Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Wednesday, June 22, 2022

3:00 p.m. – 5:00 p.m.

Teleconference Meeting

(Pursuant to Assembly Bill 361 signed by Governor Newsom, September 16, 2021)

Important notice regarding COVID-19: In the interest of public health and safety due to the state of emergency caused by the spread of COVID-19, this meeting will be conducted via teleconference. Alliance offices will be closed for this meeting. The following alternatives are available to members of the public to view this meeting and to provide comment to the Board.

1. Members of the public wishing to join the meeting may do so as follows:
    a. 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: 910 401 259#

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, June 21, 2022 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 five minutes.
    b. Public comment during the meeting when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

3. Mute your phone during presentations to eliminate background noise.
    a. State your name prior to speaking during comment periods.
    b. Limit background noise when unmuted (i.e., paper shuffling, cell phone calls, etc.).

1. **Call to Order by Chairperson Jimenez. 3:00 p.m.**

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.

2. **Consider approving findings that the state of emergency continues to impact the ability of members to meet safely in person and/or State or local officials continue to impose or recommend measures to promote social distancing. (3:05 – 3:10 p.m.)**

A. Ms. Stephanie Sonnenshine, Chief Executive Officer, will review and Board will consider approving findings that the state of emergency continues to impact the ability of members to meet safely in person and/or State of local officials continue to impose or recommend measures to promote social distancing.

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

Pages 2-01 to 2-02

3. **Oral Communications. 3:10 p.m.**

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

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

A. Board members may provide comments and announcements.

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

A. The Chief Executive Officer (CEO) may provide comments and announcements.

Consent Agenda Items: (6. – 9B.): 3:15 p.m.

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

- Reference materials: Executive Summary from the CEO.

Pages 6-01 to 6-08

7. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the fourth month ending April 30, 2022.**

- Reference materials: Financial Statements as above.

Pages 7-01 to 7-09

Minutes: (8A. – 8D.)

8A. **Approve Commission meeting minutes of May 25, 2022.**

- Reference materials: Minutes as above.

Pages 8A-01 to 8A-06

8B. **Accept Compliance Committee meeting minutes of April 20, 2022.**

- Reference materials: Minutes as above.

Pages 8B-01 to 8B-05

8C. **Accept Physicians Advisory Group meeting minutes of March 3, 2022.**

- Reference materials: Minutes as above.

Pages 8C-01 to 8C-07

8D. **Accept Whole Child Model Clinical Advisory Committee meeting minutes of March 17, 2022.**

- Reference materials: Minutes as above.

Pages 8D-01 to 8D-06

Reports: (9A – 9B.)

9A. **Accept report on 2022 Legislative Session Update.**

- Reference materials: Staff report on above topic.

Pages 9A-01 to 9A-02

9B. **Accept Quality Improvement System Workplan for 2022.**

- Reference materials: Staff report and recommendation on above topic; and Quality Improvement System Workplan 2022.

Pages 9B-01 to 9B-19

Regular Agenda Items: (10. – 13.): 3:20 p.m.

10. **Consider adopting Alliance Health Care Expense Reserve Policy. (3:20 – 3:45 p.m.)**

A. Ms. Lisa Ba, Chief Financial Officer, will review and Board will consider adopting Alliance Health Care Expense Reserve Policy.

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

Pages 10-01 to 10-02

11. **Consider approving Chief Executive Officer (CEO) Succession Plan and Recruitment Process. (3:45 – 4:05 p.m.)**

A. Mr. Scott Fortner, Chief Administrative Officer (CAO), will review and Board will consider establishing an ad hoc committee of the Board, consistent with Brown Act requirements, to develop a CEO succession plan and carry out the CEO recruitment process.

B. Mr. Fortner, CAO, will review and Board will consider approving a recruitment budget not to exceed $215,000.

- Reference materials: Staff report and recommendation on above topic; Draft CEO Succession Criteria; and CEO Position Description.

Pages 11-01 to 11-07

12. **Discuss evolution of the Medi-Cal Capacity Grant Program (MCGP): Framework for Administration. (4:05 – 4:40 p.m.)**

A. Ms. Sonnenshine, CEO, will review and Board will discuss evolution of the MCGP.

- Reference materials: Staff report on above topic.

Pages 12-01 to 12-03

13. **Discuss agenda and arrangements for the Board's annual retreat on September 28, 2022. (4:40 – 5:00 p.m.)**

A. Ms. Sonnenshine, CEO, will present draft agenda topics and Board will discuss planning of September 28, 2022 retreat.

Information Items: (14A. – 14E.)

A. Alliance in the News — Page 14A-01
B. Membership Enrollment Report — Page 14B-01
C. Member Newsletter (English) – June 2022
https://thealliance.health/wp-content/uploads/MSNewsletter_202206-E.pdf
D. Member Newsletter (Spanish) – June 2022
https://thealliance.health/wp-content/uploads/MSNewsletter_202206-S.pdf
E. Provider Bulletin – June 2022
https://thealliance.health/wp-content/uploads/CCAH-Provider-Summer-2022.pdf

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, August 24, 2022; 1:30 – 2:45 p.m.

- Member Services Advisory Group
  Thursday, August 11, 2022; 10:00 – 11:30 a.m.

- Physicians Advisory Group
  Thursday, September 1, 2022; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee
  Thursday, September 15, 2022; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee
  Monday, July 11, 2022; 1:30 – 3:00 p.m.

The above meetings will be held via teleconference unless otherwise noticed.

The next special meetings of the Commission, after this June 22, 2022 regular meeting will be held via teleconference unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Friday, July 22, 2022, time to be determined *[pending Board approval]*

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Friday, August 19, 2022, time to be determined *[pending Board approval]*

The next regular meeting of the Commission, after this June 22, 2022 meeting will be held via teleconference unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, August 24, 2022, 3:00 – 5:00 p.m.

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.

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

DATE: June 22, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: AB 361 – Brown Act: Teleconferencing Meeting Procedures

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Recommendation. Staff recommend the Board consider making the following findings by majority vote, pursuant to Government Code § 54953 (e) (3), to allow for the Board to meet remotely through teleconferencing, due to the present state of emergency, under the permissions provided via AB 361:

(A) The Board has considered the circumstances of the current COVID-19 state of emergency; and,

(B) Any of the following exists:

(i) The state of emergency continues to directly impact the ability of the members to meet safely in person.
(ii) State or local officials continue to impose or recommend measures to promote social distancing.

Staff further recommend that the Board consider making these findings on behalf of its Committees and the Advisory Groups of the Board to allow for the conduct of business via teleconferencing compliant with Government Code § 54953.

Staff recommend the Board convene Special Meetings on July 22, 2022 and August 19, 2022 to reconsider the circumstances of the state of emergency and to determine if there are applicable conditions present to continue meeting under the provisions afforded through AB 361.

Summary. AB 361 (Statutes 2021) amended Government Code § 54953 to modify rules requiring the physical presence of members of a public agency for the purposes of conducting a public meeting during declared states of emergency and when state or local officials have imposed or recommended measures to promote social distancing. To meet while in compliance with the permissions provided by AB 361, the Board must make the above referenced findings by majority vote and must reconsider the circumstances every 30 days.

Background. On September 16, 2021 Governor Newsom signed AB 361 (Rivas) which allows a local agency to use teleconferencing without complying with certain Brown Act requirements as long as notice and accessibility requirements are met, public members are allowed to observe and address the local agency body at the meeting, and the local agency body has a procedure for receiving and swiftly resolving requests for reasonable accommodations.

Under the provisions of AB 361, during a proclaimed state of emergency and when state or local officials have imposed or recommended measures to promote social distancing, a public body may meet via the specified teleconferencing procedures when the public body has determined by majority vote that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

Discussion. Since the Board's May 25, 2022 meeting, the COVID-19 surge has continued and the CDC Community Level rating in Alliance service area counties has changed, with Monterey County moving from medium to high on the CDC county ratings, Santa Cruz County remaining at medium and Merced County moving from medium to low.

In order to continue utilizing teleconferencing under the procedures outlined by AB 361, after this Regular Meeting of the Board, and if the state of emergency remains active or state or local officials continue to impose or recommend measures to promote social distancing, the Board must, no later than 30 days after this meeting and every 30 days thereafter, reconsider the circumstances of the state of emergency. Therefore, the Board will be asked to convene special meetings on July 22, 2022 and August 19, 2022 to reconsider these circumstances as they relate to the next regular meeting of the Board on August 24, 2022.

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

Attachments. N/A

DATE: June 22, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

Alternate Health Care Service Plan (AHCSP): AB 2724 (Arambula). On May 26, 2022, the Assembly voted on AB 2724, narrowly passing the bill with just enough votes to secure passage (*41 ayes - including Assembly member Rivas, 18 noes – including Assembly member Stone, and 19 members not voting – including Assembly member Gray*). The policy bill will now move to the Senate, where it is expected to be heard in the Senate Health Committee.

Staff, with the support of our Sacramento lobbyists continue advocacy with our representatives in the Senate, including Senators Caballero and Laird, as well as Senate leadership including Senators Atkins, Eggman, and Pan. Messaging includes that the direct deal enabled by AB 2724 remains a threat to local governance and the decisions of counties who chose the County Organized Health System (COHS) model to best meet their communities' needs. AB 2724 also remains a real threat to the integrity of the COHS model and to the benefits a COHS offers to its members. These benefits include:

- Each member has access to the same care, regardless of the degree of poverty.
- Members have a voice in governance of the COHS plans.
- Members enjoy expanded benefits and services developed in response to locally determined needs.
- Members enjoy a provider network that has historically included *both* public and private providers who commit to collaboratively ensuring capacity to serve all Medi-Cal members in the community.

It is critical that our Senators hear that amendments can be made to both advance the Administration's interest in expanding Kaiser's reach in Medi-Cal and to protect the COHS model and the stability of our safety net delivery system. Such amendments may include:

1. Specify the counties to which the AHCSP proposal is applicable, specifically excluding the COHS counties, including counties which are slated to become COHS counties in 2024, and explicitly including only those non-COHS counties where Kaiser is currently licensed for Medi-Cal today.
2. Include guardrails and protections around enrollment, contracting, process, and risk adjustment to ensure that the proposal achieves public and not private interests.

Staff will continue to keep the Board apprised of significant issues and events related to AB 2724.

2022-23 State Budget. The Legislature has developed its budget proposal which is being heard by the respective budget committees. However, staff understand that many of the issues in the proposal remain under negotiation with the Administration and also require Department of Finance concurrence with the fiscal assumptions. Key budget deadlines include June 15th for the legislature to pass the budget and June 30th for the Governor to sign for a July 1st implementation date.

Housing and Homelessness Incentive Program (HHIP). As approved by the Board at the March 23, 2022 meeting, staff submitted a letter of intent to participate in the Department of Health Care Services (DHCS) HHIP and are developing the program in compliance with program requirements. Staff are working with each county Continuum of Care to develop a Local Homelessness Plan which is due to DHCS by June 30, 2022. The Alliance has received initial funding allocation per county by program year with a total two-year fund allocation of $46.8M.

Student Behavioral Health Incentive Program (SBHIP). In April, 2022 following submission of the Partner List to DHCS and distribution of the Letter of Agreement (LOA) to SBHIP partners, there was a change in participating partners. In Monterey County, Salinas City Elementary School District decided not to participate. DHCS was notified and the Department informed staff that since the County Office of Education is a Local Educational Agency (LEA), the Alliance still meets the minimum LEA requirement in Monterey County.

Below is the updated list of SBHIP partners in each county:

- Merced County: Atwater Elementary School District, Los Banos Unified School District, Merced County Office of Education and Merced County Behavioral Health & Recovery Services
- Monterey County: Alisal Union School District, Soledad Unified School District, Monterey County Office of Education and Monterey County Behavioral Health
- Santa Cruz County: Pajaro Valley Unified School District, Pajaro Valley Prevention and Student Assistance, Santa Cruz County Office of Education and County of Santa Cruz, Health Services Agency, Behavioral Health Division

LOAs have been executed with all SBHIP partners. The initial 30% payment is being distributed to partners upon receipt of the fully executed LOAs.

The LEAs have been oriented to the Needs Assessment templates and regular check-in meetings are ongoing. Additionally, county-wide partner meetings have been scheduled for June (Merced County: June 8, 2022; Santa Cruz County: June 15, 2022; Monterey County: June 28, 2022) with the purpose of checking in on the Needs Assessment progress.

Community Involvement. On June 8, 2022 I attended the virtual June All Plan CEO meeting and the virtual Housing for Health Partnership Policy Board meeting. I attended the virtual Health Improvement Partnership of Santa Cruz County Council meeting on June 9, 2022 and I plan to attend the virtual MoReHEALTH meeting on June 30, 2022.

Health Services

Following Board approval in May of the plan for Care Based Incentives (CBI) 2023, the CBI contract is being completed for submission to DHCS. Progress is being made with addition of the new Behavioral Health (BH) Department and the BH Director recruitment is going well.

Promotion of COVID-19 vaccination for children is a Quality Improvement-Population Health Department priority and data for the Medi-Cal Accountability Set (MCAS) quality metrics for 2021 is being finalized and submitted to DHCS. Work continues in preparation for the July 1, 2022 launch of the Enhanced Case Management (ECM) and Community Services (CS) programs in Merced County as well as increasing ECM and CS member and provider engagement in Santa Cruz and Monterey Counties.

Care Based Incentives Implementation Update. Pursuant to the Alliance Board request to consider offering the fee-for-service incentive for completion of ACE Screening training and attestation to residents in regional Family Medicine training programs, staff have determined that this payment can be offered for this situation. Contract modifications are being completed now for submission to DHCS for their consideration.

COVID-19 Report

COVID Disease Activity (Collected on June 3, 2022)

County	Cases per 100K (7-day average)	14-Day Average of Hospitalized Patients	Rate of Positive Tests (7-day rate)	Confirmed Deaths (total)
Merced	19.4	5.0	11.9%	825
Monterey	18.7	13.6	7.7%	738
Santa Cruz	25.3	10.3	10.0%	263
California	34.6	2,012.4	8.3%	90,815

Source: https://covid19.ca.gov/state-dashboard/#location-california

When comparing the data collected on June 3, 2022 to the May COVID-19 Report, rates of COVID-19 cases tripled in Merced County (May 5.6 cases per 100,000 members, 7-day average) and more than doubled in Monterey (May 9.6). Santa Cruz County has dropped from a rate of 33.7. All three counties have experienced increasing rates of test positivity and Merced and Monterey County both have had additional deaths attributed to COVID-19 reported.

Current COVID-19 Vaccination Status

COVID-19 Vaccination Rates for Eligible Alliance Members as of 5/31/2022				
	% Alliance members with at least one dose	% Alliance members fully vaccinated	% Alliance members partially vaccinated	% Alliance members with >1 Booster dose (5+)
Merced	49.9%	44.1%	5.8%	30.5%
Monterey	64.1%	59.5%	4.6%	37.2%
Santa Cruz	70.0%	66.0%	4.0%	46.9%
CCAH	60.2%	55.3%	5.0%	37.7%
Alliance vaccination data is collected from numerous sources including CAIR, claims, DHCS, RIDE, and SCHIO.				

Note: We have expanded the denominator for booster doses as of this report to include all members five years of age and older. Therefore, our booster rates have decreased from the prior report.

On March 1, 2022, the Alliance implemented a member incentive for receiving their first or second booster dose. Alliance data (tri-county) shows that as of March 1, 2022 was 37.6% for fully vaccinated members ages 12 years and older with booster doses on file. Using the CDPH data we identified that the overall county (Merced, Monterey and Santa Cruz combined) rate of fully vaccinated persons with booster doses was 49.6% on March 1, 2022. The target rate identified for the Alliance Booster program is to achieve 45% by May 31, 2022 and that goal was achieved the week of May 23, 2022 at 47.7% for Medi-Cal members in Merced, Monterey and Santa Cruz counties combined.

Quality Improvement and Population Health (QIPH)

Population Health Management. Work continues in development of the Alliance Population Health Management program in anticipation of the January 2023 implementation. The effort involves stratifying membership by complexity and identifying populations of focus. The Cave business intelligence software program will be core to this effort. The MCAS metrics for measurement year 2021 is complete and results have been submitted. DHCS will report results in September.

Department of Health Care Services Population Needs Assessment (PNA). Work has been underway, and oversight of the Alliance PNA report is provided by the Alliance Quality Improvement and Population Health Department as required by DHCS and described in the All Plan Letter (APL) 19-011 Health Education and Cultural & Linguistic Population Needs Assessment. The PNA report provides an overview of the Alliance Medi-Cal members' health status and behaviors. The primary purpose of the PNA is to improve health outcomes for Medi-Cal members by identifying needs and gaps in health education and cultural and linguistic services. Findings from the PNA highlight areas of success and areas of opportunities for improvement in the health plan. Multiple internal and external data sources will be used, including claims/encounter data, HEDIS, and state and county-level data. To continue supporting the annual PNA work, the Quality and Health Programs (QHP) team has started to conduct outreach calls with Alliance members to gather input from members on how well the Alliance is addressing their needs (i.e., health plan services and materials, primary care providers, and cultural and linguistic services, and social determinates of health). Based on the findings, a 2022-2023 PNA Action Plan will be developed for activities for the Alliance's tri-county service areas. The annual PNA report is due to DHCS on June 30, 2022. To learn more about the PNA report and review previous Alliance PNA reports, visit our website at https://thealliance.health/for-providers/manage-care/cultural-and-linguistic-services/.

Health Education and Disease Management. The QHP team engages with members through various health education and disease management programs telephonically, virtually, and provides members with resources. Outreach efforts were launched in Q2 2022.

- Healthy Weight for Life (HWL) Program. The HWL is an Alliance program designed for members ages 2-18 whose Body Mass Index (BMI) is at or above the 85th percentile. The program promotes healthy lifestyles, self-care, and chronic disease prevention. It also helps children and teens maintain a healthy weight. In 2021 the Alliance enhanced the HWL program by implementing the National Lifestyle Positive Parenting Program (Triple P). The HWL program will continue providing the 5210 concepts and Triple P 10-weekly session in-person workshop. The Triple P workshop is a comprehensive, evidence-based, multi-level parenting program designed to strengthen families by promoting positive relationships, help parents promote healthy social-emotional

development in their children, and teaches parents simple and effective strategies for handling everyday parenting challenges with additional focus on promoting children's physical health and managing childhood obesity. Triple P was designed as a specific strategy of intensive family intervention for families with an overweight or obese child. Traditionally, the HWL workshops are held in person at community locations for Alliance members in our tri-county servicing areas. Due to the COVID-19 pandemic, the Alliance modified this program to be offered over the phone in 2021. In Q2 2022, the QHP team launched its very first virtual workshop. In-person workshops will resume in Q3 - Q4 2022. Trained Alliance Health Educators lead these workshops, and the workshops consist of ten 1 ½ hour sessions.

Utilization Management/Complex Case Management (UM/CCM)

Inpatient/Emergency Department (ED). Overall, ED utilization rates in March and April showed a typical seasonal pattern of decrease from highs in January and February. ED utilization so far in 2022 has been higher than that seen during the pandemic starting in March 2020 and continuing through 2021 but remains below pre-pandemic levels seen in 2019 and early 2020.

Inpatient utilization rates from January through March have approximated rates seen in the same period in 2021 but remain below pre-pandemic utilization rates seen in 2019 through February 2020. Alliance concurrent review teams in all three counties have noted increases in inpatient admissions since March due to all causes including non-emergent conditions and return-to-care. COVID-19 admissions have remained stable and at low rates since March with far fewer ICU stays than in previous COVID-19 surges. An increase in readmission rates from February to April is being evaluated.

Prior Authorization. Following a process that started in early 2021 to identify codes for which authorization review does not add value, authorization requirements for 143 codes have been removed. This change is resulting in improved efficiency for providers and Alliance staff. Monitoring for changes in utilization of these codes is ongoing as part of the Alliance Utilization Management Work Plan.

Pharmacy. DHCS is finalizing plans for instatement or prior authorization requirements through the Medi-Cal Rx program for medications that were previously approved through Plans. They are proposing a phased approach and are receiving Plan input with the goal to minimize potential problems with refilling chronic medications.

Community Care Coordination

Enhanced Case Management and Community Support Services. New, updated documentation was received by DHCS on May 27, 2022. This included the revised ECM Policy Guide, updated ECM and CS Frequently Asked Questions, as well as updated Model of Care documents to be submitted to DHCS for ECM and CS. Ongoing DHCS and professional organization calls continue.

DHCS recently announced that the implementation of the 2023 Population of Focus for adults and youth who are incarcerated and transitioning to the community will be postponed and not implemented on January 2023, as originally planned. This is to align with ongoing work within CMS for this population. Further updates on when this Population of Focus will be implemented will be provided, when additional information becomes available from the state.

Staff are continuing to work towards the ECM and CS go-live in Merced County in July. Several provider engagement sessions have occurred since the last update, and the Alliance is working towards contracting to provide ECM and CS services with Merced County Community Based Organizations (CBOs). In addition, planning efforts are well underway to transition Recuperative Care and Bridge Housing over to CS services in all three counties in July.

Additional efforts to expand the ECM and CS contracted provider network continue. Staff are working with an additional three new providers in Santa Cruz and Monterey Counties to expand the network for additional members. Provider engagement sessions have also been held with a few providers who have experience in serving the new 2023 Populations of Focus, adults at risk of institutionalization and eligible for long-term care, and adult nursing facility residents transitioning back to the community, including at least one CBO in all three counties within the Alliance's service area.

Behavioral Health. Meetings have been scheduled with County Behavioral Health partners to implement new state guidance regarding the implementation of No Wrong Door, Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders and Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services. Revisions to the Memorandum of Understanding between the Alliance and County Behavioral Health partners are under review. Additionally, staff training and revisions to policies to align with this work has been completed.

Recruitment for the new role of the Behavioral Health Director is nearing completion. The Alliance hopes to complete the hiring process and bring the new director on for onboarding and orientation in Q3 2022.

Employee Services and Communications

Alliance Workforce. As of May 23, 2022, the Alliance has 522.55 budgeted positions of which our active workforce number is 503.4 (active FTE and temporary workers). There are 25 positions in active recruitment, and 43 positions are vacant. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets. Human Resources continues to partner with Budget & Reporting to ensure alignment in FTE goals.

With our transition to a hybrid working environment, Human Resources is assessing and updating all onboarding processes. Talent Acquisition and Training & Development have finalized the new Integration Plan and have implemented the pilot program. Our goal is to create an enriched employee experience, which begins with the onboarding of new staff. The next phase of the Onboarding Reboot is expected to go live this month with an interactive platform.

In response to feedback from the 2021 Employee Engagement Survey results, Human Resources is currently working on a competency and career development/pathway system designed to focus on position competency and career navigation and growth. This project is expected to continue through the end of 2022. Implementation of the platform is underway.

Human Resources has implemented a COVID-19 tracking module within our HRIS/Payroll system designed to easily monitor and track vaccination and booster status, including reporting capability. In addition, the module can intake COVID-19 test results for those employees required to submit a negative COVID-19 test based on company policy.

Communications. The paid media campaign to promote the COVID-19 booster incentive wrapped up on May 31, 2022. Paid media components included digital ads, streaming Pandora radio ads, billboard posters and interior bus ads. The campaign also included a website landing page and member-facing flyers. Referrals to the state's MyTurn site was also tracked via QR codes in transit ads. Although the campaign metrics are still being finalized, through mid-May we have seen the following:

- More than 9,000 unique pageviews for the English version of the website landing page.
- More than 7,500 unique pageviews for the Spanish version of the website landing page.
- Nearly 5 million impressions on digital advertisements and streaming radio ads, resulting in over 16,000 visits to Alliance website.
- Nearly 7,000 users reached on Facebook.
- Over 200 visits to the state's MyTurn vaccine site (direct clicks from QR code on transit ads and member flyer).

Staff finished the Executive Summary of the Strategic Plan. This one-page, two-sided document provides a succinct overview of our Strategic Priorities and Goals and is available in digital format. A limited number of copies will also be printed to be distributed to a variety of external stakeholders and partners. These hard copies will be delivered in mid-June.

Staff have also begun work on brainstorming media campaigns for the upcoming flu vaccine season. The campaign will leverage reach and engagement learnings from the COVID-19 vaccine media campaign and will include a mix of owned and paid media tactics. The campaign will be finalized in late summer for an early fall launch and will run approximately eight weeks. More information will be provided in the coming months.

Facilities and Administrative Services.

1098 38th Avenue**:** The demolition of the former Capitola Manor structure has been completed.

HVAC Replacement: The Facilities Department is working to replace several large heating and air conditioning units at 1600 and 1800 Green Hills Road as part of the capital project plan.

Community Events: An event application form and policy is being developed to guide usage of Alliance auditoriums for community partners who may be interested in renting the space.

Operations

Member Calls. The Member Services Call Center continues to evaluate the increase in call talk time due to more complex calls, leading to members waiting longer than usual to speak with an Alliance representative. As a result, the Alliance is engaging our current transportation vendor to take on the intake and scheduling of member requests for transportation services. As our transportation vendor currently supports this work for many large health plans in California, they have the capacity to provide high quality service to our members while meeting established call center service levels. The Alliance is looking to transition transportation calls to our transportation vendor in Q4 2022.

COVID-19 Public Health Emergency (PHE). The Member Services department continues to prepare for the potential end of the COVID-19 PHE, which would require California counties to resume the full Medi-Cal redetermination process. In partnership with the Communications department, Member Services staff developed a flyer to educate members on the upcoming

changes when the PHE ends. Further, the Alliance is actively working with our partner counties to develop a process to freely share member information to ensure we collectively engage with as many members as possible in order to limit the number of members falling off Medi-Cal.

Claims. Prior to Memorial Day weekend and the holiday office closure, claims inventory was beginning to trend down, with three straight week-over-week reductions in both inventory and claims aging. As noted in prior Board reports, volume of claims per 1,000 members have returned to a pre-pandemic level thus resulting in a higher overall inventory. The good news is that three of our new temporary employees began processing claims on May 31, 2022. We have three other temporary employees who will begin processing claims on June 23, 2022. While we expect to see further reductions in inventory as we close out June, we are looking forward to making substantial gain in inventory reduction in July, when we will have all six temporary employees processing claims, gaining more experience each week.

The launch of our HSP Platform level Claims Quality program remains on track. We have completed the interview process for our two Claims Quality analyst positions, and we are working with Human Resources on the offers.

Provider Services. DHCS has recently issued its 2021 audit. As an outcome of the findings, the Provider Services team will be updating the New Provider Training Process to be integrated with new credentialing of providers. Additionally, the Provider Services team is working diligently to ensure all Non-Emergency Medical Transportation (NEMT) providers are enrolled with Medi-Cal. The Provider Services team continues to ensure member access to NEMT by supporting existing NEMT providers and recruitment of new NEMT providers.

The Provider Services department continues to work closely with Merced based ECM and CS providers who requested contracts to provide services to eligible Alliance members. ECM and CS will go live in Merced County on July 1, 2022. Our internal ECM and CS team continue to meet with prospective ECM and CS providers located within Santa Cruz and Monterey County to support their request to contract and discuss operational inquiries. The Alliance is currently contracted with 12 ECM and CS providers in Santa Cruz and Monterey County. Additionally, the Alliance ECM and CS team has conducted preliminary planning sessions for expanding providers in Santa Cruz, Monterey and Merced Counties for the 2023 populations of focus.

Regional Operations Santa Cruz/Monterey/Merced. The Regional Operations Directors and other Alliance leadership met with San Benito and Mariposa County staff in May. This meeting included discussions to begin developing collaborative partnerships with Community Based Organizations that serve the Medi-Cal population in these counties. We will initiate outreach to these important partners within 2022.

The Regional Operations departments continue to promote vaccines in our tri-county area through in-person outreach at community events. In late May, we released the seventh issue of The Beat, our community newsletter and included information on keeping our community strong through Well Visits, provided updates regarding the end of the public health emergency and Medi-Cal expansion. We also included updates to the Medi-Cal Capacity Grant Program.

DATE: June 22, 2022

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Fourth Month Ending April 30, 2022

For the month ending April 30, 2022, the Alliance reported an Operating Income of $11.8M. The Year-to-Date (YTD) Operating Income is at $50.8M, with a Medical Loss Ratio (MLR) of 84.7% and an Administrative Loss Ratio (ALR) of 5.2%.

For April 2022 YTD, an operating income of $32.1M was expected based on the 2022 budget. The actual operating income is favorable to budget by $18.8M or 58.5%, driven primarily by $13.5M in favorable revenue rate variances and $1.5M from medical expense rate variances. Increased enrollment as compared to budget drove offsetting revenue and medical expense variances of $15.6M and ($14.0M), respectively. Such increased enrollment is driven by the extension of the Public Health Emergency (PHE) into 2022; the 2022 budget assumed the PHE would end and enrollment would decrease effective January 1, 2022, while the PHE is currently anticipated to end in mid-July 2022 with decreased enrollment to follow.

The 2022 budget assumed utilization levels to return to the 2019 level by Q1 2022, incrementally increasing each quarter and ending at a 5% increase from pre-pandemic levels. Staff expected that utilization would rise as members resumed delayed elective procedures, surgeries, and specialist referrals in 2022. Actual utilization continues to rebound from the lowest observed levels from 2020 and is heading towards 2019 levels. The 2022 budget additionally assumed that the LTC rate increase which was implemented in response to the PHE would be discontinued, which has not been realized.

	Apr-22 MTD (In $000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*395,252*	*373,452*	*21,800*	*5.8%*
Revenue	125,572	116,313	9,260	8.0%
Medical Expenses	107,518	100,751	(6,767)	-6.7%
Administrative Expenses	6,274	6,973	699	10.0%
Operating Income/(Loss)	11,781	8,589	3,192	37.2%
Net Income/(Loss)	7,223	7,356	(133)	-1.8%
MLR %	*85.6%*	*86.6%*	*1.0%*	
ALR %	*5.0%*	*6.0%*	*1.0%*	
Operating Income %	*9.4%*	*7.4%*	*2.0%*	
Net Income %	*5.8%*	*6.3%*	*-0.6%*	

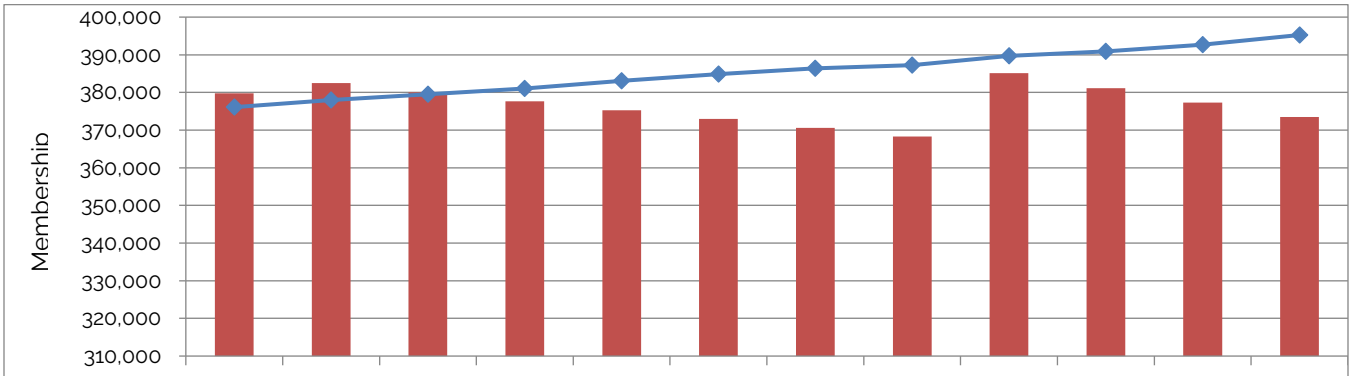
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Apr-22 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*1,568,473*	*1,516,990*	*51,483*	*3.4%*
Revenue	501,593	472,519	29,074	6.2%
Medical Expenses	424,906	412,414	(12,492)	-3.0%
Administrative Expenses	25,838	28,027	2,189	7.8%
Operating Income/(Loss)	50,848	32,078	18,771	58.5%
Net Income/(Loss)	34,476	27,136	7,340	27.0%
PMPM				
Revenue	319.80	311.48	8.31	2.7%
Medical Expenses	270.90	271.86	0.96	0.4%
Administrative Expenses	16.47	18.48	2.00	10.8%
Operating Income/(Loss)	32.42	21.15	11.27	53.3%
MLR %	84.7%	*87.3%*	*2.6%*	
ALR %	*5.2%*	*5.9%*	*0.7%*	
Operating Income %	*10.1%*	*6.8%*	*3.3%*	
Net Income %	*6.9%*	*5.7%*	*1.1%*	

Per Member Per Month. Capitation revenue and medical expenses are variables based on enrollment fluctuations; therefore, the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not directly correspond with enrollment and are consequently viewed in terms of total dollar amount. At a PMPM level, YTD revenue is $319.80, which is favorable to budget by $8.31 or 2.7%. Medical cost PMPM is $270.90, which is favorable by $0.96 or 0.4%. The resulting operating income PMPM is $32.42, which is favorable by $11.27 as compared to budget.

Membership. April 2022 Member Months are favorable to budget by 5.8%. Please note that the 2022 budget assumed the PHE would end in January 2022 and redetermination would resume. Therefore, it was expected that enrollment would decrease gradually to the pre-pandemic level by December 2022. The State anticipates the PHE will expire no sooner than July 2022. This will result in favorable membership and member months for the first half of the year, with the percentage variance anticipated to increase monthly.

Membership. Actual vs. Budget (based on actual enrollment trend for Apr-22 rolling 12 months)



	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Budget	379,753	382,481	380,048	377,645	375,273	372,929	370,611	368,326	385,108	381,158	377,272	373,452
Actual	376,094	377,967	379,537	381,066	383,089	384,876	386,374	387,235	389,667	390,866	392,688	395,252
Variance	(3,659)	(4,514)	(511)	3,421	7,816	11,947	15,763	18,909	4,559	9,708	15,416	21,800
Variance %	-1.0%	-1.2%	-0.1%	0.9%	2.1%	3.2%	4.3%	5.1%	1.2%	2.5%	4.1%	5.8%

Revenue. The 2022 revenue budget was based on the 2022 Department of Health Care Services rate package received in October 2021. The rate package included funding for Enhanced Care Management (ECM) and Community Supports (CS); both are new programs in 2022 and are assumed to be budget-neutral in the 2022 budget. Pharmacy revenue was removed from 2022 rates in alignment with the Medi-Cal Rx carve-out effective January 1, 2022.

April 2022 capitation revenue of $125.2M is favorable to budget by $9.2M or 7.9%. Favorability to budget is attributed to increased enrollment revenue of $6.8M, prior month true-up adjustments from supplemental revenue of $0.4M, MCO Tax revenue of $1.4M, CalAIM Incentive Payment Programs revenue of $0.4M, and other miscellaneous rate adjustments of $0.3M.

April 2022 YTD revenue of $500.3M is favorable to budget by $28.9M or 6.1%, of which $15.5M is attributed to enrollment and $13.4M to rate variance. This includes funding for various programs not yet finalized when preparing the 2022 budget, including CalAIM Incentive Payment Programs, rapid genome sequencing and the expansion of Medi-Cal benefits to undocumented Californians age 50 and older.

Apr-22 YTD Capitation Revenue Summary (In $000s)

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	11,943	106,657	6,286	3,327	2,959
Monterey	214,277	201,067	13,210	6,184	7,026
Merced	173,114	163,723	9,391	5,971	3,420
Total	**500,335**	**471,448**	**28,887**	**15,481**	**13,406**

Note: Excludes Apr-22 YTD In-Home Supportive Services (IHSS) premiums revenue of $1.3M.

Medical Expenses. April 2022 Medical Expenses of $107.5M are $6.8M or 6.7% unfavorable to budget. April 2022 YTD Medical Expenses of $424.9M are unfavorable to budget by $12.5M or 3.0%, with an MLR of 84.7%. Of this $12.5M unfavorable variance, $14.0M is due to enrollment and is partially offset by $1.5M attributed to PMPM cost variance.

Apr-22 YTD Medical Expense Summary (In $000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	168,303	157,154	(11,149)	(5,333)	(5,815)
Inpatient Services (LTC)	52,943	50,054	(2,889)	(1,699)	(1,190)
Physician Services	82,304	86,580	4,276	(2,938)	7,214
Outpatient Facility	51,204	54,543	3,340	(1,851)	5,191
Pharmacy	(959)	271	1,230	(9)	1,240
Other Medical	71,112	63,811	(7,301)	(2,166)	(5,135)
Total	**424,906**	**412,414**	**(12,492)**	**(13,996)**	**1,504**

Note: Other Medical includes Allied Health, Non-Claims HC Cost, transportation, ECM, ILOS, BHT, Lab, and other medical cost.

At a PMPM level, YTD Medical Expenses are $270.90, which is favorable by $0.96 or 0.4% as compared to budget. Please note that rate (PMPM) is the unit cost for a service multiplied by the utilization for the service.

Authorization per 1,000 in the first quarter of 2022 indicates services suppressed during the pandemic are trending upwards to CY 2019 levels. The overall patterns indicate services are resuming with loosened COVID-19 restrictions. Overall, utilization could continue to gradually increase from a backlog of delayed scheduled outpatient surgeries and procedures as a result of members' increased confidence in seeking care outside of emergency care. The 2022 budget assumed utilization would return to the 2019 level during Q1 2022 and increase 5% over 2019 by year-end.

Actual overall 2022 utilization has not achieved the 2019 level through April. Authorizations indicate that Inpatient (Hospital) utilization continued to be suppressed below the 2019 level through early 2022, which represents approximately 50% of medical expenses. However, $2M in retroactive claims payments from 2019 and 2020 and $8.9M in Incurred but Not Reported (IBNR) increases due to recent October and November 2021 payments have driven Inpatient Services costs higher than budget both on a PMPM and dollar basis.

The 2022 budget further assumed that the LTC rate increase implemented in response to the PHE would be discontinued. This assumption has not been realized, and an additional 4% LTC rate increase was assumed for 2022. Unknown impacts from the continuation of the PHE in Q1 2022 could further impact utilization and will drive continuing variances in actual versus budgeted LTC costs.

Apr-22 YTD Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	107.30	103.60	(3.71)	-3.6%
Inpatient Services (LTC)	33.75	33.00	(0.76)	-2.3%
Physician Services	52.47	57.07	4.60	8.1%
Outpatient Facility	32.65	35.95	3.31	9.2%
Pharmacy	(0.61)	0.18	0.79	100.0%
Other Medical	45.34	42.06	(3.27)	-7.8%
Total	**270.90**	**271.86**	**0.96**	**0.4%**

Administrative Expenses. April 2022 YTD Administrative Expenses are favorable to budget by $2.2M or 7.8% with a 5.2% ALR. Salaries, Wages, & Benefits (SWB) are favorable by $1.4M or 7.1% due to Benefits running lower than budget and vacant positions savings. Non-Salary Administrative Expenses are favorable by $0.8M or 9.5% due to the timing of the actual spend versus budget.

Non-Operating Revenue/Expenses. April 2022 YTD Total Non-Operating Revenue is unfavorable to budget by $13.2M, primarily driven by unrealized gains/loss on investments. This is offset by a favorable April 2022 YTD Non-Operating Expense of $1.8M, resulting in an unfavorable net loss of $11.4M.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $34.5M, with an MLR of 84.7%, and an ALR of 5.2%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Fourth Month Ending April 30, 2022
(In $000s)

Assets	
Cash	$80,105
Restricted Cash	300
Short Term Investments	578,769
Receivables	162,246
Prepaid Expenses	4,665
Other Current Assets	16,944
Total Current Assets	**$843,028**
Building, Land, Furniture & Equipment	
Capital Assets	$83,392
Accumulated Depreciation	(42,371)
CIP	200
Total Non-Current Assets	**41,222**
Total Assets	**$884,250**
Liabilities	
Accounts Payable	$15,303
IBNR/Claims Payable	241,536
Accrued Expenses	1
Estimated Risk Share Payable	3,333
Other Current Liabilities	6,808
Due to State	0
Total Current Liabilities	**$266,981**
Fund Balance	
Fund Balance - Prior	$582,793
Retained Earnings - CY	34,476
Total Fund Balance	**617,269**
Total Liabilities & Fund Balance	**$884,250**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Fourth Month Ending April 30, 2022
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*395,252*	*373,452*	*21,800*	*5.8%*	*1,568,473*	*1,516,990*	*51,483*	*3.4%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$125,219	$116,045	$9,174	7.9%	$500,335	$471,448	$28,887	6.1%
Premiums Commercial	354	268	86	32.1%	1,258	1,071	187	17.5%
Total Operating Revenue	**$125,572**	**$116,313**	**$9,260**	**8.0%**	**$501,593**	**$472,519**	**$29,074**	**6.2%**
Medical Expenses								
Inpatient Services (Hospital)	$41,293	$38,031	($3,263)	-8.6%	$168,303	$157,154	($11,149)	-7.1%
Inpatient Services (LTC)	10,844	13,428	2,584	19.2%	52,943	50,054	(2,889)	-5.8%
Physician Services	20,499	21,280	781	3.7%	82,304	86,580	4,276	4.9%
Outpatient Facility	15,584	14,184	(1,400)	-9.9%	51,204	54,543	3,340	6.1%
Pharmacy	(4)	70	74	100.0%	(959)	271	1,230	100.0%
Other Medical	19,301	13,758	(5,543)	-40.3%	71,112	63,811	(7,301)	-11.4%
Total Medical Expenses	**$107,518**	**$100,751**	**($6,767)**	**-6.7%**	**$424,906**	**$412,414**	**($12,492)**	**-3.0%**
Gross Margin	**$18,055**	**$15,562**	**$2,493**	**16.0%**	**$76,687**	**$60,105**	**$16,582**	**27.6%**
Administrative Expenses								
Salaries	$4,443	$4,885	$443	9.1%	$18,230	$19,617	$1,387	7.1%
Professional Fees	110	176	66	37.6%	530	724	194	26.8%
Purchased Services	683	644	(39)	-6.1%	2,740	2,694	(46)	-1.7%
Supplies & Other	671	873	203	23.2%	2,847	3,435	588	17.1%
Occupancy	86	102	16	15.5%	369	410	40	9.9%
Depreciation/Amortization	281	292	11	3.8%	1,122	1,147	25	2.2%
Total Administrative Expenses	**$6,274**	**$6,973**	**$699**	**10.0%**	**$25,838**	**$28,027**	**$2,189**	**7.8%**
Operating Income	**$11,781**	**$8,589**	**$3,192**	**37.2%**	**$50,848**	**$32,078**	**$18,771**	**58.5%**
Non-Op Income/(Expense)								
Interest	$558	$316	$241	76.2%	$1,881	$1,263	$618	48.9%
Gain/(Loss) on Investments	(3,076)	(239)	(2,837)	-100.0%	(14,966)	(954)	(14,013)	-100.0%
Other Revenues	124	86	38	43.7%	508	336	172	51.0%
Grants	(2,164)	(1,397)	(767)	-54.9%	(3,795)	(5,587)	1,792	32.1%
Total Non-Op Income/(Expense)	**($4,558)**	**($1,233)**	**($3,325)**	**-100.0%**	**($16,373)**	**($4,942)**	**($11,431)**	**-100.0%**
Net Income/(Loss)	**$7,223**	**$7,356**	**($133)**	**-1.8%**	**$34,476**	**$27,136**	**$7,340**	**27.0%**
MLR	*85.6%*	*86.6%*			*84.7%*	*87.3%*		
ALR	*5.0%*	*6.0%*			*5.2%*	*5.9%*		
Operating Income	*9.4%*	*7.4%*			*10.1%*	*6.8%*		
Net Income %	*5.8%*	*6.3%*			*6.9%*	*5.7%*		

Back to Agenda

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Fourth Month Ending April 30, 2022
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*395,252*	*373,452*	*21,800*	*5.8%*	*1,568,473*	*1,516,990*	*51,483*	*3.4%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$316.81	$310.74	$6.07	2.0%	$318.99	$310.78	$8.22	2.6%
Premiums Commercial	0.89	0.72	0.18	24.8%	0.80	0.71	0.10	13.6%
Total Operating Revenue	**$317.70**	**$311.45**	**$6.25**	**2.0%**	**$319.80**	**$311.48**	**$8.31**	**2.7%**
Medical Expenses								
Inpatient Services (Hospital)	$104.47	$101.84	($2.64)	-2.6%	$107.30	$103.60	($3.71)	-3.6%
Inpatient Services (LTC)	27.43	35.96	8.52	23.7%	33.75	33.00	(0.76)	-2.3%
Physician Services	51.86	56.98	5.12	9.0%	52.47	57.07	4.60	8.1%
Outpatient Facility	39.43	37.98	(1.45)	-3.8%	32.65	35.95	3.31	9.2%
Pharmacy	(0.01)	0.19	0.20	100.0%	(0.61)	0.18	0.79	100.0%
Other Medical	48.83	36.84	(11.99)	-32.5%	45.34	42.06	(3.27)	-7.8%
Total Medical Expenses	**$272.02**	**$269.78**	**($2.24)**	**-0.8%**	**$270.90**	**$271.86**	**$0.96**	**0.4%**
Gross Margin	**$45.68**	**$41.67**	**$4.01**	**9.6%**	**$48.89**	**$39.62**	**$9.27**	**23.4%**
Administrative Expenses								
Salaries	$11.24	$13.08	$1.84	14.1%	$11.62	$12.93	$1.31	10.1%
Professional Fees	0.28	0.47	0.19	41.1%	0.34	0.48	0.14	29.2%
Purchased Services	1.73	1.72	(0.00)	-0.2%	1.75	1.78	0.03	1.6%
Supplies & Other	1.70	2.34	0.64	27.4%	1.82	2.26	0.45	19.8%
Occupancy	0.22	0.27	0.05	20.1%	0.24	0.27	0.03	12.8%
Depreciation/Amortization	0.71	0.78	0.07	9.1%	0.72	0.76	0.04	5.4%
Total Administrative Expenses	**$15.87**	**$18.67**	**$2.80**	**15.0%**	**$16.47**	**$18.48**	**$2.00**	**10.8%**
Operating Income	**$29.81**	**$23.00**	**$6.81**	**29.6%**	**$32.42**	**$21.15**	**$11.27**	**53.3%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Fourth Month Ending April 30, 2022
(In $000s)

	MTD	YTD
Net Income	$7,223	$34,476
Items not requiring the use of cash: Depreciation	281	1,122
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	2,344	83,303
Prepaid Expenses	(21)	(2,467)
Current Assets	780	(840)
Net Changes to Assets	**$3,103**	**$79,997**
Changes to Payables:		
Accounts Payable	(31,929)	(41,637)
Accrued Expenses	-	-
Other Current Liabilities	(37)	(507)
Incurred But Not Reported Claims/Claims Payable	(102,800)	(83,213)
Estimated Risk Share Payable	(9,167)	(6,667)
Due to State	-	-
Net Changes to Payables	**($143,933)**	**($132,025)**
Net Cash Provided by (Used in) Operating Activities	**($133,326)**	**($16,430)**
Change in Investments	(22,465)	(40,885)
Other Equipment Acquisitions	-	(108)
Net Cash Provided by (Used in) Investing Activities	**($22,465)**	**($40,993)**
Net Increase (Decrease) in Cash & Cash Equivalents	**($155,791)**	**($57,423)**
Cash & Cash Equivalents at Beginning of Period	**$235,896**	**$137,528**
Cash & Cash Equivalents at April 30, 2022	**$80,105**	**$80,105**

Meeting Minutes

Wednesday, May 25, 2022
3:00 – 5:00 p.m.

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

Commissioners Present:

Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Dr. Larry deGhetaldi	Provider Representative
Ms. Julie Edgcomb	Public Representative
Dr. Charles Harris	Hospital Representative
Ms. Dori Rose Inda	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Mr. Michael Molesky	Public Representative
Ms. Mónica Morales	County Health Services Agency Director
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Mr. Rob Smith	Public Representative

Commissioners Absent:

Supervisor Wendy Root Askew	County Board of Supervisors
Dr. Maximiliano Cuevas	Provider Representative
Supervisor Zach Friend	County Board of Supervisors
Ms. Shebreh Kalantari-Johnson	Public Representative

Ms. Rebecca Nanyonjo	Director of Public Health
Dr. Joerg Schuller	Hospital Representative
Mr. Tony Weber	Provider Representative

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Mr. Scott Fortner	Chief Administrative Officer
Dr. Maurice Herbelin	Chief Medical Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
Dr. Dale Bishop	Medical Director
Dr. Dianna Diallo	Medical Director
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Jimenez.

Commission Chairperson Jimenez called the meeting to order at 3:08 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

Ms. Sonnenshine, CEO, indicated that Closed Session item 15 would be discussed prior to item 14 due to Counsel availability.

2. Oral Communications.

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

No members of the public addressed the Commission.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

No comments or announcements from Commissioners at this time.

[Commissioner Harris arrived at this time: 3:11 p.m.]

4. Comments and announcements by Chief Executive Officer.

Chair Jimenez opened the floor for Ms. Stephanie Sonnenshine, Chief Executive Officer (CEO).

Ms. Sonnenshine announced the resignation of Commissioner Elsa Quezada from the Board, effective May 19, 2022, and thanked her for her dedication and commitment to the Alliance for over 20 years. Staff are in contact with Monterey County to fill the vacant Public Representative seat.

Ms. Sonnenshine noted that she did not attend the grand opening of the Coastal Kids Home Care, Rodgers Center for Children's Health in Salinas (included in the Executive Report from the CEO) due to a COVID-19 exposure. Ms. Kathleen McCarthy, Strategic Development Director, was able to attend the event.

Additionally, she confirmed that five attending Board members who were not disqualified from voting on Regular Agenda item 12 due to potential conflict of interest would remain at the meeting to act on the Care-Based Incentive 2023 recommendation.

Lastly, she provided an update on the May revise, the Alternate Health Care Service Plan: AB 2724 (Arambula) proposal and the impact of the recent gun violence as a public health issue.

Consent Agenda Items: (5. – 10E.): 3:14 p.m.

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

MOTION: Commissioner Bizzini moved to approve the Consent Agenda seconded by Commissioner Smith.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Conner, deGhetaldi, Edgcomb, Harris, Inda, Jimenez, Molesky, Morales, Pedrozo, Radner and Smith.

Noes: None.

Absent: Commissioners Askew, Cuevas, Friend, Kalantari-Johnson, Nanyonjo, Rabago, Schuller and Weber.

Abstain: None.

Regular Agenda Item: (11. - 13.): 3:15 p.m.

11. Consider accepting audited financial statements and management letters for Alliance's fiscal year ending December 31, 2021 from Moss Adams LLP, independent auditors. (3:15 – 3:31 p.m.)

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

The asset composition included information derived from the statement of net position. Part of the audit included obtaining third party confirmation of bank balances and management prepared reconciliations, to ensure those balances agree and were prepared accurately. There were no issues with Management's ability to reconcile the cash account. Capitation receivables from the State of California were reviewed.

The short-term and Board designated investments were presented. Part of the audit procedure included obtaining third party financial statements or financial institution confirmations to ensure the amounts stated in the balance sheet were presented at fair market

value in accordance with Governmental accounting standards basis. No discrepancies were found on the confirmed amount and investments and related disclosures are complete and accurate.

[Commissioner Rabago arrived at this time: 3:24 p.m.]

Capital assets and other assets remained consistent from the prior year and are properly capitalized and in accordance with Management's capitalization policy. Other Assets balance remains fairly consistent with the prior year and are property supported. Composition of liabilities and net positions of the financial statements were discussed. Medical claims liability was one of the largest estimates in the financial statements and included both known claims and those that were incurred but not reported medical claims liability. Directed payments payable related to pass through payment to providers subsequent to year end were found to be effectively paid out to the related providers. Provider incentives payable is fairly consistent with the prior year balance. Total operating expenses increased from the prior year due mainly to slight increases in capitation rates from the State and an increase in members from the pause in redetermination eligibility status due to the public health emergency. Claims payments to providers are the largest expense followed by member drug costs in this category.

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

MOTION: Commissioner Molesky moved to accept audited financial statements and management letters for Alliance's fiscal year ending December 31, 2021 from Moss Adams LLP, independent auditors, seconded by Commissioner Conner.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Conner, deGhetaldi, Edgcomb, Harris, Inda, Jimenez, Molesky, Morales, Pedrozo, Rabago, Radner and Smith.

Noes: None.

Absent: Commissioners Askew, Cuevas, Friend, Kalantari-Johnson, Nanyonjo, Schuller and Weber.

Abstain: None.

12. Consider approving proposed changes to Alliance's Care-Based Incentives (CBI) for 2023. (3:31 – 4:01 p.m.)

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

Dr. Dianna Diallo, Medical Director, summarized the proposed changes to CBI for 2023.

Staff recommended the following changes:

1. Programmatic Measures
   - Add: Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents, and Health Plan Health Disparity Metric
   - Retire: Unhealthy Alcohol Use in Adolescents and Adults, and Asthma Medication Ratio
2. Fee-for-Service (FFS) Measures
   - Add: $200 FFS measure for completion of the ACEs training and attestation
3. Exploratory Measures
   - Add: Colorectal Cancer Screening
   - Retire: 90-Day Referral Completion, and Latent Tuberculosis Infection (LTBI) Screening

Commissioners commented on the FFS measure, the colorectal cancer screening exploratory measure, and tracking children with disabilities vs. non-disabled children.

MOTION: Commissioner Molesky moved to approve the proposed changes to Care-Based Incentives for 2023, seconded by Commissioner Pedrozo.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Edgcomb, Molesky, Pedrozo and Smith.

Noes: None.

Absent: Commissioners Askew, Cuevas, Friend, Kalantari-Johnson, Nanyonjo, Schuller and Weber.

Abstain: Commissioners Conner, deGhetaldi, Harris, Inda, Jimenez, Morales, Rabago and Radner.

[Chair Jimenez departed at this time: 4:01 p.m.]

Vice Chair Pedrozo presided over the remainder of the meeting.

13. Discuss Alliance Security. (4:01 – 4:21 p.m.)

Mr. Cecil Newton, Chief Information Officer and Information Security Officer, provided an update on Alliance security and 2022 ransomware readiness timeline implementation. Healthcare organizations are being targeted by security attacks due to the value of healthcare data and the belief that security controls are lacking in healthcare organizations. A significant effort is underway to improve the Alliance's overall security posture. The Alliance is implementing security controls, technology and processes with the goal of further protecting the organization against ransomware attacks.

Adjourn to Closed Session

Vice Chair Pedrozo moved the Commission into Closed Session at 4:25 p.m. Closed Session items were taken in reverse order to accommodate Counsel participation.

15. Closed session pursuant to Government Code Section 54956.9(d)(2) – Conference with Legal Counsel – Potential litigation (One Case).

14. Closed session pursuant to Government Code Section 54957(b)(1) regarding Public Employment (three Executive roles).

Return to Open Session

Vice Chair Pedrozo reconvened the meeting to Open Session at 4:59 p.m.

16. Open Session pursuant to Government Code Section 54957(b)(1) regarding Public Employment (three Executive roles).

Vice Chair Pedrozo reported from Closed Session that the Board reviewed, discussed and accepted staff's report.

17. Open Session pursuant to Government Code Section 54956.9(d)(2) – Conference with Legal Counsel - Potential litigation (One Case).

Vice Chair Pedrozo reported from Closed Session that the Board reviewed, discussed and accepted staff's report.

The Commission adjourned its regular meeting of May 25, 2022 at 5:03 p.m. to the regular meeting of June 22, 2022 at 3:00 p.m. via videoconference from Alliance offices in Scotts Valley, Salinas, and Merced unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, April 20, 2022
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Bob Trinh	Technology Services Director
Bonnie Liang	Controller
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Dale Bishop	Chief Medical Officer
Danita Carlson	Government Relations Director
Dianna Diallo	Medical Director
Gordon Arakawa	Medical Director
Jenifer Mandella	Compliance Officer (Chair)
Jennifer Mockus	Community Care Coordination Director
Jordan Turetsky	Provider Services Director
Joy Cubbin	Accounting Director
Kate Knutson	Compliance Manager
Kathleen McCarthy	Strategic Development Director
Kay Lor	Provider Payment Director
Lilia Chagolla	Regional Operations Director, Monterey County
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Luis Somoza	Member Services Director
Michelle Stott	Quality Improvement and Population Health Director
Navneet Sachdeva	Pharmacy Director
Rick Dabir	Application Services Director
Ryan Inlow	Facilities & Administrative Services Director
Scott Fortner	Chief Administrative Officer
Stephanie Sonnenshine	Chief Executive Officer
Van Wong	Chief Information Officer

Committee Members Absent:

Committee Members Excused:

Frank Song	Analytics Director
Ronita Margain	Regional Operations Director, Merced County

Ad-Hoc Attendees:

Jessie Dybdahl	Credentialing and Provider Data Configuration Manager
Rebecca Seligman	Compliance Supervisor
Sara Halward	Compliance Specialist II

1. Call to Order by Chairperson Mandella.

Chairperson Jenifer Mandella called the meeting to order at 9:03 a.m.

2. Review and Approval of March 16, 2022 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of March 16, 2022 meeting.

3. Consent Agenda.

1. **Policy Hub Approvals**
2. **Regulatory and All Plan Letter Updates**
3. **Quarterly Policy Monitoring**

Mandella, Compliance Officer pulled the revised Quarterly Policy Monitoring from the consent agenda and noted that many of the Past Due policies have been updated and reminded the Committee to revise and submit Policy Attachments when revising policies.

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. Delegate Oversight Quarterly Report

Knutson, Compliance Manager, presented the Q4 2021 Delegate Oversight Quarterly Activity Report and 2022 Annual Review.

2022 Annual Review
Staff recommended approval of the following documents received from delegates:

- Arista MD: Credentialing
- Beacon/CHIPA: Claims, Credentialing, Cultural & Linguistics (C&L), Finance, Fraud, Waste and Abuse (FWA), Member Connections, Member Grievance, Member Rights, Member Rights-PHI, and Network Adequacy
- CareNet: Compliance, C&L and Member Connections, Member Grievance, Member Rights and Member Rights-PHI
- MedImpact: Claims, Compliance, Credentialing, C&L, FWA, Member Connections and Network Adequacy
- PAMF: Credentialing
- SCVMC: Credentialing
- VSP: Claims, Credentialing, C&L, FWA, Member Connections, Member Rights, Network Adequacy and Quality Improvement (QI)

Knutson noted that requests for additional documentation for the Annual Review resulted in a delay in availability of some reports and advised the Committee that further updates to the 2022 Annual Review will be provided in Q3 2022.

COMMITTEE ACTION: Committee reviewed and approved the continued delegation of the identified functions as indicated for the 2022 Annual Review.

Q3 2021 Continuous Oversight Activities
Staff recommended approval of the following documents received from delegates:

- Beacon/CHIPA: Member Grievance

COMMITTEE ACTION: Committee reviewed and approved the Q3 2021 Continuous Oversight Activities.

Q4 2021 Continuous Oversight Activities
Staff recommended approval of the following documents received from delegates:

- Beacon/CHIPA: Claims, Credentialing, Member Connections, Network Adequacy, Provider Disputes, QI, and Utilization Management (UM)
- ChildNet: Credentialing
- LPCH: Credentialing
- MedImpact: Claims, Network Adequacy and Provider Disputes
- PAMF: Credentialing
- SCVMC: Credentialing
- UCSF: Credentialing
- VSP: Claims, Credentialing, Member Connections, Member Grievance, Provider Disputes, and QI

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

- Beacon/CHIPA: Member Grievance

COMMITTEE ACTION: Committee reviewed and approved the Q4 2021 Continuous Oversight Activities and assigned the following action items:

- Sanders to review Beacon/CHIPA Member Grievances documentation upon receipt and complete quarterly review

Additional Oversight Activities
Knutson reviewed the Q4 2021 Beacon Performance Guarantees noting that MedImpact met all measurement requirements in Q421 and that Beacon failed to meet requirements for Average Speed to Answer.

Knutson reported on the Beacon Quality Corrective Action Plan (CAP), noting that 3 of 7 actions items remain completed on Timely Access and 18 of 19 action items remain completed on Coordination of Care. Knutson advised the committee that this CAP will remain open until data related to the CAP's performance improvement plan efficacy is assessed.

Knutson reported an additional CAP was imposed on Beacon related to ongoing reports of excessive delays in their processing of credentialing applications. This CAP was imposed in April 2022 and is pending response from Beacon.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2021 Delegate Oversight Quarterly Report.

2. Stanford Pre-Delegation Assessment

Dybdahl, Credentialing and Provider Data Configuration Manager, presented the Stanford Pre-Delegation Assessment. Including the identification that the pre-delegation assessment had not been conducted, Provider Services' assessment that Stanford is in compliance with Alliance requirements by virtue of sharing medical staff services with other delegated entities and noting that a revised MOU with Stanford was drafted and ready for execution, pending Compliance Committee's approval of the delegation.

COMMITTEE ACTION: Committee reviewed and approved the Stanford Pre-Delegation Assessment.

3. 2022 Record Retention

Knutson presented the timeline and resources of the 2022 Record Retention project noting that all departments are asked to engage in this annual project and review of hard-copy records has been reinstated for this year.

Record Retention Project Timeline:

- Project Kick-off: April 22, 2022
- Reviews Completed: October 01, 2022
- Compliance provides summary to Chiefs: November 01, 2022

Knutson advised the Committee of resources available to staff to aid in completion of Record Retention.

4. APL Discussion

Mandella, Chair, introduced new regular agenda item to review in-process All Plan Letters (APLs) and:

- Identify a department to lead APL implementation efforts across impacted department;
- Review current APL status and challenges; and
- Determine Project Management Office support requirements

The Committee reviewed the following APLs:

- DMHC 22-003 - AB 457 Protection of patient choice in Telehealth Provider Act
- DMHC 22-007 - DPN Monitoring and Annual Reporting Changes
- DHCS 22-002 – Alternative Format Selection for Members with Visual Impairments
- DHCS 22-003 – Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders

The meeting adjourned at 10:00 a.m.

Respectfully submitted,

Robin Sihler
Compliance Administrative and Data Reporting Assistant

Physicians Advisory Group

Meeting Minutes

Thursday, March 3, 2022
12:00 - 1:30 p.m.

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

Group Members Present:

Dr. Misty Navarro	Provider Representative
Dr. Scott Prysi	Provider Representative
Dr. Amy McEntee	Provider Representative
Dr. Devon Francis	Provider Representative
Dr. Shirley Dickinson	Provider Representative
Dr. Michael Yen	Provider Representative
Dr. Barry Norris	Provider Representative
Dr. Casey Kirkhart	Provider Representative
Dr. Jennifer Hastings	Provider Representative
Dr. Salvador Sandoval	Provider Representative
Dr. James Rabago	Provider Representative
Dr. Caroline Kennedy	Provider Representative

Group Members Absent:

Dr. Anjani Thakur	Provider Representative
Dr. Patrick Clyne	Provider Representative

Staff Present:

Dr. Dale Bishop	Chief Medical Officer
Dr. Dianna Diallo	Medical Director
Dr. Gordon Arakawa	Medical Director
Ms. Navneet Sachdeva	Pharmacy Director
Ms. Hilary Gillette-Walch	Quality & Population Health Manager
Ms. Deborah Pineada	Quality & Health Programs Manager
Ms. Tracy Neves	Clerk of the Advisory Group

Public Representatives Present:

Ms. Becky Shaw	Public Representative

1. Call to Order by Chairperson Dr. Dale Bishop.

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

   No supplements or deletions were made to the agenda.

2. Oral Communications.

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

   No members of the public addressed the Group.

   Consent Agenda

   A. The group reviewed the December 2, 2021 Physicians Advisory Group (PAG) minutes.

      Action: Minutes approved as written.

3. **Old Business**

   A. Pharmacy Carve-Out Update
      Navneet Sachdeva provided a pharmacy carve-out update and noted there have been many overrides and the Prior Authorization (PA) policy has been temporarily removed. Magellan has been meeting their 24-hour turnaround time and the call center has about a 15-minute wait, wait times are improving. There is a concern when the overrides return and how this will impact Magellan. Health plans are working with the Department of Health Care Services (DHCS) and Magellan and providing feedback. A provider noted things have improved and having the PA waiver has helped and the partnership with the Alliance Pharmacy team has been invaluable. Another provider noted she thought there would be a 6-month grace period before there was a need to submit PAs, and she was not prepared. Navneet noted it is the understanding if the member has a claim in last 180 days, the claim would be approved but there is a caveat in DHCS' formulary regarding billing and manufacturers and this resulted in issues. There was a requirement for PA specific manufacturers or NDC codes for approval. There will be prior authorization relief until April and DHCS will reassess the situation at that time.

      Provider noted that ICD 10 codes for Alliance members are now needed for prescriptions upon discharge from the emergency department (ED). **Action:** Navneet will discuss this issue further with DHCS.

   B. COVID-19 Vaccine Incentive Program Update
      Hilary Gillette-Walch shared DHCS metric data for the vaccine incentive program for January 2022, August, and October 2021 for population 12 years and

older. Ages 5-11 years was recently added, and metrics are for those with one vaccine dose. The two lowest vaccinated populations identified were American Indian and African American, and these populations showed improvement as of January 2022. The target for the Alliance for those 5+ years and older is 76.2% and as of January the Alliance had reached overall 52%. There will be another measurement on March 2 and that will wrap-up the DHCS program. It was noted, homebound members were targeted early on during the vaccine incentive program. A provider inquired about getting homebound members vaccinated. It was noted that the Alliance's case management team can assist, and information is also available on the My Turn website to connect members with services.

Deborah Pineda noted that the COVID-19 Member Incentive Program began on September 1, 2021 and ended on February 28, 2022. The program was created to promote vaccinations for Alliance members ages 5 years and older in receiving their first or second dose of the COVID-19 vaccine. Members were provided a $50 Target gift card for receiving the vaccine. Over 60,000+ Alliance members ages 5 years and older received incentives and over 70% of gift cards have been claimed. The Alliance contracted with the vendor, Customer Motivators to mail out gift cards to eligible members. Alliance members were able to redeem their gift cards in three ways via phone, online, and mail. The Alliance percent rate of claimed gift cards is 5 points higher than any other health plan the vendor has worked with in California. Member feedback has been positive, and members have shared information with others. The Alliance continues to follow-up with members if a gift card mailing is not received. Members are also able to receive incentives at point-of-service and the Alliance's Your Health Matters team has led these initiatives. The Alliance has also partnered with Homeless Persons Health Project for point-of-service member incentives, which began on February 1, 2022. The goal is to reach members with the lowest vaccination rates and hardest to reach populations.

The Alliance is continuing to meet local needs and will implement an Alliance COVID-19 vaccine member incentive for members 12 years and older for a COVID-19 booster vaccine from March 1 – May 31, 2022. Members will receive a $50 Target gift card. The Alliance will continue to offer these member incentives through the point-of-service efforts and Customer Motivators (mailing). It was noted, the Alliance continues to work with community-based organizations and public health departments. Provider noted he will touch base with Ronita regarding work with community-based organizations in Merced County. Providers can also contact their Provider Services Representative if you have questions.

The Provider Vaccine Incentive program began on February 1 and the Alliance is working to increase visibility with providers. There were some individuals out in the field that were uninsured, so providing incentives at the clinics made more sense. The Alliance is developing a letter of agreement to allow other providers and community organizations to participate in the program.

Provider incentive rates are still being developed, and providers are encouraged to return their provider amendment. It was suggested that getting homeless individuals enrolled in Medi-Cal and vaccinated is important work.

The Alliance will be exploring additional incentives for 2022. The Group suggested member incentives for participation in diabetes education, healthy eating, and or cooking programs and for initial appointment visits. Deborah shared information about the Alliance Healthier Living Program (HLP) workshops. The Alliance's HLP is an evidence-based self-management program originally developed at Stanford University. It is designed to help Alliance members diagnosed with chronic conditions gain self-confidence in their ability to control their symptoms and understand how their health problems affect their lives. It's six (6) weekly workshops for members with chronic conditions and members receive incentives for participating. Due to COVID-19, the workshops are held telephonically and virtually. We will soon start transiting back to in-person workshops. **Action:** Deborah will share an informational workshop flyer with the Group.

4. **New Business**

A. Strategic Plan 2022 - 2026

Dr. Bishop provided an overview of the Strategic Plan. The Strategic Plan helps the Alliance successfully navigate external challenges and opportunities such as pandemic response and recovery, constrained delivery system capacity and CalAIM transformation to maximize health. The Strategic Plan establishes a high-level plan to achieve priorities under conditions of uncertainly, provides a roadmap for future initiates, provides staff, Board and the community with a common focus and perspective to achieve results. The Physician Advisory Group's input has been an important part of developing the Strategic Plan.

There were two priorities established: Health Equity and Person-Centered Delivery System Transformation. Health Equity will focus to address health inequities, the health care system will need to shift practices and policies that have traditionally benefitted some groups of people and left others out. The Health Equity goals will eliminate health disparities and achieve optimal health outcomes for children and youth and increase member access to culturally and linguistically appropriate health care. Person Centered Delivery System Transformation will focus to create a system that yields member health through shared decision making and action, rather than a system that simply delivers health care services. The Person Centered Delivery System goals will improve behavioral health services and systems to be person-centered and equitable and improve the system of care for members with complex medical and social needs. The initial steps to advance goals in 2022 include:

- Understand opportunities to resolve root cause disparities in pediatric health.

- Enhance member engagement to gain insights aimed at improving programs, policies, and practices.
- Understand gaps and opportunities to improve the behavioral health system.
- Improve the model of care for members experiencing homelessness, serious mental illness/substance use disorder and/or who are high utilizers.

B. Care Based Incentives (CBI) 2022
Dr. Bishop noted planning for CBI begins a year and half in advance and the current plan was developed in 2020 at the beginning of the pandemic. There were issues achieving the Quality of Care benchmarks due to the pandemic and adjustments of downward payment of CBI. Measurement payment adjustments for scores less than 50th percentile were excused for 2021 as the pandemic was making it impossible to achieve benchmarks. In 2022, there will be no elimination of adjustments since 2020 NCQA has dropped the requirements substantially and this has been captured in the Quality of Care measures.

Care Based Incentive 2022 benchmark changes for Quality of Care measures were shared with the Group. PAG members agreed that comparing 2022 to 2020 benchmarks should not present any additional challenges in achieving the measurements. If there are unforeseen challenges that effect the ability to achieve these benchmarks, they may be presented to the Board for further consideration.

C. Care Based Incentives 2023
Dr. Diallo reviewed the proposed changes for 2023 for Care Coordination Measures,

Care Coordination - Hospital and Outpatient Measures
- Ambulatory Care Sensitive Admissions
- Plan All-Cause Readmissions
- Preventable Emergency Visits

Care Coordination – Access Measures
- Application of Dental Fluoride Varnish
- Developmental Screening in the First 3 Years
- Initial Health Assessment
- Post-Discharge Care

Change Recommendation:
- Retire Unhealthy Alcohol Use in Adolescents and Adults
- Add Adverse Childhood Experiences (ACE) Screening in Children and Adolescents

The Alliance has not seen an impact with the Unhealthy Alcohol Use measure in addition to much impact to the recent change to add the adolescent population to the measure. If this measure is retired, it will open three points to be disbursed. The ACE screening would be changed from an exploratory to a paid

measure, and ACE screening numbers are low in Alliance service areas. A provider noted that ACE training would be important and could also be a barrier. Incentivizing providers for the ACE training would be helpful. Provider noted he set a 90-day limit to complete training and that it was part of the orientation to the provider group. **Action:** The Alliance will consider adding fee-for-service payment for the ACE training. Provider suggested addition of other SUD screening for clinics in place of the alcohol measure.

Provider inquired about post discharge measure. It was noted the post discharge care measure requires a primary care provider visit within 14 days of ED discharge (patient must be formally admitted).

Proposed changes for 2023 Quality of Care Measures include:

- Addition of Screening for Depression and follow-up plan.
- Addition of Lead Screening in Children.
- Retirement of Asthma Medication Ratio.

DHCS will retire the BMI measure from managed care measure, but this will remain a CBI measure. Provider noted that there is a state recall on the lead screening machine, and this is problematic. Dr. Bishop suggested this measure remain an exploratory measure for another year.

The Group discussed the Depression and Follow-up plan considerations.

- Current CMS measure uses Medi-Cal benefit codes.
- Two possible age stratifications: 12-17 or 18 and older.
- MCAS 2023 changes CMS measure to NCQA measures using LOINCs:
  - Postpartum Depression Screening and Follow Up
  - Prenatal Depression Screening and Follow Up
  - Depression Remission or Response for Adolescents and Adults
  - Depression Screening and Follow-Up for Adolescents and Adults

Currently the Alliance has Medi-Cal billing codes. Provider noted given this would be cumbersome for providers, it would be essential to discuss with DHCS behavioral health as the goal is an integrated approach. Consulting as part of a team would be important in moving forward with this measure. **Action:** The Alliance will consult with DHCS regarding this measure.

Dr. Diallo reviewed the proposed Health Plan Disparity Measure:

- This is a health plan performance measure, using the Child and Adolescent Well-Care Visit measure to determine whether different ethnic groups had or did not have equal access to primary care.
- Offer payment for 50% gap closure for racial/ethnic subpopulations to the NCQA 50% percentile.
- Consider future payment for PCP proposal of plan to address disparities.

In the recent 2020 Population Needs Assessment (PNA), the report findings showed that there are disparities between ethnic groups for some HEDIS measures among our member populations. Caucasians have lower rates than Hispanics and Blacks for Prenatal Care. Blacks have lower rates than Hispanics and Caucasians for several measures, including Asthma Medication Ratio, Well-Child Visits in the first 15 Months, Well-Child Visits at 3-6 years, and Diabetes A1c Screening.

The goal of the measure is to bring each ethnic group to the 50th percentile and close gaps within populations. The Alliance is considering what is the highest-level percentile we would like to achieve, and whether to consider commercial plan or MCAS levels. There would be a gap closure payment and possible project-based payment in 2024. The Alliance will be developing this measure further and looking at initial well visits.

6. **Open Discussion**

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

No further discussion.

The meeting adjourned at 1:30 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Group

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

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, March 17, 2022
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

Jennie Jet, MD	Provider Representative
Cal Gordon, MD	Provider Representative
Devon Francis, MD	Provider Representative
Sarah Smith, MD	Provider Representative

Committee Members Absent:

John Mark, MD	Provider Representative
Patrick Clyne, MD	Provider Representative
Salvador Sandoval, MD	Provider Representative

Staff Present:

Dale Bishop, MD	Chief Medical Officer
Dianna Diallo, MD	Medical Director
Gordan Arakawa, MD	Medical Director
Jennifer Mockus, RN	Community Care Coordination Director
Michelle Stott, RN	QI & Population Health Director
Hilary Gillette-Walch, RN, MPH	Quality and Population Heath Manager
Kelsey Riggs, RN	Complex Case Management Supervisor
Jessie Newton, RN	Care Coordination Manager
Jessica Hampton, RN	Enhanced Care Management/CS Manager
Vera Eichenbaum, Pharm D.	Clinical Pharmacist
Jeanette Revelez	Pharmacy Services Supervisor
Yasuno Sato, Pharm D.	Clinical Pharmacy Manager
Tammy Brass, RN	UM & Complex Case Management Manager
Sarah Sanders	Grievance and Quality Manager
Tracy Neves	Clerk of the Committee

Hospital Representatives Present:

James Rabago, MD	Board Representative
Becky Shaw	Provider Representative

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

2. **Oral Communications.**

Back to Agenda

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

No members of the public addressed the Committee.

3. Consent Agenda Items.

A. Approval of WCMCAC Minutes
Minutes from the December 16, 2021 meeting were reviewed.

B. Grievance Update
Grievance data was reviewed and provided to the Committee.

M/S/A Consent agenda items approved.

4. Regular Business.

A. Pharmacy Carve-Out

Vera Eichenbaum noted on January 1st 2022, the pharmacy benefit was transitioned to Medi-Cal Rx. This means that prescriptions that are filled at a pharmacy are now covered by Medi-Cal Rx instead of the Alliance. There is no change for drugs administered by providers in their office and infusion clinics, these remain Alliance responsibility.

Proactive actions taken by Medi-Cal Rx included:

- Medi-Cal Rx 180-day Transitional Period through June 30, 2022.
- Reject Code Suspension until April 30, 2022.
- Auto-Prior Authorization (PA) for Synagis and Makena until April 30. 2022.

Proactive actions taken by the Alliance included:

- Review of daily data feeds from Medi-Cal Rx and MedImpact.
- Utilization of Medi-Cal Rx Portal and Clinical Liaison for care coordination.
- Communication with DHCS and Medi-Cal Rx on ongoing issues.

As part of our proactive provider outreach, the Alliance generates and evaluates multiple daily reports. Information reviewed includes prescriptions that pharmacies are unable to fill due to denial by Medi-Cal Rx, and denied prior authorizations and medication requests from pharmacies and doctors that are sent to the Alliance in error. The Alliance ensures pharmacies are billing correctly and provides correct information if there are discrepancies. In addition, pharmacies are provided appropriate override codes for example when there is a continuation of therapy to override a denial. Providers are contacted when medications are denied, and a prior authorization is needed and assisted with the process. California Children's Services (CCS) patients and other high-risk members such as recent discharge, or previous related hospitalizations and those with medication access issues are referred to Care Management for assistance and follow-up.

As a result of Alliance Pharmacy Outreach, our members have faster access to medications and medication issues are proactively resolved preventing gaps in therapy. Also, provider burden is decreased by unnecessary submission or avoidable PA requests. The outreach helps pharmacies process medications and focus on their patients without the need to call Medi-Cal Rx for assistance. The Alliance's pharmacy outreach results in fewer phone calls from members and providers requesting assistance, and fewer unnecessary prior authorization requests submitted to Medi-Cal Rx.

Medication access issues encountered included off label use and not FDA approved medications not covered and requiring PA submission with evidence-based literature support such as clinical guidelines and large case studies, etc. (small case reports are generally not accepted). The Alliance was unable to find a pharmacy to provide sterile compounding for Medi-Cal Rx members which means these members will be switched to a non-compounded, commercially available formulation, or must pay out of pocket for the medication.

Recommendations to Providers:

- Be aware of restrictions.
- Submit chart notes and relevant documentation.
- Provide accurate and complete details on PA requests and pay attention to questions.

Provider inquired about the contract drug list and if there is an easier way to search for medications. Yasuno suggested utilizing the drug look-up tool, and then review the PDF version for the details. Cover MY Meds is also recommended by Medi-Cal Rx. Some of the larger clinics are working to integrate the information into their EMR systems. Also, Sure Scripts has information from Medi-Cal Rx.

Providers can call the Alliance directly to assist with medication issues if needed. Policy questions can be relayed to Navneet, and she can communicate them to DHCS.

B. WCM Update

Kelsey Riggs provided an update on California Children's Services Eligibility and Member Volumes. At the end of quarter 4, there was a total of 7,208 CCS members with a total of 373 new members which was the highest amount per quarter. CCS referrals for all counties included 294 referrals for quarter 2, 419 referrals for quarter 3 and 513 referrals for quarter 4 (data unavailable for quarter 1 due to the new reporting system). For quarter 4 2021, the team ended the year with a total of 1,979 CCS Individualized Care Plans (ICPS) with 714 in Merced, 961 in Monterey, and 304 in Santa Cruz. Provider letters are being distributed to engage provider paneling, and the team is seeing positive responses. Tammy shared that the Alliance recently completed the DHCS audit and is awaiting results. The audit and exit interview went

well, and the auditors were very complementary of the growth in the WCM programs.

C. CalAIM Enhanced Care Management & Community Support Services (ECM/CS)
Jessica Hampton provided an overview of the Enhanced Care Management and Community Supports program. ECM became a Medi-Cal benefit on January 1, 2022 in Santa Cruz and Monterey Counties and will begin in Merced County on July 1st. ECM is high-touch, face-to-face community work with frequent member contact and is available to Medi/Medi's. The ECM benefit provides intensive whole-person care management and coordination to help address the clinical and non-clinical needs of the Medi-Cal Managed Care Plans' highest risk members. ECM is person-centered, goal-oriented, and culturally relevant and services are arranged through the county or community-based providers that serve the populations of focus.

The ECM Populations of Focus Timeline includes:
Phase I – January 2022
- Individuals and Families Experiencing Homelessness (one of the only populations that will include the pediatric population this year).
- High Utilizer Adults.
- Adults who have serious mental illness (SMI) and substance use disorder (SUD) conditions.

Phase II – January 2023
- Adults & Children/Youth Transitioning from incarceration.
- Eligible for long-term care and at risk for institutionalization.
- Nursing Facility Residents who want to transition back to the community.

Phase III – July 2023
- Children and Youth who are high utilizers, serious emotional disturbance (SED), CCS with needs beyond physical needs, and child welfare.

Homelessness will be a primary focus this year. The seven core components of the ECM Core Services are outreach, comprehensive assessment and care management plan, enhanced coordination of care, health promotion, comprehensive transitional care, member, and family supports and coordination of referral to community and support services.

Community Supports was implemented on January 1st and builds upon the work of the Whole Person Care Pilots to better address health related social needs of Medi-Cal members. Supports are medically appropriate, cost-effective alternative services or settings that are provided "in lieu of" and as a substitute for more costly services or settings such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. These services are optional for Medi-Cal Managed Care members to receive.

An overview of each of the Community Supports listed below was provided to the Committee.

Community Supports	Santa Cruz County	Monterey County	Merced County
Housing Transition Navigation Services	January 1, 2022	January 1, 2022	TBD
Housing Deposits	January 1, 2022	January 1, 2022	TBD
Housing Tenancy and Sustaining Services	January 1, 2022	January 1, 2022	TBD
Recuperative Care	**July 1, 2022**	**July 1, 2022**	**July 1, 2022**
Short-Term Post Hospitalization Housing	**July 1, 2022**	**July 1, 2022**	**July 1, 2022**
Medically Tailored Meals	January 1, 2022	January 1, 2022	January 1, 2022
Sobering Centers		January 1, 2022	TBD

There is no wrong door approach for referrals. Referrals can be initiated by contracted providers, non-contracted provider, members, and family. The Provider Referral forms were shared with the Committee and are available on the provider website.

5. Open Discussion.

Chairperson Diallo opened the floor for the Committee to have an open discussion.

Provider had a question regarding CCS paneling. It was noted, there is a CCS paneling application on the DHCS website. There are resources on the Alliance provider website and Provider Services can assist as well. The DHCS website has a search function to look-up CCS paneled providers. **Action:** Kelsey will provide DHCS provider paneling resources and Tracy will email the information to the Committee.

Provider noted they are missing case management with patients, and she would like to know which patients are being case managed by the Alliance. Kelsey noted the provider can reach out to her or the pediatric team for assistance. **Action**: Tracy to email Pediatric Case Management contact information to the Committee.

Provider noted a pharmacy issue when contacting a patient's pulmonologist to refill a compounding medication. The pulmonologist was no longer prescribing the medication and provider had been referring to the patient notes. After a discussion with the pulmonologist, it was determined the patient no longer needed to take the medication. It was noted the Alliance Pharmacy department is working on a medication reconciliation program this year, and Yasuno suggested adding CCS members as one group of focus. **Action:** Yasuno will investigate CCS medication reconciliation further for the possibility of discussion at a future meeting.

Provider requested more information regarding transportation access for patients to specialty appointments. Provider noted families have barriers around emergency transportation to appointments (Stanford). Emergency room to emergency room or in-patient transfers are sometimes required due to barriers and children needing specialty

care. Kelsey noted that the pediatric team can also work with the facility regarding options for families. Provider noted transportation on weekends and holidays is challenging. **Action:** Dr. Diallo noted transportation is handled by Member Services and this important topic will be discussed further at the next meeting.

The meeting adjourned at 1:20 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Committee

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

DATE: June 22, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: 2022 Legislative Session Update

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

Background. Each legislative session, staff work with health plan associations, including the Local Health Plans of California and California Association of Health Plans, as well as the Alliance's representatives in Sacramento, Edelstein, Gilbert, Robson, and Smith to identify, review and monitor newly introduced legislation in the following areas of focus:

- Health Care Coverage/Delivery System Reform
- Medi-Cal eligibility
- Medi-Cal benefits
- Medi-Cal provider payments
- Medi-Cal health plan revenue
- Medi-Cal and/or Managed Care policies and initiatives

Bills in these categories are compiled into a bill list which staff monitors throughout the legislative session in order to provide legislative updates to the Board at its regular Board meetings in April and June, or as needed.

At the March 23, 2022 and April 27, 2022 Board meetings, the Board reviewed bills identified in the above areas of focus and adopted a position of support on the following bills: AB 1900 (Arambula), AB 1995 (Arambula), AB 2402 (Blanca Rubio), AB 1944 (Lee), and SB 966 (Limon).

AB 1900 (Arambula) – Medi-Cal Income Level for Maintenance. Increases the income level for maintenance for seniors and persons with disabilities to 138% of the federal poverty level.

AB 1995 (Arambula) – Medi-Cal: Premiums or Contributions. Eliminates premiums and subscriber contributions for low-income children, pregnant and post-partum women.

AB 2402 (Blanca Rubio) – Medi-Cal: Continuous Eligibility. Establishes continuous eligibility for any eligible child under five years of age without regard to income and without an annual review of eligibility. This bill would also apply this continuous eligibility to children who are without satisfactory immigration status but who are otherwise eligible for Medi-Cal, as specified.

AB 1944 (Lee) – Local Government: open and public meetings. Authorizes, upon a determination by a majority vote of the legislative body, a member to be exempt from identifying the address of their teleconference location in the notice and agenda or from having the location be accessible to the public, if the member elects to teleconference from a location that is not a public place.

Letters of Support were drafted and registered with the bill authors.

Discussion. Certain key legislative deadlines have already occurred, including May 27, 2022, which was the deadline for bills to pass out of their respective house of origin to continue to be heard this year. Each of the above-referenced bills supported by the Board continues to progress in the Legislature and staff continue to advocate for as appropriate and to monitor for any amendments.

To that end, AB 1944 was amended in the Assembly Committee on Local Government to add language that presents significant concerns related to its impact on the Alliance's Board meeting processes. The bill was amended to state that the exemptions to agenda and noticing requirements are allowed if *at least a quorum of members* of the legislative body *participates from a single physical location* that is clearly identified in the agenda, that is open to the public, and that is situated within the boundaries of the territory over which the local agency has jurisdiction.

Given the Alliance Board's multi-county jurisdiction spanning a large geographic area, these amendments present significant concerns and would effectively negate the opportunities afforded under this bill. Staff will discuss concerns with the author's office, and unless acceptable amendments are secured, will remove support.

Staff continues to monitor all active bills and will report back to the Board as legislative activity may warrant and will return to the Board with a final report upon conclusion of the legislative session.

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

Attachments. N/A

DATE: June 22, 2022

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

FROM: Michelle N. Stott, RN, MSN, Quality Improvement & Population Health Director

SUBJECT: Quality Improvement System Workplan for 2022

Recommendation. Staff recommend the Board accept the Quality Improvement System (QIS) Workplan for 2022.

Summary. This informational report provides a summary of the activities planned for the 2022 QIS Workplan. The Workplan includes contractual required Performance Improvement Projects, operational performance metrics, health programs and cultural and linguistic services, and development of the population health management program. Refer to the attached QIS Workplan for additional details.

Discussion. The Alliance is contractually required by the Department of Healthcare Services to maintain a quality improvement system to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. This is monitored through an annual QIS Workplan with a written description of goals, objectives, and planned activities, reviewed quarterly and evaluated at the end of the year. The QIS Workplan is approved by the Continuous Quality Improvement Committee, and ultimately, the Alliance Board. The Board can direct and provide modifications to the quality improvement system on an on-going basis to ensure that actions and improvements meet the overall Alliance mission.

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

Attachment.

1. Quality Improvement System Workplan 2022

Quality Improvement System (QIS) Workplan
2022

INITIAL WORKPLAN & EVALUATION APROVAL	FINAL WORKPLAN & EVALUATION APROVAL
Submitted and approved by:	Submitted and approved by:
CQIW-I Date: 03/31/2022 CQIC Date: 04/28/2022 Board Date: 05/25/2022	CQIW-I Date:_____ CQIC Date:_____ Board Date:_____
 05/25/2022 Dale Bishop, MD, CMO Date	Dale Bishop, MD, CMO Date
, MD, Medical Director Date	, MD, Medical Director Date
 05/25/2022 Michelle N. Stott, RN, MSN Date Quality Improvement & Population Health Director	Michelle N. Stott, RN, MSN Date Quality Improvement & Population Health Director

Quality Improvement System Workplan

Section I: Member Experience
- A. Member Experience
  - Member engagement rate of Member Outreach Campaigns
  - Health Services Division Member Outreach & Engagement Campaigns
  - Member Support
  - Cultural and Linguistics (C&L) Services & Population Needs Assessment Education
  - CAHPS: How Well Doctors Communicate

Section II: Quality of Service
- B. Access and Availability
  - Annual Access Plan
  - Provider Choice: In-Area Market Share
  - CAHPS Survey: Access Measures
- C. Provider Experience
  - Provider Satisfaction

Section III: Quality of Clinical Care
- D. Utilization
  - Under / Overutilization
  - Physician Administered Drugs (PAD) utilization review
  - Medication Reconciliation

Section III (cont.): Quality of Clinical Care
- E. Adult Preventive Care Services
  - Health Education and Disease Management
  - Controlling Blood Pressure
  - Diabetes HbA1c >9% (poor control)
  - Preventive Care Measure: Colorectal Cancer Screening (HEDIS)
- F. Maternal and Children's Preventive Care
  - Maternal and children's preventive care (HEDIS)
- G. Performance Improvement Projects (State Mandated)
  - Breast Cancer Screening PDSA
  - COVID-19 QIP
  - Childhood Immunizations
  - Child and Adolescent Well Care Visits
- H. Behavioral Health
  - Adverse Childhood Experiences (ACE)
  - Eating Disorders

Section IV: Clinical Safety
- I. Clinical Safety
  - Grievance and PQI Management
  - Facility Site Review (FSR) Management

Quality Improvement System (QIS) Workplan
2022

The Alliance strategic priorities includes 1) Health Equity and 2) Person-Centered Delivery System Transformation. There are noted Breakthrough objectives and organizational tactics that may relate to the QIS Workplan (QISW). The following grid provides QISW activities that may have connection points with the Strategic Goals through activities of assessment, planning, monitoring, or interventions for improved member outcomes.

Strategic Priority #1: Health Equity

Strategic Goal #1: Eliminate health disparities and achieve ***optimal health outcomes for children and youth***

- Breakthrough Objective #1 Understand opportunities to resolve root cause disparities in pediatric health
- Organizational Tactic: Manage and Improve Care: Conduct Pediatric Health Disparity Assessment

QISW:

- CAHPS Survey (Child): Access Measures, How Well Doctors Communicate
- Maternal and children's preventive care (HEDIS)
- Childhood Immunizations – Combo 10 (HEDIS)
- Adverse Childhood Experiences (ACE) Screening
- Eating Disorders
- Child and Adolescent Well-Care Visit (PIP)

Strategic Goal #2: Increase member ***access to culturally and linguistically appropriate health care.***

- Breakthrough Objective #2: Enhance member engagement to gain insights aimed at improving programs, policies and practices
- Organizational Tactic: Engage and Support Members: Develop Organizational Plan to Transform Member Engagement

QISW:

- Member engagement rate of Member Outreach Campaigns
- Health Services Division Member Outreach & Engagement Campaigns
- Member Support (Calls to Member Services)
- Cultural and Linguistics (C&L) Services & Population Needs Assessment
- Annual Access Plan
- Provider Choice: In-Area Market Share
- Provider Satisfaction
- CAHPS Survey (Adult): Access Measures, How Well Doctors Communicate

Strategic Priority #2: Person-Centered Delivery System Transformation

Strategic Goal #3: Improve ***behavioral health services and systems*** to be person-centered and equitable

- Breakthrough Objective #3: Understand gaps and opportunities to improve behavioral health system
- Organizational Tactic: Manage and Improve Care: Conduct Comprehensive Behavioral Health System Assessment

QISW:

- Adverse Childhood Experiences (ACE) screening*
- Eating Disorders*

*As above, for children and youth

Strategic Goal #4: Improve the system of ***care for members with complex medical and social needs***

- Breakthrough Objective #4: Improve model of care for members experiencing homelessness, SMI/SUD and/or who are high utilizers
- Organizational Tactic: Manage and Improve Care: Design and Implement ECM/CS Lifecycle

QISW:

- Medication Reconciliation
- Over/under utilization
- Physician Administered Drugs (PAD) utilization review
- Preventive Care:
  - Health Education & Disease Management
  - Controlling Blood Pressure (HEDIS)
  - Diabetes A1c > 9% Poor Control (HEDIS)
  - Colorectal Cancer Screening (HEDIS)
  - PIPs: Breast Cancer Screening (HEDIS), COVID-19 QIP

Quality Improvement System (QIS) Workplan
2022

Section I: Member Experience		
A: Member Experience		
Topic: Member engagement rate of Member Outreach Campaigns **Domain:** Member Experience **Priority:** Alliance Operating Plan	**Committee:** Member Support and Engagement Committee (MSEC) **Responsible Person(s):** Lilia Chagolla, Regional Operations Director Santa Cruz/Monterey	**Goals:** Composite metric that rolls up normalized engagement rates from the outreach methods: Drive-through, Phone calls, Virtual, and Face to face to calculate an average member engagement rate across all outreach methods and attempts **Opportunities for Improvement:** • Equally weights the four methods of engagement and averages the normalized performance of each method. **Known Barrier(s)/Root Cause(s):** 1) Enough staff to perform activities
Topic: Health Services Division Member Outreach & Engagement Campaigns **Domain:** • Member Experience • Quality of Service • Quality of Care **Priority:** Alliance Operating Plan	**Committee:** Continuous Quality Improvement Workgroup (CQIW), Member Support and Engagement Committee (MSEC) **Responsible Person(s):** Deborah Pineda, Quality and Health Programs Manager; Desirre Herrera, Quality and Health Programs Supervisor; Hilary Gillette-Walch, Quality and Population Health Manager;	**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 (i.e., PNA outreach). An internal team mobilized to identify members, developed scripting and information of appropriate resources and health education, and conducted telephonic outreach to high-risk, vulnerable members. **Activities:** 1) In 2022, 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 **Barrier(s)/Root Cause(s):** There is not enough staff to support outreach activities. Core work is also impacted when deploying other teams to support outreach campaigns. There is not enough planning time.
Topic: Member Support **Domain:** Member Experience **Priority:** • Regulatory (DHCS)	**Committee:** MSEC **Responsible Person(s):** Luis Somoza, Member Services Director; Gisela Taboada, Call Center Manager	**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:** 1) Identify additional barriers to being able to continuously meet this requirement. **Known Barrier(s)/Root Cause(s):** 1) Lack of sufficient staffing levels to meet the goals. 2) Not enough time and resources to provide necessary training and updates to staff.
Topic: Cultural and Linguistics (C&L) Services & Population Needs Assessment Education **Domain:** • Member Experience • Quality of Service • Quality of Care	**Committee:** CQIW **Responsible Person(s):** Deborah Pineda, Quality and Health Programs Manager, Desirre Herrera, Quality and Health Programs Supervisor, Ivonne Munoz, C&L	**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 (annual provider satisfaction survey)

Priority: • Regulatory (DHCS)	Quality Improvement Program Advisor	3) Increase members satisfaction levels (PNA member outreach survey): o indicating that the materials they received from the Alliance provide information that is easy to understand and in their preferred language o when asked how well their language needs are being met by their PCPs by getting an interpreter when needed during their visit at their doctor's office **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) **Barrier(s)/Root Cause(s):** Not enough C&L staffing to support core work. The volume of work for C&L services continues to increase over time significantly. We've been able to meet our required timelines by shifting a few tasks to the Heath Educators. This was done to assist with the increased demand for interpreting and

		translation services. Not enough time for Providers to receive training, currently impacted with COVID-19 and resuming care.
Topic: CAHPS: How Well Doctors Communicate **Domain:** Member Experience **Priority:** Regulatory (DHCS)	**Committee:** MSEC, CQIW **Responsible Person(s):** Amit Karkhanis, MBA, Quality and Performance Improvement Manager	**Goals:** • Achieve xx% in How Well Doctors Communicate - Child • Achieve x % in How Well Doctors Communicate - Adult **Opportunities for Improvement:** 1) Assess CAHPS surveys administered in 2022 and identify any improvements if the threshold/targets are not met **Known Barrier(s)/Root Cause(s):** TBD

Section II: Quality of Service

B: Access & Availability

***The Network Development Steering Committee (NDSC) monitors the Annual Access Plan**

Topic: Annual Access Plan **Domain:** • Quality of Service • Quality of Care • Member Experience **Priority:** Regulatory (meeting regulatory obligations for timely and geographically accessible access to care); Core Operational work	**Committee:** NDSC **Responsible Person(s):** Rachaelle Schultze	**Goals:** The Annual Access Plan focus areas and improvement goals are established in January of each year and are solidified by the NDSC. The 2022 Access Plan goals will be finalized in January 2022. **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 2022 improvement opportunities will be identified in January 2022. **Barrier(s)/Root Cause(s):** TBD
Topic: Provider Choice: In-Area Market Share **Domain:** • Quality of Service • Member Experience **Priority:** Regulatory (meeting regulatory obligations for timely and geographically accessible access to care); Core Operational work	**Committee:** NDSC **Responsible Person(s): Rachaelle Schultze**	**Goals:** 80% Market Share (PCP and Specialist) target with 75% lower threshold Market Share stability with a no more than 5% decrease annually. **Opportunities for Improvement:** Credential non-credentialed providers practicing at contracted locations. Engage providers who have historically declined to contract. **Barrier(s)/Root Cause(s):** Difficulty obtaining timely credentialing applications for new or existing providers, priority to engage new entities in contracting over credentialing providers at existing contracted sites.

Topic: CAHPS Survey: Access Measures **Domain:** • Quality of Service • Member Experience **Priority:** Regulatory (DHCS)	**Committee:** NDSC, CQIW, CQIW-I **Responsible Person(s):** Amit Karkhanis, MBA, Quality and Performance Improvement Manager	**Goals:** • Achieve xx% in Getting Care Quickly for Child and Adult CAHPS • Achieve xx% in Getting Needed Care for Child and Adult CAHPS **Opportunities for Improvement:** Assess CAHPS surveys administered in 2022 and identify any improvements if the threshold/targets are not met **Barrier(s)/Root Cause(s):** TBD
C: Provider Experience		
Topic: Provider Satisfaction **Domain:** • Quality of Service **Priority:** Regulatory; Core Operational work	**Committee:** Network Development Steering Committee (NDSC) **Responsible Person(s): Rachaelle Schultze**	**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 **Barrier(s)/Root Cause(s):** None
Section III: Quality of Clinical Care		
D: Utilization ***The Utilization Management Program is monitored through the Utilization Management Workplan**		
Topic: Under / Overutilization **Domain:** • Quality of Care (QOC) • Quality of Service (QOS) • Clinical Safety (CS) **Priority:** • Regulatory	**Committee:** • UMWG • CQIW CQIC • Program Integrity / Compliance Committee • Claims • Advanced Analytics • Health Services Finance Collaborative	**Goal(s):** An interdepartmental over/underutilization report will be developed by December 31, 2022. **Opportunities for Improvement:** Coordinated collaboration with all sources of monitoring for over and underutilization. Linking reporting from multiple sources to ensure compliance with monitoring.

	• PS / HS Collaborative **Responsible Person(s):** • Director of UM / CCM • Medical Directors	**Known Barrier(s)/Root Cause(s):** Lack of consolidation of all efforts toward oversight of over /utilization.
Topic (preferred): Physician Administered Drugs (PAD) utilization review *(Prelude to Site of Care Program) **Domain:** Quality of Service **Priority:** (Alliance Operating Plan – *site of care program is an organizational tactic for Pharmacy. This program is being developed to direct providers and members to the most appropriate Site of care for infusion. Policy 403-1152 Site of Care has been developed and approved by P&T and Policy Hub. By reviewing all PADs utilization will level set us to develop Site of Care strategy for high utilized/high cost PADs	**Committee:** Pharmacy and Therapeutics Committee **Responsible Person(s):** Navneet Sachdeva, PharmD Yasuno Sato, PharmD	**Goals:** Perform PAD utilization review on a quarterly basis and present to P&T Committee PA criteria and formulary inclusion input. **Opportunities for Improvement:** Remove PA requirement for PAD with high approval rate. Educate providers on more cost-effective products. Prelude to Site of Care program. **Barrier(s)/Root Cause(s):** TBD
Topic: Medication Reconciliation **Domain:** • Quality of Care • Member Experience • Clinical Safety **Priority:** Regulatory	**Committee(s):** Pharmacy and Therapeutics Committee, CQIW **Responsible Person(s):** Navneet Sachdeva, PharmD Yasuno Sato, PharmD	**Goals:** Perform Medication Reconciliation for 50% of high-risk members within 30 days of discharge from acute setting. **Opportunities for Improvement:** (Not being done at the Alliance, and not being done at Transition of Care at all sites) **Known Barrier(s)/Root Cause(s):** • Pharmacy staffing • Pharmacy not having member facing role.

E: Adult Preventive Care Services		
Topic: Health Education and Disease Management **Domain:** • Quality of Service • Member Experience • Quality of Care **Priority:** Regulatory (DHCS)	**Committee:** CQIW **Responsible Person(s):** Deborah Pineda, Quality and Health Programs Manager; Desirre Herrera, Quality and Health Programs Supervisor	**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, 2022, 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) The COVID-19 pandemic has driven an inevitable shift in the way these workshops are delivered from face-to-face to telephonic, and now the implementation of virtual sessions 2) Increase participation in the Healthier Living Program workshop by prompting the member incentive and offering different format options. (telephonic, virtual, and in-person) 3) 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 **Barrier(s)/Root Cause(s):** Technology resources constraints (i.e., phone/network systems not working, MS Teams connectivity issues, a lot more power outages). Unable to offer in-person workshops at this time.
Topic: Controlling Blood Pressure **Domain:** Quality of Care **Priority:** Regulatory: DHCS Health Equity Goals, HEDIS	**Committee:** CQIW **Responsible Person(s):** Jo Pirie, Hilary Gillette-Walch, RN, MPH, and Naomi Kawabata, RN,	**Goals:** 1) Improve hypertension control by improving the accuracy of blood pressure measurement by reducing potential false positives of elevated blood pressure readings. 2) (Pending project start) By X date, BP rechecks will improve from X% to X% after implementing the new BP rechecking protocol, where a

		second BP reading is taken when the first BP reading is greater than 130/80. 3) Create EHR flags for BP recheck when the initial Bp is 130/80 or greater. Also consider visual reminders to alert staff and patient when a Bp recheck should be considered. **Opportunities for Improvement:** 1) Increase members that are accurately identified as having hypertension. 2) For those members with hypertension established accurate readings support the clinical management of the patient. 3) Establish this best practice in a busy ambulatory care center. **Known Barrier(s)/Root Cause(s):** 1) Staff turn over may dilute results without consistently providing appropriate training. 2) New process may be slowly adopted, will need to focus on education and job aids. 3) Volume of members may continue to lag as the pandemic continues.
Topic: Diabetes HbA1c >9% (poor control) **Domain:** Quality of Care **Priority:** Regulatory: DHCS Health Equity Goals, HEDIS	**Committee:** CQIW **Responsible Person(s)**: Hilary Gillette-Walch, RN, MPH,	**Goals:** 1). Identify a health care system willing to partner with the Alliance team in implementing an evidenced based practice for members with Diabetes Type II (Community Guide) 2. Establish a team of clinic staff and technical support staff from the Alliance to champion the program and support selection of an intervention. 3. Set an objective that identifies a target number of members that are able to decrease HbA1c values to below 7.5. **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) Opportunity to not just manage blood glucose, but support adoption of healthy choices, tobacco use, increase physical activity. **Known Barrier(s)/Root Cause(s):**

		3) Clinics are currently struggling to maintain staff and continue to care for members with COVID. 4) Limited capacity at many primary care offices to adopt a new initiative. 5) Alliance members have few resources, may be limited to not having safe areas for physical activity or support to prepare healthy meals.
Topic: Preventive Care Measure: Colorectal Cancer Screening (HEDIS) **Domain:** Quality of Care **Priority:** Regulatory: DHCS Health Equity Goals, HEDIS	**Committee:** CQIW **Responsible Person(s)**: Hilary Gillette-Walch, RN, MPH and designee(s)	**Goals:** 1) Assess baseline rates for colorectal cancer screening and determine future interventions **Opportunities for Improvement:** TBD **Known Barrier(s)/Root Cause(s):** TBD
F: Maternal and Children's Preventive Care		
Topic: Maternal and children's preventive care (HEDIS) **Domain:** Quality of Care **Priority:** Department of Health Care Services (Bold goals 50 x 2025)	**Committee:** Continuous Quality Improvement Workgoup (CQIW) **Responsible Person(s):** Hilary Gillette-Walch, MPH, Quality & Population Health Manager	**Goals:** 1) Ensure all health plans exceed the 50th percentile for all children's preventive care measures; 2) Close racial/ethnic disparities in well-child visits and immunizations by 50%: • *Child and adolescent WCV • Childhood immunizations • Adolescent immunizations 3) Improve maternal and adolescent depression screening by 50%; 4) Close maternity care disparity for Black and Native American persons by 50%: • *Prenatal and postpartum care • Perinatal and postpartum depression screening **Metrics recommended by National Committee for Quality Assurance for stratification by race/ethnicity* **Opportunities for Improvement:** TBD **Known Barrier(s)/Root Cause(s):** TBD

G: Performance Improvement Projects (State Mandated)

Topic: Breast Cancer Screening PDSA **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)	**Committee:** CQIW **Responsible Person(s):** Amit Karkhanis, MBA, Charley Aebersold, CSSBB, Quality Improvement Program Advisor IV Sara Forbes, MS, Quality Improvement Program Advisor III Britta Vigurs, Quality Improvement Project Specialist	**Goals:** 1) By January 30, 2022, complete PDSA cycle 4 intervention to improve the breast cancer screening rate at Dignity Health Medical Group in Merced. 2) By May 30, 2022, complete PDSA cycle 5 intervention to improve the breast cancer screening rate at TBD. **Opportunities for Improvement:** 1) Application of standing orders for mammogram screening at provider offices. 2) Retrospective referral process of eligible members and member outreach by the imaging center. **Known Barrier(s)/Root Cause(s):** No barriers identified at this time.
Topic: COVID-19 QIP **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)	**Committee:** CQIW **Responsible Person(s):** Hilary Gillette-Walch, RN, MPH, Quality and Population Health Manager Amit Karkhanis, MBA, Quality and Performance Improvement Manager Jo Pirie, Quality Improvement Program Advisor II Shannon Fletcher, Quality Improvement Program Advisor Tera Mendoza, CPC, Coding Resource Specialist	**Goals:** 1) By March 31, 2022, complete the follow up COVID-19 QIP submission **Opportunities for Improvement:** 1) Member incentive for those 7-24 months of age who receive their second flu shot. 2) Adolescent well care letters for members 11-13 years of age. 3) Outreach to prenatal and postpartum members as part of the Healthy Mom and Health Babies program. **Known Barrier(s)/Root Cause(s):** No barriers identified at this time.

Quality Improvement System (QIS) Workplan
2022

Topic: Childhood Immunizations **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)	**Committee:** CQIW **Responsible Person(s):** Amit Karkhanis, MBA, Quality and Performance Improvement Manager, and Naomi Kawabata, Senior Quality Improvement Nurse	**Goals:** By December 31, 2022, Castle Family Health Center will increase Childhood Immunization Status (CIS) Combo 10 rates among the three targeted sites from a baseline of 12.22% to 19.51% **Opportunities for Improvement:** • 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. • Prioritize health equity strategies by increasing outreach to populations with lower rates. • Promote member incentives to encourage members to complete their immunizations. **Barrier(s)/Root Cause(s):** Limited provider engagement due to conflicting priorities with the COVID-19 vaccine, staffing challenges due to COVID-19 variants, and member hesitancy to resume preventative care.
Topic: Child and Adolescent Well Care Visits **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)	**Committee:** CQIW **Responsible Person(s):** Amit Karkhanis, MBA, Quality and Performance Improvement Manager, and Veronica Lozano, CHES, Quality Improvement Program Advisor II	**Goals:** By December 31, 2022, increase the percentage of child and adolescent members 3-17 years of age, linked to Golden Valley Health Center - Los Banos clinic, who receive at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the intervention period, from 32.65% to 48.56%. **Opportunities for Improvement:** • Improve access by increasing the number of in-person well care visit appointment slots per week. • Prioritize health equity strategies by increasing outreach to populations with lower rates. • Promote member incentives to encourage members to complete their well-care visits.

		Barrier(s)/Root Cause(s): Limited provider engagement due to conflicting priorities with the COVID-19 vaccine, staffing challenges due to COVID-19 variants, and member hesitancy to resume preventative care.
H: Behavioral Health		
Topic: Adverse Childhood Experiences (ACE) **Domain:** • Quality of Care **Priority:** • Divisional Goal, Diversity Leadership Program (DLP)	**Committee:** • CQIW, CQIC **Responsible Person(s):** • Michelle N. Stott, RN, MSN, QI/PH Director • Diana Diallo, MD, Medical Director • Amit Karkhanis, MBA, Quality & Performance Improvement Manager • Britta Vigurs, Quality Improvement Project Specialist Health Improvement Partnership	**Goal(s):** 1) By 12/31/22, assess the current landscape in Merced County to address any barriers or factors to complete ACE screening. 2) By 12/31/22, promote education and best practices among providers and clinic staff to conduct the screening. 3) By 12/31/22, support a network of care with experts in the community (providers, community-based organizations, other experts). **Opportunities for Improvement:** 1) Minimal ACE screenings in Merced County **Known Barrier(s)/Root Cause(s):** TBD

Quality Improvement System (QIS) Workplan
2022

Topic: Eating Disorders **Domain:** • Quality of Care • Quality of Service • Member Experience • Clinical Safety **Priority:** Operating Plan	**Committee:** UMWG CQIC Beacon Oversight Committee Health Services Finance Committee **Responsible Person(s):** UM /CCM Director Behavioral Health Manager Medical Directors	**Goals:** By June 31, 2022 develop workflow process for coordinating and expediting eating disorder referrals to Behavioral Health. **Opportunities for Improvement:** 1) Provide specific pathways for referrals and escalation processes. 2) Delineate processes for mild to moderate and severe mental illness care coordination. 3) Establish clear contact information for all levels of behavioral health interventions to increase timely access to care. **Known Barrier(s)/Root Cause(s):** 1) Eating disorders post pandemic have increased significantly. Unclear pathways have caused delays in treatment. 2) Gaps in handoffs between levels of care.

Section IV: Clinical Safety

I: Clinical Safety

Topic: Grievance and PQI Management **Domain:** Clinical Safety (CS) **Priority:** Regulatory	**Committee:** CQIW **Responsible Person(s):** Hilary Gillette-Walch, RN, MPH, Quality and Population Health Manager DeAnna Leamon, FNP, Quality Improvement Supervisor	**Goals:** 1) By December 31, 2022 100% of Potential Quality Issues (PQI) completed within 90 calendar days of receipt. 2) By December 31, 2022 Quality Improvement (QI) nurse to route 100% of grievances related to medical quality of care issues to the Medical Director. Conduct an inter-rater reliability audit on a quarterly basis. **Opportunities for Improvement:** 1) MD peer to peer IRR of member complaints resulted in 100% agreement, indicating Medical Directors are resolving cases with consistent methodology 2) Maintain adequate staffing of program; expedite training of new hires. 3) Continue work with OpEx regarding Corrective Action Plan workflow and methods. **Known Barrier(s)/Root Cause(s):** 1) Retaining qualified and well-trained staff. 2) Managing coverage of the member grievance queue; ensuring that the turnaround in 25 days or less is met.

Quality Improvement System (QIS) Workplan
2022

Topic: Facility Site Review (FSR) Management **Domain:** Clinical Safety (CS) **Priority:** Regulatory	**Committee:** CQIW **Responsible Person(s):** Hilary Gillette-Walch, RN, MPH, Quality and Population Health Manager DeAnna Leamon, FNP, Quality Improvement Supervisor	**Goals:** 1) By December 31, 2022 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, 2022 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. 3) By December 31, 2022 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, 2022 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) Create a plan to ensure the smooth transition from Policy Letter 14-004 to All Plan Letter 20-006; 2) Collaborate with Provider Services to ensure that all providers are updated on the new USPSTF requirements that will be implemented in the FSR and MRR tool in January; 3) Collaborate with Practice Coaching and Provider Services to prepare for an influx in Corrective Action Plans (CAPs) due to the new FSR requirements. **Barrier(s)/Root Cause(s):** 1) Large PCP offices with many staff must conduct many small trainings to address CAPs in order to prevent large staff gathering in compliance with reducing risk of COVID transmission. 2) Staff shortages in response to COVID, such as turnover and absence for childcare, delayed the provider's implementation of CAPs. 3) Supply chain shortages, including international Oxygen shortages. 4) Practices adopting new Electronic Medical Records.

DATE: June 22, 2022

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Alliance Health Care Expense Reserve Policy

Recommendation. Staff recommend the Board adopt the following as its Health Care Expense Reserve Policy.

1. Establish a Health Care Expense Reserve target, or Board designated reserves target, at three times its monthly premium capitation.
2. Require [Develop/Implement] cost containment measures if its financial projection indicates that reserves would fall below 300% of the tangible net equity (TNE) level.
3. Provider payments must be in line with revenue rate and utilization trends and industry benchmarks.
4. Annually, following the acceptance of the annual independent financial audit, the Alliance Board may strategically allocate net income to:
    a. Enable implementation of future requirements, with such funds remaining in Alliance reserves until expended.
    b. Medi-Cal Capacity Grant Program (MCGP), with such funds not available for other purposes and which if otherwise held in reserves would result in reserves beyond the Health Care Expense Reserve.

Summary. In this action item, staff recommend documentation of a policy relating to the development and maintenance of the Health Care Expense Reserve and strategic use of Alliance reserves which exceed the Health Care Expense Reserve, otherwise to be known as the Health Care Expense Reserve Policy.

Background. On December 3, 2014, in the approval of the Alliance investment framework, the Alliance's Board increased the Health Care Expense Reserve target from two times to three times the annual average of monthly premium capitation. The Board also approved the framework for strategic use of reserves, resulting in the MCGP. On February 25, 2015, the Board explicitly and separately approved the Health Care Expense Reserve, the Board designated reserve target, of three times average monthly premium capitation. On June 24, 2020, the Alliance Board approved the execution a cost containment plan, which recognized a policy that required that provider payments align with revenue rate and utilization trends and industry standard payments to ensure financial performance as approved by the Board. These policy principles were not previously incorporated into a policy and procedure.

Discussion. Although approved in prior Board meetings, staff recommend making explicit the Board's policies relating to the observation, development and maintenance of a Health Care Expense Reserve target, as well as permissible allocations of net income, exceeding the target, which would otherwise be incorporated into the reserve. Staff will document the final policy pursuant to the Board's discussion and action on staff's recommendation.

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Fiscal Impact. There is no fiscal impact associated with this agenda item. The Alliance fund balance in internal or regulatory reporting remain the same as the current policy. There will be additional internal tracking on the MCGP and future program requirements.

Attachments. N/A

DATE: June 22, 2022

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Chief Executive Officer Succession Plan and Recruitment Process

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Recommendation. Staff recommend the Board:

1. Establish an ad hoc committee of the Board, consistent with Brown Act requirements, to develop a Chief Executive Officer (CEO) succession plan and carry out the CEO recruitment process.
2. Approve a recruitment budget not to exceed $215,000.

Background. The Alliance's CEO initiated succession planning for the CEO role in May 2022. Recruitment for the successor CEO is slated to commence in Q3 2022 and to conclude by Q1 2023. Staff will retain an executive search firm, selected in accordance with the Alliance's Procurement policy, 701-1100 to conduct the Board's search and support the Board interview process. The Alliance's Chief Administrative Officer will serve as the staff liaison to the Board and executive search firm, including an ad hoc committee established by the Board. The committee will guide the recruitment process and make an advisory recommendation as to the top candidates for selection interview by the full Board, with such interviews occurring early in 2023. This executive search cost was not included in the 2022 budget.

The Ralph M. Brown Act (Brown Act) governs the conduct for open and public meetings by "legislative bodies" of local agencies. Under the Brown Act and as established in the Board's bylaws, the Board may create subcommittees. Committees must be comprised of less than a quorum of Commissioners and are advisory in nature only. Committees that are not standing committees of the Commission with either a fixed continuing subject matter jurisdiction or a meeting schedule fixed by formal action of the Commission are not "legislative bodies" as defined by the Brown Act.

Discussion. The Board may establish ad hoc committees which are not standing committees to serve for a limited term to address a non-continuing subject matter. In order to efficiently and effectively develop a CEO succession plan and recruitment process, the Board may elect to establish an ad hoc committee to include less than a quorum of interested Commissioners to participate and to meet for a limited time to develop the CEO succession plan and carry out the CEO recruitment process.

Staff recommends that the ad hoc committee should include at least one representative from each county and no more than five members. The ad hoc committee will objectively evaluate candidates and make an advisory recommendation of the top 1 to 3 candidates for full Board selection interviews. Committee members must be able to prioritize attendance and participation in committee activities to ensure a timely and successful recruitment process. The most significant time commitment for committee members can be expected between December 2022 and February 2023.

As noted above, an executive search firm will be retained to support the search and recruitment process. The 2022 administrative budget did not include costs associated with this recruitment.

Staff surveyed local health plans who recently conducted Chief Executive searches in the past two years to identify search firms familiar with Medi-Cal managed care plans and the local health plans in California. In addition, surveying included the typical budgets for executive searches. A request for proposal has been issued with selection of the firm expected the week of July 11, 2022. The Alliance Board Chair will be involved in the search firm selection. Staff recommend a not to exceed budget of $215,000 for the recruitment and selection costs.

Fiscal Impact. This item if approved increases the administrative budget by $215,000.

Attachments.

1. Draft CEO Succession Criteria
2. CEO Position Description

Attachment 1
Draft CEO Succession Criteria

Prior to 2016, the Board considered CEO succession criteria to be used in the evaluation of candidates. The criteria have been updated to reflect attributes that will enable the CEO's success in the current environment.

1. Management style compatible with the Board and with Alliance leadership and staff.

2. Experience in managed care and public organizations of similar structure, size and constituency. Experience in commercial plan operations desirable.

3. Expertise in strategic planning and tactical health program planning.

4. Working knowledge of Medi-Cal, Medi-Cal managed care, Medicare and Medicare Advantage, including finance and quality and key strategic initiatives.

5. Knowledge of the technical aspects of managed care, including utilization management, quality improvement, risk adjustment and value-based payments.

6. Passion for the Alliance's mission and serving Alliance membership.

7. Excellent management skills.

8. Excellent verbal and written communication skills and skilled in building and maintaining relationships, with staff, partners, and regulators.

9. Skilled in advocacy, policy design and deliberation, and representation of organizational interests.

10. Ability to develop and communicate vision and inspire dedicated service from staff.

11. Demonstrated alignment with the Alliance's values. Character that demonstrates confidence, motivation, creativity and innovation.

12. Willing to live and actively work within the Alliance's service area.

13. Demonstrated success in implementing and changes to the delivery system with a focus on equity and improving health outcomes for/in underserved populations.

CHIEF EXECUTIVE OFFICER

Position Status: Exempt
Reports To: Alliance Governing Board
Effective Date: 05/31/95
Revised Date: 06/22/22
Job Level: M4

POSITION SUMMARY

Under general policy determination, this position:

1. Provides strategic vision and leadership for the health plan
2. Ensures access, quality, efficiency, compliance and innovation
3. Ensures and facilitates effective and productive governmental and community relations
4. Manages, supervises and leads the Alliance executive leadership team and other direct reports
5. Performs other duties as assigned

RESPONSIBILITIES

1. Provides strategic vision and leadership for the health plan, with duties including but not limited to:
   - Anticipating, monitoring, identifying and considering industry trends and environmental factors
   - Developing organizational priorities, establishing clear goals, and developing and overseeing the implementation of strategies to achieve organizational results
   - Liaising with the Governing Board on all policy and strategic matters related to health plan operations
   - Supporting and making recommendations to the Board related to developing the mission, policies, and programs of the health plan
   - Ensuring that decisions and actions align with Alliance strategy
   - Making decisions and creating plans that take into consideration how resulting changes will affect the organization
   - Conveying the organization's Vision, Mission, Values (V/M/V) and goals, connecting staff to strategy, and helping staff translate their understanding of the V/M/V into concrete action
   - Serving as a role model and motivating staff to be innovative and engaged in their work
   - Modeling and promoting effective internal and external communication
   - Maintaining current knowledge of relevant Federal and State laws, policies and directives, and legal changes related to Alliance functions

2. Ensures access, quality, efficiency, compliance and innovation, with duties including but not limited to:
   - Ensuring a monitoring system is in place to evaluate operational performance and capability, and communicating operational performance to the Board, regulators, staff, and other stakeholders
   - Ensuring the identification and implementation of new business plans, policies, and programs to ensure access, quality, efficiency, compliance and achievement of strategic objectives
   - Ensuring the financial viability of the organization through strong fiscal management and the development of fiscal strategy and annual administrative and medical budgets
   - Ensuring the availability of a skilled, mission driven, motivated and effective workforce

- Creating and supporting an environment that encourages improvement, innovation and positive growth across the organization

3. Ensures and facilitates effective and productive governmental and community relations, with duties including but not limited to:
   - Liaising with local governmental and public agencies as necessary and with community groups as appropriate
   - Representing the Alliance in discussions regarding health care issues and solutions on local, state, and national levels
   - Engaging in advocacy, such as legislative advocacy or advocacy with regulators and government officials, in matters pertaining to the Alliance
   - Ensuring effective communication and promotion of the Alliance's culture, V/M/V, and objectives
   - Partnering with and engaging the community to achieve the Alliance's strategies, objectives, vision, and mission.

4. Manages, supervises, and leads the Alliance executive leadership team and other direct reports, with duties including but not limited to:
   - Setting direction and fostering alignment with executives and their respective divisions to successfully achieve organizational priorities in alignment with Alliance V/M/V, and communicating strategy to operationalize decisions
   - Supervising direct reports, including responsibility for performance appraisal, hiring, salary administration, training, and development
   - Setting clear goals aligned with organizational strategy and objectives and communicating performance expectations
   - Ensuring executives set goals, objectives, and standards and monitor and evaluate staff performance
   - Delegating day-to-day operational decisions in an effective manner, in order to focus on policy, strategy, and budgetary decisions
   - Holding self and others accountable and answerable for job performance
   - Taking ownership of commitments and performance

EDUCATION AND EXPERIENCE

- Master's degree in Health Administration, Public Administration, Business Administration or a related field and a minimum of ten years of management experience in the administration of a prepaid health delivery system, including a minimum of five years of experience in an executive leadership position and five years of experience in a Medi-Cal environment; or an equivalent combination of education and experience may be qualifying.

KNOWLEDGE, SKILLS, AND ABILITIES

- Thorough knowledge of managed care, clinically and administratively
- Thorough knowledge of California Medi-Cal and Medi-Care and entitlement programs and related regulations
- Thorough knowledge of and proficiency in applying effective leadership and people management skills, including leading team building, facilitating efficient and effective

meetings, problem solving, conflict resolution and negotiating with and influencing others
- Thorough knowledge of the principles and practices of program development and project management
- Thorough knowledge of the principles and practices of organizational management
- Thorough knowledge of the principles and practices of customer service
- Thorough knowledge of and proficiency in promoting and applying change management principles
- Thorough knowledge of the principles and practices of supervision and training
- Working knowledge of public policy and regulatory issues in health care
- Working knowledge of State and Federal legislative processes
- Working knowledge of data collection and analysis and management practices related to quality of medical care
- Working knowledge of and proficiency with Windows-based PC systems and Microsoft Word, Excel, Outlook, and PowerPoint
- Some knowledge of the California Code of Regulations
- Ability to communicate effectively with health professionals and administrators, both orally and in writing
- Ability to oversee, develop, plan, organize, and direct programs and activities that are complex in nature and regional in scope
- Ability to oversee and measure the performance of a broad range of functional areas
- Ability to identify new programs, processes and systems to improve productivity and results
- Ability to direct, manage, supervise, mentor, train, and evaluate the work of staff, and assist department directors in doing so
- Ability to promote an atmosphere of teamwork and cooperation, convey the mission and values of the organization, and motivate staff to achieve goals and objectives
- Ability to provide leadership, facilitate meetings, and partner with and guide leaders and staff in the resolution of issues that are complex and may have considerable operational impact
- Ability to manage multiple projects simultaneously, organize work, and achieve goals and timelines, while holding others accountable
- Ability to consistently demonstrate a commitment to health equity and foster an environment characterized by belonging
- Ability to demonstrate a collaborative leadership style, build rapport, and effectively manage business relationships and administrative contracts with consultants and vendors
- Ability to foster effective working relationships, influence others, negotiate, and build consensus with individuals at all levels in the organization and with external stakeholders
- Ability to make presentations and adjust communication style in order to facilitate collaboration and understanding
- Ability to oversee, review and approve subordinate budget recommendations and participate in the development of the annual budget
- Ability to prepare narrative and statistical written reports, oral reports, correspondence and other program documents and maintain organized and accurate records

DESIRABLE QUALIFICATIONS

- Working knowledge of the health care delivery systems and communities in Santa Cruz, Monterey and Merced counties

WORK ENVIRONMENT

- Ability to sit in front of and operate a video display terminal for extended periods of time
- Ability to bend, lift and carry objects of varying size weighing up to 10 pounds
- Ability to travel to different locations in the course of work

This position description, and all content, is representative only and not exhaustive of the tasks that an employee may be required to perform. Employees are additionally held responsible to the Employee Handbook, the Alliance Standard Knowledge, Skills and Abilities and the Alliance Code of Conduct. The Alliance reserves the right to revise this position description at any time.

DATE: June 22, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Medi-Cal Capacity Grant Program Evolution: Framework for Administration

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

Summary. In this informational discussion item, staff will solicit input from the Board as to the administration of the evolved Medi-Cal Capacity Grant Program (MCGP). Board input will inform future staff recommendations on the MCGP's administrative structure to develop and implement new grantmaking opportunities.

Background. The Alliance established the MCGP in 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act (ACA) and responsive to a commitment to strategic use of reserves which exceeded the Alliance's health care reserve requirements. Through the MCGP, the Alliance's Board sought to invest such reserves to support local efforts to increase the availability, quality and access of health care and supportive services for Medi-Cal members in Merced, Monterey, and Santa Cruz counties.

Key administrative principles in establishing the MCGP included:

1) Prudence to ensure health plan financial viability;
2) Use only of fund balance not obligated or reserved for health care expenses (i.e. only uncommitted funds above the reserve target);
3) Investments for Medi-Cal purposes only;
4) Funding not to be used to supplant or duplicate other funding sources;
5) Compliance with legal requirements; and
6) Avoiding conflicts of interests.

At establishment, it was assumed that the availability of funds beyond reserve targets was a unique situation, not likely to be repeated in future years. For this reason, the MCGP focused on one-time investments that would be spent down over time, with early discussions referencing investment decisions over a three-to-five-year period. At the time the MCGP was created, the Board was cautious to not segregate the MCGP allocated cash reserves until the program administration was time tested.

The MCGP has been successful in meeting its original aims while adhering to its founding principles and developing skill and expertise in grant administration. Since 2015, the Board has considered and acted on MCGP policies and funding recommendations in 29 meetings and over 46 different agenda items. Through those items and actions, the Alliance has awarded 565 grants totaling $128.6M to 138 health care and community-based organizations in the service area. Seven years into the administration of the program, the unallocated MCGP budget remains at a total of $92.6M.

At the March 23, 2022 Board meeting, responsive to the current health care landscape and organizational priorities, the Board approved three new MCGP grantmaking focus areas to enable the evolution of the MCGP: 1) Access to Care; 2) Healthy Beginnings; and 3) Healthy Communities. At the April 27, 2022 Board meeting, the Board provided input to inform the development of funding goals for each new focus area and a new theory of change that will connect MCGP strategies and anticipated outcomes. At the June 22, 2022 Board meeting, the Board will consider the Alliance's reserves policy, including the process for future allocations to the MCGP, and in August 2022, staff anticipate bringing forward a recommendation for the funding goals in each of the MCGP focus areas and a recommendation for an allocation of reserves in accordance with the revised Health Care Reserve policy.

Discussion. Staff seek input from the Board regarding the administration of the evolved MCGP, responsive to which staff may bring future recommendations. Factors driving staff's exploration with the Board of the administration of the MCGP include the following:

1. *New Focus Areas and Competing Priorities*. The Board recently adopted new focus areas for the MCGP and the adoption of goals responsive to those areas is pending. The development of new funding opportunities and the review and award of grants responsive to programmatic opportunities will be labor intensive work that merits dedicated attention. The administration of such funds must be conducted in a rigorous and professional manner. At the same time, the Alliance is advancing key health plan strategic initiatives, including the Department of Health Care Services CalAIM transformation, preparing for a Dual Special Needs Plan, possible adjustments to operations relating to the implementation of AB 2724, and the 2024 model change county expansions. There is also substantial work in the area of core health plan governance in the years ahead.

2. *Additional MCGP Allocations*. As noted above, based on 2021 financial performance, at the August Board meeting staff anticipate a recommendation to allocate net income or otherwise uncommitted reserves which exceed the health care reserve target to the MCGP. This possible allocation will increase the breadth and duration of possible funding opportunities responsive to the newly established focus areas and goals. It is notable that even with an allocation to the MCGP, the current structure and administration of the program as a health plan function leaves the Alliance in an outlier status in reserves calculated as a multiplier of TNE given that the grant funds remain in that calculation. This is a relevant consideration for the Board in that key in its establishment of the MCGP was a principle to not supplant other funding (including revenue) as well as a desire to bring its reserves in line with peer health plans.

3. *Sustainability of MCGP Investments*. At the time the program was established, it was unclear what commitment the Alliance could make to either the value of annual grant making, or regarding the duration of expected grant making. The Board noted the need to assess the process over time, with an eye towards the health plan's financial condition, revenue patterns and business needs to determine whether grantmaking would be a longer-term commitment. The Alliance now has seven years of financial performance evaluation whilst operating the MCGP, demonstrating a pattern of earnings and losses. Staff's financial forecasting indicates that longer term investment through the MCGP is a stable and reliable long-term strategy that can continue to support capacity in the Medi-Cal delivery system. On average, the Alliance has distributed $12.3M annually. Staff seek the Board's input as to the possible adoption of an annual spending plan for the MCGP. Adopting such a practice for the MCGP would ensure clarity as to what the Alliance aimed to distribute annually. Adopting a spending plan would also formalize an approach to prudently offer

grants as a long-term benefit to the community, responsive to priorities and focus areas established by the governing board for the MCGP.

4. *Conflict of Interest*. As noted above, the Board considers programs, reports or actions for the MCGP at between five and seven Board meetings annually. This is a significant investment of Board time and attention, diverting attention from core health plan governance. Thirty-eight of the 46 MCGP items since 2015 were action items and of those, 18 or 47% of MCGP items presented potential conflicts of interest, requiring Board members to refrain from influencing the discussion or action on the items, and requiring staff to navigate such potential conflicts to ensure action is possible. Staff seek the Board's input as to a possible change in governance over the MCGP, whether through the establishment of a Board committee authorized to approve programs, funding allocations and grant awards and constituted by individuals who do not have potential conflicts of interest, or through revisiting the concept of a foundation model, with a separate administrative structure and a foundation Board.

Conclusion. Effective management of the MCGP requires design, development, implementation, fiscal management, monitoring and evaluation of MCGP funded projects. There are sizable assets involved. The Alliance has significant Medi-Cal managed care policies to implement in the coming years requiring the full focus of the Alliance Board on health plan governance. It is appropriate at this point to consider the administration of the MCGP to ensure the proper focus and attention on governing the Alliance and on governing the MCGP.

Staff will consider the Board's discussion regarding the administration of the evolved MCGP, and in particular as to the establishment of an annual spending plan and as to adjustments to governance for the MCGP. Depending on the outcomes of the Board's discussion of this report, staff anticipate returning with recommendations regarding the MCGP administrative structure to develop and implement new grantmaking opportunities.

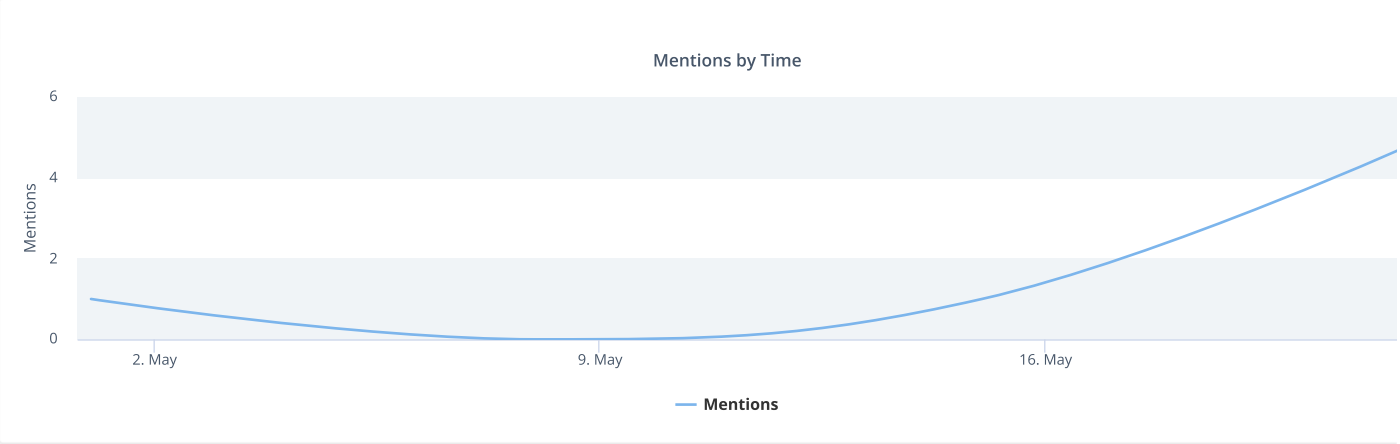
Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments. N/A

Information Items: (14A. – 14E.)

June 2022 Board Report

Mention Analytics



Total Online + Print Audience
85,829

Total Online + Print Publicity
USD $849

Total Number of Clips 7

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Full Article

Name dropping | Herbelin joins Alliance

Date Collected May 28, 2022 6:09 PM EDT
Category Local
Source Santa Cruz Sentinel
Author Santa Cruz Sentinel

Est. Audience 22,001
Est. Publicity Value USD $289
Market Santa Cruz, CA
Language English

Herbelin joins Alliance
Central California Alliance for Health on Monday announced Dr. Maurice Herbelin as the Alliance's Chief Medical Officer. The role was previously h
by Dr. Dale Bishop.

Herbelin brings more than two decades of health care experience to the role, including population health and value-based care models, accordin
release from the alliance. Most recently, Herbelin served as chief medical officer for Optum Market Performance Partnerships at UnitedHealth Gr

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Online News

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Print Article

Un rayo de esperanza a pacientes vulnerables

Powered by LexisNexis

Date Collected May 28, 2022 9:28 AM EDT
Category Local
Source The Californian (Salinas, California)
Author By Jocelyn Ortega, El Sol de Salinas

Est. Audience 6,000
Est. Publicity Value USD $60
Market California, US
Language English

Read More

Print Article

Children's healthcare center in downtown Salinas offers glimmer of hope to vulnerable patients

Online News

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(Requires Critical Mention login)

Powered by LexisNexis

Date Collected May 26, 2022 2:15 AM EDT
Category Local
Source The Salinas Californian
Author Jocelyn Ortega, Salinas Californian

Market Salinas, CA
Language English

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Full Article

Watsonville Community Hospital in jeopardy as purchase deadline looms

Date Collected May 25, 2022 8:32 PM EDT
Category Local
Source Santa Cruz Sentinel
Author Ethan Baron

Est. Audience 22,001
Est. Publicity Value USD $219
Market Santa Cruz, CA
Language English

WATSONVILLE — Fundraising to buy the bankrupt Watsonville Community Hospital is still millions of dollars short, and officials worry the purchas will fail, the facility will shut down, and residents of Santa Cruz and Monterey counties will suffer.

"I'm scared we won't be able to close the sale," said Mimi Hall, chair of the Pajaro Valley Healthcare District Project, a non-profit community group to buy the facility.

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Full Article

$16 million in 90 days: What's needed to close public purchase of Watsonville Community Hospital

Date Collected May 24, 2022 8:56 AM EDT
Category
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

... more than three months away. The court set a purchase price of $63 million. With over $46 million committed so far, about $16 million remains raised.

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Online News

Full Article

Children's healthcare center in downtown Salinas offers glimmer of hope to vulnerable patients

Date Collected May 20, 2022 10:39 PM EDT
Category Local
Source Californian
Author Jocelyn Ortega

Est. Audience 3,091
Est. Publicity Value USD $2
Market Salinas, CA
Language English

... in Salinas.

"During COVID, the amount of calls for counseling was very high," Ceja said. "This population seems to have more sick and vulnerable families an nurses worked non-stop. We want to continue that work."

The new building was made possible through fundraising, a grant from the **Central California Alliance for Health**, and a $300,000 donation from Silicon Valley couple Valeta and T.J. Rodgers. The couple says they were inspired by the CKHC's mission to help children.

"You hear stories about children who need help, children you don't want to be in a hospital, they could get an infection there," T.J. said. "Then ...

Print Article

Take Over

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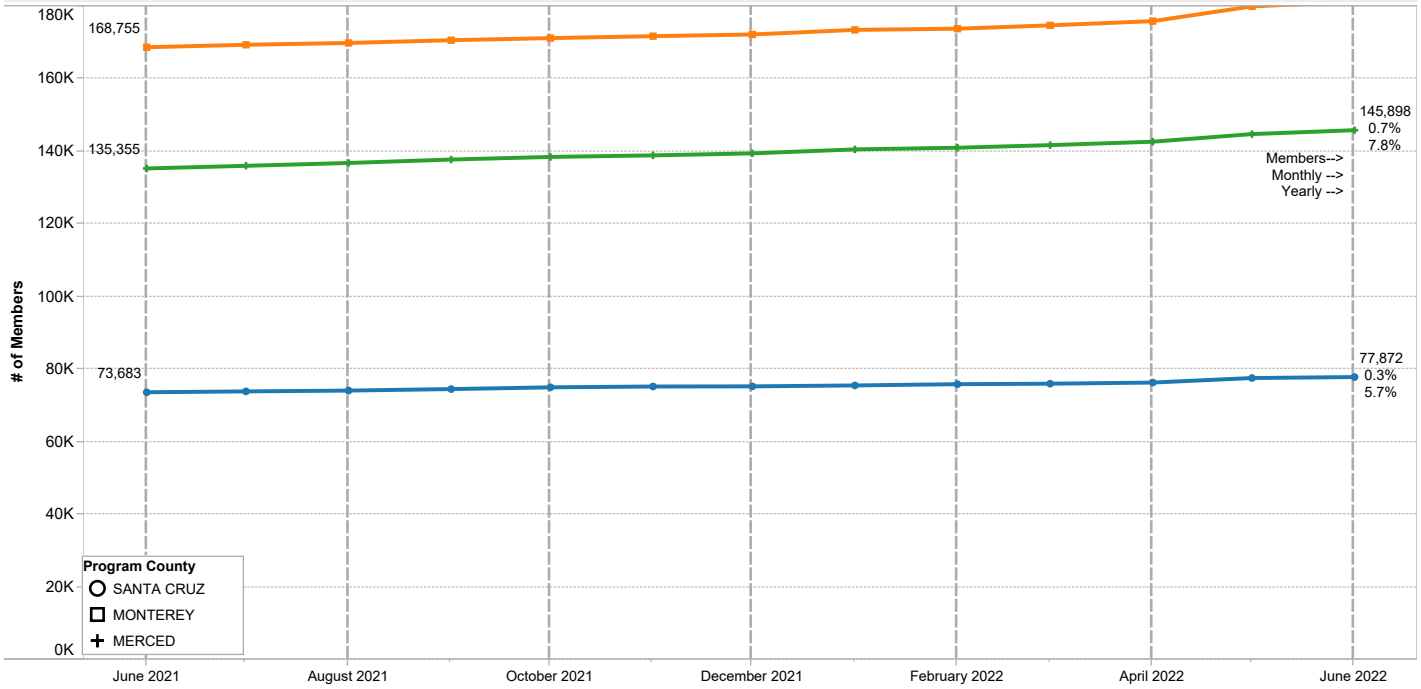
Enrollment Report

Year: *2017 & 2018* **County:** *All* **Program:** *IHSS & Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *6/6/2022*

StaticDate
6/1/2021 12:00:00 AM to 6/30/2022 11:59:59 PM

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



Program..	ProgramCo..	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022
Medi-Cal	SANTA CRUZ	73,683	73,924	74,145	74,559	75,039	75,269	75,309	75,565	75,909	76,047	76,358	77,605	77,872
	MONTEREY	168,254	168,938	169,423	170,178	170,758	171,291	171,757	173,028	173,349	174,197	175,323	179,363	180,606
	MERCED	135,355	136,081	136,865	137,810	138,530	138,956	139,516	140,604	141,065	141,779	142,723	144,824	145,898
IHSS	MONTEREY	501	498	509	516	513	515	517	511	511	589	624	650	657
Total Members		**377,793**	**379,441**	**380,942**	**383,063**	**384,840**	**386,031**	**387,099**	**389,708**	**390,834**	**392,612**	**395,028**	**402,442**	**405,033**