on selecting targeted health education, cultural and linguistic, and QI strategies. • Discuss the development and implementation of cultural and linguistic accessibility standards and procedures. • Identify and advocate for preventive care practices to be utilized by the Alliance. • Provide input on developing and updating cultural and linguistic policy and procedure decisions. **Responsibilities of Chair and Vice Chair During Meetings** • Provide meeting facilitation and direct the meeting process through the agenda. • Guide and lead discussion to ensure all participants are provided equal opportunity for participation.

	Responsibilities of Alliance Staff During Meetings • Alliance Staff will ensure and monitor member and/or parent and caregiver input into appropriate policies and decision-making.
Composition	**Membership** • The MSAG will be comprised primarily of Alliance members. • MSAG will be comprised of Alliance members, local consumer advocates, contracted providers, and Alliance Commissioner(s). • One member of the MSAG will serve as Chair of the MSAG and one member will serve as Vice Chair of the MSAG. **Membership Terms** • Members will be selected by the Member Services Advisory Group (MSAG) Selection Committee and appointed by the Alliance Board. • Members will be appointed to a one-year term. At the end of the term the member may be reappointed to a subsequent one-year term. • Members must attend at least 50% of meetings per calendar year. **Chair and Vice Chair Terms** • The Chair and Vice Chair shall be selected by MSAG members. • If both Chair and Vice Chair are absent, MSAG members present will select one member to act as Chair for the meeting. The Chair and Vice Chair shall serve renewable one-year terms. **Serving as Support Staff** • Alliance staff will serve as staff to MSAG. Support staff to the MSAG includes: o Alliance Staff – Community Engagement Director, Community Engagement Administrative Specialist, and Member Services Director or assigned designee. • Ad Hoc Staff – Staff from the Alliance as needed.
Meeting Frequency and Locations	• Meetings will be held quarterly. • Meetings will be held at least three times per year.

	• The meeting calendar shall be established annually at the MSAG's August meeting. • Meetings will take place in person in the Alliance offices listed below and joined together via videoconferencing. o Mariposa County: Cathey's Valley Room Mariposa County Health and Human Services 5362 Lemee Lane, Mariposa, CA 95338 o Merced County: Board Room 530 West 16th Street, Suite B, Merced, CA 95340 o Monterey County: Board Room 950 East Blanco Road, Suite 101, Salinas, CA 93901 o San Benito County: Conference Room Community Services & Workforce Development (CSWD) 1161 San Felipe Road, Building B, Hollister, CA 95023 o Santa Cruz County: Board Room 1600 Green Hills Road, Suite 101, Scotts Valley, CA 95066
Agendas, Minutes, and Reporting	• Alliance staff are responsible for agenda and meeting material production and distribution. • Alliance staff will record minutes of meetings which will be approved by the MSAG members at each subsequent meeting.
Advisory Group Member Support	• The Alliance provides resources to ensure MSAG members are able to effectively participate in MSAG meetings including but not limited to providing transportation to MSAG meetings and arranging childcare as necessary. • MSAG members may receive a stipend to cover travel expenses and other costs associated with in-person meeting attendance. • Requests for translation and interpreter services, including sign-language interpretation or other assistive devices such as real-time captioning, note takers, reading or writing assistance and conversion of meeting materials into Braille, large print or computer flash drive can be made available if requested at least ten (10) business days prior to the meeting.
Open and Public Meetings	• Meetings are subject to the Brown Act, thus are open to the public. • Agendas and meeting materials will be published and posted publicly at least seventy-two (72) hours prior to each meeting.

	• Staff will record minutes of meetings which will be approved by MSAG members at each subsequent meeting. • Agenda packets are available by mail upon request.
References	
Review of Charter	MSAG shall review this charter at least annually. Any proposed changes shall be submitted to the Board for approval.

Revision History:

Date	Changes Made By	Approved By
October 10, 2023	Kayla Zoliniak Administrative Specialist	
October 25, 2023		Alliance Board of Commissioners
October 26, 2023	Ronita Margain Community Engagement Director	

DATE: December 6, 2023

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

FROM: Danita Carlson, Government Relations Director

SUBJECT: 2023 Legislative Session Wrap-Up

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

Summary. Staff provides a summary of the 2023 legislative session including the outcomes of bills on which the Board took a position of advocacy. In addition, attached for your Board's information is a final list of bills that staff has tracked throughout the legislative session.

Background. The official end of the 2023 legislative session came on October 14, 2023 with the deadline for Governor Newsom to sign or veto bills passed by the legislature prior to recessing for the year.

Throughout the legislative session, staff, in conjunction with the Local Health Plans of California and our Sacramento representatives, Edelstein, Gilbert, Robson and Smith, identified, tracked, and monitored bills in the six areas of focus of the Alliance's Board-approved Policy Priorities:

- Access to Care
- Local Innovation
- Eligibility and Benefits
- Financing and Rates
- Health Equity
- Person-Centered Delivery System Transformation

Discussion. The Alliance tracked 70 bills in these areas of focus, including four priority bills, on which the Alliance took an official position of support or opposition. Of the 70 bills tracked, 23 were signed into law.

The Alliance held a Support position on three bills and an Oppose Unless Amended position on one bill. The following provides a report on the outcome of each of these bills:

> AB 1379 (Papan) – Open meetings: local agencies: teleconferences. Allows additional flexibilities to Brown Act meetings for local agencies utilizing teleconferencing from multiple teleconferencing locations.
>
> Final Disposition. Two-year bill.
>
> SB 282 (Eggman, McGuire) Medi-Cal: federally qualified health centers and rural health clinics. Authorizes additional flexibilities to ensure reimbursement for a maximum of two visits that take place on the same day at the same site and adds other related changes.

Final Disposition. Dead.

SB 311 (Eggman) Medi-Cal: Part A buy-in. This bill would require the Department of Health Care Services to enter into a Medicare Part A buy-in agreement, as for qualified Medicare beneficiaries with the federal Centers for Medicare and Medicaid Services by submitting a state plan amendment. Under the bill, the buy-in agreement would be effective on January 1, 2025, or the date the department communicates to the Department of Finance in writing that systems have been programmed for implementation of these provisions, whichever date is later.

Final Disposition. Signed by the Governor.

SB 424 (Durazo) Medi-Cal: Whole Child Model program. Extends the operation of the statewide Whole Child Model program stakeholder advisory group until December 31, 2026.

Final Disposition. Two-year bill.

Staff continue to review all applicable bills that were signed into law by the Governor to identify implementation issues and potential impact on the plan, members, providers and other key stakeholders and will report to the Board on any significant concern on items that may arise from this review that warrant Board attention.

Attached is the final bill list indicating those bills that staff were tracking based on the Board's established areas of focus. The status of each bill is indicated.

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

Attachments.

1. 2023 Legislation - Final

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

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

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

Central California Alliance for Health
2023 Bill List

Priority Bills	
AB 1379 **Papan** **Status:** Two-Year Bill **Position:** Support	**Open meetings: local agencies: teleconferences** **Summary:** Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. This bill, with respect to those general provisions on teleconferencing, would require a legislative body electing to use teleconferencing to instead post agendas at a singular designated physical meeting location, as defined, rather than at all teleconference locations. The bill would remove the requirements for the legislative body of the local agency to identify each teleconference location in the notice and agenda, that each teleconference location be accessible to the public, and that at least a quorum of the members participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The bill would instead provide that, for purposes of establishing a quorum of the legislative body, members of the body may participate remotely, at the designated physical location, or at both the designated physical meeting location and remotely. The bill would require the legislative body to have at least 2 meetings per year in which the legislative body's members are in person at a singular designated physical meeting location. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing provisions without complying with the general teleconferencing requirements that agendas be posted at each teleconference, that each teleconference location be identified in the notice and agenda, and that each teleconference location be accessible to the public, if at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction. Under existing law, these alternative teleconferencing provisions require the legislative body to provide at least one of 2 specified means by which the public may remotely hear and visually observe the meeting. Under existing law, these alternative teleconferencing provisions authorize a member to participate remotely if the member is participating remotely for just cause, limited to twice per year, or due to emergency circumstances, contingent upon a request to, and action by, the legislative body, as prescribed. Existing law

	specifies that just cause includes travel while on official business of the legislative body or another state or local agency. This bill would revise the alternative provisions, operative until January 1, 2026, to make these provisions operative indefinitely. The bill would delete the restriction that prohibits a member, based on just cause, from participating remotely for more than 2 meetings per calendar year. The bill would delete the requirement for the legislative body to provide at least one of 2 specified means by which the public may remotely hear and visually observe the meeting. The bill would also delete a provision that requires a member participating remotely to publicly disclose at the meeting before action is taken whether there are individuals 18 years of age present in the room at the remote location and the general nature of the member's relationship to those individuals. The bill would further delete a provision that prohibits a member from participating remotely for a period of more than 3 consecutive months or 20% of the regular meetings within a calendar year, or more than 2 meetings if the legislative body regularly meets fewer than 10 times per calendar year. The bill would expand the definition of just cause to include travel related to a member of a legislative body's occupation. The bill would make related, conforming changes.
SB 282 **Eggman and McGuire** **Status:** Dead **Position:** Support	**Medi-Cal: federally qualified health centers and rural health clinics** **Summary:** Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and a physician or other specified health care professionals. Under existing law, "visit" also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified. This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions. The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a "visit." The bill would also make a change to the provision relating to physicians and would make other technical changes.
SB 311 **Eggman** **Status:** Chaptered **Position:** Support	**Medi-Cal: Part A buy-in** **Summary:** This bill would require the department to enter into a Medicare Part A buy-in agreement, as defined, for qualified Medicare beneficiaries with the federal Centers for Medicare and Medicaid Services by submitting a state plan amendment. Under the bill, the buy-in agreement would be effective on January 1, 2025, or the date the department communicates to the Department of Finance in writing that systems have been programmed for implementation of these provisions, whichever date is later.

	The bill would authorize the department to implement these provisions through all-county letters or similar instructions until regulations are adopted. Under the bill, these provisions would be implemented only to the extent that any necessary federal approvals are obtained and that federal financial participation is available and is not otherwise jeopardized.
SB 424 **Durazo** **Status:** Two-Year Bill **Position:** Oppose unless Amended	**Medi-Cal: Whole Child Model Program** **Summary:** Existing law requires the department to establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Existing law terminates the advisory group on December 31, 2023. This bill would extend the operation of the advisory group until December 31, 2026.
Assembly Bills	
AB 55 **Rodriguez** **Status:** Dead	**Medi-Cal: workforce adjustment for ground ambulance transports** **Summary:** Existing law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under existing law, those increased payments are funded solely from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other related federal funds. Existing law sets forth separate provisions for increased Medi-Cal reimbursement to providers of ground emergency medical transportation services that are owned or operated by certain types of public entities. This bill would establish, for dates of service on or after July 1, 2024, a workforce adjustment, serving as an additional payment, for each ground ambulance transport performed by a provider of medical transportation services, excluding the above-described public entity providers. The bill would vary the rate of adjustment depending on the point of pickup and whether the service was for an emergency or nonemergency, with the workforce adjustment being equal to 80% of the lowest maximum allowance established by the federal Medicare Program reduced by the fee-for-service payment schedule amount, as specified. The bill would require that the workforce adjustment meet a certain workforce standard, as determined by the department, which would apply to specified classes of employees, including emergency medical dispatchers, emergency medical technicians, paramedics, and registered nurses. The bill would set forth criteria for a provider to meet the workforce standard, with formulas taking into account the fiscal year and base hourly wage rates within a class of employees, and whether the provider is a new provider of ground ambulance services. The bill would require the department to direct each Medi-Cal managed care plan to implement a value-based purchasing model that provides for reimbursement to a network provider that meets the workforce standard requirement and that furnishes ambulance transport services, as specified.

	The bill would require the department to establish the manner and format for participating providers to report the required data, as specified. The bill would require a provider that has received the workforce adjustment to certify under penalty of perjury that it met the workforce standard, as specified. By expanding the scope of the crime of perjury, the bill would impose a state-mandated local program. The bill would authorize the department to recoup any workforce adjustments paid to a provider that did not meet the workforce standard. The bill would prohibit implementation of the workforce adjustment from affecting the calculation of the above-described QAF-based add-on, and would prohibit adjustments to the workforce adjustment, except as specified to comply with federal requirements. The bill would condition implementation of the workforce adjustment on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would make conforming changes.
AB 232 **Aguiar-Curry** **Status:** Chaptered	**Temporary practice allowances** **Summary:** Existing law, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act, generally govern the provision of marriage and family therapy services, clinical social work services, and professional clinical counseling services, respectively, in the state and prohibit a person from practicing those healing arts without a license granted pursuant to the respective provisions of each act. This bill, until January 1, 2026, would, under all of the acts described above, authorize a person who holds a license in another jurisdiction of the United States as a marriage and family therapist, clinical social worker, or professional clinical counselor to provide services in the state for a period not to exceed 30 consecutive days in any calendar year if certain conditions are met, including the license from another jurisdiction is at the highest level for independent clinical practice in the jurisdiction in which the license was granted, the client is located in California during the time the person seeks to provide care in California, and the client is a current client of the person and had an established, ongoing client-provider relationship with the person at the time the client became located in California. The bill would require a person who intends to provide services pursuant to those provisions to provide the Board of Behavioral Sciences with certain information before providing services, including the jurisdiction in which the person is licensed, the type of license held, and the license number. The bill would also make various nonsubstantive and conforming changes.
AB 236 **Holden** **Status:** Two-Year Bill	**Health care coverage: provider directories** **Summary:** This bill would require a plan or insurer to annually audit and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on January 1, 2024, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before January 1, 2027. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2024, unless specified criteria applies. The bill would require a plan or insurer to provide information about in-network providers to

	enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 286 **Wood** **Status:** Chaptered	**Broadband infrastructure: mapping** **Summary:** Existing law requires the Public Utilities Commission, in collaboration with relevant state agencies and stakeholders, to maintain and update a statewide, publicly accessible, and interactive map showing the accessibility of broadband service in the state. Existing law authorizes the commission to collect information from providers of broadband services at the address level and prohibits the commission from disclosing certain protected residential subscriber information. This bill would require that the map identify, for each address in the state, each provider of broadband services that offers service at the address and the maximum speed of broadband services offered by each provider of broadband services at the address. The bill would additionally require that map to include certain features to receive self-reported data, including, among others, a feature that allows individuals to refute the broadband speed or technology, or both, that an internet service provider claims to offer at an address. The bill would require that map to include a feature for users to submit a verified speed test, as defined, at their location. The bill would make this self-reported data publicly available by address and would require the commission to obtain consent from an individual before publicly disclosing information that the individual submits, as provided. The bill would prohibit the commission from accepting certain self-reported information collected by the commission as evidence in a commission proceeding unless the commission validates the accuracy of that self-reported information.
AB 317 **Weber** **Status:** Chaptered	**Pharmacist service coverage** **Summary:** Existing law authorizes health care service plans and certain disability insurers, that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist, to pay or reimburse the cost of the service performed by a pharmacist for the plan or insurer if the pharmacist otherwise provides services for the plan or insurer. This bill would instead require a health care service plan and certain disability insurers that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of services performed by a pharmacist at an in-network pharmacy or by a pharmacist at an out-of-network pharmacy if the health care service plan or insurer has an out-of-network pharmacy benefit. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.
AB 365 **Aguiar-Curry** **Status:** Inactive	**Medi-Cal: diabetes management** **Summary:** This bill would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program, subject to utilization controls. The bill would require the department, by July 1, 2024, to review and update, as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a

	manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized. The bill would make related findings and declarations.
AB 412 **Soria** **Status:** Two-Year Bill	**Distressed Hospital Loan Program** **Summary**: This bill would create the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. The bill would require, subject to an appropriation by the Legislature, the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement the program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, as specified. Notwithstanding that methodology, the bill would deem a hospital applying for aid to be immediately eligible for state assistance from the program if the hospital has 90 or fewer days cash on hand and has experienced a negative operating margin over the preceding 12 months. The bill would require a hospital or a closed hospital to provide the authority and the department with financial information, in a format determined by the authority, demonstrating the hospital's need for assistance due to financial hardship. The bill would additionally require that the department, in consultation with the authority, develop a loan forgiveness application and approval process, as specified. The bill would specify that the authority and the department may implement these provisions by information notices or other similar instructions, without taking any further regulatory action. This bill would create the Distressed Hospital Loan Program Fund, a continuously appropriated fund, for use by the department and the authority to administer the loan program, as specified. The bill would authorize both the authority and the department to recover administrative costs from the fund, as specified. By creating a continuously appropriated fund, the bill would make an appropriation. Existing law generally requires a health care facility to report specified data to the department, including total inpatient and outpatient revenues by payer, including Medicare and Medi-Cal. Existing law requires the department to adopt regulations regarding the identification and reporting of charity care services, and specifies various obligations to provide hard copies of hospital data reports submitted pursuant to these provisions. This bill would additionally require data for total inpatient and outpatient revenues by payer to include commercial coverage payers. The bill would require a hospital subject to these data reporting requirements to submit a balance sheet detailing the assets, liabilities, and net worth at the end of the quarter as specified by the department. The bill would also remove the provisions regarding regulations related to charity care services and obligations to provide hard copies of hospital data reports.

	This bill would declare that it is to take effect immediately as an urgency statute.
AB 424 **Bryan** **Status:** Chaptered	**Neurodegenerative disease registry** **Summary:** Existing law, until January 1, 2028, and to the extent funds are made available for these purposes, requires the State Department of Public Health to collect data on the incidence of neurodegenerative disease in California, and requires a hospital, facility, physician and surgeon, or other health care provider diagnosing or providing treatment to a patient for a neurodegenerative disease to report each case of a neurodegenerative disease to the department, as prescribed. Existing law specifies that for this purpose, "neurodegenerative disease" may include, but need not be limited to, amyotrophic lateral sclerosis (ALS), among other diseases. This bill would require the term "neurodegenerative disease" to include, but not be limited to, ALS.
AB 425 **Alvarez** **Status:** Chaptered	**Medi-Cal: pharmacogenomic testing** **Summary:** This bill would, commencing on July 1, 2024, add pharmacogenomic testing as a covered benefit under Medi-Cal, as specified. The bill would define pharmacogenomic testing as laboratory genetic testing that includes, but it not limited to, a panel test, to identify how a person's genetics may impact the efficacy, toxicity, and safety of medications. The bill would condition implementation of this benefit coverage on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would authorize the department to implement these provisions through all-county letters or similar instructions.
AB 459 **Kalra** **Status:** Two-Year Bill	**Contracts against public policy: personal or professional services: digital replicas** **Summary:** This bill would provide that a provision in an agreement between an individual and any other person for the performance of personal or professional services is contrary to public policy and deemed unconscionable if the provision meets specified conditions relating to the use of a digital replica of the voice or likeness of an individual in lieu of the work of the individual or to train a generative artificial intelligence system. The bill would provide that it shall apply retroactively. The bill would require any person who is currently under, or has entered into, an agreement with an individual performing personal or professional services containing such a provision, by February 1, 2024, to notify that individual in writing that the provision is unenforceable.
AB 492 **Pellerin** **Status:** Two-Year Bill	**Medi-Cal: reproductive and behavioral health integration pilot programs** **Summary:** Existing law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to a federal waiver, as part of the schedule of Medi-Cal benefits. Under existing law, the Family PACT Program provides comprehensive clinical family planning services to a person who has a family income at or below 200% of the federal poverty level and who is eligible to receive those services pursuant to the waiver. Under the Family PACT Program, comprehensive clinical family planning services include, among other things, contraception and general reproductive health care, and exclude abortion. Abortion services are covered under the Medi-Cal program.

	This bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants, incentive payments, or other financial support available to Medi-Cal managed care plans to develop and implement reproductive and behavioral health integration pilot programs in partnership with identified qualified providers, in order to improve access to behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions. The bill would define "qualified provider" as a Medi-Cal provider that is enrolled in the Family PACT Program and that provides abortion- and contraception-related services. For funding eligibility, the bill would require a Medi-Cal managed care plan to identify the qualified providers and the services that will be provided through the pilot program, as specified. The bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants or other financial support available to qualified providers for reproductive and behavioral health integration pilot programs, in order to support development and expansion of services, infrastructure, and capacity for the integration of behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions. For funding eligibility, the bill would require a qualified provider to identify both the patient population or gap in access to care and the types of services provided, as specified. The bill would require the department to convene a working group, with a certain composition, to develop criteria for evaluating applications and awarding funding, to conduct an evaluation of the pilot programs, and to submit a report to the Legislature, as specified.
AB 531 **Irwin** **Status:** Chaptered	**The Behavioral Health Infrastructure Bond Act of 2023** **Summary:** This bill would enact the Behavioral Health Infrastructure Bond Act of 2023 which, if approved by the voters, would authorize the issuance of bonds in the amount of $6,380,000,000 to finance loans or grants for the acquisition of capital assets for the conversion, rehabilitation, or new construction of permanent supportive housing for veterans and others who are homeless and meet specified criteria, and for grants for the Behavioral Health Continuum Infrastructure Program, as specified. The bill would provide for the submission of specified sections of this bill and SB 326 to the voters at the March 5, 2024, statewide primary election.
AB 557 **Hart** **Status:** Chaptered	**Open meetings: local agencies: teleconferences** **Summary:** This bill would revise the authority of a legislative body to hold a teleconference meeting under those abbreviated teleconferencing procedures when a declared state of emergency is in effect. Specifically, the bill would extend indefinitely that authority in the circumstances under which the legislative body either (1) meets for the purpose of determining whether, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees, or (2) has previously made that determination. The bill would also extend the period for a legislative body to make the above-described findings related to a continuing state of emergency to not later than 45 days after the first teleconferenced meeting,

	and every 45 days thereafter, in order to continue to meet under the abbreviated teleconferencing procedures.
AB 564 **Villapudua** **Status:** Two-Year Bill	**Medi-Cal: claim or remittance forms: signature** **Summary:** This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.
AB 576 **Weber** **Status:** Vetoed	**Medi-Cal: reimbursement for abortion** **Summary:** This bill would require the department, by March 1, 2024, to review and update Medi-Cal coverage policies for medication abortion to align with current evidence-based clinical guidelines. After the initial review, the bill would require the department to update its Medi-Cal coverage policies for medication abortion as needed to align with evidence-based clinical guidelines. The bill would require the department to allow flexibility for providers to exercise their clinical judgment when services are performed in a manner that aligns with one or more evidence-based clinical guidelines.
AB 586 **Calderon** **Status:** Dead	**Medi-Cal: community supports: climate change or environmental remediation devices** **Summary:** Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation. This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define "climate change or environmental remediation devices" as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality, or other climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.
AB 608 **Schiavo** **Status:** Vetoed	**Medi-Cal: comprehensive perinatal services** **Summary:** This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department, in coordination with the State Department of Public Health, to consider input from certain stakeholders, as specified, in determining the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered. The bill would require the department to cover comprehensive perinatal services that are rendered by a nonlicensed perinatal health worker in a beneficiary's home

	or other community setting away from a medical site, as specified. The bill would also require the department to allow a nonlicensed perinatal health worker rendering those services to be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ). For these purposes, the bill would require a CBO or LHJ supervising a nonlicensed perinatal health worker to provide those services under contract with a Comprehensive Perinatal Services Program provider. The bill would condition implementation of the provisions above on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would authorize the department to implement these provisions by all-county letters or similar instructions until regulations are adopted.
AB 614 **Wood** **Status:** Chaptered	**Medi-Cal** **Summary:** This bill would make a change to an obsolete reference to the former Healthy Families Program, whose health services for children have been transitioned to the Medi-Cal program. The bill would make a change to an obsolete reference to the former Access for Infants and Mothers Program and would revise a related provision to instead refer to the successor Medi-Cal Access Program. The bill would delete, within certain Medi-Cal provisions, obsolete references to a repealed provision relating to nonprofit hospital service plans. Existing law establishes, under Medi-Cal, the County Health Initiative Matching Fund, a program administered by the department, through which an applicant county, county agency, local initiative, or county organized health system that provides an intergovernmental transfer, as specified, is authorized to submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to certain children. The program is sometimes known as the County Children's Health Initiative Program (CCHIP). This bill would revise certain provisions to rename that program as CCHIP. Existing law requires the Director of Health Care Services to enter into contracts with managed care plans under Medi-Cal and related provisions, including health maintenance organizations, prepaid health plans, or other specified entities, for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs. This bill would delete that list of entities and would instead specify that the director would be required to enter into contracts with managed care plans licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, except as otherwise authorized under the Medi-Cal program. The bill would require the director, prior to issuing a new request for proposal or entering into new contracts, to provide an opportunity for interested stakeholders to provider input to inform the development of contract provisions.
AB 632 **Gipson** **Status:** Vetoed	**Health care coverage: prostate cancer screening** **Summary:** Existing law requires an individual and group health care service plan contract or health insurance policy to provide coverage for the screening and diagnosis of prostate cancer when medically necessary and consistent with good professional practice. Under existing law, the application of a deductible or copayment for those services is not prohibited.

	This bill would instead require that coverage when medically necessary and consistent with nationally recognized, evidence-based clinical guidelines. The bill would prohibit a health care service plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, from applying a deductible, copayment, or coinsurance to coverage for prostate cancer screening services for an enrollee or insured who is 55 years of age or older or who is 40 years of age or older and is high risk, as determined by the attending or treating health care provider. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 666 **Arambula** **Status:** Two-Year Bill	**Health systems: community benefits plans** **Summary:** Existing law establishes the Department of Health Care Access and Information to oversee various aspects of the health care market, including oversight of hospital facilities and community benefit plans. benefits plans. Existing law requires a private, not-for-profit hospital to adopt and update a community benefits plan that describes the activities the hospital has undertaken to address identified community needs within its mission and financial capacity, including health care services rendered to vulnerable populations. Existing law defines the term "community" as the service areas or patient populations for which the hospital provides health care services, defines "vulnerable populations" for these purposes to include a population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs, and defines "community benefit" to mean the hospital's activities that are intended to address community needs, such as support to local health departments, among other things. Existing law requires a hospital to conduct a community needs assessment to evaluate the health needs of the community and to update that assessment at least once every 3 years. Existing law requires a hospital to annually submit a community benefits plan to the department not later than 150 days after the hospital's fiscal year ends. Existing law authorizes the department to impose a fine not to exceed $5,000 against a hospital that fails to adopt, update, or submit a community benefits plan, and requires the department to annually report on its internet website the amount of community benefit spending and list those that failed to report community benefit spending, among other things. This bill would require the department to define the term "community" by regulation within certain parameters, would redefine the term "community benefit" to mean services rendered to those eligible for, but not enrolled in the above-described programs, the unreimbursed costs as reported in specified tax filings, and the support to local health departments as documented by those local health departments, among other things, and would redefine the term "vulnerable populations" to include those eligible for, but not enrolled in the above-described programs, those below median income experiencing economic disparities, and certain socially disadvantaged groups, such as those who are incarcerated. The bill would require that a community needs assessment include the needs of the vulnerable populations and include a description of which vulnerable populations are low or moderate income, coordination with a local health department, and require that it be updated at least once every 2 years. The bill would require that a community benefits plan demonstrate alignment with the State Health Improvement Plan and the Community Health Improvement Plan, include the proportion and amount of community benefit spending on vulnerable populations, and include measurable objectives that outline

	equity benchmarks. The bill would additionally require a hospital to annually submit a copy of a specified Internal Revenue Service form to the department. The bill would increase the maximum fine for failure to adopt, update, or submit, a community benefits plan to $25,000 and would authorize the department to impose a maximum fine of $50,000 for a hospital's failure to demonstrate implementation of a community benefits plan. The bill would require the department to include in its annual report the amount of community benefits spending attributable to public health needs and a list of hospitals that fail to comply with specified requirements.
AB 716 **Boerner** **Status:** Chaptered	**Ground medical transportation** **Summary:** This bill would require the authority to annually report the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county, as specified. Existing law requires that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including medical transportation services, and requires a policy or contract to provide for the direct reimbursement of a covered medical transportation services provider if the provider has not received payment from another source. This bill would delete that direct reimbursement requirement and would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2024, to require an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. The bill would prohibit a noncontracting ground ambulance provider from sending to collections a higher amount, would limit the amount an enrollee or insured owes a noncontracting ground ambulance provider to no more than the in-network cost-sharing amount, and would prohibit a ground ambulance provider from billing an uninsured or self-pay patient more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. The bill would require a plan or insurer to directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as specified, unless it reaches another agreement with the noncontracting ground ambulance provider.
AB 719 **Boerner** **Status:** Vetoed	**Medi-Cal: nonmedical and nonemergency medical transportation** **Summary:** This bill would require the department to require Medi-Cal managed care plans that are contracted to provide nonmedical transportation or nonemergency medical transportation to contract with public paratransit service operators who are enrolled Medi-Cal providers for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by a public paratransit service operator. The bill would require the rates reimbursed by the managed care plan to the public paratransit service operator to be based on the department's fee-for-service rates for nonmedical and nonemergency medical transportation service, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.
AB 815 **Wood**	**Health care coverage: provider credentials**

Status: Two-Year Bill	**Summary:** This bill would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons in lieu of a health care service plan's or health insurer's credentialing process. The bill would require the board to convene by July 1, 2024, develop criteria for the certification of public and private credentialing entities by January 1, 2025, and develop an application process for certification by July 1, 2025. This bill would require a health care service plan or health insurer, or its delegated entity, to accept a valid credential from a board-certified entity without imposing additional criteria requirements and to pay a fee to a board-certified entity based on the number of contracted providers credentialed through the board-certified entity.
AB 817 **Pacheco** **Status:** Two-Year Bill	**Open meetings: teleconferencing: subsidiary body** **Summary:** Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. This bill would authorize a subsidiary body, as defined, to use alternative teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. In order to use teleconferencing pursuant to this act, the bill would require the legislative body that established the subsidiary body by charter, ordinance, resolution, or other formal action to make specified findings by majority vote, before the subsidiary body uses teleconferencing for the first time and every 12 months thereafter.
AB 847 **Luz Rivas** **Status:** Chaptered	**Medi-Cal: pediatric palliative care services** **Summary:** Existing law requires the department to develop a pediatric palliative care benefit as a pilot program to Medi-Cal beneficiaries under 21 years of age, to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available. Existing law requires that program to include, among other things, hospice services to individuals whose conditions may result in death, regardless of the estimated length of the individual's remaining period of life. Pursuant to the above-described provisions, the department established the Pediatric Palliative Care (PPC) Waiver in 2009, upon receiving federal approval in December 2008. After the waiver ended on December 31, 2018, the department implemented a plan in 2019 to transition some pediatric palliative care services to

	the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit, which is available to Medi-Cal beneficiaries under 21 years of age, as specified. This bill, Sophia's Act, would extend eligibility for pediatric palliative care services for those individuals who have been determined eligible for those services prior to 21 years of age, until 26 years of age and would extend eligibility for hospice services after 21 years of age. To the extent that these provisions would alter the eligibility of individuals for these services, the bill would create a state-mandated local program. The bill would implement these provisions only to the extent that necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized. This bill would state the Legislature's intent to investigate future legislation to make pediatric palliative and hospice care more accessible to families.
AB 904 **Calderon and Cervantes** **Status:** Chaptered	**Health care coverage: doulas** **Summary:** This bill would require a health care service plan or health insurer, on or before January 1, 2025, to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. Under the bill, a Medi-Cal managed care plan would satisfy that requirement by providing coverage of doula services so long as doula services are a Medi-Cal covered benefit. The bill would require the Department of Managed Health Care, in consultation with the Department of Insurance, to collect data and submit a report describing the doula coverage and the above-described programs to the Legislature by January 1, 2027.
AB 931 **Irwin** **Status:** Vetoed	**Prior authorization: physical therapy** **Summary:** This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. The bill would require a physical therapy provider to verify an enrollee's or an insured's coverage and disclose their share of the cost of care, as specified. The bill would require a physical therapy provider to disclose if the provider is not in the network of the enrollee's plan or the insured's policy, and if so, to obtain the enrollee's or the insured's consent in writing to receive services from the noncontracting provider prior to initiating care. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 948 **Berman** **Status:** Chaptered	**Prescription drugs** **Summary:** Existing law requires a health care service plan contract or health insurance policy for a nongrandfathered individual or small group product that maintains a drug formulary grouped into tiers, and that includes a 4th tier, to define each tier of the drug formulary, as specified. Existing law defines Tier 4 to include, among others, drugs that are biologics. Existing law repeals these provisions on January 1, 2024. This bill would delete drugs that are biologics from the definition of Tier 4. The bill would require a health care service plan or a health insurer, if there is a generic equivalent to a brand name drug, to ensure that an enrollee or insured is subject to

	the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. This bill also would delete the January 1, 2024, repeal date of the above provisions, thus making them operative indefinitely. Because extension of the bill's requirements relative to health care service plans would extend the existence of a crime, the bill would impose a state-mandated local program.
AB 1036 **Bryan** **Status:** Two-Year Bill.	**Health care coverage: emergency medical transport** **Summary:** This bill would require a physician, upon an individual's arrival to an emergency department of a hospital, to certify in the treatment record whether an emergency medical condition existed, or was reasonably believed to have existed, and required emergency medical transportation services, as specified. This bill would, if a physician has certified that emergency medical transportation services according to these provisions, require a health care service plan, disability insurance policy, and Medi-Cal managed care plan, to provide coverage for emergency medical transport, consistent with an individual's plan or policy. The bill would specify that the indication by a physician pursuant to these provisions is limited to an assessment of the medical necessity of the emergency medical transport services, and does not apply or otherwise impact provisions regarding coverage for care provided following completion of the emergency medical transport. The bill would specify for Medi-Cal benefits, these provisions do not apply to various specified provisions relating to nonemergency transport services or any other law or regulation related to reimbursement or authorization requirements for services provided for emergency services and care.
AB 1085 **Maienschein** **Status:** Vetoed	**Medi-Cal: housing support services** **Summary:** Existing law, subject to an appropriation, requires the department to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. Existing law requires that the analysis take into consideration specified information, including the number of providers in relation to each region's or county's number of people experiencing homelessness. Existing law requires the department to report the outcomes of the analysis to the Legislature by January 1, 2024. This bill would require the department, if the independent analysis finds that the state has sufficient network capacity to meet state and federal guidelines to create a new housing support services benefit, to seek any necessary federal approvals for a Medi-Cal benefit to cover housing support services within 6 months of the completion of the analysis. The bill would require the department to report the outcomes of the analysis to the Legislature by July 1, 2024. Under the bill, subject to receipt of those federal approvals, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness, as specified. Under the bill, the services would include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services, as defined. If the evaluation finds that the state has insufficient network capacity to meet state and federal guidelines to create a new housing support services benefit, the bill would require the department to provide recommendations for building capacity and the timeline for creating sufficient capacity consistent with the analysis findings.
AB 1122 **Bains**	**Medi-Cal provider applications**

Status: Two-Year Bill	**Summary:** Existing law generally requires an applicant that currently is not enrolled in the Medi-Cal program, a provider applying for continued enrollment, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location, as specified. Existing law requires an applicant or provider, for new or continued enrollment in the Medi-Cal program, to disclose all information as required in federal Medicaid regulations and any other information required by the department, as specified. This bill would require the Director of Health Care Services to develop a process to allow an applicant or provider to submit an alternative type of primary, authoritative source documentation to meet the requirement of submitting the above-described information. The bill would require the department to document each case of an applicant or provider submitting an alternative type of primary, authoritative source documentation, as specified. The bill would condition implementation of these provisions on lack of conflict with federal law or regulation, federal financial participation not being jeopardized, and receipt of any necessary federal approvals. Existing law authorizes the department to make unannounced visits to an applicant or provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. Existing law requires, at the time of the visit, the applicant or provider to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as specified. This bill would authorize the applicant or provider to submit its application for enrollment up to 30 days before having an established place of business and have its application considered by the department, to the extent not in conflict with federal law.
AB 1202 **Lackey** **Status:** Vetoed	**Medi-Cal: health care services data: children and pregnant or postpartum persons** **Summary:** This bill would require the department, no later than January 1, 2025, to prepare and submit a report to the Legislature that includes certain information, including an analysis of the adequacy of each Medi-Cal managed care plan's network for pediatric primary care, including the number and geographic distribution of providers and the plan's compliance with the above-described time or distance and appointment standards. Under the bill, the report would also include data, disaggregated as specified, on the number of children and pregnant or postpartum persons who are Medi-Cal beneficiaries receiving certain health care services during the 2021-22, 2022-23, and 2023-24 fiscal years. The report would also include additional information regarding the department's efforts to improve access to pediatric preventive care, as specified. The bill would require that the report be made publicly available through its posting on the department's internet website. The bill would repeal these reporting provisions on January 1, 2029.

AB 1230 **Valencia** **Status:** Two-Year Bill	**Medi-Cal and Medicare: dual eligible beneficiaries: special needs plans** **Summary:** This bill would require the department, commencing no later than January 1, 2025, to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), as defined, to provide care to dual eligible beneficiaries. The bill would require that a HIDE-SNP or FIDE-SNP contract authorize a beneficiary to select from a number of available options and to maintain their established or selected health care providers. The bill would also require a contracting plan to perform all applicable required care coordination and data-sharing functions, and to provide documentation demonstrating the care integration that dual eligible beneficiaries receive through a HIDE-SNP or FIDE-SNP contract.
AB 1241 **Weber** **Status:** Chaptered	**Telehealth** **Summary:** Under existing law, in-person, face-to-face contact is not required when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Existing law requires a provider furnishing services through video synchronous interaction or audio-only synchronous interaction, by a date set by the department, no sooner than January 1, 2024, to also either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care, as specified. This bill would instead require, under the above-described circumstance, a provider to maintain and follow protocols to either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care. The bill would specify that the referral and facilitation arrangement would not require a provider to schedule an appointment with a different provider on behalf of a patient.
AB 1316 **Irwin and Ward** **Status:** Two-Year Bill	**Emergency services: psychiatric emergency medical conditions** **Summary:** Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined. Existing law defines “psychiatric emergency medical condition,” for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Existing law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition. This bill would revise the definition of “psychiatric emergency medical condition” to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program.

	The bill would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, as defined, including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the beneficiary. The bill would require coverage, including by a Medi-Cal managed care plan, for emergency services necessary to relieve or eliminate a psychiatric emergency medical condition, regardless of duration, or whether the beneficiary is voluntary, or involuntarily detained for evaluation and treatment, including emergency room professional services.
AB 1331 **Wood** **Status:** Dead	**California Health and Human Services Data Exchange Framework** **Summary:** Existing law establishes the Center for Data Insights and Innovation within the California Health and Human Services Agency to ensure the enforcement of state law mandating the confidentiality of medical information. Existing law, subject to an appropriation in the annual Budget Act, requires the California Health and Human Services Agency to establish the California Health and Human Services Data Exchange Framework on or before July 1, 2022, to govern and require the exchange of health information among health care entities and government agencies. This bill would require the Center for Data Insights and Innovation to take over establishment, implementation, and all the functions related to the California Health and Human Services Data Exchange Framework on or before January 1, 2024, subject to an appropriation in the annual Budget Act. The bill would require the center to establish the CalHHS Data Exchange Board, with specified membership, to develop recommendations and to review, modify, and approve any modifications to the Data Exchange Framework data sharing agreement, among other things. The bill would require the center to submit an annual report to the Legislature that includes required signatory compliance with the data sharing agreement, assessment of consumer experiences with health information exchange, and evaluation of technical assistance and other grant programs. The bill would require the center, by July 1, 2024, to establish a process to designate qualified health information organizations according to specified criteria.
AB 1338 **Petrie-Norris** **Status:** Dead	**Medi-Cal: community supports** **Summary:** Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services. This bill would add fitness, physical activity, or recreational sports programs, activities, or memberships to the above-described list of community supports.
AB 1437 **Irwin and Quirk-Silva**	**Medi-Cal: serious mental illness** **Summary:** Existing law sets forth a schedule of benefits under the Medi-Cal program, including specialty and nonspecialty mental health services through

Status: Vetoed	different delivery systems, in certain cases subject to utilization controls, such as prior authorization. Under existing law, prior authorization is approval of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Existing law sets forth various provisions relating to processing, or appealing the decision of, treatment authorization requests, and provisions relating to certain services requiring or not requiring a treatment authorization request. After a determination of cost benefit, existing law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs, as specified. Under this bill, a prescription refill for a drug for serious mental illness would automatically be approved for a period of 365 days after the initial prescription is dispensed. The bill would condition the above-described provisions on the prescription being for a person 18 years of age or over, and on the person not being within the transition jurisdiction of the juvenile court, as specified.
AB 1451 **Jackson** **Status:** Vetoed	**Urgent and emergency mental health and substance use disorder treatment** **Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of urgent and emergency mental health and substance use disorders. The bill would require the treatment to be provided without preauthorization, and to be reimbursed in a timely manner, pursuant to specified provisions. The bill's provisions would only be implemented upon appropriation by the Legislature for administrative costs of the departments. The bill would clarify that it would not relieve a health plan or insurer of existing obligations, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 1470 **Quirk-Silva** **Status:** Dead	**Medi-Cal: behavioral health services: documentation standards** **Summary:** The bill, as part of CalAIM, and with respect to behavioral health services provided under the Medi-Cal program, would require the department to standardize data elements relating to documentation requirements, including, but not limited to, medically necessary criteria, and would require the department to develop standard forms containing information necessary to properly adjudicate claims pursuant to CalAIM Terms and Conditions. The bill would require the department to consult with representatives of specified associations and programs for purposes of implementing these provisions. The bill would require the department to conduct, on or before July 1, 2025, regional trainings for personnel and provider networks of applicable entities, including county mental health plans, Medi-Cal managed care plans, and entities within the fee-for-service delivery system, on proper completion of the standard forms. The bill would require each applicable entity to distribute the training material and standard forms to its provider networks, and to commence, no later than July 1, 2025, using the standard forms. The bill would require providers of applicable

	entities to use those forms, as specified. The bill would authorize the department to restrict the imposition of additional documentation requirements beyond those included on standard forms, as specified. The bill would require the department to conduct an analysis on the status of utilization of the standard forms by applicable entities, and on the status of the trainings and training material, in order to determine the effectiveness of implementation of the above-described provisions. The bill would require the department to prepare a report containing findings from the analysis no later than July 1, 2026, and a followup report no later than July 1, 2028, and to submit each report to the Legislature and post it on the department's internet website.
AB 1481 **Boerner and Bauer-Kahan** **Status:** Chaptered	**Medi-Cal: presumptive eligibility** **Summary:** This bill would expand presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). For a pregnant person covered under PE4PP who applies for full-scope Medi-Cal benefits, if the application is submitted at any time from the date of their presumptive eligibility determination through the last day of the subsequent calendar month, the bill would require the department to ensure the pregnant person is covered under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified. The bill would require the department to require providers participating in the PE4PP program to provide information to pregnant persons enrolled in PE4PP on how to contact the person's county to expedite the county's determination of a Medi-Cal application. The bill would make conforming changes to related provisions. Because counties are required to make eligibility determinations, and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.
AB 1549 **Carrillo** **Status:** Dead	**Medi-Cal: federally qualified health centers and rural health clinics** **Summary:** Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. This bill would, among other things, require that per-visit rate to account for the costs of the FQHC or RHC that are reasonable and related to the provision of covered services, including the specific staffing and care delivery models used by the FQHC and RHC to deliver those services. The bill would also require the rate for any newly qualified health center to include the cost of care coordination services provided by the health center, as specified.
AB 1608 **Patterson** **Status:** Two-Year Bill	**Medi-Cal: managed care plans** **Summary:** The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Pursuant to that law, the department contracts with regional centers to provide services and supports to persons with developmental disabilities. The act requires regional centers to pursue all possible sources of funding for consumers receiving regional center services, including, among others, Medi-Cal. Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid

	code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment. This bill would additionally exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage.
AB 1644 **Bonta** **Status:** Dead	**Medi-Cal: medically supportive food and nutrition services** **Summary:** This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the department. The bill would require medically supportive food and nutrition interventions to be covered when determined to be medically necessary by a health care provider or health care plan, as specified. In order to qualify for coverage under the Medi-Cal program, the bill would require a patient to be offered at least 3 of 6 specified medically supportive food and nutrition interventions and for the interventions to be provided for a minimum duration of 12 weeks, as specified. The bill would only provide coverage for nutrition support interventions when paired with the provision of food through one of the 3 offered interventions. The bill would require a health care provider to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention and include culturally appropriate foods whenever possible. The bill would establish a medically supportive food and nutrition benefit advisory workgroup to advise the department in developing final guidance related to eligible populations, the duration and dosage of medically supportive food and nutrition interventions, the ratesetting process, determination of permitted providers, and continuing education for health care providers, as specified. The bill would require the workgroup to include certain stakeholders knowledgeable in medically supportive food and nutrition interventions and stakeholders from Medi-Cal consumer advocacy organizations. The bill would require the workgroup to meet at least quarterly and would require the department to issue final guidance on or before July 1, 2026. The bill would also include findings and declarations of the Legislature relating to the need for medically supportive food and nutrition intervention coverage under the Medi-Cal program.
AB 1690 **Kalra** **Status:** Two-Year Bill	**Universal health care coverage** **Summary:** This bill would state the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.
AB 1698 **Wood** **Status:** Two-Year Bill	**Medi-Cal** **Summary:** This bill would make specified findings and would express the intent of the Legislature to enact future legislation relating to Medi-Cal.
Senate Bills	
SB 43 **Eggman**	**Behavioral health**

Status: Chaptered	**Summary:** This bill expands the definition of "gravely disabled" to also include a condition in which a person, as a result of a severe substance use disorder, or a co-occurring mental health disorder and a severe substance use disorder, is, in addition to the basic personal needs described above, unable to provide for their personal safety or necessary medical care, as defined. The bill would also expand the definition of "gravely disabled," as it applies to specified sections, to include, in addition to the basic needs described above, the inability for a person to provide for their personal safety or necessary medical care as a result of chronic alcoholism. The bill would authorize counties to defer implementation of these provisions to January 1, 2026, as specified. The bill would make conforming changes. To the extent that this change increases the level of service required of county mental health departments, the bill would impose a state-mandated local program. Under this bill, for purposes of an opinion offered by an expert witness in any proceeding relating to the appointment or reappointment of a conservator pursuant to the above-described provisions, the statements of specified health practitioners or a licensed clinical social worker included in the medical record would not be made inadmissible by the hearsay rule under specified conditions. The bill would authorize the court to grant a reasonable continuance if an expert witness in a proceeding relied on the medical record and the medical record has not been provided to the parties or their counsel. This bill would, beginning with the report due May 1, 2024, require the report to also include the number of persons admitted or detained, as specified, for conditions that include, among others, grave disability due to a mental health disorder, severe substance use disorder, or both a mental health disorder and a severe substance use disorder.
SB 238 **Wiener** **Status:** Dead	**Health care coverage: independent medical review** **Summary:** Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may

	cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. The bill would authorize the Insurance Commissioner to promulgate regulations subject to the Administrative Procedure Act to implement and enforce the bill, and to issue interim guidance, as specified.
SB 324 **Limón** **Status:** Dead	**Health care coverage: endometriosis** **Summary:** This bill would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2024, from requiring prior authorization or other utilization review for any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would add any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines, as a covered benefit under Medi-Cal without prior authorization or other utilization review.
SB 326 **Eggman** **Status:** Chaptered	**The Behavioral Health Services Act** **Summary:** If approved by the voters at the March 5, 2024, statewide primary election, this bill would recast the MHSA by, among other things, renaming it the Behavioral Health Services Act (BHSA), expanding it to include treatment of substance use disorders, changing the county planning process, and expanding services for which counties and the state can use funds. The bill would revise the distribution of MHSA moneys, including allocating up to $36,000,000 to the department for behavioral health workforce funding. The bill would authorize the department to require a county to implement specific evidence-based practices. This bill would require a county, for behavioral health services eligible for reimbursement pursuant to the federal Social Security Act, to submit the claims for reimbursement to the State Department of Health Care Services (the department) under specific circumstances. The bill would require counties to pursue reimbursement through various channels and would authorize the counties to report issues with managed care plans and insurers to the Department of Managed Health Care or the Department of Insurance. The MHSA establishes the Mental Health Services Oversight and Accountability Commission and requires it to adopt regulations for programs and expenditures for innovative programs and prevention and early intervention programs established by the act. Existing law requires counties to develop plans for innovative programs funded under the MHSA.

	This bill would rename the commission the Behavioral Health Services Oversight and Accountability Commission and would change the composition and duties of the commission, as specified. The bill would delete the provisions relating to innovative programs and instead would require the counties to establish and administer a program to provide housing interventions. The bill would provide that "low rent housing project," as defined, does not apply to a project that meets specified criteria. This bill would make extensive technical and conforming changes. (2) Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law further provides that, to the extent resources are available, community mental health services should be organized to provide an array of treatment options in specified areas, including, among others, case management and individual service plans. Under existing law, mental health services are provided through contracts with county mental health programs. The bill would authorize the State Department of Health Care Services to develop and revise documentation standards for individual service plans, as specified. The bill would revise the contracting process, including authorizing the department to temporarily withhold funds or impose monetary sanctions on a county behavioral health department that is not in compliance with the contract. (3) The bill would provide that its provisions are severable. (4) The bill would provide for the submission of specified sections of this bill and AB 531 to the voters at the March 5, 2024, statewide primary election, as specified. (5) This bill would declare that it is to take effect immediately as an urgency statute.
SB 411 **Portantino** **Status:** Chaptered	**Open meetings: teleconferences: neighborhood councils** **Summary:** Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body.

	This bill, until January 1, 2028, would authorize an eligible legislative body to use alternate teleconferencing provisions related to notice, agenda, and public participation, as prescribed, if the city council has adopted an authorizing resolution and $^{2}/_{3}$ of an eligible legislative body votes to use the alternate teleconferencing provisions. The bill would define "eligible legislative body" for this purpose to mean a neighborhood council that is an advisory body with the purpose to promote more citizen participation in government and make government more responsive to local needs that is established pursuant to the charter of a city with a population of more than 3,000,000 people that is subject to the act. The bill would require an eligible legislative body authorized under the bill to provide publicly accessible physical locations for public participation, as prescribed. The bill would also require that at least a quorum of the members of the neighborhood council participate from locations within the boundaries of the city in which the neighborhood council is established.
SB 496 **Limón** **Status:** Chaptered	**Biomarker testing** **Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2024, to provide coverage for medically necessary biomarker testing, as prescribed, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition to guide treatment decisions, as prescribed. The bill would specify that it does not require a health care service plan or health insurer to cover biomarker testing for screening purposes unless otherwise required by law. The bill would subject restricted or denied use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of a medical condition to state and federal grievance and appeal processes. This bill, by July 1, 2024, would expand the Medi-Cal schedule of benefits to include biomarker testing, as prescribed, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Medi-Cal beneficiary's disease or condition to guide treatment decisions, as prescribed.
SB 502 **Allen** **Status:** Chaptered	**Medi-Cal: children: mobile optometric office** **Summary:** This bill would require the department to file all necessary state plan amendments to exercise the HSI option made available under CHIP provisions to cover vision services provided to low-income children statewide through a mobile optometric office, as specified. The bill would require implementation of these provisions by January 1, 2025, or the date that any necessary federal approvals have been obtained, whichever date is later. Existing law prohibits the owner and operator of a mobile optometric office and the optometrist providing services from accepting payment for services other than those provided to Medi-Cal beneficiaries. This bill would authorize acceptance of payment for those services provided through any of the state's programs under CHIP, in addition to the Medi-Cal program.
SB 516 **Skinner**	**Health care coverage: prior authorization**

Status: Two-Year Bill	**Summary:** On or after January 1, 2026, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
SB 525 **Durazo** **Status:** Chaptered	**Minimum wage: health care workers** **Summary:** This bill would establish 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer. This bill would require, for any covered health care facility employer, as defined, with 10,000 or more full-time equivalent employees (FTEE), as defined, any covered health care facility employer that is a part of an integrated health care delivery system or a health care system with 10,000 or more FTEEs, a covered health care facility employer that is a dialysis clinic or is a person that owns, controls, or operates a dialysis clinic, or a covered health facility owned, affiliated, or operated by a county with a population of more than 5,000,000 as of January 1, 2023, the minimum wage for covered health care employees to be $23 per hour from June 1, 2024, to May 31, 2025, inclusive, $24 per hour from June 1, 2025, to May 31, 2026, inclusive, and $25 per hour from June 1, 2026, and until as adjusted as specified. This bill would require, for any hospital that is a hospital with a high governmental payor mix, an independent hospital with an elevated governmental payor mix, a rural independent covered health care facility, or a covered health care facility that is owned, affiliated, or operated by a county with a population of less than 250,000 as of January 1, 2023, as those terms are defined, the minimum wage for covered health care employees to be $18 per hour from June 1, 2024, to May 31, 2033, inclusive, and $25 per hour from June 1, 2033, and until as adjusted as specified.

	This bill would require, for specified clinics that meet certain requirements, the minimum wage for covered health care employees to be $21 per hour from June 1, 2024, to May 31, 2026, inclusive, and $22 per hour from June 1, 2026, to May 31, 2027, inclusive, and $25 from June 1, 2027, and until as adjusted as specified. This bill would require, for all other covered health care facility employers, the minimum wage for covered health care employees to be $21 per hour from June 1, 2024, to May 31, 2026, inclusive, $23 per hour from June 1, 2026, to May 31, 2028, inclusive, and $25 per hour from June 1, 2028, and until as adjusted as specified. This bill would provide that a covered health care facility that is county owned, affiliated, or operated must implement the appropriate minimum wage schedule described above, as applicable, beginning January 1, 2025. This bill would also separately require, for a licensed skilled nursing facility, as described, the minimum wage for certain other covered health care employees, as described, to be $21 per hour from June 1, 2024, to May 31, 2026, inclusive, $23 per hour from June 1, 2026, to May 31, 2028, inclusive, and $25 per hour from June 1, 2028, and until as adjusted as specified. The bill would make this minimum wage requirement effective only when a patient care minimum spending requirement applicable to skilled nursing facilities is in effect. This bill would provide that the health care worker minimum wages constitute the state minimum wage for covered health care employment for all purposes under the Labor Code and the Wage Orders of the Industrial Welfare Commission. The bill would provide that a health care worker minimum wage is enforceable by the Labor Commissioner or by a covered worker through a civil action, through the same means and with the same relief available for violation of any other state minimum wage requirement. By establishing new minimum wages, the violation of which would be a crime, the bill would impose a state-mandated local program. This bill would require, for covered health care employment where the employee is paid on a salary basis, that the employee earn a monthly salary equivalent to no less than 150% of the health care worker minimum wage or 200% of the applicable minimum wage, whichever is greater, for full-time employment in order to qualify as exempt from the payment of minimum wage and overtime. This bill would require the Department of Health Care Access and Information to publish, on or before January 31, 2024, and on the department's internet website, specified information, including a list of hospitals that qualify under certain classifications. The bill would provide, until January 31, 2025, a process for hospitals excluded from that list to request classification. This bill would authorize, until January 1, 2025, the adoption of any necessary rules and regulations for purposes of implementing certain provisions of the bill as emergency regulations in accordance with the Administrative Procedure Act and would deem the adoption of those emergency regulations an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The bill would require the Department of Health Care Access and

	Information to consider input from specified stakeholders when adopting those rules and regulations, as specified. This bill would, by March 1, 2024, require the Department of Industrial Relations, in collaboration with the State Department of Health Care Services and the Department of Health Care Access and Information, to develop a waiver program that would allow a covered health care facility, as defined, to apply for and receive a temporary pause or alternative phase in schedule of the minimum wage requirements described above. In order to obtain a waiver, the bill would require a covered health care facility to demonstrate that compliance with the minimum wage requirements would raise doubts about the covered health care facility's ability to continue as a going concern under generally accepted accounting principles, as specified. The bill would provide that issuance of the terms of the pause or alternative phase in schedule is solely and exclusively within the authority of the Department of Industrial Relations, and the authority regarding whether the covered health care facility demonstrates the inability to continue as a going concern pursuant is solely and exclusively within the authority of the State Department of Health Care Services. This bill would prohibit any ordinance, regulations, or administrative action that is applicable to a covered health care facility and that establishes, requires, imposes, limits, or otherwise relates to wages or compensation for covered health care facility employees from being enacted or enforced in or by any city, county, or city and county, except as provided. This bill would also make its provisions severable. This bill would make legislative findings and declarations as to the necessity of a special statute for health care workers. The bill would include findings that changes proposed by this bill address a matter of statewide concern rather than a municipal affair and, therefore, apply to all cities, including charter cities. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.
SB 535 **Nguyen** **Status:** Two-Year Bill	**Knox-Keene Health Care Service Plan Act of 1975** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Among other provisions, existing law requires a health care service plan to meet specified requirements, including, but not limited to, furnishing services in a manner providing continuity of care, ready referral of patients to other providers at appropriate times, and making services readily accessible to all enrollees, as specified. This bill would make technical, nonsubstantive changes to those provisions.

SB 537 **Becker** **Status:** Inactive	**Open meetings: multijurisdictional, cross-county agencies: teleconferences** **Summary:** Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. These circumstances include if a member shows "just cause," including for a childcare or caregiving need of a relative that requires the member to participate remotely. This bill would expand the circumstances of "just cause" to apply to the situation in which an immunocompromised child, parent, grandparent, or other specified relative requires the member to participate remotely. The bill would authorize the legislative body of a multijurisdictional, cross-county agency, as specified, to use alternate teleconferencing provisions if the eligible legislative body has adopted an authorizing resolution, as specified. The bill would also require the legislative body to provide a record of attendance and the number of public comments on its internet website within 7 days after a teleconference meeting, as specified. The bill would require at least a quorum of members of the legislative body to participate from one or more physical locations that are open to the public and within the boundaries of the territory over which the local agency exercises jurisdiction. The bill would require a member who receives compensation for their service, as specified, on the legislative body to participate from a physical location that is open to the public. The bill would require the legislative body to identify in the agenda each member who plans to participate remotely and to include the address of the publicly accessible building from which each member will participate via teleconference. The bill would prohibit a member from participating remotely pursuant to these provisions unless the remote location is the member's office or another location in a publicly accessible building and is more than 40 miles from the in-person location of the meeting. The bill would repeal these alternative teleconferencing provisions on January 1, 2026.
SB 598 **Skinner** **Status:** Dead	**Health care coverage: prior authorization** **Summary:** On or after January 1, 2026, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful

	violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.
SB 635 **Menjivar and Portantino** **Status:** Vetoed In Senate. Consideration of Governor's veto pending.	**Health care coverage: hearing aids** **Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for hearing aids for enrollees and insureds under 21 years of age, if medically necessary. The bill would limit the maximum required coverage amount to $3,000 per individual hearing aid, as specified. Because a willful violation of the bill's requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program.
SB 694 **Eggman** **Status:** Vetoed In Senate. Consideration of Governor's veto pending.	**Medi-Cal: self-measured blood pressure devices and services** **Summary:** This bill would make self-measured blood pressure (SMBP) devices and SMBP services, as defined, covered benefits under the Medi-Cal program subject to utilization controls. The bill would state the intent of the Legislature that those covered devices and services be no less in scope than the devices and services that are recognized under specified existing billing codes or their successors. The bill would condition implementation of that coverage on receipt of any necessary federal approvals and the availability of federal financial participation.
SB 770 **Wiener and McGuire** **Status:** Chaptered	**Health care: unified health care financing** **Summary:** This bill would direct the Secretary of the California Health and Human Services Agency to pursue waiver discussions with the federal government with the objective of a unified health care financing system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments. The bill would further require the secretary to establish a Waiver Development Workgroup comprised of members appointed by the Governor, Speaker of the Assembly, and President Pro Tempore of the Senate, as specified. The bill would require the workgroup to include stakeholders representing various specified interests, including consumers, patients, health care professionals, labor unions, government agencies, and philanthropic organizations. The bill would require the secretary to provide quarterly reports to the chairs of the Assembly and Senate Health Committees on the status and outcomes of waiver discussions with the federal government and the progress of the workgroup. The bill would also require the secretary to submit a complete set of recommendations regarding the elements to be included in a formal waiver application, as specified, by no later than June 1, 2024. The bill would also include findings and declarations of the Legislature related to the implementation of a unified health care financing system.
SB 779 **Stern** **Status:** Chaptered	**Primary Care Clinic Data Modernization Act** **Summary:** Commencing January 1, 2027, this bill would repeal and recast these reporting requirements, including, but not limited to, extending their application to intermittent clinics operated by licensed clinics. The bill would establish specific reporting requirements for specialty clinics, as defined. The bill would require an organization that operates, conducts, owns, or maintains a primary care clinic or

	intermittent clinic, and its officers, to file specified reports with the Department of Health Care Access and Information for every primary care clinic and every intermittent clinic that it operates, conducts, owns, or maintains, on or before the 15th day of February each year, including, but not limited to, a report of all mergers and acquisitions, a detailed labor report, and a report of quality and equity measures. The bill would require the department to adopt regulations necessary to implement these reporting requirements and to require the first annual reports to be submitted on or before February 15, 2028, using information relating to the calendar year beginning January 1, 2027.
SB 805 **Portantino** **Status:** Chaptered	**Health care coverage: pervasive developmental disorders or autism** **Summary:** This bill would expand the criteria for a qualified autism service professional to include a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as specified. The bill would require those positions to meet the criteria for a Behavioral Health Professional, as provided. This bill would require the department to adopt regulations, on or before July 1, 2026, to address the use of Behavioral Health Professionals and Behavioral Health Paraprofessionals in behavioral health treatment group practice. The bill would require the department to establish rates and the educational or experiential qualifications and professional supervision requirements necessary for these positions to provide behavioral intervention services, as specified.
SB 819 **Eggman** **Status:** Inactive	**Medi-Cal: certification** **Summary:** Existing law requires the State Department of Public Health to license and regulate clinics. Existing law exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Existing law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week. Existing law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under existing law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures. Under existing law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units. This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.

	The bill would make legislative findings stating that this bill is declaratory of existing law, as specified.
SB 870 **Caballero** **Status:** Two-Year Bill	**Medi-Cal: managed care organization provider tax** **Summary:** Existing law, inoperative on January 1, 2023, and to be repealed on January 1, 2024, imposed a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Those provisions set forth taxing tiers and corresponding per enrollee tax amounts for the 2019–20, 2020–21, and 2021–22, fiscal years, and the first 6 months of the 2022–23 fiscal year. Under those provisions, all revenues, less refunds, derived from the tax were deposited into the State Treasury to the credit of the Health Care Services Special Fund, and continuously appropriated to the department for purposes of funding the nonfederal share of Medi-Cal managed care rates, as specified. Those inoperative provisions authorized the department, subject to certain conditions, to modify or make adjustments to any methodology, tax amount, taxing tier, or other provision relating to the MCO provider tax to the extent the department deemed necessary to meet federal requirements, to obtain or maintain federal approval, or to ensure federal financial participation was available or was not otherwise jeopardized. Those provisions required the department to request approval from the federal Centers for Medicare and Medicaid Services (CMS) as was necessary to implement those provisions. In April 2020, CMS approved a modified tax structure that the department had submitted as part of a waiver request, involving taxing tiers that were based on cumulative Medi-Cal or other member months for certain fiscal years. This bill would extend the above-described MCO provider tax to an unspecified date and would make conforming changes to the timeline of related provisions by incorporating other unspecified dates. The bill would reorganize the taxing tiers of the MCO provider tax, in a manner consistent with the above-described modified tax structure under the previous waiver, but with unspecified tax rate amounts. By extending the authority to fund the nonfederal share of Medi-Cal managed care rates from the continuously appropriated fund, the bill would make an appropriation. This bill would make these provisions inoperative on an unspecified date, and would repeal the provisions as of an unspecified date. This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $^{2}/_{3}$ of the membership of each house of the Legislature.

DATE: December 6, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Alliance Donations and Sponsorship of Events and Organizations 2023 Annual Report

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Recommendation. Staff recommend the Board accept the Alliance Donations and Sponsorship of Events and Organizations Annual Report for 2023.

Summary. On an annual basis all donation and sponsorship activities are reported to the Board to assure compliance and consistency with the criteria set forth in the Alliance Donations and Sponsorship of Events and Organizations Policy.

Background. On September 22, 2021 the Board approved the Alliance Donations and Sponsorship of Event and Organizations Policy to provide guidelines to promote and implement opportunities for donations to non-profit 501(c)(3) community organizations and sponsorship of such organizations' events within the Alliance's service area.

Listed below are donation and sponsorship activities for 2023.

Organization	Request Type		County and $ Amount
Insured the Unsured Project (ITUP)	Event Sponsorship	Annual conference where the California health policy community gathers each year to look towards the future of equitable health in California.	Santa Cruz | $1,667 Monterey | $1,667 Merced | $1,667
The Parenting Connection of Monterey County	Event Sponsorship	Provides parent education and maternal mental health support from pregnancy to age five.	Monterey | $1,000
Mariposa Butterfly Festival	Event Sponsorship	An iconic parade through historic, downtown Mariposa delivering a warm welcome to eventgoers and a great opportunity for our community to share what we love most about our town.	Mariposa | $500
Raices y Carino, a program of the 418 Project	Event Sponsorship	Supports families with children to connect and access support in their community.	Santa Cruz | $2,000
Bright Beginnings Monterey County. (fiscally sponsored by First 5 Monterey County)	Event Sponsorship	A series of events and activities culminating in national MMH awareness week.	Monterey | $2,000
County Park Friends	Event Sponsorship	Wheelin' Basketball Youth Camp.	Santa Cruz | $2,000
Adverse Childhood Experiences (ACE Overcomers)	Event Sponsorship	Creating a better world for our children, families, and communities.	Merced | $1,000

Golden Valley Health Centers	Event Sponsorship	Celebrates National Health Center Week.	Merced | $1,000
Merced Lao Family	Event Sponsorship	Hmong New Year Program.	Merced | $2,000
Coalition of Homeless Services Providers	Event Sponsorship	All-day conference with the objective of creating concrete solutions to end homelessness in our counties.	Monterey | $1,000
Health Projects Center	Event Sponsorship	Caregiver University Conference.	Santa Cruz | $1,000 Merced | $1,000 San Benito | $500
Diversity Center of Santa Cruz County	Event Sponsorship	Inspire and support LGBTQ+ people.	Santa Cruz | $2,500
Community FoodBank of San Benito	Event Sponsorship	Allow families to gather information on their new Medi-Cal provider.	San Benito | $1,500
Mariposa Heritage House	Event Sponsorship	Drop-in recovery support center where people can gain access to essential resources and supports that promote long-term recovery.	Mariposa | $1,000
Pajaro Valley Pride	Event Sponsorship	Support, uplift, educate, and create safe spaces for LGBTQI2S+ people of color in Watsonville and the central coast.	Santa Cruz | $1,500
United Way of Merced County	Event Sponsorship	Fight for the health, education, and financial stability of all Merced County residents.	Merced | $500

Fiscal Impact. The Chief Executive Officer proposes a budget to be included in the annual Alliance administrative budget proposal acted on by the Alliance's Board. The budget is adequate to provide sponsorships and/or donations aligned with the policy in each of the counties in which the Alliance operates. Sponsorships and donations may only be awarded to the extent funds budgeted for such donations/sponsorships are available and there is no guarantee of Alliance sponsorships or donations.

Attachments. N/A

DATE: December 6, 2023

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

FROM: Andrea Swan, Quality Improvement and Population Health Director

SUBJECT: Quality Improvement Health Equity Transformation Workplan – Q2 2023

Recommendation. Staff recommend the Board accept the Q2 2023 Quality Improvement Health Equity Transformation (QIHET) Workplan report.

Summary. This report provides pertinent highlights, trends, and activities from the Q2 2023 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-San Benito-Mariposa 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 the Quality Improvement and Health Equity Workgroup.

The 2023 QIHET Workplan was developed to align with the Alliance Strategic Plan of Member Wellness, Access to Care, and Promotion of Value. This is accomplished through the following initiatives:

Section I: Member Experience	**Status**
A. Member Experience	
1. Health Care Collaboratives	**Goal Not Met**
2. Health Services Division Member Outreach & Engagement Campaigns	**In Progress**
3. Member Support – Call Center	**Goal Met**
4. Cultural and Linguistics (C&L) Services & Population Needs Assessment Education	**In Progress**
5. CAHPS: How Well Doctors Communicate	**In Progress**
Section II: Quality of Service	
B. Access and Availability	
1. Annual Access Plan	**In Progress**
2. Provider Choice: In-Area Market Share	**In Progress**
3. CAHPS Survey: Access Measures	**In Progress**
C. Provider Experience	
1. Provider Satisfaction	**Goal Met**
Section III: Quality of Clinical Care	
D. Utilization	

1. Under / Overutilization	**Goal Met**
2. Site of Care	**In Progress**
3. Drug Utilization Review (DUR)	**In Progress**
E. Adult Preventive Care Services	
1. Health Education and Disease Management	**In Progress**
2. Controlling Blood Pressure	**In Progress**
3. Diabetes HbA1c >9% (poor control)	**Goal Met**
F. Performance Improvement Projects (State Mandated)	
1. Women's Health Domain SWOT	**In Progress**
2. Children's Domain SWOT	**Goal Partially Met**
3. Childhood Immunizations	**Goal Met**
4. Child and Adolescent Well Care Visits in Merced County	**Goal Met**
5. Well-Child Visits in the First 30 Months of Life; Well-Child Visits in the first 15 Months – Six or More Well Child Visits W 30 – 6 Measure	**In Progress**
6. Follow-Up After Emergency Department Visits for Mental Illness – 30 Day Follow-Up; Total and Follow-Up after Emergency Department Visit for Substance Use; 30-day Follow-Up - Total	**In Progress**
G. Behavioral Health	
1. Eating Disorders	**Goal Partially Met**
Section IV: Clinical Safety	
H. Clinical Safety	
1. Grievance and PQI Management	**Goal Partially Met**
2. Facility Site Review (FSR) Management	**Goal Partially Met**

Discussion.

2023 QIHET Workplan Outcomes and Evaluation

Member Experience:

- Health Care Collaboratives. Metric is on hold now and currently reassessing member input from these collaborative meetings. These meetings are with Community Based Organizations (CBOs) and do not get much member input from these meetings.
- Health Services Division Member Outreach and Engagement Campaigns. During Q2 2023 the Alliance Quality and Health Programs team completed 120 Member Outreach calls for the Department of Health Care Services (DHCS) strengths, weaknesses, opportunities, and threats (SWOT) for pediatric measures. Health Educators called members that were due for well-child visits in Merced County. Out of 120 calls a total of 95 were successful; this resulted in 79% success rate for Q2.
- Member Support – Call Center. During Q2 2023 the Alliance Member Services' Call Center focused on sharing redetermination information with members and ensuring that their mailing address is up updated.
- Cultural and Linguistics Services & Population Needs Assessment Education. In Q2 2023 there was a 48.4% total increase compared to Q2 2022 of providers utilizing face-to-face (in-person) interpreting services. County specific data was as follows:
    - Merced County had 470% increase in Q2 2023 compared to Q2 2022
    - Santa Cruz County had 7% decrease in Q2 2023 compared to Q2 2022

    - Monterey County had 37% increase in Q2 2023 compared to Q2 2022
- Consumer Assessment of Healthcare Providers and Systems (CAHPS): How Well Doctors Communicate. Sample Frames for the 2023 Adult and Child CG CAHPS survey were submitted to the vendor in March. Field surveys are anticipated to begin in April.

Quality of Service

Access and Availability:

- Annual Access Plan. Working with the Network Development Steering Committee (NDSC) attendees to develop criteria to assist in ensuring appropriate prioritization of access areas.
- Provider Choice: In-Area Market Share. St. Michael Nephrology agreed to contract with the Alliance in the San Luis Obispo (SLO) area. Additionally, a new psychiatrist in SLO also agreed to contract. Both providers have historically declined to contract with the Alliance.
- CAHPS Survey: Access Measures. Sample Frames for the 2023 Adult and Child CG CAHPS survey were submitted to the vendor in March. Field surveys anticipated to begin in April.

Provider Experience:

- Provider Satisfaction. Results final, presented to National Development Steering Committee and Continuous Quality Improvement Workgroup in December. Overall Provider Satisfaction for 2022 was 87%.

Quality of Clinical Care

Utilization:

- Under/Overutilization. Report finalized in Q1 and metrics updated for Utilization Management Work Plan quarterly reporting. Continued development of depression screening metrics underway for Q2 2023. Increases noted across the Quality Improvement (QI) metrics of under/utilization focus with decreased utilization in area of monitoring for potential over utilization (EMG). Continue to monitor for trends and opportunities for further intervention.
- Site of Care. We focused on completing the Site of Care transition for the members who were identified in Q1. We also chose a new target drug, ocrelizumab (Ocrevus) and identified 13 members who were eligible for our Site of Care program. We conducted outreach to all 13 members on ocrelizumab. Of these 13 members, two have accepted the program (15% member acceptance rate). The two members who have accepted the program are pending provider decision. We have completed training for this program for all pharmacy technicians and two out of the three pharmacists.
- Drug Utilization Review (DUR). DUR was performed to identify members at increased risk for serious harms related to opioid therapy, based on Morphine Milligram Equivalent (MME) of their opioid's total daily dose. Out of 23,266 members with at least one opioid prescription during 2022, only 0.5% members were found to be at highest risk due to the high dosage of ≥ 100 MME. An educational article on opioid tapering was published in the Provider Digest, and a letter was faxed to eight providers that have two or more members on high MME (90 or above). DUR was performed on members who were less than or equal to 18 years of age with a diagnosis of bipolar disorder and a prescription for

a mood stabilizer medication. In 2022, 213 pediatric members with bipolar disorder were on a mood stabilizer, and there were more female members (138) on mood stabilizers than male members (75). We analyzed members who were on three or more mood stabilizers without seeing a provider board certified in psychiatry, and the investigation concluded that there were no prescribing concerns. Statin utilization was reviewed for Alliance members with Type 2 diabetes age 40 through 75. In 2022, about 63% of members received statins, whereas 37% did not. To increase statin utilization in members with Type 2 diabetes, a fax blast was sent to all providers with reminders of most recent American Diabetes Association guidelines. An educational article will be published in the Provider Bulletin with tips on how to manage statin related muscle pain in addition to ADA guideline recommendations. Statin utilization was reviewed for Alliance members with cardiovascular diseases age 20 through 75. In 2022, about 62% of members with cardiovascular disease received statins, whereas 38% did not. To increase statin utilization members with cardiovascular disease, an article will be published in Member News regarding the importance of taking statins and how to manage the most common statin related side effect of muscle pain.

Adult Preventive Care Services:

- Health Education and Disease Management. In Q2 the Quality and Health Programs team completed two Healthier Living Program workshops series. The workshops were offered in virtual and in-person modalities. One workshop series was offered in English and one workshop series was offered in Spanish.
- Controlling Blood Pressure (BP). Project placed on hold until June while continuing to track BP recheck rates monthly.
- Diabetes HbA1c >9% (poor control). Conducted clinic outreach to identify clinics interested in program participation. Developed/modified program content to meet clinic requests. Met with clinics to plan the sessions. Generated registry list of members to track A1C and follow-up visits throughout the program.

Performance Improvement Projects (State Mandated):

- Women's Health Domain SWOT. Golden Valley Health Center Merced has agreed to partner on improving breast cancer screenings (BCS) in collaboration with their Care-Based Quality Improvement Project application. QIPH is continuing outreach for another clinic to partner on BCS. QIPH will provide practice coaching, best practice information and a member recall list for clinics to outreach to members. Apex Medical Group has agreed to partner on chlamydia screenings. Merced Faculty Associates - North is requesting their leadership's approval to partner on chlamydia screenings. QIPH will provide practice coaching, best practice information and a member recall list for clinics to outreach to members. Member letters drafted and U.S. Preventive Services Task Force flyer decided as the outreach flyer for black members for BCS mailer. For Q2 QIPH provided best practices information and slide presentations for Golden Valley Health Center and Merced Faculty Associates to get leadership approval to participate in SWOTs. Golden Valley Health Center is working with their operations team to create a team to work on the BCS SWOT. QIPH met with Apex to address questions on the project and provided best practice information.
- Children's Domain SWOT. Health Services Advisory Group's (HSAG's) final validation findings on the CIS performance improvement plan (PIP) was received on June 12, 2023 and no further submissions were required. Project completed.

- Childhood Immunizations.
    - 1) SWOT 1 Actions A-C: QIPH staff made outreach calls to Merced County members deficient* (or at risk of becoming ineligible) for W15 and CIS-10 immunizations to assess for trends in barriers to receiving care, and to connect member to primary care providers (PCPs) for appointments. Outreach completed April 10, 2023 and summary of results presented at the May 8, 2023 and July 31, 2023 Pediatric Equity Task Force committee meeting. Next steps:
        - Share barrier data with PR team then PCPs that participated.
        - Encourage PCPs to perform member recall for W15 & CIS-10.

    - 2) SWOT 2 Action A: Staff are coordinating the promotion of the Infant Wellness Map (IWM) to Merced County CBOs and clinics that serve the target population to partner in disseminating the tool to parents to help them track WCVs and immunizations 0-15 months of life. In Q2, staff provided 200 copies (100 English, 75 Spanish, 25 Hmong) of the IWM to the Merced Office of Education - Head Start Program to give to new members of their program. Staff are meeting with the Provider Relations team to discuss which clinics in Merced may benefit from targeted outreach.

    - SWOT 2 Action B: Merced Pediatrician engaged in hosting a webinar focused on pediatric measures for Merced County providers. Staff are drafting webinar content in collaboration with MD and preparing various internal and external communications to promote webinar, which is tentatively set for September 2023. The webinar will be announced in the Alliance's Provider Digest to facilitate provider registration and attendance and may be recorded for posting to our provider resources website.

      Pre and post education will be assessed to measure effectiveness of webinar. Content may include Child Lead Screening, Well-Child Visits (WCVs), CIS-10, coding and billing, fluoride application and Adverse Childhood Experiences screenings.

    - 3) SWOT 3 Action A: Due to delay in further information from DHCS regarding tech funding for 2024, QI staff are assisting our Grant and Program Development Department's tech funding currently available through the Alliance's Medi-Cal Capacity Grant Program (MCGP) or the CDIII grants for the statewide Data Sharing Agreement requirement.

      Staff currently collaborating with Grants Department and Program Development to assist in promoting MCGP and CDIII funding to Merced County sites identified as benefiting from the tech funding grant(s).

    - SWOT 3 Action B: Due to unanticipated internal and external staffing constraints some external outreach/training sessions (Care Based Incentive (CBI) Forensic visits, Practice Coaching, PIP engagements, etc.) with providers were delayed or postponed for Q3 2023. Given that staffing could intermittently pause individual outreach sessions in 2023, Alliance staff are discussing disseminating Provider Portal recall best practices to larger groups by considering incorporating them into the annual CBI Provider Workshop, CBI Forensic Visit templates, targeting

low-performers in the mid-year CBI report, and/or updating the webinar currently available on the Alliance's website. Staff are assessing the feasibility of implementing one of the broader approaches above in conjunction with individual outreach sessions.

- Child and Adolescent Well Care Visits in Merced County. Our final rate for the WCV PIP was 62.61%; 14.05% above our goal rate for this project. Module 4 was submitted to DHCS on April 21, 2023. DHCS provided validation findings on June 2, 2023. We met all requirements and were given a High confidence level rating for this PIP. No further actions need to be taken and this PIP cycle is officially closed.

- Well-Child Visits in the First 30 Months of Life; Well-Child Visits in the first 15 Months – Six or More Well Child Visits W 30 – 6 Measure. PIP design/first submission steps 1-6 due September 8, 2023 in draft. The next submission is due September 2024 with 2023 baseline data for W30 (W15 6 visits in the first 15 months of life). PIP topic selection occurred in Q2. No further requirements from HSAG.

- Follow-Up After Emergency Department Visits for Mental Illness – 30 Day Follow-Up; Total and Follow-Up after Emergency Department Visit for Substance Use; 30-day Follow-Up – Total. Discussions with delegated Behavioral Health provider Carelon have been initiated to develop a data transfer process to identify Alliance members in the emergency department. Cross departmental work is in progress to establish member identification through claims and eCensus data, as well as file layout for data transfers to Carelon. PIP topic selection occurred in Q2. No further requirements from HSAG.

Behavioral Health

- Eating Disorders. The Project Charter was adopted by the Deputy Medical Director and the Process Improvement workflow group launched kick-off and is in the process of documenting current state mapping.

Clinical Safety

- Grievance and Potential Quality Issue (PQI) Management. The team successfully onboarded two Medical Directors to assist in processing member Grievances, PQIs, and Quality Studies. The additional support has reduced administrative burden between Medical Directors and increased QI RN access to clinical input for quality concerns. The team is in collaboration with the Grievance and Provider Relations teams regarding Provider communication for quality of care member grievances and PQIs to better inform providers of our grievance and PQI review process. The goal is to decrease unnecessary contact with Providers and to educate them on the difference between member grievance processing and PQI processing. The team delivered an updated "Potential Quality Issue Overview" presentation to QI staff and plans to review the presentation with Alliance staff outside of QI to increase understanding of the program and promote internal referrals.

- Facility Site Review (FSR) Management. Attend collaborative meetings to plan the implementation of the DHCS mandated Manage Care Site Review Portal (MSRP). Collaborate with Alliance Application Services to create an interface for MSRP to

effectively meet DHCS reporting requirements. Collaborate with Anthem DHCS Certified Master Trainer to ensure a smooth expansion to San Benito and Mariposa counties; and attend Statewide Managed Care Plan collaborative to continue education, align continued implementation of FSR tools and standards, and share resources.

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 2023 QIHET Workplan

Q2 2023 QIHET Workplan

Topic	Health Care Collaboratives - feedback from community engagement
Status	Goal Not Met
Topic	Health Services Division Member Outreach & Engagement Campaigns
Status	In Progress
Topic	Member Support - Call Center
Status	Goal Met
Topic	Cultural and Linguistics (C&L) Services & Population Needs Assessment Education
Status	In Progress
Topic	CAHPS: How Well Doctors Communicate
Status	In Progress
Topic	Annual Access Plan
Status	In Progress
Topic	Provider Choice: In-Area Market Share
Status	In Progress
Topic	CAHPS Survey: Access Measures
Status	In Progress
Topic	Provider Satisfaction
Status	Goal Met
Topic	Under / Overutilization
Status	Goal Met
Topic	Site of Care
Status	In Progress
Topic	Drug Utilization Review (DUR)
Status	In Progress
Topic	Health Education and Disease Management
Status	In Progress
Topic	Controlling Blood Pressure
Status	In Progress
Topic	Diabetes HbA1c >9% (poor control)
Status	Goal Met
Topic	Women's Health Domain SWOT
Status	In Progress
Topic	Childhood Immunizations
Status	Goal Met
Topic	Children's Domain SWOT
Status	Goal Partially Met
Topic	Child and Adolescent Well-Care Visits in Merced County
Status	Goal Met
Topic	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure
Status	In Progress
Topic	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total and Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total
Status	In Progress
Topic	Eating Disorders
Status	Goal Partially Met
Topic	Grievance and PQI Management
Status	Goal Partially Met
Topic	Facility Site Review (FSR) Management
Status	Goal Partially Met

PROGRESS SUMMARY

66%

Percent Complete

Composite Score

4

Sections above target

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Q2 2023 QIS Workplan

SECTION 1: MEMBER EXPERIENCE

A: MEMBER EXPERIENCE

Topic	Health Care Collaboratives - feedback from community engagement
Domain	Member Experience
Priority	Alliance Operating Plan
Committee	MSEC
Goals	Determine baseline performance by calculating the number of ideas acted upon by the organization (as defined by: assessing feasibility of, starting or completing a project, taking direct action) against of ideas brought back to the organizations by Community Engagement Team from Health Care Collaborative meetings
Opportunities for Improvement	Staff input to the status report forms has not been consistent and my need leadership support.
Results Q2	0%
Summary of Quarterly Activities Narrative	Metric is on hold now and currently reassessing member input from these collaborative meetings. these meetings are with CBOs and do not get much member input from these meetings.
Known Barriers/Root Cause(s) (as applicable)	Adequate staff to perform activities
Next Steps	Meet with internal stakeholders and discuss steps for improvement.

Topic	Health Services Division Member Outreach & Engagement Campaigns
Domain	Member Experience, Quality of Care, Quality of Service
Priority	Core
Committee	QIHET-W, MSEC
Goals	Member outreach is critical to inform, foster dialogue, and support at risk Alliance members. Member outreach will consist of calling members impacted by the emergent issues, impact on access to care, and member voice assessments. Mobilize an internal team to identify members, develop scripting and information of appropriate resources and health education, and conduct telephonic outreach to high-risk, vulnerable members. Activities: 1. In 2023, track and monitor all ad hoc member outreach and engagement campaigns 2. Track each campaigns intervention, percentage of successful calls (information provided/LVM) vs. unsuccessful calls, and member counts
Opportunities for Improvement	1. Coordinated collaboration with multiple sources in the development of member written materials and staff talking points 2. Development of member roster lists with the verification if there is more than one member in the same household on the list 3. Identification of the right level of staff to support these outreach campaigns (i.e., clinical vs. non-clinical) 4. Coordinated approach for documenting, tracking, and reporting the outcome of each outreach call 5. Develop enough time to train staff on talking points and new outreach campaigns
Results Q2	79.00%
Summary of Quarterly Activities Narrative	During Q2 2023 the Alliance Quality and Health Programs team completed 120 Member Outreach calls for the DHCS SWOT for pediatric measures. Health Educators called members that were due for well-child visits in Merced County. Out of 120 calls a total of 95 were successful, this resulted in 79% success rate for Q2.
Known Barriers/Root Cause(s) (as applicable)	This project was in response to an assigned SWOT from DHCS. We learned from this project that parents/guardians need additional information and education regarding what well-child visits are and why timing for visits is part of being considered "up-to-date" with check-ups and vaccines for children under 15 months. Additionally the outreach team did not have access to the clinic schedules or chart information to provide any additional information for parents. Additionally we learned the data we pulled can be incorrect due to claims lags and other issues with the data being accurate. This takes additional time to validate for staff that are assigned to these projects.
Next Steps	It is recommended that this type of outreach be completed by the provider office staff. They will have the information needed to look up when in the records the child was last seen at the office and can schedule appointments immediately. Some parent/guardians asked why the clinic was not calling them directly. There can be issues with trust in the community and this is another reason outreach campaigns and outreach scripts should be closely reviewed and monitored by leaders coordinating different outreach efforts.

Topic	**Member Support - Call Center**
Domain	Member Experience
Priority	**Regulatory (DHCS)**
Committee	**MSEC**
Goals	**1. 95% of Calls to Member Services Answered Before Being Abandoned** **2. 80% of Calls to Member Services Answered Within 30 Seconds**
Opportunities for Improvement	**Identify additional barriers to being able to continuously meet this requirement.**
Results Q2	**1. 98% 2. 88%**
Summary of Quarterly Activities Narrative	**During Q2 2023 the Alliance Member Services' Call Center focused on sharing redetermination information with members and ensuring that their mailing address is up updated.**
Known Barriers/Root Cause(s) (as applicable)	
Next Steps	**Keep eye on member walk-in volume**

Topic	**Cultural and Linguistics (C&L) Services & Population Needs Assessment Education**
Domain	Member Experience, Quality of Care, Quality of Service
Priority	**Regulatory (DHCS)**
Committee	**QIHET-W**
Goals	**To measure the performance of the Alliance C&L Services program and to make improvements accordingly (measure utilization per County).** **1. Increase Provider Utilization of the Alliance Language Assistance Services program by 5% when compared to the previous year** **2. Increase the Alliance network provider's familiarity with the Alliance Language Assistance Services Program**
Opportunities for Improvement	**Effective communication is critical for our members to ensure understanding, empowerment and provide high-quality care. The Alliance Language Assistance Services program ensures that Alliance members receive high-quality and appropriate language services by reducing health disparities related to language/cultural barriers.** **1. Explore the effectiveness of cultural competency services provided by the Alliance in ensuring that members receive high-quality, person-centered care and identifying opportunities for improvement where necessary** **2. Monitor telephonic interpreting, face-to-face interpreting, translations, and readability requests** **3. Monitor member and provider complaints and PQIs** **4. Develop a Health Literacy Tool kit for the organization (PNA)** **5. Collaborate with PS in the development and launching of provider cultural competency training (PNA)** **6. Implement audio interpreting services for Telehealth visits** **7. Promote the Alliance Language Assistance Services with our external network providers (i.e., quarterly fax blasts, training videos to support providers on how to use the services) (PNA)**
Results Q2	**48.40%**
Summary of Quarterly Activities Narrative	**In Q2 2023 there was a 48.4% total increase compared to Q2 of 2022 of providers utilizing face-to-face (in-person) interpreting services.** **County specific data was as follows:** **Merced County had 470% increase in Q2 2023 compared to Q2 2022** **Santa Cruz County had 7% decrease in Q2 2023 compared to Q2 2022** **Monterey County had 37% increase in Q2 2023 compared to Q2 2022**
Known Barriers/Root Cause(s) (as applicable)	**In Q2 there continued to be a high increase in provider utilization of face-to-face interpreting services in Merced County. There was also an increase in Monterey County utilization. The C&L team will continue to monitor utilization rates to ensure member access.**
Next Steps	**In Q3-Q4 the C&L team will be working on county expansion efforts to ensure access to interpreting services in the new counties starting in 2024.**

Topic	**CAHPS: How Well Doctors Communicate**
Domain	Member Experience
Priority	**Regulatory (DHCS)**
Committee	**QIHET-W, MSEC**
Goals	**1. Achieve xx% in How Well Doctors Communicate - Child 2. Achieve x % in How Well Doctors Communicate - Adult**
Opportunities for Improvement	**Assess CAHPS surveys administered in 2022, determine thresholds and targets, and identify any improvements**
Results Q2	**Results anticipated in Q3/Q4 2023.**
Summary of Quarterly Activities Narrative	**Sample Frames for the 2023 Adult and Child CG CAHPS survey were submitted to the vendor in March. Field surveys anticipated to begin in April.**
Known Barriers/Root Cause(s) (as applicable)	**TBD**
Next Steps	**Review the finalized analysis by the vendor for 2023 survey results in Q3 2023**

SECTION 2: QUALITY OF SERVICE

B: ACCESS & AVAILABILITY

Topic	**Annual Access Plan**
Domain	Member Experience, Quality of Care, Quality of Service
Priority	**Regulatory, Core**
Committee	**NDSC**
Goals	**The Annual Access Plan focus areas and improvement goals are established in January of each year and are solidified by the NDSC. The 2023 Access Plan goals will be finalized in January 2023.**
Opportunities for Improvement	**The Access Plan will articulate identified areas within the Alliance provider network where targeted activities can increase or enhance choice and/or access. The 2023 improvement opportunities will be identified in January 2023.**
Results Q2	**Access areas identified based on specific access criteria for compliance, operational impact, return on investment, strategic alignment and stakeholder value.**
Summary of Quarterly Activities Narrative	**Working w/ NDSC attendees to develop criteria to assist in ensuring appropriate prioritization of access areas.**
Known Barriers/Root Cause(s) (as applicable)	**TBD**
Next Steps	

Topic	**Provider Choice: In-Area Market Share**
Domain	Member Experience, Quality of Service
Priority	**Regulatory, Core**
Committee	**NDSC**
Goals	**1. 80% Market Share (PCP and Specialist) target with 75% lower threshold 2. Market Share stability with a no more than 5% decrease annually.**
Opportunities for Improvement	**1. Credential non-credentialed providers practicing at contracted locations. 2. Engage providers who have historically declined to contract.**
Results Q2	**St. Michael Nephrology agreed to contract with the Alliance in the San Luis Obispo area. Additionally a new psychiatrist in SLO also agreed to contract. Both providers have historically declined to contract with the Alliance.**
Summary of Quarterly Activities Narrative	**St. Michael Nephrology agreed to contract with the Alliance in the San Luis Obispo area. Additionally a new psychiatrist in SLO also agreed to contract. Both providers have historically declined to contract with the Alliance.**
Known Barriers/Root Cause(s) (as applicable)	**Difficulty obtaining timely credentialing applications for new or existing providers, priority to engage new entities in contracting over credentialing providers at existing contracted sites.**
Next Steps	

Topic	**CAHPS Survey: Access Measures**
Domain	**Member Experience** **Quality of Service**
Priority	**DHCS**
Committee	**HDC, QIHET-W, QIHET-C**
Goals	**1. Achieve xx% in Getting Care Quickly for Child and Adult CAHPS 2. Achieve xx% in Getting Needed Care for Child and Adult CAHPS**
Opportunities for Improvement	**Assess CAHPS surveys administered in 2022, determine thresholds and targets, and identify any improvements**
Results Q2	**Results anticipated in Q3 2023.**
Summary of Quarterly Activities Narrative	**Sample Frames for the 2023 Adult and Child CG CAHPS survey were submitted to the vendor in March. Field surveys anticipated to begin in April.**
Known Barriers/Root Cause(s) (as applicable)	**TBD**
Next Steps	**Review the finalized analysis by the vendor for 2023 survey results in Q3 2023**

C: PROVIDER EXPERIENCE

Topic	**Provider Satisfaction**
Domain	**Quality of Service**
Priority	**Regulatory, Core**
Committee	**HDSC**
Goals	**Target of 88% of surveyed providers who are satisfied with the Alliance (annual measure based on Satisfaction Survey); lower threshold is 79.2%.**
Opportunities for Improvement	**Engage more providers in responding to the annual survey; continue to explore new or evolved questions to best inform the Alliance as to feedback in targeted areas**
Results Q2	**2022 results were 87% overall satisfaction with the Alliance**
Summary of Quarterly Activities Narrative	**Results final, presented to NDSC and CQIW-I in December. Overall Provider Satisfaction for 2022 was 87%.**
Known Barriers/Root Cause(s) (as applicable)	**None**
Next Steps	

SECTION 3: QUALITY OF CLINICAL CARE

D: UTILIZATION

Topic	**Under / Overutilization**
Domain	**Clinical Safety** **Quality of Care** **Quality of Service**
Priority	**Regulatory**
Committee	**UMWG, QIHET-W, QIHET-C, Program Integrity/Compliance Committee, Claims, Advanced Analytics, Health Services Finance Collaborative, PS/HS Collaborative**
Goals	**An interdepartmental over/underutilization report will be developed by December 31, 2023.**
Opportunities for Improvement	**1. Coordinated collaboration with all sources of monitoring for over and underutilization. 2. Linking reporting from multiple sources to ensure compliance with monitoring.**
Results Q2	**Assessment: Q2 UMWP data reflects the following Claims activity, with percentages measured against Claims activity in prior quarter (Q1 2023). ACE at 11,105 claims, a 17% increase over prior quarter (n=9462). Breast Cancer Screening at 5273 claims, a 26% decrease over prior quarter (n=6631). Colorectal Cancer Screening at 4768 claims, a 21% decrease over prior quarter (n=5754). EMG at 195 claims, a 46% decrease over prior quarter (n=422). Initial Health Assessment at 58,191 claims, a 35% decrease over prior quarter (n=78,442). Lead Screening in Children at 4856 claims, a 20% decrease over prior quarter (n=5830). Depression screening remains unchanged from prior quarter and likely reflects incomplete capture of screening activity with new metric, consistently noting fewer than 50 claims/quarter. Interventions: Newly developed report with notable increases in ACE metrics indicates progress in this area of assessment. Noted decreases in Breast Cancer Screening, IHA, lead and colorectal screening may be indicative of incomplete data sets and will need continued monitoring in quarters ahead to determine if this is an outlier with delayed data submissions or continued trend.**
Summary of Quarterly Activities Narrative	**Report finalized in Q1 and metrics updated for UMWP quarterly reporting. Continued development of depression screening metrics underway for Q2-3. Increases noted across the QI metrics of under utilization focus with decreased utilization in area of monitoring for potential over utilization (EMG). Continue to monitor for trends and opportunities for further intervention.**
Known Barriers/Root Cause(s) (as applicable)	**Lack of consolidation of all efforts toward oversight of over /utilization.**
Next Steps	**Dyadic codes, depression screening, doula benefits being added to report. Current report in place for Q1UMWG reporting.**

Topic	**Site of Care**
Domain	Clinical Safety · Member Experience · Quality of Care
Priority	**Organizational Tactic**
Committee	**P&T, CQIC**
Goals	**1. Perform Site of Care outreach to 50% of Site of Care eligible members on targeted drugs in a form of informational letter and infusion provider phone calls. 2. Determine any barriers for Site of Care transition from members, prescribing providers, and infusion providers perspective.**
Opportunities for Improvement	**1. Improve access to home infusions and outpatient infusion center infusions for members. 2. Develop infusion provider and member relationship, which can eventually improve medication adherence and health outcomes.**
Results Q2	**100%**
Summary of Quarterly Activities Narrative	**We focused on completing the Site of Care transition for the members who were identified in Q1. We also chose a new target drug, ocrelizumab (Ocrevus) and identified 13 members who were eligible for our Site of Care program. We conducted outreach to all 13 members on ocrelizumab. Of these 13 members, two have accepted the program (15% -member acceptance rate). The two members who have accepted the program are pending provider decision. We have completed training for this program for of all pharmacy technicians and two out the three pharmacists.**
Known Barriers/Root Cause(s) (as applicable)	**1. Pharmacy staffing 2. Insufficient Home infusion and outpatient infusion contracted providers 3. Hospital contract limiting transition of infusions out of Hospital based outpatient infusions center. 4. Difficult to find the best contact information for providers. 5. Administrative tasks such as setting up member/provider letters and referrals are time consuming. 6. Tableau reports take time to create and modify. 7. The members who have declined the program have done so for multiple reasons, including not wanting anyone in their home or they would like to continue at their current site of care because they receive other services from that site at the same time. 8. It takes a long time for the prescribers to send clinical information and medication orders to the infusion pharmacy. The infusion pharmacy must follow up with the provider multiple times to obtain all the necessary information from the prescriber.**
Next Steps	**Finish training the last pharmacy team member. Identify one new target drug and conduct member outreach. Finish transition to home infusion for all pending members who were originally identified in Q2.**

Topic	**Drug Utilization Review (DUR)**
Domain	Clinical Safety · Member Experience · Quality of Care
Priority	**Regulatory**
Committee	**P&T, QIHET-W**
Goals	**1. Perform retrospective drug utilization review on a quarterly basis, to assure that drug utilization is appropriate, medically necessary, and not likely to result in adverse events. 2. Based on DUR, provide active and ongoing outreach to educate providers on common drug therapy problems (e.g., new prescribing guidelines and advisories) with the goals of improving prescribing and dispensing practices, increasing medication compliance, and improvement of over-all member health.**
Opportunities for Improvement	**Improve awareness among members on providers on any drug utilization is not in line with current clinical guidelines.**
Results Q2	**44%**
Summary of Quarterly Activities Narrative	**Drug utilization review was performed to identify members at increased risk for serious harms related to opioid therapy, based on Morphine Milligram Equivalent (MME) of their opioid's total daily dose. Out of 23,266 members with at least one opioid prescription during 2022, only 0.5% members were found to be at highest risk due to the high dosage of ≥ 100 MME. An educational article on opioid tapering was published in Provider Digest, and a letter was faxed to eight providers that have 2 or more members on high MME (90 or above). DUR was performed on members who were less than or equal to 18 years of age with a diagnosis of bipolar disorder and a prescription for a mood stabilizer medication. In 2022. 213 pediatric members with bipolar disorder were on a mood stabilizer, and there were more female members (138) on mood stabilizers than male members (75). We analyzed members who were on three or more mood stabilizers without seeing a provider board certified in psychiatry, and the investigation concluded that there were no prescribing concerns. Statin utilization was reviewed for Alliance members with Type 2 diabetes and ages 40-75. In 2022, about 63% of members received statins, whereas 37% did not. To increase statin utilization in members with Type 2 diabetes, a fax blast was sent to all providers with reminders of most recent American Diabetes Association guidelines. An educational article will be published in the Provider Bulletin with tips on how to manage statin related muscle pain in addition to ADA guideline recommendations. Statin utilization was reviewed for Alliance members with cardiovascular diseases and ages 20-75. In 2022, about 62% of members with cardiovascular disease received statins, whereas 38% did not. To increase statin utilization members with**

	cardiovascular disease, an article will be published in Member News regarding the importance of taking statins and how to manage the most common statin related side effect of muscle pain.
Known Barriers/Root Cause(s) (as applicable)	1. Limitation in report generation, requiring manual analyses that are time-consuming. 2.Competing priorities for pharmacists.
Next Steps	Results of DURs will be presented to P&T Committee for additional feedback. As less DURs are being performed than originally planned due to time constraints, topics will be prioritized based on regulatory and contractual requirements.

E: ADULT PREVENTIVE CARE SERVICES

Topic	Health Education and Disease Management
Domain	Member Experience · Quality of Care · Quality of Service
Priority	Regulatory (DHCS)
Committee	QIHET-W
Goals	To increase member self-efficacy in performing self-management behaviors by having members participate in the Alliance Healthier Living Program. (Chronic Disease Self-Management Program) 1. By December 31, 2023, at least 50% of participants in the Healthier Living Program will have scored "Good/Very Good/Excellent" for their ability to manage their chronic health conditions after the workshop 2. Overall increasing improvements of the scores (i.e., poor to fair)
Opportunities for Improvement	1. Increase participation in the Healthier Living Program workshop by prompting the member incentive and offering different format options. (Telephonic, virtual, and in-person) 2. Coordinated collaboration with multiple sources to ensure to expand the quality improvement system in the community by having a greater presence and promoting Alliance quality initiatives related to wellness and health promotion
Results Q2	83%
Summary of Quarterly Activities Narrative	In Q2 the Quality and Health Programs team completed 2 Healthier Living Program workshops series. The workshops were offered in the virtual and in-person modalities. One workshop series was offered in English and one workshop series was offered in Spanish.
Known Barriers/Root Cause(s) (as applicable)	There were no barriers to delivering this workshop series.
Next Steps	In Q3 the QHP team will be offering a telephonic workshop series and an in-person series in Salinas.

Topic	Controlling Blood Pressure
Domain	Quality of Care
Priority	Regulatory (DHCS Health Equity Goals), HEDIS
Committee	QIHET-W
Goals	1. Support the Pharmacy Team in initiating the Pharmacist-Led Academic Detailing Hypertension Program which will decrease the percentage of members with uncontrolled blood pressures (or BP greater than or equal to 140/90). 2. Identify a health care systems willing to partner with the Alliance team in implementing an evidenced based practice for members with Hypertension. 3. By 12/31/2023, the Santa Cruz County Clinics proportion of patients with BP at goal (or less than 140/90) will increase from 52% to 57%.
Opportunities for Improvement	1. Improving accurate BP readings will allows clinical interventions such as the Pharmacists-Led Academic Detailing Hypertension Program to be more effective in improving BP control in members with uncontrolled hypertension. 2. Increase members that are accurately identified as having hypertension. 3. For those members with hypertension established accurate readings support the clinical management of the patient. 4. Establish this best practice in a busy ambulatory care center.
Results Q2	1. Goal not met - pharmacy hypertension program has not yet been initiated. 2. Goal partially met - received verbal interest from Santa Cruz County Clinics in their interest in participating in the PLAD Hypertension program. 3. Goal not met - Mar 2023 CBP = 53%
Summary of Quarterly Activities Narrative	1. Project placed on hold until June while continuing to track BP recheck rates monthly.
Known Barriers/Root Cause(s) (as applicable)	1. Clinician and staff turnover limits clinics from participating in improvement activities (i.e. Lost Emeline medical director and clinic manager in Mar 2023) 2. New process may be slowly adopted, will need to focus on education and job aids.
Next Steps	1. Check back in with clinic to assess ability to continue working on improving CBP rates.

Topic	**Diabetes HbA1c >9% (poor control)**
Domain	**Quality of Care**
Priority	**Regulatory (DHCS Health Equity Goals), HEDIS**
Committee	**QIHET-W**
Goals	**1. Identify a health care system willing to partner with the Alliance team in implementing clinical practice recommendations on the latest pharmacologic recommendations for managing members with Diabetes Type II (ADA 2023: Pharmacologic Approaches to Glycemic Treatment)** **2. Support the Pharmacy Team in initiating the Pharmacist-Led Academic Detailing Diabetes Program which will decrease the percentage of members with uncontrolled diabetes (or A1c > 9%).**
Opportunities for Improvement	**1. Opportunities to engage with a practice with a cohort of members with DM and interest in improving and/or expanding services to these members.** **2. For those clinics who do not have a member recall process for routine diabetes care follow-up, provide practice coaching to empower the clinic to develop a sustainable system.** **3. Opportunity to connect members to Diabetes Self-Management Education (DSME) and grow our network of Certified Diabetes Educators.**
Results Q2	**1. Goal met in quarter 1.** **2. Goal met: Completed PLAD DM program: CSVS on 6/8/23; Start date pending: DoD**
Summary of Quarterly Activities Narrative	**1. Conduct clinic outreach to identify clinics interested in program participation.** **2. Develop/modify program content to meet clinic requests.** **3. Meet with clinics to plan the sessions.** **4. Generate registry list of members to track A1C and f/up visits throughout program.**
Known Barriers/Root Cause(s) (as applicable)	**1. Clinics are currently struggling to maintain staff and continue to care for members with COVID.** **2. Limited capacity at many primary care offices to adopt a new initiative. (For some clinics (i.e. CSVS) have had to modify the intervention by limiting the number of sessions and allowing a larger group sizes to participate)** **3. Limited network of accessible Certified Diabetes Educators.** **4. Alliance members have few resources, may be limited to not having safe areas for physical activity or support to prepare healthy meals.**
Next Steps	**1. In planning phase with DoD to schedule sessions with pharmacist.** **2. Awaiting list of CBI QIP clinics interested in the DM PLAD Program to outreach to.**

Topic	**Women's Health Domain SWOT**
Domain	**Quality of Care**
Priority	**Statewide DHCS Performance**
Committee	**QIHET-W**
Goals	**To increase Breast Cancer Screening and Chlamydia Screening rates by providing practice coaching and learning collaboratives to support provider implementation of QI Interventions, and supporting providers through Alliance member recall and health education.** **1. By 11/11/2022 Submission 1 Technical Assistance PRN.** **2. By 1/30/2023 Strategies, measurable action items and short-term objectives.** **3. By 5/30/2023 Progress on strategies and action items.** **4. By 9/30/2023 Progress on strategies and action items.**
Opportunities for Improvement	**I. The Alliance created a Care-Based Quality Improvement Program (CB QIP) with the aim to provide financial investment for practices to make quality improvement interventions. This program is designed to assist practices who are performing below minimum performance levels (MPL) on prioritized MCAS measures to make sustained improvements in staffing, processes, and technology. The application opened to eligible contracted network providers on March 14, 2023 and closed on May 19th, 2023 with a total of 44 applications. Only one eligible provider chose to not apply to the program.** **II. Three providers have been selected for targeted outreach.** **III. Black members had the lowest rate of screening of all racial/ethnic groups in 2021 for BCS. Facilitate targeted mailing for this population to educate and to notify member of screening recommendations.**
Results Q2	**I.:** **• Five provider applicants selected to make quality improvements in both chlamydia screening and breast cancer screening. Of those five, all providers requested additional assistance through practice coaching through program operations June-December 2023.** **• Two provider applicants selected to make quality improvements in Chlamydia Screening only. Of the two submissions, one provider requested additional assistance through practice coaching through program operations June-December 2023.** **• Eight provider applicants selected to make quality improvements in Breast Cancer Screening only. Of the eight submissions, five providers requested additional assistance through practice coaching through program operations June-December 2023.** **II: Determined large group providers for outreach with greatest EP and lowest compliance. Presently Merced Faculty Associates North, Golden Valley Health Centers, and Apex Medical Group are participating. Gettysburg is pending approval as a fourth provider as of 5/31/2023.** **• Provided best practice information to clinics for completing breast cancer and chlamydia screening during well-visits.** **• Provide member rosters for members due for breast cancer screening.** **• Host bi-weekly check-ins with clinics to address questions and to assist if any barriers arise.** **III: Drafted letter for specific Black Member recall, tested it for readability, and had it translated as of May 26, 2023. In addition to letter, mailer to include informatic from USPSTF related to Black women and their mortality statistics from undiagnosed Breast Cancer. Presently building rosters for a population of about 150 women.**
Summary of Quarterly Activities Narrative	**Golden Valley Health Center Merced has agreed to partner on improving breast cancer screenings in collaboration with their Care-Based Quality Improvement Project application. QIPH is continuing outreach for another clinic to partner on breast cancer screenings. QIPH will provide practice coaching, best practice information and a member recall list for clinics to outreach to members.** **Apex Medical Group has agreed to partner on chlamydia screenings. Merced Faculty Associates - North is requesting their leadership's approval to partner on chlamydia screenings. QIPH will provide practice coaching, best practice information and a member recall list for clinics to outreach to members.** **Member letters drafted and USPSTF flyer decided as outreach flyer for Black members for BCS mailer.** **For Q2 QIPH provided best practices information and slide presentations for Golden Valley Health Center and Merced Faculty Associates to get leadership approval to participate in SWOTs. Golden Valley Health Center is working with their operations team to create a team to work on the Breast Cancer Screening SWOT. QIPH met with Apex to address questions on the project, and provided best practice information.**
Known Barriers/Root Cause(s) (as applicable)	**Due to QIPH staff limitations it was decided to focus on increasing breast cancer screening and chlamydia screening rates.** **QIPH staff has competing priorities with the completion of CB QIP applications and being low staffed.** **Breast Cancer Screenings: having difficulty getting an additional clinic to partner on increasing breast cancer screenings. Looking at clinics who have chosen this measure as part of the CB QIP application and have low rates.**

	Since chlamydia screenings population starts at age 16, it is a hard population to call in for screenings since outreach goes to the member, not the parent/guardian. QIPH will be focusing on members who have not had their well-visit for 2023, and educating partnering clinics to screen all members for Chlamydia screening with the option to opt out.
Next Steps	Reach out to additional clinics to partner on increasing breast cancer screening rates. Create PowerPoint presentation for MFA to take to leadership to get their approval to partner with QIPH. Generate member lists and provide best practice information. For Q2 QIPH will continue to meet with clinics to address barriers and provide updated member lists based on member enrollment.

Topic	Childhood Immunizations
Domain	Quality of Care
Priority	Statewide DHCS PIP
Committee	QIHET-W
Goals	1. By April 21, 2023, complete final modules for DHCS PIP and summarize outcomes. 2. (2022 goal) CIS PIP SMART Goal: By December 31,2022, CFHC will increase CIS rates among the three targeted sites from a baseline of 12.22% to 19.51%
Opportunities for Improvement	1. For those providers who indicated that they do not have a member recall process for immunizations (Provider Access Survey), provide practice coaching to empower the clinic to develop a sustainable system. 2. Flu vaccinations are the limiting vaccine in CIS compliance; therefore, conducting focus groups to further understand the root causes of flu vaccine hesitancy in Merced County may help to develop more effective interventions.
Results Q2	N/A
Summary of Quarterly Activities Narrative	HSAG's final validation findings on the CIS PIP was received on 6/12/23 and no further submissions were required. Project completed.
Known Barriers/Root Cause(s) (as applicable)	Goal 1: No Barriers.
Next Steps	Project completed.

Topic	Children's Domain SWOT
Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Performance
Committee	QIHEW
Goals	1) Outreach to high risk racial ethnic groups in Merced County who are deficient in CIS and/or W30 to address barriers to care and connect member with PCP. 2) Provide education on children's preventative services to Merced County clinics to support clinic staff in becoming subject matter experts (SME) for their clinic. 3) Support practices in maximizing data optimization through the Alliance Portal to prompt providers to order all recommended preventative services. 1. By 11/11/2022 Submission 1 Technical Assistance PRN. 2. By 1/30/2023 Strategies, measurable action items and short-term objectives. 3. By 5/30/2023 Progress on strategies and action items. 4. By 9/30/2023 Progress on strategies and action items.
Opportunities for Improvement	
Results Q2	1A-1C) Member outreach project completed and results reported to PETF committee. 2A) Infant Wellness Map (IWM) dissemination in progress for Merced County CBOs and Clinics. 2B) Merced Co. Pediatrician-led Webinar focused on pediatric measures is in progress with aim for go-live Q3-2023. 3A) Promotion of DHCS 2024 Tech funding delayed due to no further information received from DHCS at this time. In lieu, staff are assisting the promotion of the MCGP and CDIII tech grants. 3B) Provider Portal Recall Best Practices/Training delayed due to internal and external staffing constraints. Staff are discussing incorporating recall best practices into broader training outlets to ensure this education is provided.

Summary of Quarterly Activities Narrative	**1) SWOT 1 Actions A-C:** **QIPH Staff made outreach calls to Merced County members deficient* (or at risk of becoming ineligible) for W15 and CIS-10 immunizations to assess for trends in barriers to receiving care, and to connect member to PCP for appointments. Outreach completed 4/10/2023 and summary of results presented at 5/8/2023 and 7/31/2023 PETF committee meeting.** **Next Steps:** **• Share barrier data with PR team then PCPs that participated.** **• Encourage PCPs to perform member recall for W15 & CIS-10.** **2) SWOT 2 Action A:** **Staff are coordinating the promotion of the Infant Wellness Map (IWM) to Merced County CBOs and clinics that serve the target population to partner in disseminating the tool to parents to help them track WCVs and immunizations 0-15 months of life.** **In Q2, staff provided 200 copies (100 English, 75 Spanish, 25 Hmong) of the IWM to the Merced Office of Education - Head Start Program to give to new members of their program. Staff are meeting with Provider Relations team to discuss which clinics in Merced may benefit from targeted outreach.** **SWOT 2 Action B:** **Merced Pediatrician engaged in hosting a webinar focused on pediatric measures for Merced County providers. Staff are drafting webinar content in collaboration with MD and preparing various internal and external communications to promote webinar, which is tentatively set for September 2023. The webinar will be announced in the Alliance's Provider Digest to facilitate provider registration and attendance and may be recorded for posting to our provider resources website.** **Pre and post education will be assessed to measure effectiveness of webinar. Content may include Child Lead Screening, WCV, CIS-10, coding & billing, fluoride application and ACE screenings.** **3) SWOT 3 Action A:** **Due to delay in further information from DHCS re tech funding for 2024, QI staff are coordinating assisting our Grant and Program Development Department's tech funding currently available through the Alliance's Medi-Cal Capacity Grant Program (MCGP) or the CDIII grants for the statewide Data Sharing Agreement (DSA) requirement.** **Staff currently collaborating with Grants Department and Program Development to assist in promoting MCGP and CDIII funding to Merced County sites identified as benefiting from the tech funding grant(s).** **SWOT 3 Action B:** **Due to unanticipated internal and external staffing constraints some external outreach/training sessions (CBI Forensic visits, Practice Coaching, PIP engagements, etc.) with providers were delayed or postponed for Q3-23.** **Given that staffing could intermittently pause individual outreach sessions in 2023, CCAH staff are discussing disseminating Provider Portal recall best practices to larger groups by considering incorporating them into the annual CBI Provider Workshop, CBI Forensic Visit templates, targeting low-performers in the mid-year CBI report, and/or updating the webinar currently available on the Alliance's website.** **Staff are assessing the feasibility of implementing one of the broader approaches above in conjunction with individual outreach sessions.**
Known Barriers/Root Cause(s) (as applicable)	**Staff turnover, provider availability, member education**
Next Steps	**- Continue to promote and distribute the Infant Wellness Map in Merced County.** **- Conduct Pediatric webinar for Merced County providers.** **- Continue to promote internal and external tech grands/funding to Merced County providers.** **- Incorporate provider portal recall best practice training into CBI forensic visits and/or mid-year provider reports.** **- Prepare third and final progress update for DHCS due September 2023.**

Topic	**Child and Adolescent Well-Care Visits in Merced County**
Domain	**Quality of Care**
Priority	**Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)**
Committee	**QIHET-W**
Goals	**1. By April 21, 2023, complete final modules for DHCS PIP and summarize outcomes:** **2. WCV PIP SMART Goal: By December 31, 2022, use key driver diagram interventions to increase the percentage of child and adolescent members who receive at least one child and adolescent well-care visit with a PCP or OB/GYN practitioner during the intervention period among MCO members ages 3-17 years old, linked to Golden Valley Health Centers - Los Banos, from 32.65% to 48.56% (rate of peer benchmark [Taylor Farms Family Health & Wellness Center – Gonzales, CA] in Monterey/reference county).**
Opportunities for Improvement	**1. Providers need to block out time for dedicated staff to do recall outreach and schedule members who are non-compliant for a well care visit.** **2. Prioritize health equity strategies by increasing outreach to populations with lower rates.**
Results Q2	**On 6/2/23 DHCS provided the final validation findings for our Module 4. Our confidence level for this PIP was determined to be High confidence (highest score possible) and all other requirements for Module 4 were met. No additional action was needed. This PIP has officially ended.**
Summary of Quarterly Activities Narrative	**Our final rate for the WCV PIP was 62.61%; 14.05% above our goal rate for this project. Module 4 was submitted to DHCS on April 21, 2023. DHCS provided validation findings on June 2, 2023. We met all requirements and given a High confidence level rating for this PIP. No further actions need to be taken; this PIP cycle is officially closed.**
Known Barriers/Root Cause(s) (as applicable)	**No barriers identified**
Next Steps	**None.**

Topic	**Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure**
Domain	**Quality of Care**
Priority	**Statewide Department of Healthcare Services (DHCS) Clinical Performance Improvement Project (PIP) 2023-2026**
Committee	**QIHET-W**
Goals	**Reduce disparity in well-child visits in the first 15 months among Hispanic Population living in Merced County.** **1. By quarter 3 2023, complete first modules for DHCS PIP.**
Opportunities for Improvement	**1. Prioritize health equity strategies by increasing outreach to populations with lower rates.**
Results Q2	**PIP design/first submission steps 1-6 due 9/8/2023 in draft. Next submission due September 2024 with 2023 baseline data for W30 (W15 6 visits in the first 15 months of life).**
Summary of Quarterly Activities Narrative	**PIP topic selection occurred in Q2. No further requirements from HSAG.**
Known Barriers/Root Cause(s) (as applicable)	**TBD**
Next Steps	**First Module submission due in September 2023**

Topic	**Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total and Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total**
Domain	Quality of Care
Priority	**Statewide Department of Healthcare Services (DHCS) Non-Clinical Performance Improvement Project (PIP) 2023-2026**
Committee	**QIHET-W**
Goals	**By quarter 3 2023, complete first modules for DHCS PIP.**
Opportunities for Improvement	**1. Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit. 2. Increase data sharing to Behavioral Health Delegate.**
Results Q2	**HEDIS MY2022 FUA-30 final rates for SC/MON were 37.35% and 22.48% for Merced. HEDIS MY2022 FUM-30days final rates for SC/MON were 60.67% and 70.72% for Merced. All four rates were above the 50th percentile, with one HPL for FUA in SC/MON.**
Summary of Quarterly Activities Narrative	**Discussions with delegated Behavioral Health provider Carelon have been initiated to develop a data transfer process to identify Alliance members in the emergency department. Cross departmental work is in progress to establish member identification through claims and eCensus data, as well as file layout for data transfers to Carelon. PIP topic selection occurred in Q2. No further requirements from HSAG.**
Known Barriers/Root Cause(s) (as applicable)	**Patient privacy concerns for protected health information created barriers for notifications.**
Next Steps	**First Module submission due in September 2023**

G: BEHAVIORAL HEALTH

Topic	**Eating Disorders**
Domain	Clinical Safety, Member Experience, Quality of Care, Quality of Service
Priority	**Operating Plan**
Committee	**UMWG, CQIC, Beacon Oversight Committee, Health Services Finance Committee**
Goals	**By December 21, 2023, improve workflow process for coordinating and expediting eating disorder referrals to Behavioral Health through pilot project and then scaling results to all counties.**
Opportunities for Improvement	
Results Q2	**(1) 4/23/2023 Met with SCBHS to determine EDO process for accessing care and repayment of services (2) Project accepted for PI Academy.**
Summary of Quarterly Activities Narrative	**Project Charter was adopted by the Deputy Medical Director and the Process Improvement workflow group launched kick-off and is in the process of documenting current state mapping.**
Known Barriers/Root Cause(s) (as applicable)	**1. Eating disorders post pandemic have increased significantly. Unclear pathways have caused delays in treatment. 2. Gaps in handoffs between levels of care.**
Next Steps	**Complete next level of current state mapping. Conduct analysis of current state. Complete root cause analysis. Engage in partnership discussions with County Mental Health department staff.**

SECTION 4: CLINICAL SAFETY

H: CLINICAL SAFETY

Topic	**Grievance and PQI Management**
Domain	**Clinical Safety**
Priority	**Regulatory**
Committee	**QIHET-W**
Goals	**1. By December 31, 2023, 100% of Potential Quality Issues (PQI) are completed within 90 calendar days of receipt.** **2. By December 31, 2023, 100% member grievances opened as PQIs are closed within 30-days or less per regulatory requirement.** **3. By December 31, 2023, quarterly MD IRR of QoS grievances shall be in 100% agreement, indicating QI RNs are resolving cases with consistent methodology. Quarterly MD IRR shall be a 10% sample of QoS Grievances resolved by QI RN.**
Opportunities for Improvement	**Maintain adequate staffing of program; expedite training of new hires.**
Results Q2	**Data as of 7/31/2023** **1. 147/149 (99%) PQIs were closed within timeframe this quarter.** **13/15 (87%) of internally referred PQIs were completed within 90 calendar days or less; and** **134/134 (100%) of Member Grievance PQIs were completed within 30 calendar days or less; and** **2. 46 QoS member grievances closed by QI RN will be audited by Medical Director for IRR (results pending).**
Summary of Quarterly Activities Narrative	**This quarter:** **- The team successfully onboarded two Medical Directors to assist in processing member Grievances, PQIs, and Quality Studies. The additional support has reduced administrative burden between Medical Directors and increased QI RN access to clinical input for Quality concerns; and** **- The team is in collaboration with Grievance and Provider Relations teams regarding Provider communication for QoC member grievances and PQIs to better inform providers of our grievance and PQI review process. The goal is to decrease unnecessary contact with Providers and to educate them on the difference between member grievance processing and PQI processing; and** **- The team delivered an updated "Potential Quality Issue Overview" presentation to QI staff and plans to review the presentation with Alliance staff outside of QI to increase understanding of the program and promote internal referrals.**
Known Barriers/Root Cause(s) (as applicable)	**1. Retaining qualified and well-trained staff.**
Next Steps	**- Continue to collaborate with Grievance and Provider Relations regarding Provider communications for QoC grievances and PQIs.** **- Present PQI Overview to Alliance staff and/or post PowerPoint to the intranet.**

Topic	**Facility Site Review (FSR) Management**
Domain	**Clinical Safety**
Priority	**Regulatory**
Committee	**QIHET-W**
Goals	**1. By December 31, 2023 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date. 2. By December 31, 2023 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. 3. By December 31, 2023 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4. By December 31, 2023 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by the FSR team.**
Opportunities for Improvement	**1. Ensure to carve out the appropriate amount of time to complete the entire Medical Record Review according to the expanded tool guidelines; 2. Initiate request to gain Electronic Medical Record access for Medical Record Review (MRR) at time of scheduling to ensure timely MRR; and 3. Update resources in the current Corrective Action Plan template to ensure that providers are supported in implementing improvements;**
Results Q2	**1. 100% (7/7) of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date. 2. 100% (2 of 2) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. 3. 91% (10 of 11) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4. 80% (8 of 10) of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by the FSR team.**
Summary of Quarterly Activities Narrative	**1. Attend collaborative meetings to plan the implementation of the DHCS mandated Manage Care Site Review Portal (MSRP); 2. Collaborate with Alliance Application Services to create an interface for MSRP to effectively meet DHCS reporting requirements; 3. Collaborate with Anthem DHCS Certified Master Trainer to ensure a smooth expansion to San Benito and Mariposa counties; and 4. Attend Statewide Managed Care Plan collaborative to continue education, align continued implementation of FSR tools and standards, and share resources.**
Known Barriers/Root Cause(s) (as applicable)	**1. PCP office short staffed due to employee health issues and personal time off; 2. Failed scores due to expanded DHCS FSR Tool create larger than normal CAP; and 3. Natural Disaster caused site to close and postpone completion of CAP.**
Next Steps	**1. Continue to update resources in the current Corrective Action Plan template to ensure that providers are supported in implementing improvements; 2. Attend Inter Rater Reliability IRR for Certified Master Trainer recertification; and 3. Test MSPR interface.**

DATE: December 6, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Proposed Medical and Administrative Budget for Calendar Year (CY) 2024

Recommendation. Staff recommend the Board approve the following 2024 budgets:

1. Medical Budget of $1,532,465,637
2. Administrative Budget of $105,375,704

Summary. The Alliance is committed to putting forward a budget that ensures adequate funds for efficient and effective operations and demonstrates fiscal responsibility for long-term sustainability. This shall be achieved through:

- Maintaining access to and ensuring quality of care for members.
- Aligning payment rate with revenue rate, utilization trends, and industry benchmarks.
- Improving provider reimbursement through value-based payment (VBP).
- Sustaining operational efficiency while adequately funding administrative resources to execute regulatory requirements,

Background. Due to the pause in redetermination since the COVID-19 pandemic in March 2020, Alliance enrollment grew more than 20% and peaked in June 2023. Staff observed that members have been seeking care in the post-pandemic era and the cost has exceeded the pre-pandemic level. As the redetermination resumes and membership loss begins in July 2023, staff expect the acuity and medical costs to continue rising.

The medical cost budget incorporates the expected enrollment changes, utilization, and cost increases. The administrative budget incorporates the efforts to meet our 2024 Medi-Cal contract requirement, improve behavioral health by 2025, and implement the Dual Eligible Special Needs Plan (D-SNP) by 2026.

Overall, the Alliance will spend 92% of its revenue on medical and 6.3% on administrative costs.

Discussion. Staff developed the 2024 Medical Budget based on claims data from 2018 through June 30, 2023, paid through September 30, 2023. The 2024 medical cost budget includes changes in provider contracts, base fee schedules, new benefits, utilization, redetermination, and revenue rates. If any yet unknown program or funding changes materially impact the 2024 budget, such differences will be addressed in the 2024 financial forecast.

Enrollment: The 2024 budget is based on the Department of Health Care Services (DHCS) projected enrollment. The impact of redetermination was offset by the increased enrollment from the expansion counties and newly eligible undocumented members ages 26-49. Staff expect the membership at 396,631 by December 2024, a 0.5% decrease from the December 2023 enrollment.

Revenue: The budget is based on the CY 2024 draft rates released on October 13, 2023. The rate is based on our Rate Development Template crosswalk provided to DHCS in December 2022 and is based on the State fiscal year 2021-22 cost experience.

DHCS implements phase 1 of the regional rate. That is, DHCS assigns two rating regions for the Alliance. One region includes Santa Cruz, Monterey, Merced and Mariposa Counties and another for San Benito County. In addition, DHCS assumes utilization decreases for many categories of services, such as outpatient decreases by 14% and Emergency Department by 6%.

There is a positive acuity adjustment of $14.5M offset by a negative managed care efficiency adjustment of $9.3M. These adjustments include potentially preventable hospital admission, low acuity non-emergent visits, and the Healthcare Common Procedures Coding System (HCPCS) efficiency adjustment for physician-administered drugs.

The draft rates represent a 0.3% increase from 2023 for non-Enhanced Care Management (ECM) and 15% for the ECM program. Overall, the budget revenue totals $1.67 billion.

Medical Expense: The medical cost budget is developed based on trended historical utilization and unit cost experience in recent years. The budget factors a 3.7% average utilization increase despite the utilization reduction assumption from DHCS and a 2.9% unit cost for fee schedule changes and case mix.

The budget assumes the ongoing ECM and Community Supports (CS) programs. To increase ECM enrollment, staff increase the provider payments for ECM care management and outreach per target.

Just as the State continues to advance regional rates, seek cost efficiency, and improve the quality of care, staff continue the payment policy to offer provider rates within the revenue rate, utilization trends, and industry benchmarks and offer VBP opportunities to improve provider reimbursement. The 2024 budget includes a $47M investment in various incentive programs to improve quality and member outcomes. This includes a $15M Care-Based Incentive, an $18M Hospital Quality Incentive Program, a $10M Specialist Care Incentive, and a $4M Data Sharing Incentive.

The medical expense budget totals $1.53 billion. The largest categories of service for the 2024 budget are inpatient/outpatient services (Hospital) at 49.0%, physician services at 21.3%, other medical services at 21.2%, and long-term care at 8.6%.

Administrative Expense: The administrative budget totals $105.4M, or 6.3% of revenue. This reflects an increase of $8.9M or 9.2% from the 2023 budget. Staff invest administrative resources to fulfill the 2024 Medi-Cal contracts requirement, prepare for behavioral health in-house in 2025, and continue D-SNP implementation by 2026. The administrative budget aims to maintain organizational efficiency through department assessment, technology, and process improvement to achieve long-term financial sustainability and stewardship.

Non-Operating Income/(Expense): The non-operating income budget is at $16.0M, including income earned from investments such as interest income, gain on investment, and rental income from real estate. The non-operating expense has a $17.6M scheduled grant distribution.

Fiscal Impact. Overall, the proposed medical and administrative budgets yield an operating income of $22.3M, with a medical loss ratio of 92.3% and an administrative loss ratio of 6.3%.

Attachments.

1. Proposed Medical and Administrative Budget for CY 2024
2. Capital Budget and Depreciation Expense for CY 2024

Central California Alliance For Health

Proposed Medical and Administrative Budget for Calendar Year 2024
(In $000's)

	2021 ACTUAL	2022 ACTUAL	2023 BUDGET	2023 FORECAST	2024 BUDGET
Total Member Months	4,537,806	4,852,922	4,840,672	5,041,420	4,908,292
Total Operating Revenue	$1,575,194	$1,546,914	$1,534,521	$1,639,760	$1,660,129
Total Medical Expenses	1,360,894	1,358,876	1,373,690	1,453,838	1,532,466
Gross Margin	**214,300**	**188,038**	**160,831**	**185,921**	**127,663**
Total Administrative Expenses	85,612	82,262	96,481	95,041	105,376
Operating Income/ (Loss)	**128,687**	**105,775**	**64,350**	**90,881**	**22,287**
Total Non-Op Income/(Expenses)	(10,484)	(21,842)	(697)	15,012	16,040
Net Income/(Loss)	**$118,203**	**$83,934**	**$63,652**	**$105,893**	**$38,327**
MLR	*86.4%*	*87.8%*	*89.5%*	*88.7%*	*92.3%*
ALR	*5.4%*	*5.3%*	*6.3%*	*5.8%*	*6.3%*
Operating Income	*8.2%*	*6.8%*	*4.2%*	*5.5%*	*1.3%*
Net Income %	*7.5%*	*5.4%*	*4.1%*	*6.5%*	*2.3%*

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Central California Alliance for Health

Proposed Medical and Administrative Budget for Calendar Year 2024

(In $000's)

	2021 ACTUAL	2022 ACTUAL	2023 BUDGET	2023 FORECAST	2024 BUDGET
Average Monthly Enrollment	*378,151*	*404,410*	*403,389*	*420,118*	*409,024*
Total Member Months	*4,537,806*	*4,852,922*	*4,840,672*	*5,041,420*	*4,908,292*
Revenues					
Capitation Revenue: Medi-Cal	$1,571,906	$1,542,693	$1,530,391	$1,635,439	$1,655,999
Capitation Revenue: IHSS	3,288	4,221	4,129	4,320	4,129
Total Revenues	**$1,575,194**	**$1,546,914**	**$1,534,521**	**$1,639,760**	**$1,660,129**
Medical Costs					
Inpatient Services (Hospital)	$423,729	$526,205	$513,750	$560,434	$560,328
Inpatient Services (LTC)	146,571	160,270	184,002	159,171	131,491
Physician Services	238,145	265,026	287,192	310,062	325,736
Outpatient Facility	108,510	169,713	190,224	180,082	190,114
Other Medical	443,939	237,661	198,522	244,089	324,797
Total Medical Costs	**$1,360,894**	**$1,358,876**	**$1,373,690**	**$1,453,838**	**$1,532,466**
Administration					
Salaries, Wages and Benefits	$51,664	$56,342	$66,492	$64,392	$72,420
Professional Fees	2,047	3,491	3,659	3,659	3,945
Purchased Services	10,661	8,492	10,454	11,113	11,791
Supplies, Occupancy and Other	15,482	10,604	12,330	12,330	13,515
Depreciation and Amortization	5,759	3,333	3,546	3,546	3,704
Total Administrative Costs	**$85,612**	**$82,262**	**$96,481**	**$95,041**	**$105,376**
Total Costs	**$1,446,506**	**$1,441,138**	**$1,470,171**	**$1,548,879**	**$1,637,842**
Operating Income (Loss)	**$128,687**	**$105,775**	**$64,350**	**$90,881**	**$22,287**
Non-Op Income/(Expense)					
Interest & Gains/(Losses) On Inv.	($1,802)	($12,647)	$15,491	$31,819	$31,490
Other Revenues	1,384	1,639	1,807	1,188	2,105
Grants	(10,066)	(10,834)	(17,995)	(17,995)	(17,554)
Total Non-Op Income/Expenses	**($10,484)**	**($21,842)**	**($697)**	**$15,012**	**$16,040**
Net Income (Loss)	**$118,203**	**$83,934**	**$63,652**	**$105,893**	**$38,327**
Medical Loss Ratio	*86.4%*	*87.8%*	*89.5%*	*88.7%*	*92.3%*
Administration Cost Ratio	*5.4%*	*5.3%*	*6.3%*	*5.8%*	*6.3%*
Operating Income %	*8.2%*	*6.8%*	*4.2%*	*5.5%*	*1.3%*

Back to Agenda

Central California Alliance for Health

Proposed Medical and Administrative Budget for Calendar Year 2024

PMPM	2021 ACTUAL	2022 ACTUAL	2023 BUDGET	2023 FORECAST	2024 BUDGET
Average Monthly Enrollment	*378,151*	*404,410*	*403,389*	*420,118*	*409,024*
Total Member Months	*4,537,806*	*4,852,922*	*4,840,672*	*5,041,420*	*4,908,292*
Revenues					
Capitation Revenue: Medi-Cal	$346.40	$317.89	$316.15	$324.40	$337.39
Premiums: Commercial (IHSS)	0.72	0.87	0.85	0.86	0.84
Total Revenues	**$347.13**	**$318.76**	**$317.01**	**$325.26**	**$338.23**
Medical Costs					
Inpatient Services (Hospital)	$93.38	$108.43	$106.13	$111.17	$114.16
Inpatient Services (LTC)	32.30	33.03	38.01	31.57	26.79
Physician Services	52.48	54.61	59.33	61.50	66.36
Outpatient Facility	23.91	34.97	39.30	35.72	38.73
Other Medical	97.83	48.97	41.01	48.42	66.17
Total Medical Costs	**$299.90**	**$280.01**	**$283.78**	**$288.38**	**$312.22**
Administrative					
Salaries, Wages and Benefits	$11.39	$11.61	$13.74	$12.77	$14.75
Professional Fees	0.45	0.72	0.76	0.73	0.80
Purchased Services	2.35	1.75	2.16	2.20	2.40
Supplies, Occupancy and Other	3.41	2.19	2.55	2.45	2.75
Depreciation and Amortization	1.27	0.69	0.73	0.70	0.75
Total Administrative Costs	**$18.87**	**$16.95**	**$19.93**	**$18.85**	**$21.47**
Total Costs	$318.77	$296.96	$303.71	$307.23	$333.69
Operating Income (Loss)	**$28.36**	**$21.80**	**$13.29**	**$18.03**	**$4.54**
Non-Op Income/(Expense)					
Interest & Gains/(Losses) On Inv.	($0.40)	($2.61)	$3.20	$6.31	$6.42
Other Revenues	0.30	0.34	0.37	0.24	0.43
Grants	(2.22)	(2.23)	(3.72)	(3.57)	(3.58)
Total Non-Op Income/Expenses	**($2.31)**	**($4.50)**	**($0.14)**	**$2.98**	**$3.27**
Net Income (Loss)	**$26.05**	**$17.30**	**$13.15**	**$21.00**	**$7.81**
Medical Loss Ratio	*86.4%*	*87.8%*	*89.5%*	*88.7%*	*92.3%*
Administration Cost Ratio	*5.4%*	*5.3%*	*6.3%*	*5.8%*	*6.3%*
Operating Income %	*8.2%*	*6.8%*	*4.2%*	*5.5%*	*1.3%*

Central California Alliance for Health

Capital Budget & Depreciation Expense for Calendar Year 2024

CAPITAL ITEM	DESCRIPTION	CAPITAL REQUEST	2024 DEPRECIATION
Office Building Improvement (1600, 1700 & 18000 Green Hills, Salinas and Merced)			
#	Tenant Improvement 1600	250,000	8,333
#	Tenant Improvement 1700	250,000	8,333
#	Tenant Improvement 1800	250,000	12,500
#	EV Charging Stations 1800	80,000	1,333
	HVAC for IT Server Merced	30,000	500
	HVAC Control System Replacement	175,000	17,500
#	**Subtotal**	**$1,035,000**	**$48,500**
Technology Improvement			
#	UPS Battery	70,000	11,667
#	BCDRP Software	40,000	7,778
#	Data Loss Prevention (DLP) Software	57,500	6,389
	Rubrik	30,000	9,167
	Encounter Management Solutions	561,833	-
	Risk Management and Risk Analysis	250,000	37,500
	Project Management Tool	40,000	8,889
	Identity and Access Management Solution	55,000	12,222
	E-mail Encryption Solution	30,000	5,833
	File Integrity Managemen (FIM)	36,000	8,000
	Live Chat Website Configuration	30,000	3,333
	Subtotal	**$1,200,333**	**$110,778**
	2024 New Capital Request	**$2,235,333**	**$159,278**
Existing Depreciation Assets			
	Current Depreciating Assets		$2,765,605
	Projects In Process - CIP		$779,598
	Total Existing		$3,545,203
	Total 2024 Depreciation Expenses		**$3,704,481**

DATE: December 6, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Proposed 2024 Provider Payment Policy on Enhanced Care Management

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Recommendation. Staff recommend the Board approve the payment policy on Enhanced Care Management (ECM) outlined below across all five counties.

1. ECM: $625 per enrolled member per month (PEPM)
2. Outreach per Target: $264 per target and an additional $200 for each successful enrollment

Summary. The ECM benefit was introduced in January 2022 as part of the State's CalAIM initiative. It is a comprehensive care management benefit to address the clinical and non-clinical needs of the highest-need members enrolled in Medi-Cal managed care plans. The Alliance has experienced challenges in expanding the ECM providers and enrolling members into the program. Many providers have declined participation, citing that the revenue will not cover their costs. A new payment policy is needed.

Background. CalAIM is a multi-year initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of our population by implementing a broad delivery system, program, and payment reform across the Medi-Cal program. The Alliance has implemented the program for nine populations of focus. In 2024, two new populations of focus will be included in the program. In addition, the Alliance will begin administering this benefit for the two expansion counties.

The Alliance has paid the ECM providers following the state methodology, that is, reimbursing providers for the medical cost component of the Alliance's revenue by county. The Board approved this payment methodology in October 2021.

Discussion. DHCS provided the 2024 ECM revenue to the Alliance on October 13, 2023. Similar to the previous years, the ECM revenue includes two components relating to medical cost: a PEPM amount for delivering care management services and a dollar amount per member outreach target. The outreach payment is a one-time payment for the targeted outreach to engage eligible members to enroll in the ECM benefit. Besides the medical cost component of the Alliance revenue, the Alliance receives administrative revenue and an underwriting gain to cover the Alliance's internal costs in operating the program. For 2024, the overall revenue has increased by approximately 15%.

Due to the provider cost challenges, the Alliance has enrolled approximately 60% of the State's expected members, with the lowest enrollment in Merced. Despite the existing enrollment challenges, the State expects the Alliance to increase 37% in ECM enrollment and 26% increase in

outreach in 2024. This increase does not include the justice-involved population, as DHCS is still gathering data and will release the information in December 2023.

Staff recommend passing the entire PEPM and outreach per target revenue to our providers to support our providers. This means that the Alliance will give up the administrative funding and income from the program to our providers.

Staff also recommend a blended payment across all five counties to advance health equity and ensure a person-centered delivery system. In addition, the Alliance will offer an additional $200 for each successful enrollment.

Staff's recommendation aims to maximize payments to Alliance providers from the revenue made available by DHCS in order to expand provider capacity.

Provider Payment	2023	2024	Dollar Increase	% increase
PEPM	$448	**$625**	$177	*40%*
Outreach - Unsuccessful Enrollment	$164	**$264**	$100	*61%*
Outreach - Successful Enrollment	$164	**$464**	$300	*183%*

Fiscal Impact. The Alliance will budget revenue neutral for ECM in the 2024 budget. There is a risk corridor to mitigate any potential risk.

Attachments. N/A

DATE: December 6, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Proposed Incentive Program Funding for Calendar Year (CY) 2023

Recommendation. Staff recommend the Board approve $40M incentive payments for provider performance in year 2023 as follows:

Care-Based Incentive (CBI) - $15M
Specialist Care Incentive (SCI) - $10M
Hospital Quality Incentive Program (HQIP) - $15M

Summary. The Alliance offers three incentives in 2023, CBI, SCI, and HQIP. The Board approved the program design throughout 2022 and the budget for these programs in the 2023 budget. The actual payout funding will be decided in December 2023.

Background. The Alliance payment strategy is to align payment rate with revenue rate, utilization trends, and industry benchmarks and increase provider revenue through value-based payment (VBP). As a result, staff resumed SCI and introduced HQIP in 2023.

CBI is designed to encourage contracted primary care providers (PCPs) to promote and implement the Patient-Centered Medical Home model, improve access to care, and promote the delivery of high-quality care. CBI offers contracted PCPs financial incentives for improved care coordination, quality of care, preventive care, and practice management. CBI is calculated based on outcomes of performance measures.

The SCI program was launched in 2014 and retired in 2020 when specialty care providers were transitioned to a reimbursement methodology based on the current Medicare Fee Schedule, which is among the highest payment levels for specialists through Medi-Cal managed care plans. The Medicare Fee Schedule is typically 60% above Medi-Cal payments on average. Staff re-launched this program for 2023 to incentivize specialists to prioritize appointment availability to members as the care resumes in a post-pandemic era. Staff would like to engage specialists toward VBP in future years.

HQIP, introduced in 2023, offers financial incentives for hospitals that meet performance targets for quality and operational efficiencies, reduce unnecessary healthcare costs, and improve service delivery. The measures include 30-day All-Cause Readmission, Avoidable Emergency Room (ER) visit, Post Discharge follow-up within 14 days, and Cesarean Delivery Rate.

Historically, the Alliance has considered financial performance when approving the incentive programs' funding at the year's end.

Discussion. In 2020, the Department of Health Care Services (DHCS) raised the minimum performance level (MPL) from the 25th percentile to the 50th percentile for all measures. It implemented financial sanctions on plans for non-performance. DHCS removed the sanctions and corrective action plans (CAPs) in 2020 due to the COVID-19 public health emergency but enforced the sanction for 2021 performance. For the performance year 2022 reporting year 2023, the Alliance improved in many areas of the Managed Care Accountability Set. For example, the follow-up after an Emergency Department (ED) visit for mental illness improved by 34% in the Santa Cruz/Monterey reporting region and 41% in Merced. As a result, the Alliance needs to continue partnering with our PCPs to achieve new performance levels.

The Alliance appreciates and encourages specialists to provide care to the Medi-Cal population. The SCI program is intended to improve members' access to specialty care. Due to the pause of redetermination, Alliance enrollment has increased from 350,000 in March 2020 to the peak of 430,000 in June 2023. The specialty care visits have increased 14% in 2021, 9% in 2022, and 6% in YTD through June 2023. The average visits per member also increased by 5% in 2021, 2% in 2022, and 1% in 2023.

The HQIP has made progress in our inpatient and outpatient metrics. The overall 30-day all-cause readmission rate was reduced by 9.3% through September 30, 2023, avoidable ED was decreased by 3.8% for the same period, and the discharge follow-up within 14 days increased by 2.4% through June 30, 2023.

The Alliance appreciates the efforts of PCPs, specialists, and hospitals to improve access and quality care for our members. Staff recommends increasing the incentive funding by $15M to a total of $40M.

Fiscal Impact. The Alliance has an operating income of $90M YTD through September. This is $25M favorable compared to the budget. Staff recommend increasing the payout by $15M to $40M. With this recommendation, the Alliance will achieve a better-than-budget performance in 2023.

Performance Year	Payout	CBI	SCI	HQIP	Total
2023	Recommendation	$15M	$10M	$15M	**$40M**
2023	Budget	$10M	$5M	$10M	$25M

Attachments. N/A

DATE: December 6, 2023

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

FROM: Dr. Dianna Diallo, Medical Director

SUBJECT: Care-Based Incentive Program for 2024

Recommendation. Staff recommend the Board approve the Care-Based Incentive (CBI) Program proposal as described in detail below for 2024.

Summary. This report provides an overview of the CBI Program and makes a recommendation for structural program changes to CBI 2024.

The proposed 2024 programmatic changes are:

- Remove programmatic payment based on comparison group pools.
- Assign a maximum practice programmatic payment based on member months.
- Remove the Quality of Care Performance payment adjustment.
- Remove the risk stratification score.
- Update point calculation for Quality of Care and Care Coordination measures.

Background. Since 2010, the Alliance's CBI program has encouraged primary care physicians to adopt and implement the Patient Centered Medical Home model. CBI aligns with the Alliance's Strategic Priorities for Health Equity and Person-Centered Delivery System Transformation, offering an upside-risk value-based payment to primary care providers to promote better health outcomes, improved access to care and promotes the delivery of high-value care. These health outcomes are reflected in part by the health plan's annual reporting to the Department of Health Care Services (DHCS) for National Committee for Quality Assurance (NCQA)'s Healthcare Effectiveness and Data Information Set (HEDIS), referred to as Managed Care Accountability Set (MCAS), which includes measures from both HEDIS and the Centers for Medicare and Medicaid Services Medicaid Child Core Measure Sets. Measure selection for CBI has also taken into consideration preventive service measure gaps with a focus on health equity in alignment with DHCS Quality Strategy and the Alliance's Strategic Plan as a way to support the Medi-Cal population.

Discussion. The proposed 2024 programmatic changes support increased reward for quality improvement. The comparison group pool payment is proposed to be removed, and instead divided based upon membership. Each practice will have an allocated maximum award which may be earned through achievement, improvement, and/or performance improvement activities. This process allows our investment in practices to be equally distributed.

The proposed calculation of Quality of Care measures for practices meeting the Medicaid 50th percentile is to earn:

- 70% of measure points at 50th percentile
- Another 30% for meeting 75th percentile or a 2.5 percentage point improvement

For practices below the 50th percentile in Quality of Care measures to proposal is to earn:

- 50% at 2.5 percentage point improvement
- The other 50% at five percentage point improvement

The proposed calculation of Care Coordination measures allow practices to earn full points by meeting the plan benchmark or by a 2.5 percentage/percent point improvement/reduction.

For money not earned above, practices may participate in performance improvement activities with the Alliance to earn the rest of their allotted maximum funds.

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

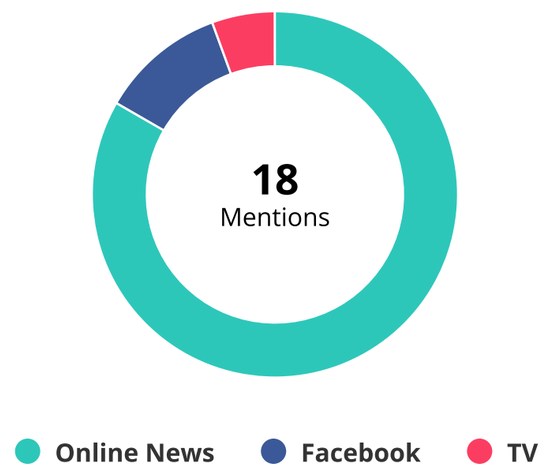
Attachments. N/A

Information Items: (16A. – 16E.)

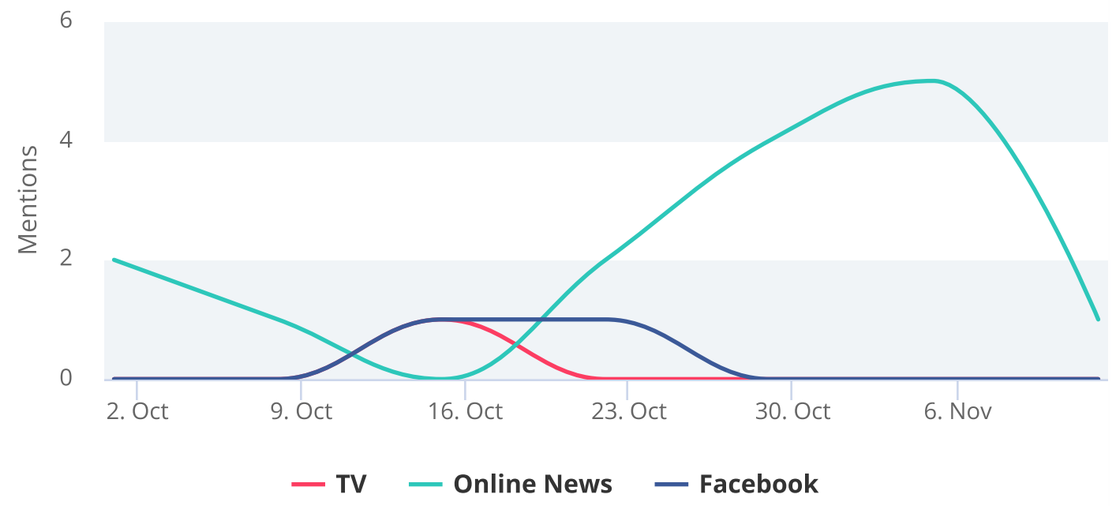
December 2023 Board Report

Mention Analytics

Mentions by Media Type



Mentions by Media Type and Time



Total Local TV Audience
16,028

Total Local TV Publicity
USD $2,483

Total Online + Print Audience
139,157

Total Online + Print Publicity
USD $3,491

Total Social Followers
2,390

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Total Number of Clips 18

Santa Cruz County's plan to tackle homelessness is seeing results

1

Date Collected Nov 14, 2023 9:11 AM EST
Category Digital News
Source Lookout Santa Cruz
Author Source, Carlos Palacios

Market United States
Language English

... of housing and services resources that tracks outcomes and assists and moves people from the streets and shelters into homes. We are working to use data to improve our system to find the most cost-effective ways to help people secure and keep permanent homes. We partner and contract with the **Central California Alliance for Health** to better connect people with health care services.

The county is establishing three navigation centers (low-barrier shelters with intensive supportive services) to intake, assess and help those living on the streets. One will be located at the Coral Street campus in Santa Cruz, another will be ...

CSU Monterey Bay; Physician assistant program closing

2

Powered by LexisNexis

(Requires Critical Mention login)

Date Collected Nov 10, 2023 11:27 AM EST
Category Print
Source Monterey County Herald (CA)
Author Molly Gibbs ; mgibbs@montereyherald.com

Est. Audience 23,862
Est. Publicity Value USD $358
Market Monterey, CA
Language English

... close its Masters of Science Physician Assistant program in May following a loss of accreditation.

Back to Agenda

The university 's physician assistant degree program kicked off in 2019 and 29 students from the inaugural cohort graduated in 2021. To help establish the program, Montage Health donated $600,000 and **Central California Alliance for Health** $750,000.

CSUMB President Vanya Quiñones announced the change in accreditation status to the campus community Monday.

The Accreditation Review Commission on Education for the Physician Assistant, Inc. placed the university on accreditation-probation status in 2021 until the agency's following ...

A CSUMB program, designed to alleviate the region’s physician shortage, loses accreditation.

3

Date Collected Nov 9, 2023 4:55 AM EST
Category Digital News
Source Monterey County Weekly
Author Pam Marino

Est. Audience 7,608
Est. Publicity Value USD $174
Market Seaside, CA
Language English

... Physician Assistant program to much fanfare. It was the first of its kind in the California State University system and held the promise of filling the gaps of a primary care physician shortage, since PAs are able to perform some of the same tasks as doctors. It was that promise that spurred **Central California Alliance for Health** and Montage Health to donate a combined $1.35 million for the degree's creation.

On Monday, Nov. 6, current and future students were informed the program is losing its accreditation, effective May 2024, from the Accreditation Review Commission on Education for the Physician Assistant, called ARC- ...

Online News

CSU Monterey Bay physician assistant program to close in May 2024

4

Date Collected Nov 8, 2023 6:37 PM EST
Category Digital News
Source Monterey Herald
Author Molly Gibbs

Est. Audience 15,216
Est. Publicity Value USD $257
Market Monterey, CA
Language English

... its Masters of Science Physician Assistant program in May following a loss of accreditation.

The university's physician assistant degree program kicked off in 2019 and 29 students from the inaugural cohort graduated in 2021. To help establish the program, Montage Health donated $600,000 and **Central California Alliance for Health** contributed $750,000.

University President Vanya Quiñones announced the change in accreditation status to the campus community Monday.

The Accreditation Review Commission on Education for the Physician Assistant, Inc. placed the university on accreditation-probation status in 2021 until the ...

Against the odds, Watsonville Community Hospital survived bankruptcy. Will it survive the next few years?

5

Date Collected Nov 6, 2023 9:08 AM EST
Category Digital News
Source Lookout Santa Cruz
Author Source, Hillary Covers Education Issues At Schools, Uc Santa Cruz, Cabrillo College For Lookout. Before Reporting On Public Safety At The Iowa City Press-Citizen For Three Years, The California Native Earned A Master S Degree At Columbia Journalism School.

Market United States
Language English

In early October, a small crowd mingled under the main entrance portico at Watsonville Community Hospital. Joined by a revolving door of on-the-clock nurses and hospital administrators, the group of local dignitaries, health care executives and political leaders gathered around cocktail tables to sip wine, pick at plates of cheese and fruit, and celebrate the hospital’s first re-birthday — one year since the community rescued Watsonville Community Hospital from closure and transitioned to public ownership.

“In Watsonville, everything went right,” state Sen. John Laird told the crowd. Laird ...

Central California Alliance for Health expanding to San Benito Co.

6

Date Collected Nov 3, 2023 4:53 PM EDT
Category Digital News
Source KSBW Channel.com
Author Jake Flores

Est. Audience 34,236
Est. Publicity Value USD $831
Market Salinas, CA
Language English

OPEN ENROLLMENT RUNS THROUGH THE END OF JANUARY.. ## MEDI-CAL MEMBERS LISTEN UP... EFFECTIVE JANUARY 1... áCENTRAL CALIFORNIA ALLIANCE FOR HEALTHá.... THE MEDI-CAL MANAGED CARE HEALTH PLAN ...WILL SERVE SAN BENITO COUNTY. CURRENT MEDI-CAL BENEFICIARIES WILL AUTOMATICALLY TRANSITION TO áALLIANCEá... AND WILL SOON RECEIVE A WELCOME PACKET IN THE MAIL.## THERE IS AN INFORMATIONAL MEETING IN HOLLISTER.... THIS SATURDAY MORNING... AT T Updated: 1:44 PM PDT Nov 3, 2023

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Jake Flores

Effective January 1, 2024, Central Coast Alliance For Health, the Medi-Cal managed care health plan, will serve San ...

Central California Alliance for Health expanding to San Benito Co.

7

Date Collected Nov 3, 2023 4:44 PM EDT
Category Digital News
Source KSBW 8
Author Jake Flores, Https, Www.Facebook.Com

Market United States
Language English

Effective January 1, 2024, Central Coast Alliance For Health, the Medi-Cal managed care health plan, will serve San Benito County. Current Medi-Cal beneficiaries will automatically transition to Alliance and will soon receive a welcome packet in the mail. An informational meeting will happen in Hollister at the Community Food Bank of San Benito County on November 4, from 9 a.m. - noon. Residents who have Medi-Cal or are interested in applying are encouraged to attend to get their health plan questions answered.The Alliance already serves more than 428,000 residents in Merced, Monterey and ...

Central California Alliance for Health Will Serve Medi-Cal Beneficiaries in Mariposa and San Benito Counties Starting January 1, 2024 – Mariposa Meet and Greet at the Creekside Terrace Community Cente

8

Date Collected Nov 3, 2023 3:55 AM EDT
Category Digital News
Source Sierra Sun Times

Market United States
Language English

November 3, 2023 - Scotts Valley, Calif.— Central California Alliance for Health (the Alliance), the Medi-Cal managed care health plan for more than 428,000 residents in Merced, Monterey and Santa Cruz counties, will soon serve the counties of Mariposa and San Benito. Effective January 1, 2024, the Alliance will be a local ally in providing trusted, no-cost Medi-Cal benefits to approximately 28,000 new Medi-Cal beneficiaries in these counties. Both counties elected to partner with the Alliance through its locally governed public health plan.

The Alliance has been contracting with local ...

Alliance to begin providing health benefits in San Benito County

9

Date Collected Nov 2, 2023 3:32 PM EDT
Category Digital News
Source SanBenito.com

Est. Audience 217
Est. Publicity Value USD $3
Market Hollister, CA
Language English

November 2, 2023

Meet and greet scheduled for Nov. 4 at Community Food Bank

November 2, 202380

Central California Alliance for Health (the Alliance), the Medi-Cal managed care health plan for more than 428,000 residents in Merced, Monterey and Santa Cruz counties, will soon serve the counties of Mariposa and San Benito, according to a press release.

Effective Jan. 1, 2024, the Alliance will provide no-cost Medi-Cal benefits to about 28,000 new Medi-Cal beneficiaries in the two counties. Both counties elected to partner with the Alliance through its locally governed public health plan, ...

Online News

Coast Line | Kaiser Permanente offers free flu shots Tuesday in Watsonville

10

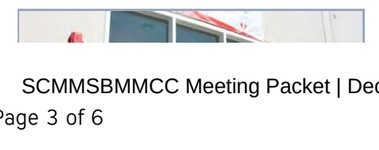
Date Collected Oct 24, 2023 12:35 AM EDT
Category Digital News
Source Santa Cruz Sentinel
Author Donald Fukui

Est. Audience 28,259
Est. Publicity Value USD $1,582
Market Santa Cruz, CA
Language English

... at Ramsay Park, 1301 Main St., Watsonville.

El Mercado is a weekly farmers market aiming to decrease food insecurity and improve access to health-promoting resources for Pajaro Valley families, according to a release from Kaiser Permanente. El Mercado was originally funded by a grant from the **Central California Alliance for Health** in 2020.

If you have a news event or announcement for Coast Lines, email newsroom@santacruzsentinel.com and place "Coast Lines" in the email subject line. Coast Lines items are run at no charge. Please include contact information for questions. Information: 831-706-3252 Tuesdays to Saturdays.



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Unlocking hope: Elderday Adult Day Health Care’s grand opening marks a milestone in Santa Cruz County

11

Date Collected Oct 23, 2023 3:01 PM EDT
Category Digital News
Source Lookout Santa Cruz
Author Community Bridges

Market United States
Language English

On October 12, Community Bridges celebrated a momentous occasion, marking the grand opening of Elderday Adult Day Health Care’s new state-of-the-art headquarters located at 501 Main Street in Watsonville. This landmark event not only serves as a testament to the unwavering commitment of Elderday and its parent organization, Community Bridges, but also signifies a significant expansion in response to the growing need for older adult services in Santa Cruz County and the Central Coast.

Since its establishment in 1981, Elderday has been a lifeline for countless older adults, offering a wide ...

Central California Alliance for Health

12

Time Oct 23, 2023 2:17 PM EDT
Type Post
Language English

Followers 1.2K

As of January 2024, Central California Alliance for Health (the Alliance) will be Mariposa County’s Medi-Cal health care plan! Come to this free event to learn more about trusted, no-cost health care from a local team that understands you!

Alliance in the News

Salinas Ciclovia Celebrates 10 Years

13

Time Oct 19, 2023 5:00 PM EDT
Local Broadcast Time 9:00 PM UTC
Call Sign KSBW (Monterey)
Market
Language English

Est. Local Audience 16,028
Est. Local Publicity Value USD $2,483

Central California Alliance for Health

14

Time Oct 18, 2023 2:58 PM EDT
Type Post
Language Spanish

Followers 1.2K

As of January 2024, Central California Alliance for Health (the Alliance) will be San Benito County’s Medi-Cal health care plan! Come to this free event to learn more about trusted, no-cost health care from a local team that understands you!

¡A partir de enero de 2024, Central California Alliance for Health (la Alianza) será el plan de cuidado de salud de Medi-Cal del Condado de San Benito! ¡Asista a este evento gratuito para obtener más información sobre un cuidado de salud confiable y gratuito por parte de un equipo local que lo comprende!

Community Bridges celebrates opening of new Elderday center

15

Date Collected Oct 13, 2023 6:11 PM EDT
Category Digital News
Source Santa Cruz Sentinel
Author Nick Sestanovich

Est. Audience 28,259
Est. Publicity Value USD $186
Market Santa Cruz, CA
Language English

WATSONVILLE — Senior services in Santa Cruz County just got a little bigger with the grand opening of Elderday’s new headquarters in Watsonville.

Elderday is an adult day health care program that has operated in Santa Cruz County since 1981 to provide resources and activities for older adults with disabilities during the day while still allowing them to live independent lives at home. The program is run by Community Bridges, a nonprofit

based in Watsonville that provides human services.

After 19 years on Pioneer Street in Santa Cruz, Elderday's new digs aren't too far from Community ...

Medi-Cal rules prompt enrollment drop in Santa Cruz County

16

Date Collected Oct 4, 2023 9:56 PM EDT
Category Digital News
Source Santa cruz local
Author Jesse Kathan, Root, --M-A-Box-Bp, --M-A-Box-Bp-L, .M-A-Box, Margin-Top, Important Margin-Right, Important Margin-Bottom, Important Margin-Left, Important

Market United States
Language English

Losing coverage also means losing access to preventative care like checkups and health screenings, said Luis Somoza, member services director for the Central California Alliance for Health. The alliance is a nonprofit group that helps administer Medi-Cal plans for the county. Patients without coverage will likely seek care from emergency departments, Somoza said.

If patients re-enroll in Medi-Cal after being billed, the insurance will retroactively cover any care for up to three months before enrollment. But that process is longer and more time-consuming, Spickler said. "It's arduous in ...

Online News

Alliance in the News

Medi-Cal rules prompt enrollment drop in Santa Cruz County

17

Date Collected Oct 4, 2023 11:33 AM EDT
Category Local
Source Santa Cruz Local
Author Jesse Kathan

Est. Audience 1,500
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Market Santa Cruz, CA
Language English

SANTA CRUZ >> Thousands of Santa Cruz County Medi-Cal patients have lost their health care coverage in the past five months as automatic re-enrollment ended, according to county data.

Medi-Cal rolls grew during the COVID pandemic as patients were automatically re-enrolled each year. Now enrollment is dropping — nearly 9% from June to August, county records state. To try to prevent more people from losing access to health care, county health and nonprofit leaders have been trying to contact and re-enroll hundreds of low-income Santa Cruz County residents for months.

Losing coverage "causes stress and worry for folks unnecessarily," said Adam Spickler, a senior analyst for the Santa Cruz County Human Services Department. People who seek medical care after losing coverage could be billed for the full cost of care, Spickler said.

If patients re-enroll in Medi-Cal after being billed, the insurance will retroactively cover any care for up to three months before enrollment. But that process is longer and more time-consuming, Spickler said. "It's arduous in different ways for the recipient as well as the county," he said.

Losing coverage also means losing access to preventative care like checkups and health screenings, said Luis Somoza, member services director for the Central California Alliance for Health. The alliance is a nonprofit group that helps administer Medi-Cal plans for the county. Patients without coverage will likely seek care from emergency departments, Somoza said

... READ MORE

Santa Cruz Sentinel

Coast Lines

18

(Requires Critical Mention login)

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Source Santa Cruz Sentinel (California)

Market Santa Cruz, CA
Language English

... Demers, the guru of knitting physical therapy, explores the tiny elements that we often overlook when knitting. Using his techniques may help prevent injury and finger/hand pain while knitting.

For questions, call 831-475-5668.

SCOTTS VALLEY

Alliance for Health meetings set for Thursday

The **Central California Alliance for Health** will hold its Member Services Advisory Group meeting from 10-11:30 a.m. Thursday at all five alliance offices including the one at 1600 Green Hills Road, Scotts Valley.

Meetings will also be held at Salinas, Hollister, Mariposa and Merced.

For questions, email MSAG@**ccah**- ...

Back to Agenda

Alliance Fact Sheet
October 2023

ABOUT THE ALLIANCE

The Alliance is an award-winning regional non-profit health plan, established in 1996, with **over 27 years** of successful operation. Using the State's County Organized Health System (COHS) model, we currently serve **418,022 members** in Merced, Monterey and Santa Cruz counties. We work in partnership with our contracted providers to promote prevention, early detection and effective treatment, and improve access to quality health care for those we serve. This results in the delivery of innovative community-based health care services, better medical outcomes and cost savings. The Alliance is governed with local representation from each county on our Board of Commissioners.

Quick Facts[2]

1996
Year Established

542
Number of Employees

$1.28B
YTD Revenue

5.3%
Spent on Administration

Service Area:
Merced, Monterey and Santa Cruz counties.

Membership by Program

Total Membership: **418,022**[3]

417,322
Medi-Cal

700
Alliance Care IHSS

OUR VISION

Healthy People,
Healthy Communities.

OUR MISSION

Accessible, quality health care guided by local innovation.

WHAT WE DO

The Alliance is a health plan that was developed to improve access to health care for lower income residents who often lacked a primary care "medical home" and so relied on emergency rooms for basic services. The Alliance has pursued this mission by linking members to primary care physicians (PCPs) and clinics that deliver timely services and preventive care, and arrange referrals to specialty care.

WHO WE SERVE

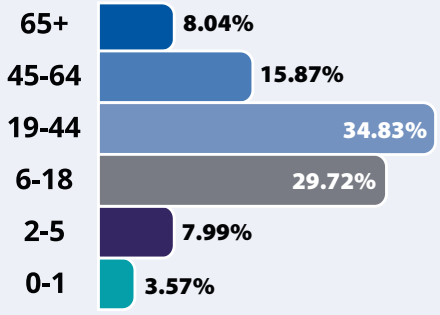
Our members represent 42 percent[1] of the population in Merced, Monterey and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income mothers and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled, and low-income, childless adults ages 19–64.

Our programs currently include Medi-Cal Managed Care serving Merced, Monterey and Santa Cruz counties and Alliance Care In-Home Supportive Services (IHSS) in Monterey County.

PROVIDER PARTNERSHIPS

The Alliance partners with more than 11,981 providers to form our provider network, with 87 percent of primary care physicians and 85 percent of specialists within our service area contracted to provide services to our members. The Alliance also partners with more than **3,624** providers to deliver behavioral health and vision services.

Membership by Age Group



EXECUTIVE LEADERSHIP

Michael Schrader
Chief Executive Officer

Lisa Ba
Chief Financial Officer

Scott Fortner
Chief Administrative Officer

Dennis Hsieh, MD
Chief Medical Officer

Jenifer Mandella,
Chief Compliance Officer

Cecil Newton
Chief Information Officer

Van Wong
Chief Operating Officer

GOVERNING BOARD

The Alliance's 18-member governing board, the San Benito-Santa Cruz-Mariposa-Monterey-Merced 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
- **Ralph Armstrong, DO FACOG,** Hollister Women's Health
- **Supervisor Wendy Root Askew,** County of Monterey
- **Tracey Belton,** Health and Human Services Agency Director, San Benito County
- **Dorothy Bizzini,** Public Representative
- **Leslie Conner,** Executive Director, Santa Cruz Community Health Centers
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas
- **Janna Espinoza,** Public Representative
- **Supervisor Zach Friend,** County of Santa Cruz
- **Donaldo Hernandez, MD,** Provider Representative
- **Elsa Jimenez,** Director of Health, Monterey County Health Department - Alliance Board Chairperson
- **Michael Molesky,** Public Representative
- **Monica Morales,** Health Services Agency Director, County of Santa Cruz Health Services Agency
- **Rebecca Nanyonjo,** Director of Public Health, Merced County, Department of Public Health
- **Supervisor Josh Pedrozo,** County of Merced – Alliance Board Vice Chairperson
- **James Rabago, MD,** Merced Faculty Associates Medical Group
- **Allen Radner, MD,** Salinas Valley Memorial Healthcare System
- **Eric Sergienko, MD,** Public Health Officer, Mariposa County Health Services Division

AWARDS

The Alliance is a multi-award winning organization for outstanding health plan performance, quality and leadership in health care.

State Quality Awards:

Over the years, the Alliance has received numerous awards including the Department of Health Care Services (DHCS) Quality Awards for performance in the state's annual Healthcare Effectiveness Data Information Set (HEDIS®) measures for Medi-Cal managed care plans. The recent awards include:

DHCS 2021

- Consumer Satisfaction Award for going above and beyond in children's care for medium-sized health plans in 2021

2019

- Outstanding Performance for Medium-sized Plan

2018

- Most Improved Runner Up for Santa Cruz and Monterey Counties
- Innovation Award for Academic Detailing

Customer Service Honors:

- DHCS 2011 Gold Quality Award for Outstanding Service and Support

Employer Workplace Distinctions:

- American Heart Association 2016 Workplace Health Achievement Gold Level Award as a "Fit and Friendly Workplace"
- Second Harvest Food Bank, Santa Cruz County – CEO Cup 2018, 2017; Titanium Award 2015, 2014, 2013
- United Way of Santa Cruz County 2018, 2013 Corporate Campaign Gold Award
- 2020 Certified California Green Business - Program Participant since 2008
- 2020 Blue Zones Project Approved Worksite
- Recognized by the Santa Cruz County Breastfeeding Coalition and Community Bridges WIC for being a model for employee lactation accommodation, 2021

[1]County population data source: U.S. Census Bureau 2021 population estimate (as of Jul. 1, 2021).
Membership percentage by county: Merced (54 percent); Monterey (43 percent); Santa Cruz (29 percent).
[2]Fact sheet data as of October 1, 2023. [3]Fact sheet data as of October 1, 2023.

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

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

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

September 22, 2023

Ms. Leslie Conner
Chief Executive Officer
Santa Cruz Community Health Centers
125 Water Street
Santa Cruz, CA 95060

Dear Ms. Conner:

This letter is to confirm and provide information on the collaborative partnership between the Central California Alliance for Health (the Alliance) and Santa Cruz Community Health Centers (SCCHC) to create healthcare solutions for publicly insured residents of Santa Cruz County. The Alliance is a regional, County Organized Health System model Medi-Cal managed care health plan established in 1996 to improve access to health care for lower income residents. One in four residents in Santa Cruz County receive their health care coverage through the Alliance. We pursue our mission of accessible, quality health care guided by local innovation by connecting patients with providers that deliver timely services and preventive care.

SCCHC participates in the Alliance's Care-Based Incentive (CBI) program which is comprised of a set of measures encouraging preventive health services and connecting Medi-Cal members with their primary care provider (PCP). Participation in this program reaffirms SCCHC's commitment to delivering high value care when addressing pediatric and adult health. The health center also makes important contributions to our collaborative work to improve access to care and find strong solutions to health systems challenges. We appreciate the time and effort you contribute as a member of the Alliance governing board and the participation of SCCHC Medical Director Casey KirkHart, MD in our Physicians Advisory Group.

We look forward to continuing to work with SCCHC toward our mutual priorities of access to care, member wellness and promotion of value.

Sincerely,

Michael Schrader
Chief Executive Officer

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

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

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

October 3, 2023

To Whom It May Concern:

This letter is in support of the submission of the DHCS CYBHI Round 3: Early Childhood Wraparound Services grant proposal by Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO). This grant will be used to start up a new Parents as Teachers (PAT) home visiting program in Monterey County that is specifically for Indigenous Mexican families. This new PAT program will be staffed by those with direct lived experiences in the culture and who can provide services in the home language of Indigenous Mexican Americans, a current critical unmet need. CBDIO's proposal, which will be carried out in partnership with First 5 Monterey County (F5MC) aligns with DHCS's funding objective to increase access, sustainability, and coordination of home visiting services that are culturally and linguistically representative of and responsive to the needs of under-served communities.

CBDIO and F5MC have been partners for over 20 years in providing early childhood services and have long-standing relationships that will enable the successful implementation of this grant. CBDIO has been serving the Indigenous community since 1993 and is a trusted ally and service provider. F5MC has invested Prop 10 (tobacco tax dollars) and other public and private dollars in direct services that seek to improve outcomes for children and families for the past 25 years. Additionally, F5MC has funded, helped initiate, and championed the existing local PAT home visiting programs for nearly 20 years.

The Alliance is a County Organized Health system model Medi-Cal managed care plan that serves over 428,000 members in Merced, Monterey and Santa Cruz counties. The Alliance is committed to ensuring that our members receive health care services that are high quality, culturally competent and guided by cultural humility. Our organization's strategic plan includes the goal to eliminate health disparities and achieve optimal health outcomes for children and youth. We actively support evidence-based home visiting as a key early intervention and prevention strategy to improve health outcomes. The Alliance makes investments to health care and community organizations in our service area through the Medi-Cal Capacity Grant Program and are pleased to have awarded F5MC a Home Visiting grant to implement PAT with three other community partners.

We support the work of CBDIO and F5MC in meeting the needs of local Indigenous Mexican Americans through the evidence-based service delivery of PAT.

Please feel free to contact our Grant Program staff with any questions at grants@ccah-alliance.org.

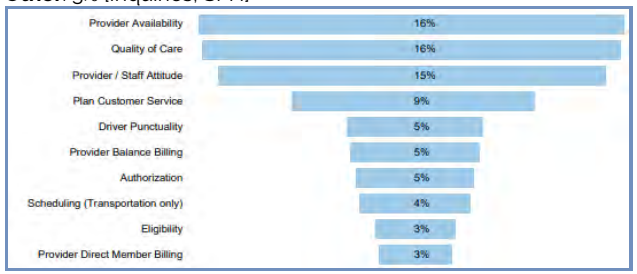
Sincerely,

Michael Schrader
Chief Executive Officer

Member Appeals and Grievance Report
Q3, 2023

Q3 2023 Appeals and Grievances: 1,396* including Carelon.

Appeals: 4% [73% in favor of Plan; 27% in favor of Member]
Exempt: 50%
Grievances: 43%
Other: 3% [Inquiries, SFH]



Analysis and Trends

- Access issues regarding provider availability in MRY continue.

Highest Grievances Filed by County

1. **Monterey**: 43%
2. Merced: 33%
3. Santa Cruz: 24%

Behavioral Health Carelon Grievances: #34

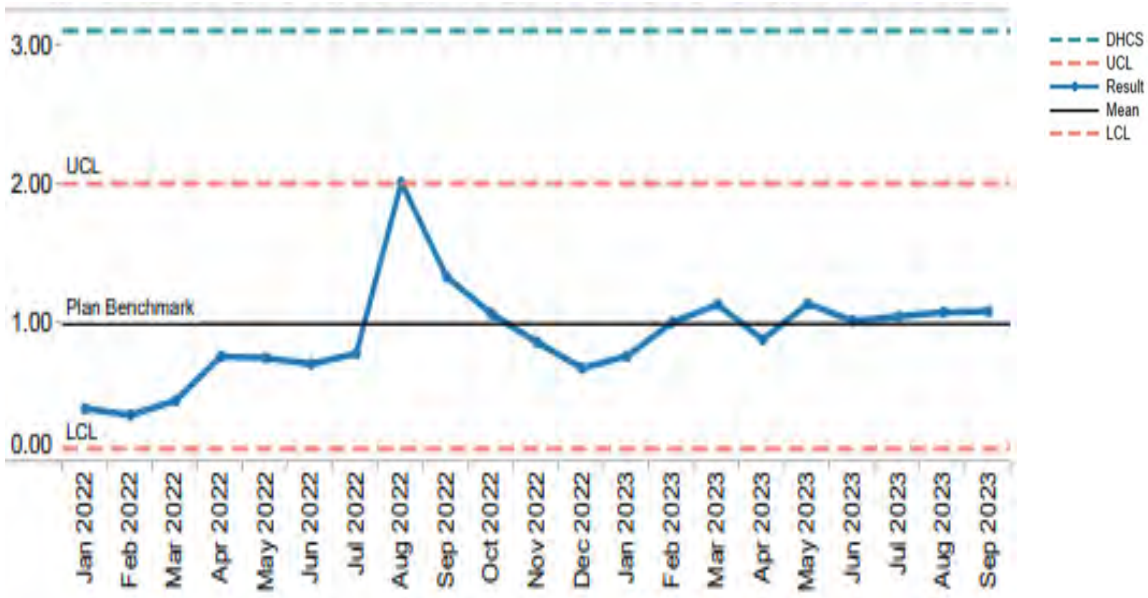
- **Monterey**: 18
- Santa Cruz: 7
- Merced: 9

IHSS Summary: #5

- Member Grievances: 4
- 24-Hour Exempt Complaints: 1

☒ **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
2022	MemberMonths	390,341	391,464	393,337	395,726	403,182	404,955	407,176	408,786	411,163	413,245	415,587	416,995
	Case Count	150	132	174	301	302	286	318	824	549	441	359	282
	Case Count Per 1000 MM ..	0.38	0.34	0.44	0.76	0.75	0.71	0.78	2.02	1.34	1.07	0.86	0.68
2023	MemberMonths	420,192	421,711	423,157	426,072	427,730	428,887	427,070	425,433	418,884			
	Case Count	321	425	480	376	488	436	448	459	455			
	Case Count Per 1000 MM ..	0.76	1.01	1.13	0.88	1.14	1.02	1.05	1.08	1.09			

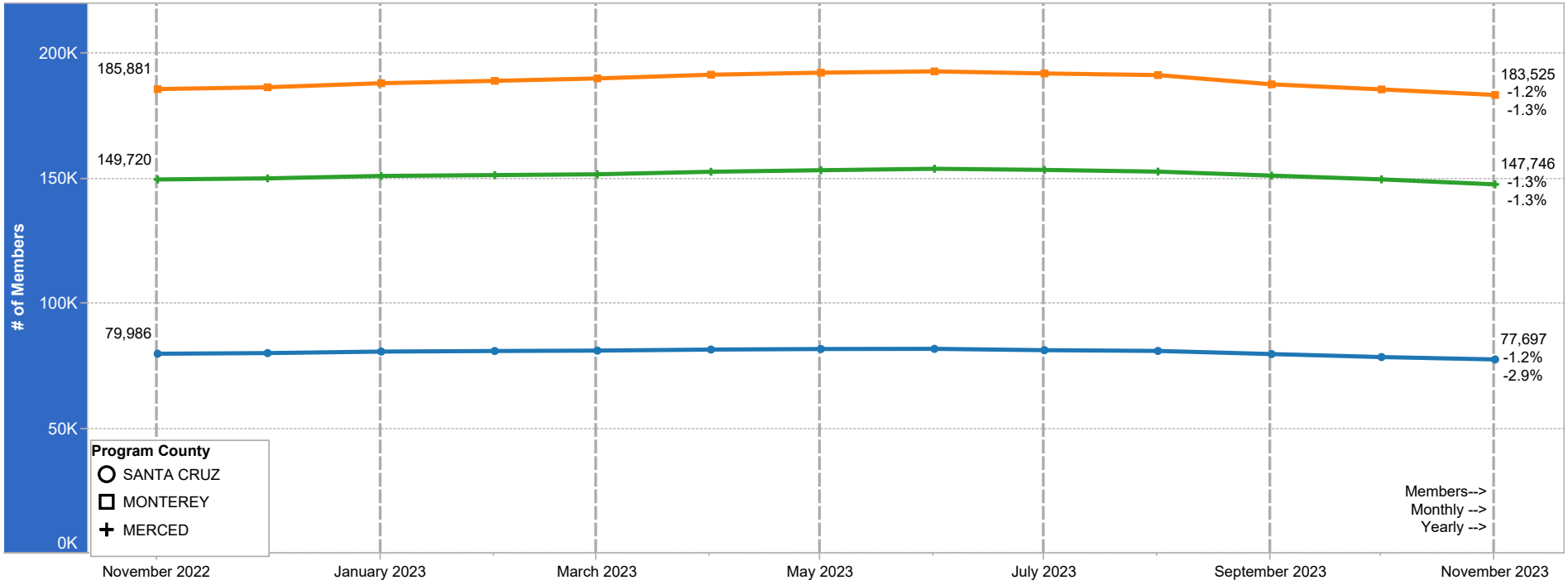
*Grievances Per 1,000 Member Month

Enrollment Report

Year: *2022 & 2023* **County:** *All* **Program:** *AIM, IHSS, Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *11/7/2023*

StaticDate
11/1/2022 12:00:00 AM to 11/30/2023 11:59:59 PM

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



Program..	ProgramCo..	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
Medi-Cal	SANTA CRUZ	79,986	80,241	80,843	81,072	81,236	81,647	81,869	81,935	81,403	81,104	79,851	78,651	77,697
	MONTEREY	185,225	185,949	187,575	188,524	189,492	190,983	191,792	192,295	191,448	190,788	187,076	185,040	182,801
	MERCED	149,720	150,151	151,122	151,464	151,783	152,794	153,413	153,987	153,540	152,850	151,257	149,742	147,746
IHSS	MONTEREY	656	654	652	651	646	648	656	670	679	691	700	710	724
Total Members		**415,587**	**416,995**	**420,192**	**421,711**	**423,157**	**426,072**	**427,730**	**428,887**	**427,070**	**425,433**	**418,884**	**414,143**	**408,968**