Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Wednesday, June 28, 2023

3:00 p.m. – 5:00 p.m.

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

Alliance offices are open to attend Board meetings in each county.

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows. Note: Livestreaming for the public is listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 (323) 705-3950
    Phone Conference ID: 270 316 637#

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 27, 2023 to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to five minutes.
    b. In person, from an Alliance County office, during the meeting when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

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

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.
C. Welcome Dr. Donaldo Hernandez, Provider Representative, Santa Cruz County to the Board.

2. **Oral Communications. 3:05 p.m.**

A. Members of the public may address the Commission on items not listed on today's agenda that are within the jurisdiction of the Commission. Presentations must not exceed 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.

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

A. Board members may provide comments and announcements.

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

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

Consent Agenda Items: (5. – 9E.): 3:10 p.m.

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

- Reference materials: Executive Summary from the CEO; and Central California Alliance for Health June 2023 Bill List.

Pages 5-01 to 5-41

6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the fourth month ending April 30, 2023.**

- Reference materials: Financial Statements as above.

Pages 6-01 to 6-09

Appointments: (7A.)

7A. **Approve appointment of Allyson Garcia, MD to the Whole Child Model Clinical Advisory Committee.**

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

Page 7A-01

Minutes: (8A. – 8D.)

8A. **Approve Commission meeting minutes of May 24, 2023.**

- Reference materials: Minutes as above.

Pages 8A-01 to 8A-06

8B. **Accept Physicians Advisory Group meeting minutes of March 2, 2023.**

- Reference materials: Minutes as above.

Pages 8B-01 to 8B-07

8C. **Accept Whole Child Model Clinical Advisory Committee meeting minutes of April 6, 2023.**

- Reference materials: Minutes as above.

Pages 8C-01 to 8C-05

8D. **Accept Whole Child Model Family Advisory Committee meeting minutes of March 13, 2023.**
- Reference materials: Minutes as above.

Pages 8D-01 to 8D-04

Reports: (9A. – 9E.)

9A. **Authorize the Board to ratify the execution by the Chairperson of Medi-Cal Contract 08-85216 A-56 to incorporate updated Capitation Payment rates for CY 2021.**
- Reference materials: Staff report and recommendation on above topic.

Page 9A-01

9B. **Approve future state of Behavioral Health recommendation.**
- Reference materials: Staff report and recommendation on above topic.

Pages 9B-01 to 9B-02

9C. **Approve Department of Health Care Services CalAIM Incentive Payment Program recommendation.**
- Reference materials: Staff report and recommendation on above topic.

Pages 9C-01 to 9C-02

9D. **Approve Medi-Cal Capacity Grants: Funding Recommendations. (Group A)**
A. Action on grants with no Board member affiliation.
- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; Recommendation Summaries by Organization; and Medi-Cal Capacity Grant Program Current Funding Opportunities.

Pages 9D-01 to 9D-20

9E **Approve Medi-Cal Capacity Grants: Funding Recommendations. (Group B)**
A. Action on grants with Board member affiliation.
- Reference materials: Staff report and recommendation on above topic; Grant Recommendations by Program; and Recommendation Summaries by Organization.

Pages 9E-01 to 9E-08

Regular Agenda Items: (10. – 13.): 3:15 p.m.

10. **Consider approving Dual Eligible Special Needs Plan (D-SNP) readiness budget items. (3:15 – 3:35 p.m.)**
A. Ms. Lisa Ba, Chief Financial Officer (CFO), will review and Board will consider approving FY 2023 budget adjustment of D-SNP readiness activities.
B. Ms. Ba, CFO, will review and Board will consider approving a D-SNP implementation consultant, including the budget for such an engagement.
- Reference materials: Staff report and recommendation on above topic.

Pages 10-01 to 10-02

11. **Discuss Model Change Implementation and consider approving provider payment policy for Model Change Counties. (3:35 – 3:55 p.m.)**
A. Ms. Ba, CFO, will review and Board will consider approving payment policy for provider contracts for San Benito and Mariposa County expansions.
- Reference materials: Staff report and recommendation on above topic.

Pages 11-01 to 11-02

12. **Consider approving Provider Payment Strategy – Part 2: Value-Based Payment and Strategic Allocation to Value-Based Payment. (3:55 – 4:20 p.m.)**

A. Ms. Ba, CFO, will review and Board will consider approving strategic allocation of reserve for value-based payment.

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

Pages 12-01 to 12-02

13. **Discuss Alliance State of Technology, Data and Security. (4:20 – 4:40 p.m.)**

A. Mr. Cecil Newton, Chief Information Officer (CIO), will review and Board will discuss Alliance's state of technology, data and security.

- Reference materials: Staff report on above topic.

Pages 13-01 to 13-02

Adjourn to Closed Session

14. **Closed session pursuant to Government Code Section 54956.9, subdivision (d)(1) – Conference with Legal Counsel – Pending Litigation (THC – Orange County, LLC d/b/a Kindred Hospital – San Francisco Bay Area v. Santa Cruz-Monterey-Merced Managed Medical Care Commission, dba Central California Alliance for Health). (4:40 – 4:55 p.m.)**

A. Closed session agenda item.

Return to Open Session

15. **Open session pursuant to Government Code Section 54956.9, subdivision (d)(1) – Conference with Legal Counsel – Pending Litigation (THC – Orange County, LLC d/b/a Kindred Hospital – San Francisco Bay Area v. Santa Cruz-Monterey-Merced Managed Medical Care Commission, dba Central California Alliance for Health). (4:55 – 5:00 p.m.)**

A. Board will report on action taken in closed session.

Information Items: (16A. – 16E.)

A. Alliance in the News — Page 16A-01
B. Membership Enrollment Report — Page 16B-01
C. Member Newsletter (English) – June 2023
https://thealliance.health/wp-content/uploads/MSNewsletter_202306-E.pdf
D. Member Newsletter (Spanish) – June 2023
https://thealliance.health/wp-content/uploads/MSNewsletter_202306-S.pdf
E. Provider Bulletin – June 2023
https://thealliance.health/wp-content/uploads/CCAH-Provider-June2023-HighRes.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, June 28, 2023; 1:30 – 2:45 p.m.
- Member Services Advisory Group
  Thursday, August 10, 2023; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, September 7, 2023; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [*In-person and remote teleconference*]
  Thursday, September 21, 2023; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [*In-person and remote teleconference*]
  Monday, July 10, 2023; 1:30 – 3:00 p.m.

The above meetings will be held in person unless otherwise noticed. Audio livestreaming will be available to listen/view the meeting. Note: Livestreaming for the public is listening/viewing only.

The next regular meeting of the Commission, after this June 28, 2023 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, August 23, 2023; 3:00 – 5:00 p.m.
  Locations: Videoconference from Alliance offices in Scotts Valley, Salinas and Merced

Locations for the meeting:

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

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

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

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

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

DATE: June 28, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

2023-24 State Budget. The Legislature met the June 15, 2023 Constitutional deadline to adopt a budget to send to the Governor. While the budget shortfall has continued to climb to a projected $31.5M, notably there are no reductions to Medi-Cal funding, benefits or programs. In fact, the proposed coverage for all income-eligible residents ages 26 – 49 regardless of immigration status, remains funded for implementation effective January 1, 2024. However, staff understand that many budget issues remain under negotiation between the Legislature and the Administration and a subsequent "Budget Bill Jr." is expected in the coming days that will make revisions to the budget based on outcomes of those negotiations. The budget must be signed by the Governor by June 30, 2023 for implementation July 1, 2023.

Managed Care Organization (MCO) Tax. A key component of the budget that remains under negotiation is the MCO Tax. As previously discussed, the MCO tax program is a tax on managed care plans with the proceeds used to leverage federal funds to support the Medi-Cal program. The funds generated by the MCO tax proposal have tripled from the initial proposal to over $19B. The key aspects under deliberation relate to the spending plan for these funds. A total of $8.3B is proposed in General Fund offset with the remaining $11.1B supporting investments that improve access, quality and equity in the Medi-Cal program including increases to Medi-Cal base payments to specified providers. Through its health plan associations including the Local Health Plans of California and the California Association of Health Plans, the Alliance is a part of a coalition of stakeholders advocating for an MCO Tax spending plan that includes a shorter expenditure timeframe resulting in an immediate impact that improves access to health care for Medi-Cal beneficiaries. Staff will provide updates at the June meeting on developments of these negotiations.

2023 Legislation. Staff continue to monitor and advocate for legislation in alignment with the Board's adopted 2023 Policy Principles. Attached to this report you will find the 2023 bill list that includes sixty bills that staff are monitoring including those priority bills on which the Board has taken an advocacy position. The status of each bill is listed as either Active (the bill has moved to the second house for continued deliberation), Dead (bill did not pass procedural steps to move forward) or Two-Year Bill (the bill will be pended for further deliberation in the second year of this two-year legislative session). Staff will continue to monitor these bills to assess potential impact and consider necessary planning and implementation steps.

County Expansion: San Benito and Mariposa Counties. Implementation efforts continue towards a January 1, 2024 expansion of Alliance services to San Benito and Mariposa County Medi-Cal beneficiaries. Staff continue provider network development, community engagement, operational readiness, governance and board development and financial analysis to ensure the Alliance is prepared for this expansion of our service area. Discussions with DHCS

towards revenue adequacy have been positive and staff will present a provider payment policy recommendation at the Board's meeting on June 28, 2023.

Community Involvement Community Involvement. On June 8, 2023 I attended the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Council Meeting. I presented an update on the transition to the County Organized Health System to the San Benito County Board of Supervisors on June 13, 2023. On June 14, 2023 I attended the Department of Health Care Services (DHCS) June All-Plan CEO meeting in Sacramento and the virtual California Association of Health Plans Board meeting. I plan to attend the virtual HIPSCC Executive Committee Meeting on June 26, 2023.

Health Services

Current Health Services division priorities include finalizing provider applications for the Care-Based Quality Improvement Program, completing the Managed Care Accountability Set (MCAS) audit for 2022, continued development of the Population Health Management Program, preparing for the addition of the high-risk pediatric population to the Enhanced Care Management program and continuing development of Street Medicine, Doula benefit and the Dyadic Care benefit.

Quality Improvement and Population Health (QIPH)

Healthcare Effectiveness Data and Information Set/MCAS Report 2023. Finalized MCAS audit rates will be submitted to National Committee for Quality Assurance (NCQA) and DHCS by the June 15, 2023 deadline. New to the submission process this year are additional race and ethnicity stratifications at the health plan level.

Care-Based Quality Improvement Program. Forty-four eligible providers applied for the Care-Based Quality Improvement Program (CB QIP) program by the May 19, 2023 deadline. Staff have completed reviews, offered initial feedback on SMART AIM objectives and measure selection, and have approved the finalized applications. Provider Services staff will outreach this month to obtain signatures for the program's Letter of Agreement, with funding to begin shortly thereafter. Consideration is being given to how the Alliance can actively assist providers more with metric improvement as the program operates through the end of December.

Performance Improvement Projects. Health Services Advisory Group (HSAG) has completed validating the 2020–2022 Childhood Immunizations Performance Improvement Project (PIP) and the 2020–2022 Well-Care Visits Health Equity PIP. Both projects ended their submission cycle successfully with no additional findings.

Encounter Data Validation Audit 2023. The attestation for the Encounter Data Validation audit was completed and uploaded to HSAG on May 26, 2023. The project started with sample files shared by HSAG in mid-February, with medical record procurement by Alliance staff continuing until May 18, 2023. In our final submission status report in June, we had achieved 99.03% of completed uploaded records, totaling 407 out of 411 records. For the records not submitted, one record had contact information that had been disconnected, one record was done as part of a pop-up testing site at a nursing school with no records kept onsite, and the last two records included members with no documentation available for the selected DOS.

Utilization Management

Inpatient and Emergency Department (ED). Overall inpatient admissions for Q1 2023 decreased in comparison to activity noted in Q4 2022, with metrics near or below state averages and within goal targets for Medi-Cal population groupings. Overall inpatient per 1,000 members per year (PKPY) remained consistently lower in Q1, consistent with metrics seen in 2021 and a reversal from highs seen in 2022. Current 30-day readmission rates are at 12% and overall average length of stay decreased in Q1, which may be correlated with the plan's increased Population Health outreach and initiatives.

When considering inpatient metrics for specific Medi-Cal groupings, Medi-Cal Child and Family admissions fell below state average in an environment with increased membership for this population. A slight decrease was noted for inpatient admissions among the seniors and persons with disabilities subgroup, with an additional slight decrease in average length of stay (ALOS) and bed days coming in slightly above state average. Medi-Cal Expansion membership increased by 3,000 members over Q4 2022, with a reduction in ALOS and readmission rates consistent over prior quarters for this population.

ED utilization similarly reflects a continued decrease in activity, with reduced rates noted across the three counties. Avoidable ED visit rates by population groupings, though lower than seen in prior quarters, indicates a continued opportunity to widen primary and urgent care access across the three counties.

The Alliance continues work with acute care and long-term care/skilled nursing facilities (LTC/SNF) across the counties in operationalizing the new Required Preadmission Screening and Resident Review (PASRR) requirement that went live on May 1, 2023.

Prior Authorization. Prior authorization determination metrics continue at or above target goal for 2023, with authorizations processed timely and generally exceeding DHCS required timeframes. Outpatient authorization volumes were slightly lower than peak volumes seen in March; however, overall authorization totals remain consistently higher than metrics seen throughout 2022. The increase is likely due to current increased membership and in the interim of redetermination impacts which we anticipate will reduce membership over the next few months. Utilization overall remains consistent with prior quarters with minor increases noted in Non-Emergency Medical Transportation, dental anesthesia, and acupuncture services. Q2 authorization activity also reflected an increase in provider telephonic authorization requests, an atypical trend that peaked in May and appears to be dropping off in June.

Member Benefits. Configuration efforts are underway for further automation of durable medical equipment codes, specific to manual wheelchair repairs and nebulizers. Additional reporting has been established to further monitor activity as newer benefits are established, including Community Health Workers, doulas, dyadic care, and street medicine.

Pharmacy

Site of Care Program. The Alliance initiated the Site of Care Program in December 2022. The goal of the program is to transition members from hospital-based outpatient infusion to home-based infusion of their medication. The member and prescribing provider can opt in or out of the Site of Care Program depending on the member's clinical and social needs. Currently, we are focusing on members who are on infliximab (Remicade), its biosimilars, vedolizumab (Entyvio), intravenous immune globulin (IVIG), and ocrelizumab (Ocrevus).

Thus far, we have identified 56 members who are candidates for this program.

- Seven members have accepted the program:
  - Two members received provider approval; both have started receiving their infusion medication at home.
  - Three members accepted the program but did not transition to home-infusion. One member no longer had Alliance coverage after the member and provider opted into the program, and the other two had no response from the provider after multiple attempts.
  - There are currently two members who accepted the program and are pending provider decision.
- The members who have declined the program have done so for multiple reasons, including not wanting anyone in their home or they would like to continue at their current site of care because they receive other services from that site at the same time.

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

We are currently conducting training for all the Alliance pharmacy department staff on the Site of Care Program. So far, we have finished training all pharmacy technicians and two out of the three clinical pharmacists. We will complete training the entire pharmacy department within the next three months. In the future, we will begin targeting members on other infusion medications.

Pharmacist-Led Academic Detailing (PLAD) Program. Alliance pharmacists have been developing a pharmacist-led academic detailing program with focus on diabetes during Q1 and Q2 2023. The program goal is to assist clinicians in managing Alliance members with uncontrolled diabetes (A1c > 9%) through tailored 10 educational sessions dedicated to reviewing the latest standards on pharmacologic approaches to glycemic control and case studies to show how to incorporate these recommendations into practice.

Outreach has been conducted to clinics that serve a large proportion of Alliance members with uncontrolled diabetes. One clinic expressed interest in participating in the program. However, they requested to deviate from its original design due to time constraints. The clinic was able to commit to two 45-minute sessions and selected topics that were of most interest. Alliance pharmacist presented condensed versions on the chosen topics to 30 clinic staff on May 18 and June 1, 2023. The sessions were interactive, where providers were asked to participate in the chat during the virtual meetings and complete pre and post-tests. To measure the success of the program, we will evaluate provider knowledge gain from pre- and post-tests and conduct a provider satisfaction survey.

Community Care Coordination (CCC)

The CCC department is contemplating the necessary operations and collaboration needed to provide Transitional Care Services (TCS) to all Alliance members in 2024. TCS are described as members transferring from one setting/level of care to another, including, but not limited to: discharges from hospitals, institutions, other acute care facilities, and SNFs to home- or community-based settings. Services will include coordinating with the discharging facility,

Enhanced Care Management (ECM) providers, incoming facility, and other organizations to conduct a discharge assessment and plan of care, identifying a single point of contact for TCS for the member/support system, and must ensure needed post-discharge services are provided, and follow-ups are scheduled, including but not limited to follow-up provider appointments, substance use disorders and mental health treatment initiation, medication reconciliation, referrals to social service organizations, and referrals to necessary at-home services.

Enhanced Care Management (ECM)/Community Supports (CS). Final preparations are underway to initiate ECM services for two new populations of focus, Children and Youth enrolled in California Children's Services (CCS) Whole Child Model with additional needs beyond their CCS condition, as well as Children and Youth involved with the Child Welfare System on July 1. Five of the Alliance's existing ECM contracted providers will expand to serve this population moving forward. In addition, 12 new ECM and CS contracted providers will be added to the network beginning in July. These include providers for the new Children and Youth population of focus, as well as expanding providers for the existing ECM populations of focus and CS services.

There are two new CS services that will be added in July: Personal Care and Homemaker Services and Respite Services for Caregivers. Work is underway to develop provider tools to support the billing and documentation for these new services. Additional development of tools to support providers submitting clean claims is also a priority area for the Alliance.

Complex Care Management (CCM). The second phase of the CalAIM Population Health Management Program (PHMP) project work started this month. The focus of this project will be to utilize the information gained in the prior project's gap analysis and to further develop and implement PHMP based on DHCS and NCQA requirements. Some of the DHCS requirements have not been finalized so this project will close the gap identified from the PHM readiness assessment in addition to new work provided by further DHCS guidance. PHM is a cyclical improvement model; this project will implement a basic first iteration that will be improved in future years and will align with NCQA standards.

Whole Child Model/Pediatric Complex Care Management. Overall, CCS total member counts continue to hold over 8,000 total members. Specific county member counts vary. The Pediatric CCM team continues engagement in Alliance proactive outreach initiatives for population health, vaccines, and well child visit rates, incorporating these methods into routine member outreach activities. Targeted efforts and specific outreach continue to engage members in securing appointments and assessing for barriers to accessing care. The pediatric team continue to manage high caseloads with an average of 120 members per team member, while maintaining strong compliance with regulatory requirements related to CCS.

Behavioral Health (BH)

The BH team welcomed new Program Manager Rebecca McMullen, who is conducting her orientation and acclimating to the position. Onboarding activities have included shadowing at an array of meetings, reviewing policies, orienting to the Carelon contract, and spending one on one time with both the Program Director and existing Program Manager. With this recruitment complete, the BH team will shift focus to onboarding the final position allocated to the 2023 budget, namely an analyst position with funding beginning July 1, 2023.

The Alliance team has continued to build a relationship with new Account Executive Kim Van Der Ham. Efforts have included collaborative analysis of meeting cadence and structure, discussion of areas requiring improvement, and weekly executive check ins to ensure clear leadership communication.

The BH team has further coordinated on sole source contracting with Jennifer Clancy Associates to explore the details of BH benefit insourcing. The contract is scheduled to begin in June and commence at the end of the 2023 calendar year, culminating in a comprehensive analysis of resource needs and workload.

In addition to our existing project partnerships, the Alliance has agreed to participate in a new children and youth BH continuum initiative led by the County of Santa Cruz Health Services Agency. The initiative includes key partners such as the County Office of Education and community-based organizations. Scope will include a gap analysis across shared resources and efforts to fill the identified gaps. As part of this partnership, the Alliance will extend a contract to the selected community consultant who will execute the gap analysis, quoted at $30,625 and scheduled to extend from June to December.

Finally, the Scotts Valley based BH team was privileged to conduct a health equity tour of Merced led by Ronita Margain, Community Engagement Director. Tour sites included Mercy Medical Center Emergency Department, County BH and Recovery Services facilities such as the Marie Green Psychiatric Center, and the Merced Navigation Center. BH staff got the opportunity to connect face to face with leadership throughout these sites, learn more about the specific needs of the community, and discuss collaborative solutions to presenting issues.

Program Development

CalAIM Incentive Payment Program (IPP). The aim of this program is to increase capacity of ECM/CS providers through increased care management capabilities, community supports infrastructure, information technology and data exchange, and workforce capacity. On June 5, 2023, DHCS notified staff that the Alliance had been awarded 100% of the Payment 2 possible funding allocation: an additional $10,849,620 for investments in the Alliance service area. These funds will be used to support building capacity of partners bringing on new ECM/CS populations of focus. Staff are in discussions with Anthem Blue Cross (exiting Medi-Cal plan in Mariposa and San Benito Counties), California Health and Wellness (exiting Medi-Cal plan in Mariposa County) to prepare and submit Needs Assessments and Gap Filling Plans to DHCS and assume responsibility for IPP in Mariposa and San Benito Counties beginning in 2024.

Housing and Homelessness Incentive Program (HHIP). The aim of this program is to address homelessness and housing through a collaborative plan and implementation of services and supports. On May 31, 2023, DHCS notified staff that the Alliance had been awarded $11,645,470 of the $16,366,085 Payment 1 funding allocation (71%). Staff believe this reduction does not align with the progress report submitted and have requested to further discuss and contest with DHCS. In Q2 2023, Alliance staff solicited input from local homelessness continuums of care and their affiliated members on HHIP Program Year 2023-2024 investment strategies. Staff aim to execute a next round of letters of agreements with local partners in Q3 2023. The final HHIP measurement period takes place from January through October 2023. Therefore, the Alliance will not have an opportunity to earn and distribute HHIP funds in Mariposa or San Benito County, as service area expansion will not commence until 2024.

Student Behavioral Health Incentive Program (SBHIP). The aim of this program is to increase access to preventative early intervention and BH services by school-affiliated providers for TK-12 public school students. Progress report #1 is due from the Alliance to DHCS on June 30, 2023, and is associated with an additional $1,437,273 possible total funding allocation; decision and payment will be received by August 2023. Staff are in discussions with Anthem Blue Cross (exiting Medi-Cal plan in Mariposa and San Benito Counties) and California Health and Wellness (exiting Medi-Cal plan in Mariposa County) to prepare and submit transition documents to DHCS, and to assume responsibility for SBHIP in Mariposa and San Benito Counties beginning in 2024.

Employee Services and Communications

Alliance Workforce. As of June 5, 2023, the Alliance has 561.6 budgeted positions of which our active workforce number is 539 (active FTE and temporary workers). There are 29 positions in active recruitment, and we are 96% staffed. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets. Human Resources partners with Finance to ensure alignment in this area and provides a bi-weekly workforce dashboard to all Directors and Chiefs for transparency regarding our workforce statistics.

Mid-Year Check-in. This year, the Alliance moved from quarterly performance check-ins to a semi-annual cadence. The first mid-year check-in will kick off at the end June, providing an opportunity for staff to self-reflect on their performance over the first half of the year. Supervisors will provide feedback and meet with their staff, providing an opportunity to check in on performance expectations and goals. The Alliance focuses on a continuous feedback model, with the goal of engaging staff in open, two-way communication.

Competencies and Career Development. Human Resources provided an update at the May Operations Committee meeting, announcing the new core, leadership, and director level competencies. Human Resources is actively working with each department to validate competencies by classification and populating the new platform. We expect this work to run through the end of August 2023. Once this body of work is complete, Training & Development will begin work on the navigation and career development module, with education and training sessions scheduled to start in Q4 2023.

Facilities and Administrative Services.

Alliance Footprint Reduction. The Facilities Department is working to clear out employee workstations/offices in the areas targeted for footprint reduction. The team is proceeding with an 80,000 square foot reduction of Alliance occupied square footage and an increase of potential space for leasing which was included in the Facilities Management Annual Report.

Collaborative Office Space Survey. While the Alliance has transitioned to a hybrid, work-from-home environment, there are still organizational needs for departments and staff to meet and collaborate onsite in an Alliance office. A survey was created to get input from staff to determine and evaluate business needs, desires, and ideas for the use of technology in collaborative spaces such as conference rooms and auditoriums. The survey has been completed and results were summarized at the May Admin Forum meeting. Facilities and Information Technology Services will be working with the Project Management Operations team to implement some of the technology in the conference rooms at a future date.

Building Appraisals. Facilities has partnered with Pacific Appraisers to complete full building appraisals for all Alliance locations. A summary will be provided to the Facility Asset Management team.

Service Area Expansion. Facilities is actively working with Mariposa and San Benito Counties to coordinate leasing space with a targeted occupancy of October 1, 2023, in both service areas.

Communications. The member texting pilot is continuing, with the expectation that we will wrap up the feasibility report by the end of June. The report will detail the results of the texting pilot as well as any lessons learned and other considerations for establishing a permanent texting program at the Alliance. In May, we began sending targeted texts to members who are up for redetermination and who have received packets from the county. We expect to continue this effort for the remainder of the year, and we are tracking the results.

The paid campaign promoting Redetermination wrapped up at the end of May. Tactics included website copy, social media ads, Member Bulletin articles, The Beat articles, mobile ads, and bus ads. Results of the campaign included:

- Flyer distribution to 72 schools: 18,000 impressions and 3,400 views
- Website views: 20,000 unique views in English and Spanish (Hmong views did not meet Google threshold for measurement)
- Facebook: 53,000 views in Spanish; 45,000 views in English
- Mobile ads: 473,000 impressions in Spanish; 371,000 impressions in English
- 126,000 member households contacted via text message

To support enhanced awareness of the new Healthy Start program (rewards program for well checks and immunizations), we launched a paid media campaign in May which will run through early July. Messaging encourages people to see their doctor for checkups and to remain on track with vaccinations. The bilingual paid media campaign is in all three counties and includes internal and exterior bus ads, mobile ads, Facebook ads, clinic ads, Peachjar ads (flyers to 72 schools), website copy and newsletter articles.

To support the need to increase well checks and vaccine rates among elementary and middle school children in Merced, we are launching a paid media campaign targeting the Merced community. The campaign encourages families to make a well check appointment with their primary care provider to start the school year. The bilingual campaign will consist of mobile ads, Facebook ads, Merced clinic signage at Golden Valley Health Centers lobbies, school flyers and YouTube ads. This will be the first time we are testing YouTube ads. The campaign launches in early July and will run until mid-August.

Operations

Claims. The Alliance continues to make substantial progress with our OHC/COB payment integrity project, as we move towards implementation by the end of July. The objective is to identify members that have other insurance, using the vendor's algorithm and the claims reclamation process, which is the method of recovery when our members were primary with another carrier. We will also initiate a 12-week engagement in August with Mazars to review our claims configuration process from end to end. There will be an executive summary as a deliverable that includes a set of recommendations to increase the accuracy of our claim's payment. We continue to receive positive feedback related to the Monthly Claims Department Newsletter that we launched earlier this year, to increase staff connection in a hybrid work

environment. We have now completed our new HSP Platform audit for the first five months of the year. In addition, for the second straight month, we have achieved all three of our Quality targets, including Financial, Payment, and Processing accuracy.

Member Services. As the continuous coverage requirement has now ended, the Member Services Department continues to actively collaborate with our county partners to share member information regarding address updates and redetermination dates. In May, the Alliance used data obtained from our county partners to conduct targeted text and live outreach to members with redetermination packets due in June. As a result, our call center experienced only a slight increase in calls, with most calls related to address updates. DHCS released the first redetermination list in May and will be providing this monthly going forward to assist with the efforts for continuous coverage. Currently, we are preparing for both text and live outreach to members with a July renewal.

Provider Services. The Provider Services team is continuing with the recruitment process for Mariposa and San Benito providers. The team is also engaged in building out access prioritization criteria for the 2023 access plan which will help the team to focus recruitment priority. Key inputs include provider appointment availability, grievance trends, primary care providers to member ratios, and regulatory requirements. Each input is then assessed against access scoring criteria that consider compliance, operational impact, return on investment, strategic alignment, as well as member and provider value. As shared during the April Board meeting, the focus for the 2023 access plan includes utilizing non-traditional provider types to support the provider network and members in alignment with our strategic priorities. Specifically, this includes building out a doula network and engaging with community-based organizations to contract Community Health Workers. Additional focused efforts will be made to support Merced County primary care providers and engaging with Carelon our BH subcontractor.

Community Engagement Santa Cruz/Monterey/Merced. Community Engagement staff have begun to meet with the Providing Access and Transforming Health (PATH) facilitators in a collaborative meeting to align roles and responsibilities for the CalAIM initiative. This work has allowed the health plan to assure a partnership is developed with these important stakeholders to engage community-based organizations around this work. Staff have also attended the CalAIM Partner Collaborative in each county and contributed information and resources as needed to the community based organizations who may be interested in providing community support services within this program.

The Community Engagement team continue to look for ways to increase immunization rates, especially in Merced County. To that end, a collaboration has formed between the health plan, Mercy Medical Center, the Merced Fire Department and the Merced County Office of Education. With this partnership, there will be increased pop-up vaccine events throughout Merced County focusing primarily on school-based locations.

Attachments.

1. Central California Alliance for Health June 2023 Bill List

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

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

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

Central California Alliance for Health
June 2023 Bill List

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

	specifies that just cause includes travel while on official business of the legislative body or another state or local agency. This bill would revise the alternative provisions, operative until January 1, 2026, to make these provisions operative indefinitely. The bill would delete the restriction that prohibits a member, based on just cause, from participating remotely for more than 2 meetings per calendar year. The bill would delete the requirement for the legislative body to provide at least one of 2 specified means by which the public may remotely hear and visually observe the meeting. The bill would also delete a provision that requires a member participating remotely to publicly disclose at the meeting before action is taken whether there are individuals 18 years of age present in the room at the remote location and the general nature of the member's relationship to those individuals. The bill would further delete a provision that prohibits a member from participating remotely for a period of more than 3 consecutive months or 20% of the regular meetings within a calendar year, or more than 2 meetings if the legislative body regularly meets fewer than 10 times per calendar year. The bill would expand the definition of just cause to include travel related to a member of a legislative body's occupation. The bill would make related, conforming changes.
SB 282 **Eggman and McGuire** **Status:** Active In Assembly Read first time and held at desk, on May 25, 2023. **Position:** Support	**Medi-Cal: federally qualified health centers and rural health clinics** **Summary:** Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and a physician or other specified health care professionals. Under existing law, "visit" also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified. This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions. The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a "visit." The bill would also make a change to the provision relating to physicians and would make other technical changes.
SB 311 **Eggman** **Status:** Active In Assembly	**Medi-Cal: Part A buy-in** **Summary:** Existing law requires the State Department of Health Care Services, to the extent required by federal law, for Medi–Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for certain elderly and disabled persons. Existing federal law authorizes states to pay for Medicare benefits for specified enrollees pursuant to either a buy-in agreement to directly enroll and pay premiums or a group payer arrangement to pay premiums.

Read first time and held at desk, on May 25, 2023. **Position:** Support	This bill would require the department to submit a state plan amendment no later than January 1, 2024, to enter into a Medicare Part A buy-in agreement with the federal Centers for Medicare and Medicaid Services. To the extent that the bill would increase duties for a county, the bill would create a state-mandated local program.
SB 424 **Durazo** **Status:** Active In Assembly Read first time and held at desk, on June 1, 2023.	**Medi-Cal: Whole Child Model Program** **Summary:** Existing law requires the department to establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Existing law terminates the advisory group on December 31, 2023. This bill would extend the operation of the advisory group until December 31, 2026.
Assembly Bills	
AB 55 **Rodriguez** **Status:** Dead	**Medi-Cal: workforce adjustment for ground ambulance transports** **Summary:** Existing law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under existing law, those increased payments are funded solely from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other related federal funds. Existing law sets forth separate provisions for increased Medi-Cal reimbursement to providers of ground emergency medical transportation services that are owned or operated by certain types of public entities. This bill would establish, for dates of service on or after July 1, 2024, a workforce adjustment, serving as an additional payment, for each ground ambulance transport performed by a provider of medical transportation services, excluding the above-described public entity providers. The bill would vary the rate of adjustment depending on the point of pickup and whether the service was for an emergency or nonemergency, with the workforce adjustment being equal to 80% of the lowest maximum allowance established by the federal Medicare Program reduced by the fee-for-service payment schedule amount, as specified. The bill would require that the workforce adjustment meet a certain workforce standard, as determined by the department, which would apply to specified classes of employees, including emergency medical dispatchers, emergency medical technicians, paramedics, and registered nurses. The bill would set forth criteria for a provider to meet the workforce standard, with formulas taking into account the fiscal year and base hourly wage rates within a class of employees, and whether the provider is a new provider of ground ambulance services. The bill would require the department to direct each Medi-Cal managed care plan to implement a value-based purchasing model that provides for reimbursement to

	a network provider that meets the workforce standard requirement and that furnishes ambulance transport services, as specified. The bill would require the department to establish the manner and format for participating providers to report the required data, as specified. The bill would require a provider that has received the workforce adjustment to certify under penalty of perjury that it met the workforce standard, as specified. By expanding the scope of the crime of perjury, the bill would impose a state-mandated local program. The bill would authorize the department to recoup any workforce adjustments paid to a provider that did not meet the workforce standard. The bill would prohibit implementation of the workforce adjustment from affecting the calculation of the above-described QAF-based add-on, and would prohibit adjustments to the workforce adjustment, except as specified to comply with federal requirements. The bill would condition implementation of the workforce adjustment on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would make conforming changes.
AB 232 **Aguiar-Curry** **Status:** Active In Senate Read a second time, amended, and re-referred to the Committee on Business, Professions and Economic Development on May 31, 2023.	**Temporary practice allowances** **Summary:** Existing law, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act generally govern the provision of marriage and family therapy services, clinical social work services, and professional clinical counseling services, respectively, in the state and prohibit a person from practicing those healing arts without a license granted pursuant to the respective provisions of each act. This bill, until January 1, 2026, would, under all of the acts described above, authorize a person who holds a license in another jurisdiction of the United States as a marriage and family therapist, clinical social worker, or professional clinical counselor to provide services in the state for a period not to exceed 30 consecutive days in any calendar year if certain conditions are met, including the license from another jurisdiction is at the highest level for independent clinical practice in the jurisdiction in which the license was granted, the client is located in California during the time the person seeks to provide care in California, and the client is a client of the person and was the person's client immediately before the client became located in California. The bill would require a person who intends to provide services pursuant to those provisions to provide the Board of Behavioral Sciences with certain information before providing services, including the jurisdiction in which the person is licensed, the type of license held, and the license number. The bill would also make various nonsubstantive and conforming changes.
AB 236 **Holden** **Status:** Two-Year Bill	**Health care coverage: provider directories** **Summary:** This bill would require a plan or insurer to annually audit and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on January 1, 2024, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before January 1, 2027. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks and for each inaccurate

	listing in its directories. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2024, unless specified criteria applies. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 286 **Wood** **Status:** Active In Senate Referred to the Committee on Energy, Utilities, and Communications on May 31, 2023.	**Broadband infrastructure: mapping** **Summary:** Existing law requires the Public Utilities Commission, in collaboration with relevant state agencies and stakeholders, to maintain and update a statewide, publicly accessible, and interactive map showing the accessibility of broadband service in the state. Existing law authorizes the commission to collect information from providers of broadband services at the address level and prohibits the commission from disclosing certain protected residential subscriber information. This bill would require that the map identify, for each address in the state, each provider of broadband services that offers service at the address and the maximum speed of broadband services offered by each provider of broadband services at the address. The bill would additionally require that map to include certain features to receive self-reported data, including, among others, a feature that allows individuals to refute the broadband speed or technology, or both, that an internet service provider claims to offer at an address. The bill would make this self-reported data publicly available by address and would require the commission to make individuals aware that this information will be made publicly available by address, as provided.
AB 317 **Weber** **Status:** Active In Senate Referred to the Committee on Health on May 10, 2023.	**Pharmacist service coverage** **Summary:** Existing law authorizes health care service plans and certain disability insurers, that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist, to pay or reimburse the cost of the service performed by a pharmacist for the plan or insurer if the pharmacist otherwise provides services for the plan or insurer. This bill would instead require a health care service plan and certain disability insurers that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of services performed by a pharmacist at an in-network pharmacy or by a pharmacist at an out-of-network pharmacy if the health care service plan or insurer has an out-of-network pharmacy benefit. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.
AB 365 **Aguiar-Curry** **Status:** Active	**Medi-Cal: diabetes management** **Summary:** This bill would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program, subject to utilization controls. The bill would require the department, by July 1, 2024, to review and update, as appropriate, coverage policies for continuous

In Senate Read first time and sent to the Commission on Rules for assignment on June 1, 2023.	glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized. The bill would make related findings and declarations.
AB 412 **Soria, Garcia, and Wood** **Status:** Active In Senate Read first time and sent to the Commission on Rules for assignment on June 1, 2023.	**Distressed Hospital Loan Program** **Summary**: This bill would create the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. The bill would require, subject to an appropriation by the Legislature, the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement the program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, as specified. Notwithstanding that methodology, the bill would deem a hospital applying for aid to be immediately eligible for state assistance from the program if the hospital has 90 or fewer days cash on hand and has experienced a negative operating margin over the preceding 12 months. The bill would require a hospital or a closed hospital to provide the authority and the department with financial information, in a format determined by the authority, demonstrating the hospital's need for assistance due to financial hardship. The bill would additionally require that the department, in consultation with the authority, develop a loan forgiveness application and approval process, as specified. The bill would specify that the authority and the department may implement these provisions by information notices or other similar instructions, without taking any further regulatory action. This bill would create the Distressed Hospital Loan Program Fund, a continuously appropriated fund, for use by the department and the authority to administer the loan program, as specified. The bill would authorize both the authority and the department to recover administrative costs from the fund, as specified. By creating a continuously appropriated fund, the bill would make an appropriation. Existing law generally requires a health care facility to report specified data to the department, including total inpatient and outpatient revenues by payer, including Medicare and Medi-Cal. Existing law requires the department to adopt regulations regarding the identification and reporting of charity care services, and specifies various obligations to provide hard copies of hospital data reports submitted pursuant to these provisions. This bill would additionally require data for total inpatient and outpatient revenues by payer to include commercial coverage payers. The bill would require a hospital

	subject to these data reporting requirements to submit a balance sheet detailing the assets, liabilities, and net worth at the end of the quarter as specified by the department. The bill would also remove the provisions regarding regulations related to charity care services and obligations to provide hard copies of hospital data reports. This bill would declare that it is to take effect immediately as an urgency statute.
AB 424 **Bryan** **Status:** Active In Senate Read first time and sent to the Commission on Rules for assignment on June 1, 2023.	**Neurodegenerative disease registry** **Summary:** Existing law, until January 1, 2028, and to the extent funds are made available for these purposes, requires the State Department of Public Health to collect data on the incidence of neurodegenerative disease in California, and requires a hospital, facility, physician and surgeon, or other health care provider diagnosing or providing treatment to a patient for a neurodegenerative disease to report each case of a neurodegenerative disease to the department, as prescribed. Existing law specifies that for this purpose, "neurodegenerative disease" may include, but need not be limited to, amyotrophic lateral sclerosis (ALS), among other diseases. This bill would require the term "neurodegenerative disease" to include, but not be limited to, ALS.
AB 425 **Alvarez** **Status:** Active In Senate Read first time and sent to the Commission on Rules for assignment on June 1, 2023.	**Medi-Cal: pharmacogenomic testing** **Summary:** This bill would add pharmacogenomic testing as a covered benefit under Medi-Cal, as specified. The bill would define pharmacogenomic testing as laboratory genetic testing that includes, but it not limited to, a panel test, to identify how a person's genetics may impact the efficacy, toxicity, and safety of medications, including medications prescribed for behavioral or mental health, oncology, hematology, pain management, infectious disease, urology, reproductive or sexual health, neurology, gastroenterology, or cardiovascular diseases.
AB 459 **Haney** **Status:** Active In Senate Read first time and sent to the Commission on Rules for assignment on June 1, 2023.	**California Behavioral Health Outcomes and Accountability Review** **Summary:** Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 in the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs, including prevention and early intervention programs. This bill would require the California Health and Human Services Agency, by July 1, 2026, to establish the California Behavioral Health Outcomes and Accountability

	Review (CBH-OAR), consisting of performance indicators, county self-assessments, and county and health plan improvement plans, to facilitate an accountability system that fosters continuous quality improvement in county and commercial behavioral health services and in the collection and dissemination of best practices in service delivery by the agency. The bill would require the agency to convene a workgroup, as specified, to establish a workplan by which the CBH-OAR shall be conducted. The bill would require the agency to establish specific process measures and uniform elements for the county and health plan improvement plan updates. The bill would require the agency to report to the Legislature, as specified. By imposing new requirements on counties, this bill would impose a state-mandated local program. This bill would require the agency to request the University of California to enter into a contract with the state to provide specific services, including preparing an analysis of how data pertaining to the provision of behavioral health services and client outcomes collected by the counties and health plans may be used to demonstrate the impact of services on life outcomes. The bill would require the analysis to be delivered to the agency, the Legislature, and the workgroup on or before July 1, 2026.
AB 492 **Pellerin** **Status:** Active In Senate Read first time, sent to Committee on Rules for assignment, on June 1, 2023.	**Medi-Cal: reproductive and behavioral health integration pilot programs** **Summary:** Existing law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to a federal waiver, as part of the schedule of Medi-Cal benefits. Under existing law, the Family PACT Program provides comprehensive clinical family planning services to a person who has a family income at or below 200% of the federal poverty level and who is eligible to receive those services pursuant to the waiver. Under the Family PACT Program, comprehensive clinical family planning services include, among other things, contraception and general reproductive health care, and exclude abortion. Abortion services are covered under the Medi-Cal program. This bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants, incentive payments, or other financial support available to Medi-Cal managed care plans to develop and implement reproductive and behavioral health integration pilot programs in partnership with identified qualified providers, in order to improve access to behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions. The bill would define "qualified provider" as a Medi-Cal provider that is enrolled in the Family PACT Program and that provides abortion- and contraception-related services. For funding eligibility, the bill would require a Medi-Cal managed care plan to identify the qualified providers and the services that will be provided through the pilot program, as specified. The bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants or other financial support available to qualified providers for reproductive and behavioral health integration pilot programs, in order to support development and expansion of services, infrastructure, and capacity for the integration of behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions.

	For funding eligibility, the bill would require a qualified provider to identify both the patient population or gap in access to care and the types of services provided, as specified. The bill would require the department to convene a working group, with a certain composition, to develop criteria for evaluating applications and awarding funding, to conduct an evaluation of the pilot programs, and to submit a report to the Legislature, as specified.
AB 557 **Hart** **Status:** Active In Senate Referred to the Committees on Governance and Finance, and the Judiciary, on May 24, 2023.	**Open meetings: local agencies: teleconferences** **Summary:** (1) Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Existing law, until January 1, 2024, authorizes a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health, as specified. If there is a continuing state of emergency, or if state or local officials have imposed or recommended measures to promote social distancing, existing law requires a legislative body to make specified findings not later than 30 days after the first teleconferenced meeting, and to make those findings every 30 days thereafter, in order to continue to meet under these abbreviated teleconferencing procedures. Existing law requires a legislative body that holds a teleconferenced meeting under these abbreviated teleconferencing procedures to give notice of the meeting and post agendas, as described, to allow members of the public to access the meeting and address the legislative body, to give notice of the means by which members of the public may access the meeting and offer public comment, including an opportunity for all persons to attend via a call-in option or an internet-based service option. Existing law prohibits a legislative body that holds a teleconferenced meeting under these abbreviated teleconferencing procedures from requiring public comments to be submitted in advance of the meeting and would specify that the legislative body must provide an opportunity for the public to address the legislative body and offer comment in real time. This bill would extend the above-described abbreviated teleconferencing provisions when a declared state of emergency is in effect, or in other situations related to public health, as specified, indefinitely. The bill would also extend the period for a legislative

	body to make the above-described findings related to a continuing state of emergency and social distancing to not later than 45 days after the first teleconferenced meeting, and every 45 days thereafter, in order to continue to meet under the abbreviated teleconferencing procedures.
AB 564 **Villapudua** **Status:** Active In Senate Read first time, sent to Committee on Rules for assignment, on June 1, 2023.	**Medi-Cal: claim or remittance forms: signature** **Summary:** Existing law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Existing law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Existing law states the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, as specified. This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.
AB 576 **Weber** **Status:** Active In Senate Read first time, sent to Committee on Rules for assignment, on June 1, 2023.	**Medi-Cal: reimbursement for abortion** **Summary:** Existing law provides that abortion is a covered benefit under Medi-Cal. Existing regulation authorizes reimbursement for specified medications used to terminate a pregnancy through the 70th day from the first day of the recipient's last menstrual period. This bill would require the department, by March 1, 2024, to review and update Medi-Cal coverage policies for medication abortion to align with current evidence-based clinical guidelines. After the initial review, the bill would require the department to update its Medi-Cal coverage policies for medication abortion as needed to align with evidence-based clinical guidelines. The bill would require the department to allow flexibility for providers to exercise their clinical judgment when services are performed in a manner that aligns with one or more evidence-based clinical guidelines.
AB 586 **Calderon** **Status:** Dead	**Medi-Cal: community supports: climate change or environmental remediation devices** **Summary:** Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation. This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define "climate change or environmental remediation devices" as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality,

	or other climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.
AB 608 **Schiavo** **Status:** Active In Senate Read first time, sent to Committee on Rules for assignment, on June 1, 2023.	**Medi-Cal: comprehensive perinatal services** **Summary:** Under existing law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy. This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department to consider input from the State Department of Public Health and certain stakeholders, as specified, in determining the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered. The bill would require the department to cover comprehensive perinatal services that are rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site, as specified. The bill would also require the department to allow a nonlicensed perinatal health worker rendering those services to be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ). For these purposes, the bill would require a CBO or LHJ supervising a nonlicensed perinatal health worker to provide those services under contract with a Comprehensive Perinatal Services Program provider. The bill would condition implementation of the provisions above on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would authorize the department to implement these provisions by all-county letters or similar instructions until regulations are adopted.
AB 614 **Wood** **Status:** Active In Senate Referred to the Committee on Health, on May 31, 2023.	**Medi-Cal** **Summary:** This bill would make a change to an obsolete reference to the former Healthy Families Program, whose health services for children have been transitioned to the Medi-Cal program. The bill would make a change to an obsolete reference to the former Access for Infants and Mothers Program and would revise a related provision to instead refer to the successor Medi-Cal Access Program. The bill would delete, within certain Medi-Cal provisions, obsolete references to a repealed provision relating to nonprofit hospital service plans. Existing law establishes, under Medi-Cal, the County Health Initiative Matching Fund, a program administered by the department, through which an applicant county, county agency, local initiative, or county organized health system that provides an intergovernmental transfer, as specified, is authorized to submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to certain children. The program is sometimes known as the County Children's Health Initiative Program (CCHIP).

	This bill would revise certain provisions to rename that program as CCHIP. Existing law requires the Director of Health Care Services to enter into contracts with managed care plans under Medi-Cal and related provisions, including health maintenance organizations, prepaid health plans, or other specified entities, for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs. This bill would delete that list of entities and would instead specify that the director would be required to enter into contracts with managed care plans licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, except as otherwise authorized under the Medi-Cal program. The bill would require the director, prior to issuing a new request for proposal or entering into new contracts, to provide an opportunity for interested stakeholders to provider input to inform the development of contract provisions.
AB 632 **Gipson** **Status:** Active In Senate Referred to the Committee on Health, on May 10, 2023.	**Health care coverage: prostate cancer screening** **Summary:** Existing law requires an individual and group health care service plan contract or health insurance policy to provide coverage for the screening and diagnosis of prostate cancer when medically necessary and consistent with good professional practice. Under existing law, the application of a deductible or copayment for those services is not prohibited. This bill would prohibit a health care service plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, from applying a deductible, copayment, or coinsurance to coverage for prostate cancer screening services for an enrollee or insured who is 55 years of age or older or who is 40 years of age or older and is high risk, as determined by the attending or treating health care provider. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 666 **Arambula** **Status:** Two-Year Bill	**Health systems: community benefits plans** **Summary:** Existing law establishes the Department of Health Care Access and Information to oversee various aspects of the health care market, including oversight of hospital facilities and community benefit plans. benefits plans. Existing law requires a private, not-for-profit hospital to adopt and update a community benefits plan that describes the activities the hospital has undertaken to address identified community needs within its mission and financial capacity, including health care services rendered to vulnerable populations. Existing law defines the term "community" as the service areas or patient populations for which the hospital provides health care services, defines "vulnerable populations" for these purposes to include a population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs, and defines "community benefit" to mean the hospital's activities that are intended to address community needs, such as support to local health departments, among other things. Existing law requires a hospital to conduct a community needs assessment to evaluate the health needs of the community and to update that assessment at least once every 3 years. Existing law requires a hospital to annually submit a community benefits plan to the department not later than 150 days after the hospital's fiscal year ends. Existing law authorizes the department to impose a fine not to exceed $5,000 against a hospital that fails to adopt, update, or

	submit a community benefits plan, and requires the department to annually report on its internet website the amount of community benefit spending and list those that failed to report community benefit spending, among other things. This bill would require the department to define the term "community" by regulation within certain parameters, would redefine the term "community benefit" to mean services rendered to those eligible for, but not enrolled in the above-described programs, the unreimbursed costs as reported in specified tax filings, and the support to local health departments as documented by those local health departments, among other things, and would redefine the term "vulnerable populations" to include those eligible for, but not enrolled in the above-described programs, those below median income experiencing economic disparities, and certain socially disadvantaged groups, such as those who are incarcerated. The bill would require that a community needs assessment include the needs of the vulnerable populations and include a description of which vulnerable populations are low or moderate income, coordination with a local health department, and require that it be updated at least once every 2 years. The bill would require that a community benefits plan demonstrate alignment with the State Health Improvement Plan and the Community Health Improvement Plan, include the proportion and amount of community benefit spending on vulnerable populations, and include measurable objectives that outline equity benchmarks. The bill would additionally require a hospital to annually submit a copy of a specified Internal Revenue Service form to the department. The bill would increase the maximum fine for failure to adopt, update, or submit, a community benefits plan to $25,000 and would authorize the department to impose a maximum fine of $50,000 for a hospital's failure to demonstrate implementation of a community benefits plan. The bill would require the department to include in its annual report the amount of community benefits spending attributable to public health needs and a list of hospitals that fail to comply with specified requirements.
AB 719 **Horvath** **Status:** Active In Senate Read first time, referred to the Committee on Rules for assignment, on May 31, 2023.	**Medi-Cal benefits** **Summary:** Existing law establishes a schedule of benefits under the Medi-Cal program, including nonmedical transportation for a beneficiary to obtain covered Medi-Cal services. Existing law requires nonmedical transportation to be provided by the beneficiary's managed care plan or by the department for a Medi-Cal fee-for-service beneficiary. This bill would require the department to require managed care plans to contract with public transit operators for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by a public transit operator. The bill would require the rates reimbursed by the managed care plan to the public transit operator to be based on the department's fee-for-service rates for nonmedical and nonemergency medical transportation service.
AB 815 **Wood** **Status:** Active In Senate	**Health care coverage: provider credentials** **Summary:** Existing law establishes the California Health and Human Services Agency, which includes departments charged with the administration of health, social, and other human services. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and the regulation of health insurers by the Department of Insurance. Existing law

Read first time, referred to the Committee on Rules for assignment, on May 31, 2023.	sets forth requirements for provider credentialing by a health care service plan or health insurer. This bill would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons in lieu of a health care service plan's or health insurer's credentialing process. The bill would require the board to convene by July 1, 2024, develop criteria for the certification of public and private credentialing entities by January 1, 2025, and develop an application process for certification by July 1, 2025. This bill would require a health care service plan or health insurer, or its delegated entity, to accept a valid credential from a board-certified entity without imposing additional criteria requirements and to pay a fee to a board-certified entity based on the number of contracted providers credentialed through the board-certified entity.
AB 817 **Pacheco** **Status:** Two-Year Bill	**Open meetings: teleconferencing: subsidiary body** **Summary:** Existing law, the Ralph M. Brown Act, requires, with specified exceptions, each legislative body of a local agency to provide notice of the time and place for its regular meetings and an agenda containing a brief general description of each item of business to be transacted. The act also requires that all meetings of a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. This bill would authorize a subsidiary body, as defined, to use alternative teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. In order to use teleconferencing pursuant to this act, the bill would require the legislative body that established the subsidiary

	body by charter, ordinance, resolution, or other formal action to make specified findings by majority vote, before the subsidiary body uses teleconferencing for the first time and every 12 months thereafter.
AB 847 **Luz Rivas** **Status:** Active In Senate Read first time, referred to the Committee on Rules for assignment, on May 31, 2023.	**Medi-Cal: pediatric palliative care services** **Summary:** Existing law requires the department to develop a pediatric palliative care benefit as a pilot program to Medi-Cal beneficiaries under 21 years of age, to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available. Existing law requires that program to include, among other things, hospice services to individuals whose conditions may result in death, regardless of the estimated length of the individual's remaining period of life. Pursuant to the above-described provisions, the department established the Pediatric Palliative Care (PPC) Waiver in 2009, upon receiving federal approval in December 2008. After the waiver ended on December 31, 2018, the department implemented a plan in 2019 to transition some pediatric palliative care services to the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit, which is available to Medi-Cal beneficiaries under 21 years of age, as specified. This bill would extend eligibility for pediatric palliative care services for those individuals who have been determined eligible for those services prior to 21 years of age, until 26 years of age and would extend eligibility for hospice services after 21 years of age. To the extent that these provisions would alter the eligibility of individuals for these services, the bill would create a state-mandated local program. The bill would implement these provisions only to the extent that necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized.
AB 931 **Irwin** **Status:** Active In Senate Referred to the Committee on Health, on May 10, 2023.	**Prior authorization: physical therapy** **Summary:** This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 948 **Berman** **Status:** Active In Senate	**Prescription drugs** **Summary:** Existing law, until January 1, 2024, prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days, except as specified. Existing law, until January 1, 2024, requires a nongrandfathered individual or small group plan contract or policy to use specified definitions for each tier of a drug formulary.

Referred to the Committee on Health, on May 10, 2023.	This bill would delete the January 1, 2024, repeal date of those provisions, thus making them operative indefinitely. Because extension of the bill's requirements relative to health care service plans would extend the existence of a crime, the bill would impose a state-mandated local program.
AB 1036 **Bryan** **Status:** Two-Year Bill.	**Health care coverage: emergency medical transport** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan contract or large group health insurance policy to provide an enrollee or insured with basic health care services, which include emergency health care services. Existing law prohibits a health care service plan that provides basic health care services from requiring prior authorization or refusing to pay for an ambulance or ambulance transport services if the request was made for an emergency medical condition and the services were required or if an enrollee reasonably believed the medical condition was an emergency that required ambulance transport services. Existing law requires a policy of disability insurance issued, amended, delivered, or renewed in this state on or after January 1, 1999, that provides hospital, medical, or surgical coverage with coverage for emergency health care services to include coverage for emergency medical transportation services without regard to whether or not the emergency provider contracts with the insurer or to prior authorization. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program, including various emergency medical services. This bill would require a physician, upon an individual's arrival to an emergency department of a hospital, to certify in the treatment record whether an emergency medical condition existed, or was reasonably believed to have existed, and required emergency medical transportation services, as specified. This bill would, if a physician has certified that emergency medical transportation services according to these provisions, require a health care service plan, disability insurance policy, and Medi-Cal managed care plan, to provide coverage for emergency medical transport, consistent with an individual's plan or policy. The bill would specify that the indication by a physician pursuant to these provisions is limited to an assessment of the medical necessity of the emergency medical transport services, and does not apply or otherwise impact provisions regarding coverage for care provided following completion of the emergency medical transport. The bill would specify for Medi-Cal benefits, these provisions do not apply to various specified provisions relating to nonemergency transport services or any other law or regulation related to reimbursement or authorization requirements for services provided for emergency services and care.
AB 1085 **Maienschein**	**Medi-Cal: housing support services** **Summary:** Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to

Status: Active In Senate Read first time, referred to the Committee on Rules for assignment, on May 31, 2023.	elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, housing deposits, and housing tenancy and sustaining services. Existing law, subject to an appropriation, requires the department to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. Existing law requires that the analysis take into consideration specified information, including the number of providers in relation to each region's or county's number of people experiencing homelessness. Existing law requires the department to report the outcomes of the analysis to the Legislature by January 1, 2024. This bill would require the department to seek any necessary federal approvals for a Medi-Cal benefit to cover housing support services within 6 months of the completion of the above-described analysis. Under the bill, subject to receipt of those federal approvals, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness, as specified. Under the bill, the services would include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services, as defined. If the evaluation finds that the state has insufficient network capacity to meet state and federal guidelines to create a new housing support services benefit, the bill would require the department to provide recommendations for building capacity and the timeline for creating sufficient capacity consistent with the analysis findings.
AB 1122 **Bains** **Status:** Active In Senate Read first time, referred to the Committee on Rules for assignment, on May 26, 2023.	**Medi-Cal provider applications** **Summary:** Existing law generally requires an applicant that currently is not enrolled in the Medi-Cal program, a provider applying for continued enrollment, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location, as specified. Existing law requires an applicant or provider, for new or continued enrollment in the Medi-Cal program, to disclose all information as required in federal Medicaid regulations and any other information required by the department, as specified. This bill would require the Director of Health Care Services to develop a process to allow an applicant or provider to submit an alternative type of primary, authoritative source documentation to meet the requirement of submitting the above-described information. The bill would require the department to document each case of an applicant or provider submitting an alternative type of primary, authoritative source documentation, as specified. The bill would condition implementation of these provisions on lack of conflict with federal law or regulation, federal financial participation not being jeopardized, and receipt of any necessary federal approvals.

	Existing law authorizes the department to make unannounced visits to an applicant or provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. Existing law requires, at the time of the visit, the applicant or provider to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as specified. This bill would authorize the applicant or provider to submit its application for enrollment up to 30 days before having an established place of business and have its application considered by the department, to the extent not in conflict with federal law.
AB 1202 **Lackey** **Status:** Active In Senate Read first time, referred to the Committee on Rules for assignment, on June 1, 2023.	**Medi-Cal: time or distance standards: children's health care services** **Summary:** Existing law establishes, until January 1, 2026, certain time or distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Existing law sets forth various limits on the number of miles or minutes from the enrollee's place of residence, depending on the type of service or specialty and, in some cases, on the county. Existing law authorizes a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with those standards. Existing law authorizes the department, upon request of a Medi-Cal managed care plan, to authorize alternative access standards for those standards under certain conditions, with the request being approved or denied on ZIP Code and provider type basis, as specified. This bill would, no later than January 1, 2025, require each Medi-Cal managed care plan to conduct, and report to the department the results of, an analysis to identify the number and, as appropriate, the geographic distribution of Medi-Cal providers needed to ensure the Medi-Cal managed care plan's compliance with the above-described time or distance and appointment time standards for pediatric primary care, across all service areas of the plan. The bill would, no later than January 1, 2026, require the department to prepare and submit a report to the Legislature that includes certain information, including a summary of the results reported by Medi-Cal managed care plans, specific steps for Medi-Cal managed care plan accountability, evidence of progress and compliance, and level of accuracy of provider directories, as specified. The bill would, no later than July 1, 2024, require the department to submit a report to the Legislature, and to make it publicly available, with certain information for the 2019, 2020, 2021, and 2022 calendar years, including (1) the number of children 0 to 5 years of age, inclusive, and the number of children 6 to 18 years of age, inclusive, who are Medi-Cal beneficiaries receiving any of specified early childhood preventive or developmental services, and (2) the number of pregnant persons, and the number of postpartum persons, who are Medi-Cal beneficiaries receiving any of specified services. The bill would require that the report also include, for those

	populations, information about any disparities across racial or ethnic groups, primary languages spoken at home, service areas or counties, or age groups. The bill would repeal the analysis and reporting provisions on January 1, 2030.
AB 1230 **Valencia** **Status:** Two-Year Bill	**Medi-Cal and Medicare: dual eligible beneficiaries: special needs plans** **Summary:** Existing law sets forth various provisions, including within the Coordinated Care Initiative (CCI) and the California Advancing and Innovating Medi-Cal (CalAIM) initiative, relating to beneficiaries who are dually eligible for the Medicare Program and the Medi-Cal program, for purposes of promoting more integrated care through those beneficiaries' aligned enrollment in a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP), as defined. This bill would require the department, commencing no later than January 1, 2025, to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), as defined, to provide care to dual eligible beneficiaries. The bill would require that a HIDE-SNP or FIDE-SNP contract authorize a beneficiary to select from a number of available options and to maintain their established or selected health care providers. The bill would also require a contracting plan to perform all applicable required care coordination and data-sharing functions, and to provide documentation demonstrating the care integration that dual eligible beneficiaries receive through a HIDE-SNP or FIDE-SNP contract.
AB 1241 **Weber** **Status:** Active In Senate From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Committee on Health, on May 24, 2023.	**Telehealth** **Summary:** Under existing law, in-person, face-to-face contact is not required when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Existing law requires a provider furnishing services through video synchronous interaction or audio-only synchronous interaction, by a date set by the department, no sooner than January 1, 2024, to also either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care, as specified. This bill would instead require, under the above-described circumstance, a provider to maintain and follow protocols to either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care. The bill would specify that the referral and facilitation arrangement would not require a provider to schedule an appointment with a different provider on behalf of a patient.
AB 1316 **Irwin and Ward** **Status:** Two-Year Bill	**Emergency services: psychiatric emergency medical conditions** **Summary:** Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined. Pursuant to a schedule of covered benefits, existing law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with

	respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified. Existing law defines "psychiatric emergency medical condition," for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Existing law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition. This bill would revise the definition of "psychiatric emergency medical condition" to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program. The bill would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, as defined, including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the beneficiary. The bill would require coverage, including by a Medi-Cal managed care plan, for emergency services necessary to relieve or eliminate a psychiatric emergency medical condition, regardless of duration, or whether the beneficiary is voluntary, or involuntarily detained for evaluation and treatment, including emergency room professional services.
AB 1338 **Petrie-Norris** **Status:** Dead	**Medi-Cal: community supports** **Summary:** Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services. This bill would add fitness, physical activity, or recreational sports programs, activities, or memberships to the above-described list of community supports.
AB 1437 **Irwin and Quirk-Silva** **Status:**	**Medi-Cal: serious mental illness** **Summary:** Existing law sets forth a schedule of benefits under the Medi-Cal program, including specialty and nonspecialty mental health services through different delivery systems, in certain cases subject to utilization controls, such as prior authorization. Under existing law, prior authorization is approval of a specified

Active In Senate Read first time, sent to Committee on Rules for assignment, on May 26, 2023.	service in advance of the rendering of that service based upon a determination of medical necessity. Existing law sets forth various provisions relating to processing, or appealing the decision of, treatment authorization requests, and provisions relating to certain services requiring or not requiring a treatment authorization request. After a determination of cost benefit, existing law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs, as specified. Under this bill, a prescription refill for a drug for serious mental illness would automatically be approved for a period of 365 days after the initial prescription is dispensed. The bill would condition the above-described provisions on the prescription being for a person 18 years of age or over, and on the person not being within the transition jurisdiction of the juvenile court, as specified.
AB 1451 **Jackson** **Status:** Active In Senate Read first time, sent to Committee on Rules for assignment, on June 1, 2023.	**Urgent and emergency mental health and substance use disorder treatment** **Summary:** Existing law requires a health care service plan or health insurer that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Existing law also includes requirements for timely access to care, including mental health services, including a requirement that a health care service plan or health insurer provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's or insured's condition consistent with good professional practice. This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of urgent and emergency mental health and substance use disorders. The bill would require the treatment to be provided without preauthorization, and to be reimbursed in a timely manner, pursuant to specified provisions. The bill's provisions would only be implemented upon appropriation by the Legislature. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.
AB 1470 **Quirk-Silva** **Status:** Active In Senate Read first time, sent to Committee on Rules for	**Medi-Cal: behavioral health services: documentation standards** **Summary:** The bill, as part of CalAIM, and with respect to behavioral health services provided under the Medi-Cal program, would require the department to standardize data elements relating to documentation requirements, including, but not limited to, medically necessary criteria, and would require the department to develop standard forms containing information necessary to properly adjudicate claims pursuant to CalAIM Terms and Conditions. The bill would require the department to consult with representatives of specified associations and programs for purposes of implementing these provisions.

assignment, on June 1, 2023.	The bill would require the department to conduct, on or before July 1, 2025, regional trainings for personnel and provider networks of applicable entities, including county mental health plans, Medi-Cal managed care plans, and entities within the fee-for-service delivery system, on proper completion of the standard forms. The bill would require each applicable entity to distribute the training material and standard forms to its provider networks, and to commence, no later than July 1, 2025, using the standard forms. The bill would require providers of applicable entities to use those forms, as specified. The bill would authorize the department to restrict the imposition of additional documentation requirements beyond those included on standard forms, as specified. The bill would require the department to conduct an analysis on the status of utilization of the standard forms by applicable entities, and on the status of the trainings and training material, in order to determine the effectiveness of implementation of the above-described provisions. The bill would require the department to prepare annual reports containing findings from the analysis, and, commencing on July 1, 2026, and each year thereafter, to submit the most recent report to the Legislature and to post it on the department's internet website.
AB 1481 **Boerner and Bauer-Kahan** **Status:** Active In Senate Read first time, sent to Committee on Rules for assignment, on May 26, 2023.	**Medi-Cal: presumptive eligibility** **Summary:** Existing federal law, as a condition of receiving federal Medicaid funds, requires states to provide health care services to specified individuals. Existing federal law authorizes states to provide presumptive eligibility to pregnant women or children, and existing state law requires the department to provide presumptive eligibility to pregnant women and children, as specified. This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). The bill would also require the department to ensure that a pregnant person receiving coverage under PE4PP who applies for full-scope Medi-Cal benefits within 60 days receives coverage under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified. The bill would make conforming changes to related provisions. Because counties are required to make eligibility determinations, and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.
AB 1549 **Carrillo** **Status:** Dead	**Medi-Cal: federally qualified health centers and rural health clinics** **Summary:** Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. This bill would, among other things, require that per-visit rate to account for the costs of the FQHC or RHC that are reasonable and related to the provision of covered services, including the specific staffing and care delivery models used by the FQHC and RHC to deliver those services. The bill would also require the rate for any newly qualified health center to include the cost of care coordination services provided by the health center, as specified.
AB 1608 **Patterson**	**Medi-Cal: managed care plans** **Summary:** The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services

Status: Two-Year Bill	and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Pursuant to that law, the department contracts with regional centers to provide services and supports to persons with developmental disabilities. The act requires regional centers to pursue all possible sources of funding for consumers receiving regional center services, including, among others, Medi-Cal. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility. Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment. This bill would additionally exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage.
AB 1644 **Bonta** **Status:** Dead	**Medi-Cal: medically supportive food and nutrition services** **Summary:** Existing law requires the department to establish the Medically Tailored Meals Pilot Program and the Short-Term Medically Tailored Meals Intervention Services Program, to operate in specified counties and during limited periods for the purpose of providing medically tailored meal intervention services to eligible Medi-Cal beneficiaries with certain health conditions, including congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease. Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals. This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the department. The bill would require medically supportive food and nutrition interventions to be covered when determined to be medically necessary by a health care provider or health care plan, as specified. In order to qualify for coverage under the Medi-Cal program, the bill would require a patient to be offered at least 3 of 6 specified medically supportive food and nutrition interventions and for

	the interventions to be provided for a minimum duration of 12 weeks, as specified. The bill would only provide coverage for nutrition support interventions when paired with the provision of food through one of the 3 offered interventions. The bill would require a health care provider to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention and include culturally appropriate foods whenever possible. The bill would establish a medically supportive food and nutrition benefit advisory workgroup to advise the department in developing final guidance related to eligible populations, the duration and dosage of medically supportive food and nutrition interventions, the ratesetting process, determination of permitted providers, and continuing education for health care providers, as specified. The bill would require the workgroup to include certain stakeholders knowledgeable in medically supportive food and nutrition interventions and stakeholders from Medi-Cal consumer advocacy organizations. The bill would require the workgroup to meet at least quarterly and would require the department to issue final guidance on or before July 1, 2026. The bill would also include findings and declarations of the Legislature relating to the need for medically supportive food and nutrition intervention coverage under the Medi-Cal program.
AB 1690 **Kalra** **Status:** Two-Year Bill	**Universal health care coverage** **Summary:** This bill would state the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.
AB 1698 **Wood** **Status:** Two-Year Bill	**Medi-Cal** **Summary:** This bill would make specified findings and would express the intent of the Legislature to enact future legislation relating to Medi-Cal.
Senate Bills	
SB 238 **Wiener** **Status:** Active In Assembly Referred to the Committee on Health, on June 1, 2023.	**Health care coverage: independent medical review** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days. This bill would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or

	disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified. The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. The bill would authorize the Insurance Commissioner to promulgate regulations subject to the Administrative Procedure Act to implement and enforce the bill.
SB 299 **Eggman** **Status:** Active In Assembly Referred to the Committee on Health, on June 1, 2023.	**Medi-Cal eligibility: redetermination** **Summary:** Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. In response to a change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility, existing law requires the county to send to the beneficiary a form that is prepopulated with the information that the county has obtained and that states the information needed to renew eligibility. Under existing law, if the purpose for a redetermination is loss of contact with the beneficiary, as evidenced by the return of mail, as specified, a return of the prepopulated form requires the county to immediately send a notice of action terminating Medi-Cal eligibility. This bill would remove loss of contact with a beneficiary, as evidenced by the return of mail, as a circumstance requiring prompt redetermination and would delete the above-described requirement for a county to send a notice of action terminating eligibility if the prepopulated form is returned and the purpose for the redetermination is loss of contact with the beneficiary. To the extent that the bill would modify county duties relating to the redetermination of Medi-Cal eligibility, the bill would impose a state-mandated local program.
SB 324 **Limón** **Status:** Active In Assembly Read first time and held at desk, on May 25, 2023.	**Health care coverage: endometriosis** **Summary:** This bill would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2024, from requiring prior authorization or other utilization review for any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. This bill would add any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines, as a covered benefit under Medi-Cal without prior authorization or other utilization review.

SB 411 **Portantino** **Status:** Active In Assembly Referred to the Committee on Local Government on May 26, 2023.	**Open meetings: teleconferences: neighborhood councils** **Summary:** Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. This bill, until January 1, 2028, would authorize an eligible legislative body to use alternate teleconferencing provisions related to notice, agenda, and public participation, as prescribed, if the city council has adopted an authorizing resolution and $^{2}/_{3}$ of an eligible legislative body votes to use the alternate teleconferencing provisions. The bill would define "eligible legislative body" for this purpose to mean a neighborhood council that is an advisory body with the purpose to promote more citizen participation in government and make government more responsive to local needs that is established pursuant to the charter of a city with a population of more than 3,000,000 people that is subject to the act. The bill would require an eligible legislative body authorized under the bill to provide publicly accessible physical locations for public participation, as prescribed. The bill would also require that at least a quorum of the members of the neighborhood council participate from locations within the boundaries of the city in which the neighborhood council is established.
SB 496 **Limón** **Status:** Active In Assembly	**Biomarker testing** **Summary:** This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2024, to provide coverage for medically necessary biomarker testing, as prescribed, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition to guide treatment decisions if the test is supported by medical and

Referred to the Committee on Health, on June 1, 2023.	scientific evidence, as prescribed. The bill would specify that it does not require a health care service plan or health insurer to cover biomarker testing for screening purposes unless otherwise required by law. The bill would subject restricted use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of a medical condition to state and federal grievance and appeal processes. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. Existing law includes Rapid Whole Genome Sequencing as a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. Subject to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained, this bill, by July 1, 2024, would expand the Medi-Cal schedule of benefits to include medically necessary biomarker testing, as prescribed, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Medi-Cal beneficiary's disease or condition to guide treatment decisions if the test is supported by medical and scientific evidence, as prescribed. The bill would authorize the department to implement this provision by various means without taking regulatory action.
SB 502 **Allen** **Status:** Active In Assembly Read first time and held at desk, on May 25, 2023.	**Medi-Cal: children: mobile optometric office** **Summary:** The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions, with specified coverage for eligible children and pregnant persons funded by the federal Children's Health Insurance Program (CHIP). Existing law authorizes an applicant or provider that meets the requirements to qualify as a mobile optometric office to be enrolled in the Medi-Cal program as either a mobile optometric office or within any other provider category for which the applicant or provider qualifies. Existing law defines "mobile optometric office" as a trailer, van, or other means of transportation in which the practice of optometry is performed and which is not affiliated with an approved optometry school in the state. Under existing law, the ownership and operation of a mobile optometric office is limited to a nonprofit or charitable organization, as specified, with the owner and operator registering with the State Board of Optometry. This bill would require the department to file all necessary state plan amendments to exercise the option made available under CHIP provisions to cover vision services provided to low-income children statewide through a mobile optometric office, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would require implementation of these provisions by January 1, 2025, or the date that any necessary federal approvals have been obtained, whichever date is later.

	The bill would require the department to seek to fund implementation of the above-described provisions with funding other than General Fund moneys, as specified. The bill would require that all of those derived revenues and applicable federal financial participation be deposited in the State Treasury to the credit of the Vision Services CHIP-HSI Special Fund, which the bill would create, with the moneys being continuously appropriated. The bill would require implementation of these provisions through the 2026–27 fiscal year only if no General Fund moneys are used for these provisions. For the 2027–28 fiscal year and each fiscal year thereafter, the bill would authorize implementation of these provisions using General Fund moneys upon appropriation made by the Legislature. Existing law prohibits the owner and operator of a mobile optometric office and the optometrist providing services from accepting payment for services other than those provided to Medi-Cal beneficiaries. This bill would authorize acceptance of payment for those services provided through any of the state's programs under CHIP, in addition to the Medi-Cal program.
SB 525 **Durazo** **Status:** Active In Assembly Read first time and held at desk, on June 1, 2023.	**Minimum wage: health care workers** **Summary:** Existing law generally requires the minimum wage for all industries to not be less than specified amounts to be increased until it is $15 per hour commencing January 1, 2022, for employers employing 26 or more employees and commencing January 1, 2023, for employers employing 25 or fewer employees. Existing law makes a violation of minimum wage requirements a misdemeanor. Commencing June 1, 2024 and until June 1, 2025, this bill would require a health care worker minimum wage of $21 per hour for hours worked in covered health care employment, as defined. Commencing June 1, 2025, the bill would require a health care minimum wage of $25 per hour for hours worked in covered health care employment, as defined, subject to adjustment, as prescribed. The bill would provide that the health care worker minimum wage constitutes the state minimum wage for covered health care employment for all purposes under the Labor Code and the Wage Orders of the Industrial Welfare Commission. The health care worker minimum wage would be enforceable by the Labor Commissioner or by a covered worker through a civil action, through the same means and with the same relief available for violation of any other state minimum wage requirement. By establishing a new minimum wage, the violation of which would be a crime, the bill would impose a state-mandated local program. This bill would require, for covered health care employment where the employee is paid on a salary basis, that the employee earn a monthly salary equivalent to no less than 150% of the health care worker minimum wage for full-time employment in order to qualify as exempt from the payment of minimum wage and overtime. This bill would make legislative findings and declarations as to the necessity of a special statute for health care workers.

SB 535 **Nguyen** **Status:** Two-Year Bill	**Knox-Keene Health Care Service Plan Act of 1975** **Summary:** Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Among other provisions, existing law requires a health care service plan to meet specified requirements, including, but not limited to, furnishing services in a manner providing continuity of care, ready referral of patients to other providers at appropriate times, and making services readily accessible to all enrollees, as specified. This bill would make technical, nonsubstantive changes to those provisions.
SB 537 **Becker** **Status:** Active In Assembly Read first time and held at desk, on May 31, 2023.	**Open meetings: local agencies: teleconferences** **Summary:** Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment. Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. These circumstances include if a member shows "just cause," including for a childcare or caregiving need of a relative that requires the member to participate remotely. This bill would authorize certain legislative bodies to use alternate teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. The bill would also require a legislative body to provide a record of attendance on its internet website within 7 days after a teleconference meeting, as specified. The bill would define "legislative body" for this purpose to mean a board, commission, or advisory body of a multijurisdictional cross county agency, the membership of which board, commission, or advisory body is appointed and which board, commission, or advisory body is otherwise subject to the act. The bill would also define "multijurisdictional" to mean a legislative body

	that includes representatives from more than one county, city, city and county, special district, or a joint powers entity. With respect to the alternative teleconferencing provisions operative until January 1, 2026, the bill would expand the circumstances of "just cause" to apply to the situation in which an immunocompromised child, parent, grandparent, or other specified relative requires the member to participate remotely.
SB 598 **Skinner** **Status:** Active In Assembly Referred to the Committee on Health on June 1, 2023.	**Health care coverage: prior authorization** **Summary:** On or after January 1, 2025, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.
SB 694 **Eggman** **Status:** Active In Assembly Read first time and held at desk, on May 25, 2023.	**Medi-Cal: self-measured blood pressure devices and services** **Summary:** Existing law sets forth a schedule of benefits under the Medi-Cal program, including pharmacy benefits (Medi-Cal Rx) and durable medical equipment. The department announced that, effective June 1, 2022, personal home blood pressure monitoring devices, and blood pressure cuffs for use with those devices, are a covered benefit under Medi-Cal Rx as a pharmacy-billed item. This bill would make self-measured blood pressure (SMBP) devices and SMBP services, as defined, covered benefits under the Medi-Cal program for the treatment of high blood pressure. The bill would state the intent of the Legislature that those covered devices and services be consistent in scope with devices and services that are recognized under specified existing billing codes or their successors. The bill would condition implementation of that coverage on receipt of any necessary federal approvals and the availability of federal financial participation.
SB 770 **Wiener and McGuire** **Status:** Active In Assembly	**Health care: unified health care financing** **Summary:** Prior state law established the Healthy California for All Commission for the purpose of developing a plan towards the goal of achieving a health care delivery system in California that provides coverage and access through a unified health care financing system for all Californians, including, among other options, a single-payer financing system. This bill would direct the Secretary of the California Health and Human Services Agency to pursue waiver discussions with the federal government with the

Read first time and held at desk, on May 31, 2023.	objective of a unified health care financing system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments. The bill would further require the secretary to establish a Waiver Development Workgroup comprised of members appointed by the Governor, Speaker of the Assembly, and President Pro Tempore of the Senate, as specified. The bill would require the workgroup to include stakeholders representing various specified interests, including consumers, patients, health care professionals, labor unions, government agencies, and philanthropic organizations. The bill would require the secretary to provide quarterly reports to the chairs of the Assembly and Senate Health Committees on the status and outcomes of waiver discussions with the federal government and the progress of the workgroup. The bill would also require the secretary to submit a complete set of recommendations regarding the elements to be included in a formal waiver application, as specified, by no later than June 1, 2024. The bill would also include findings and declarations of the Legislature related to the implementation of a unified health care financing system.
SB 819 **Eggman** **Status:** Active In Assembly Referred to the Committee on Health on May 11, 2023.	**Medi-Cal: certification** **Summary:** Existing law requires the State Department of Public Health to license and regulate clinics. Existing law exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Existing law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department) and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under existing law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures. Under existing law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units. This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.

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

DATE: June 28, 2023

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, 2023

For the month ending April 30, 2023, the Alliance reported an Operating Income of $2.8M. The Year-to-Date (YTD) Operating Income is $28.7M, with a Medical Loss Ratio (MLR) of 89.3% and an Administrative Loss Ratio (ALR) of 5.4%. The Net Income is $41.2M after accounting for Non-Operating Income/Expenses.

The budget expected a $52.0M Operating Income for YTD April. The actual result is unfavorable to budget by $23.3M or 44.8%, driven primarily by medical expenses.

	Apr-23 ($ In 000's)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*426,328*	*410,347*	*15,981*	*3.9%*
Revenue	135,756	130,389	5,366	4.1%
Medical Expenses	125,354	110,824	(14,530)	-13.1%
Administrative Expenses	7,555	7,334	(222)	-3.0%
Operating Income	2,847	12,232	(9,385)	-76.7%
Net Income	6,593	10,716	(4,123)	-38.5%
MLR %	*92.3%*	*85.0%*	*-7.3%*	
ALR %	*5.6%*	*5.6%*	*0.1%*	
Operating Income %	*2.1%*	*9.4%*	*-7.3%*	
Net Income %	*4.9%*	*8.2%*	*-3.4%*	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

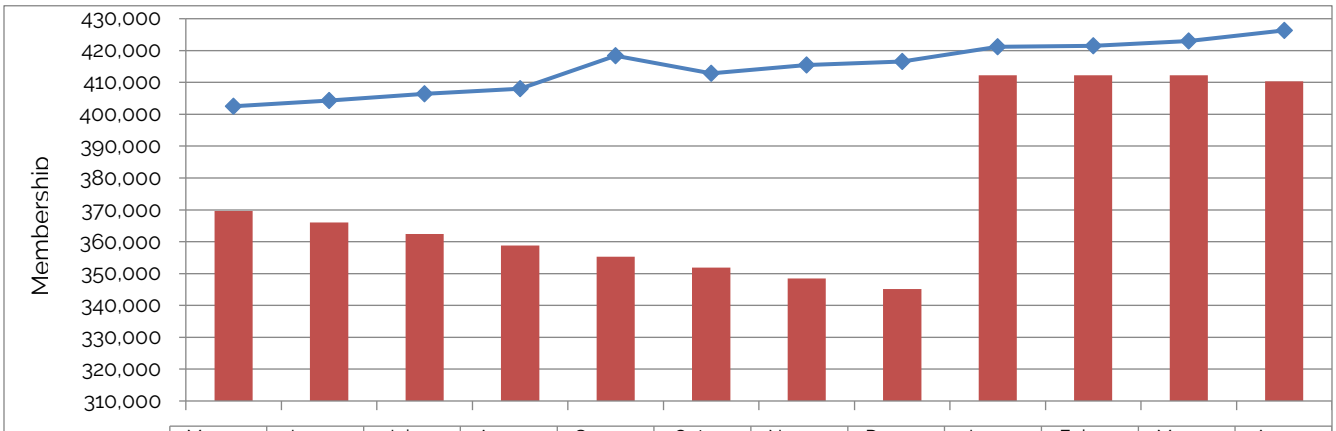
Apr-23 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*1,692,020*	*1,647,040*	*44,980*	*2.7%*
Revenue	543,141	523,598	19,543	3.7%
Medical Expenses	484,828	440,192	(44,636)	-10.1%
Administrative Expenses	29,593	31,412	1,819	5.8%
Operating Income/(Loss)	28,720	51,995	(23,275)	-44.8%
Net Income/(Loss)	41,243	42,427	(1,184)	-2.8%
PMPM				
Revenue	321.00	317.90	3.10	1.0%
Medical Expenses	286.54	267.26	(19.28)	-7.2%
Administrative Expenses	17.49	19.07	1.58	8.3%
Operating Income/(Loss)	16.97	31.57	(14.59)	-46.2%
MLR %	89.3%	*84.1%*	*-5.2%*	
ALR %	*5.4%*	*6.0%*	*0.6%*	
Operating Income %	*5.3%*	*9.9%*	*-4.6%*	
Net Income %	*7.6%*	*8.1%*	*0.5%*	

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

At a PMPM level, YTD revenue is $321.00, which is favorable to budget by $3.10 or 1.0%. Medical cost PMPM is $286.54, which is unfavorable by $19.28 or 7.2%. The resulting operating income PMPM is $16.97, which is unfavorable by $14.59 compared to the budget.

Membership. April 2023 membership is favorable to budget by 3.9%. Please note that the 2023 budget assumed the Public Health Emergency (PHE) would end in January 2023, with membership beginning to decline in April 2023. The Health and Human Services Department announced that the PHE ended on May 11, 2023. The current Department of Healthcare Services (DHCS) states that the redetermination began in April 2023 for the June 2023 renewal month, with the actual enrollment loss expected to begin in July 2023.

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



	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Budget	369,700	366,008	362,379	358,808	355,301	351,849	348,456	345,117	412,231	412,231	412,231	410,347
Actual	402,517	404,261	406,414	407,983	418,380	412,859	415,506	416,529	421,212	421,478	423,002	426,328
Variance	32,817	38,253	44,035	49,175	63,079	61,010	67,050	71,412	8,981	9,247	10,771	15,981
Variance %	8.9%	10.5%	12.2%	13.7%	17.8%	17.3%	19.2%	20.7%	2.2%	2.2%	2.6%	3.9%

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

April 2023 capitation revenue of $135.4M is favorable to budget by $5.3M or 4.1%, mainly attributed to higher enrollment of $5.0M and rate variances of $0.3M. April 2023 YTD capitation revenue of $541.7M is favorable to budget by $19.5M or 3.7%. Of this amount, $13.1M is from boosted enrollment, and $6.4M is due to rate variance.

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

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	111,545	111,513	32	1,577	(1,545)
Monterey	231,509	224,064	7,445	6,719	726
Merced	198,619	186,645	11,974	4,802	7,172
Total	**541,673**	**522,222**	**19,451**	**13,097**	**6,354**

Note: Excludes Apr-23 YTD In-Home Supportive Services (IHSS) premiums revenue of $1.5M.

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

April 2023 Medical Expenses of $125.4M are $14.5M or 13.1% unfavorable to budget. April 2023 YTD Medical Expenses of $484.8M are above budget by $44.6M or 10.1%. Of this amount, $32.6M is due to rate, and $12.0M is due to higher enrollment. Other Medical expense is unfavorable to budget by $11.8M or 18.6% due to higher utilization in behavioral health services, Allied Health, lab, and medical transportation. A general increase in respiratory-related expenses and overall claim volumes for typical services contributed to the Physician Services expenses.

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	188,441	164,624	(23,817)	(4,496)	(19,321)
Inpatient Services (LTC)	56,121	58,960	2,839	(1,610)	4,449
Physician Services	104,791	92,031	(12,760)	(2,513)	(10,247)
Outpatient Facility	60,015	60,955	940	(1,665)	2,605
Other Medical	75,459	63,621	(11,838)	(1,737)	(10,100)
Total	**484,828**	**440,192**	**(44,636)**	**(12,022)**	**(32,615)**

Note: Other Medical Actual includes Allied Health, Non-Claims HC Cost, Transportation, ECM, ILOS, BHT, Lab, and Pharmacy.

At a PMPM level, YTD Medical Expenses are $286.54, unfavorable by $19.28 or 7.2% compared to the budget. Please note that the rate (PMPM) is the unit cost for a service multiplied by the utilization.

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

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	111.37	99.95	(11.42)	-11.4%
Inpatient Services (LTC)	33.17	35.80	2.63	7.3%
Physician Services	61.93	55.88	(6.06)	-10.8%
Outpatient Facility	35.47	37.01	1.54	4.2%
Other Medical	44.60	38.63	(5.97)	-15.5%
Total	**286.54**	**267.26**	**(19.28)**	**-7.2%**

Administrative Expenses. April YTD Administrative Expenses are favorable to budget by $1.8M or 5.8% with a 5.4% ALR. Salaries are slightly unfavorable by $0.1M due to the staff bonus accrual for the period of January through April 2023. Non-Salary Administrative Expenses are favorable by $1.9M or 19.4% due to the timing of expenses versus the budget for projects in the new year.

Non-Operating Revenue/Expenses. April YTD Total Non-Operating Revenue is favorable to budget by $19.4M, attributed to $12.9M in unrealized gain on investments and $6.5M in interest income. Non-Operating Expenses are favorable by $2.7M due to the timing of grant

expenses, resulting in a favorable Net Non-Operating income of $22.1M compared to the budget.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $41.2M, with an MLR of 89.3% and an ALR of 5.4%.

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

Assets	
Cash	$183,507
Restricted Cash	300
Short Term Investments	686,325
Receivables	142,446
Prepaid Expenses	5,252
Other Current Assets	16,403
Total Current Assets	**$1,034,233**
Building, Land, Furniture & Equipment	
Capital Assets	$81,303
Accumulated Depreciation	(45,591)
CIP	888
Lease Receivable	2,539
Total Non-Current Assets	**39,138**
Total Assets	**$1,073,372**
Liabilities	
Accounts Payable	$25,709
IBNR/Claims Payable	311,497
Accrued Expenses	-
Estimated Risk Share Payable	10,000
Other Current Liabilities	7,560
Due to State	8,198
Total Current Liabilities	**$362,964**
Deferred Inflow of Resources	$2,437
Total Long-Term Liabilities	**$2,437**
Fund Balance	
Fund Balance - Prior	$666,727
Retained Earnings - CY	41,243
Total Fund Balance	**707,970**
Total Liabilities & Fund Balance	**$1,073,372**
Additional Information	
Total Fund Balance	**$707,970**
Board Designated Reserves Target	407,275
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	171,340
Total Reserves	**635,315**
Total Operating Reserve	**$72,656**

* MCGP includes Additional Contribution of $43.6M

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

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*426,328*	*410,347*	*15,981*	*3.9%*	*1,692,020*	*1,647,040*	*44,980*	*2.7%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$135,389	$130,045	$5,344	4.1%	$541,673	$522,222	$19,451	3.7%
Premiums Commercial	367	344	23	6.6%	1,468	1,376	92	6.7%
Total Operating Revenue	**$135,756**	**$130,389**	**$5,366**	**4.1%**	**$543,141**	**$523,598**	**$19,543**	**3.7%**
Medical Expenses								
Inpatient Services (Hospital)	$46,837	$41,446	($5,390)	-13.0%	$188,441	$164,624	($23,817)	-14.5%
Inpatient Services (LTC)	14,133	14,844	711	4.8%	56,121	58,960	2,839	4.8%
Physician Services	28,338	23,170	(5,168)	-22.3%	104,791	92,031	(12,760)	-13.9%
Outpatient Facility	14,111	15,346	1,235	8.1%	60,015	60,955	940	1.5%
Other Medical*	21,935	16,018	(5,918)	-36.9%	75,459	63,621	(11,838)	-18.6%
Total Medical Expenses	**$125,354**	**$110,824**	**($14,530)**	**-13.1%**	**$484,828**	**$440,192**	**($44,636)**	**-10.1%**
Gross Margin	**$10,402**	**$19,565**	**($9,163)**	**-46.8%**	**$58,313**	**$83,407**	**($25,094)**	**-30.1%**
Administrative Expenses								
Salaries	$5,520	$5,048	($472)	-9.4%	$21,634	$21,533	($101)	-0.5%
Professional Fees	143	250	107	42.7%	713	893	181	20.2%
Purchased Services	806	800	(6)	-0.8%	3,229	3,793	564	14.9%
Supplies & Other	725	849	123	14.5%	2,517	3,670	1,153	31.4%
Occupancy	113	113	(0)	-0.4%	452	415	(37)	-8.8%
Depreciation/Amortization	246	273	27	9.9%	1,048	1,107	59	5.3%
Total Administrative Expenses	**$7,555**	**$7,334**	**($222)**	**-3.0%**	**$29,593**	**$31,412**	**$1,819**	**5.8%**
Operating Income	**$2,847**	**$12,232**	**($9,385)**	**-76.7%**	**$28,720**	**$51,995**	**($23,275)**	**-44.8%**
Non-Op Income/(Expense)								
Interest	$3,205	$1,025	$2,180	100.0%	$10,600	$4,099	$6,501	100.0%
Gain/(Loss) on Investments	799	(1,195)	1,995	100.0%	4,613	(8,289)	12,902	100.0%
Other Revenues	141	155	(13)	-8.7%	594	620	(26)	-4.2%
Grants	(399)	(1,500)	1,101	73.4%	(3,284)	(5,998)	2,714	45.3%
Total Non-Op Income/(Expense)	**$3,747**	**($1,515)**	**$5,262**	**100.0%**	**$12,523**	**($9,568)**	**$22,091**	**100.0%**
Net Income/(Loss)	**$6,593**	**$10,716**	**($4,123)**	**-38.5%**	**$41,243**	**$42,427**	**($1,184)**	**-2.8%**
MLR	*92.3%*	*85.0%*			*89.3%*	*84.1%*		
ALR	*5.6%*	*5.6%*			*5.4%*	*6.0%*		
Operating Income	*2.1%*	*9.4%*			*5.3%*	*9.9%*		
Net Income %	*4.9%*	*8.2%*			*7.6%*	*8.1%*		

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

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*426,328*	*410,347*	*15,981*	*3.9%*	*1,692,020*	*1,647,040*	*44,980*	*2.7%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$317.57	$316.92	$0.65	0.2%	$320.13	$317.07	$3.07	1.0%
Premiums Commercial	0.86	0.84	0.02	2.6%	0.87	0.84	0.03	3.8%
Total Operating Revenue	**$318.43**	**$317.75**	**$0.68**	**0.2%**	**$321.00**	**$317.90**	**$3.10**	**1.0%**
Medical Expenses								
Inpatient Services (Hospital)	$109.86	$101.00	($8.86)	-8.8%	$111.37	$99.95	($11.42)	-11.4%
Inpatient Services (LTC)	33.15	36.17	3.02	8.4%	33.17	35.80	2.63	7.3%
Physician Services	66.47	56.46	(10.01)	-17.7%	61.93	55.88	(6.06)	-10.8%
Outpatient Facility	33.10	37.40	4.30	11.5%	35.47	37.01	1.54	4.2%
Other Medical*	51.45	39.03	(12.42)	-31.8%	44.60	38.63	(5.97)	-15.5%
Total Medical Expenses	**$294.03**	**$270.07**	**($23.96)**	**-8.9%**	**$286.54**	**$267.26**	**($19.28)**	**-7.2%**
Gross Margin	**$24.40**	**$47.68**	**($23.28)**	**-48.8%**	**$34.46**	**$50.64**	**($16.18)**	**-31.9%**
Administrative Expenses								
Salaries	$12.95	$12.30	($0.65)	-5.3%	$12.79	$13.07	$0.29	2.2%
Professional Fees	0.34	0.61	0.27	44.9%	0.42	0.54	0.12	22.3%
Purchased Services	1.89	1.95	0.06	3.0%	1.91	2.30	0.39	17.1%
Supplies & Other	1.70	2.07	0.37	17.7%	1.49	2.23	0.74	33.2%
Occupancy	0.27	0.28	0.01	3.4%	0.27	0.25	(0.01)	-5.9%
Depreciation/Amortization	0.58	0.67	0.09	13.3%	0.62	0.67	0.05	7.8%
Total Administrative Expenses	**$17.72**	**$17.87**	**$0.15**	**0.8%**	**$17.49**	**$19.07**	**$1.58**	**8.3%**
Operating Income	**$6.68**	**$29.81**	**($23.13)**	**-77.6%**	**$16.97**	**$31.57**	**($14.59)**	**-46.2%**

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

	MTD	YTD
Net Income	$6,593	$41,243
Items not requiring the use of cash: Depreciation	246	1,009
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	8,607	28,334
Prepaid Expenses	(408)	(1,202)
Current Assets	(380)	(2,988)
Net Changes to Assets	**$7,819**	**$24,143**
Changes to Payables:		
Accounts Payable	1,415	(44,965)
Accrued Expenses	-	-
Other Current Liabilities	550	(149)
Incurred But Not Reported Claims/Claims Payable	(215,255)	29,129
Estimated Risk Share Payable	(7,500)	-
Due to State	602	3,152
Net Changes to Payables	**($220,188)**	**($12,833)**
Net Cash Provided by (Used in) Operating Activities	**($205,530)**	**$53,563**
Change in Investments	(2,885)	(10,330)
Other Equipment Acquisitions	(154)	1,935
Net Cash Provided by (Used in) Investing Activities	**($3,039)**	**($8,395)**
Lease Interest Income	-	-
Net Cash Provided by (Used in) Financing Activities	**$0**	**$0**
Net Increase (Decrease) in Cash & Cash Equivalents	**($208,569)**	**$45,168**
Cash & Cash Equivalents at Beginning of Period	**$392,076**	**$138,338**
Cash & Cash Equivalents at April 30, 2023	**$183,507**	**$183,507**

DATE: June 28, 2023

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Whole Child Model Clinical Advisory Committee: Member Appointment

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Recommendation. Staff recommend the Board approve the appointment of the individual listed below to the Whole Child Model Clinical Advisory Committee (WCMCAC).

Background. The Board established the WCMCAC as required by Statute.

Discussion. The following individual has indicated interest in participating on the WCMCAC and is recommended.

Name	Affiliation	County
Allyson Garcia, MD	Provider Representative	Monterey

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, May 24, 2023

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

Commissioners Present:

Ms. Leslie Abasta-Cummings	Provider Representative
Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Dr. Maximiliano Cuevas	Provider Representative
Ms. Julie Edgcomb	Public Representative
Ms. Janna Espinoza	Public Representative
Supervisor Zach Friend	County Board of Supervisors
Dr. Charles Harris	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Mr. Michael Molesky	Public Representative
Supervisor Josh Pedrozo	County Board of Supervisors
Ms. Leslie Peterson	Hospital Representative
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Dr. Joerg Schuller	Hospital Representative

Commissioners Absent:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Shebreh Kalantari-Johnson	Public Representative
Ms. Mónica Morales	County Health Services Agency Director
Ms. Rebecca Nanyonjo	Director of Public Health
Mr. Rob Smith	Public Representative

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Dr. Dale Bishop	Chief Medical Officer
Ms. Lisa Ba	Chief Financial Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
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 3:01 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

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

No members of the public addressed the Commission.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

No comments or announcements from Commissioners at this time.

4. Comments and announcements by Chief Executive Officer.

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

Mr. Schrader informed the Board that Item 10B on consent was staff's recommendation to revise the 2023 Board meeting schedule to include a regular meeting from 3:00 – 5:00 p.m. on September 27, 2023 via videoconference from the three Alliance offices. This will be the last meeting for the existing three-County Commission. The convening of the new five-County Commission is scheduled for October 25, 2023 from 10:30 a.m. to 2:00 p.m. at a single location to be determined in mid-Santa Cruz County. This schedule will allow for the Department of Health Care Services (DHCS) readiness review in September for the model change to occur prior to initiating the new Board.

Staff continue efforts for the expansion into San Benito and Mariposa Counties. This includes coordination with Health Directors in each of the Counties. Mr. Schrader plans to present to the San Benito County Board of Supervisors in June 2023 and the Mariposa County Board of Supervisors in July 2023 an informational item to reorient them on the upcoming expansion and the appointments to the Board.

[Commissioner Conner arrived at this time: 3:09 p.m.]

Coordination to establish the new five-county Commission continues. The ordinance stipulates that the number of Commissioners per county be proportionate to the number of Medi-Cal beneficiaries for that County. This means at this time there will be five seats for Santa Cruz, Merced and Monterey Counties, two seats for San Benito County and one seat for Mariposa County for a total of 18 commissioners. Staff will follow up with the Board, estimates of eligibility by county, with respect to the upcoming January 1, 2024 expansion of Medi-Cal eligibility to all income eligible adults ages 26-49 regardless of immigration status.

[Commissioner Abasta-Cummings arrived at this time: 3:11 p.m.]

Staff met with Hazel Hawkins Memorial Hospital on May 24, 2023 where they confirmed that the San Benito County Health Care District unanimously voted to file for Chapter 9 bankruptcy allowing the hospital to remain open longer and to restructure contracts. Related to the expansion, staff are meeting with DHCS and Mercer actuaries regarding the expansion into San Benito County to help address access and quality issues related to primary and specialty care for Medi-Cal beneficiaries in San Benito County.

Governor Newsom's May Revise of the proposed State budget for FY 2024 which begins on July 1, 2023 and includes spending delays and non-health related cuts to address the $31B deficit. The May Revise maintains funding levels for expansion of full-scope Medi-Cal coverage to all income eligible adults aged 26 through 49 regardless of immigration status beginning January 1, 2024. The May revise proposes to substantially increase the three-year Managed Care Organization (MCO) tax from three years and $6.5B to 3.75 years and $19.4B. Of the $19.4B in MCO tax revenue, the Administration proposes that $11.1B be invested in a special fund for providers to improve access, quality and equity over an eight to 10 year period. Staff will continue to update Commissioner's via reports in upcoming Board packets.

Item 10A on consent was staff's recommendation to renew the annual Monterey County In-Home Supportive Services (IHSS) annual agreement. The Alliance has provided healthcare coverage to IHSS workers in Monterey County since 2005.

Mr. Schrader thanked Board members for accepting his invitation to meet individually with each of them to learn more about their organizations, local delivery system and member experience.

Consent Agenda Items: (5. – 10H.): 3:18 p.m.

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

MOTION: Vice Chair Pedrozo moved to approve the Consent Agenda seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummins, Bizzini, Conner, Cuevas, Edgcomb, Espinoza, Friend, Harris, Jimenez, Molesky, Pedrozo, Peterson, Rabago, Radner and Schuller.

Noes: None.

Absent: Commissioners Askew, Kalantari-Johnson, Morales, Nanyonjo and Smith.

Abstain: None.

Regular Agenda Item: (11. - 13.): 3:19 p.m.

11. Consider accepting audited financial statements and management letters for Alliance's fiscal year ending December 31, 2022 from Moss Adams LLP, independent auditors. (3:19 – 3:34 p.m.)

Mr. Chris Pritchard, Partner, and Ms. Rianne Suico, Partner, from Moss Adams LLP, 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, accurate and in compliance.

Capital assets and other assets remained fairly 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 consistent with the prior year balance with no notable changes. Accounts payable and accrued liabilities consists mainly of MCO tax payable in the Q4 2022. The increase in net positions is due mainly to positive operating results in 2022.

Revenues in 2022 decreased slightly over 2021. Even though revenue increased due to Medi-Cal membership growth as well as increased capitation rates from DHCS, the increase was offset against the reduction in revenue due to the pharmacy carve out. Capitation and claims expenses remain the largest expense to the organization.

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 audit procedures. The plan's accounting policies are reviewed annually to ensure compliance with known accounting standards.

Commissioners recognized and complimented staff for a clean, zero finding audit.

MOTION: Commissioner Cuevas moved to accept audited financial statements and management letters for Alliance's fiscal year ending December 31, 2022 from Moss Adams LLP, independent auditors, seconded by Vice Chair Pedrozo.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta-Cummings, Askew, Bizzini, Conner, Cuevas, Edgcomb, Espinoza, Friend, Harris, Jimenez, Molesky, Pedrozo, Peterson, Rabago, Radner and Schuller.

Noes: None.

Absent: Commissioners Askew, Kalantari-Johnson, Morales, Nanyonjo and Smith.

Abstain: None.

12. Consider approving proposed changes to Alliance's Care-Based Incentives (CBI) for 2024. (3:34 – 4:04 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 2024.

Staff recommended the following changes to CBI 2024:

1. Programmatic Measures
   - Add: Lead Screening in Children
   - Retire: Body Mass Index Assessment: Children and Adolescent
2. Fee-for-Service (FFS) Measures
   - Add: $200 for Diagnostic Accuracy and Completeness Training, $200 for Cognitive Health Assessment Training and Attestation, $1000 for Social Determinants of Health (SDOH) ICD-10 Z-Codes, and $1,000 for participation in in Quality Performance Improvement Projects including the Pharmacist-Led Academic Detailing Diabetes Program
3. Exploratory Measures
   - Add: Well-Child Visits for Age 15 months - 30 months
   - Retire: Immunizations: Adults
4. Payment Adjustment
   - Add: Measures with 10% improvement from prior year will not be included in adjustment (put into effect for current CBI 2023 year as well)

Commissioners discussed and provided the following comment: Commissioners requested additional information on the 25 Priority Social Determinants of Health codes; and recommended exploring options for recognizing conflicts of interest, soliciting stakeholder input and maximizing Board participation.

MOTION: Commissioner Friend moved to approve the proposed changes to Care-Based Incentives for 2024, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Bizzini, Edgcomb, Espinoza, Friend, Molesky and Pedrozo.

Noes: None.

Absent: Commissioners Askew, Kalantari-Johnson, Morales, Nanyonjo and Smith.

Abstain: Commissioners Abasta-Cummings, Conner, Cuevas, Harris, Jimenez, Peterson, Rabago, Radner and Schuller.

13. Discuss Provider Payment Strategy Part 1: Current State Assessment. (4:04 – 4:53 p.m.)

Ms. Lisa Ba, Chief Financial Officer, provided a comprehensive assessment of the Alliance provider payment policy and reviewed the current state of provider payment. Plan and providers are responsible for the availability and quality of services to drive appropriate utilization. The plan and providers should have a shared focus on unit cost containment to ensure the sustainability of the Medi-Cal program. Medical cost is a key factor in revenue development. The Department of Health Care Services (DHCS) does not recognize the total costs and demands quality services.

The Alliance follows the Board approved payment policy. Under Medi-Cal financing, providers are entitled to and have received various supplemental payments by serving Medi-Cal members. DHCS will implement regional rates no sooner than 2025 to improve cost efficiency across the plans. The current higher than Medicare payment will likely negatively impact the Alliance's Dual Eligible Special Needs Plans financial performance in 2026. The Alliance is considering a shift in focus from fee-for-service based reimbursement to quality-based value payments.

Staff plan to return to the Board in June to discuss a recommendation for value-based payment opportunities.

Commissioners discussed and provided the following comment: rewarding service is great, however, imposing penalties may pose significant financial challenges to hospitals; incentivizing does not help with capacity issues and infrastructure; and consider forums for partnering and information sharing opportunities.

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

The Commission adjourned its regular meeting of May 24, 2023 at 4:53 p.m. to the regular meeting of June 28, 2023 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

Physicians Advisory Group

Meeting Minutes

Thursday, March 2, 2023
12:00 - 1:30 p.m.

Santa Cruz County:
Central California Alliance for Health – Monterey Room
1600 Green Hills Road, Suite 101, Scotts Valley, CA
Monterey County:
Central California Alliance for Health - Board Room
950 East Blanco Road, Suite 101, Salinas, CA
Merced County:
Central California Alliance for Health – Los Banos Room
530 West 16th Street, Suite B, Merced, CA

Group Members Present:

Dr. Shirley Dickinson	Provider Representative
Dr. James Rabago	Provider Representative
Dr. Cristina Mercado	Provider Representative
Dr. Casey KirkHart	Provider Representative
Dr. Salvador Sandoval	Provider Representative

Group Members Absent:

Dr. Misty Navarro	Provider Representative
Dr. Amy McEntee	Provider Representative
Dr. Devon Francis	Provider Representative
Dr. Michael Yen	Provider Representative
Dr. Caroline Kennedy	Provider Representative
Dr. Anjani Thakur	Provider Representative
Dr. Patrick Clyne	Provider Representative
Dr. Jennifer Hastings	Provider Representative
Dr. Scott Prysi	Provider Representative

Staff Present:

Dr. Dale Bishop	Chief Medical Officer
Dr. Dianna Diallo	Medical Director
Dr. Gordon Arakawa	Medical Director
Ms. Kristen Rohlf	QI Program Advisor
Mr. Jim Lyons	Provider Relations Manager
Ms. Ronita Margain	Community Engagement Director
Ms. Veronica Lozano	Quality Improvement Program Advisor
Ms. Van Wong	Chief Operating Officer
Ms. Tracy Neves	Clerk of the Advisory Group

Public Representatives Present:

Ms. Becky Shaw	Public Representative
Dr. Maximiliano Cuevas	Board Member
Dr. Allen Radner	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 1, 2022 Physicians Advisory Group (PAG) minutes.

      Action: Minutes approved with changes.

3. **New Business**

   A. Care Based Improvement/Care Based Incentives 2024

      Dr. Bishop provided an overview of the CBI Purpose.

      - Promotion of the Patient Centered Medical Home
      - PCP encouraged to move from illness treatment to a population–based treatment paradigm:
        - Access
        - Optimal Preventive Care
        - Management of Chronic Conditions
      - Payment reform that promotes practice reform
      - High performing practices have reinvested CBI payments into improvement.

      A CBI Payment adjustment was recommended by staff and approved by the Board to reduce earnings for performance below the NCQA Medicaid 50th percentile for quality measures.

      It was noted 40% of practices will have some sort of adjustment. Final results won't be known until 2022 metrics are received, and the information will be communicated to providers regarding improving metrics. The purpose of the adjustment is not to penalize, but to reward achievement, focus on optimizing health outcomes, and eliminate disparities by encouraging performance above the national Medicaid average. In addition to providing incentives, the Alliance will provide support for providers to address barriers and achieve high quality and equitable results for Alliance members.

      - In 2023, $5M was allocated to the Care-Based Quality Improvement Program for CBI practices that received CBI adjustments due to results below the 50th percentile in 2022.
      - The target goal is to raise scores above the 50th percentile in 2023 focusing on the Alliance strategic priority of health equity and goal to eliminate health disparities and achieve optimal health outcomes for children and youth.

- Providers with metrics below the 50th percentile will have the opportunity to put forward a plan for performance improvement and earn dollars for resources needed to address barriers to performance.
- Alliance staff will review and approve project applications using a select set of criteria, and provide ongoing support including best-practice information, regular reports, and coaching through a rapid Plan Do Study Act (PDSA) cycle process.

In anticipation of CBI 2022 payment adjustments, the Board approved a new project that will reallocate funding back into practices who are set to lose CBI dollars. This project is the Care-Based Quality Improvement Program (CBQIP). The aim of the project is to provide financial investment in quality improvement practices for sites that have CBI metrics below the 50th percentile for Medicaid, and therefore will be receiving a CBI 2022 payment reduction between 25-100%. The application is set to open in March and will prioritize the following:

- CBI 2022 Q4 profile release to submit edits to the final application for the program.
- The Alliance to review final applications and escalate application concerns to providers.
- Providers to adjust application from the Alliance MD outreach.
- Final payments after application close May 11 -12, 2023.
- Collection of signed Letters of Agreement.

The primary application requirements will include selection of measure(s), selection of best practice(s), and creation of a SMART AIM statement. The goal is to keep the requirements short and concise, while also kicking off key critical thinking strategies for quality improvement. Additionally, the Alliance will be working with the assistance of our grants team to digitalize the application and review process.

A provider asked if they would be notified regarding the metrics, and it was noted that QI will provide Provider Relations with a list of providers they anticipate will be eligible for the program. Updates will be provided regarding who has applied and who still needs to apply. The Alliance will make certain those eligible apply for the program and have made the process as simply as possible. Meetings will be held with providers.

An example of the application was shared with the Group and a SMART AIM statement will be included with the application.

B. Care Based Incentives 2024
Dr. Diallo presented on CBI 2024. The Care Coordination Measures will remain the same with a name change to Initial Health Assessment to Initial Health Appointment to align with DHCS policy changes.
Care Coordination - Hospital and Outpatient Measures
    - Ambulatory Care Sensitive Admissions
    - Plan All-Cause Readmissions
    - Preventable Emergency Visits

Care Coordination - Access Measures
    - Adverse Childhood Experiences (ACEs) screening in Children and Adolescents
    - Application of Dental Fluoride Varnish
    - Developmental Screening in the First 3 Years
    - Initial Health Appointment

- Unhealthy Alcohol Use in Adolescents and Adults
- Post-Discharge Care

Dr. Diallo shared the CBI Quality of Care & Performance Measures with proposed additions from exploratory to paid for Chlamydia Screening in Women, Controlling High Blood Pressure and Lead Screening in Children. A provider asked if blood pressure can be monitored over the year and not in one visit. It was noted blood pressure for2 hypertension diagnoses before June 30 and the most recent blood pressure reading which must be below 140/90 is reviewed. **Action:** The Alliance noted it will leave the measure exploratory for now and work on clarifying the measurement. It was noted the National Committee Quality Assurance (NCQA) has a public comment period for their metrics, and the Alliance can also take back provider input back to NCQA.

For the Quality of Care and Performance Measures, BMI Assessment: Children & Adolescents and Screening for Depression and Follow-up are the measures that the Alliance is considering retiring. Both measures have been retired from MCAS reporting. A provider noted, CMS data shows that 70% of patients have depression, and it routinely gets missed. Without screening tools providers tend to forget about this screening, and this can result in suicide. Depression patient data needs to be captured. Counseling is also needed for patients. Provider recommended adjustments to the electronic medical records (EMRs). The Alliance is looking into EMR funding, codes, and efforts to make certain the codes are captured.

Another provider noted screening for anxiety and depression is important but also drug and ACES are especially important. Providers noted that exploring screening for depression further is needed. Also screening younger patients for depression is needed as providers are seeing patients as young as 8 years old in psychiatry. **Action:** The Alliance will look further into pediatric and adolescent depression screening.

Provider noted it is a problem getting lead screening completed for children, and they do not have machines needed and getting patients to the labs is challenging.. The Alliance may be able to assist providers in obtaining screening equipment. For the fee-for-service (FFS) measures, the Alliance is considering retiring the Patient Centered Medical Home (PCMH) and Behavioral Health Integration measure. In recent years, there has not been any interest in new practices obtaining the PCMH recognition or certification, or Behavioral Health integration recognition through NCQA.

For FFS additions, the Alliance is looking into paying providers for completion of diagnostic accuracy and completeness training, Medicare providers may already have completed this training. The state will perform a risk adjustment on plan rates based on diagnostic accuracy and completeness beginning next year and Medicare dual eligible rates are very dependent on accurate diagnosis.

In addition, inclusion of Social Determinants of Health (SDOH) ICD-10 Z-Codes, LOINC, and SNOMED codes. Providers will receive credit for z codes if captured in claims. The Alliance will continue the Health Equity Measure and retire Adult Immunizations and continue exploratory measure for Colorectal Cancer Screening and add Well Child Visits for age 15-30 months that requires two visits between that time.

This year, DHCS will be implementing penalties to health plans for reported measures, as well as auditors have expressed concerns with the Alliance paying provider incentives

for performance below the 25th percentile, so the payment adjustment remains. If the CBI group is above the 50th percentile for all measures, then they will receive their full CBI payment.. For the past 3 years, the Alliance shared the Mid-Year Performance Reports in July, allowing for an earlier look at Q2 performance rates to allow for time to review and make improvements before the Q4 data is reviewed. Another resource available to all providers is the opportunity to participate in the practice coaching program. Our practice coaches will work with providers to assess and help implement a quality improvement plan or project.

Dr. Diallo noted that the following measures will be removed from payment adjustments: Immunizations for children Combo 10 and well child visits first 15 months. Providers noted the Combo 10 is extremely difficult to complete in time. A provider asked if there are incentives for well child visits under 2 years, Dr. Diallo noted member incentives will be effective beginning April 1st and a list will be provided on the on provider portal noting members that need immunizations.

C. Specialist Access

Dr. KirkHart presented on Specialty Access for Community Health Centers. There are some opportunities as a result of the challenges and there has been collaboration across specialties and agencies, refinement of workflows and efficiency, and enhanced primary care provider (PCP) experience. In May 2022; Palo Alto Medical Foundation (PAMF) stated it would close to external gastrointestinal, rheumatology and dermatology. At risk was cardiology, allergy, and nephrology. PAMF provides 100% of allergy care and this was a concern.

Various clinic and agency leaders met to discuss their concerns. Implemented in July 2022 were cardiology referral guidelines with testing, diagnosis, and RN trained consult and then referral to cardiologist if necessary. In August 2022, there were discussions with AristaMD and the Alliance around whether there was any other functionality available to assist with specialty care. In addition, internally Santa Cruz Community Health (SCCH) reviewed allergy and nephrology that was at risk for several months. The same group met again, and it was noted PAMF was planning to close allergy to adults in February and pediatrics was also at risk. SCCH began an eConsult. First approach for allergy with AristaMD. Later, SCCH met with PAMF to review the data. Prior to the changes made, there were 8.4 cardiology referrals per month in January 2022. After implemented changes, in January 2023, there were 3.1 cardiology referrals per month with 63% reduction in external Medi-Cal referrals. The take aways included:

- Management guidance from specialists and clear workflows improve referrals and access.
- Continue clear workflows.
- PAMF adopting this workflow internally.

Regarding allergy, in December 2022, SCCH implemented an eConsult First policy and 4 patients were referred to PAMF. In January, there were 13 patients referred directly to PAMF with 9 patients going directly to PAMF, 3 to eConsult and were not seen at PAMF and 1 went directly to Central Coast Allergy in Salinas. In January 2023, PAMF received 24 allergy patient referrals.

Of the referrals to PAMF, most were pediatric. with 2 adult and 7 pediatric from SCCH. Additional take aways:

- Closure to adult allergy affects other clinics.
- "eConsult First" process did not work.

Recommendations include:

- Screen referrals for appropriateness, more to be done in clinic.
- Implement "eConsult First" especially for adult allergy (no referrals to PAMF without eConsult).
- Develop referral guidelines.
- AristaMD functionality (referral nursing team available).

In February 2023, PAMF announced it would close gynecology and general surgery for 6-9 months to work on staffing, so having a strategy in place is important. Communicating with other practices and possibly providing allergy testing in clinic is important. This effort provides access in clinic and limits specialty care to those that need it most. It was noted this will be an ongoing process and SCCH will continue to work with the Alliance. The Alliance is pleased to be working on this collaboration.

D. Urgent Care Access
Dr.. Bishop presented on Urgent Care and noted emergency department (ED) rates are rising similar to pre-pandemic levels and EDs are congested. Providers were asked if they are able to accommodate members on a walk-in basis. The Alliance is considering expanding urgent care access, and changes in payment for urgent care.

A provider in Salinas noted they still have about 30 to 34 walk-in patients waiting after all others have been seen. Another provider in Santa Cruz, noted not all walk-ins need to be seen right away and are scheduled for appointments; and they are able to accommodate patients since they are open util 8 PM and Saturdays. A provider noted on any given day a provider will only have a few open spots. A suggestion might be to have a dedicated person for walk-ins, but deciding what model works best still needs work. The Alliance is considering contracting with free standing urgent care providers, but the concern is that patients may not utilize primary care. Currently some primary care providers (PCPs) are acting as urgent care.

Some PCPs are seeing unlinked members and there are issues with rates. A provider expressed concerns that this will affect CBI negatively. The Alliance will review the incentives to make certain they align and do not have negative impacts on providers. Some possible reasons for the increase in ED visits noted were increased membership, seasonal issues, and COVID. A provider inquired about telehealth and Dr. Bishop noted the Alliance has a Nurse Advice Line and the ability to triage to a physician. Provider also noted that FQHCs are understaffed and overwhelmed. More information to come on this topic in the future.

4. 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, April 06, 2023
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

Ibraheem Al Shareef, MD	Provider Representative
Cal Gordon, MD	Provider Representative
John Mark, MD	Provider Representative
Salvador Sandoval, MD	Provider Representative
Sarah Smith, MD	Provider Representative
Jennifer Yu, MD	Provider Representative
James Rabago, MD	Board Representative

Committee Members Absent:

Camille Guzel, MD	Provider Representative
Patrick Clyne, MD	Provider Representative
Devon Francis, MD	Provider Representative

Staff Present:

Dianna Diallo, MD	Medical Director
Dale Bishop, MD	Chief Medical Officer
Marwan Kanafani	Health Services Officer
Navneet Sachdeva	Pharmacy Director
Shaina Zurlin, LCSW, PsyD.	Behavioral Health Director
Andrea Swan	QI & Population Health Director
Jennifer Mockus, RN	Community Care Coordination Director
Tammy Brass, RN	Utilization Management Director
Kelsey Riggs, RN	Pediatric Complex Case Mgmt. Manager
Jessie Newton, RN	Care Coordination Manager
Cynthia Balli	Provider Relations Supervisor
Jenna Stromsoe, RN	Complex Case Management Supervisor
Jacqueline Morales	Provider Relations Representative
Jessica Hampton	ECM/CS Manager
Sarah Sanders	Grievance & Quality Manager
Ashley McEowen, RN	Pediatric CCM Supervisor
Bri Ruiz	Pediatric Care Coordination Supervisor
Veronica Lozano	Quality Improvement Program Advisor
Gisela Taboada	Member Services Call Center Manager
Tracy Neves	Clerk of the Committee

Other Representatives Present:

Becky Shaw	Provider Representative
Laurie Soman	Provider Representative
Kenny Ha	Aveanna Representative
Mike Barrett	Aveanna 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.**
   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 15, 2022 meeting were reviewed.

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

   M/S/A Consent agenda items approved.

4. **Regular Business.**
   A. Pediatric Complex Case Management Emergency Outreach
   Ashley McEowen, RN presented on emergency outreach from the pediatric team during emergencies. The pediatric team provides support to members during emergencies such as, but not limited to power outages, fires, flooding, evacuations, primary care provider, office closures due to inclement weather, as well as public health emergencies such as during the COVID-19 pandemic. During these times, the goal, of the team is to identify those pediatric members who are recognized as being at the highest risk, and this does include both CCS and non CCS children. The pediatric team then outreaches to provide resources and education utilizing specific talking points to those members and families who have been identified. The team also provides education surrounding emergency preparedness during routine check ins with members and their families.

   High risk and moderate risk members were identified particularly those members requiring electricity dependent durable medical equipment (DME) and those in geographic locations that were specific to the risk of being affected.

   The pediatric team provided education to members and their families, including information regarding evacuation zones throughout the state of California, and shelter locations. Outreach was conducted to 650+ members and additional information was provided regarding:
   - Evacuation zones throughout the state of California
   - Evacuation sites/shelters
   - Weather Service Updates
   - General information for service delivery counties
   - California Emergency Notifications
   - Sandbag locations
   - Food resources

   In addition, contact information for Member Services and the Nurse Advice Line was provided to members. The team also directed members to their primary care provider (PCP) and or emergency room or urgent care for any medical emergencies.

Dr. Diallo acknowledged all the support and teamwork between Santa Cruz and Monterey in assisting displaced families.

B. Whole Child Model California Children's Services (CCS) Referral Updates
Kelsey Riggs, RN shared CCS referral data from Q4. Referral trends from September 2022 to February 2023 were shared with the Committee. Total referral approval rates by county for Q4 includes Merced – 73.7%, Monterey – 76.5% and Santa Cruz – 81.4%. Average approval rate is 76.2%.

CCS Referral Approval Counts by County:
Merced: 137
Monterey: 170
Santa Cruz: 67
Total Referrals: 374

In Quarter 4, there were 285 new CCS members, with 8,233 eligible members. Referral volumes and approval rates continue to steadily increase. Dr. Diallo wanted to acknowledge the partnership with our CCS partners and noted we really need your community support with the referrals. There was a question regarding the geographic mobility that we saw during COVID and does the Alliance think that is affecting referral numbers or is it now stabilizing? **Action**: The Alliance can investigate this further and get back to the Committee. The Alliance, however, has a solid process in working with the counties to support members that are transferring either between our counties or outside of our counties. The Alliance has had members transfer out of county and was able to support the member through the change without gaps in care.

A provider had questions regarding numbers for Merced County being slightly below average. The provider asked if it is something related to the communication between the referrals department or is it related to the providers assignment of certain codes and diagnosis. It was noted, Merced continues to trend below average regarding referral rates. The Alliance continues to monitor referrals and shares information with the county CCS referral team regularly. In addition, the provider asked if it was possible to have access to the Alliance portal. **Action:** The Alliance will check on portal access and will contact the CCS team.

C. Transportation Update
Gisela Taboada provided a Transportation Update. Gisela acknowledged Dr. Mark and the Stanford core team for being the best partners when it comes to bringing issues forward regarding transportation services and the Alliance could not have done many of the improvements without the feedback from Stanford core. On January 1, 2023, the Alliance delegated all customer service and intake of non-medical transportation (NMT) over to our vendor Call the Car. There were pain points and improvements that needed to be made around communication and support for our CCS members. Some members were waiting an exceedingly long time to connect with Call the Car, or they were not getting updates about pick-up times for their transportation.

Gisela thanked Dr. Diallo and team for holding a collaborative meeting with Stanford core and Call the Car to emphasize the importance of ensuring that our members specifically in South Monterey County were being picked up to go to their appointments at Stanford. Through this collaboration, we can ensure that all of our CCS members in our system are now flagged and in the Call the Car system, so it is known that this is a CCS member that requires more support and guidance.

To ensure that children were being picked up on time, the Alliance also provided Stanford core with a direct connection to Call the Car case management and that has taken out the waiting period. Members are now connecting to their case management. Additionally, the Alliance assigned a lead Member Service Representative (MSR) within our call center to have more direct connection with certain families as we have families that speak only Mixteco. This kind of relationship building with our members has been helpful. Call the Car is also working on texting updates in Spanish. This is a barrier to understanding when a driver is outside of the home. and this issue has been escalated to Call the Car and their development team.

Dr. Mark wanted to acknowledge Gisela and everybody at the Alliance who just really stepped up and made this happen. Gisela also noted there is research being conducted regarding transportation for San Benito and Mariposa counties, since those are going to be our expansion counties for 2024. Dr. Diallo acknowledged Dr. Mark and his team; it is extremely helpful when our partners bring issues/barriers forward so that we can work together and make it better. Thank you.

D. Enhanced Case Management (ECM) and Community Supports (CS) Pediatric Update
Jessica Hampton presented on ECM and CS Pediatric updates. In July, the Alliance is rolling out two new populations of focus for children and youth. children and youth who are enrolled in CCS or CCS Whole Child Model with additional needs beyond the CCS condition are going to be eligible for ECM beginning July 1. In addition to this population, children and youth involved in the child welfare system will also be eligible. The Alliance is focusing on those populations that are under the age of twenty-one and that meet specific criteria. For the CCS population, children should be enrolled in CCS or CCS Whole Child Model and experiencing at least one complex social factor influencing their health.

Community Supports offered were shared with the committee and two new community supports will be offered: personal care and homemaker services and respite services for caregivers. Personal care and homemaker services will be for those members that are receiving IHSS, and this will be approved above and beyond their IHSS hours.

There was a question regarding updates on vendor contracts for ECM and CS. In terms of contracting with vendors, the Alliance is recruiting and collaborating with community based organizations, and larger organizations to identify people who can serve these populations of focus. The Alliance collaborates with Provider Services to understand organizations capability to serve our members and their understanding of the benefits. The Alliance is working to get vendors contracted in the next few weeks. It is helpful to receive feedback in terms of community based organizations that you think would be able to provide and support these services. There was a question regarding contracting with those that have direct pediatric experience especially CCS and coordination with County CCS programs. The Alliance does assess providers ability and their background in servicing the populations of focus. There is no requirement, but something that is taken into heavy consideration and the Alliance has not contracted with anyone that does not have experience with the populations of focus that they serve. ECM eligible member data by population of focus and program county was shared with the Committee. There are about 1,400 pediatric members eligible for services. Housing community supports, housing transition and navigation is another benefit. This benefit assists members with obtaining safe and stable housing. It is available to our youth population and families. This is not necessarily short term and providers work with people to find safe and stable housing.

There was a question regarding issues identified in a recent evaluation regarding decreased enrollment and referrals and issues with case management and what is being done to address these concerns. It was noted the report identified that case management was more difficult to access in Whole Child Model than prior, no direct contact, multiple phone calls and the need to navigate the phone tree. Also, it was noted, there was actually good satisfaction overall among most families with the transition with 10% of the families stating the services were worse. **Action:** The Alliance will take this information back and present at the next WCMCAC Meeting since the evaluation report was just recently released.

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

Stanford reported respiratory season has stopped, and no cases reported in 48 hours. Grace Lee is new Chief Quality Officer. In Merced, work is being done on immunization gaps, hiring, and conducting clinics. In Santa Cruz, there were two families displaced at Watsonville County Fairgrounds, with DME and post operative requiring coordination of services. Many people are still displaced in Pajaro due to recent flooding.

The meeting adjourned at 1:00 p.m.

Respectfully submitted.

Ms. Tracy Neves
Clerk of the Advisory Committee

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

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 13, 2023

1:30p.m. – 3:00p.m.

Teleconference Meeting
(Pursuant to Governor Newsom's Executive Order N-29-20)

Chairperson: Janna Espinoza, WCM Family Member, WCMFAC Chair

CCAH Support Staff Present: Lilia Chagolla, Community Engagement Director**;** Maria Marquez, Administrative Specialist

WCMFAC Committee Present: Heloisa Junqueira, MD, Monterey County Provider

WCMFAC Committee Absent: Ashley Gregory, Santa Cruz County – CCS WCM Family Member; Cristal Vera, Merced County – CCS WCM Family Member; Cynthia Rico, Merced County – CCS WCM Family Member; Cindy Guzman, Merced County – CCS WCM Family Member; Deadra Cline; Santa Cruz County – CCS WCMF Family Member; Frances Wong, Monterey County – CCS WCM Family Member; Irma Espinoza, Merced County - CCS WCM Family Member; Kim Pierce, Monterey County Local Consumer Advocate; Manuel López Mejia, Monterey County – CCS WCM Family Member Susan Skotzke, Santa Cruz – CCS WCM Family Member; Viki Gomez, Merced County – CCS WCM Family Member

CCAH Staff Present: Ashley McEowen, Complex Case Management Supervisor – Pediatric, RN; Bri Ruiz, RN, Interim Complex Case Management Supervisor – Pediatric; Dianna Diallo, MD, Medical Director; Gisela Taboada, Member Services Call Center Manager; Jenna Stromsoe, RN, Complex Case Management Supervisor – Pediatric; Jennifer Mockus, RN, Community Care Coordination Director; Kelsey Riggs, RN, Complex Case Management Supervisor; Ronita Margain, Merced County Community Engagement Director

Guest: Christine Betts, Monterey County – Local Consumer Advocate; Denise Sanford, Santa Cruz County CCS

Agenda Topic	Minutes	Action Items
Meeting Administration Lilia Chagolla	• Lilia Chagolla welcomed the group.	
Call to Order Janna Espinoza	• Janna Espinoza called the meeting to order. WCMFAC Mission read in English/Spanish.	
Roll Call Maria Marquez	• Committee introductions and roll call was taken.	
Oral Communications Janna Espinoza	• Janna Espinoza opened the floor for any members of the public to address the Committee on items not listed on the agenda. • Janna Espinoza and Christine Betts shared on the Pajaro flooding and on the challenges Alliance members are facing due to the evacuations.	Kelsey to connect offline with Christine Betts on the members needing support due to the floodings.

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 13, 2023

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
Consent Agenda Items: Accept WCMFAC Meeting Minutes from Previous Meeting Janna Espinoza	• Janna Espinoza opened the floor for approval of the meeting minutes of the previous meeting on December 5, 2023. • All committee members were given the meeting minutes prior to the meeting via USPS mail. • Minutes were approved with no further edits.	
CCS Advisory Group Representative Report Susan Skotzke	• Susan Skotzke was an excused absence. No CCS Advisory Group report back was given. • The following topic was brought back as discussed during the meeting held on January 23, 2023. -CalAIM: Jennifer Mockus, Community Coordination Director for the Alliance will be presenting to this community in quarter 3 of 2023.	
Community Partner Feedback New Issues | Impact on Members – Open Forum Member/Community Voice Community Based Organizations Alliance Updates	• Janna Espinoza voiced her concerns when children with special needs are admitted to the hospital and the need to access their medications. Further expanded on the complexity of managing medications. • Janna Espinoza mentioned on her request to being pediatric Grievances reporting to the FAC meetings and see if there are any trends. The reporting is requested on a quarterly basis. • Christine Betts shared that a report was ran on families affected by Pajaro evacuation zones and have reached out to these families to support. At the time of pulling this information, only three families were out of their homes. Was able to assist affected families with DME needs and wheelchair. • Kelsey. Riggs shared that the Alliance is doing similar outreach for those members from Pajaro evacuated areas. Requested for Christine Betts to share the members ID offline to ensure the coordinators reach out for further support as needed. • Christine Betts added that she received an email from Department of Health Care Services asking for	Lilia Chagolla to connect with Member Services/Sarah Sanders to reinitiate the Member Grievances reporting. Christine Betts to share Alliance Member's ID information.

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 13, 2023

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	information on any families who have had to evacuate, and they will also be reaching out. • Janna Espinoza inquired about donating DME and or any other medical supplies. Previously, donations were facilitated by the school districts within classrooms or infant programs and/or delivered during home visits. Added that she will be reaching out to her school district to see if this still active. • Gisela Taboada added that transportation services are available for members that need to get to a pharmacy to pick up their medications or need to get to their medical appointments. • Dr. Junqueira shared on her personal experience in terms of preparing for situations. Mentioned on legal restrictions. Added that there are community parent support groups for parents with kids with type one diabetes or alike diagnosis. This group is used for parents to communicate. Suggested forming a group via Facebook or WhatsApp and to get the word out about that group. • Lilia Chagolla shared on the Alliance updates: 1. WCMFAC meeting quality survey will be delivered after this meeting. Encouraged everyone, including Community Based Organizations and members to complete. 2. WCMFAC Roadshows will be conducted to various organizations in the communities the Alliance serves to talk about the WCMFAC in hopes to get more membership and educate the community on this committee. Will be presenting to the Monterey County Caring Partners on March 15, 2023. 3. Presented on Medi-Cal Redeterminations starting on April 1, 2023. Shared the various work being done in the separate phases.	Maria Marquez to share the WCMFAC meeting survey.

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 13, 2023

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
Introduction of Dr. Junqueira Dr. Junqueira	• Dr. Junqueira was presented to the committee. Shared on her professional and personal experience. • Has been in Monterey County for approximately 16 years and loves working with the Alliance's population.	
The Alliance Non-Medical Transportation Services Gisela Taboada	• Gisela Taboada presented on the Alliance's Non-Medical Transportation (NMT) services. • Shared on what is NMT, its eligibility, services included and the request process. • Members can call the Alliance at 800-700-3874, ext. 5577 (TTY: Dial 711), Monday through Friday from 8 a.m. to 5:30 p.m., at least 5 to 7 business days before your appointment. • Members can also call CTC directly 24 hours a day 7 days a week to receive assistance. Call The Car: 833-244-1678 • Denise Sanford asked if siblings are allowed to be transported as well. Gisela Taboada shared that an All-Plan Letter (APL) was updated in July of 2022, that ok'd for siblings to ride with members. It was asked if there is an age limit for siblings.	Gisela Taboada to further connect with Denise Sanford on age limits for siblings to ride with members.
Review Action Items Maria Marquez	• Maria Marquez reviewed the actions items as listed on the meeting minutes.	
Future Agenda Items	• Family Voices of California Health Summit: Janna Espinoza • Grievance Reporting: Sarah Sanders	
Adjourn (end) Meeting Janna Espinoza	The meeting adjourned at 2:55p.m.	
Minutes Submission	The meeting minutes are respectfully submitted by Maria Marquez, Administrative Specialist	

Next Meeting: Monday, May 8, 2023, at 1:30p.m.

DATE: June 28, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services Medi-Cal Contract 08-85216 A-56

Recommendation. Staff recommend the Board ratify the execution by the Chairperson of Medi-Cal Contract 08-85216 A-56 as described below to incorporate updated Capitation Payment rates for CY 2021.

Background. The Alliance contracts with the Department of Health Care Services (DHCS) to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey, and Merced counties. The Alliance entered into the primary Agreement 08-85216 with DHCS on January 1, 2009. The agreement has subsequently been amended via written amendments (A-1 through A-50 and A-54 through A-55).

Discussion. DHCS prepared A-56, an amendment to the Alliance's State Medi-Cal contract to incorporate Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into a SIS version and UIS version, as required by the Centers for Medicare and Medicaid Services. The amendment implements what is essentially a "bookkeeping change" and is revenue neutral to the Alliance.

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

Attachments. N/A

DATE: June 28, 2023

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

FROM: Shaina Zurlin, Behavioral Health Director

SUBJECT: Behavioral Health Future State

Recommendation. Staff recommend the Board approve monitoring Carelon Behavioral Health (Carelon) improvements while concurrently planning insourcing behavioral health benefits so the plan is prepared to move forward with insourcing should Carelon fail to improve.

Summary. In alignment with the Strategic Plan goal to improve behavioral health services and systems to be person-centered and equitable, the Alliance has identified two potential pathways for future state which can be explored concurrently. First, the Alliance will continue to closely monitor the performance of the Managed Behavioral Healthcare Organization (MBHO) Carelon and maintain regular communications to discuss desired improvements. Second, the Alliance will engage a consultant to map the action steps and resource needs of an insourced behavioral health benefit. Should Carelon fail to deliver improvements, the Alliance will be well positioned to begin an insourced model.

Background. In 2014, the Department of Health Care Services (DHCS) allocated responsibility of non-specialty mental health services to the managed care plan (MCP). This includes member servicing, network development and credentialing, claims processing, utilization management, care coordination, and appeals and grievances. The Alliance met this responsibility by selecting Carelon Behavioral Health (formerly Beacon Health Options) as the MBHO to execute the full spectrum of non-specialty mental health services on its behalf. Since the execution of the contract, Carelon performance has ranged from adequate to substandard in a range of elements. Alliance staff continue working with Carelon leadership to improve in a number of areas of concern including utilization disparities, care coordination gaps, system integration needs and CalAIM implementation advancement. In recognition of concerns, the Board articulated areas of concern and subsequently issued a request for proposal to explore an alternate vendor in 2020. The combination of limited response and the onset of COVID-19 resulted in the decision to continue the working relationship with Carelon via execution of a two-year contract planned for commencement in 2021. While the Alliance secured contract approvals from DHCS as well as the Department of Managed Health Care (DMCH), Carelon was not able to secure DMHC approval until May of 2023. The contract is in process for a service range of July 1, 2023 to June 30, 2025.

Discussion. There are three identified pathways for behavioral health provision by MCPs, namely MBHO contracting, insourcing and delegating to County Mental Health Plans (MHPs). Prior research has ruled out the latter, as county systems are under resourced and overburdened in their existing responsibilities. The Alliance has a long-standing relationship with the selected MBHO which, should the organization deliver on improvements to member and provider experience, has value to the organization. However, historically Carelon has not been able to achieve and maintain a level of service in all areas of

behavioral health in line with the Alliance's expectations or values. As such, considering an alternative path to behavioral health system improvements through insourcing while seeking sustained change from Carelon offers increased flexibility. A thorough analysis of insourcing factors is necessary for the Board to make an informed decision about the feasibility of insourcing as compared to the benefits and risks of maintain an MBHO. Elements for exploration include program design, staffing needs, service and administration cost, network adequacy feasibility and quality of provider and member experience. This research will be conducted with support of a specialized consultant throughout the remainder of the 2023 calendar year and culminate in a workplan including policy analysis, workflow development, data exchange plans, program descriptions, staffing needs and fiscal impact projections by December 31, 2023. Executing this project while concurrently evaluating results of Alliance efforts to improve care delivery through the MBHO prepares the Board to make an informed decision about the future of behavioral health in January 2024.

Fiscal Impact. The cost of the consultant based on the submitted proposal and scope of work is $93,000. In anticipation of this need a $100,000 allocation was made in the 2023 budget for behavioral health consulting. As such, the expenditure is covered in the 2023 budget with no addition allocation required.

Attachments. N/A

DATE: June 28, 2023

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

FROM: Kristynn Sullivan, PhD, Program Development Director

SUBJECT: Department of Health Care Services CalAIM Incentive Payment Program

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Recommendation. Staff recommend the Board:

1. Authorize staff to continue funding Enhanced Care Management (ECM) and/or Community Support (CS) providers through the CalAIM Incentive Payment Program (IPP); and
2. Authorize payment of up to 100% of the expected amount of IPP Payment 3 to providers in advance of receipt from the Department of Health Care Services (DHCS).

Summary. This report provides an update on the Incentive Payment Program (IPP) funding, including investments made to date to enhance infrastructure to deliver ECM and CS programs as part of the CalAIM initiative. This report recommends continuing to invest IPP dollars in the community at up to 100% of total dollars earned and advancing spend down on Payment 3, anticipated to be received in December 2023.

Background. DHCS implemented the IPP program in January 2022. DHCS has four stated IPP goals: 1) member engagement and service delivery, including reaching new members; 2) building sustainable infrastructure and capacity, including health information technology, workforce, and provider networks; 3) promoting program quality, with measurable impacts on utilization; and 4) creating equitable access for ECM Populations of Focus. The Alliance Board approved participation in the program in October 2021.

Originally, each year of the CalAIM IPP program had two potential payments from DHCS. Program Year 1 corresponded to $21,699,239 total potential allocation to the Alliance. In October 2022, DHCS announced a change in the Year 1 payment schedule for earned IPP dollars to Managed Care Plans. Payment 2, which was originally to be distributed in full late 2022, was split into two equal payments, the second of which was anticipated to be distributed in June 2023. The total potential funding amount ($21.7M) did not change.

In December 2022, the Alliance Board approved staff to continue to provide IPP investments to ECM/CS providers of up to 75% of the June 2023 anticipated DHCS payment (Payment 2B), assuming financial risk for costs associated with these investments prior to receiving the earned IPP revenue from DHCS.

For the duration of the CalAIM IPP program, there will be two chances to earn additional funding per year. The Alliance will submit workplans to DHCS in September 2023, March 2024, and September 2024 for allocation distribution in December 2023 (Payment 3), June 2024 (Payment 4) and December 2024 (Payment 5). See table below for future funding schedule.

	Measurement Period	Alliance Workplan Submission Date	Expected Payment Distribution Date
Payment 3	January – June 2023	September 2023	December 2023
Payment 4	July-December 2023	March 2024	June 2024
Payment 5	January-June 2024	September 2024	December 2024

Discussion. To date, $2.2M of the projected $10.8M Payment 2B IPP funds have been invested in the community (assumed financial risk), well below the $8.1M approved by the Alliance Board in December. On June5, 2023, Alliance staff were notified that they had received the full Payment 2B allocation.

	Santa Cruz	Monterey	Merced	Total
IPP Payments 1 and 2 (Received) As of 6/5/2023	$4,277,047	$9,014,239	$8,407,963	$21,699,239
Alliance Distribution of IPP Dollars As of 6/5/2023	$4,133,588 (96.6%)	$5,694,413 (63.2%)	$3,098,573 (36.9%)	$12,926,574 (59.6%)
IPP Payment 3 Maximum Allocation Date Expected: Dec 2023	$2,031,415	$4,392,666	$4,330,433	$10,754,513

With this allocation, the financial risk for expenditure of Payment 2 is alleviated. As such, staff recommend continuing to invest up to 100% of the earned allocation amount of $21,699,239 in ECM/CS providers. Funding priorities will be to continue to support building capacity of partners bringing on new populations of focus, including existing providers with expanded capacity, and reoccurring Medical Budget expenditures for continuity of care and data sharing (e.g., Unite Us and Activate Care).

To date, the Alliance has earned the full possible allocation from DHCS for Payments 1, 2A, and 2B. $10.8M is the maximum potential allocation across all three counties for Payment 3 (see possible maximum allocation by county in table above). To encourage maximum capacity building and increase assess to ECM and CS services for members, staff recommend continuing to award incentive dollars to providers able to expand capacity, either in existing caseload or in onboarding of a new Population of Focus (e.g., Children and Youth, Birth Equity, etc.), up to 100% of the expected Payment 3 allocation in each county.

Fiscal Impact. There is no fiscal impact associated with the recommendation to invest 100% of the allocation earned for Payment 2. The Alliance has successfully obtained 100% of funds available for Program Year 1 (Payments 1, 2A, and 2B) and is on track to do the same for future funding. However, the receipt of IPP funding is not guaranteed. There is a low risk that the Alliance may not obtain the full expected Payment 3 funding.

Attachments. N/A

DATE: June 28, 2023

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

FROM: Jessica Finney, Grants Director

SUBJECT: Medi-Cal Capacity Grants: Funding Recommendations (Group A)

Recommendation. Staff recommend the Board approve grant recommendations that total $1,209,341 for Group A of funding recommendations under Consent Agenda Item 9D.

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

Background. Since the launch of the MCGP in July 2015, the Alliance has awarded 614 grants totaling over $137 million to 146 organizations in the Alliance's service area to strengthen the local health care delivery system.

In March and April 2023, the Board approved new grant programs to be implemented in two phases in 2023. Phase 1 new programs included Community Health Worker (CHW) Recruitment, Healthcare Technology, Home Visiting and Partners for Active Living. These programs were included in an extra funding cycle in 2023 with an application deadline of May 5, 2023 and award date of June 28, 2023.

The next application deadline is July 18, 2023 for all funding opportunities. This current open round includes the Phase 2 new programs approved by the Board in April 2023: Medical Assistant (MA) Recruitment, Equity Learning, Parent Education & Support and Community Health Champions. *MCGP Current Funding Opportunities* is attached as a reference guide with grant program descriptions. The award date for Workforce Recruitment applications will be September 15, 2023 and the award date for all other programs is October 25, 2023.

Funding announcements have been shared widely with the Alliance's provider network and community partners. Grant Program staff have responded to numerous community inquiries and requests for proposal meetings and presentations. Staff conducted a virtual MCGP Informational Session on June 6, 2023 that was attended by over 70 providers and community organization representatives in Alliance service areas.

In March 2023, the Board also approved a policy change to allow Provider Recruitment applications to be accepted and approved four times per year, with the Internal Review Committee recommending applications for approval by the Alliance Chief Executive Officer (CEO). The Workforce Recruitment Programs, which is a new umbrella term of all recruitment grant types, support recruitment of CHWs, MAs and specific kinds of health care providers. The number and total award amount of grant applications approved by the CEO for Provider Recruitment and CHW Recruitment out of a total of 23 applications received from 20 organizations are as follows:

Grant Program	Number of Provider Recruitment Approvals	Number of CHW Recruitment Approvals	Total Workforce Recruitment Award Amount
Merced	4	1	$560,800
Monterey	7	4	$1,076,565
Santa Cruz	1	2	$259,300
Total	**12**	**7**	**$1,896,665**

Discussion.

Grant Application Review and Recommendation Process. Grant applications in the current round of funding were due on May 5, 2023. This funding cycle, the Alliance received 22 applications from 22 organizations for all programs (not including Workforce Recruitment, per above). Staff carefully reviewed each application to determine eligibility and is recommending approval of 15 out of the 22 eligible applications received.

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

Of the 15 grant applications being recommended for approval, 13% (two) are from Merced County, 60% (nine) are from Monterey County and 27% (four) are from Santa Cruz County. Of the 15 applications recommended for approval 47% (seven) fall under the Access to Care focus area, 13% (two) fall under the Healthy Beginnings focus area and 40% (six) fall under the Healthy Communities focus area. The 15 grant applications recommended for approval are distributed across programs as follows:

Grant Program	Number of Awards Recommended	Award Amount Recommended
Healthcare Technology	7	$309,341
Home Visiting	2	$750,000
Partners for Active Living	4	$994,632
Partners for Healthy Food Access	2	$400,000
Total	**15**	**2,453,973**

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

Grant award recommendations are listed in the table below with totals by county and grouped by Board member affiliation so that Board members with potential fiscal interests

in grant awards may abstain from voting on Group B. Details for each grant award recommendation are included in the reference materials listed below.

County	Group A | Not Board Affiliated	Group B | Board Affiliated
Merced	$50,000	$250,000
Monterey	$950,000	$495,255
Santa Cruz	$209, 341	$499,377
Total	$1,209,341	$1,244,632
Total Grant Award Recommendation: $2,453,973		

Additional Program Allocations Recommendation. The Home Visiting Program and Healthcare Technology Program are new funding opportunities approved by the Board in March 2023. The qualified demand for these programs in Monterey County is exceeding the initial allocated budget. Staff recommend additional allocations to these programs to meet the identified need and organizational capacity in this county. Staff recommend an additional allocation of $200K from the MCGP unallocated budget for Monterey County to the Healthcare Technology Program budget for Monterey County to fully fund the recommended awards in this round and to allow for additional grants in a future round. Staff also recommend allocating an additional $500K from the MCGP unallocated budget for Monterey County to the Home Visiting Program budget to fully fund the recommended awards in this round and to allow for one additional grant in a future round. If approved, the remaining MCGP unallocated budget for Monterey County would be $50,370,885.

Criteria Exception Recommendation. The award recommendation for the Home Visiting Program includes an exception to the funding criteria of a maximum of $250K award per grant for one organization. The exception would allow an award of $500K for First 5 Monterey County to coordinate the award administration for three affiliated direct service organizations, thereby extending the impact of the available funding.

Next Steps. Staff will return to the Board prior to the next award date on October 26, 2023 with a recommendation to adjust program budgets as needed to accommodate the emerging demand for the new programs implemented in 2023. The October 26, 2023 Consent Agenda will include an updated MCGP Performance Dashboard which reflects new programs introduced in 2023 and details on grants awarded to date.

Fiscal Impact. Recommended grant awards totaling $2,453,973 would be funded by the MCGP budget, which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan's reserves to create the MCGP.

Attachments.

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

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

Healthcare Technology

County	Page*	Organization	Award**
Merced	5	Golden Valley Health Centers	$50,000
Monterey	1	Central Coast VNA & Hospice, Inc	$50,000
	2	Doctors on Duty Medical Group, Inc.	$50,000
	3	Eric J. Del Piero, MD, A Medical Corporation	$50,000
	4	George L. Mee Memorial Hospital	$50,000
Santa Cruz	6	Teen Kitchen Project	$9,341
		Subtotal	**$259,341**

Home Visiting

County	Page*	Organization	Award**
Monterey	7	First 5 Monterey County	$500,000
	10	Harmony At Home	$250,000
		Subtotal	**$750,000**

Partners for Healthy Food Access

County	Page*	Organization	Award**
Santa Cruz	14	Second Harvest Food Bank Santa Cruz County	$200,000
		Subtotal	**$200,000**

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

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Central Coast VNA & Hospice, Inc.**
County: **Monterey**
Grant Award History: Yes

Healthcare Technology Program

Project Name: VitalCare System
Proposed Start/End Dates: 7/1/23 – 6/30/24 (12 months)
Total Project Budget: $54,770
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: According to a report published in Health Affairs in April 2022, the total supply of RN's decreased by more than 100,000 from 2020 to 2021 – the largest drop ever observed over the last four decades. California specifically shows shortages in every country and metropolitan district over the next fifteen years. VitalCare allows CCVNA to fill in the gaps, reduce the need for in-person patient visits, and continue providing services in face of a RN shortage.

Proposal Summary: Central Coast VNA & Hospice (CCVNA) is requesting funds for the implementation of the VitalCare virtual care system. This technology will provide patients and staff with a proactive health, safety, and engagement platform. By engaging patients in their plan of care, CCVNA will improve patient and family compliance, reduce hospital admissions and re-admissions, and provide a continuous care experience for the patients and our staff. VitalCare would allow CCVNA to evolve from a visit-only care model to a more continuous care model. Patient vitals, health information and patient reported data can be shared daily, enabling constant engagement between patients, their families and the care team. While the number of members is relatively low compared to other recommended approved Healthcare Technology awards in this round, the potential cost savings from the intervention are significant with this medically complex patient population.

Number to be Served by Project: 120
Medi-Cal Percentage Served by Project: 60%

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Doctors on Duty Medical Group, Inc.**
County: **Monterey**
Grant Award History: Yes

Healthcare Technology Program

Project Name: Patient Registration System
Proposed Start/End Dates: 07/01/2023 – 12/31/2023 (6 months)
Total Project Budget: $146,253
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: Doctors on Duty is currently facing staffing shortages that impact patient experiences. An increase in staffing costs competitive wages offered by other employers, makes it difficult to retain staff. Self-registration kiosks can help Doctors on Duty improve efficiency by reducing the workload of administrative staff and improve workflows for patient care.

Proposal Summary: Doctors on Duty requests grant funding to implement patient self-registration kiosks at all Doctors on Duty locations. Patient self-registration kiosks can increase Doctors on Duty's capacity to serve Alliance members by streamlining the check in process, increasing the overall efficiency of the organization, dedicating more staff time for patient care, improving data accuracy, and reducing costs. Kiosks will reduce wait times, increase the number of patients that can be seen in a day, and help Doctors on Duty improve efficiency by reducing the workload of administrative staff. Self-registration kiosks will also help reduce errors in patient data entry by allowing patients to enter their own information directly into the system and improve security of patient data. The system will be integrated with Doctors on Duty's EMR and linked to their online scheduling platform for seamless patient check in.

Number to be Served by Project: 72,277
Medi-Cal Percentage Served by Project: 26%

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Second Harvest Food Bank Santa Cruz County**
County: **Santa Cruz**
Grant Award History: Yes

Partners for Healthy Food Access Program

Project Name: Families Cooking For Health
Project Partners: Salud Para La Gente
South County Triage Group
Proposed Start/End Dates: 10/1/2023 - 9/30/2025 (24 months)
Total Project Budget: $293,085
Request Amount: **$200,000**
***Recommended Award:** **$200,000**

Proposal Summary: Second Harvest Food Bank (SHFB) seeks funding for Families Cooking for Health, a project in conjunction with Salud Para La Gente (SPLG) and South County Triage Group (SCTG), a collective of non-profits, public institutions and individuals serving the needs of families in South County, which will identify food insecure families with youth aged 14-17 who are pre-diabetic and have high cholesterol and to lower their BMI and cholesterol figures through diet and nutrition. Clinicians at SPLG will conduct food insecurity screenings for all patients seeking medical care using the Hunger Vital Sign™. Those who screen positive will be enrolled in a cohort and work with the SHFB nutrition education team in their new teaching kitchen in Watsonville. Each cohort will attend these nutrition education and cooking classes for a total of 12 sessions for six months total and receive a medically tailored food box at each session with key ingredients used in the cooking class. There will be four cohorts during the project period. When needed, SHFB will provide transportation to these sessions. After each cohort, SPLG will collect food insecurity screening and clinical measures such as blood pressure, BMI, and cholesterol on all participants, who will have approved the release of their medical baseline information and monitoring throughout the six-month program period. SHFB will conduct pre- and post-surveys to measure confidence in culinary skills and cooking with produce. SHFB received a Partners for Healthy Food Access grant award in October 2018 and encountered the need for programmatic changes due to the COVID-19 pandemic.

Objectives:
1. Increase food security for families with youth aged 14-17 living in the Pajaro Valley through the distribution of medically tailored food boxes.
2. Lower the BMI, cholesterol, and/or blood pressure of participants aged 14-17.
3. Provide nutrition education, cooking classes and connection to support services for project participants to increase knowledge and skills to maintain long-term health outcomes and food security.

Impact:
- Families Cooking for Health is estimated to serve 160 individuals during the project period, 100% of whom are Medi-Cal members living in Pajaro Valley. Most participants will be Latinx.

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **George L. Mee Memorial Hospital**
County: **Monterey**
Grant Award History: Yes

Healthcare Technology Program

Project Name: i2i Population Health
Proposed Start/End Dates: 8/01/2023 – 1/31/2024 (6 months)
Total Project Budget: $129,850
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: Mee Memorial seeks funding for technology that will support extended outreach to patients in need of services within an accurate timeframe. Additionally, the software funded by the grant will allow Mee Memorial staff to view timely reports and data to identify areas to improve patient outcomes.

Proposal Summary: George L. Mee Memorial seeks funding for a i2i, a community-based population health software program that will interface with Cerner EMR to pull quality focused patient data, improve outreach and communication with patients, and set meaningful benchmarks and quality improvement and operational goals. Configuration of the software with Mee Memorial's existing EMR will be provided by Cerner, including a ten-week implementation period which will include staff training on how to build registries and reports. I2i allows clinics to create registries and score cards by cohort and improve management of at-risk patients. reducing costs and improving the health status of the South Monterey County community.

The i2i software is a community-based population health management system that will allow Mee to improve access to care by providing reports capable of formulating a clearer picture of patient needs and coordinate care appropriately. It will allow for better-quality and more efficient workflows including actionable quality and care gap reports, improved referral tracking and enable two-way patient engagement and communication.

Number to be Served by Project: 40,000
Medi-Cal Percentage Served by Project: 60%

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Golden Valley Health Centers**
County: **Merced**
Grant Award History: Yes

Healthcare Technology Program

Project Name: Epic Welcome & Tonic Health
Proposed Start/End Dates: 7/01/2023 – 6/30/2024 (12 months)
Total Project Budget: $223,300
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: Golden Valley Health Centers (GVHC) is seeking to achieve greater equity in access, patient experience and satisfaction, and data representation to more effectively shape service delivery to address patient needs. The introduction of new programming, modalities, and access routes can often have the unintended effect of further marginalizing some patient populations who face the most significant barriers to care. As GVHC has striven, in recent years, to increase access via virtual modalities for care delivery and patient engagement, increases in access are most pronounced among relatively small subsets of the patient population including those who are young, white, English-speaking, more educated, higher-income, or various combinations of these demographics. The proposed project will seek to increase equity, specifically among patients best served in a language other than English, in access to in-person and virtual modalities; patients' ability to report on satisfaction and experiences; and accurate representation in population health measures.

Proposal Summary: GVHC is requesting $50,000 of funding support the purchase, management, and implementation of tablets to aid in the integration of the Epic Welcome and Tonic Health platforms designed to streamline intake, screening, consents, surveys, and other processes for both in-person and virtual encounters. Patients will use in-office iPads for initial and ongoing Epic Welcome registration, access, and to provide general and targeted feedback. By providing surveys and questionnaires in patients' preferred languages, the organization will ensure that the ability to provide feedback and shape ongoing experiences is not limited by language proficiency.

Number to be Served by Project: 65,000
Medi-Cal Percentage Served by Project: 76%

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Teen Kitchen Project**
County: **Santa Cruz**
Grant Award History: Yes

Healthcare Technology Program

Project Name: Client Connection
Proposed Start/End Dates: 7/01/2023 – 6/30/24 (12 months)
Total Project Budget: $18,131
Request Amount: **$9,341**
***Recommended Award:** **$9,341**

Problem/Needs Statement: The project addresses the need to provide medically fragile, low-income people in Santa Cruz County with home delivered meals, which have been proven to improve health outcomes. Eighty-four percent of TKP's meal recipients are low-income. Studies show people living in poverty are especially vulnerable to poor nutrition and obesity due to risk factors such as lack of access to healthy and affordable foods and high levels of stress, anxiety, and depression. (Food Research Action Center, December 2017).

Proposal Summary: Teen Kitchen Project requests funding to purchase telecommunications equipment for staff and to create a HIPPA compliant patient portal within the Teen Kitchen Project website. The patient portal would allow clients to access meal menus, consult with a Registered Dietitian via a password protected client site, watch informative meal preparation videos, and learn more about the teens who prepare the meals. The project will increase Teen Kitchen Project's capacity to educate clients on preparing healthy meals at home, increase clients' access to a Registered Dietitian, and improve client experience through updated communications infrastructure.

Number to be Served by Project: 800
Medi-Cal Percentage Served by Project: 75%

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **First 5 Monterey County**
County: **Monterey**
Grant Award History: No awards to date

Home Visiting Program

Project Name: Parents as Teachers (PAT) Collaborative
Proposed Start/End Dates: 07/01/23 - 06/31/25 (24 months)
Total Project Budget: $2,397,136.00
Request Amount: **$500,000**
***Recommended Award:** **$500,000**

Proposal Summary: First 5 Monterey County (F5MC) proposes to be the lead agency to support the Parents as Teachers (PAT) home visiting Collaborative (PAT Collaborative) in Monterey County. F5MC will be working with existing partners Door To Hope, GoKids and North Monterey County Unified School District to offer PAT services to Medi-Cal member families. All three organizations implementing PAT are well known for their commitment to quality services for children that have been underserved in our community.

F5MC, on behalf of the PAT Collaborative, is requesting $500K for the 2-year period to support three providers in the PAT Collaborative to implement home visiting services in Monterey County. F5MC will not be taking any administrative fees from the grant award to support this work. By funding this request, the Home Visiting grant will be providing support for direct service provision by the three PAT providers and countywide coordination.

F5MC supported the capacity of partners to become full-fledged affiliates with the PAT National Office, which is required in order to be considered an evidence-based program. Under this partnership, Prop 10 dollars are braided together with CalWORKS and California Department of Social Services funding to support families who are part of the CalWORKs program with wrap-around services. F5MC serves as the "supervising provider" for the County's CalWORKs Home Visiting Program and has subcontracts with the PAT Collaborative partners who provide high-quality direct home visiting services to families and children. The Alliance grant will be helping to fill a gap left by declining F5MC funding.

Through the PAT, F5MC seeks to eliminate health disparities, achieve optimal health outcomes for children, and improve the system of care for members with complex social needs. With an emphasis on children under 5 years of age, it seeks to focus on the early childhood period when 90% of the brain develops and when the chances for prevention are highest. It does so by implementing a culturally responsive evidence-based approach that leverages other services and supports to provide holistic care and support for the children and their families. The PAT model aims to: (1) increase parent knowledge of early childhood development and improve parenting practices, (2) provide early detection of developmental delays and health issues, (3) prevent child abuse and neglect, and (4)

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increase children's school readiness and school success. The PAT Collaborative has high performance in providing developmental and depression screening to families. In Fiscal Year 21/22, 91.8% of children between 0 and 36 months received at least one developmental screening using an evidenced based tool in the fiscal year (calculated to compare to HEDIS developmental screening metric) and 58% of eligible parents were screened for depression within 90 days of enrollment or birth of child (comparable to HEDIS depression screening metric).

PAT offers bi-monthly in-home visits for a minimum of two years (available also virtually and/or outside of the home in settings in which parents prefer and feel most comfortable). Parent educators support families by screening children for developmental delays, and parents and/or children for mental health challenges, such as postpartum depression and trauma. The PAT Collaborative encourages reflective, healing and trauma-informed practices that model calm, responsive, and emotionally safe behaviors.

Potential participants are identified via various means including:

- Community partners and health care or other health service providers (including public libraries, health care clinics, Monterey County Behavioral Health, school districts, school sites, early learning programs, and partners who are in relationship with Alliance member, etc.) identify families in need of service through interaction with them in other services they are providing; and/or
- Walk-ins and self-referrals often receive a developmental screening that can be helpful in determining prioritizing selection for referral to PAT.

The PAT Collaborative prioritizes bi-directional relationship building among partners and health care providers to increase referrals and access to health services. The PAT Collaborative has strong and existing relationships with health providers, and F5MC is ready to facilitate increased connections with Medi-Cal providers in the County. Collaborative partners make and receive referrals and connect those families that are not already connected to a medical home.

The PAT Collaborative plans to blend and braid funds, including the Alliance's Home Visiting grant, to support a holistic program that includes: supervisors, home visitors, personnel benefits and taxes, reflective practice for the staff, material goods for the families, technology, training costs, certification and affiliate fees, travel and mileage, data entry, facilities/utilities, and indirect costs. In addition, support from First 5 Monterey County will cover cross-county collaborative coordination, data review/analysis, and sustainability research/exploration. First 5 Monterey County will subcontract with the PAT Collaborative Partners. F5MC will also be leveraging grant dollars from First 5 California (F5CA) to support exploration of how to sustain PAT home visiting services through Medi-Cal dollars after the completion of the 2-year grant.

Number to be Served by Project Annually: 100 Medi-Cal families (in addition to current CalWorks funded program).

Outcomes: F5MC has established a Clinical Quality Improvement infrastructure and evaluation framework to support the PAT programs in meeting the health outcome needs of those that are most

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vulnerable, while also maintaining programmatic fidelity. F5MC would like to explore with the Alliance how PAT screenings can be integrated with the Medi-Cal delivery system. Outcomes include:

1. By the end of Y1Q1 of the program, establish a process with partners to meet the following metric: 40% of newly enrolled children in the fiscal year are enrolled prenatally (FY 21/22 baseline: 5%).
2. By the end of Y1Q1, establish a continuous quality improvement process for connecting children identified without a medical home to a Medi-Cal provider (target goal:90%).
3. By the end of Y1Q2, have a plan in place to work with Medi-Cal providers to access more timely and accurate data on well child visits attended by home visiting clients, with the goal of increasing the percent of home visiting clients attending the recommended well child visits.
4. By the end of Y1Q1, establish process for better tracking and reviewing connections made to early intervention resources for children with a concern indicated by a developmental screening. Establish goal to increase the percent of children with a concern indicated on a developmental screening who are connected to early intervention resources.
5. By end of Y1Q2, have a process for better tracking and reviewing connections made to mental health resources for parents with a concern indicated on a depression screening. Establish goal to increase the percent of parents with a concern indicated on a depression screening who are connected to early intervention resources.
6. By end of Y1Q2, have a plan in place for how to utilize the PAT model to support improvement of early childhood prevention performance (as measured through HEDIS).

PAT program-level SMART performance standards (measures of fidelity to program):

1. At least 60% of families enrolled receive at least 75% of the required number of visits in the program year. Required number of visits is determined by the number of family stressors. The number of family stressors is measured through a family intake process; frequency of visits is measured by administrative data on visits. PAT Collaborative services in Monterey County already meet this metric; the goal is to maintain this performance standard.
2. At least 60% of the children at age 4 months or older complete initial developmental screening within 90 days of enrollment in the program and at least yearly thereafter. This is measured through administrative data: partners enter developmental screening date (and results) in the data system. PAT Collaborative services in Monterey County already meet this metric. Goal is to maintain this performance standard.
3. At least 60% of families that receive at least one home visit are connected by their parent educator to at least one community resource in the program year. This is measured through administrative data. PAT services in Monterey County already meet this metric. Goal is to maintain this performance standard.
4. At least 60% of children receive a complete, initial health review within 90 days of enrollment or child's birth and yearly thereafter. This is measured through completion of health review documents as entered in the data system.
5. At least 60% of eligible families participate in an annual assessment of parenting skills and practices using the tool: PICCOLO.
6. At least 50% of parents receive a depression screening within 90 days of enrollment or birth of a child. This is measured through administrative data. PAT Collaborative services in Monterey County already meet this metric. Goal is to maintain this performance standard.

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Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Harmony at Home**
County: **Monterey**
Grant Award History: No awards to date

Home Visiting Program

Project Name: Family First
Proposed Start/End Dates: 07/01/23 - 06/31/25 (24 months)
Total Project Budget: $ 1,425,000
Request Amount: **$250,000**
***Recommended Award:** **$250,000**

Proposal Summary: Harmony at Home's mission is to end the cycles of violence and abuse by empowering children and young adults with the knowledge, skills, and confidence to lead healthy and productive lives. Harmony At Home's county-wide programming reaches 20,000 annually through comprehensive Social and Emotional Support Packages, employing caring and qualified counselors, mentors, and coaches address the trauma of Adverse Childhood Experiences while empowering the community with the knowledge, skills, and confidence to lead healthy and productive lives.

Harmony at Home is seeking funding for the Family First program which supports pregnant mothers and parenting mothers, fathers, and guardians aged 13-25 who have not graduated from high school or acquired their GED. Participants often have experienced chronic trauma and Adverse Childhood Experiences that impact their mental health. Harmony At Home's Family First program is an evolution of their Teen Success program that has been successfully implemented over the past ten years. The program grew significantly in 2020, and since that time has increased from one to seven Case Advocates, each serving up to 16 young moms and 17 children. The program has spread across Monterey County and currently serves 72 expectant mothers or mothers and their 70 children with 10 Members in the process of enrolling.

The Family First program uses the Parents as Teachers (PAT) home visiting model to increase parent knowledge, detect developmental delays and health issues, prevent child abuse, and increase self-sufficiency. The program supports young expectant mothers, mothers, fathers, and guardians ages 13-25 who have become parents before having the opportunity to finish school or acquire their GED. The support includes assigning a 1:1 home visiting Case Advocate, offering peer support groups and family bonding activities, and supplementing for the basic needs of infants (diapers, wipes, formula), as well as providing education and connection to resources.

With support from the Alliance's Home Visiting Program grant, the Family First program will sustain and expand their home visiting program to include implementation of the PAT home visiting model that incorporates evidence-based practices. The PAT model is very similar to their existing model while placing increased and more formalized emphasis on child development. In their assessment, the existing Family First program is 90% aligned with the PAT model. Grant funding will support the

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

alignment with the PAT model and expansion to additionally serve fathers while continuing to serve mothers and their infants and children up to age three. The project specifically addresses the Alliance's funding goals by linking pregnant mothers to timely prenatal and post-natal care as well as by increasing access to preventative health care services and community resources for children (prenatal through age 3) and their parents/caregivers. Additionally, Family First equips parents/caregivers with the coping skills, knowledge, resources, and support they need to promote healthy child development and enhance overall family well-being and family self-sufficiency.

Harmony At Home goes above and beyond other home visiting programs to also support the educational goals of our young parent Members. Family First partners with young families to earn a high school diploma and pursue secondary education or a certificate to break cycles of poverty and unlock a brighter future for the entire family. Tiered programs, depending on member's educational goals, include individual support meetings, family bonding activities, peer group support meetings, incentives (gift card, baby care supplies), and employment search support. Family First program support is available through high school graduation or GED completion and two years following graduation or the child reaches 3 years of age for Members interested in pursuing a postsecondary degree or certificate. Family First offers program support throughout the entire year and follows school schedules for peer group sessions. Currently, 87% of the young mothers and fathers served have graduated/or are on track to graduate high school compared to the national average of only 38% teen mothers nationwide. It is expected this percentage will remain at least at 85%.

Referrals to Family First are received through partner agencies, including schools, community-based organizations, Monterey County Behavioral Health, the County Office of Education, and the juvenile court system. The top three referral services are 1) school counselor or teacher; 2) social services and community-based agencies, and 3) doctor, nurse, or medical social worker. Often, young parents self-refer as they are researching resources for themselves on the internet. New referrals are assigned to Case Advocates by the Program Manager or Program Lead based on caseload capacity and region.

Family First incorporates the following components into their home visiting program.

- Ages & Stages Questionnaire (ASQ) developmental screenings at least annually and quarterly for children who may not be meeting the milestones and need monitoring, supporting parents in setting necessary appointments for health, hearing, and vision screenings for their children.
- Parenting Navigation to build new parent skills and promote child's development; setting parenting goals and conducting health, developmental, and wellness screenings for infants and children.
- Case Advocates conduct quarterly Wellness Checks to ensure children have a healthcare provider to address medical concerns and that they are receiving healthcare services as needed. The Wellness Checks inquire about the last doctor/wellness visit for the child and if the child is up to date with immunizations. Case Advocates assist members to explore transportation options to doctor's appointments and provide bus passes as needed.
- Resource navigation based on a self-sufficiency screening by members with Case Advocates at least twice per year. Resource needs are assessed in the domains of healthcare coverage, food stability, income, housing, mental health, childcare, family/social relationships, transportation, education, and employment. The Resource Guide was developed in collaboration with the

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Monterey County Health Department and community partners to support system navigation. Referrals are entered in each member's profile along with details of enrollment into services. If an agency being referred to is part of United Way's Smart Referral Network, the system can be utilized to further track referrals. Case Advocates identify additional needs during regular individual home visits and check-ins therefore make referrals as needed instead of waiting for the next self-sufficiency screening.

Harmony at Home collaborates with Monterey County Health Department and other agencies that support Mother, Child, Adolescent, and Family services to bridge the gap between needs and services including WIC, Planned Parenthood, The Parenting Connection, First 5 Monterey County, CalWorks, etc. For mental health services, members are generally referred to Harmony At Home's Sticks & Stones program for individual or family counseling services or another appropriate mental health service. The Sticks & Stones® school-based counseling program targets children and youth who have experienced trauma which is negatively impacting their overall functioning. The program uses evidence-based cognitive behavioral strategies to best address the trauma they may be holding, which if not addressed, can not only negatively impact learning opportunities, but also social and emotional functioning. Participants are also referred to Harmony at Home's Children 1st classes for parents experiencing conflict in the home. For reproductive health, Harmony at Home works closely with Planned Parenthood.

To date, Family First has been fully supported by foundation grants and donations so participants do not have any cost barriers to participating. Harmony at Home has developed a plan to secure and sustain the additional annual costs, inclusive of the funding opportunity with the Alliance. Grant funds will be used for:

- Personnel expenses for individuals with direct responsibilities for the home visiting program.
- Personnel expenses for individuals with support role responsibilities for the home visiting program—such as human resources and operations.
- Employee costs such as background checks, health insurance, and worker's comp insurance, mileage reimbursement.
- Occupancy costs such as rent, telephone, and internet.
- Staff training and development. (Additional training may be required from utilizing the Parents As Teachers model, and our Program Manager will oversee our compliance.)
- Programmatic costs (materials, supplies, participant incentives, participant transportation, etc.).

Number to be Served by Project Annually: 95-110 Medi-Cal member families.

Outcomes:

1. By June 30, 2025, Harmony At Home's Family First program will increase parent knowledge of early childhood development and improve parenting practices for expecting parents or parents ages 13-25 with expected 85% of participants reporting that the program has helped them improve their parenting skills. This will occur through monthly or bi-monthly home visiting sessions with an assigned Case Advocate and monthly peer group sessions and measured by attendance data and survey results.

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2. By June 30, 2025, Harmony At Home's Family First program will provide early detection of developmental delays and health issues by conducting the ASQ at least quarterly with infants and children up to age 3 during home visiting sessions and by completing the Wellness Check tool to ensure they attend their routine prenatal and pediatric visits for health, vision, and hearing checks.. The outcome will be measured by tracking data points (e.g. milestones and appointments) by Case Advocate within their custom Family First database.
3. By June 30, 2025, Harmony At Home's Family First program will prevent child abuse and neglect within families with young parents ages 13-25 and their children up to age 3. This will be measured by surveying parents or caregivers to assess their knowledge of child development and parenting strategies to help determine if they are more equipped to handle stressors and prevent abusive or neglectful behaviors, and using the Self-Sufficiency Scale to identify any family needs that might place them in crisis. It is expected that 85% of participants will report improvement in building healthy relationships and remain above "crisis" in all domains throughout each program year.
4. By June 30, 2025, Harmony At Home's Family First program will increase parent and family self-sufficiency, including educational success, for members ages 13-25 who are expecting parents or parents with children up to age three. This will occur through monthly or bi-monthly home visiting sessions with an assigned Case Advocate and monthly peer group sessions and measured using the self-sufficiency screenings. Referrals and progression along the Self-Sufficiency Scale are tracked by Case Advocates in the Family First database.

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Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Second Harvest Food Bank Santa Cruz County**
County: **Santa Cruz**
Grant Award History: Yes

Partners for Healthy Food Access Program

Project Name: Families Cooking For Health
Project Partners: Salud Para La Gente
South County Triage Group
Proposed Start/End Dates: 10/1/2023 - 9/30/2025 (24 months)
Total Project Budget: $293,085
Request Amount: **$200,000**
***Recommended Award:** **$200,000**

Proposal Summary: Second Harvest Food Bank (SHFB) seeks funding for Families Cooking for Health, a project in conjunction with Salud Para La Gente (SPLG) and South County Triage Group (SCTG), a collective of non-profits, public institutions and individuals serving the needs of families in South County, which will identify food insecure families with youth aged 14-17 who are pre-diabetic and have high cholesterol and to lower their BMI and cholesterol figures through diet and nutrition. Clinicians at SPLG will conduct food insecurity screenings for all patients seeking medical care using the Hunger Vital Sign™. Those who screen positive will be enrolled in a cohort and work with the SHFB nutrition education team in their new teaching kitchen in Watsonville. Each cohort will attend these nutrition education and cooking classes for a total of 12 sessions for six months total and receive a medically tailored food box at each session with key ingredients used in the cooking class. There will be four cohorts during the project period. When needed, SHFB will provide transportation to these sessions. After each cohort, SPLG will collect food insecurity screening and clinical measures such as blood pressure, BMI, and cholesterol on all participants, who will have approved the release of their medical baseline information and monitoring throughout the six-month program period. SHFB will conduct pre- and post-surveys to measure confidence in culinary skills and cooking with produce. SHFB received a Partners for Healthy Food Access grant award in October 2018 and encountered the need for programmatic changes due to the COVID-19 pandemic.

Objectives:

1. Increase food security for families with youth aged 14-17 living in the Pajaro Valley through the distribution of medically tailored food boxes.
2. Lower the BMI, cholesterol, and/or blood pressure of participants aged 14-17.
3. Provide nutrition education, cooking classes and connection to support services for project participants to increase knowledge and skills to maintain long-term health outcomes and food security.

Impact:

- Families Cooking for Health is estimated to serve 160 individuals during the project period, 100% of whom are Medi-Cal members living in Pajaro Valley. Most participants will be Latinx.

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

Medi-Cal Capacity Grant Program

CURRENT FUNDING OPPORTUNITIES

PURPOSE

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

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

FUNDING PRIORITIES

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

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

CURRENT FUNDING OPPORTUNITIES

Focus Area: *Access to Care*

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

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

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

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

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

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

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

Focus Area: *Healthy Beginnings*

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

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

Focus Area: *Healthy Communities*

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

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

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

APPLICATION PROCESS

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

FOR MORE INFORMATION

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

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

DATE: June 28, 2023

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

FROM: Jessica Finney, Grants Director

SUBJECT: Medi-Cal Capacity Grants: Funding Recommendations (Group B)

Recommendation. Staff recommend the Board approve grant recommendations that total $1,244,632 for Group B of funding recommendations under Consent Agenda Item 9E, voted upon separately due to potential conflicts of interest.

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

Discussion.

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

County	Group A | Not Board Affiliated	Group B | Board Affiliated
Merced	$50,000	$250,000
Monterey	$950,000	$495,255
Santa Cruz	$209, 341	$499,377
Total	$1,209,341	$1,244,632
Total Grant Award Recommendation: $2,453,973		

Fiscal Impact. Recommended grant awards totaling $2,453,973 would be funded by the MCGP budget which was established in December 2014 when the Alliance Board approved allocation of a portion of the Plan's reserves to create the MCGP.

Attachments.

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

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

Healthcare Technology

County	Page*	Organization	Award**
Monterey	1	Salinas Valley Medical Clinic	$50,000
		Subtotal	**$50,000**

Partners for Active Living

County	Page*	Organization	Award**
Merced	2	Boys and Girls Club of Merced County	$250,000
Monterey	3	Salinas Police Activities League	$245,255
Santa Cruz	4	Cradle to Career	$250,000
	5	Friends of Santa Cruz County Parks	$249,377
		Subtotal	**$994,632**

Partners for Healthy Food Access

County	Page*	Organization	Award**
Monterey	6	Monterey County Health Department- Public Health Bureau	$200,000
		Subtotal	**$200,000**

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

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Salinas Valley Medical Clinic**
County: **Monterey**
Grant Award History: Yes

Healthcare Technology Program

Project Name: Patient Check-In Kiosk Systems
Proposed Start/End Dates: 9/01/2023 – 12/31/23 (4 months)
Total Project Budget: $57.658
Request Amount: **$50,000**
***Recommended Award:** **$50,000**

Problem/Needs Statement: In some of Salinas Valley Medical Clinic's (SVMC) higher traffic clinics, particularly Salinas Valley Health-PrimeCare Salinas, patients endure significant wait times upon arriving at the clinic. In some cases, it can take up to 10 minutes to simply check-in for a scheduled appointment due to high patient volume and staffing constraints. Additionally, SVMC will soon welcome three additional physicians to the practice who will require significant operational support. The self-check-in kiosks allow for a reallocation of staff who will now be available to serve the needs of the providers, resulting in improved patient access and experience.

Proposal Summary: SVMC is requesting funding for Patient Check-In Kiosk Systems. The kiosks will be accessible for individuals with disabilities, including those who use wheelchairs and will be available in multiple languages to accommodate the diverse language needs of patients. Each system will consist of three technology components: the free-standing Austin Landscape Kiosk, a personal computer (PC), and a credit card machine. Kiosks will be in the reception area where patients can access the large free-standing touchscreen to facilitate the check-in process. These kiosks will be equipped to collect a patient's copay, accept copies of photo IDs & insurance cards, and successfully check-in a patient for their scheduled appointment.

Leveraging technology to handle the check-in process allows clinic staff members to focus on a myriad of other operational tasks that the clinic requires. There will be greater availability for patients who need face to face assistance, more staff to answer phones, and greater support for providers who rely on staff to manage patient flow. In addition to operational efficiencies, SVMC hopes to improve the patient experience with decreased wait times during the check-in process.

Number to be Served by Project: 106, 893
Medi-Cal Percentage Served by Project: 23%

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Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Boys and Girls Club of Merced County**
County: **Merced**
Grant Award History: No awards to date

Partners for Active Living Program

Project Name: Be Great Program
Project Partners: Dole Foods Sunshine for All
Dignity Health
Proposed Start/End Dates: 7/01/2023 – 6/30/25 (24 months)
Total Project Budget: $299,700
Request Amount: **$250,000**
***Recommended Award:** **$250,000**

Proposal Summary: The Be Great Program will incorporate Boys and Girls Club of America's Triple Play Curriculum, which is a suite of three targeted programs that work together to promote healthy lifestyles and increase daily physical activity. The programs are designed to build the skills, attitudes, knowledge, and behaviors essential to an overall healthy living. Grant funds will be used to cover program costs, a contract Nutritionist, part-time Youth Development Profession, and a full-time Athletics Coordinator, who will led the Be Great Program and deliver diverse games, cooperative activities, conditioning, and athletics program that will develop a young person's ability, confidence, and motivation.

Be Great will be implemented in Los Banos, Gustine/Santa Nella and Planada communities in the summer months and culminate with a competitive tournament between the sites. In addition to BGCA's program and athletics component, Be Great will include specialty programs such as martial arts, yoga, mindfulness, and an array of cultural dances facilitated by local vendors as way to introduce different opportunities to Club Members. To engage parents and families, BGCM proposes to host family nights on a quarterly basis where they can enjoy food and partake in fun physical activities. During these family events and tournaments, Medi-Cal provider(s) and community organizations will be invited to share their resources with our families to offer wrap-around services to families.

Objectives:
1. Club Members will receive 45-60 minutes of physical activity five days per week.
2. Seventy-five (75%) will understand the importance of daily physical activity.
3. Ten percent (10%) of parents will be engaged in quarterly family nights.

Impact:
- Individuals Served by Project Annually: 100
- Percentage of Medi-Cal Members To Be Served: 60%
- Geographic Area: Los Banos, Gustine/Santa Nella, Planada
- Population of Focus: Population of focus would comprise of 65% youth who are enrolled in Alliance and between the grades of TK-12.

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Salinas Police Activities League**
County: **Monterey**
Grant Award History: No awards to date

Partners for Active Living Program

Project Name: Community Health and Wellness Program
Project Partners: Government Agencies
CBOs
School Districts
Healthcare Providers
Proposed Start/End Dates: 7/01/2023 – 6/30/25 (24 months)
Total Project Budget: $245,255
Request Amount: **$245,255**
***Recommended Award:** **$245,255** *Contingent upon submission of collaborative partners implementation plan.*

Proposal Summary: The Salinas Police Activities League seeks funding to implement the Community Health and Wellness program, which includes a new health education program, multiple community health fairs, and expansion of current athletic programs. Funds will be used to hire 4 part-time program staff, their travel/mileage, and cover equipment and marketing fees. Through established partnerships with government agencies, local community-based organizations, school districts, healthcare providers, clinics, and local businesses, PAL will implement culturally responsive strategies to ensure that athletic opportunities are available and maintained in a way that is welcoming and accessible to youth. PAL will develop and implement health education and promotion initiatives that engage Medi-Cal members in forming healthy habits and behaviors and provide resources and access to healthcare to Medi-Cal members by coordinating Community Health Fairs with local healthcare providers.

Objectives:

1. By December 31, 2025, provide physical wellness education and activities to 2,000 participants by coordinating athletics leagues and day camps that incorporate wellness education at easily accessible locations in the County of Monterey.
2. The Health and Wellness program aims to offer health and wellness education to 3,000 participants by December 31, 2025. By offering at least 25 Healthy Eating and Lifestyle classes, 25 Chronic Disease Prevention classes, and 2 Wellness Fairs.

Impact:

- Individuals Served by Project Annually: 2,500
- Percentage of Medi-Cal Members to Be Served: 65%
- Geographic Area: Monterey County
- Population of Focus: Most Monterey County residents are Hispanic/Latino, comprising about 60% of the population. Of the total population, an estimated 128,954, or 30%, are foreign-born. Of this foreign-born population, 79% are of Hispanic or Latino origin, and 72% are not current U.S. citizens. Spanish is the most common language spoken at home (48% of the households in Monterey County).

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Cradle to Career**
County: **Santa Cruz**
Grant Award History: No awards to date

Partners for Active Living Program

Project Name: Active Family Time
Project Partners: Live Oak Elementary School District
Santa Cruz City Schools
San Lorenzo Valley School District
Soquel Union Elementary School District
Santa Cruz Community Health Centers
Proposed Start/End Dates: 7/01/2023 – 6/30/25 (24 months)
Total Project Budget: $318, 398
Request Amount: **$250,000**
***Recommended Award:** **$250,000**

Proposal Summary: Cradle to Career (C2C) proposes an expanded *Active Family Time Program* in partnership with Santa Cruz Community Health Centers the Live Oak Elementary School District, Santa Cruz City Schools. San Lorenzo Valley School District, and Soquel Union Elementary School District. *Active Family Time* currently provides a holistic, culturally responsive, multi-generational approach to improving health outcomes for low income, predominantly Latinx families of color by creating safe spaces for physical activity and empowering families to initiate these enrichment activities. Grants funds will be used to hire a Recreational Community Organizer who will work with C2C School Based Community Organizers, Promotores, Volunteer Parent Coordinators and youth leaders to systematize the *Active Family Time* program and support parent leaders in coordinating programs at their respective sites. C2C staff will connect with other community-based organizations who offer a variety of activities, such as dance, karate, gymnastics, swimming, to offer a diverse array of opportunities to families.

Objectives:

1. By June 2025, increase the number of unique low-income/Medi-Cal member individuals in Santa Cruz County who have access to and engage in culturally responsive physical activity and recreation opportunities by 50%, as measured by program data.
2. By June 2025, 90% of C2C parent leaders will report feeling confident in promoting healthy lifestyles among low-income/Medi-Cal member families of color in Santa Cruz County (as measured by parent leader meetings, focus groups and program data).

Impact:

- Individuals Served by Project Annually: 850
- Percentage of Medi-Cal Members to Be Served: 80%
- Geographic areas to be served include the unincorporated areas of Santa Cruz County including San Lorenzo Valley, Live Oak, and Soquel and the City of Santa Cruz.
- Population of Focus: The population of focus is low-income (Medi-Cal members and those eligible) Latinx, Black, Indigenous, Pacific Islander and other children/families of color.

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

Medi-Cal Capacity Grant Program
Recommendation Summary

Applicant: **Friends of Santa Cruz County Parks**
County: **Santa Cruz**
Grant Award History: No awards to date

Partners for Active Living Program

Project Name: ParkRx SCC
Project Partners: Salud Para La Gente
Santa Cruz Community Health Centers
Santa Cruz County Public Health Department
Proposed Start/End Dates: 7/01/2023 – 6/30/25 (24 months)
Total Project Budget: $593,102
Request Amount: **$249,377**
***Recommended Award:** **$249,377**

Proposal Summary: County Park Friends requests funding to expand the ParkRx Santa Cruz County program. ParkRx supports health systems and their patients by promoting equitable access to culturally relevant, nature-based activities designed to prevent illness. ParkRx currently serves multiple generations of underserved Pajaro Valley residents through activities that improve quality of life and health outcomes. To be eligible for ParkRx, a patient must be Medi-Cal eligible, have a need for outdoor physical activity based on underlying health concerns, and express interest in the program. County Park Friends' clinical partners have identified existing social determinants of health screening questions that are research-based and determine eligibility for a ParkRx. The current ParkRx partner, Salud Para La Gente, launched their active prescription and referrals via the UniteUs referral platform in November 2022. The additional partner, Santa Cruz Community Health Centers, allowing the program to serve an additional 250 patients per year. County Park Friends has been partnering with local medical, public health, and parks partners for over a year to develop and manage the ParkRx system of care and coordinate culturally responsive activities.

Objectives:

1. By June 30, 2025, Salud Para La Gente and Santa Cruz Community Health Centers will be actively prescribing ParkRx, increasing the number ParkRx prescriptions provided for physical activity outdoors for Medi-Cal patients by at least 50%.
2. By June 30, 2025, County Park Friends and parks partners will increase availability of park programs as ParkRx eligible and available for Medi-Cal patients by at least 50%.
3. By June 30, 2025, County Park Friends and partners will increase participation in Active Outdoor ParkRx programs by Medi-Cal patients by at least 50%.

Impact:

- Individuals Served by Project Annually: 250
- Percentage of Medi-Cal Members To Be Served: 100%
- Geographic Area: Pajaro Valley and Live Oak
- Population of Focus: ParkRX currently serves a 90% Latinx, 77% Spanish-speaking, and 45% farmworker population. Santa Cruz Community Health Centers currently serves: 47% Latinx, 31% Spanish-speaking, and 61% at Federal Poverty Level or higher.

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

Medi-Cal Capacity Grant Program
Recommendation Summary

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

Partners for Healthy Food Access Program

Project Name: Artichoke Pizza
Project Partners: Aggrigator
Everyone's Harvest
Proposed Start/End Dates: 9/01/2023 – 8/31/25 (24 months)
Total Project Budget: $200,000
Request Amount: **$200,000**
***Recommended Award:** **$200,000**

Proposal Summary: Monterey County Health Department Public Health Bureau (MCHD-PH) seeks funding for Artichoke Pizza, a project which aims to make nutritious food accessible to MCHD-PH's Medi-Cal members enrolled in Enhanced Care Management (ECM) through Everyone's Harvest farmers market vouchers, Aggrigator food delivery boxes, and educational resources to clients. ECM members living in South Monterey County (i.e., Greenfield, Soledad, King City) identified as food insecure with either diabetes or hypertension will receive bi-weekly food boxes designed by a nutritionist from Aggrigator delivered directly to their homes. MCHD-PH will conduct bi-weekly cooking classes for this subset of participants, and Public Health Nurses will accompany them grocery shopping to provide strategies for selecting healthy options. All participants will receive guidance for utilizing farmers market vouchers, and assistance with CalFresh and WIC enrollment and other available support services. Participants who attend cooking classes will conduct class evaluations to inform future program development. Experienced project partners, Everyone's Harvest and Aggrigator, provide culturally relevant services and resources and have bilingual staff in preferred languages.

Objectives:

1. Promote health equity for Medi-Cal members living enrolled in ECM who are food insecure and have diabetes or hypertension by increasing access to fresh, healthy foods.
2. Increase access and participant knowledge of clients to behavioral/nutrition education and/or healthy cooking.
3. Increase access for ECM members to community-based resources that support nutrition.

Impact:

- Artichoke Pizza is estimated to serve 486 individuals during the project period, 100% of whom are Medi-Cal members. A specific subset of the project participants will also have diabetes and/or hypertension and reside in South Monterey County.

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

DATE: June 28, 2023

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

FROM: Lisa Ba, Chief Financial Officer and Van Wong, Chief Operating Officer

SUBJECT: 2023 Dual Eligible Special Needs Plan Supplemental Budget

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Recommendation. Staff recommend the Board approve the following;

1. An additional $1.5M calendar year (CY) 2023 budget adjustment for Dual Eligible Special Needs Plan (D-SNP) readiness activities in preparation for a product launch on January 1, 2026.
2. The execution of a multi-year consulting contract with the Alliance's implementation partner of choice, including the budget for such an engagement.

Summary. The Department of Health Care Services (DHCS) is requiring that all non-Coordinated Care Initiative County Managed Care Plans, of which the Alliance is one, offer a D-SNP product by January 1, 2026. The Alliance initiated planning for the 2026 launch of a D-SNP, including a consultant-led financial feasibility assessment and a consultant-led operational gap assessment (OGA). This report follows the April Board presentation and outlines additional funding needed to continue our D-SNP implementation activities in 2023.

Background. DHCS is implementing policies to promote integrated care for beneficiaries dually eligible for Medicare and Medi-Cal as a component of the CalAIM initiative. These policies include enrolling all dually enrolled beneficiaries in Medi-Cal Managed Care Plans in 2023, aligning Medi-Cal plan enrollment with the beneficiary's choice of Medicare Advantage plan, and the Alliance, operating a D-SNP by January 1, 2026, as noted above.

As part of our planning, the Alliance conducted a financial feasibility study of a D-SNP program via Milliman and an operational gap assessment via Health Management Associates (HMA) to ensure readiness by January 2026. The OGA deliverables comprised an operational gap narrative, a multi-year implementation work plan, and a high-level staffing model, including staffing for the ramp-up period starting in 2023. HMA and staff presented summary findings to the Board in April with the intent for staff to return in June with a proposed D-SNP implementation budget to support a final implementation plan.

On December 7, 2022, the Board approved the 2023 budget with the understanding that there would be a supplemental budget request related to D-SNP once the OGA is completed.

On February 22, 2023, the Board approved a request for $840,000 in funding to hire an Executive Medicare Director and Medicare Program Manager and an additional budget for consulting and recruiting fees.

Discussion. Staff completed a thorough review of the OGA deliverables provided by HMA and have identified a need for additional staffing and consultative resources to support ongoing planning and implementation activities toward a successful product launch in 2026.

In addition, staff have identified a need to retain a consulting partner with specialized Medicare knowledge for a multi-year implementation engagement to assist with key areas of developmental work, including quality, risk adjustment, provider network strategies, and organizational design. The vendor will support the Alliance with implementing processes and systems not currently needed in the Medi-Cal environment, such as benefit design, sales and marketing, Star program management, and enrollment. The Alliance intends to execute the activities outlined in the multi-year work plan starting in Q3 2023 with a target completion of Q1 2026, in line with the D-SNP program launch date.

The Alliance is completing the last stage of a request for proposal to identify an experienced partner to assist with the multi-year work plan implementation. Staff will need to negotiate and execute the contract quickly upon finalizing the best-fit vendor, which is anticipated around July 2023. The Alliance's contract signature authority policy gives the Chief Executive Officer (CEO) the authority to sign all budgeted administrative contracts and contracts for unbudgeted expenditures up to $149,999.99. The total cost of the consultant agreement exceeds the CEO's contract signature authority.

The staffing and the multi-year consulting cost total $1.5M for July through December 2023.

Fiscal Impact. The $1.5M D-SNP supplemental budget per this report and the $840,000 approved in February make the total D-SNP budget for 2023 at $2.3M representing an increase of 2.4% of the approved 2023 administrative budget. Future funding for D-SNP will be incorporated into the Alliance's overall annual budget planning and approval process with the Board.

Attachments. N/A

DATE: June 28, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: County Expansion: Provider Payment Policy

Recommendation. Staff recommend the Board approve a provider payment policy for the Alliance's service area expansion to San Benito and Mariposa counties, including provider payment policies and payment rates consistent with those applied in the Alliance's existing provider contracts in its current three county service area.

Background. At its March 22, 2023 meeting, your Board received an update on activities to support the expansion of services to San Benito and Mariposa counties, including updates in the areas of Governance, Community and Member Engagement, Provider Outreach and Network Development, Fiscal Viability, Operational Readiness, and Conditions Necessary for Final Approval. Staff reported on potential challenges and impacts in each of these areas and reported on discussions with the Department of Health Care Services (DHCS) to resolve and/or mitigate issues, including fiscal viability and provider network development.

Staff provide the report below on activities and discussions resulting in a recommendation to your Board to adopt a provider payment policy in San Benito and Mariposa Counties that mirrors the policy in effect across the Alliance's current service area.

Discussion. DHCS' timeline for developing plan capitation rates for 2024 includes providing final rates to plans in Q4 2023. Staff's typical approach to recruitment and contracting for a new provider network would include the execution of provider contracts *after* receipt of final revenue rates from DHCS to ensure that provider rates for network development are in line with the revenue rate and utilization trends. However, DHCS' proposed timeline for this model change is not conducive to this approach. With final rates provided in Q4 2023, the Alliance would be challenged to demonstrate an adequate network for a DHCS readiness review in September. Following discussions with DHCS, the department confirmed a willingness to engage regarding the timing and adequacy of health plan revenue and the implications to the Alliance's network strategy.

Furthermore, staff have continued to engage with DHCS Capitated Rates Development Division (CRDD) leadership, staff, and contracted actuaries on concerns regarding the Alliance's need for a level of assurance from CRDD that the capitation rates provided will be sufficient to support the expansion of the Alliance's existing provider payment policy to the two expansion counties.

Circumstances in San Benito County, in particular, raise concerns regarding the financial performance that staff presented to DHCS. These concerns include the precarious fiscal viability of Hazel Hawkins Hospital, the sole hospital operating in San Benito County, which adds an element of both complexity and uncertainty to the Alliance's efforts in developing an adequate network that meets regulatory time and distance access standards. In addition, staff reviewed available rates and utilization data for both expansion counties and

identified concerns regarding utilization volume substantially lower than the Alliance's current experience. Lastly, San Benito County is currently the only county within the state of California to allow Medi-Cal beneficiaries to choose between joining a Medi-Cal managed care plan (currently Anthem) or remaining in fee-for-service Medi-Cal. This exception presents unique challenges with respect to financial forecasting.

Furthermore, an environmental scan of San Benito and Mariposa Counties identified gaps in available providers. In San Benito County, there are currently no Dermatology, Otolaryngology, or Physiatry providers, and in Mariposa County, gaps include Dermatology, Otolaryngology, Physiatry, HIV/AIDs/Infection Disease, Ophthalmology, Orthopedic Surgery, and OB/GYN providers. Non-emergency Medical Transportation providers are also lacking in both counties. These gaps result in the assumption that the volume of out-of-county services will increase.

Staff presented these factors to DHCS through a series of meetings, wherein concerns were voiced that the application of historical utilization and cost trends may not yield revenue that would be adequate with the potential change in utilization patterns, and which may increase member reliance on contracted providers within the Alliance's existing provider network.

DHCS was thoughtful in its consideration of the issues presented and acknowledged the potential underutilization attributable to San Benito's unique managed care model, as well as the impact of a possible closure of Hazel Hawkins Hospital and the Alliance's need to negotiate rates with the hospital to aid its long-term sustainability.

DHCS indicated its mutual interest in the Alliance's successful expansion of services to San Benito and Mariposa counties and demonstrated an understanding of the Board's concern regarding the expansion's financial viability, including considering unique factors present in San Benito County. To that end, DHCS has committed to considering these factors in the development of capitation rates for 2024 and has also agreed to apply a risk corridor in San Benito County to mitigate financial risk to the Alliance related to this expansion.

Staff have modeled potential outcomes using available data, applying existing provider payment policies, and assuming the application of a two-sided risk corridor, and expect a break-even performance in the two counties.

Conclusion. Staff have contemplated the above factors in considering the potential successful expansion of services to San Benito and Mariposa Counties and recommend that the Board approve the recommendation that staff execute contracts with providers to serve beneficiaries in San Benito and Mariposa Counties that include provider payment policies and rates of payment that are consistent with those applied in the Alliance's current provider contracts. Staff anticipate receiving final capitation revenue rates and contract language in October and will return to the Board in December with a recommendation regarding the execution of the contract with DHCS to enable the Alliance to begin services in San Benito and Mariposa Counties effective January 1, 2024.

Fiscal Impact. There is no financial impact on the 2023 financial performance. Staff modeled the potential outcomes using available data, existing provider payment policies, and risk corridor methodology. The expected 2024 financial performance is breakeven or better.

Attachments. N/A

DATE: June 28, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Provider Payment Strategy – Part 2: Value-Based Payment and Strategic Allocation to Value-Based Payment

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Recommendation. Staff recommend the Board approve strategically allocating the following amounts from the Reserve:

1. $46.1M in Value-based Payment (VBP) to promote the quality and efficiency of care; and
2. $5M to establish a Medi-Cal Capacity Grant Program (MCGP) for San Benito and Mariposa.

Summary. A Managed Care Plan is designed to manage costs and improve the quality of care. In the managed care environment, providers are typically paid through various payment models that incentivize efficiency and quality of care. This report describes the definition, benefits, and models of VBP and the Alliance's commitment to leverage our reserve to fund VBP and support our provider network.

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

On May 24, 2023, the Board accepted the audited financials for calendar year 2022, recognizing $83.9M in net income, resulting in a $51.1M operating reserve on December 31, 2022. In addition, staff presented the current state of the Alliance provider model. Overall, the Alliance's provider payment is above Medi-Cal and Medicare fee schedules and higher than that of our sister plans in nearby geographic areas. The current level of provider payments will negatively impact the Alliance's financial performance when the Department of Health Care Services (DHCS) implements the regional rates, where DHCS will compare the cost of services and efficiency across all managed care plans. In addition, the higher-than-Medicare payment level will make it challenging for the Alliance to break even under the Dual Eligible Special Needs Plan (D-SNP) line of business in 2026.

Discussion. As shared in the May Board presentation, staff have little room to increase the base fee-for-service (FFS) reimbursement model as the costs will not be recognized in the revenue rate-setting process. However, many opportunities exist to improve provider reimbursement through VBP models.

VBP is a broad set of performance-based payment strategies linking financial incentives to providers' quality and resource use. It creates adequate flexibility and calls for cost, access, utilization, and quality accountability. VBP promotes alignment across the delivery systems

to achieve quadruple aims: improving population health, reducing the cost of care, enhancing patient experience, and improving provider satisfaction. VBP is a departure from traditional fee-for-service payment models, where healthcare providers are paid based on the volume of services they provide, regardless of the outcomes.

VBP models can take several forms, such as bundled payments, shared savings programs, and pay-for-performance models. In a bundled payment model, providers are paid a single fee for an episode of care, which includes all the services needed to treat a specific condition. In a shared savings program, providers are rewarded for reducing costs while maintaining quality standards. In a pay-for-performance model, providers are paid based on the quality of the outcomes they achieve.

Both Medi-Cal and Medicare financing models recognize and encourage VBP. Of the Alliance's $1.4 billion medical cost budget, $1.3 billion or 95% is FFS. VBP accounts for only $70M, or 5.0% of the total provider payment. The Alliance includes incentive programs in the annual medical cost budget, and the Board approves them in December before the performance year. Based on the Alliance's financial results, the Board also supports the final funding at the end of the performance year. When the Alliance had financial losses in the past, the Board opted to reduce or eliminate incentive programs.

There is an opportunity to grow beyond the existing VBP and expand quality measures and performance-based provider contracts. VBP can align the provider's financial interests with the Alliance's strategic priorities to advance health equity and ensure a person-centered delivery system. To ensure the continuity of the existing incentive programs and expand VBP models, staff recommend allocating $46.1M of the operating reserve to guarantee the incentive payment even when the Alliance experiences financial losses. Staff also recommend allocating the remaining $5M operating reserve to establish a MCGP for San Benito and Mariposa Counties to expand the provider network and improve member access.

Fiscal Impact. There is no financial impact. The Alliance's fund balance remains the same. The internal reporting of the fund balance will include the reserve target, strategic allocation to future programs, and the MCGP.

Attachments. N/A

DATE: June 28, 2023

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

FROM: Cecil Newton, Chief Information Officer & Information Security Officer

SUBJECT: Alliance State of Technology, Data and Security Report

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

Summary. The Alliance State of Technology, Data and Security Report is provided as part of regular Board updates, including key updates about the Alliance's technology, security and data.

Background. The Alliance relies on cost-effective, uninterrupted, secure, smoothly operating technology systems.

Discussion.

Alliance Data Strategy. The Alliance has developed a Data Management Strategy. The Alliance Data Management Strategy outlines how data is to be created, acquired, stored, shared and managed as well as processed by the Alliance. It describes the existing data sharing regulatory environment. The Alliance's Data Management Strategy, specifically as it relates to data sharing, is that of a health information exchange (HIE) centric strategy. The intent is that data sharing to and from the Alliance be facilitated by use of HIE(s).

It includes recommendations to develop the required data management infrastructure, including data governance and associated policies. It also describes plans for the development of a provider data sharing incentive plan, which will enable providers and the Alliance to actively share data, satisfy the data sharing requirements of the CalAIM initiative as well as satisfy state and federal data sharing compliance requirements.

Security Improvements. The Alliance continues to improve its overall security posture to reduce the possibility of a successful attack. Significant progress has been made regarding the Alliance's ransomware readiness initiative.

The Information Technology Services (ITS) team conducted a security assessment led by Moss Adams, LLP in Q4 2022. The findings were delivered on December 19, 2022. The findings by priority included zero critical items, 41 high items, 37 medium items and 24 low items. All items are currently in the process of being remediated.

The ITS team conducted a penetration test with a leading security firm, Praetorian. Penetration testing is the practice of cyberattack simulation launched on computer systems in order to discover points of exploitation and test IT breach security.

The findings by priority included zero critical items, four high items, eight medium items and 13 low items. All items are currently in the process of being remediated.

In May 2023 the Alliance renewed its Cyber Security Insurance policy at a lower cost and with expanded coverage due to its improved security posture, as determined by the carrier.

Care Management System Replacement. The Alliance is completing the process of selecting a new Care Management system. The current system, Essette will be at end of life as of December 31, 2023. As a result, the Alliance engaged multiple technology vendors, conducted vendor demonstrations and has made a technology replacement recommendation. The Alliance is currently in contract negotiations with the recommended vendor.

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

Attachments. N/A

Information Items: (16A. – 16E.)

June 2023 Board Report

Total Online + Print Audience
52,121

Total Online + Print Publicity
USD $564

Total Number of Clips 4

Editorial; Hike in Medi-Cal payments long overdue

1

Powered by LexisNexis

Date Collected May 26, 2023 11:35 AM EDT
Category Print
Source Monterey County Herald (CA)
Author Santa Cruz Sentinel

Est. Audience 23,862
Est. Publicity Value USD $252
Market Monterey, CA
Language English

... .

Some potential recipients might be confused about Medi-Cal and Covered California. The latter is the state's health insurance marketplace where Californians can shop for health plans and access financial help if they qualify for it. Medi-Cal typically is the lower cost option,

(Locally, the **Central California Alliance for Health** is a managed care plan for people who have Medi-Cal. The Alliance works with the state to provide health care to people who live in Merced, Monterey and Santa Cruz counties.)

A lot of people are on Medi-Cal 15.2 million Californians. During the COVID pandemic, the program saw a 16 percent ...

As We See It; Hike in Medi-Cal payments is long overdue

2

Powered by LexisNexis

Date Collected May 26, 2023 1:44 PM EDT
Category Print
Source Santa Cruz Sentinel (California)

Market Santa Cruz, CA
Language English

... .

Some potential recipients might be confused about Medi-Cal and Covered California. The latter is the state's health insurance marketplace where Californians can shop for health plans and access financial help if they qualify for it. Medi-Cal typically is the lower-cost option,

(Locally, the **Central California Alliance for Health** is a managed care plan for people who have Medi-Cal. The alliance works with the state to provide health care to people who live in Merced, Monterey and Santa Cruz counties.)

A lot of people are on Medi-Cal 15.2 million Californians. During the COVID-19 pandemic, the program saw a 16% enrollment ...

Online News

Editorial | Raising reimbursement rates for Medi-Cal long overdue

3

Date Collected May 25, 2023 3:52 PM EDT
Category Digital News
Source Santa Cruz Sentinel

Est. Audience 28,259
Est. Publicity Value USD $312
Market Santa Cruz, CA
Language English

To those who have decent health insurance, Medi-Cal, which is the state's Medicaid program to provide low or no-cost health coverage to

Back to Agenda

Californians, might be something of a mystery.

That is, unless someone in their family or immediate circle needs to obtain Medi-Cal coverage or needs medical help and struggles to find a provider.

Some potential recipients might be confused about Medi-Cal and Covered California. The latter is the state's health insurance marketplace where Californians can shop for health plans and access financial help if they qualify for it. Medi-Cal typically is the ...

Online News

Local Plan Strategies for CalAIM Incentive Payment Program

4

Date Collected May 18, 2023 9:50 AM EDT
Language English
Category Local
Source California Health Care Foundation

Managed care plans are a key partner in the statewide CalAIM initiative. To support the implementation and expansion of CalAIM, the Department of Health Care Services (DHCS) developed the CalAIM Incentive Payment Program. DHCS anticipates participating managed care plans will use incentive funds to make strategic investments in Enhanced Care Management and Community Supports providers, local partners, and other providers. In 2022, the first year of the program, DHCS distributed $300 million in incentive funds to Medi-Cal managed care plans.

In an issue brief, Local Health Plans of California reviewed four local plans' strategies for disbursing incentive funds in their service areas. With information gathered through interview and survey responses from member plans, Local Plan Strategies for CalAIM Incentive Payment Program, examines how the plans are using incentive funds to enhance their internal systems and expand Enhanced Care Management and Community Support services to support Medi-Cal members with the most complex needs.

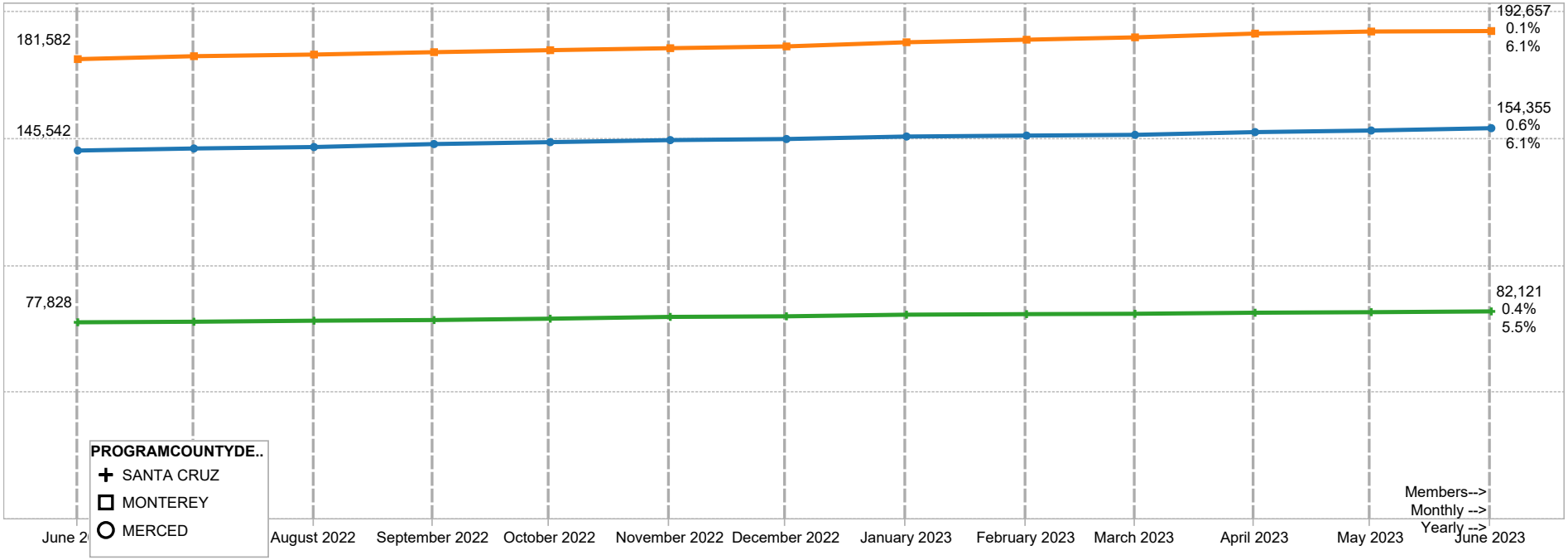
The four plans profiled are Inland Empire Health Plan, Kern Family Health Care, Partnership HealthPlan of California, and **Central California Alliance for Health**.

Enrollment Report

Year: *2022 & 2023* **County:** *MERCED, MONTEREY, SANTA CRUZ* **Program:** *AIM, IHSS, Medi-Cal*
Aid Cat Roll Up: *ACA Expansion, Adult & Family/OTLIC, BCCTP and 7 more* **Data Refresh Date:** *6/6/2023*

STATICDATE
6/1/2022 12:00:00 AM to 6/30/2023 11:59:59 PM

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



Program ..	PROGRAMC..	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023
Medi-Cal	SANTA CRUZ	77,828	78,049	78,456	78,714	79,248	79,958	80,185	80,827	81,046	81,185	81,606	81,815	82,121	
	MONTEREY	180,925	182,085	182,727	183,671	184,454	185,242	185,944	187,584	188,591	189,525	191,010	191,811	191,987	
	MERCED	145,542	146,357	146,926	148,100	148,852	149,656	150,085	151,067	151,440	151,727	152,807	153,437	154,355	
IHSS	MONTEREY	657	654	660	658	654	656	654	652	651	646	648	656	670	
Total Members		**404,952**	**407,145**	**408,769**	**411,143**	**413,208**	**415,512**	**416,868**	**420,130**	**421,728**	**423,083**	**426,071**	**427,719**	**429,133**	