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

Meeting Agenda

Wednesday, May 28, 2025

3:00 p.m. – 5:00 p.m.

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

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows. Note: Livestreaming for the public is listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 (323) 705-3950
    Phone Conference ID: 134 425 70#

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 Monday, May 26, 2025, to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to three minutes.
    b. In person, from an Alliance County office, during the meeting when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to three minutes.

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

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

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

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

Consent Agenda Items: (5. – 12D.): 3:15 p.m.

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

   Pages 5-1 to 5-5

6. **Accept Alliance Dashboard for Q1 2025.**
   - Reference materials: Staff report on above topic.

   Page 6-1

7. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the third month ending March 30, 2025.**
   - Reference materials: Financial Statements as above.

   Pages 7-1 to 7-10

8. **Authorize the Chairperson to sign the State Medicaid Agency Contract (SMAC) for Medicare Dual Eligible Special Needs Plan (D-SNP).**
   - Reference materials: Staff report and recommendations on above topic.

   Page 8-1

9. **Authorize the Chairperson to sign the agreement between the Alliance and the Monterey County In-Home Supportive Services Public Authority to provide Covered Services to eligible and enrolled In-Home Supportive Services providers for the period July 1, 2024 through June 30, 2025.**
   - Reference materials: Staff report and recommendation on above topic

   Page 9-1

10. **Accept 2025 Strategic Objectives Update.**
    - Reference materials: Staff report on above topic

    Pages 10-1 to 10-2

Minutes: (11A – 11E):

11A. **Approve Commission regular meeting minutes of April 23, 2025.**
   - Reference materials: Minutes as above.

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Pages 11A-1 to 11A-8

11B. Accept Compliance Committee meeting minutes of March 19, 2025.
- Reference materials: Minutes as above.

Pages 11B-1 to 11B-4

11C. Accept Quality Improvement Health Equity Committee meeting minutes for March 20, 2025.
- Reference materials: Minutes as above.

Pages 11C-1 to 11C-7

11D. Accept Whole Child Model Family Advisory meeting minutes of February 3, 2025.
- Reference materials: Minutes as above.

Pages 11D-1 to 11D-4

11E. Accept Member Services Advisory Group meeting minutes of March 13, 2025.
- Reference materials: Minutes as above

Pages 11E-1 to 11E-5

Reports: (12A. – 12D):

12A. Approve the Quality Improvement Health Equity Transformation Workplan for 2025.
- Reference materials: Staff report and recommendation on above topic; and 2025 Quality Improvement System Workplan

Pages 12A-1 to 12A-19

12B. Approve revisions to Alliance Policy 401-1101 Quality Improvement and Health Equity Transformation Program (QIHETP).
- Reference materials: Staff report and recommendations on above topic and Policy 401-1101 Quality Improvement and Health Equity Transformation Program.

Pages 12B-1 to 12B-99

12C. Approve revisions to Alliance Policy 401-1201 – Quality Improvement Health Equity Committee (QIHEC).
- Reference materials: Staff report and recommendations on above topic and Policy 401-12-1 – Quality Improvement Health Equity Committee.

Pages 12C-1 to 12C-11

12D. Accept report on Q4 2024 Quality Improvement Health Equity Transformation (QIHET) Workplan.
- Reference materials: Staff report on above topic and Q4 2024 Quality Improvement and Population Health Transformation Program Workplan.

Pages 12D-1 to 12D-28

Regular Agenda Items: (13. – 15.): 3:20 p.m. – 4:40 p.m.

13. Consider and accept audited financial statements and management letters for Alliance's fiscal year ending December 31, 2024 from Moss Adams LLP, independent auditors. (3:20 p.m. – 3:50 p.m.)

A. Moss Adams staff will present and Board will consider and accept audited financial statements and findings of independent auditors for FY 2024.
   - Reference materials: Audited Financial statements FY 2024.

Page 13-1 to 13-60

14.. Discuss May Revise and Federal Budget Proposals. (3:50 p.m. – 4:20 p.m.)

A. Mr. Michael Shrader, Chief Executive Officer, will update the board on the May Revise and Federal Budget proposal and board will discuss.

- Reference materials: Staff report and attachments

Pages 14-1 to 14-49

15. Consider and approve the Alliance's legal and regulatory Compliance Program Report for Q3-4 2024. (4:20 p.m. – 4:40 p.m.)

A. Ms. Jenifer Mandella, Chief Compliance Officer, will review and Board will consider and approve the Alliance's Compliance Program Report for Q3-4 2024.

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

Pages 15-1 to 15-13

Adjourn to Closed Session: (4:40 p.m. – 4:55 p.m.)

16. Conference with legal counsel – Pending litigation (Gov. Code section 54956.9(d)(1)): *Aggrigator, Inc. v. Central California Alliance for Health*; Monterey County Superior Court case number 25CV000738.

A. Closed Session agenda item.

B. Discussion item only; no action will be taken or reported by the Board.

Return to Open Session: (4:55 p.m. – 5:00 p.m.)

17. Report out on any action taken regarding conference with legal counsel.

Information Items: (18A. - 18D.)

A.	Alliance in the News	Page 18A-1 to 18A-4
B.	Membership Enrollment Report	Page 18B-1
C.	Member Appeals and Grievance Report	Page 18C-1
D.	Alliance Fact Sheet	Pages 18D-1 to 18D-2

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 25, 2025; 1:30-2:45 p.m.
- Member Services Advisory Group
  Thursday, August 14, 2025; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, September 4, 2025; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Thursday, June 26, 2025; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, August 4, 2025; 1:30 – 3:00 p.m.

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

The next regular meeting of the Commission, after this May 28, 2025 meeting, unless otherwise noticed:

Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
Wednesday, June 25, 2025; 3:00 – 5:00p.m.

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

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

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

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

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

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

Members of the public interested in attending should call the Alliance at (831) 430-2568 to verify meeting date and location prior to the meeting.

The complete agenda packet is available for review on the Alliance website at https://thealliance.health/about-the-alliance/public-meetings/. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-2568. 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	May 28, 2025
TO	Governing Commission of the Central California Alliance for Health
FROM	Michael Schrader, Chief Executive Officer
SUBJECT	CEO Report

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

Federal Budget. **The House Energy and Commerce Committee released its Mark-up including Medicaid provisions totaling $625B in reductions over ten years**. Notable provisions include those related to federal matching funds for states, funding mechanisms such as provider taxes and eligibility and enrollment provisions. Agenda Item 14 includes a summary of the bill. Staff, along with the Local Health Plans of California have continued advocacy efforts with our Congressional delegation to urge representatives to protect funding for the Medicaid program.

May Revise. **Governor Newsom unveiled the May Revise of California's State Budget, which includes proposed cuts to Medi-Cal for the upcoming fiscal year which begins July 1st**. Some of the more relevant proposals include an enrollment freeze, elimination of certain benefits, implementation of cost sharing and reduction in provider payments for services provided to individuals with unsatisfactory immigration status. Agenda Item 14 includes a more details summary of the May Revise.

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

Community Engagement. Outreach staff participated in multiple events, including services for migrant families, support programs for families with special needs, and initiatives for seniors.

- Staff provided health plan information at the Lisa Project event. The Lisa Project, in partnership with the Merced County Office of Education, is a powerful and immersive interactive exhibit that brings awareness to child abuse prevention. This exhibit offers a multi-sensory experience that provides insight into the realities of abuse, household dysfunction, and neglect, inspiring communities to act and protect children.

- The Alliance team also attended the Cultivating Indigenous Knowledge Conference in Monterey County. The conference, hosted by Centro Binacional para el Desarrollo

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Indígena Oaxaqueño (CBDIO), offered details on the indigenous Oaxacan community, challenges they face, and best practices for support.

- At the Donor Milk Drive Event at Dignity Health, staff gathered valuable feedback from Doulas and nurses. Lastly, we celebrated National Volunteer Week on the week of April 20th. Staff recognized the hard work of our Your Health Matters volunteers.

Marketing and Communications. The current bi-lingual media campaign running in Merced and Mariposa wraps up at the end of June. This campaign urges people to stay current on vaccines as they prevent 20+ diseases. The campaign includes radio ads and interviews, physical banners in local businesses, social media ads, connected TV ads, website content, and articles in member, provider and community publications. In July, we will run an awareness campaign through the end of the year. Staff are finalizing messaging and tactics, with updates coming next month.

Alliance Priority Initiatives.
Alliance Six Priority Initiatives. The Alliance team has been working on six major initiatives at once. This "two-year marathon" through 2024 and 2025 involves a heavy workload, competing priorities, regulatory submissions, and strict deadlines. Despite these challenges, the team is motivated by the chance to more fully and better serve our members.

We are proud to report that three of our six priority initiatives—ECM Enrollment, Quality & Health Equity in Merced, and Jiva Care Management System—have been successfully completed, marking significant progress toward our goals. Details about these completed initiatives follow below.

We have dedicated our full attention, ensuring steady progress continues to implement the three remaining impactful and larger-scale initiatives: Medicare D-SNP, NCQA Accreditation, Behavioral Health Insourcing. Details of these ongoing initiatives are also provided below.

ECM Enrollment, Quality & Health Equity in Merced County, and Jiva Care Management System. We are proud to have achieved what we originally set out to accomplish on three of our six priority initiatives: 1) We increased our ECM enrollment by a factor of six, such that approximately three percent of our Medi-Cal membership is now enrolled in ECM, such that our enrollment rate is now within the range expected by DHCS; 2) In collaboration with 15 clinics across Merced County, we improved quality scores, reflecting higher percentages of children receiving preventative care, including immunizations, lead screenings, and well-child visits; and 3) We successfully completed a major systems conversion to the Jiva Care Management System, enhancing our operational capabilities.

Medicare Dual Special Needs Plan (D-SNP). The Alliance is preparing to launch a Medicare Dual Special Needs Plan (D-SNP) by January 1, 2026. This new offering will enable the Alliance to serve as a single, comprehensive plan for individuals eligible for both Medi-Cal and Medicare, including low-income seniors and people with disabilities.

In May, we received the positive news that CMS has approved our Medicare D-SNP application and awarded the Alliance a perfect score of 100% on our Model of Care. Necessary for application approval, the Alliance team completed contracts with hundreds of providers, representing thousands of rendering practitioners, establishing a provider network that meets CMS requirements. The application encompassed the Model of Care, Pharmacy Benefits Manager, and provider network. The Alliance team submitted our application to CMS in February, with swift completion of all required follow-ups, ensuring a seamless process.

Launching this new line of business requires updates to existing information systems and the implementation of several new ones—a major effort engaging much of the Alliance workforce. Additionally, staff recently completed marketing personas to shape messaging, and the team is now developing marketing templates and writing website content. The Alliance is also onboarding a team to drive the execution of our sales strategy.

Behavioral Health Insourcing. The Alliance team has been diligently working to bring the behavioral health benefit in-house, effective July 1, 2025. Bringing behavioral health in-house will grant us direct control and a better opportunity to improve access for members, support providers, and collaborate with counties and schools. **Currently, the Alliance team is focused on network development, ensuring that we secure contracts with all the same providers in the Carelon network who have been serving our members to ensure continuity. As part of executed provider contracts, we have been credentialing rendering practitioners, including a batch of 293 in May.** The Alliance has also been hiring clinical staff in the areas of BH case management, BH therapy, and BH analysis. The insourcing effort includes a comprehensive communications plan, featuring a website landing page, member and provider bulletins, social media posts, flyers, text message campaigns, a press release, and an article in The Beat.

NCQA Accreditations. As part of CalAIM, DHCS requires that by January 1, 2026 all Medi-Cal managed care plans achieve two separate NCQA accreditations.

1. Health Equity Accreditation – Ensures plans address health disparities and promote equitable care.

2. Health Plan Accreditation – Evaluates plans based on quality, accountability, and transparency.

Consumers—including those comparing Medicare Advantage plans—reference NCQA's Star Ranking System. Achieving both accreditations strengthens the Alliance's ability to launch and sustain a successful Medicare Advantage D-SNP program.

For Health Equity Accreditation, in May, the external NCQA Surveyor held a closing conference with the Alliance team and confirmed that we achieved a perfect 100% score. The Alliance anticipates receiving formal notice of full accreditation from NCQA in the coming few weeks.

The Health Plan Accreditation survey is far more extensive and has been underway. It covers the lookback period from October 1, 2024, to March 31, 2025. NCQA has already reviewed and scored plan documentation. On May 19, the external surveyor began interviewing Alliance staff, including conducting live file review audits. Once the interviews conclude, we will receive our unofficial score, providing insight into our standing.

These surveys hold deep meaning for staff, representing the culmination of two years of work. During this time, the Alliance team has been committed to revamping operations to ensure full compliance with NCQA standards. This effort has required significant updates to policies, workflows, and systems, all designed to align with NCQA requirements. More importantly, we believe these enhancements will result in even better service for our Medi-Cal members.

Regulatory Audits and Compliance. The Alliance has structured processes to ensure that we operate in an ethical and compliant manner, so that we protect our members' rights. Like all Managed Care Plans, the Alliance is in a continuous state of preparing for routine audits, experiencing them, or following up on regulators' requests.

Active Audits. 2025 DHCS Medi-Cal Audit. DHCS auditors conducted the annual audit virtually in January of 2025. This was a limited scope audit covering UM, population health management, coordination of care, access and availability of care, member rights, quality management, and administrative and organizational capacity. **On May 13, 2025, we received our Preliminary Findings Report which indicated, in total, only two findings within the audited areas related to resolution of quality grievance, oversight of grievance and appeals**. Overall, we are pleased with these results while acknowledging there are opportunities to improve. We are working on our response to the DHCS' preliminary findings, due to the DHCS by the end of May 2025.

2025 DMHC Financial Examination. DMHC auditors initiated their virtual audit in January of 2025, reviewing the Alliance's fiscal and administrative affairs, including claims payment practices. In May 2025, the DMHC issued its preliminary findings, which include claims and provider dispute-related issues to which we have responded indicating our agreement or dispute. At a date to be determined, the DMHC will issue its official Preliminary Findings Report.

2025 DMHC Medical Survey. We received DMHC's preliminary report from its 2024 Medical Survey of the Alliance that occurred in March 2024. Agenda item 10, There were preliminary audit findings in the areas of Grievances, Utilization Management, Pharmacy, and Behavioral Health. As is standard process, we accepted certain findings as opportunities to improve and have clarified or contested others. We provided the DMHC with our response in May 2025.

Alliance Medi-Cal Capacity Grant Program (MCGP). The Alliance makes investments to strengthen health care and community organizations across the five counties we serve. The purpose is to pursue 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. They also address social drivers that influence health and wellness.

> Trends in the Number of Awards and Total Spend. The MCGP has paid out $11.9M year to date. New MCGP awards year-to-date total $8M, which is 23% of the 2025 total award amount target of $35M. Currently in the second of three funding rounds this year, the MCGP received 91 eligible applications by the May 6, 2025 deadline for a total requested amount of $14M across eight programs in the five-county service area. These applications are currently under review for award decisions on July 18, 2025. The application deadline for the third round is August 19, 2025 with award decisions on October 31, 2025. Details of all 2025 awards will be included in the mid-year report in the August 2025 Board packet and in the end-of-year report in the January 2026 Board packet.

Q1 2025 Organizational Dashboard. The Q1 2025 Organizational Dashboard provides a structured overview of the organization's performance for the first quarter of the year. It is included in this month's Board packet under Agenda Item 7.

The Dashboard monitors four core processes, each consisting of multiple subprocesses:

- **Engage & Support Members**
- **Manage & Improve Care**
- **Develop and Maintain the Provider Network**
- **Pay Providers** (which fell below the performance threshold this quarter)

The performance issue with **Pay Providers** stems from a significant increase in **Enhanced Care Management (ECM) encounter receipts**, leading to **high claims inventory**. Performance thresholds and targets are set by Alliance leadership based on contractual obligations and best practices.

Alliance Dashboard

Quarter 1, 2025

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

Context & Limitations: *Target* and *Threshold* levels are established by Alliance leadership and informed by contractual requirements and best practice standards (where available). This dashboard is produced using composites, meaning the performance of multiple sub-processes is combined for aggregate performance scores. All metrics are normalized to a 100 point scale to create the composites, so *Target* performance is always 100%.

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DATE: May 28, 2025

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Third Month Ending March 31, 2025

For the month ending March 31, 2025, the Alliance reported an Operating Loss of $9.6M. The Year-to-Date (YTD) Operating Income is $8.1M, with a Medical Loss Ratio (MLR) of 93.3% and an Administrative Loss Ratio (ALR) of 5.2%. The Net Income is $23.6M after accounting for Non-Operating Income/Expenses.

The budget expected an Operating Loss of $8.2M for YTD March. The actual result is favorable to budget by $16.3M or 100.0%, driven primarily by rate variances.

	Mar-25 MTD ($ In 000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*446,424*	*438,821*	*7,603*	*1.7%*
Revenue	$182,874	$173,831	$9,048	5.2%
Medical Expenses	182,684	174,909	(7,775)	-4.4%
Administrative Expenses	9,813	9,723	(90)	-0.9%
Operating Income	(9,622)	(10,801)	1,179	10.9%
Net Income	$(4,654)	$(8,702)	$4,048	46.5%
MLR %	99.9%	100.6%	0.7%	
ALR %	5.4%	5.6%	0.2%	
Operating Income %	-5.3%	-6.2%	1.0%	
Net Income %	-2.5%	-5.0%	2.5%	

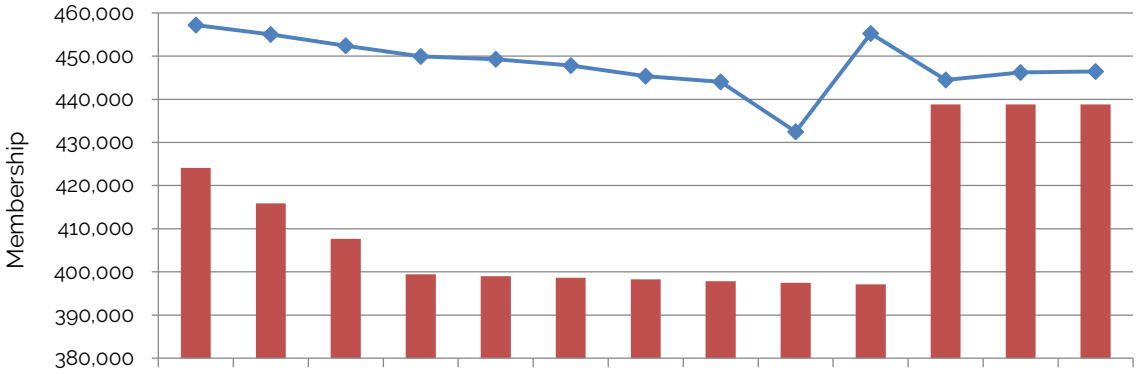
Mar-25 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*1,337,079*	*1,316,480*	*20,599*	*1.6%*
Revenue	$559,628	$521,493	$38,135	7.3%
Medical Expenses	522,412	501,297	(21,115)	-4.2%
Administrative Expenses	29,103	28,355	(748)	-2.6%
Operating Income/(Loss)	8,113	(8,159)	16,272	100.0%
Net Income/(Loss)	$23,602	$(1,235)	$24,837	100.0%
PMPM				
Revenue	$418.55	$396.13	$22.42	5.7%
Medical Expenses	390.71	380.79	(9.93)	-2.6%
Administrative Expenses	21.77	21.54	(0.23)	-1.1%
Operating Income/(Loss)	$6.07	$(6.20)	$12.27	100.0%
MLR %	93.3%	96.1%	- 2.8%	
ALR %	5.2%	5.4%	-0.2%	
Operating Income %	1.4%	-1.6%	3.0%	
Net Income %	4.2%	-0.2%	4.5%	

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

At a PMPM level, revenue is $418.55, which is favorable to budget by $22.42 or 5.7%. Medical cost PMPM is $390.71, which is unfavorable by $9.93 or 2.6%. This results in a favorable gross margin of $12.49 or 81.4% compared to the budget. The operating income PMPM is $6.07, compared to the budget of $(6.20).

Membership: March 2025 membership is favorable to the budget by 1.6%. The 2025 budget assumed a flat budget with 438k members per month for all of 2025. Please note that the State is leveraging the federal eligibility flexibilities, which remain in place through mid-year, to help minimize the impacts of the redetermination process, leading to slight enrollment increases in the first half and slight decreases in the second half.

Membership. Actual vs. Budget (based on actual enrollment trend for Mar-25 rolling 13 months)



	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Budget	424.11	415.88	407.64	399.41	399.02	398.63	398.24	397.85	397.46	397.07	438.83	438.82	438.82
Actual	457.19	455.00	452.43	449.95	449.31	447.80	445.35	444.05	432.46	455.25	444.44	446.21	446.42
Variance	33.078	39.117	44.782	50.546	50.288	49.172	47.114	46.207	35.007	58.183	5.609	7.386	7.603
Variance %	7.8%	9.4%	11.0%	12.7%	12.6%	12.3%	11.8%	11.6%	8.8%	14.7%	1.3%	1.7%	1.7%

Revenue: The 2025 revenue budget was based on the Department of Health Care Services (DHCS) 2025 draft rate package (dated 10/21/24), which reflected a –0.1% rate decrease, over the CY 24 Final Amended rates (dated 12/30/24), not including the Targeted Rate Increase (TRI) and Enhanced Care Management (ECM). Furthermore, the budget assumed breakeven performances for the San Benito Region and for our Unsatisfactory Immigrant Status (UIS) population. The CY 2025 Prospective rates from DHCS (dated 1/27/2025, including Maternity) represented a 5.0.% increase over CY 2024 Final Amended Rates, excluding TRI and ECM.

As of March, actuals exceeded the budget by $9.0M, representing a 5.2% positive variance. This is driven by favorable enrollment, contributing $2.9M, and rate variances totaling $6.2M, resulting from increases in the prospective rates compared to the budget. Additionally, a portion of the rate variance is offset by risk corridors, including the San Benito Risk Corridor resulting in a $1.4M payable and $3.5M downward prior-year revenue adjustment related to the CY 2023 Rate Adjustment which will be trued up in April through the liability accrual. Lastly, it has come to the Plan's attention that DHCS will continue the State portion of UIS Risk Corridor for CY 2025. As a result, a $2.4M payable was recognized in March related to this risk corridor and will be closely monitored and adjusted as necessary in the coming months.

As of March 2025 YTD, operating revenue stands at $554.7M, surpassing the budget by $34.5M or 6.6%. This favorable variance includes $7.4M from increased enrollment and $27.1M from positive rate variances.

Mar-25 YTD Capitation Revenue Summary (In $000s)

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	$416,046	$393,266	$22,781	8,373	14,407
CEC UIS	113,525	104,767	8,757	(632)	9,390
SBN SIS	20,611	17,223	3,388	475	2,913
SBN UIS	4,544	4,972	(428)	(799)	371
Total*	**$554,726**	**$520,227**	**$34,498**	**$7,417**	**$27,081**

*Excludes Mar-25 In-Home Supportive Services (IHSS) premiums revenue of $1.4M and Prior Year Revenue of $3.5M.

Medical Expenses: The 2025 budget assumed a 3.3% increase in utilization over the 2024 forecast, based on data from 2022 through September 2024, and a 4.2% increase in unit cost driven by changes in case mix and fee schedule adjustments. 2025 incentives include a $20M for the Hospital Quality Incentive Program (HQIP), $15M Care-Based Incentive (CBI), $12.5M for the Specialist Care Incentive (SCI), $4M Data Sharing Incentives, $3.7M Behavioral Health Value Based Program (BH VBP) and $1M Risk Adjustment Incentives.

March 2025 Medical Expenses of $182.7M are $7.8M or 4.4% unfavorable to budget. March 2025 YTD Medical Expenses of $522.4M are above budget by $21.1M or 4.2%. Of this amount, $7.8M is due to higher enrollment, and $13.3M is due to rate variances. The unfavorability is primarily driven by Other Medical, ECM, and Community Supports (CS).

Mar-25 YTD Medical Expense Summary ($ In 000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services - Hospital	$147,510	$142,576	$(4,933)	$(2,228)	$(2,706)
Inpatient Services - LTC	49,193	51,393	2,200	(791)	2,991
Physician Services	116,550	128,663	12,112	(2,023)	14,135
Outpatient Facility	59,125	55,211	(3,915)	(862)	(3,053)
ECM	38,361	27,431	(10,929)	(431)	(10,498)
Community Supports	17,144	10,124	(7,020)	(159)	(6,861)
Behavioral Health	21,250	21,214	(36)	(333)	297
Other Medical*	73,279	64,685	(8,594)	(996)	(7,598)
TOTAL COST	$522,412	$501,297	$(21,115)	$(7,823)	$(13,292)

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

At a PMPM level, YTD Medical Expenses are $390.71, unfavorable by $9.93 or 2.6% compared to the budget.

Inpatient Services: Inpatient Services remain slightly unfavorable to budget due to a few high dollar claims totaling $11M paid in March 2025 for 2024 dates of service. Also, incurred but not reported (IBNR) increased by $2M in March to account for January and February activity. Excluding these prior year adjustments, 2025 YTD PMPM stands at $104.36, below

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the budgeted $107.13, with actual utilization at 306 per 1k compared to a budget of 310. This suggests prior year costs were under-budgeted, but the rest of 2025 is expected to align with projections.

Inpatient Services—Long Term Care (LTC): LTC utilization is generally trending in line with the expected seasonal fluctuations within the budget. PMPM trends slightly higher by 2.6% at $40.60, driven by a 1% higher rate increase for 2024 and 2025 than the initial budget. DHCS released updated rates for the 2024 and 2025 fee schedule. Implementation began in February and is anticipated to be completed by April.

Physician Services: Favorability is influenced by the claims lag associated with TRI. However, we anticipate better alignment with the budget as we process more TRI payments. Currently, just over half of the TRI budget is utilized for primary care providers (PCPs), with a similar proportion for federally qualified health centers (FQHCs). These claims lag drive a favorability in unit cost compared to the budget for FQHC, PCP, and Specialty. Utilization has been generally consistent with the 2025 budget and within seasonal trends. Please note that the Specialty Physicians category includes a $52M supplemental payment in 2025, funded by Board-approved reserves, with an estimated $14.3M to be utilized as of March YTD.

Outpatient Facility: The Outpatient Facility category consists of both Outpatient and Emergency Room (ER) services. ER continues to show an upward trend in both utilization per 1k and unit cost, as expected. However, the slight unfavourability is due to the increase of prior period IBNR by $2M, mainly added to January's Outpatient Facility costs. Outpatient was budgeted at $23.89 PMPM for Q1 2025, matching actuals (despite a $27.30 PMPM in January), and ER was budgeted at $18.37 PMPM, and actuals are coming in line as budgeted.

ECM: The ECM budget for 2025 was based on a cautious enrollment growth projection with an anticipated 15.4k enrollments by year-end, as the program is on its path toward stabilization. However, ECM enrollments started the year at 16k and have increased to 18.7k as of March. We anticipate this growth will continue, with the program remaining under the risk corridor framework to help mitigate the higher expenses associated with this expansion.

Community Supports: Enrollments for the Community Support (CS) program were kept modest due to its newness and limited history. Since the budget preparation, there has been a significant increase in CS enrollments. The 2025 PMPM expense is trending at $13.12, 67% higher than the budget and 54% higher than the revenue PMPM of $8.51. We are actively engaging with the State, sharing this most recent data to underscore the need for a rate adjustment as the current revenue is insufficient to offset the higher expenses. As a result, our monthly loss for CS is averaging at $2M, with a YTD loss of $6.1M through March. We expect the unfavorable variance in ECM and CS to continue throughout the year.

Behavioral Health: Behavioral Health is now on budget, as the Targeted Rate Increase (TRI) dollars have been appropriately included in the March budget. Previously, costs appeared 3.2% over budget due to higher-than-expected unit costs associated with the TRI implementation. In February, the TRI allocation was inadvertently applied only to Physician Services, excluding Behavioral Health. The March budget has since corrected this, ensuring Behavioral Health reflects the intended funding and remains aligned with budget expectations going forward.

Other Medical: The Other Medical category is over budget primarily due to increased utilization, with the most significant impact stemming from Medical Transportation, which accounts for a $4.8M unfavorable variance. Hospice services have also contributed to the overage, driven by higher utilization and increased unit costs, resulting in a $1.8M variance. Additionally, Non-Medical Transportation has created a smaller, notable impact of $1.0M from increased utilization. These areas are the key drivers of the unfavorable budget variance within the Other Medical category.

Mar-25 YTD Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$110.32	$108.30	($2.02)	-1.9%
Inpatient Services - LTC	36.79	39.04	2.25	5.8%
Physician Services	87.17	97.73	10.56	10.8%
Outpatient Facility	44.22	41.94	(2.28)	-5.4%
ECM	28.69	20.84	(7.85)	-37.7%
Community Supports	12.82	7.69	(5.13)	-66.7%
Behavioral Health	15.89	16.11	0.22	1.4%
Other Medical	54.81	49.13	(5.67)	-11.5%
TOTAL MEDICAL COST	**$390.71**	**$380.79**	**($9.93)**	**-2.6%**

Administrative Expenses: March YTD Administrative Expenses are unfavorable to budget by $0.7M or 2.6% with 5.2% ALR. Salaries are unfavorable by $1.0M due to salaries and temporary services. Non-Salary Administrative Expenses are favorable by $0.3M or 3.3% due to savings and unspent budgets.

Non-Operating Revenue/Expenses: March YTD Net Non-Operating Income is $15.5M, which is favorable to budget by $8.6M. The favorability is from the YTD Investment Income of $19.8M, which is favorable to the budget by $4.5M due to the higher interest rates. The YTD Other Revenue is $0.5M and is slightly below budget by $25k. The YTD Non-Operating Expense is $4.9M and is favorable to budget by $3.3M due to lower Grant disbursements.

Summary of Results: Overall, the Alliance generated a YTD Net Income of $23.6M, with an MLR of 93.3% and an ALR of 5.2%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Third Month Ending March 31, 2025
(In $000s)

Assets	
Cash	$368,995
Restricted Cash	304
Short Term Investments	1,053,300
Receivables	240,026
Prepaid Expenses	2,074
Other Current Assets	3,048
Total Current Assets	**$1,667,747**
Building, Land, Furniture & Equipment	
Capital Assets	$83,392
Accumulated Depreciation	(48,210)
CIP	1,110
Lease Receivable	4,133
Subscription Asset net Accum Depr	13,214
Total Non-Current Assets	**53,638**
Total Assets	**$1,721,385**
Liabilities	
Accounts Payable	$196,720
IBNR/Claims Payable	530,435
Provider Incentives Payable	56,318
Other Current Liabilities	11,179
Due to State	(2,536)
Total Current Liabilities	**$792,116**
Subscription Liabilities	10,590
Deferred Inflow of Resources	3,899
Total Long-Term Liabilities	**$14,489**
Fund Balance	
Fund Balance - Prior	$891,178
Retained Earnings - CY	23,602
Total Fund Balance	**914,780**
Total Liabilities & Fund Balance	**$1,721,385**
Additional Information	
Total Fund Balance	**$914,780**
Board Designated Reserves Target	496,955
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	134,963
Value Based Payments	46,100
Provider Supplemental Payments	148,057
Total Reserves	**882,775**
Total Operating Reserve	**$32,005**

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2025
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*446,424*	*438,821*	*7,603*	*1.7%*	*1,337,079*	*1,316,480*	*20,599*	*1.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$178,911	$173,412	$5,498	3.2%	$554,726	$520,227	$34,498	6.6%
Prior Year Revenue*	3,498	-	3,498	100.0%	3,498	-	$3,498	100.0%
Premiums Commercial	466	419	47	11.2%	1,404	1,266	139	10.9%
Total Operating Revenue	**$182,874**	**$173,831**	**$9,043**	**5.2%**	**$559,628**	**$521,493**	**$38,135**	**7.3%**
Medical Expenses								
Inpatient Services (Hospital)	$50,538	$49,748	($790)	-1.6%	$147,510	$142,576	($4,933)	-3.5%
Inpatient Services (LTC)	19,170	17,927	(1,243)	-6.9%	49,193	51,393	2,200	4.3%
Physician Services	42,416	44,527	2,111	4.7%	116,550	128,663	12,112	9.4%
Outpatient Facility	21,359	19,264	(2,095)	-10.9%	59,125	55,211	(3,915)	-7.1%
ECM	13,362	9,572	(3,790)	-39.6%	38,361	27,431	(10,929)	-39.8%
Community Supports	5,822	3,533	(2,289)	-64.8%	17,144	10,124	(7,020)	-69.3%
Behavioral Health	7,384	7,774	390	5.0%	21,250	21,214	(36)	-0.2%
Other Medical**	22,633	22,564	(69)	-0.3%	73,279	64,685	(8,594)	-13.3%
Total Medical Expenses	**$182,684**	**$174,909**	**($7,775)**	**-4.4%**	**$522,412**	**$501,297**	**($21,115)**	**-4.2%**
Gross Margin	**$191**	**($1,078)**	**$1,268**	**100.0%**	**$37,216**	**$20,196**	**$17,020**	**84.3%**
Administrative Expenses								
Salaries	$6,825	$6,277	($548)	-8.7%	$20,180	$19,132	($1,048)	-5.5%
Professional Fees	448	494	46	9.3%	1,305	1,410	104	7.4%
Purchased Services	987	1,266	279	22.0%	3,063	3,329	265	8.0%
Supplies & Other	1,246	955	(291)	-30.4%	3,532	2,337	(1,196)	-51.2%
Occupancy	88	133	45	33.9%	366	381	16	4.1%
Depreciation/Amortization	219	598	379	63.4%	657	1,767	1,110	62.8%
Total Administrative Expenses	**$9,813**	**$9,723**	**($90)**	**-0.9%**	**$29,103**	**$28,355**	**($748)**	**-2.6%**
Operating Income	**($9,622)**	**($10,801)**	**$1,179**	**10.9%**	**$8,113**	**($8,159)**	**$16,272**	**100.0%**
Non-Op Income/(Expense)								
Interest	$4,990	$3,899	$1,091	28.0%	$13,161	$12,324	$837	6.8%
Gain/(Loss) on Investments	777	750	27	3.6%	6,751	2,250	4,501	100.0%
Bank & Investment Fees	(68)	(62)	(6)	-9.8%	(128)	(185)	57	30.7%
Other Revenues	189	178	11	6.1%	509	534	(25)	-4.7%
Grants	(920)	(2,667)	1,747	65.5%	(4,804)	(8,000)	3,196	40.0%
Total Non-Op Income/(Expense)	**4,969**	**2,099**	**2,870**	**100.0%**	**$15,489**	**$6,923**	**$8,565**	**100.0%**
Net Income/(Loss)	**($4,654)**	**($8,702)**	**$4,048**	**46.5%**	**$23,602**	**($1,235)**	**$24,837**	**100.0%**
MLR	*99.9%*	*100.6%*			*93.3%*	*96.1%*		
ALR	*5.4%*	*5.6%*			*5.2%*	*5.4%*		
Operating Income	*-5.3%*	*-6.2%*			*1.4%*	*-1.6%*		
Net Income %	*-2.5%*	*-5.0%*			*4.2%*	*-0.2%*		

**Other Medical includes Pharmacy and IHSS.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2025
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*446,424*	*438,821*	*7,603*	*1.7%*	*1,337,079*	*1,316,480*	*20,599*	*1.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$400.76	$395.18	$5.59	1.4%	$414.88	$395.17	$19.71	5.0%
Prior Year Revenue*	7.84	-	7.84	100.0%	2.62	-	2.62	100.0%
Premiums Commercial	1.04	0.95	0.09	9.3%	1.05	0.96	0.09	9.2%
Total Operating Revenue	**$409.64**	**$396.13**	**$13.51**	**3.4%**	**$418.55**	**$396.13**	**$22.42**	**5.7%**
Medical Expenses								
Inpatient Services (Hospital)	$113.21	$113.37	$0.16	0.1%	$110.32	$108.30	($2.02)	-1.9%
Inpatient Services (LTC)	42.94	40.85	(2.09)	-5.1%	36.79	39.04	2.25	5.8%
Physician Services	95.01	101.47	6.46	6.4%	87.17	97.73	10.56	10.8%
Outpatient Facility	47.84	43.90	(3.95)	-9.0%	44.22	41.94	(2.28)	-5.4%
ECM	29.93	21.81	(8.12)	-37.2%	28.69	20.84	(7.85)	-37.7%
Community Supports	13.04	8.05	(4.99)	-62.0%	12.82	7.69	(5.13)	-66.7%
Behavioral Health	16.54	17.72	1.18	6.6%	15.89	16.11	0.22	1.4%
Other Medical**	50.70	51.42	0.72	1.4%	54.81	49.13	(5.67)	-11.5%
Total Medical Expenses	**$409.22**	**$398.59**	**($10.63)**	**-2.7%**	**$390.71**	**$380.79**	**($9.93)**	**-2.6%**
Gross Margin	**$0.43**	**($2.46)**	**$2.88**	**100.0%**	**$27.83**	**$15.34**	**$12.49**	**81.4%**
Administrative Expenses								
Salaries	$15.29	$14.30	($0.98)	-6.9%	$15.09	$14.53	($0.56)	-3.9%
Professional Fees	1.00	1.13	0.12	10.9%	0.98	1.07	0.09	8.8%
Purchased Services	2.21	2.88	0.67	23.4%	2.29	2.53	0.24	9.4%
Supplies & Other	2.79	2.18	(0.61)	-28.2%	2.64	1.77	(0.87)	-48.8%
Occupancy	0.20	0.30	0.11	35.0%	0.27	0.29	0.02	5.6%
Depreciation/Amortization	0.49	1.36	0.87	64.0%	0.49	1.34	0.85	63.4%
Total Administrative Expenses	**$21.98**	**$22.16**	**$0.18**	**0.8%**	**$21.77**	**$21.54**	**($0.23)**	**-1.1%**
Operating Income	**($21.55)**	**($24.61)**	**$3.06**	**12.4%**	**$6.07**	**($6.20)**	**$12.27**	**100.0%**

*Prior Year Revenue consist of revenue booked in the current calendar year for services rendered in prior years.
**Other Medical includes Pharmacy and IHSS.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Third Month Ending March 31, 2025
(In $000s)

	MTD	YTD
Net Income	($4,654)	$23,602
Items not requiring the use of cash: Depreciation	239	718
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	244,879	184,217
Prepaid Expenses	(203)	(1,238)
Current Assets	(590)	812
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**244,087**	**183,791**
Changes to Payables:		
Accounts Payable	(186,511)	(186,714)
Other Current Liabilities	773	(342)
Incurred But Not Reported Claims/Claims Payable	164,889	53,242
Provider Incentives Payable	3,606	12,859
Due to State	(3,809)	(19,206)
Subscription Liabilities	0	0
Net Changes to Payables	**(21,052)**	**(140,161)**
Net Cash Provided by (Used in) Operating Activities	**218,621**	**67,949**
Change in Investments	(4,305)	(14,624)
Other Equipment Acquisitions	(235)	(568)
Net Cash Provided by (Used in) Investing Activities	**(4,540)**	**(15,192)**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**214,081**	**52,757**
Cash & Cash Equivalents at Beginning of Period	**154,914**	**316,238**
Cash & Cash Equivalents at March 31, 2025	**$368,995**	**$368,995**

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DATE: May 28, 2025

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

FROM: Scott Crawford, Medicare Executive Director

SUBJECT: D-SNP Implementation Update & Medicare Bid Submission Overview

Recommendation. Staff recommend the Board authorize the Chairperson to sign the State Medicaid Agency Contract (SMAC) for Medicare Dual Eligible Special Needs Plan (D-SNP).

Summary. The Alliance submitted its Medicare D-SNP application to the Centers for Medicare and Medicaid Services (CMS) in early February. The next step in the process is for the Alliance to execute a State Medicaid Agency Contract (SMAC). D-SNPs coordinate and integrate Medicare and Medi-Cal benefits for dually eligible beneficiaries. The SMAC outlines the roles and responsibilities of a D-SNP with dually eligible individuals enrolled in their plan. D-SNPs must have a SMAC to operate within a state.

Background. The Department of Healthcare Service's (DHCS) CalAIM initiative includes a requirement that local health plans implement Dual Eligible Special Needs Plans (D-SNPs) by January 1, 2026. Additionally, the requirement mandates that dual eligibles in managed Medicare transition to an exclusively aligned enrollment (EAE) model. This means that D-SNPs will only enroll individuals who are also enrolled in the affiliated Medi-Cal managed care plan.

The goal of this requirement is to improve care coordination and integration for beneficiaries who are eligible for both Medicare and Medi-Cal. The EAE D-SNPs are designed to provide a more seamless experience by aligning Medicare and Medi-Cal benefits, reducing administrative burdens, and enhancing the quality of care.

Discussion. The Alliance has been diligently working towards standing up a compliant D-SNP program for January 1, 2026, with key accomplishments including submission of the application to CMS, Model of Care development, D-SNP provider network development, systems acquisition and staff acquisition. Execution of the SMAC is one of the two final steps, the other being the approval of our Medicare bid, before a new D-SNP contract is awarded by CMS.

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

Attachments. N/A

DATE: May 28, 2025

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Contract with Monterey County In-Home Supportive Services (IHSS) program

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Recommendation. Staff recommends the board authorize the Chair to sign the agreement between the Alliance and the Monterey County In-Home Supportive Services Public Authority (Public Authority) to provide Covered Services to eligible and enrolled In-Home Supportive Services (IHSS) providers for the period July 1, 2025 through June 30, 2026

Background. The Alliance has offered the Alliance Care IHSS product under an agreement with the Public Authority since July 1, 2005. Alliance Care IHSS provides comprehensive health coverage, including hospital, outpatient, primary and specialty care prescription drug and mental health services to providers of IHSS services in Monterey County who meet the county's eligibility criteria and are enrolled by the county into coverage. Alliance staff communicate with County representatives at least annually to determine if contract terms, conditions or monthly premiums require adjustment.

Discussion. The benefit year covered under the current agreement with the Public Authority ends June 30, 2025 and the contract must be renewed to support the ongoing provision of services. Staff and County representatives have reviewed contract provisions, program performance and medical costs and utilization and have determined that no changes are needed to the contract terms, conditions or premiums.

Fiscal Impact. The premium is set to achieve a minimum breakeven performance based on the available information.

Attachments. N/A

DATE: May 28, 2025

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

FROM: Van Wong, Chief Operating Officer

SUBJECT: 2025 Strategic Objectives Update

Recommendation. This report is informational only.

Summary. The Alliance has entered the fourth year of its ambitious five-year strategic plan (2022–2026). This report outlines updates to two of the four performance measures tied to the 2025 strategic objectives, made to support steady progress toward achieving the 2026 goals. Notably, modifications were made to the Health Equity targets in response to updated data and findings.

Background. In January 2025, staff presented the 2025 strategic objectives to the Board, reaffirming our continued focus on the core strategic priorities: Health Equity and Person-Centered System Transformation. The accompanying graphic illustrates the strategic objectives and associated performance measures shared during that presentation.

2025 Goals		Baseline
	STRATEGIC OBJECTIVES	
	Health Equity-1: Alliance children in Merced and Mariposa counties receive quality care as compared to the NCQA 50th percentiles for Medicaid for the relevant HEDIS measures % of total MCAS Pediatric Measures under P50 meeting 5 percentile improvement target *Min: 80% | Meets: 90% | Stretch: 95%*	Varies by County & Measures
	Health Equity-2: Meet NCQA standards for culturally and linguistically appropriate care	
	a. Achieve 5% increase in telephonic interpretation service utilization as measured in calls by provider offices *Min: 3%, Meets: 4%, Stretch: 5%*	135 PKPY
	b. Achieve 5% increase in face-to-face interpretation service utilization as measured by provider requests *Min: 3%, Meets: 4%, Stretch: 5%*	35 PKPY
	Person Centered System Transformation-1: Improve behavioral health services and systems to be person-centered and equitable	
	a. BH Insourcing Workplan Execution: % timely execution by 12/31/2025 of key milestones as established on the final BH workplan i. Network Adequacy ii. Operational Readiness iii. New Hires	N/A
	b. Post Go-Live Operations (6 months post 7/1/2025)	N/A
	c. Utilization of Behavioral Health Services: Ensure same level of utilization or better for our members once BH service is in-house (6 months post 7/1/2025) Meets: Baseline %, Stretch: > Baseline %	8.27%
	Person Centered System Transformation-2: Ensure appropriate Enhanced Care Management program enrollment and member engagement	
	a. Achieve at least 3% enrollment of total Medi-Cal population into ECM services *Min: 3%, Meets: 3.25%, Stretch: 3.5%*	N/A
	b. Achieve 90% of enrolled ECM members with at least one encounter per enrolled member per month (PEPM) *Min: 75%, Meets: 85%, Stretch: 90%*	45.8%

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Discussion. To advance the Alliance's Health Equity objective, the pediatric goal for Mariposa County was refined by incorporating six child and youth-focused measures from the Managed Care Accountability Set (MCAS). These measures aimed to improve performance in areas falling below the 50th percentile. However, the final 2024 MCAS results revealed that five of the six measures lacked a sufficient number of eligible members to be statistically valid. The affected measures include:

- Well-Child Visits for Age 15 to 30 Months – Two or More Visits
- Well-Child Visits in the First 15 Months – Six or More Visits
- Immunizations for Adolescents – Combo 2
- Childhood Immunizations – Combo 10
- Lead Screening

In response, the Alliance has revised the pediatric goal for Mariposa County to focus on a single, statistically valid measure: Child and Adolescent Well-Care Visits, which had a 2024 MCAS result of 33.9%. The revised target sets a goal of a 5-percentage point increase over this baseline, aiming for 41.5% in 2025. It is important to note that the Alliance will continue to monitor and report on all six pediatric MCAS measures for Merced County, where sufficient data is available.

A second key adjustment to the Health Equity strategic priority relates to the Cultural and Linguistic Services measure. The goal remains a 5% increase in the utilization of both telephonic and face-to-face interpretive services for non-English speaking members. Initially, efforts focused on members without a primary care provider (PCP) or clinic staff who spoke their language, based on the assumption that most interpretation occurred during primary care visits. However, updated data indicates that a significant portion of interpretive services take place in specialty care settings. As a result, while the performance target remains unchanged, the focus has expanded to include all non-English speaking members, regardless of PCP assignment.

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

Attachments. N/A

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

Meeting Minutes

Wednesday, April 23, 2025
10:00 a.m. – 3:00 p.m.

El Capitan Hotel
Sentinel Conference Room
609 W Main Street
Merced, CA 95340

Commissioners Present:

Ms. Leslie Abasta-Cummings,	At Large Health Care Provider Representative
Ms. Anita Aguirre,	At Large Health Care Provider Representative
Dr. Ralph Armstrong,	At Large Health Care Provider Representative
Dr. Maximiliano Cuevas,	Health Care Provider Representative
Ms. Kim De Serpa	County Board of Supervisors
Ms. Janna Espinoza,	Public Representative
Dr. Donaldo Hernandez,	Health Care Provider Representative
Ms. Elsa Jimenez,	County Director of Health Services
Mr. Michael Molesky,	Public Representative
Ms. Mónica Morales,	County Health Services Agency Director
Ms. Wendy Root Askew	County Board of Supervisors

Commissioners Absent:

Ms. Tracey Belton,	County Health and Human Services Agency Director
Ms. Dorothy Bizzini	Public Representative
Mr. Mark Hendrickson	Assistant County Executive Officer
Dr. Kristina Keheley	Interim Health and Human Services Agency Director
Supervisor Josh Pedrozo,	County Board of Supervisors
Dr. James Rabago,	Health Care Provider Representative
Dr. Allen Radner,	At Large Health Care Provider Representative

Staff Present:

Mr. Michael Schrader,	Chief Executive Officer
Mr. Scott Fortner,	Chief Administrative Officer
Mr. Cecil Newton,	Chief Information Officer
Ms. Jenifer Mandella,	Chief Compliance Officer

Ms. Van Wong,	Chief Operating Officer
Ms. Hayley Tut,	Interim Clerk of the Board
Ms. Danita Carlson,	Government Relations Director
Mr. Ryan Markley	Compliance Director
Mr. Scott Crawford	Medicare Program Executive Director
Mr. Fabian Licerio	Risk Adjustment Director
Dr. Gray Clarke	Behavioral Health Medical Director
Ms. Sherri Katz	Medicare Operations Director
Ms. Lilia Chagolla	Member Services Director
Ms. Tammy Brass, RN	UM Director/Interim HS Operations Exec Director

1. Call to Order by Chair Jimenez.

Roll call was not taken as a quorum was not yet present to call the meeting to order. Information items were presented until a quorum could be established.

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 made by Commission members.

4. Comments and announcements by Chief Executive Officer.

Mr. Michael Schrader highlighted that meeting retreat aims to strengthen connections and deepen understanding and commitment to the Alliance. He reviewed the agenda for the day and noted that it focuses on three main areas: Medicaid, key initiatives for 2025, and administrative matters.

Mr. Schrader highlighted that participants have the Community impact report and materials related to the guest speaker's presentation, including a fact sheet developed by LHPC on Medicaid. The Community impact report highlights the Alliance Community investments totaling $93 million across five counties in 2024.

Mr. Schrader made two announcements:

1. Last week, the Monterey County Board of Supervisors recognized the Alliance's Whole Child Family Advisory Committee with a World Health Day resolution. Committee members present to receive the honor were Chair Janna Espinosa and committee member Francis Wong. The Alliance's Whole Child Model Family Advisory Committee, composed of representatives from five counties, addresses the unique needs of families with children who have special healthcare needs.
2. Board members need to complete the online training module on conflicts of interest by June 1st. The training takes about 20 minutes to complete. For those preferring a personal

experience, our Legal Services Director would be happy to offer a live individual session by phone or Teams.

Regular Agenda Items: (11. – 13.): 10:18 a.m.

11. Discuss Federal Medicaid Budget Activities. (10:18 – 11:45 a.m.)

[Vice Chair Commissioner Abasta-Cummings arrived at this time: 10:18 a.m.]

Mr. Michael Schrader introduced Jonathan Freedman, Senior Advisor at Health Management Associates, highlighting his collaboration with health plans, counties, clinics, associations, and other safety net organizations related to the Medi-Cal program. Michael also mentioned Jonathan's previous roles, including Chief of Strategy at L.A. Care Health Plan and various leadership positions in Los Angeles County. Jonathan is highly regarded by the CEOs of the 17 local plans for his updates on Medicaid and his involvement with the association LHPC.

Mr. Jonathan Freedman provided an overview of the federal Medicaid budget and current budget reconciliation activities. Mr. Freedman explained that budget reconciliation is a legislative process combining taxes, spending, and policy into a single budget package. It involves setting budgetary targets over a future period, typically 10 years, and the budget committees of the House and Senate set financial targets directing the policy committees to produce changes to meet those targets. Congress needs to pass legislation to address the debt ceiling, a statutory cap on federal debt, by August or September. Additionally, the tax rules, known as the Trump tax cuts, expire in December, requiring Congress to pass legislation to extend them, which must be done in the summer to give the IRS time to inform taxpayers of the rules. Mr. Freedman discussed the challenges of the reconciliation process, including the need for a majority vote in the House and Senate, and the limited ways to amend the package.

Mr. Freedman presented a chart showing the federal deficit, explaining that the federal government has been spending more than it has been taking in, except for a few periods. He emphasized that the budget reconciliation process aims to address this deficit by evaluating proposals over a 10-year period.

Mr. Freedman discussed the potential changes to the Medicaid program, including the introduction of per capita caps, changes to the federal-state funding ratio, and the implementation of work requirements. One proposal is to convert the Medicaid program to per capita caps, where the federal government would pay states on a per member per month basis, similar to how states pay health plans today. This change is estimated to save $900 billion over 10 years. Another proposal discussed is changing the federal-state funding ratio from the current 90-10 for Medicaid expansion to a 50-50 ratio. This change would significantly reduce federal funding for states, with California potentially losing $20 billion per year. He highlighted the proposal to establish work requirements for Medicaid eligibility, which would require specified beneficiaries to engage in community participation, active work activities, or job searching. This could result in 1 to 1.2 million fewer people on Medi-Cal in California due to the additional administrative burden and barriers to coverage.

There is also a proposal for a potential limitation on provider taxes, which are used by states to raise funds for Medicaid. These taxes are seen by some as abuse or gimmicks, but they are

essential for supplementing Medicaid payments to providers. Limiting these taxes could result in reduced payments or the need for states to backfill the lost funds.

Mr. Freedman emphasized that because states may need to backfill the loss of federal funds resulting from changes to the Medicaid program it could involve increasing state funding to maintain current levels of coverage and services. To address this, States may choose to limit the scope of their Medicaid programs in response to reduced federal funding. This could include narrowing eligibility criteria, reducing benefits, or lowering payment rates to providers. He highlighted the need for states to develop new administrative structures to manage work requirements for Medicaid eligibility. This would involve setting up systems to track and verify beneficiaries' compliance with work requirements, adding to the administrative burden on states and ultimately on counties. Changes to the Medicaid program could impact providers, particularly those who rely on Medicaid payments. Reduced funding and increased administrative requirements could strain providers' resources and affect their ability to deliver care.

Mr. Freedman explained that California is experiencing lower revenues, which complicates the state's ability to manage its budget and respond to federal Medicaid cuts. This includes lower-than-expected tax revenues and other financial pressures. He discussed new demands on California's budget, including fire relief efforts, the crisis in the casualty insurance market, and other emerging issues. These demands add to the fiscal challenges faced by the state.

There is a challenge of backfilling federal Medicaid cuts while managing other state priorities. The state may need to find additional funding sources or make difficult budgetary decisions to maintain Medicaid coverage and services. Education funding, protected by Proposition 98, receives a significant portion of the state budget. This limits the flexibility of the state to reallocate funds to other areas, including Medicaid.

[Commissioners Cuevas arrived at this time: 10:25 a.m.]
[Commissioners Morales arrived at this time: 11:21 a.m.]

Roll call was taken and Chair Jimenez established a quorum was present and the meeting was called to order.

Chair Jimenez opened the floor for approval of Consent Agenda items

Consent Agenda Items: (5. – 10C.): 11:45 a.m.

MOTION:	Commissioner Cuevas moved to approve Consent Agenda items 5 through 10C, seconded by Commissioner Molesky.
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners Abasta-Cummings, Aguirre, Armstrong, Askew, De Serpa, Espinoza, Hernandez, Jimenez, and Morales,
Noes:	None.
Absent:	Commissioners Belton, Bizzini, Hendrickson, Keheley, Pedrozo. Rabago and Radner.

Abstain: None.

12. Discuss Alliance's Key Priority Initiatives; including National Committee for Quality Assurance (NCQA) accreditation, Medicare Dual Eligible Special Needs Plan (D-SNP) Implementation, including considering and approving delegating the Annual Medicare Bid Submission to Staff, and Update on Insourcing of the Behavioral Health Benefit. (11:47 a.m. – 2:18 p.m.)

A. Mr. Michael Schrader introduced the Key priority initiatives. (11:47 a.m. – 11:50 a.m.)

B. National Committee for Quality Assurance (NCQA). (11:50 a.m. – 12:13 p.m.)

Mr. Ryan Markley, Compliance Director, spoke about how NCQA accreditation ensures that the health plan has the right systems, policies, procedures, and infrastructure in place to deliver reliable and affordable results. It focuses on areas such as member experience, utilization management, network management, credentialing, quality improvement, population health, and HealthEquity.

The Alliance, led by Mr. Markley, has been working for over a year to revamp and document operations to meet NCQA standards. This involved updating policies, workflows, and ensuring compliance with NCQA criteria.

Key Improvements include enhanced focus on culturally and linguistically appropriate services, improved member communication and health literacy, streamlined utilization management and care management processes, and action-driven quality program structure.

[Meeting broke for lunch at this time: 12:13 p.m. – 12:37 p.m.]

C./D. Medicare Dual Eligible Special Needs Plan (D-SNP). (12:37 p.m. – 1:35 p.m.)

Mr. Scott Crawford, Medicare Program Executive Director and Mr. Fabian Licerio, Risk Adjustment Director, presented the design and implementation plan for the Alliance's Medicare D-SNP program, emphasizing the importance of membership growth, controlling administrative costs, and achieving high star ratings. The Medicare D-SNP program is designed to coordinate Medicare and Medicaid benefits for dual-eligible individuals, providing comprehensive care through a single health plan. The program aims to improve care coordination and outcomes for members. The plan includes targeted marketing and outreach efforts to convert existing Medi-Cal members and attract new enrollees from original Medicare. Mr. Crawford highlighted the need to control administrative costs to ensure the program's sustainability. This includes leveraging existing infrastructure, streamlining operations, and implementing efficient workflows to minimize expenses. He discussed the significance of achieving high star ratings, which are based on quality measures and member satisfaction. Higher star ratings result in greater rebates from the Centers for Medicare and Medicaid Services (CMS), which can be used to offer supplemental benefits and attract more members.

Mr. Crawford explained the Medicare bid process, including the importance of setting accurate benchmarks, achieving cost savings, and using rebates to offer supplemental benefits to members. The plan's bid must be lower than the benchmark to receive rebates from CMS. Cost savings through efficient care management and utilization controls, allow the plan to offer competitive bids and secure rebates. Rebates from CMS are used to offer supplemental benefits to members, such as dental, vision, and over-the-counter allowances.

These benefits enhance the attractiveness of the plan and support member retention. Mr. Crawford outlined the timeline for bid submission, with the final bid due by the first Monday in June. The plan will receive feedback from CMS and could address any issues before final approval.

Mr. Licerio provided an overview of the risk adjustment process, explaining how accurate documentation of patient conditions is essential for ensuring appropriate reimbursement and managing the cost of care.

Chair Jimenez opened the floor for approval of staff recommendation to delegate the Annual Medicare Bid Submission process to staff.

MOTION:	Commissioner Askew moved to approve the delegation of the D-SNP Annual Medicare Bid Submission process to staff seconded by Commissioner Cuevas.
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners Abasta-Cummings, Aguirre, Armstrong, De Serpa, Espinoza, Hernandez, Jimenez, Molesky, and Morales,
Noes:	None.
Absent:	Commissioners Belton, Bizzini, Hendrickson, Keheley, Pedrozo. Rabago and Radner.
Abstain:	None.

E. Insourcing of Behavioral Health (1:35 p.m. – 2:13 p.m.)

Dr. Gray Clarke, Behavioral Health Medical Director, discussed the insourcing of the behavioral health benefit, highlighting the prevalence of behavioral health conditions among Alliance members and the need for improved access to services. She presented data on behavioral health utilization across different counties and age groups, identifying areas where service utilization is below the state average and highlighting the need for targeted interventions.

Dr. Clarke discussed the high prevalence of health conditions, and the stigma associated with mental health, which leads to people not following up on their care plans. She emphasized the need to increase service utilization and ensure high-quality services.

Dr. Clarke provided a historical review of the in-sourcing project, mentioning the integration project with behavioral health that started in 2024 and the planned transition for July 1st, 2025, highlighting the five-year strategic plan aligning with the 2026 Strategic Plan goals.

The development of the Behavioral Health Clinical Strategy principles in 2024, aimed for high-quality, low-barrier services. There is a need for integration across medical and behavioral health services to ensure higher quality care. Dr. Clarke stressed the importance of viewing the program through a quality lens to ensure effective and person-centered services.

Dr. Clarke described the development of a behavioral health-focused care management team, including licensed medical professionals and behavioral health advocates. The team is embedded within the overall care management structure to drive integration and support members with behavioral conditions. Additionally, there is a behavioral health-focused

utilization management team, primarily reviewing children's behavioral health needs. Dr. Clarke emphasized the importance of meeting all care needs and developing policies, workflows, and frameworks based on best practices.

The governance structure for the in-sourcing project will focus on shared language and principles to achieve equity across all work. There is a need for primary care providers to take responsibility for behavioral health services.

Lastly, Dr. Clarke spoke about provider network development, mentioning the progress in contracting behavioral health practitioners and the implementation of sign-on bonuses. She emphasized the importance of expanding the network and ensuring a smooth transition for members.

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13. Consider and approve Senior Leadership Team Incentive Plan Proposal. (2:13 p.m. – 2:53 p.m.)

Mr. Scott Fortner, Chief Administrative Officer, presented a proposal for a Senior Leadership Incentive Plan (SLIP) to support recruitment and retention of senior leaders. The plan includes a bonus structure for directors and executives, with criteria to be developed annually based on organizational needs. The plan includes a bonus structure for directors and executives, with potential bonuses ranging from 3% to 5% based on performance and organizational needs. Mr. Fortner explained that the criteria for the bonus plan would be developed annually, considering operational readiness, service provider satisfaction, and community engagement.

The board discussed the proposed SLIP, considering the financial impact and the need for a long-term incentive plan.

Chair Jimenez opened the floor for approval of staff recommendation of the Senior Leadership Team Incentive Plan Proposal.

MOTION:	Commissioner Henandez moved to approve the Senior Leadership Team Incentive Plan Proposal (SLIP) for one year, with a request for staff to bring back a modified plan that includes a three-year component for future consideration. seconded by Commissioner Molesky.
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners Abasta-Cummings, Aguirre, Armstrong, Askew, Cuevas, De Serpa, Espinoza, Jimenez, and Morales,
Noes:	None.
Absent:	Commissioners Belton, Bizzini, Hendrickson, Keheley, Pedrozo. Rabago and Radner.
Abstain:	None.

Adjourn to Closed Session

Chair Jimenez moved the commission into Closed Session at 2:55 p.m.

14. **Closed session pursuant to Government Code Section 54957.6 regarding the Agency's performance evaluation of the CEO.**

Return to Open Session

Chair Jimenez reconvened the meeting to Open Session at 3:05 p.m.

15. **Open session pursuant to Government Code Section 54957.6 regarding the Agency's performance evaluation of the CEO.**

Chair Jimenez reported from Closed Session that the Board accepted the evaluation of the CEO and approved a 5% merit increase for Mr. Michael Schrader. The vote passed with 11 ayes and 7 absent.

The Commission adjourned its regular meeting of April 25, 2025 at 3:07 p.m. to the regular meeting of May 28, 2025 at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa unless otherwise noticed.

Respectfully submitted,

Ms. Hayley Tut
Interim Clerk of the Board

Minutes were supported by AI-generated content.

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, March 19, 2025
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
Anne Lee	Financial Planning and Analysis Director
Arti Sinha	Application Services Director
Anita Guevin	Medicare Compliance Program Manager
Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Dave McDonough	Legal Services Director
Fabian Licerio	Risk Adjustment Director
Gray Clarke	Behavioral Health Medical Director
Jenifer Mandella	Chief Compliance Officer
Jimmy Ho	Accounting Director
Kay Lor	Payment Strategy Director
Kelsey Riggs	Care Management Director
Krishan Patel	Data Analytics Services Director
Lilia Chagolla	Community Engagement Director
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Michael Schrader	Chief Executive Officer
Michael Wang	Medical Director
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Nicolette Shalita Vega	NCQA Compliance Program Manager
Omar Guzman	Chief Health Equity Officer
Ronita Margain	Community Engagement Director
Ryan Inlow	Facilities & Administrative Services Director
Ryan Markley (Chair)	Compliance Director
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Shelly Papadopoulos	Operations Management Director
Tammy Brass	Utilization Management Director
Tammy Hoeffel	Enhanced Health Services Director
Van Wong	Chief Operating Officer

Back to Agenda

Committee Members Absent:

Dianna Myers	Medical Director

Committee Members Excused:

Jessie Dybdahl	Provider Services Director

Ad-Hoc Attendees:

Anita Guevin	Medicare Compliance Program Manager
Ka Vang	Compliance Specialist
Kat Reddell	Compliance Specialist
Paige Harris	Regulatory Affairs Specialist
Rachel Siwajek	Program Integrity Specialist
Sara Halward	Compliance Specialist
Stephanie Vue	Regulatory Affairs Specialist
Vanessa Paz	Health Equity Program Manager

1. Call to Order by Chairperson Markley.

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

2. Review and Approval of February 19, 2025 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of February 19, 2025, meeting.

3. Consent Agenda.

1. **Policy Hub Approvals**
2. **Regulatory and All Plan Letter Updates**
3. **Delegate Oversight Quarterly Report**
4. **MedImpact Pre-Delegation Memo**

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. NCQA Accreditation Update

Shalita-Vega, NCQA Compliance Program Manager, provided updates on project status, survey readiness and outstanding materials. Shalita-Vega emphasized the importance of timely, accurate, and complete submission of pending materials for the Alliance's upcoming NCQA Health Plan and Health Equity Accreditation Surveys.

2. CAPs Q324 Report

Mandella, Chief Compliance Officer, presented the Q324 CAPs Report (Corrective Action Plan). Mandella reviewed the status of various CAPs, including Internal Operations, Delegate CAPs and Regulatory CAPs noted the following for the quarter:

- 1 Internal CAP was opened, 0 were ongoing and 2 were closed
- 1 Delegate CAP was opened, 1 was ongoing and 2 were closed
- 1 Regulator CAP was opened, 2 were ongoing and 0 were closed

3. HIPAA Privacy and Security Quarterly Report

Mandella, Chief Compliance Officer, and McMurray, Information Security Analyst, presented the Q4 2024 HIPAA Privacy & Security Report.

Mandella reviewed HIPAA reporting trends for the quarter noting that of the 32 referrals received, 9 were determined to be incidents requiring report to the state, 15 were determined to be non-events, 8 were determined to be non-reportable, and 0 were determined to be breaches. The highest-ranking incident root causes for HIPAA disclosures in the quarter were incorrect selection/entry and member lost or stolen wallets.

Mandella reviewed HIPAA program metrics included on the Alliance Dashboard noting that all metrics met the targeted performance threshold for the quarter.

McMurray, Information Security Analyst, provided an update on the assessment of cybersecurity measures related to phishing attacks for Q424, noting a slight decrease in opened and failed phishing attempts.

McMurray reported an update to the security remediation program noting that vulnerability management, third party risk management, log retention, network segmentation and penetration testing were emphasized over the quarter.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2024 HIPAA Privacy & Security Quarterly Report.

4. Program Integrity Quarterly Report

Siwajek, Program Integrity Specialist III, presented the Q4 2024 Program Integrity Activity Report. Siwajek reported that 35 concerns were referred to Program Integrity in the quarter, 15 of which resulted in the opening of a matter under investigation (MUI). There were 70 active MUIs in the quarter.

Siwajek reviewed referral trends for the period noting the following:

- 4 provider related
- 4 member related
- 2 state requests
- 6 categorized as other4

Siwajek reported performance of the Program Integrity performance metrics from the Q3 2024 Alliance Dashboard noting that the quality metric met target performance for the quarter and the efficiency metric failed in October.

Siwajek reviewed Q324 Program Integrity Financials reporting the total requested recoupment was $101,192.63 and completed recoupment was $94,496.18.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2024 Program Integrity Report.

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The meeting adjourned at 9:58 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

Quality Improvement Health Equity Committee

Date: March 20, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

Chair: **Omar Guzman, MD, Chief Health Equity Officer, Interim CMO, Emergency Medicine Physician**			**Minutes by:** **Jacqueline Van Voerkens**
	Members Present:	Dr. Caroline Kennedy, Family Medicine, Dr. Eric Sanford, Family Medicine, Dr. Oguchi Nkwocha, Family Medicine, Susan Harris, MFA COO, and Dr. Jill Young, Psychiatrist.	
	Members Absent:	Gary Proctor, MD, Psychiatrist, Dr. Jessica Langenhan, Psychiatrist, Dr. Minoo Sarkarati, Internal Medicine/Pediatrics, Dr. Madhu Raghavan, Pediatrician, Dr. Stephanie Chang, Family Medicine, Dr. Stephanie Graziani, Pediatrics, and Stacey Kuzak, GVHC Director of Nursing.	
	Central California Alliance for Health staff:	Ms. Andrea Swan — QI/ Population Health Director Ms. Carissa Grepo — UM Manager – Prior Authorizations Ms. Desirre Herrera — Quality and Health Programs Manager Ms. Emily Kaufman — Clinical Safety Supervisor (RN) Ms. Georgia Gordon — Quality Improvement Program Advisor II Dr. Gray Clarke — Behavioral Health Medical Director, Psychiatric and Psychosomatic Medicine Ms. Kristen Rohlf — Quality Improvement Manager Dr. Mai Bui-Duy, MD — Medical Director, Internal Medicine Dr. Michael Wang — Medical Director, Internal Medicine and Clinical Informatics Ms. Navneet Sachdeva — Pharmacy Director Ms. Rebecca McMullen — Behavioral Health Program Manager Ms. Sarina King — Quality and Performance Improvement Manager Mr. Scott Fortner — Chief Administrative Officer Ms. Tammy Brass — Utilization Management Director Ms. Vanessa Paz — Health Equity Program Manager Ms. Viki Doolittle — Utilization Management Manager	
Item No.	**Agenda Item**		
I.	**Call to Order**	Dr. Omar Guzman called the meeting to order at 12:05 PM and welcomed the members. Dr. Guzman opened the floor for any announcements. No announcements were received from the Committee. Announcement: Dr. Guzman introduced new members of the committee	

Quality Improvement Health Equity Committee

Date: March 20, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

Items for Approval		Discussion	Action/Recommendation
II.	**Review & Approve Minutes**	**The Minutes from the December 18, 2024 QIHEC Meeting were reviewed.** **Dr. Kennedy motioned to approve the minutes from the QIHEC meeting.* **Dr. Sanford 2nd the motion for approval.* **Committee approved December 18, 2024 QIHEC as presented.*	*The QIHEC approved the December 18, 2024 QIHEC meeting minutes.*
Action Item Follow-Up			
III. 9/24/24 QIHEC	Q2 2024 Utilization Management Work Plan	Ms. Brass will follow up with Dr. Sanford Ed utilization and changing it to rates by member ship in the county. **Action Pending**	
9/24/24 QIHEC	Q2 2024 Utilization Management Work Plan	Dr. Guzman will connect with Dr. Sanford to collaborate on the outreach and health literacy training program. **Action In Process**	
9/24/24 QIHEC	Utilization Management Criteria	Dr. Langenhan from Carelon to provide neuropsychological testing referral guidelines, follow up on closing the loop on communication between the reference and the referee, and connect regarding the release of information work around. **Action Pending. Action reassigned to Mandeep Kullar.**	
9/24/24 QIHEC	Q2 2024 QIHET Workplan	Ms. Swan will work with Sarah Sanders and provide a Quality of Care and Access grievance data comparison between other counties and/or insurance groups to Dr. Sanford. **Action In Process**	
9/24/24 QIHEC	Discussion	Dr. Guzman will reach out to Dr. Sanford regarding Street Medicine. **Action In Process**	
12/18/24 QIHEC	Q3 2024 QIHET Workplan	**Behavioral Health Service Meeting:** Ms. McMullen will arrange a meeting with Dr. Kennedy's staff to discuss the Carelon transition. **Action Pending** confirmation of PS attendance at provider meeting on 1/15/25.	
12/18/24 QIHEC	Q3 2024 Utilization Management Work Plan	**Action**: Dr. Wang and Ms. Grepo to create a one-page genetic testing criteria guide for providers for easier reference. **Action Pending**	

Quality Improvement Health Equity Committee

Date: March 20, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

Items for Review/Approval		Consent Agenda Items	Action/Recommendation
IV.	**Review**	Subcommittee/Workgroup Meeting Minutes	
		• Utilization Management Workgroup (UMWG) Minutes (Q4 2024)	*Approved*
Policies: Require QIHEC Approval			
Number/Title		**Significant Changes**	**Action/Recommendation**
404-1101 Utilization Management Program		Edits included NCQA requirements/Annual review. **Discussion**: Ms. Brass informed the committee of minor edits to the policy in the packet, highlighting the importance of internal and external provider feedback for developing criteria, processes, behavioral health integration, and NCQA accreditation updates. Dr Sanford raised a concern about the added language on HIPAA training, questioning if it was excessive. Ms. Brass responded that it is a little duplicative but necessary per NCQA guidance.	*Approved*
		Regular Agenda	**Action/Recommendation**
IV.	**2024 Annual UM Program Evaluation**	Ms. Brass, Utilization Management Director presented the 2024 annual program review, focusing on inpatient admissions, bed days, average length of stay, and outpatient care achievements. Highlights included the importance of interdisciplinary team meetings and enhanced care management. Ms. Brass highlighted the metrics for inpatient admissions, noting that there was no change in the admit per thousand, while bed days slightly increased, and the average length of stay decreased. Achievements in care coordination and transitions of care, emphasizing the role of interdisciplinary teams (IDTs) in improving these metrics were noted. The goals for the upcoming year include increased care coordination, enhanced care management, and improved utilization of post-discharge care, including alternative placements like residential care for the elderly.	*Approved*

MINUTES

		Ms. Brass outlined opportunities for improvement, including enhanced transitional care, predictive analytics, provider collaboration, and patient-centered approaches. Challenges such as limited access to care, resource constraints, and socio-economic factors were discussed. Dr. Sanford suggested including readmission rates and mortality data alongside length of stay in the annual program review for a comprehensive analysis. Ms. Brass acknowledged that this information would be beneficial to include in the Program Evaluation and indicated that readmission rates are noted in the workplan. **Action:** Ms. Brass will add the readmission rates and possibly mortality data to the 2025 Annual UM Program Evaluation for a more comprehensive analysis.	
	2025 UMWP Workplan Review	Ms. Brass presented the 2025 UM work plan, highlighting additions related to case management metrics, behavioral health metrics, pharmacy metrics, and underutilization patterns. Emphasized was the importance of accurate state average comparisons. Dr. Wang provided input on the variability in data and the impact of new programs on metrics. Additions to the 2025 UM work plan, including new case management metrics, behavioral health integration, and pharmacy metrics. Additional Behavioral Health Integration metrics includes the integration of behavioral health services, aiming to improve access and coordination of care for members. Addressing Underutilization will focus on the importance of addressing underutilization of services and improving member engagement to ensure that members receive the care they need.	*Approved*
	Q4 2024 UMWP Review	Ms. Brass reviewed the Q4 UM work plan for 2024, discussing the whole child model, ECM and CS utilization, reducing readmission initiatives, and operational performance. Highlights included the success in maintaining authorization turnaround times despite increased utilization and integration of new JIVA platform. Ms. Brass highlighted the increase in authorization activity in Q4 2024, noting a 68% spike from Q3 to Q4, attributed to the addition of new counties. The committee discussed the denials and appeals activity. Ms. Brass and Ms. Sachdeva, Pharmacy Director, discussed the denial of genetic testing and nutritional counseling,	*Approved*

MINUTES

		explaining the reasons behind the denials and the steps taken to address them. Ms. Sachdeva provided insights into the specific cases and the outreach efforts. Dr. Sanford raised a concern about the denial of injectable triamcinolone in the pharmacy "Top 5 Physician Administered Drugs that Result in Medical Necessity Denial", suggesting it might be due to miscoding by the dermatologist's staff. **Action**: Ms. Sachdeva will Investigate the reason for denials of triamcinolone injections and ensure proper coding and communication with the dermatologist, educate the provider and their staff if necessary. Ms. Sachdeva communicated after the meeting that Triamcinolone is covered for Alopecia Areata. At the upcoming P&T it will be recommending triamcinolone PA criteria that allows coverage for alopecia areata. **Action Complete.** Dr. Nkwocha asked about the denial of genetic testing, specifically BRCA testing. Dr. Wang explained that the Alliance follows USPSTF guidelines and provided details on when BRCA testing is approved versus denied. Dr. Wang provided a link to the guidelines during the meeting: Pathology: Molecular Pathology (path molec) **Action**: Dr. Wang to analyze the reasons for genetic testing denials and provide education to providers if needed Dr. Nkwocha raised a concern about the denial of nutritional counseling. Ms. Brass explained that it is related to medically tailored meals and usually denied when there is no documentation to support ongoing need. Dr. Nkwocha asked about the denial of GLP-1 medications for obesity when Medi-Cal is secondary. Ms. Sachdeva explained that a denial letter from Medicare is required for Medi-Cal to cover it and offered assistance to coordinate.	

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		Action: Ms. Sachdeva to assist Dr. Nkwocha with coordinating GLP-1 medication coverage for obesity when Medi-Cal is the secondary insurance by providing necessary denial letters from Medicare. **Action complete**. Ms. Sachdeva sent an email to Dr. Nkwocha during the meeting to follow up. The focus on reducing readmission rates and improving care transitions was emphasized, with the mention of initiatives like interdisciplinary team meetings and emergency room follow-up work being key strategies. Ms. McMullen, Behavioral Health Program Manager, provided an update on the behavioral health integration, noting improvements in utilization and penetration rates across counties. Ms. McMullen informed the committee of improvements in utilization and penetration rates for behavioral health services across various counties, with a focus on increasing access in newer counties. Q4 delegate oversight reporting was presented, focusing on utilization across different age ranges and counties. Highlights included the internal cap placed by Carelon for timeliness improvements.	
	Utilization Management Criteria Review and Discussion	Ms. Grepo, UM Manager – Prior Authorizations, and Ms. Brass presented the Utilization Management Criteria review for 2025, discussing new codes, terminations, Senate Bill 729 requirements, and behavioral health integration. The presentation emphasized the alignment with Medi-Cal authorization requirements and removing authorization requirements for behavioral health codes. Ms. Grepo presented the 2025 code sets and criteria updates, including new pathology, diagnostic, and surgical codes.	*Approved*

Action Items

Agenda Item	**What is the action item**	**Due date**	**Responsible staff**
2025 Annual UM Program Evaluation	Add the readmission rates to the 2025 Annual UM Program Evaluation for a more comprehensive analysis. Develop reporting to capture mortality rates as related to LOS and consider inclusion in 2025 Annual UM program eval.	Q1 2026	Tammy Brass, UM Director

Quality Improvement Health Equity Committee

Date: March 20, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

Q4 2024 UMWP Review	Investigate the reason for denials of triamcinolone injections and ensure proper coding and communication with the dermatologist, educate the provider and their staff if necessary. **Action Complete.** Ms. Sachdeva communicated after the meeting that Triamcinolone is covered for Alopecia Areata. At the upcoming P&T it will be recommending triamcinolone PA criteria that allows coverage for alopecia areata.	Complete	Ms. Sachdeva, Pharmacy Director
Q4 2024 UMWP Review	Analyze the reasons for genetic testing denials and provide education to providers if needed.	TBD	Dr. Mike Wang, Medical Director
Q4 2024 UMWP Review	Ms. Sachdeva to assist Dr. Nkwocha with coordinating GLP-1 medication coverage for obesity when Medi-Cal is the secondary insurance by providing necessary denial letters from Medicare. Action complete. **Action Complete:** Ms. Sachdeva sent an email to Dr. Nkwocha during the meeting to follow up.	Complete	Ms. Sachdeva, Pharmacy Director
Meeting adjourned at 1:05 pm			
Next Meeting April 2, 2025			
Approved by Committee Date: April 2, 2025	***Signature:*** *Andrea Swan, RN, Quality Improvement Population Health Director*		**Date:** April 2, 2025

Meeting Minutes

Monday, February 3, 2025

Teleconference Meeting

Members Present:

Voting Members

Frances Wong	Monterey County – CCS WCM Family Member
Janna Espinoza	Monterey County – CCS WCM Family Member
Kevin Smith	Merced County – Parent Resource Center
Kim Pierce	Monterey County – Parent Resource Center
Paloma Barraza	Monterey County – CCS WCM Family Member

Non-voting Members

Anna Rubaclava	Merced County - County of Merced
Carissa Grepo	Alliance Utilization Management Manager – Prior Authorizations
Denise Sanford	Santa Cruz County - County of Santa Cruz
Esperanza Compean	Merced County - Parent Resource Center
Kayla Zoliniak	Alliance Community Engagement Administrative Specialist
Kelsey Riggs, RN	Alliance Complex Case Management Manager - Pediatric
Kevin Low	Monterey County – County of Monterey
Manuel López Mejia	Monterey County – CCS WCM Advocate
Michael Molesky	Santa Cruz County – Alliance Commissioner
Ronita Margain	Alliance Community Engagement Director
Susan Paradise	Santa Cruz County – County of Santa Cruz

Members Absent:

Voting Members

Heidi Boynton	Santa Cruz County – Local Consumer Advocate
Irma Espinoza	Merced County – CCS WCM Family Member
Janell White	San Benito County – CCS WCM Family Member

Non-voting Members

Ashley McEowen	Alliance Complex Case Management Supervisor - Pediatric
Barbara Hurtado	Merced County – Parent Resource Center
Christine Betts	Monterey County – County of Monterey

Cristina Farias-Gonzalez	Alliance Care Coordination Supervisor - Pediatric
Dianna Myers, MD	Alliance Medical Director
Heloisa Junqueira, MD	Monterey County - Provider
Jose Francisco Hernandez	Monterey County – Parent Resource Center
Oscar Flores	Monterey County – Parent Resource Center
Sarah Sanders	Alliance Grievance and Quality Manager
Susan Skotzke	Santa Cruz County – CCS WCM Advocate

Guests:

Jenna Stromsoe, RN	Alliance Complex Case Management Supervisor - Pediatric

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

   Committee introductions and roll call was taken.

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

Consent Agenda Items:

3. **Accept WCMFAC Meeting Minutes from Previous Meeting**
   Chairperson Espinoza opened the floor for approval of the meeting minutes of the previous meeting on November 4, 2024. Minutes were approved with no further edits.

Regular Agenda Items:

4. **Meeting Expectations in 2025**
   Chairperson Espinoza shared the expectation is for all members to feel comfortable to share and to be equally valued and heard.

   Vice Chairperson Smith shared updates to the committee charter. The primary change is the creation of voting members and non-voting members. There were no questions or objections to the listed changes.

5. **Pediatric Case Management and California Children's Services (CCS) Overview**
   J. Stromsoe provided an overview of the Alliance's pediatric case management team and California Children's Services program.

   Alliance staff will see if there is an update on the potential expansion of CCS eligible conditions.

The Alliance monitors metrics for CCS enrollment including the ratio of CCS members to all Alliance members and the percentage is in line with similar health plans. The Alliance also looks at referrals versus denials and if there are ways the Alliance can address the reason for the denial such as provide additional documentation. The Alliance has seen an increase in CCS members in San Benito and Mariposa since the presentation was created.

Children are eligible for CCS until their twenty-first birthday. After their twenty-first birthday, there is no change to their access to case management. The transition process begins when the child is seventeen to help a seamless transition after their twenty-first birthday.

San Benito and Mariposa are Whole Child Model Dependent Counties due to not meeting the population threshold and eligibility is determined by the State. The Alliance is aware of the added complexity of another entity being involved in the process and checks referrals at set time intervals.

Committee member inquired about children who do not have consistent guardians such as children in group homes and foster care. The Alliance acknowledged the question and recommended the conversation be held at another time.

6. **CCS Advisory Group Representative Report**
   K. Riggs, RN, provided updates from the most recent CCS Advisory Group meeting attended by Dr. Myers. Priorities for 2025 include the age out process and updates to the demographics data dashboard. There was discussion around the proposal of increasing the CCS age out age to 26 and around the ECM referral process.

7. **Updates and Announcements**
   Committee member inquired about the authorization process for Enhanced Care Management (ECM) and if there is any special notetaking for CCS children to inform the ECM provider of CCS status to minimize delays. A second committee member shared they are experiencing hardship with the appeals process.

   Committee member inquired about resources for financial assistance for eyeglasses with flexible frames as Medi-Cal doesn't cover flexible frames. Another committee member recommended getting an eye exam with the pupillary distance recorded and shopping online retailers.

   Committee member inquired about an annual legislative report in the future.

   Committee member acknowledged the potential impact on CCS children of the reduction or elimination of mental health programs in schools due to budget cuts.

Review Action Items
K. Zoliniak reviewed the actions items.

Future Agenda Items

- CCS Utilization of Enhanced Care Management (ECM)

Adjourn:
The meeting adjourned at 3:03 p.m.

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

Next Meeting: Monday, May 5, 2025.

Meeting Minutes

Thursday, March 13, 2025
10 – 11:30 a.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
Epicenter
440 San Benito Street, Hollister, California
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Members Present:

Alma Mandujano-Orta	Community Advocate
Carolina Meraz	Consumer
Doris Drost	Consumer
Francis Wong	Consumer
Guadalupe Barajas-Iniguez	Consumer Advocate
Humberto Carrillo	Consumer
John Beleutz	Community Advocate
Juana Chávez de Guízar	Consumer
Michael Molesky	Consumer, Commissioner
Mimi Park	Consumer
Moncerat Politron	Community Advocate
Rebekah Capron	Community Advocate
Stephanie Auld	Consumer

Members Absent:

Candi Walker	Consumer
Debra Barcellos	Community Advocate
Aluriel Ceballos	Community Advocate
Janna Espinoza	Consumer, Commissioner
John Alexander	Community Advocate
Jamie Berry	Consumer

Staff Present:

Adourin Malco	Community Engagement Specialist
Desirre Herrera	Quality and Health Programs Manager
Gabriela Chavez	Community Engagement Manager
Kayla Zoliniak	Administrative Specialist
Maria Elena Villalobos	Administrative Specialist
Michael Schrader	Chief Executive Officer
Omar Guzman, MD	Chief Health Equity Officer
Ronita Margain	Community Engagement Director
Sonia Menjuvar	Call Center Quality Analyst
Ulises Cisneros-Abrego	Community Engagement Specialist
Veronica Olivarria	Member Services Call Center Manager

1. Call to Order by Chairperson Beleutz.

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

Roll call was taken and a quorum was met.

2. Oral Communications.

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

No members of the public addressed the Advisory Group.

3. Comments and announcements by Member Services Advisory Group (MSAG) members.

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

MSAG member shared the Santa Cruz IHSS Advisory Counsil has four open seats.

MSAG member inquired about teleconference for attending MSAG meetings.

MSAG member inquired if the Alliance is accepting applications for Solana.

MSAG member commented about inappropriate use of Call the Car for non-medical transportation. Transportation and Call the Car were proposed for a future agenda.

MSAG member commented weight loss shots are only being approved for diabetes and not a broader application such as obesity.

MSAG member commented about the provider shortage, especially for specialty provides such as urology in Merced.

MSAG member commented on Denti-Cal utilization, role of the Alliance, the complicated process, and the specialty services provider shortage. Denti-Cal was proposed for a future agenda.

MSAG member shared care management team is not as responsive as before and inquired about a reasonable turn-around time.

MSAG member commented about the long wait time at provider offices.

4. Comments and announcements by Alliance staff.

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

Michael Schrader, Chief Executive Officer, provided updates regarding the potential government shutdown. Members should continue to access services. The March 26, 2025 Board meeting will include a presentation on Medicaid and members of the public may attend in person or listen via phone.

Dr. Dianna Myers, Medical Director, introduced herself as the Child Welfare Laision for the Alliance.

Consent Agenda Items (5 – 8):

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

Action: Consent Agenda items were approved.

Regular Agenda Items (9 – 12):

9. Annual Election of Officers of the Advisory Group

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

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

Commissioner Molesky nominated G. Barajas-Iniguez for Vice Chairperson. G. Barajas-Iniguez accepted the nomination.

Action: Nominations were approved. Chairperson Beleutz was elected to serve as Chairperson and G. Barajas-Iniguez was elected to serve as Vice Chairperson.

10. Member Services Overview

Veronica Olivarria, Member Services Call Center Manager, provided an overview of Member Services functions.

MSAG member inquired if a mobile app for the member portal is or will be available as a dedicated mobile app may be easier for members to navigate.

MSAG member inquired about transportation benefits to libraries to access technology. Alliance staff responded the transportation is for covered benefits and services only. MSAG member inquired about providing technology in provider offices. MSAG member clarified the technology would not be a covered benefit or service but an ancillary feature available at the time of a covered benefit or service.

11. Health Equity Strategy

Dr. Omar Guzman, Chief Health Equity Officer, provided an overview and solicited feedback on the Alliance's health equity strategy.

MSAG member recommended not focusing on populations only based on numbers.

MSAG member recommended making sure everyone feels entitled to care.

MSAG member inquired if data is separated by gender to address gender health disparities. Alliance staff responded yes, the data is separated by gender and the state application is expanding the definition of gender.

MSAG member recommended meeting members at their physical locations.

12. Community Resources

Due to time constraints, this presentation will be brought back to the advisory group at a future meeting.

Adjourn:

The meeting adjourned at 11:30 a.m.

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

DATE: May 28, 2025

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

FROM: Andrea Swan, MSN, Quality Improvement & Population Health Director

SUBJECT: Quality Improvement Health Equity Transformation Workplan for 2025

Recommendation. Staff recommend the Board approve the Quality Improvement Health Equity Transformation Workplan for 2025.

Summary. This informational report provides a summary of the activities planned for the 2025 QIHET workplan. The workplan includes contractual required Performance Improvement Projects, operational performance metrics, health programs and cultural and linguistic services, and development of the population health management program. Refer to the QIHET Workplan attachment for additional details.

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

Discussion. Approve the 2025 Quality Improvement Health Equity Transformation Workplan.

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

Attachment.

1. 2025 Quality Improvement System Workplan

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SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Execute completed Annual QI Evaluation meeting DHCS and NCQA standards. Finalize Annual Evaluation for presentation to QIHEC.	1. Update the 2024 Evaluation document, ensuring any regulatory updates, and assignment of sections for each respective business owner. 2. Monitor progress of evaluation update by business owners and provide feedback. 3. Create business requirements for a new section of the Alliance website to share evaluation.	8/1/2025-8/30/2025 9/1/2025-12/31/2025 12/1/2025-12/31/2025	Kristen Rohlf, MPH, Quality and Population Health Manager	1st update-	1:	1.	☐ Yes ☐ No	

PROGRAM DESCRIPTION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Finalize 2025 Program Description for presentation to QI stakeholders.	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements.	1/31/2025-2/15/2025	Andrea Swan, Quality Improvement & Population Health Director	1st update:	1:	1	☐ Yes ☐ No	
2. Presentation of the Program Description to both the	2. Submission of Program Description to QIHEW staff	3/1/2025-3/24/2025	Andrea Swan, Quality Improvement & Population Health Director				☐ Yes ☐ No	

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QIHEW, and QIHEC for approval by 4/02/2025								
3. Develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS, and NCQA requirements.	3. Review all DHCS, and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2025-12/31/2025	Andrea Swan, Quality Improvement & Population Health Director		2:	2:	☐ Yes ☐ No	
							☐ Yes ☐ No	

ANNUAL WORKPLAN (SARINA KING)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Execute a QI annual work plan that captures ongoing activities throughout the year and addresses all DHCS and NCQA requirements	1. Create a workplan that captures yearly activities, time frame for each activity's completion, staff members responsible for each activity, monitoring of previously identified issues, and evaluation of QI program.	1/1/2025-2/24/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 1:			☐ Yes ☐ No	
2. Ensure all workplan elements are properly documented and reflect appropriate follow-up by each business owner.	2. Regularly quarterly check-ins to review workplan entries with regular feedback provided to business owners when applicable.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 2			☐ Yes ☐ No	
3. Review and approval of workplan quarterly by QIHEC.	3. Review of all workplan entries prior to each committee to ensure appropriate documentation.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 3:			☐ Yes ☐ No	
1.	1.			Qtr. 4:			☐ Yes ☐ No	

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SECTION 2: QUALITY OF CLINICAL CARE

MEDI-CAL MANAGED CARE SET (MCAS) INTERVENTION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Close pediatric care gaps in Merced and Mariposa County to have all pediatric measures at or above MPL or have a 5% increase in the measure. 2. Measurement Year (MY) 2023, Reporting Year (RY) 2024 MCAS rates for Merced County: 3. Child and Adolescent Well-Care Visits (WCV) - 50.49% 4. Childhood Immunizations - Combo 10 (CIS-10) - 19.71% 5. Immunizations for Adolescents - Combo 2 (IMA–2) - 32.02% 6. Lead Screening in Children (LSC) - 47.01% 7. Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6) - 48.69% 8. Well-Child Visits for Age 15 Months to 30 Months—Two	1. Analyze data - Q1 2. Identify providers and measures- Q2. 3. Provide workforce care gap closure grants to providers with large member populations in Merced and Mariposa Q3. 4. Continue Provider Partnership program in Merced and expand to Mariposa County to support providers in their interventions that focus on measures that are below MPL Q4.	2/1/2025-12/31/2025	Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor III Georgia Gordon, Quality Improvement Program Advisor II Jada Edwards, Quality Improvement Program Advisor II Juan Velarde, Quality Improvement Program Advisor IV Annecy Majoros, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III Britta Vigurs, Quality Improvement Program Advisor III	Qtr. 1: Qtr. 2: Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

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or More Well- Child Visits (W30-2) - 61.10% Note: Mariposa County will be reported for the first time in MY2024, RY 2025.								
1. Improve Follow-Up After ED Visit for Mental Illness - 30 days (FUM) and Follow-Up After ED Visit for Substance Use - 30 days (FUA) measure rates by establishing monthly data file sharing from all five County Behavioral Health departments to the Alliance. These data files will capture services performed by the county departments for carved out services for regulatory DHCS MCAS reporting. Goal is to exceed the MPL for MY24 or increase MY23 by 5%. 2. FUM MY 2023, RY 2024 rate was 34.55% Santa Cruz/Monterey, 20.42% for Merced County Reporting. 3. FUA MY2023, RY 2024 rate was 39.37% for Santa Cruz/Monterey, and 39.97% for Merced. Note: Mariposa and San Benito Counties will be reported for the first time in MY2024, RY 2025. Single plan health plan rates will be submitted to NCQA, and county specific rates submitted to DHCS.	1. Analyze last year's Merced, Monterey, and Santa Cruz County Behavioral Health Department MCAS ad hoc data files for process improvements in Q1. 2. Contact Merced, Monterey, Mariposa, Santa Cruz, and San Benito County Behavioral Health Departments for new monthly data sharing request during Q1-Q3. 3. Provide technology support and QA of received files for file layout compliance during Q1-Q4. 4. Creation of a new Alliance database to store county data in Q2-Q4. 5. Integration of new files for HEDIS vendor software extraction in Q2-Q4.	1/1/25 -3/31/25, 1/1/25-9/30/25, 1/1/25-12/31/25, 3/1/25-12/31/25, 3/1/25-12/31/25	Magdalena Kowalska, Quality Improvement Program Advisor IV Shae Redwine, Behavioral Health Program Analyst	Qtr. 1: Qtr. 2: Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

CARE-BASE INCENTIVE (CBI) (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase CBI program resources and support to Mariposa and San Benito County participating	1. Analyze CBI Forensics (CBIF) meeting requests from 2024 from Mariposa and San Benito in Q1-Q2	1/1/25-6/30/25, 1/1/25-6/30/25, 1/1/25-3/30/25,	Alex Sanchez, MPH, Quality Improvement Program Advisor III Annecy Majoros, Quality Improvement Program Advisor III	Qtr. 1:			☐ Yes ☐ No	

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providers. Goal is to increase county specific targeted December 2024 rates to exceed the MPL or increase by 5% by December 2025. Mariposa County CBI Measures of Focus as of December 2024: 2. Child and Adolescent Well-Care Visits (37.76%) 3. Controlling High Blood Pressure (20.56%) 4. HbA1c Poor Control >9% (66.97%) 5. Cervical Cancer Screening (25.16%) 6. Chlamydia Screening in Women (48.91%) San Benito County CBI Measures of Focus as of December 2024: 7. Developmental Screening in the First Three Years of Life (21.51%) 8. Controlling High Blood Pressure (11.07%) 9. HbA1c Poor Control >9% (89.84%) 10. Cervical Cancer Screening (43.78%)	2. Analyze Alliance Provider Portal Data Submission Tool (DST) usage and training requests from 2024 from Mariposa and San Benito in Q1-Q2 3. Analyze CBI Q4 2024 final programmatic rates from Mariposa and San Benito CBI group providers in Q1-Q2 4. Outreach to providers in Mariposa and San Benito to schedule CBIF and additional provider portal report and DST submission training based on Q4 2024 performance, DST submission usage, and past forensics requests in Q2-Q3. 5. Create, record, and publish the CBI Intro Video to the Alliance website for the CBI 2025 program year. Add information on new portal reports like HEDIS (MCAS) Reports to training material. Complete in Q1-Q3	3/1/25-8/30/25, 1/1/25-8/30/25	Britta Vigurs, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III Juan Velarde, Quality Improvement Program Advisor IV	Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

BASIC POPULATION HEALTH MANAGEMENT (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provide members chronic disease management programs and wellness programs. A minimum of 4 member workshops will be provided per quarter.	1. The Health Educators will conduct a minimum of 4 member workshops per quarter. 2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs.	1/1/2025 -3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	

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				Qtr. 4:			☐ Yes ☐ No	
2. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.	1. The project team will conduct outreach and education activities to inform members of services available to them via: • Member outreach calls • Member newsletter articles • MSAG presentation • Social media and/or texting campaigns	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
3. On a bi-annual basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact. A minimum of 50 surveys will be collected annually.	1. The project team will conduct member satisfaction surveys to evaluate: • Information about the overall program • Usefulness of the information shared • Percentage of members indicating that the program helped them achieve health goals. 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning of health education activities.	1/1/2025-3/31/2025 7/1/2025-9/30/2025	Kevin Lopez, C&L Program Advisor Veronica Lozano, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
4. On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal and external partners. A minimum of 2 presentations will be conducted per quarter.	1. The project team will reach out to internal and external partners to schedule presentations. 2. Deliver Health Education and Member Health Rewards services presentations. 3. Request input regarding presentation content and any member needs that they have encountered regarding Health Education services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	

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				Qtr. 4:			☐ Yes ☐ No	

SECTION 3: SAFETY OF CLINICAL CARE

FACILITY SITE REVIEW (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.	1. Enhance provider scheduling support by onboarding three additional QI RNs dedicated to conducting facility site reviews. 2. Implement proactive planning by reviewing all upcoming site reviews one quarter in advance. 3. Streamline scheduling by offering provider sites a selection of review dates two months before the review due date.	01/01/2025-03/31/2025	Joana Castaneda, Quality Improvement Program Advisor; Tisha Criswell, Senior Quality Improvement Nurse, Yvette Sullivan, Quality Improvement Nurse, and Breena Siliznoff, Quality Improvement Nurse	Qtr. 1: Qtr. 2: Qtr. 3:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

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	4. Maintain continuous communication with provider sites until a review date is confirmed.			Qtr. 4:			☐ Yes ☐ No	
2. 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.	1. Enhance CAP management support by onboarding three additional QI RNs for facility site reviews. 2. Send email reminders to provider sites regarding upcoming CAP due dates. 3. Directly contact non-responsive providers via phone, involving PRRs as necessary.	01/01/2025-03/31/2025	Joana Castaneda, Quality Improvement Program Advisor; Tisha Criswell, Senior Quality Improvement Nurse, Yvette Sullivan, Quality Improvement Nurse, and Breena Siliznoff, Quality Improvement Nurse	Qtr. 1: Qtr. 2: Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

POTENTIAL QUALITY ISSUES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 100% of member grievances received by QI concerning potential medical quality of care issues are resolved within the regulatory timeframes for Member Grievances.	1. Establish due dates in SharePoint for PQIs that allow sufficient time for investigation, translation needs (if applicable), and for the Grievance Coordinator to resolve the case. 2. Promptly request medical records necessary for the PQI investigation upon case assignment to the QI RN. 3. Ensure timely coordination of discussions if the case requires MD guidance or potential P2/P3 recommendations.	01/01/2025-03/31/2025	Emily Kaufman, Clinical Safety Supervisor; Eleni Pappazisis, Quality Improvement Program Advisor; Naomi Kawabata, Senior Quality Improvement Nurse; Katie Lutz, Senior Quality Improvement Nurse; Sandy Clay, Senior Quality Improvement Nurse; Karen de Leon, Quality Improvement Nurse and Bethany Fung, Quality Improvement Nurse	Qtr. 1: Qtr. 2: Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
2. 80% of non-grievance related PQIs are completed within 120 calendar days.	1. Triage and prioritize incoming internal referrals for the following case types: 2. Known providers for tracking and trending. 3. Providers on a CAP or involved in an open Quality Study.	01/01/2025-03/31/2025	Emily Kaufman, Clinical Safety Supervisor; Eleni Pappazisis, Quality Improvement Program Advisor; Naomi Kawabata, Senior Quality Improvement Nurse; Katie Lutz, Senior Quality Improvement Nurse; Sandy Clay, Senior Quality Improvement Nurse; Karen de Leon, Quality Improvement	Qtr. 1: Qtr. 2: Qtr. 3:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

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	4. LTSS members.		Nurse and Bethany Fung, Quality Improvement Nurse	Qtr. 4:			☐ Yes ☐ No	

APPEALS & GRIEVANCE REVIEW (SARAH SANDERS)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Meet regulatory requirements 98% of the time for timely acknowledgments and resolutions.	1. Monitor appeal and grievance inventory for daily, weekly, and monthly oversight. 2. Ensure standard appeals and grievances are acknowledged within 5 days and resolutions occur within 30 calendar days.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-Aug 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Qtr. 2 Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
2. Monitor and maintain Grievance rates below 2 per 1,000 members per month for Quality-of-Care concerns; below 2 per 1,000 members per month for Quality-of-Service concerns (NCQA standard).	1. Track and trend appeal & grievance data by both NCQA primary categories & DHCS categories for quality of care (QOC), quality of service (QOS) and access issues. 2. Track grievance and appeals for emerging quality of care and service trends. Inclusive of access trends, system issues, and actionable corrections needed.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Qtr. 2: Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
3. Improve Appeal and Grievance (AG) data quality and reporting.	1. Identify reporting needs, gaps and areas for improvement.	24Q4- March 31, 2025 25Q1-May 30, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1:			☐ Yes ☐ No	

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	2. Develop report for substantiated grievances to support identification of systemic issues and opportunities for improvement.	25Q2-August 29, 2025 25Q3-Oct 31, 2025		Qtr. 2: Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
4. Improve monitoring and documented oversight.	1. Initiate reportable notes within appeals and grievance (AG) system to improve transparency with oversight. 2. Develop report to quality oversight activities.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 1: Qtr. 2: Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

COC OF MEDICAL & BEHAVIORIAL HEALTH (REBECCA MCMULLEN, TAMMY BRASS, TAMMY HOEFFEL, NAVNEET SACHDEVA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase Utilization of the Alliances Behavioral Health benefit overall by an average of 1.5% within the Behavioral health network by increasing provider and member education about BH benefits offered referral pathways and importance of care coordination between providers. Special attention will be given to tracking and reporting out on changes in utilization in Merced, Mariposa and San Benito, as they are lowest utilization counties.	1. At minimum, annual BH team member attendance at PAG, MSAG, QIHEC or other similar forums/ meetings to discuss BH services and education 2. Increase in provider and member outreach and education via provider newsletters, NSMHS outreach and education plan and updates to handbooks 3. Promotion of BH services at county outreach activities (Goal of at least	1/1/2025- 5/31/2025 Ongoing starting 1/1/25 Ongoing starting 1/1/25 Incentives beginning 7/1/25	Rebecca McMullen, BH Manager and/or Shae Redwine/Laura Ruell, BH Analyst With support from: Communications department manager, Provider Services Manager, Member Services Manager, QIPH Manager	Qtr. 1: Qtr. 2 Qtr. 3:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

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	1 annually in each in our lower utilization counties) 4. Education and incentives for BH providers to document and coordinate care with PCPs 5. Outreach and engage local EDs and/or PCP networks on referral pathways, benefit information and care coordination.	At minimum, 1 Per quarter, starting Q1 1/1/25-3/31/25		Qtr. 4:			☐ Yes ☐ No	
2. Will assure that ECM enrollment is maintained at 3% of plan membership.	1. Will maintain enrollment through oversight of network. 2. Will provide eligible member lists to providers on a monthly basis.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Tammy Hoeffel, Enhanced Health Services Director	Qtr. 1: Qtr. 2 Qtr. 3 Qtr. 4			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
3. Will assure ongoing compliance with ECM provider submission of one encounter claim per member per month	1. Will monitor monthly the compliance with ECM provider submitting one claim per member per month at 90%. 2. Will follow-up with providers who are not reaching this target to assure that PCRs are submitted on a consistent basis when members are lost to follow-up. 3. Will monitor in coordination with Claims Department – for claims that are getting denied resolving and address issues.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Tammy Hoeffel, Enhanced Health Services Director	Qtr. 1: Qtr. 2 Qtr. 3 Qtr. 4			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
4. Will complete ECM oversight on all providers in 2025.	1. Will schedule ECM oversight on all providers. 2. Will schedule approximately 20 providers per quarter to reach this goal 3. Guidelines have been established and reviewed with all stakeholders.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Tammy Hoeffel, Enhanced Health Services Director	Qtr. 1: Qtr. 2			☐ Yes ☐ No ☐ Yes ☐ No	

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	4. Corrective Action Plans will be provided as needed to ECM providers not meeting delivery guidelines for services in a quality manager			Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

COC OF MEDICAL CARE (TAMMY BRASS, TAMMY HOEFFEL, NAVNEET SACHDEVA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	
							☐ Yes ☐ No	

SECTION 4: MEMBER EXPERIENCE

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MEMBER SATISFACTION SURVEY – CAHPS (SARINA KING)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start& end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Improve CAHPS rates for "How Well Doctors Communicate" for members 0-18 years from 91.5% to 94.4%.	1. Elicit feedback from relevant teams to develop interventions. 2. Implement interventions. 3. Study and adjust interventions.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025,	Jada Edwards, Quality Improvement Program Advisor Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor Additional intervention collaboration from QIPH staff, provider relations	Qtr. 1: Qtr. 2 Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
2. Improve CAHPS rates for "Health Plan Customer Service" for adult members from 87.8% to 89.8%.	1. Elicit feedback from relevant teams to develop interventions. 2. Implement interventions. 3. Study and adjust interventions.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025	Jada Edwards, Quality Improvement Program Advisor Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor Additional intervention collaboration from customer service team, member services	Qtr. 1: Qtr. 2 Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

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SECTION 4: QUALITY OF SERVICE

ACCESS & AVAILABILITY (AA) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with DMHC Timely Access Survey Requirements	1. Ensure 90% of After-hours triage compliance in Timely Access Survey. (Provider Appointment Availability Survey [PAAS]). 2. Ensure 75% Urgent and routine appointment access compliance, as well as next available follow up appointment for non-physician mental health care, within required time frames. 3. PAAS work begins in the summer with vendor engagement and finalization of the project plan and contact lists. The survey is launched from August to November/December. Results are available in Q1 of the subsequent year.		Jessie Dybdahl, Provider Service Director	Qtr. 1: Qtr. 2 Qtr. 3 Qtr. 4			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	
2. Quarterly review of provider to member ratios for PCPs and High-volume/high-impact Specialties. To ensure all ratios meet regulatory requirements.	1. Ensure provider to member ratios are w/in compliance and mitigate if out of compliance on a quarterly basis. 2. Tableau report is monitored no less than quarterly to ensure provider to member ratios are met for each required provider type.		Jessie Dybdahl, Provider Service Director	Qtr. 1: Qtr. 2 Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with Time or Distance Standards set forth by DHCS	1. Ensure the network meets time or distance standards in compliance with DHCS requirements when a provider is available. 2. Monitor areas where no provider is available and ensure		Jessie Dybdahl, Provider Service Director	Qtr. 2			☐ Yes ☐ No	

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	alternative access requests are in place on a quarterly basis. 3. Evaluate the non-contracted provider network to determine if recruitment might remedy access gaps. Launch recruitment efforts as applicable.			Qtr. 4:			☐ Yes ☐ No	

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provider Satisfaction Survey	1. Monitor Provider Satisfaction annually. Ensure no less than 5% decrease in overall satisfaction with the plan from prior year. 2. The Provider Satisfaction Survey (PSS) is launched in the summer with vendor engagement in spring. Contact lists are sent for primary care, specialty care, and non-physician mental health care. The survey is launched from July to August. Results are available in quarter 4.	7/1/2025 - 12/31/2025	Jessie Dybdahl, Provider Service Director	1st update:			☐ Yes ☐ No	

TELEPHONE ACCESS (VERONICA OLIVARRIA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of calls to Member Services answered within 30 seconds.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. Improvement efforts slated for 2024: • The adoption of a Workforce Management Tool to assist with call forecasting and representative scheduling, ensuring we have appropriate levels of staff supporting the queues at any given time/day. • Call Audit Optimization: We are developing formal call audit guidelines and defined audit methodology to ensure	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Lilia Chagolla, Member Services Director Veronica Olivarria, Call Center Manager	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	

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	staff is adhering to Alliance updates and processes. • Developing additional call circles (queues) to: 1. Optimize resource availability. 2. Improve speed to answer. 3. Reduce representative training time. 4. Increase member satisfaction. • Computer Telephone Enhance HSP/Finesse by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time on phone for the MSR and will make each call more efficient. Integration: Assess staffing needs due to increase in membership			Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No	
2. Call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Lilia Chagolla, Member Services Director Veronica Olivarria, Call Center Manager	Qtr. 1: Qtr. 2 Qtr. 3: Qtr. 4:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

CULTURE & LINGUISTICS (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2024 baseline utilization data.	1. The project team will track utilization for the following services: • Phone interpreting services. • Face-to-Face (F2F) interpreting services. 2. Use quarterly utilization data to identify potential need to training of provider network on language assistance services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: Qtr. 2 Qtr. 3:			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	

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				Qtr. 4:			☐ Yes ☐ No	
2. On a bi-annual basis, collect member feedback on their experience with language assistance services in a clinical setting. A minimum of 50 surveys will be collected annually.	1. The project team will conduct satisfaction surveys with members to evaluate: • Individual ratings of access to language services. • Overall rating of interpretation services. • Access to language services at a health care encounter. • Gather individual experiences with the services. 2. Request input from members regarding programs and services. 3. Incorporate member feedback into planning and identifying areas of improvement for the services.	1/1/2025-3/31/2025 7/1/2025-9/30/2025	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager Ivonne Munoz, Quality and Health Programs Supervisor	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
3. On a quarterly basis, inform members and providers of language assistance services utilizing at least 1 member and 1 provider informing modality.	1. The C&L team will conduct outreach and education activities to inform members and providers of services available: a. Member newsletter articles b. Provider bulletin articles c. Education materials including flyers d. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning of health education activities.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
4. On a quarterly basis, provide at least 1 C&L services presentations to Alliance internal department staff that interact with members or providers to increase awareness of language assistance services available for members.	1. The C&L team will reach out to internal and external partners to schedule C&L services presentations. 2. Deliver C&L services presentation. 3. Request input regarding presentation content and any member needs that they have encountered regarding C&L services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	

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				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

DELEGATION OVERSIGHT (ANDREA SWAN)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations.	1. Quarterly review of delegate reports to ensure compliance, and identification of any issues.	3/31/2025,6/30/2025 9/30/2025,12/31/2025	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	
2. Ensure oversight of all delegated activities by governing board.	2. Present quarterly updates of all reviewed activities with identification of any issues to the governing board for review, and feedback.	3/31/2025,6/30/2025 9/30/2025,12/31/2025	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1:			☐ Yes ☐ No	
				Qtr. 2			☐ Yes ☐ No	
				Qtr. 3:			☐ Yes ☐ No	
				Qtr. 4:			☐ Yes ☐ No	

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DATE: May 28, 2025

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

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

SUBJECT: Policy Revision – 401-1101 – Quality Improvement and Health Equity Transformation Program

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Recommendation. Staff recommend the Board approve revisions to Alliance Policy 401-1101 Quality Improvement and Health Equity Transformation Program (QIHETP).

Background. The 2024 Medi-Cal contract requires establishment of a Quality Improvement and Health Equity Transformation Program to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services (DHCS) requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 438.330 and 438.340.

Discussion. The Quality Improvement and Health Equity Transformation Program (QP) was modified to align with the 2024 Medi-Cal contract and Assembly Bill 2340 for EPSDT, as described in Policy 401-1101 – Quality Improvement and Health Equity Transformation Program (QIHETP). Significant modifications were made to align with the DHCS Comprehensive Quality Strategy Guiding Principles and contractual requirements, which encompassed core continuous quality improvement activities, population health management interventions, and health equity. Further, the policy was updated to align with 2024 NCQA Accreditation standards.

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

Attachments.

1. Alliance Policy 401-1101 – Quality Improvement and Health Equity Transformation Program

	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement & Health Equity Transformation Program (QIHETP)	
Original Date: 02/01/1996	**Date Published:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Purpose

To describe Central California Alliance for Health's (the Alliance) Quality Improvement & Health Equity Transformation Program (QIHETP[1]). The QIHETP is an organizational-wide, cross-divisional, and comprehensive program that encompasses the Alliance's commitment to the delivery of quality and equitable health care services including the integration of quality, population health, and health equity principles[2]

Policy

The QIHETP[3] exists to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services (DHCS) requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 438.330 and 438.340[4]. The QIHETP aligns efforts with DHCS' Comprehensive Quality Strategy Report and also reviews actions items identified through DHCS' reports including but not limited to the Technical Report, Health Disparities Report, Preventive Services Report, Focused Studies, and Encounter Data Validation Report. Additionally, QIHETP oversight entities may electively incorporate best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) into the QIHETP as they deem appropriate.

Vision: *"Quality for All" - Quality is everyone, every time, and everywhere*

The QIHETP strives to achieve high quality, safe and excellent care, delivered in an equitable and collaborative manner, to achieve optimal health outcomes for all members in the communities we serve. It is guided by the Alliance's vision of *Healthy People, Health Communities*, our mission of *accessible, quality health care guided by local innovation*, and Alliance values of *Improvement, Integrity, Collaboration and Equity.*

QIHETP Values

The QIHETP provides a comprehensive structure that meets the following requirements:

Continuous Quality Improvement (CQI)[5]

1. Develop and maintain structures and processes that support CQI methodologies by demonstrating organizational commitment to the delivery of quality health care services through jointly developed goals and objectives across Divisions, approved by the Alliance Board, and periodically evaluated and updated.
2. Apply CQI to all aspects of Alliance's service delivery system through analysis, evaluation, and systematic enhancements of the following: 1) quantitative and qualitative data collection and data-driven decision-making, 2) up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals (consensus of professionals if none exist); and
3. Feedback provided by members and network providers in the design, planning, and implementation of its CQI activities.

Equitable and Person-Centered

1. Ensure all medically necessary covered services are: available and accessible to all members in any setting, regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age,

mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56[6], and provided in a culturally and linguistically appropriate manner[7].
2. Provide tailored, consistent, and whole-person care across all member-facing team that meet the needs and experience of our members.
3. Ensure delivery of health care services complies with all mental health parity requirements in 42 CFR section 438.900 for Alliance, Subcontractors, Downstream Subcontractors, Network Providers, and other entities.

Safe, Accessible, and Effective Quality of Care and Services

1. Ensure integration with all departments within the Alliance, current community health priorities, standards, and public health goals;
2. Continuously review, evaluate, and improve access to and availability of services, including obtaining appointments within established standards;
3. Ensure consistent patient safety processes through proactive surveillance, investigation, and appropriate actions to address quality issues related to care, service, or satisfaction; and
4. Ensure effectiveness of the quality of care and services delivered across the continuum of care by addressing preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, behavioral and ancillary care services, including complex health needs, emerging risk, and multiple chronic conditions for improved health outcomes.

Population Health Management Interventions[8]

Designed to identify, evaluate, and address social drivers of health, reduce disparities in health outcomes experienced by different subpopulations of members, and work towards achieving health equity by:

1. Developing equity focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services; and
2. Engaging in a member and family-centric approach in the development of interventions and strategies, and in the delivery of health care services.

Comprehensive Quality Strategy Guiding Principles[9]

1. Eliminating health disparities through anti-racism and community-based partnerships
2. Data-driven improvements that address the whole person
3. Transparency, accountability, and member involvement
4. Meet disparity reduction targets for specific populations and/or measures identified by DHCS.

Scope

The Alliance ensures that its Network Providers, Fully Delegated Subcontractors, and Downstream Fully Delegated Subcontractors participates and are updated on activities, findings, and recommendations of the QIHEC's QIHETP and Population Needs Assessment (PNA)[10], and represent the providers who provide health care services to Members including, but not limited to Members affected by health disparities, limited English proficiency (LEP) Members, children with special health care needs, seniors and persons with disabilities, and persons with chronic conditions. The QIHETP encompasses quality of care, quality of services, patient safety, and member experience:[11]

1. Quality of care services including, but not limited to: clinical quality of physical health care, behavioral health care focused on recovery, resiliency, and rehabilitation, preventive care, chronic disease, perinatal care, family planning services, and reduction in health disparities.
2. Quality of services including, but not limited to: availability and regular engagement with Primary Care Providers, access to primary and specialty health care, grievance process, coordination, and continuity of care across settings and at all levels of care (including transitions of care), and information standards.
3. Standards for patient safety including, but not limited to: facility site reviews, credentialing of practitioners, and quality of care/peer review.
4. Standards in member experience with respect to clinical quality, access, and availability, and culturally and linguistically competent health care and services, and continuity and coordination of care. This includes, but not limited to: satisfaction surveys and assessments, monitoring of member complaints, phone queue monitoring, access measurement and member grievance timeliness.

Goals and Objectives

The goal and objective of the QIHETP is to objectively and systematically monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all its Providers in any setting, and take appropriate action to improve upon Health Equity[12] :

1. Quality and safety of healthcare and services provided by the Alliance's provider network:
   - 1.a. Incorporate provider and other appropriate professional involvement in the QIHETP through review of findings, study outcomes, and on-going feedback for program activities
   - 1.b. Conduct facility site reviews/medical record reviews at provider sites and reviewing quality issues or trends referred for further investigation and follow-up actions
   - 1.c. Develop and maintain a high-quality provider network through credentialing, re-credentialing, and peer review processes[13]
   - 1.d. Maintain an ongoing oversight process by incorporating annual performance metrics of QIHETP-related functions performed by practitioners, providers, and delegated or independently contracted/sub-contracted delegates
   - 1.e. Ensure that care and resources are available, appropriate, accessible, and timely for all members according to standards of care and evidence-based practices
   - 1.f. Mechanisms to detect, review, and analyze results of both over/underutilization of services, but not limited to, outpatient prescription drugs[14]. Refer to Alliance Policy 404-1108 - – Monitoring of Over/Under Utilization of Services.

2. Quality of services provided by the Alliance to its members, providers, the community, and internal staff:
   - 2.a. Align quality improvement activities with activities that promote the continuous development of a provider network that meets member needs, such as the annual Access Plan
   - 2.b. Implement innovative practices, such as telephonic or virtual means, to ensure that members obtain care which is timely and meets their needs
   - 2.c. Utilize data-driven approaches and effective analysis, implementation, and evaluation towards improved clinical outcomes, services, and experiences

2.d. Ensure care is provided regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and linguistically appropriate manner[15]
2.e. Identify population-based strategies to identify, evaluate, and reduce healthcare disparities through analysis, equity-focused interventions, and meeting disparity reduction targets[16]
2.f. Provide access to services and communication in alternate formats to ensure non-discrimination of members as defined in Section 1557 of the Patient Protection and Affordable Care Act[73]
2.g. Education regarding accessing the health care system and support on obtaining care and services when needed
2.h. Concerns resolved quickly and effectively including the right to voice complaints or concerns without fear of discrimination
2.i. Engagement in the discussion about services, regardless of cost or benefit coverage
2.j. Confidence that they can reach the Alliance quickly and be satisfied with the information received.
2.k. Maintain Member confidentiality in quality Improvement discussions.

3. Members' experience of care and service provided by the Alliance and its contracted providers:
3.a. Monitor member satisfaction with quality of care and services received from network providers, practitioners and delegates and acting upon identified opportunities
3.b. Obtain information on member's values, needs, preferences, and health-related goals through feedback mechanisms and touch points, such as surveys, focus groups, member outreach, care management, and other means
3.c. Establish population health programs to empower and encourage members to actively participate in and take responsibility for their own health through the provision of health education, evidence-based tools, and shared goals for optimal health
3.d. Create a trusted health care system to assure feelings of safety, self-efficacy, and effective communication with all their care partners
3.e. Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all members[17];Integrate with current community health priorities, standards, and public health goals.

Definitions

1. California Children's Services (CCS) Program[18] (as part of the Whole Child Model Program): CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years of age can get the health care and services they need for CCS-eligible conditions. CCS also provides medical therapy services that are delivered at public schools through their Medical Therapy Unit (MTU).
2. Community Supports: Services or settings offered by a Medi-Cal health plan that are offered in place of services or settings covered under the California Medicaid State Plan, and are medically appropriate, cost-effective substitutes for services or settings under the State Plan. Services are offered at the plan's option and an enrollee cannot be required to use them.

3. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Standardized surveys of Agency for Healthcare Research and Quality (AHRQ), the CAHPS' surveys health plan members to measure their experiences with a variety of areas, including access to care and satisfaction with the health plan.
4. Corrective Action[19]: Specific identifiable activities or undertakings of the Alliance that address program deficiencies or problems.
5. Enhance Care Management (ECM): ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person centered.
6. External Accountability Set (EAS)[20]: Performance Measures: The EAS performance measures consist of a set of Healthcare Effectiveness Data Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). The EAS performance measures may also include other standardized performance measures and/or DHCS developed performance measures selected by DHCS for evaluation of health plan performance.
7. Healthcare Effectiveness Data and Information Set (HEDIS)[21]: The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.
8. High Performance Level (HPL): DHCS establishes an HPL for each required HEDIS performance measure and publicly acknowledges Managed Care Plans (MCPs) that meet or exceed the HPLs. DHCS's HPL for each required measure is the 90th percentile of the national Medicaid results.
9. Long Term Care Services: Long-term care benefit standardization and transition of members to managed care, including managing the long-term care of members in skilled nursing facilities.
10. Managed Care Accountability Set (MCAS): A set of measures based on the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets, and NCQA are selected by DHCS for evaluation of health plan performance.
11. Minimum Performance Level (MPL): Medi-Cal managed care health plans must meet or exceed the DHCS established MPL for each required HEDIS performance measure. If MPL is not met, then an Improvement Plan must be completed. DHCS's MPL for each required measure is the 50th percentile of the national Medicaid results.
12. National Committee for Quality Assurance (NCQA)[22]: A non-profit organization that committed to evaluating and publicly reporting on the quality of managed care plans.
13. Performance Improvement Projects (PIPs)[23]: Studies selected by the Alliance, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes[24].
14. Plan, Do, Study, Act (PDSA): A cyclical, four-step management method used for continuous improvement and monitoring of processes. The methodology is a rapid cycle/continuous quality improvement process designed to perform small tests of change, which allows more flexibility to make adjustments throughout the improvement process[25].

	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement & Health Equity Transformation Program (QIHETP)	
Original Date: 02/01/1996	**Date Published:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Procedures

The QIHETP is structured to develop and maintain an integrated system to continually identify, assess, measure, and improve member health outcomes. Providers and members are an integral part of the QIHETP. QIHETP activities are overseen and approved in the following manner:

1. Maintain Accountability of Care Systems
   Accountability for the QIHETP development and performance review includes the Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board), the Quality Improvement Health Equity Committee (QIHEC), Chief Health Equity Officer or designee, the Peer Review and Credentialing Committee (PRCC), the Compliance Committee, the Chief Medical Officer (CMO), and Alliance network providers[26].

   1.a. Alliance Board[27]: The Alliance Board promotes, supports, and has ultimate accountability and authority for a comprehensive and integrated QIHETP. Alliance Board responsibilities include:
   - 1.a.1. Annual review and approval of the QIHETP and applicable QIHETP reports;
   - 1.a.2. Appointment of an accountable entity or entities to provide oversight of the QIHETP;
   - 1.a.3. Routine review of written progress reports from the QIHECo;
   - 1.a.4. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and DHCS Comprehensive Quality Strategy;
   - 1.a.5. The Alliance Board has delegated direct supervision, coordination, and oversight of the QIHETP by the Quality Improvement Health Equity Committee (QIHEC), with the Chief Executive Officer (CEO) and Alliance Quality Improvement and Population Health (QIPH) Department under the supervision of the Chief Medical Officer (CMO) in collaboration with the Chief Health Equity Officer or designee. The CMO regularly provides QIHETP operational reports to the Alliance Board.

   1.b. Quality Improvement Health Equity Committee (QIHEC)[28]: The QIHEC has oversight and performance responsibility of the QIHETP – excluding credentialing and recredentialing[29] activities, which are directed by the PRCC – as described by Alliance Policy 401-1201 – *Quality Improvement Health Equity Committee.*

   1.c. Peer Review and Credentialing Committee (PRCC): The PRCC participates in the QIHETP under the authority of the Alliance Board. The PRCC maintains oversight and performance responsibility of the Alliance's credentialing and recredentialing activities, as described in Alliance Policy 300-4020 – *Peer Review and Credentialing Committee – Authority, Roles, and Responsibilities*.

   1.d. Compliance Committee: The Compliance Committee participates in the QIHETP under the authority of the Alliance Board. The Compliance Committee maintains oversight and performance responsibility of the Alliance's delegated oversight activities, as described in Alliance Policy 105-0004 – *Delegate Oversight*.

1.e. Other Committees: In addition to the Alliance Board, QIHEC, PRCC, and Compliance Committee, the following committees and workgroups contribute to the Alliance's QIHETP:

1.e.1. Quality Improvement Health Equity Workgroup (QIHEW): The QIHEW, under the direction and guidance of the QIHEC, is responsible for ongoing QIHETP activities and addressing high-priority and emerging quality and health equity trends requiring organization-wide and/or cross-departmental response as described in Alliance Policy 401-1201 –*Quality Improvement Health Equity Committee*.

1.e.2. Care-Based Incentives Workgroup (CBIW): The CMO (or designee) chairs the CBIW. Core membership includes: QIPH Director, Quality and Health Programs Manager, QI Program Analysts, Quality Improvement Program Advisors, Quality and Population Health Manager, QI Project Specialist, Medical Directors, Pharmacy Director (or designee), PS Director (or designee), Contracts Manager, Analytics Director, and Analytics Manager.

1.e.3. Physicians Advisory Group (PAG): The PAG operates under the authority of the Alliance Board and participates in the QIHETP. as described in Alliance Policy 400-1109 – *Physicians Advisory Group Responsibilities and Functions*.

1.e.4. Utilization Management Work Group (UMWG): The UMWG is a mechanism to review, monitor, evaluate, and address utilization-related concerns as well as recommend and implement interventions to improve appropriate utilization and resource allocation. The UMWG reports to the CQIC and is co-chaired by a Medical Director and Utilization Management/Complex Case Management (UM/CCM) Director. Core UMWG membership includes: CMO, Medical Directors, UM/CCM Director, UM/CCM Managers for Concurrent Review, UM/CCM Manager for Prior Authorization, Community Care Coordination (CCC) Director, QIPH Director, Pharmacy Director, and Health Services Authorization Supervisor.

1.e.5. Pharmacy and Therapeutics Committee (P&T): The P&T Committee operates under the authority of the CQIC and participates in the QIHETP as described in Alliance Policy 403-1104 – *Mission, Composition and Functions of the Pharmacy & Therapeutics Committee*.

1.e.6. Staff Grievance Review Committee (SGRC): The SGRC participates in the QIHETP as described in Alliance Policies 200-9004 – *Staff Grievance Review Committee* and 200-9001 – *Grievance Reporting, Quality Improvement and Audits*.

1.e.7. Whole Child Model Clinical Advisory Committee (WCMCAC): The WCMCAC operates under the authority of the Alliance Board and serves to advise on clinical issues relating to CCS conditions including treatment authorization guidelines, as described in Alliance Policy 400-1112 – *Whole Child Model Clinical Advisory Committee Responsibilities and Functions.*

1.e.8. Whole Child Model Family Advisory Committee (WCMFAC): The WCMFAC operates under the authority of the Alliance Board and serves as a venue to discuss perspective on issues relating to diagnosis and treatment of CCS conditions as well as to review and offer advice about policies, programs and initiatives relating to care of members in the WCM program. as described in Alliance Policy 280-0003 – *Whole Child Model Family Advisory Committee.*

1.e.9. Network Development Steering Committee:
The Network Development Steering Committee's (NDSC) primary responsibility is to: 1. Monitor and evaluate member access to care through: · Comprehensive, coordinated, and regular review of access inputs, including but not limited to survey outcomes, regulatory compliance, and process-related information (e.g., grievances). 2. Support improved member access to care through oversight of the development and execution of an annual provider network Access Plan.

1.e.10. Member Support and Engagement Committee:
The Member Support and Engagement Committee (MSEC) is an interdepartmental collaborative intended to evaluate the Alliance processes that assist members in navigating the health care system. The Alliance's goal is to ensure members are supported and engaged, while being confident that they will receive appropriate care from providers and excellent service from the health plan. This committee facilitates the collaboration and integration of relevant service indicators as defined by the monitoring process, analysis, action, and measurement. Through monitoring of appropriate indicators, MSEC will identify areas of opportunity to improve processes and implement interventions. The committee also works on member outreach to provide guidance to the Your Health Matters Outreach Program as appropriate to this committee's charter and any Quality Improvement Activities within the scope of this committee.

1.e.11. Member Reassignment Committee: Reassignment requests are presented to the Reassignment Committee for review and discussion. Determination is made by the Medical Director (MD).

1.e.12. Communications Committee: On-going updates on the QIHETP are provided to the committee to support planning, promotion, and communication of QIHETP activities.

1.f. Task Force: For emerging issues or priorities, a Task Force may be convened to cross-collaborate on needed actions or follow up until resolution or goals are met (e.g., Public Health Response Task Force, Pediatric Equity Task Force).

1.g. Program Staff
Alliance staff participating in the QIHETP are described below. Specific qualifications and training for each role are available in the respective position description for each role.

1.g.1. Chief Executive Officer (CEO): The CEOs primary role in the QIHETP is fourfold: maintain a working knowledge of clinical and service issues targeted for improvement; provide organizational leadership and direction; participate in prioritization and organizational oversight of QIHETP activities; and ensure availability of resources necessary to implement the QIHETP.

1.g.2. Chief Medical Officer (CMO): The CMO is responsible for assuring the availability and quality of health care services for Alliance members. Responsibilities include leadership and direction of UM, Quality Management and CM programs, including medical management policies and effective operation of the Health Services (HS) Division. The CMO uses the health plan's systems and data to analyze HS Division issues and policies and is responsible for communicating findings and recommendations within the health plan, to the governing board, to physician committees and other providers, and to other stakeholders. This position is an advocate and liaison for the provider network and participates in strategic planning for new programs, lines of business, and special projects at the health plan. The CMO is also responsible for direction and supervision of the Medical Directors.

The CMO shall ensure that that the organization's medical personnel follow medical protocols and rules of conduct. The CMO shall participate directly in the implementation of Quality Improvement and Health Equity activities. The CMO shall participate directly in the design and implementation of the Population Health Management Strategy and initiatives. The CMO shall participate actively in the execution of Grievance and Appeal procedures. The CMO shall ensure that the that Contractor engages with local health department. The CMO or designee's information shall be posted in an easily accessible location in their provider portal website.

1.g.3. Chief Health Equity Officer (CHEO)[30] or designee: Provide leadership to ensure health equity is prioritized and health inequities are addressed within the QIHETP. This role acts as part of the Regional Quality and Health Equity team.

1.g.4. Medical Directors: The Medical Directors provide clinical leadership within one or more of the HS functional areas including but not limited to: UM/CCM, QIPH, Pharmacy, and CCC. The Medical Directors are responsible for guidance and direction of QIHETP activities.

1.g.5. Quality Improvement and Population Health (QIPH) Director: Under the direction of the CMO, the QIPH Director is responsible for strategic direction and management of the Alliance QIHETP. The QIPH Director manages the Alliance's preparations and response to regulatory and internal medical audits and manages implementation of selected NCQA standards. The QIPH Director is also responsible for engagement with internal and external stakeholders in the QIHETP. This role acts at the Performance Improvement Lead or may

delegate this role to staff across the organization for the quality and health improvement efforts across the organization. This role acts as part of the Regional Quality and Health Equity team.

1.g.6. Quality and Performance Improvement Manager (QPIM): Under the direction of the QIPH Director, and in collaboration with the Medical Directors, the QPIM: manages and leads quality and performance improvement initiatives; supports development, management and implementation of practice coaching program activities in the community clinics to improve clinical outcomes; accountable for collaborating with staff in the implementation of the QIHETP, and assists in coordinating member experience surveys, such as the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. This role acts as part of the Regional Quality and Health Equity team.

1.g.7. Quality and Population Health Manager (QPHM): Under the direction of the QIPH Director, and in collaboration with the Medical Directors, the QPHM provides technical leadership and expertise in clinical data for one or more of the following areas in implementation of the QIHETP: data management and retrieval, reporting standards and complex analysis, state policy and procedure implementation, and systems configuration and research for Alliance HS Division leadership. The QPHM also: provides statistical modeling methodologies in the development of health plan, provider, and member analysis; coordinates HEDIS/MCAS reporting activities; and prepares and participates in audits conducted by regulatory agencies. This role acts as part of the Regional Quality and Health Equity team.

1.g.8. Clinical Safety Quality Manager (CSQM): Under the direction of the QIPH Director, and in collaboration with the Medical Directors, the CSQM provides clinical leadership and expertise in clinical data for one or more of the following areas in implementation of the QIHETP: reporting standards, state policy and procedure implementation, Potential Quality Issue investigative process, Facility Site Review audit process, and prepares and participates in audits conducted by regulatory agencies regarding all clinical quality issues.

1.g.9. Quality and Health Programs Manager (QHPM): Under the direction of the QIPH Director and in collaboration with the Medical Directors, the QHPM maintains administrative oversight and is responsible for all aspects of planning and managing the Alliance Health Education and Disease Management programs and Cultural and Linguistic services as well as the Member Incentive and Health Education Materials approval process for the Alliance. The QHPM also coordinates the Health Education and Cultural and Linguistic Population Needs Assessments reporting activities and participates in audits conducted by regulatory agencies.

1.g.10. Quality and Health Programs Supervisor(s) (QHPS): Under the direction of the QHPM, the QHPS coordinates and implements the Alliance Health Education and Disease Management

programs and Cultural and Linguistic services (oversees interpretation and translation services and vendors) and processes. The QHPS also leads preparing health and disease management program promotional materials, including newsletter articles, and member/provider communications. The QHPS also supervises the Health Educators and Care Coordinator.

1.g.11. Health Educator(s): Under the direction of the QHPM and QHPS, the Health Educators primary responsibility is to provide outreach to members participating in health education and disease management programs and implement specific programs as assigned. Health education and disease management programs are provided by the Health Educators directly by telephonic and/or workshops. They co-facilitate health education and disease management member programs, such as trainings, workshops, and community presentations.

1.g.12. Care Coordinator I: Under the direction of the QHPS, the Care Coordinator I assists with coordination of Language Assistance services via the Alliance's internal care tracking system, and other duties as needed.

1.g.13. Quality Improvement Nurse (RN) Supervisor: Under the direction of the QPHM, the QI Nurse Supervisor coordinates and implements QIPH programs and processes, including Facility Site Review (FSR), Medical Record Review (MRR), Physical Accessibility Review (PAR), and Potential Quality Issues. The QI RN Supervisor also supervises, mentors, develops, coordinates, and conducts training for QIPH staff.

1.g.14. QI Program Advisor IV (QIPA IV): Under the direction of the QPHM, the QIPA IV leads the planning, implementation, and management of select QIPH programs, including but not limited to Care Based Incentive (CBI), HEDIS/MCAS, and Performance Improvement. The QIPA IV provides orientation, training, and mentorship to subordinate QIPH staff and acts as the subject matter expert in support of QIHETP objectives. This role acts as part of the Regional Quality and Health Equity team.

1.g.15. QI Program Advisor III (QIPA III): Under the direction of the QPIM, QIPA III's lead the planning, implementation, and management of select QIPH programs, including but not limited to CBI, HEDIS, and Performance Improvement; and provide training and expertise in support of QIHETP objectives. This role acts as part of the Regional Quality and Health Equity team.

1.g.16. QI Program Advisor II (QIPA II): Under the direction of the QPHM, or QPIM, the QIPA II supports QIPH Department leadership with program administration; conducts studies and analyzes data to evaluate the Alliance's performance; and analyzes, develops, and implements improvement activities to increase performance against national, state and/or

regional benchmarks and definitions. This role acts as part of the Regional Quality and Health Equity team.

1.g.17. QI Program Advisor I (QIPA I): Under the direction of the QPH Manager, the QIPA I assists with monitoring data received from external partners. The QIPA I develops, writes, and produces reports to monitor compliance with contractual and regulatory requirements. The QIPA I also supports the department with ad hoc reporting for internal and external stakeholders. This role acts as part of the Regional Quality and Health Equity team.

1.g.18. QI Nurse: Under the direction of the QI RN Supervisor, QPHM or the QPIM, the QI Nurse develops, manages, and measures a comprehensive preventive health care strategy in collaboration with internal stakeholders and network providers to promote best evidence-based practices and improve member health outcomes. The QI Nurse participates in local, regional, and state audits and improvement initiatives.

1.g.19. Senior QI Nurse: Under the direction of the QI RN Supervisor, QPHM or the QPIM, the Senior QI Nurse develops, manages, and measures a comprehensive preventive health care strategy in collaboration with internal stakeholders and network providers to promote best evidence-based practices and improve member health outcomes. The Senior QI Nurse participates in local, regional, and state audits and improvement initiatives. In addition, the Senior QI Nurse trains, and mentors other QIPH department nurses.

1.g.20. Coding Resource Specialist: Under the direction of the QPIM, the Coding Resource Specialist acts as the clinical coding expert across all departments for the Alliance and utilizes advanced knowledge of professional coding to review and recommend changes to systems, policies, and/or procedures to guarantee current and appropriate coding guidelines are maintained.

1.g.21. QI Project Specialist: Under the direction of either the QPIM or QI RN Supervisor, the QI Project Specialist acts as a key program assistant by coordinating efforts for QIPH programs such as CBI, C&L, FSR, Health Programs, Potential Quality Issue (PQI) and HEDIS. The QI Project Specialist supports in the planning of departmental projects and communication activities.

1.g.22. QIPH Administrative Specialist (QIPH Admin): Under the direction of the QIPH Director, the QIPH Admin performs multiple administrative functions in support of the QIHETP and QIPH department; and performs administrative staff support to QIHETP committees as needed.

1.g.23. Chief Compliance Officer: Under the direction of the CEO, the Chief Compliance Officer is responsible for overseeing and coordinating Compliance Program activities, including

serving as Chair of the Compliance Committee and providing oversight of delegate oversight activities in accordance with Alliance policy 105-0004 – *Delegate Oversight*.

1.g.24. Utilization Management Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of Utilization Management Program staff.

1.g.25. Community Care Coordination (CCC) Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of CCC Program staff.

1.g.26. Pharmacy Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of Pharmacy Program staff.

1.g.27. Grievance Staff: Alliance Grievance staff is responsible for routing grievances to QIPH for research and analysis, routing, and resolution of clinically related member or provider complaints.

1.g.28. Credentialing Staff: Alliance Credentialing staff is responsible for ensuring the accuracy and completion of provider credentialing files prior to PRCC review. Credentialing staff oversee the completion of credentialing application information in accordance with Alliance Policies 300-4020 – *Peer Review and Credentialing Committee – Authority, Roles, and Responsibilities* and 300-4040 – *Professional Provider Credentialing Guidelines*. The Credentialing staff monitors timeliness of review for re-credentialing[31]. The Credentialing staff also ensure the ongoing monitoring of provider credentials and issues in accordance with Alliance Policy 300-4090 – *Ongoing Monitoring of Provider Credentials and Issues*.

1.g.29. Community Engagement Director. The Community Engagement Director and team are responsible for ensuring regional input is considered in the design and implementation of the QIHET.

1.g.30. Other staff: The Alliance encourages active involvement of all Alliance staff in the design and implementation of the QIHETP.

1.h. QIHETP Alliance Board Reports

1.h.1. Quality Improvement Health Equity Work Plan (QIHE-WP): The QIHE-WP is developed and maintained by QIPH staff. The CMO, QIPH Director, and QIPH Managers review the QIHE -W and obtain approval from QIHEW and the QIHEC prior to sending it to the Alliance Board for final approval.

1.h.2. Committee Minutes: QIHEC, Compliance Committee minutes, and PRCC credentialing/re-credentialing related reports, are reviewed by the Alliance Board on a routine basis[32]. QIHEC minutes are submitted to DHCS upon Alliance Board review and approval. A written

summary of the QIHEC activities publicly available on the Alliance website at least on a quarterly basis.[33]

1.h.3. QIHEP Annual Report: The QIHE Annual Report is submitted to the QIHEC for its review, approval, and submission to the Alliance Board[34], and subsequent submission to DHCS. The QIHE Annual Report includes a comprehensive assessment of QIHE activities, including an evaluation of areas of success and needed improvements. The report addresses clinical quality of physical, behavioral health, access and engagement or providers, continuity and coordination across setting and all levels of care, and Member experience. Effective in 2024, the evaluation includes but is not limited to: the QIHE-WP, analyses of fully delegated subcontractor's and downstream fully delegated subcontractor's performance measure results and actions to address any deficiencies, actions taken to address the annual External Quality Review (EQR) technical report and evaluation reports, planned equity-focused interventions to address identified patterns of over- or under-utilization, description of member and/or family focused care such as Community Advisory Committee (CAC) findings, Population Health management activities and findings, and outcomes/findings from Performance Improvement Projects, member satisfaction surveys, and collaborative initiatives as appropriate.

1.h.4. The QIHE Annual Report also includes copies of all independent private accrediting agencies (e.g., NCQA) if relevant, including accreditation status, survey type, and level, as applicable; accreditation agency results, including recommended actions or improvements, corrective actions plans, summaries of findings; and expiration date of accreditation[35].

2. Maintain Continuous Quality Monitoring Utilizing Specific Quality and Performance Improvement Methods: The QIHETP uses a variety of mechanisms to identify potential quality of service issues, ensure patient safety, and ensure compliance with standards of care across the care continuum (i.e., preventative health services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services). These mechanisms include, but are not limited to:

2.a. External Quality Review[36]: The Alliance incorporates external quality review requirements into the QIHETP as described in Alliance Policy 401-1607 – *Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight*. The Alliance is contractually required to annually track and report on a set of Quality Performance Measures and Health Equity measures. The Alliance works with the EQRO to undergo an external quality review using MCAS performance measures. MCAS performance measures consist of a set of CMS Adult and Child measures developed by NCQA, other standardized performance measures, and/or DHCS developed performance measures. DHCS selected MCAS measures will be stratified by various demographics, as required.

2.b. Site Review[37]: The Alliance incorporates site review requirements into the QIHETP as described in Alliance Policies 401-1508 – *Facility Site Review Process*, 401-1510 – *Medical Record Review and Requirements* and 401-1521 – *Physical Accessibility Review*. The Alliance conducts a Facility Site Review (FSR) for new primary care providers (PCPs) before initial credentialing and a minimum of every three (3) years thereafter as a requirement for participation in the California State Medi-Cal Managed Care Program. Physical Accessibility Reviews (PARs) are conducted during the initial FSR for new primary care provider sites, and at a minimum of every three (3) years upon re-credentialing[38]. Specialists and Ancillary sites that serve a high-volume of SPD members (providers whose monthly average of encounters for SPD members are above the monthly average of encounters) receive a PAR at a minimum of every three (3) years[39]. The Alliance ensures that member medical records are maintained by health care providers in accordance with contractual obligations[40]. The Alliance submits site review data to DHCS up to quarterly, or in a manner or timeframe specified by DHCS[41].

2.c. Disease Surveillance[42]: The Alliance incorporates disease surveillance requirements into the QIHETP as described in Alliance Policy 401-1519 – *Infection Control Practices*. The Alliance requires providers report diseases or conditions that must be reported to public health authorities to applicable local, state, and federal agencies as required by law.

2.d. Credentialing and Recredentialing[43]: The Alliance incorporates credentialing and recredentialing requirements into the QIHETP as described in Alliance Policies 105-0004 – *Delegate Oversight*[44], 300-4020 – *Peer Review and Credentialing Committee - Authority, Roles and Responsibilities*, 300-4030 – *Credentialing Criteria and Identified Issues*, 300-4040 – *Professional Provider Credentialing Guidelines*, 300-4090 – *Ongoing Monitoring of Provider Credentials and Issues*, 300-4110 – *Organizational Providers Credentialing Guidelines*, and 401-1523 – *Non-Physician Medical Practitioner: Scope of Practice and Supervision*.

2.d.1. The Alliance delegates oversight of credentialing, re-credentialing, recertification, and physician reappointment activities to the PRCC. The Alliance credentialing standards, as approved by PRCC, are aligned with applicable DHCS and Department of Managed Health Care (DMHC) credentialing and certification requirements[45].

2.d.2. The Alliance maintains a system of reporting serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Disciplinary actions include: reducing, suspending, or terminating a practitioner's privileges. The Alliance maintains an appeal process[46].

2.e. Timely Access Monitoring[47]: The Alliance incorporates timely access monitoring requirements into the QIHETP as described in Alliance Policies 300-1509 – *Timely Access to Care* and 300-8030 – *Monitoring Network Compliance with Accessibility Standards*. The Alliance ensures the provision of covered services in a timely manner consistent with the DMHC Timely Access requirements and

participation in the EQRO's network adequacy validation studies. The Alliance continuously reviews, evaluates, and seeks to improve access to and availability of services. This includes ensuring that members are able to obtain appointments from contracted providers according to established access standards.

2.f. Member Satisfaction Monitoring[48]: The Alliance incorporates member satisfaction monitoring requirements into the QIHETP as described in Alliance Policies 401-2001 – *Member Surveys*, 200-9001 – *Grievance Reporting, Quality Improvement and Audits*, and 200-9004 – *Staff Grievance Review Committee*. Member satisfaction survey results are reviewed and monitored for variations. Grievance data is reviewed and analyzed regularly to identify trends as part of the Alliance's efforts to improve and optimize the delivery and management of health care services. Grievance staff refers individual cases for clinical review to QIPH staff as appropriate and the SGRC reports trends in quality issues to the QIHEW.

2.g. Provider Satisfaction Monitoring[49]: The Alliance incorporates provider satisfaction monitoring requirements into the QIHETP as described in Alliance Policy 300-3092 – *Provider Satisfaction Survey*. The Alliance conducts annual surveys of contracted physicians to determine provider satisfaction with the Alliance's performance and to identify any provider concerns with compliance with various regulatory standards.

2.h. Claims Encounter Data Monitoring: The Alliance incorporates claims encounter data monitoring requirements into the QIHETP as described in Alliance Policy 105-3002 – *Program Integrity: Special Investigations Unit Operations*. Should claims review identify potential fraud, waste or abuse concerns appropriate referrals are made to the Alliance Special Investigations Unit (SIU). QIPH works with Compliance to address any PQIs, provider preventable conditions, or any other variations in practice. Appropriate actions are taken based upon these claim reviews and other fraud, waste, and abuse investigations.

2.i. Encounter Data Validation[50]: The Alliance participates in EQRO's validation of Encounter Data from the preceding 12 months to comply with requirements.

2.j. Potential Quality Issue (PQI) processes: The Alliance incorporates PQI monitoring requirements into the QIHETP as described in Alliance Policy 401-1301 – *Potential Quality Issue Review Process*. The Alliance maintains a systematic review process to identify, analyze and resolve potential quality of care issues to ensure that services provided to members meet established standards, and address any patient safety concerns.

2.k. Under/Over-Utilization Monitoring[51]: The Alliance incorporates under/over-utilization monitoring requirements into the QIHETP as described in Alliance Policies 404-1101 – *Utilization Management Program* and 404-1108 – *Monitoring of Over/Under Utilization of Services*. The UM Program serves to ensure appropriate, high quality, cost-effective utilization of health care resources and that these

resources are available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on evidence-based criteria, and expert clinical opinion when needed.

2.l. Population (PNA)[52]: The PNA evaluates the health education and cultural and linguistic needs of members, and the findings are used to guide the development and implementation of cultural and linguistic health education interventions. The Alliance prepares a PNA annually.[50] The Alliance will incorporate county or region-specific Population Needs Assessment, as detailed in the Population Health Management Policy Guide, to build community partnerships, improve member participation, and to fully understands the barriers preventing all populations from receiving care and preventive services as well as identify and address social drivers of health.

2.m. Community Health Assessment (CHA)/Community Health Improvement Project (CHIP): Based on participating in the CHA/CHIP process The Alliance must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:

- 2.m.1. Targeted health education materials for Members, including Member-Facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services (NSMHS).
- 2.m.2. Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and
- 2.m.3. Wellness and prevention programs.

2.n. Seniors and Persons with Disabilities (SPD) Activities[53]: The Alliance incorporates SPD activity requirements into the QIHETP as described in Alliance Policies 404-1114 – *Continuity of Care*, 405-1112 – *Care Management of Seniors and Persons with Disabilities for Medi-Cal*, and 401-3101 – *Health Education and Disease Management Program*. The Alliance conducts studies for SPDs or persons with chronic conditions that are designed to assure the provision of case management, coordination, and continuity of care services, including ensuring availability, access to care, and clinical services.

2.o. Focused Studies: The Alliance participates in the external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided[54].

2.p. Technical assistance: The Alliance implements EQRO's technical guidance in conducting mandatory and optional activities described in 42 CFR 438.358[55]

2.q. Ad Hoc Data Studies: The Alliance also conducts other stratified data studies to evaluate the population as needed.

2.r. Quality Improvement Health Equity Work Plan (QIHE-WP) Development and Review: The QIHE-WP is an annually developed, dynamic document that reflects the progress of QIHETP activities throughout the year. It includes measurable yearly objectives to help the organization monitor for continuous performance improvement. These are achieved through active engagement and cross-collaboration with all departments within the Alliance.

2.s. Behavioral Health Services Monitoring: The Alliance incorporates behavioral health services monitoring requirements into the QIHETP as described in Alliance Policy 408-1305 – *Behavioral Health Services for Medi-Cal to ensure delivery of Medically Necessary non-specialty and specialty mental health services*. Oversight and monitoring of any delegated portions of mental health services are outlined in Policy 105-0004 – *Delegate Oversight*.

2.t. Quality Improvement Delegate Oversight Activities[56]: The Alliance incorporates QIPH delegate oversight activities into the QIHETP as described in Alliance Policies105-0004 – *Delegate Oversight* and 401-1201 –*Quality Improvement Health Equity Committee*. The Alliance may delegate QIPH functions to subcontracting entities, as outlined in Alliance Policy 105-0004 – *Delegate Oversight*. These delegated functions are set forth in the Alliance's contracts with subcontracting entities and include specific performance and reporting standards that must be met.

2.u. Enhance Care Management (ECM) Monitoring[57]: The Alliance monitors the utilization of and/or outcomes resulting in the provision of the ECM including any activities, reports, and analysis to understand the impact of ECM delivery for Alliance members as described in Alliance Policy ECM Overview. In addition, the Alliance will work collaboratively across all departments to accomplish required audits and/or case reviews, supplemental reporting requirements, and monitor provider performance with ECM contractual terms and conditions.

2.v. Community Supports (CS)[58]: The Alliance monitors the utilization of and/or outcomes resulting in the provision of CS including any activities, reports, and analysis to understand the impact of CS delivery for Alliance members as described in Alliance Policy 405-1310 Community Supports Overview.

2.w. Long Term Care Services: The Alliance monitors quality monitoring, assurance, and improvement efforts for Long Term Care services in institutional settings to support and improve the access to and quality of long-term care provided by the Alliance's contracted facilities.

2.x. Patient Level Data Submissions: The Alliance will utilize the DHCS' EQRO File Transfer Protocol (FTP) website when sending communications containing patient-level data.

3. Analyze and Evaluate Annual Data, Incorporate Provider Feedback and Develop Interventions
Using the methods outlined above, QIPH analyzes data using current evidence-based standards as benchmarks. As stated in the provider manual, providers, practitioners, and facilities must make

performance data available to the Alliance to cooperate with and participate in quality improvement activities. Significant quality, service, or utilization issues are analyzed for barriers, trends, or root causes. This process incorporates provider review and feedback into performance improvement activities and may include a multidisciplinary team, quantitative and qualitative analysis, and development of interventions that are implemented and/or planned for continuous monitoring.

3.a. Analyze and Evaluate Annual Data: Analysis is performed utilizing various current evidence-based standards as benchmarks:

3.a.1. Meet health disparity reduction targets for specific populations and measures as identified by DHCS[59];

3.a.2. CMS Child and Adult Core Set Standards

3.a.2.a. Exceeding MCAS HPLs and MPLs for each quality Performance and health equity measures[60];

3.a.2.b. Under-utilization of DHCS identified performance measures as part of the MCAS which will be measured as part of the EQRO compliance audit[61]; and

3.a.2.c. CAHPS Survey results[62].

3.a.3. Preventive Care Guidelines: The preventive care guidelines address periodic health and behavioral risk screening and preventive services for asymptomatic adults and children. Individuals identified as being at high risk for a given condition may require more frequent or additional screening tests specific to the condition. These guidelines establish the minimum standard of preventive care. Further details are included in Alliance Policy *401-1502- Adult Preventive Care*, and *401-1505 - Childhood Preventive Care*.

3.a.3.a. Adult preventive care guidelines include[63]:

1. The United States Preventive Services Task Force (USPSTF) guidelines;
2. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (CDC ACIP); and
3. The State of California DHCS Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004.

3.a.3.b. Pediatric preventive care guidelines include[64]:

1. The provision of the Early and Periodic Screening, Diagnostic, and Treatment Services inclusive of education and outreach for members under the age of 21 years old in accordance with the American Academy of Pediatrics (AAP) Bright Future guidelines (All Plan Letter 23-005 and AB 2340);
2. CDC ACIP;
3. Child Health and Disability Prevention Program (CHDP); and
4. The DHCS MMCD Policy Letter 14-004.

3.a.4. Standards of Care: Standards of care criteria and guidelines are used to determine whether to authorize, modify or deny health care services and are based on nationally recognized guidelines, professionally recognized standards, review of applicable medical literature, and peer review. These criteria and guidelines are reviewed annually by the QIHEC (or sub-committee) as outlined in Alliance Policy 401-1501 – *Standards of Care*.

3.a.5. MCG (formerly Milliman Care Guidelines): MCG is utilized as outlined in Alliance Policy 404-1112 – *Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests*.

3.b. Incorporate Provider Feedback[65]: The Alliance ensures participation of network providers, fully delegated subcontractors, and downstream fully delegated subcontractors in the QIHETP and PNA, including distribution of information regarding QIHETP programs, activities, reports and actively elicits provider feedback through one or more of the following:

3.b.1. Distribution of Provider Bulletins, memorandums, and email communication;

3.b.2. Regular updates to Member and Quality Reports in the Provider Portal;

3.b.3. Publication of Board Reports;

3.b.4. CBI workshops and performance reviews including:
- 3.b.4.a. Comparison of provider performance to average Alliance-wide performance;
- 3.b.4.b. Reports showing provider deviation from a benchmark or an established threshold; and
- 3.b.4.c. Recommended interventions to improve performance;

3.b.5. Inclusion of providers in PDSA activities and on PIP teams;

3.b.6. Medical Director and Provider Services' onsite and network communication; Coordination and facilitation of external committee meetings, including Safety Net Clinic Coalition, and hospital and clinic Joint Operation Committees (JOC);

3.b.7. Coordination and facilitation of Alliance physician committees, including QIHEC, PAG, PRCC, and WCMCAC. Outcomes from these committees requiring modifications to the operational QIHETP are incorporated by way of receipt of directives from the Alliance Board[66] and/or by receipt of reports from the CMO, and;

3.b.8. On-going provider, fully delegated subcontractors, and downstream fully delegated subcontractor's meetings or outreach, such as technical assistance, practice coaching, or

other means to provide updates on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results.

3.c. Develop Interventions

3.c.1. Priority Setting: Use of personnel and other resources is prioritized by the QIHEC annually, taking into consideration contractual and regulatory requirements, high volume/high risk services, and quality of care issues that are relevant and meaningful to the member population. Another factor which may be considered when selecting improvement opportunities to pursue is the extent to which the issue affects care, or the likelihood of changing behavior of members or practitioners. To maximize the use of resources, QIPH activities may be selected based on their ability to satisfy multiple QIHETP requirements.

3.c.2. Performance Improvement work including Performance Improvement Projects (PIP)[67,68]: Under consultation and with guidance from the External Quality Review Organization (EQRO) and DHCS, the Alliance conducts a minimum of two (2) DHCS-approved PIPs. One PIP must be either an internal PIP or a small group collaborative. The second PIP must be a DHCS-facilitated state-wide collaborative.

PIPs are developed by identifying targeted areas for improvement (clinical or nonclinical) and are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and include the following elements:

- Measurement of performance using objective quality indicators;
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

In addition to Performance Improvement Projects quality improvement and health equity teams will participate in statewide and/or regional collaboratives that may improve quality and equity of care Medi-Cal members as directed by DHCS on a quarterly basis at a minimum, and these meetings may be in-person. The Alliance will leverage existing regional quality and health equity teams, where available, to support QI and health equity work for all counties across the various DHCS designated regions.

The Alliance will ensure appropriate staff resources are available to complete PIP submissions in a timely manner and status of each PIP at least annually to DHCS[69].

3.c.3. Corrective Action Plans (CAPs):

3.c.3.a Provider CAPs resulting from FSR and Medical Record Review (MRR) must be addressed and documented, consistent with Alliance Policy 401-1508 – *Facility*

Site Review Process. PCP sites that do not correct cited deficiencies are to be terminated from the network[70]; and

3.c.3.b. Provider CAPs may be an intervention for certain PQIs, as deemed appropriate by the CMO or a Medical Director[71]. Refer to Alliance Policy 401-1306 - *Corrective Action Plan for Quality Issues.*

3.c.4. Improvement Plan[72]:
The Alliance must submit a PDSA Cycle Worksheet to DHCS for each MCAS measure with a rate that does not meet the MPL or is given an audit result of "Not Reportable" (NR). Additionally, the Alliance will conduct Quality Improvement and health equity improvement projects in areas where performance is below DHCS' established MPLs as determined in the MCAS: Quality Improvement and Health Equity Framework Policy Guide. DHCS will notify MCPs of the due date. Submission includes analysis of barriers, targeted interventions, relevant data to support analysis, targeted interventions, and a rapid cycle /continuous quality improvement process to guide PDSA outcomes. The Alliance will conduct at least a quarterly evaluation of ongoing rapid-cycle quality improvement efforts to determine whether progress is being made.

3.c.5. Quality and Health Programs:

3.c.5.a Disease Management: Consistent with Alliance Policy 401-3101 – *Health Education and Disease Management Program*, the Alliance maintains an evidence-based disease management programs that incorporate health education interventions, target members for engagement and seek to close care gaps for members participating in these programs[73].

3.c.5.b Health Education and Promotion: Consistent with Alliance Policy 401-3101 – *Health Education and Disease Management Program*, the Alliance offers important health education and promotion programs for its members. These programs are intended to assist members to improve their health, properly manage illness, and avoid preventable conditions. These programs have been implemented in all Alliance service areas, and are routinely reviewed for access, quality, and outcomes and reported as part of the QIHETP[74].
Health Programs services and information is shared with providers through the Provider Portal and special mailings for general performance reports, which may include:

a. Listings of members who need specific services;
b. Listings of members who need intervention based on pharmacy indicators; and
c. Alliance-sponsored training directed at improving performance.

3.c.5.c. Care-Based Incentive (CBI): The CBI Program provides incentive payments to providers and members for a variety of activities and serves as a mechanism to identify specific areas of a provider's care that are below the standard of care

and may be amenable to improvement through various interventions. Details of the CBI Program are updated annually and available in the Alliance Provider Manual and on the Alliance website. Refer to Alliance Policy 401-1705 - *Care-Based Incentive Program*

3.c.5.d. Internal Improvement Projects: The Alliance implements internal improvement projects as necessary based upon monitoring activities that have identified opportunities for improvement.

References:

Alliance Policies:

105-0004 – Delegate Oversight
105-3002 – Program Integrity: Special Investigations Unit Operations
200-9001 – Grievance Reporting, Quality Improvement and Audits
200-9004 – Staff Grievance Review Committee
280-0003 – Whole Child Model Family Advisory Committee
300-1509 – Timely Access to Care
300-3092 – Provider Satisfaction Survey
300-4020 – Peer Review and Credentialing Committee – Authority, Roles, and Responsibilities
300-4030 – Credentialing Criteria and Identified Issues
300-4040 – Professional Provider Credentialing Guidelines
300-4090 – Ongoing Monitoring of Provider Credentials and Issues
300-4102 – Reporting to the Medical Board of California and the National Practitioner Data Bank
300-4103 – Fair Hearing Process for Adverse Decisions
300-4110 – Organizational Providers Credentialing Guidelines
300-8030 – Monitoring Network Compliance with Accessibility Standards
400-1109 – Physicians Advisory Group Responsibilities and Functions
400-1112 – Whole Child Model Clinical Advisory Committee Responsibilities and Functions401-1201 – Quality Improvement Health Equity Committee
401-1301 – Potential Quality Issue Review Process
401-1306 – Corrective Action Plan for Quality Issues
401-1501 – Standards of Care
401-1502 – Adult Preventive Care
401-1505 – Childhood Preventive Care
401-1508 – Facility Site Review Process
401-1510 – Medical Record Review and Requirements
401-1519 – Infection Control Practices
401-1521 – Physical Accessibility Review
401-1523 – Non-Physician Medical Practitioner: Scope of Practice and Supervision
401-1607 – Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight
401-1705 – Care-Based Incentive Program

401-2001 – Member Surveys
401-3101 – Health Education and Disease Management Program
401-4101 - Cultural and Linguistic Services Program
403-1104 – Mission, Composition and Functions of the Pharmacy and Therapeutics Committee
404-1101 – Utilization Management Program
404-1108 – Monitoring of Over/Under Utilization of Services
404-1112 – Medical Necessity- The Definition and Application of Medical Necessity Provision to Authorization Requests
404-1114 – Continuity of Care
405-1112 – Care Management of Seniors and Persons with Disabilities for Medi-Cal
408-1305 – Behavioral Health Services
450-0002 – Population Needs Assessment and Population Health Strategy Deliverable

Impacted Departments:
Behavioral Health
Community Care Coordination
Community Engagement
Compliance
Member Services
Pharmacy Services
Provider Services
Utilization Management

Regulatory:
California Evidence Code Section 1157
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.70
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.70(b)(c)
Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 440, Subpart B, Section 440.262
Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 438, Subpart E, Section 438.330
Code of Federal Regulations, Title 42, 438.330(d) incorporated via [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
DHCS communication dated 8/2016 related to Title 42, Code of Federal Regulations, Section 440.262;

Legislative:
Assembly Bills, AB-2340 Medi-Cal: EPSDT Services: informational materials

Contractual (Previous Contract):
DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2

Contractual (2024 Contract):
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.A-D
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6.K

Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6.L

DHCS All Plan Letter:

MMCD PL 14-004 Site Reviews: Facility Site Review and Medical Record Review
DHCS APL 15-023 Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers
DHCS APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, And Treatment Services for Medi-Cal Members Under the Age Of 21
DHCS APL 19-017 Quality and Performance Improvement Adjustments Due to Covid-19
DHCS APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of The California Advancing and Innovating Medi-Cal Initiative
DHCS APL 24-004 Quality Improvements and Health Equity Transformation Requirements

NCQA:

HEDIS Volume 2 Technical Specifications for Health Plans

Supersedes:

Other:

Alliance Provider Manual

Attachments:

Attachment A: Quality Improvement Health Equity Transformation Reporting Structure
Attachment B: Quality Improvement and Population Health Organizational Chart

Lines of Business This Policy Applies To	**LOB Effective Dates**
☐ DSNP	(01/01/2026 – present)
☒ Medi-Cal	(01/01/1996 – present)
☒ Alliance Care IHSS	(07/01/2005 – present)

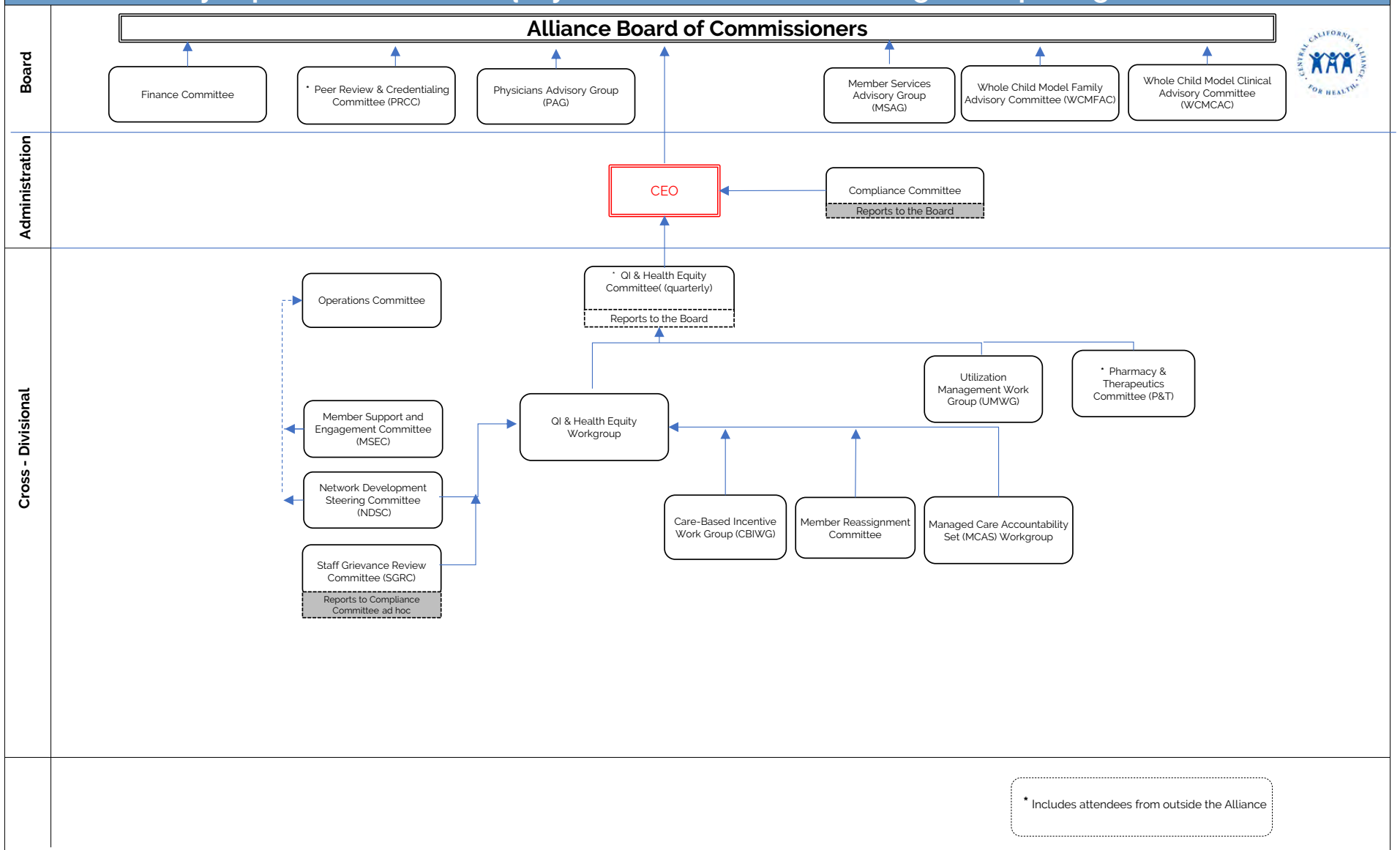
Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
01/26/2024	01/26/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
03/20/2024	03/20/2024	Sarina King, Quality and Performance Improvement Manager	QIHEW
04/25/2024	04/25/2024	Sarina King, Quality and Performance Improvement Manager	QIHEC
08/29/2024	08/29/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEW
09/24/2024	09/24/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
01/02/2025	1/02/2025	Kristen Rohlf, MPH, Quality and Population Health Manager	QIHEW
04/02/2025		Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC

[1] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[2] DHCS State Medi-Cal Contract, Exhibit A, Attachment 34, Provision 2.2.6
[3] DHCS State Medi-Cal Contract, Exhibit A, Attachment 34, Provision 2.2
[4] DHCS Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2
[5] DHCS Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2B
[6] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[7] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[8] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.C.
[9] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[10] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6.
[11] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.A.
[12] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[13] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.12
[14] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6M
[15] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6F
[16] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6G
[17] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6P
[18] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[19] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[20] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[21] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[22] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[23] DHCS All Plan Letter 19-017
[24] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[25] DHCS All Plan Letter 19-017
[26] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.1
[27] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.2
[28] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3
[29] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[30] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 1.1.7
[31] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provisions 2.2.12
[32] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.12
[33] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3D
[34] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[35] [MMC Final Rule] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7.
[36] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[37] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision5.2.14
[38] MMCD PL 14-004; DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[39] DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[40] DHCS State Medi-Cal Contract, Exhibit A, Attachment , Provision 5.2.14
[41] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.14
[42] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.11
[43] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[44] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12

[45] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[46] Policy 300-4103 – Fair Hearing Process for Adverse Decisions; Policy 300-4102 – Reporting to the Medical Board of California and the National Practitioner Data Bank; 401-1306 – Corrective Action Plan for Quality Issues; 300-4090 – Ongoing Monitoring of Provider Credentials and Issues
[47] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2, DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.5
[48] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision2.2.9.C.; DHCS All Plan Letter 19-017
[49] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)
[50] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision2.2.9E
[51] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.3.3
[52] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.2
[53] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[54] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9F
[55] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9G
[56] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.5
[57] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.4.16A
[58] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.5.13C
[59] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9.A4
[60] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[61] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[62] Policy 401-2001 – Member Surveys
[63] Policy 401-1502 – Adult Preventive Care
[64] Policy 401-1505 – Childhood Preventative Care
[65] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.4
[66] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1
[67] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9; DHCS All Plan Letter 19-017
[68] 42 CFR 438.330(d), Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9B
[69] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9B5
[70] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.14; MMCD PL 14-004
[71] Policy 401-1301 – Potential Quality Issue Review Process; Policy 401-1306 – Corrective Action Plan for Quality Issues
[72] DHCS All Plan Letter 19-017
[73] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.10
[74] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.7
[75] DHCS APL 24-004 Quality Improvements and Health Equity Transformation Requirements

Quality Improvement Health Equity Transformation (QIHET) Program Reporting Structure



Updated Feb 11, 2025

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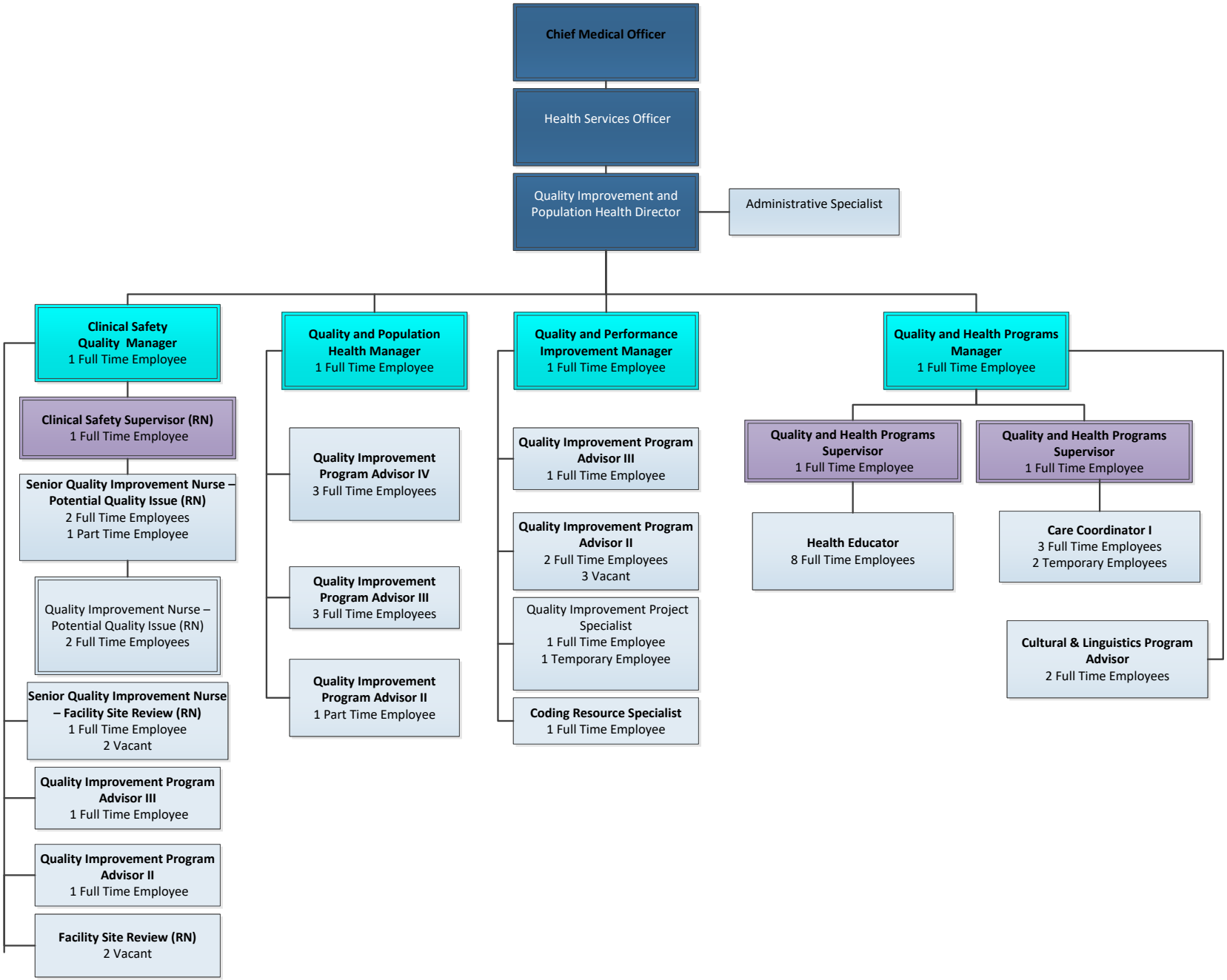

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Quality Improvement & Health Equity Transformation

Program Description

DRAFT: 03/28/25
QIHEC Committee Approval: 00/00/00
CCAH Board: 00/00/00

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Introduction

Central California Alliance for Health is a Knox-Keene state licensed health care service plan operating under the regulatory oversight of the California Department of Managed Health Care (DMHC). CCAH is contracted with the State of California Department of Health Care Services (DHCS) to serve as the local initiative in Santa Cruz, Monterey, Merced, San Benito, and Mariposa Counties for the Medi-Cal beneficiaries and the Medi-Cal Access Program (MCAP). The MCAP offers full scope health benefits for pregnant women who qualify for the program in the Alliance service areas.

CCAH's Quality Improvement and Health Equity (QIHE) Program Description is designed to meet the contract requirements set by the State of California and the Health Plan Standards established by the National Committee for Quality Assurance (NCQA).

Statement of Purpose

The purpose of the Quality Improvement and Health Equity (QIHE) Program Description is to describe the structure and framework of the organization and ensures continuous assessment, planning, implementation, evaluation, and improvements in the quality of care and services rendered by our network providers and received by our members and participants. When the Program identifies opportunities for clinical, patient safety and service improvements, CCAH works to ensure resolution of identified problems and measures intervention results over time to assess any needs for new improvement strategies. The QIHETP is an organizational-wide, cross-divisional, and comprehensive program that encompasses the Alliance's commitment to the delivery of quality and equitable health care services including the integration of quality, population health, and health equity principles.

The QIHE Program Description supports CCAH's mission and vision through the development and maintenance of a quality driven network of care for all lines of business. The QIHE Program Description provides its clear definition of authority, its relationship to other components and departments within the organization, and its accountability to the governing body of the organization. This document describes the program's mission, philosophy, goals, objectives, and staff and committee hierarchy. The Program Description, along with the Work Plan, outlines the major initiatives the QIHE Program will undertake in the coming year.

Mission, Vision, and Values

The Mission of Central California Alliance is to provide accessible, quality health care guided by local innovation. Our vision is to have healthy and healthy communities. Our values:

Collaboration	Working together toward solutions and results.
Equity	Eliminating disparity through inclusion and justice.
Improvement	Continuous pursuit of quality through learning and growth.
Integrity	Telling the truth and doing what we say we will do.

Anti-Discrimination Statement

Discrimination is against the law. Central California Alliance for Health (the Alliance) follows State and Federal civil rights laws. The Alliance does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. The Alliance provides: Free aids and services to people

with disabilities to help them communicate better, such as: Qualified sign language interpreters. Written information in other formats (large print, audio, accessible electronic formats, other formats) Free language services to people whose primary language is not English, such as: Qualified interpreters Information written in other languages.

Scope of QIHE Program

The scope of the QIHE Program is designed to monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all providers in any setting, and take appropriate action to improve upon Health Equity to improve all aspects of care to all CCAH members. It is comprehensive and addresses both the quality and safety of medical and behavioral health care provided to our members and participants for all lines of business and health equity activities.

- Behavioral Health care is a benefit for the Medi-Cal and MCAP members and is administered by CCAH. For Medi-Cal members, CCAH delegates the behavioral health services for members with behavioral health conditions that screen at non specialty level. Behavioral health services for members that screen at specialty level serviced are "carved out" of the contract by the state to the County Behavioral Health System. Coordination of medical and behavioral health care is an integral part of CCAH's Care Management Program.
- Population Health Management (PHM) program is a comprehensive service delivery framework that connects the member with the service they need, at the time they need, in the location they need. Most health service services fit within this paradigm; QIPH department is responsible for basic population health, including oversight of connecting un-served members to care, health education, and overall monitoring of service quality.
- Continuous quality management and improvement is accomplished through the collaboration of the various QIPH teams. These teams provide qualitative and quantitative data collection and data-driven decision making through technical and statistical QIPH data support to the QIHEC, subcommittees, and taskforces to ensure that QIPH activities are well designed and methodologically sound.
- To provide direction and guidance on clinical and service QIPH initiatives, including project identification and prioritizing, barrier analysis, project design, implementation of interventions, identification of indicators, as well as data collection and analysis.
- To conduct clinical investigations of potential quality issues, prepare and present cases for peer review, manage the administration of corrective actions, as well as to track, trend, and analyze quality management data related to grievances and appeals.
- To develop QIPH-related policies and procedures and ensure compliance with NCQA Standards and other quality-related regulatory requirements.
- To coordinate with HEDIS software vendors and HEDIS auditors in the preparation for annual HEDIS reporting.
- To oversee HEDIS hybrid medical record abstraction, to educate CCAH staff on the principles of quality management and serve as a subject matter resource for quality improvement.

Quality Indicators

The Quality Improvement and Population Health Program includes an array of indicators to measure critical clinical processes and outcomes. The QIHEC Work Plan delineates the critical performance measures that define the scope and range of the Quality Management Program. Components addressed include:

- Accessibility of services.
- Availability of services.
- Grievances and Appeals.

- Clinical quality improvement.
- Service quality improvement.
- Adverse outcomes/sentinel events.
- Member satisfaction/experience (CAHPS).
- Practitioner satisfaction/experience.
- Clinical practice guidelines.
- Continuity and coordination of care.
- Effectiveness of the quality improvement program.
- Patient safety.
- Delegation Oversight

Other areas that have an impact on the QIPH Program includes:

- Practitioner/Provider credentialing and recredentialing.
- Utilization management processes and outcomes.
- Inter-rater reliability testing.
- Practitioner performance.
- Pharmacy management.
- Facility site reviews.
- Data governance

Quality Improvement and Population Health Process Methodology

The QIPH Program includes a comprehensive array of clinical and service indicators that provide information about the systems, processes and outcomes of clinical care and service delivery. Explicit well-defined quality indicators are developed using sound methodological principles. The performance data that are a result of measurement are reliable so that decisions can be made with confidence.

In developing quality indicators, emphasis is placed on areas representing high risk, high volume, specific populations, and specific conditions. Most indicators are rate-based outcome measures. Indicators are measurable and have a goal against which to measure performance. Indicators are developed with input from the Chief Medical Officer (CMO), Chief Health Equity Officer, and the QIHEC Committee.

To understand and properly implement QIPH-related practices and projects, there are approaches being utilized. Such models help collect and analyze data for test change, provide guidance for effort and improvement in efficiency, member safety or quality outcomes. These models include:

- Plan-Do-Study-Act (PDSA)
- SWOT Analysis
- Performance Improvement Projects (PIPs)

Plan-Do-Study- -Act (PDSA)

The PDSA methodology is a rapid cycle/continuous QIPH process designed to perform small tests of change, which allows more flexibility to adjust throughout the improvement process. As part of this approach, CCAH performs real-time tracking and evaluation of its interventions. PDSAs which are the most common continuous quality improvement model utilized by CCAH has four major elements or stages:

A. **Plan** - The first step involves identifying preliminary opportunities for improvement. The focus is to analyze data to identify concerns and ideas for improving process and to determine anticipated outcomes. Key stakeholders and/or people served are identified, data compiled, and solutions proposed.
B. **Do** – The second step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.
C. **Study** - At the study stage, data is again collected to compare the results of the new process with those of the previous one.
D. **Act** - This final stage involves making the change a routine part of the targeted activity. It also means "Acting" to involve others (other staff, program components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting and reporting findings and follow-up.

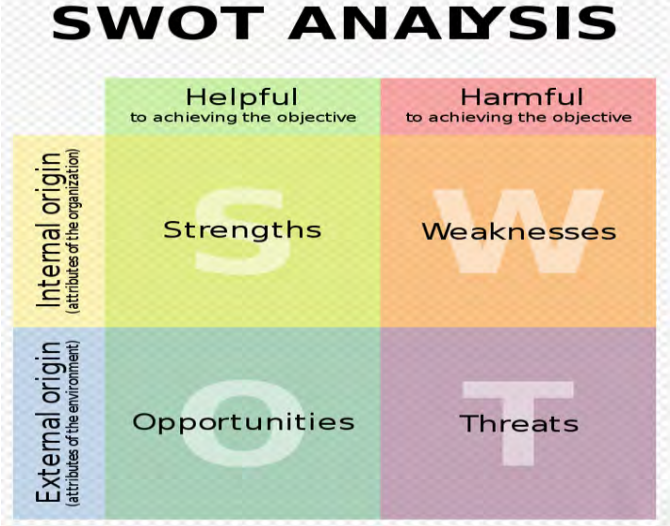
The process flow below illustrates the progression in which CCAH applies the PDSA methodology.

SWOT Analysis

A SWOT analysis is a strategic-planning technique used by CCAH to help identify strengths, weaknesses, opportunities, and threats related to project planning for improvement. It is intended to specify the objectives of the project and identify the internal and external factors that are favorable and unfavorable to achieving those objectives. The SWOT analysis investigates four parameters which are:

A. S – Strengths – characteristics of the project that give it an advantage.
B. W – Weaknesses - characteristics of the project that place it at a disadvantage
C. O – Opportunities - elements in the environment that the project could exploit to its advantage.
D. T-Threats: elements in the environment that could cause trouble for the project.

The process model below illustrates the framework in which CCAH will consider all factors applicable in a SWOT methodology.



Performance Improvement Projects (PIPs)

A Performance Improvement Project (PIP) is an approach being utilized by CCAH to the continuous study and improvement of the processes of delivering healthcare services to meet the needs of its members. A PIP's main purpose is to impact healthcare delivery and outcomes of care. It involves a concentrated effort on a particular area of concern affecting our members. The goal of this methodology can be to enhance and improve the outcomes of care, to ensure member safety, to increase efficiency of member care and related processes, to reduce costs and to reduce risks and liability. For such projects to achieve real improvements in care, and to ensure confidence in reported improvements, CCAH PIPs are designed, conducted, and reported in a methodologically sound manner that meets all state and federal requirements. CCAH works with Health Services Advisory Group (HSAG) in the validation of its PIPs, according to CMS' EQR protocol. PIPs are also made in accordance with 42 CFR §438.330, that requires Managed Care Plans (MCPs) to have a quality program that includes at a minimum, two ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction, focuses on clinical and/or nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care.
- Evaluating effectiveness of the interventions based on performance measures; and
- Planning and initiating activities for increasing and sustaining improvement.

A PIP's quality improvement framework is detailed in the following steps:

- PIP Design: Steps 1-6
    1. Selected PIP Topic
    2. Defined Aim Statement
    3. Identified Population
    4. Sound Sampling Method (if used)
    5. Selected Performance Indicator(s)
    6. Data Collection Procedures
- PIP Implementation Steps 7-8
    7. Data Analysis & Interpretation of Indicator Results
    8. Improvement Strategies

The status of the PIPs are reported at least annually to DHCS. The submission process below illustrates the progression in which CCAH will submit and HSAG will validate the modules throughout the PIP process

- PIP Design (Steps 1-6)
- Baseline: CY2023. Update Steps 1-6, complete Step 7 with baseline data and Step 8 with QI activities
- Remeasurement 1: CY2024. Update Steps 7-8
- Remeasurement 2: CY 2025. Update Steps 7-8

CCAH's non-clinical PIP is focused on improving the percentage of provider notifications for members with SUD/SMH diagnosis or within 7 days of emergency department (ED) visit, and the clinical PIP is focused on increasing well-child visits (W30-6) in the first 15-months of life for Hispanic members in Merced County.

Performance Goal Methodology

A sound, rigorous measurement methodology is developed and followed for each performance measure. Performance goals for each measure are discussed with and approved by the QIHEC Committee. Performance goals may be based on historical performance, normative data, or industry benchmarks. The initial performance goal for an indicator is often to "obtain baseline data." Performance goals specify the type of change considered an improvement.

A. Data Collection

Performance data for measures are collected, aggregated, and presented to the QIHEW and QIHEC Committees for review and recommendations at least four (4) times a year. Multiple data points are displayed together on graphs to show historical performance and facilitate data analysis and trending. Every qualitative and quantitative analysis includes evaluating the effectiveness of previous interventions. This part of the analysis influences the next step in planning. The entire process is conducted as close in time as possible to the events being measured. Interventions are planned and implemented based on the data analysis.

The Quality Improvement projects themselves consist of four (4) cycles:

- Development (pre-initiation)
- Baseline measurement (initiation)
- Intervention to improve performance and outcomes.
- Follow-up/Re-measurement to ensure that the interventions continue to be effective.

B. Data Resources

CCAH uses multiple data sources to monitor, analyze and evaluate the QIHE Program and QI activities. These sources include, but are not limited to the following:

- Enrollment
- Claims Data
- Encounter Data
- Supplemental (Ex. laboratory, immunization registry, lead registry, HIE)
- Pharmacy
- Health Risk Assessments

Quality Improvement and Health Equity Program Goals

The goals of the QIHE Program are:

- Promote an organization-wide commitment to quality of care and service through strong leadership involvement in improving quality.
- Link Strategic DHCS Quality Goals to CCAH's Strategic QI Objectives and performance improvement activities via quality improvement initiatives.
- Collaborate with CCAH health services departments to enhance continuity and coordination of care among behavioral healthcare and primary health care providers.
- Respond actively to customer expectations and patient feedback concerning the quality of patient care delivered and services provided.
- Improve the care and service delivered by our staff, network providers, and delegated entities.
    - Promoting member/patient safety as a high-level priority by minimizing patient and organizational risk of adverse occurrences.
    - Improving and enhancing the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and implementation of initiatives.
    - Promoting processes to ensure the availability of "safe, timely, effective, efficient, equitable, patient-centered care" and provide oversight within the network.
- Comply with legislative regulations, accreditation standards, and professional liability requirements.
- Ensure that medically necessary covered services are:
    - Available and accessible.
    - Provided in a culturally and linguistically appropriate manner.
    - Provided by qualified, competent practitioners and providers who are committed to CCAH's mission and vision.
- Promote collaborative relationships between CCAH, providers, delegates, and community partners.
- Promote and create condition specific health education and disease prevention materials that are age, culturally, and linguistically appropriate that encourages optimal health behaviors for members, participants, and staff.
- Ensure that members' protected health information (PHI) is protected, utilized, and released in accordance with state and federal law and regulation.
- Continue implementation of adequate computerized information management systems to support complete data entry, aggregation, display, analysis, and reporting needs for all quality management activities.
- Incorporate responsibilities for quality improvement into management performance standards.

Quality Improvement and Health Equity Program Objectives

The objectives of QIHE Program are:

- Align all organizational-wide performance improvement activities with strategic goals.
- Review the authority, responsibility, and information flow for the measurement, analysis, and improvement process and redefine as necessary.
- Ensure continued leadership and staff understanding of the tenets of quality/ performance management and improvement to be utilized by all teams.
- Charter and retain cross functional teams for each approved Strategic Quality Initiative, organization function, and/or prioritized improvement activity.
- Manage and improve the quality and safety of care provided to members, confirming compliance with the QI Program and applicable standards.

- Foster a supportive environment to ensure our practitioners and providers improve the safety of their professional practice through provider education.
- Identify actual or potential opportunities to decrease medical errors and /or improve patient safety through quality review, data collection, and risk factor analysis.
- Identify opportunities for patient care and service improvement, then implement and monitor interventions as appropriate.
- Establish priorities and outcomes for conducting focused review studies, emphasizing preventive services, high-volume low-performing practitioners/providers, and high-risk services.
- Promote outcome-driven and cost-effective care/health management programs, including preventive screening and health awareness, education, patient safety, and cultural and linguistic programs complementing QI interventions.
- Establish, maintain, and enforce policies, procedures, criteria, standards for:
    - Monitoring plan practitioner credentialing and recredentialing.
    - Confidentiality regarding member and practitioner/provider information.
    - Addressing conflict of interest staff and practitioner.
    - Resolution of actual or perceived member access or grievances and appeal.
- Establish quality standards and educate practitioners regarding performance expectations and provide compliance feedback.
- Communicate the QI process to both practitioners and members.
- Ensure availability, accessibility, delivery, coordination, support, and review as appropriate of:
- Continuity of care within the network, including effectiveness.
- Health education services.
- Cultural and linguistic services.
- Members with complex needs.
- Members with behavioral health needs.
- Establish medical and behavioral health standards reflecting current literature and benchmarks, design and implement strategies to improve compliance, and evaluate and monitor performance and adherence to guidelines.
- Identify, monitor, and address quality of care issues and trends affecting the healthcare and safety of members.
- Implement and monitor results of corrective actions and interventions; document practitioner/provider performance.
- Respond timely to address and resolve patient-specific issues.
- Assess the patient safety culture and develop the Patient Safety Program accordingly.
- Review and revise the organization wide Compliance Program as necessary.
- Demonstrate meaningful improvement in clinical and non-clinical care and services including behavioral health care.
- Reinforce Continuous Quality Improvement (CQI) principles through systematic monitoring of processes, data collection, qualitative and quantitative analysis of data, design of interventions for process improvement and determination of actual effectiveness of interventions.
- Evaluate current case management systems, identify care coordination issues for the organization, and design a patient-focused system that integrates care, case, quality, and utilization management.
- Demonstrate compliance with the quality improvement standards of regulators and accrediting organizations.

- Evaluate the Quality Improvement Program annually, modifying as necessary to achieve organizational effectiveness.
- Collaborate organizationally with the QIPH team to increase the DHCS's Managed Care Accountability Set (MCAS) measures compliance rates. The above goals and objectives are tied to the QIHEC Work plan. Performance against these goals and objectives are continuously monitored to help determine if stakeholder expectations are met. The MCAS goals set forth by DHCS. Focus planning and interventions on measures included on the DHCS' four MCAS domains for the measurement year.

MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL[i]
Behavioral Health Domain Measures				
Follow-Up After ED Visit for Mental Illness – 30 days[*, iv]	FUM	NCQA	Administrative	Yes
Follow-Up After ED Visit for Substance Abuse – 30 days[*]	FUA	NCQA	Administrative	Yes
Children's Health Domain Measures				
Child and Adolescent Well – Care Visits[*]	WCV NCQA	NCQA	Administrative	Yes
Childhood Immunization Status – Combination 10[*]	CIS-10	NCQA	Hybrid/Admin[**]	Yes
Developmental Screening in the First Three Years of Life	DEV	CMS	Administrative	Yes[iii]
Immunizations for Adolescents – Combination 2[*]	IMA-2	NCQA	Hybrid/Admin[**]	Yes
Lead Screening in Children	LSC	NCQA	Hybrid/Admin[**]	Yes
Topical Fluoride for Children	TFL-CH	DQA	Administrative	Yes[iii]
Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	NCQA	Administrative	Yes
Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits[*]	W30-2+	NCQA	Administrative	Yes
Chronic Disease Management Domain Measures				
Asthma Medication Ratio[*]	AMR	NCQA	Administrative	Yes
Controlling High Blood Pressure[*, iv]	CBP	NCQA	Hybrid/Admin**	Yes
Glycemic Status Assessment for Patients with Diabetes (>9%)[*, iv]	GSD	NCQA	Hybrid/Admin**	Yes

Reproductive Health Domain Measures				
Chlamydia Screening in Women	CHL	NCQA	Administrative	Yes
Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	NCQA	Hybrid/Admin**	Yes
Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	NCQA	Hybrid/Admin**	Ye
Cancer Prevention Domain Measures				
Breast Cancer Screening*	BCS-E	NCQA	ECDS	Yes
Cervical Cancer Screening	CCS	NCQA	Hybrid/Admin**	Yes
Report Only Measures to DHCS				
Adults' Access to Preventive/Ambulatory Health Services[iv]	AAP	NCQA	Administrative	No
Colorectal Cancer Screening*	COL-E	NCQA	ECDS	No^^
Contraceptive Care – All Women: Most or Moderately Effective Contraception	CCW-MMEC	CMS	Administrative	No
Contraceptive Care – Postpartum Women: Most or Moderately Effective Contraception – 60 Days	CCP-MMEC60	CMS	Administrative	No
Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	ECDS	No^^
Depression Screening and Follow-Up for Adolescents and Adults*	DSF-E	NCQA	ECDS	No^^
Diabetes Screening for People w/Schizophrenia Bipolar Disorder Using Antipsychotic Medications	SSD	NCQA	Administrative	No
Follow-Up After ED Visit for Mental Illness – 7 days*	FUM	NCQA	Administrative	No
Follow-Up After ED Visit for Substance Use – 7 days*	FUA	NCQA	Administrative	No
Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	ADD-E-C&M	NCQA	ECDS	No
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	ADD-E-Init	NCQA	ECDS	No

Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM-E	NCQA	ECDS	No
Low-Risk Cesarean Delivery*	LRCD	CMS	Administrative	No[iii]
Pharmacotherapy for Opioid Use Disorder*	POD	NCQA	Administrative	No^^
Plan All-Cause Readmissions*, [iv]	PCR[ii]	NCQA	Administrative	No
Postpartum Depression Screening and Follow Up	PDS-E	NCQA	ECDS	No^^
Prenatal Depression Screening and Follow Up	PND-E	NCQA	ECDS	No^^
Prenatal Immunization Status	PRS-E	NCQA	ECDS	No^^
Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	NCQA	Administrative	No
Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	NCQA	Administrative	No
LTC Report Only to DHCS				
Number of Out-patient ED Visits per 1,000 Long Stay Resident Days*, [iv]	HFS	CMS***	Administrative^	No
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization*, [iv]	SNF HAI	CMS***	Administrative^	No
Potentially Preventable 30-day Post-Discharge Readmission*, [iv]	PPR	CMS***	Administrative^	No

[i] MCPs held to the MPL for the HEDIS© total rates only; the NCQA Quality Compass© Medicaid HMO 50th and 90th percentiles represent the MPLs and high-performance levels (HPLs), respectively. MCPs will only be held to the MPL for historically established benchmarks.

[ii] Stratified by Seniors and Persons with Disabilities (SPDs)

[iii] CMS calculated national median is considered the MPL.

Cultural and Linguistic (C&L) Program

The Cultural and Linguistic (C&L) program is managed by the Quality Improvement & Population Health department and falls under the Quality Health Programs (QHP) unit. The C&L department is responsible for assessing the cultural and linguistic needs of our members and enhancing the effectiveness of the program based on the results of the assessment. The C&L program activities are developed based on the NCLAS standards, reviewed, and approved by the Compliance Department.

The C&L team collaborates with other CCAH departments and community partners to promote cultural competence appropriateness, and linguistic services awareness to our members and providers. The C&L supervisor, along with the QHP manager, develops and revises policies and procedures to foster the language assistance and cultural competence needs of the organization.

The C&L needs of our members are identified through membership data reporting; this report identifies ethnicity, gender, age, and language preference. CCAH relies on membership characteristic data distributed by the Department of Health Care Services (DHCS) to aid in the assessment of characteristics and needs of our member population. The threshold language as determined by DHCS is based on reported members' demographics. English and Spanish are threshold languages for the counties of Mariposa, Merced, Monterey, San Benito, and Santa Cruz. Additionally, Merced County has a concentration language of Hmong.

- CCAH provides interpretation and translation services to our members at no cost. The objectives are to sensitize our providers and staff on how we can integrate cultural and linguistic appropriate services into daily activities and continuously provide quality care to our members.
- Provide staff and providers with information through training to support culturally competent communication and services.
- Ensure the Alliance Community Advisory Committee (CAC) includes participation from members of diverse cultural and ethnic backgrounds, Seniors, and Persons with Disabilities (SPDs), Limited English Proficient (LEP) members and members with chronic health conditions to better understand the needs of the community we serve. The Alliance CAC is the Member Services Advisory Group (MSAG).
- Identify and analyze health disparities in our membership population.
- Provide adequate interpretation services to meet member's needs and ensure that outreach materials that focus on access to community preventive health care services are culturally competent.

The information is evaluated and used to inform the C&L program and ensure that the diverse needs of the member population are prioritized. On an annual basis the C&L department ensures an annual workplan is developed highlighting measurable goals, activities, and interventions aimed at increasing service delivery, and helping to reduce inequities. The annual workplan is reviewed on a quarterly by the Quality Improvement Health Equity Committee (QIHEC) which is the governing board. Goals for this year include evaluating utilization of services to determine if members are adequately served. Conducting member surveys and focus groups to determine if members feel program offerings are beneficial and working with the Quality Improvement Health Equity teams to identify health inequities and develop interventions based on race, ethnicity, and language disparities.

Members with Complex Health Needs

The Alliance Complex Care Management (CCM) team partners with the PCP and specialists to support members with medium/rising risk stratification in managing their acute or chronic condition(s). This may include intense coordination of resources from the multidisciplinary team to ensure the member regains optimal health or improved functionality. After comprehensive assessments, individualized person-centered care plans are created with the involvement of the care team, member, and member support system. The support may include services that address emotional, physical, and social support

needs. The Complex Care Management Team collaborates with you as the PCP to provide the following services:

- Comprehensive assessments
- Promotion of the PCMH by fostering the member-PCP relationship
- Care coordination
- Promotion of self-management through engagement
- Linkage to community and social support resources
- Creation of mutually agreed upon care plans, including targeted interventions.
- Engagement of members telephonically and in-person
- Support across the health care continuum
- Management of a member's CCS eligible condition and care

Objectives for serving members with complex health needs are to:

- Identify gaps in preventative care and promote the benefits of addressing gaps in care.
- Provide case management services as a mechanism to optimize the use of the member's health care benefits while providing high quality integrated health care to members with ongoing or complex health care needs and help coordinate care with multiple providers for multiple conditions.
- Provide case management which focuses on care coordination and transition of care to community based behavioral health services for members with behavioral and mental health care needs, as well as substance abuse treatment needs.
- Enhance continuity and coordination among and between physical and behavioral health care providers in a timely manner.
- Ensure that members receive coordinated, appropriate, and timely access to primary and specialty care services.
- Identify and reduce barriers to services for members, such as, lack of transportation, shelter, and/or the need for cultural and linguistic outreach education.

Health Education

CCAH's Health Education Program is an interdepartmental initiative set in place to ensure that members have the knowledge and tools required to achieve optimal health outcomes. In doing so, these objectives ensure that CCAH is compliant with the California Department of Health Care Services (DHCS) Health Education standards. Health Education services encompass multiple initiatives which include provision of health education materials and content, policies and procedures, and programs aimed at completing annual objectives set to improve the health of the community at large.

Health Education services are a covered benefit under CCAH and are available to members at no cost. All services are designed to complement the work of providers in promoting patient self-management and disease prevention through healthy behaviors. Initiatives are dedicated to the promotion and empowerment of healthy lifestyles.

The health education program serves the following purposes:

- Program Development
- Plan, develop, and implement CCAH health education programs.
- These programs are required to comply with state and departmental objectives and regulations.
- These programs will be developed or expanded upon as needs arise and shift within our membership and their communities.

Care Management Support

- Support Social Work, Case Management, and Disease Management programs by way of educational materials, CCAH Health Education programs, and outreach connection to community resources.
- Providing support to other departments in creating, writing, and reviewing health education messages and materials.

Member Communications and Health Messages

- Member Newsletter
- Provider Bulletin
- Health Promotion on the Alliance's social media pages
- Provider Digest
- SMS Member Text messages

Behavioral Health

CCAH works with Carelon Behavioral Health of California, Inc. (Carelon) our MBHO, to provide all of the Non-Specialty Mental Health Services (NSMHS) for Medi-cal members and full array of behavioral health services, including substance use disorder (SUD) services and specialty services for the IHSS line of business. Carelon is also delegated to support members needing Behavioral Health Treatment or Applied Behavioral Analysis services, such as, but not limited to those with a diagnosis of autism or pervasive developmental disorder. Carelon has a large network of providers to manage these members. In addition, Carelon maintains a robust telehealth network to assist and ensure adequate members' access to necessary services.

CCAH provides behavioral health services for members with mild and moderate functional impairment. The services for members with severe impairment are carved out to the County Behavioral Health Services Agencies. also works with Carelon to manage its members with Autism. Carelon has a large network of providers to manage these members. In addition, Carelon maintains a robust telehealth network to assist and ensure adequate members' access to necessary services.

Background

Carelon partners with College Health IPA to provide the full suite of clinical and administrative services necessary to manage the new Medi-Cal managed care mental health benefits on behalf of our Medi-Cal health plan clients. Previously CCAH partnered with Carelon to provide Behavioral Health Services for those members with Mild-Moderate Behavioral Health Needs from 2013-2016. In January of 2017 this partnership was amended and CCAH brought those services with the exception of autism, and BHT telehealth back into the plan. CCAH ensures that all delegated activities are conducted in compliance with California laws. These delegated services include the delivery of telehealth, autism services, and the credentialing of providers related to the delivery of those services. Case Management for members with mild to moderate behavioral health conditions are still managed by Carelon.

Current Delegated activities include:

- Claims Processing
- Provider Disputes
- Member Connections
- Member Grievances
- Credentialing & Recredentialing

- Network Management
- Quality Improvement
- Utilization Management

The scope of Carelon QIPH program encompasses the ongoing assessment, monitoring, and improvement of all aspects of care and services delivered to members, including member safety. The diverse populations served represent multiple cultural and linguistic groups, and includes pediatric, adult, and geriatric individuals with mental health and substance use disorders, as well as individuals with developmental disabilities and other special needs across the United States. A designated Behavioral health practitioner who is a licensed Medical Doctor participates in the Alliance Quality Improvement Health Equity Committee helping to review behavioral health initiatives and activities.

As of July 1, 2025, the Alliance plans to insource the above benefit administration, currently delegated to Carelon, and cease to have delegated services. The services available will not change.

Behavioral Health Initiative

CCAH QIPH department continuously works on increasing HEDIS compliance rates which also includes meeting the Medi-Cal Managed Care Accountability Set (MCAS) goals set forth by DHCS. The Behavioral Health Workgroup conducts monthly meetings to collaborate with the plan's internal departments to help develop any areas that can help the network providers improve the compliance for these measures.

The following behavioral health measures are being focused on:

- **AMM (Antidepressant Medication Management) –** Acute and Continuation phase
- **ADD (Follow up Care for Children prescribed ADHD medication) –** Initiation and Continuation Phase
- **APM (Metabolic Monitoring for Children and Adolescents on Antipsychotics)**
- **SSD (Diabetes screening for people with Schizophrenia or Bipolar disorder who are using Antipsychotic medications).**
- **FUA/FUM (Follow-Up After ED Visit for Substance Use** -30 days/ **Follow-Up After ED Visit for Mental Illness** -30 days)

Evaluation of Effectiveness of Interventions

Continuous quality improvement is realized when data are collected and analyzed; interventions are planned and implemented; measurement is repeated; and performance continually improved. The cycle is continuous and maintained on a schedule that is not limited by the end of the fiscal or calendar year. Effectiveness is evaluated with each re-measurement cycle. It includes quantitative and qualitative analysis, including an analysis of statistical significance and meaningful improvement and allows for comparison with the baseline or previous measurement. Findings from these measurements are reported to the QIHEW and the QIHEC Committee, the Physician Advisory Council as appropriate and to the governing board which is the CCAH Board.

Quality Improvement and Heath Equity Resources

The QIPH Program has staff and analytical resources available to achieve program objectives. The Quality Improvement and Populations Health Department has overall responsibility for all QIPH activities. The Department has adequate staff to fulfill its role. Departments within CCAH provide significant amounts of time for QIPH activities and responsibilities. Leadership ensures adequate resources to implement and maintain all QIPH Program activities. Additional external resources such

as, HEDIS auditors for medical record review and data abstraction and analysis, and accreditation readiness are available as needed.

The following CCAH FTE positions are 100% dedicated to QIPH.

Position/Title

Quality Improvement & Population Health Director (
Quality Performance Improvement Manager (1)
Quality & Populations Health Manager (1)
Quality & Health Programs Manager (1)
Clinical Safety Quality Manager (1)
Clinical Safety Supervisor (2)
Quality Improvement and Health Equity Supervisor (2)
Quality and Health Programs Supervisor (2)
Quality Improvement Program Advisors IV (3)
Quality Improvement Program Advisors III (5)
Quality Improvement Program Advisors II (10)
Quality Improvement Program Advisors I (1)
Senior Quality Improvement Nurses (6)
Quality Improvement Nurse (4)
Health Educators (8)
Care Coordinators (5)
Quality and Health Programs Program Advisor (2)
Quality Improvement Project Specialist (1)
Coding Resource Specialist (1)
Administrative Specialist (1)

The following CCAH FTE positions have a portion of their time allocated to the QIPH Program:

- Chief Medical Officer
- Chief Health Equity Officer
- Medical Directors
- UM Director
- Pharmacy Director
- Behavioral Health Director
- Community Grants Director
- Community Engagement Director
- Health Equity Program Manager

All CCAH departments collaborate with the QIPH department for QIPH improvement activities:

- Member Services
- Provider Services
- Provider Services Contracts/Provider Quality and Network Development
- Compliance/Privacy and Security
- Community Engagement
- Claims

- Finance
- Application Services
- Pharmacy
- Utilization Management
- Community Care Coordination
- Community Grants
- Communications
- Data Analytics Services

Functional Areas and Their Responsibilities

The Quality Improvement and Population Health department leads the improvement activities for CCAH in collaboration with other departments to integrate quality improvement activities at all levels of the Alliance. Many other functional areas are involved in aspects of, and provide support to, the QIPH Program.

Member Services

The QIPH Program provides interaction with Member Services to assure maintenance and adequacy of practitioner/provider availability and access to care, and evaluation of satisfaction feedback that is used to develop and improve quality management processes, program effectiveness, and health care delivery processes. The Member Services Department is responsible for:

- Serving as first responders to member inquiries and first call resolution when possible or if not possible, forwarding issues to designated staff to follow-up.
- Processing, to the extent possible, member complaints and appeals using established procedures.
- Documenting all member complaint and appeal data including: the nature of the complaint or appeal; appropriate complaint and appeal categories; the actions taken; and the resolution.
- Immediately referring potential quality of care, clinically urgent, and member safety issue complaints and appeals to designated clinical staff.
- Measuring average speed of telephone answer and abandonment rate; analyzing results; taking action when performance does not meet standard; and reporting results to the Quality Improvement Health Equity Workgroup Committee.

Provider Services

The QIPH Program is a foundation for planning and structuring provider/practitioner education and support efforts. Provider Services staff communicate physician, allied and ancillary health practitioner/provider satisfaction feedback that is used to develop and improve quality management processes, program effectiveness, medical review, and clinical guideline criteria. Provider Services is responsible for:

- Assisting QIPH with developing and managing communication with practitioners/providers.
- Proposing ways to improve practitioner/provider satisfaction with CCAH.
- Assisting with the coordination of practitioner/provider office staff QIPH educational trainings.
- Collaboration and facilitation of the Physician Partnership Program for the enhancement of Quality initiatives.

Provider Contracting and Network Development

The QIPH Program ensures collaboration with Provider Contracting in evaluation of potential and contracted practitioners/providers for appropriateness to meet the care and service needs of our member population. Provider Contracting and Network Development are responsible for:

- Contracting with sufficient practitioners and providers to meet access and availability standards.
- Maintaining provider contracts in full compliance with all accreditation and regulatory entities.
- Collaboration with Provider programs to improve quality standards.

Compliance / Privacy and Safety

The QIPH program reports to Compliance with information or results of any findings of non-compliance by contracted providers, facilities, and internal departments. The Compliance Department is responsible for:

- Promotes the guidelines to conduct business in compliance with both Federal and State laws, policies, contractual requirements, and accreditation standards.
- Identifies, develops, plans, and executes strategies to track organization-wide compliance to develop actions plans to address.
- Provides training and manages the plan's policies and procedures, monitors, or conducts internal audits to detect any violation of compliance procedures.
- Conducts fraud and abuse detection and prevention activities and reports credible allegation findings to the appropriate State/Federal agencies.

Community Engagement

The Community Engagement Department is dedicated to building strong relationships between the health plan and the communities it serves. Through strategic outreach, education, and partnerships, the department works to improve health equity, increase access to care, and enhance member engagement.

Key Responsibilities:

- Developing and executing community outreach programs to promote health and wellness.
- Partnering with local organizations, healthcare providers, and stakeholders to address social determinants of health.
- Participating in health fairs, educational workshops, and enrollment events to connect individuals with healthcare resources.
- Advocating for underserved populations by identifying and addressing barriers to care.
- Enhancing brand awareness and trust through culturally competent engagement strategies.
- Collecting and analyzing community feedback to inform policy and program development.

The Community Engagement Department plays a vital role in fostering a healthier, more informed, and connected community by ensuring individuals have the support and resources needed to navigate their healthcare journey.

Claims

The QIHE Program provides ongoing claims support services for evaluation of appropriate billing practices and identification of suspected fraud and abuse. The Claims Department is responsible for:

- Providing data regarding timeliness of claims for care and services according to the member Evidence of Coverage criteria.

- Providing data regarding accuracy and timeliness of claim submission.
- Identifying and communicating suspected fraudulent billing practices.
- Identifying over utilization of services.

Finance

The QIHE Program coordinates with the Finance Department who manages the financial activities and assists with the development of reports for quality reviews. The Finance Department is responsible for:

- Identifying, developing, planning and executing short, medium and long-range organization and division strategies; ensures the development and implementation of associated business plans, tactics and policies.
- Overseeing and directing the timely and accurate analysis of budgets, financial reports, medical loss analysis and financial trends.
- Developing and coordinating the budget for provider incentive programs for PCPs, hospitals, and specialists.
- Overseeing the internal and external audit function to ensure the timely and accurate completion of annual fiscal audits and other financial information.

Information Technology Services

The QIHE Program provides interaction with Information Technology Services (ITS) to access and collect standardize, timely, and accurate data to monitor, track and trend, and develop and improve quality management processes and program effectiveness. Within ITS, the Application Services Department is responsible for:

- Preparing reports to measure quality using data sources such as, but not limited to, claims, encounters, immunization and lead registry, provider submitted information and utilization.
- Technical support for MCAS reporting.
- Maintaining the systems, collecting, and reporting encounter data.
- Maintaining supplemental data sources from immunization and lead registries, laboratories, and health information exchanges (HIE).
- Maintaining and building provider supported portal reports.
- Technical support for the provider incentive programs.
- Ongoing reporting for Improvement Projects.

Pharmacy

The QIHE Program collaborates with the Pharmacy Department to continuously improve the delivery and quality or:

- Promotes clinically appropriate prescribing practices in line with national practice guidelines. The Pharmacy department educates providers and members by sharing best practices via newsletters, mailing and website updates. The Pharmacist Led Academic Detailing focus on improving health outcomes of our members with working directly with providers in medication management.
- Analyzes provider prescribing habits to develop and implement targeted education programs based on results. The Pharmacist department have elaborative Drug Utilization Review Program to analyze prescribing patterns of providers and performs subsequent inventions based on the findings of the review. Examples of topics for DUR program Opioids, behavioral health medication use in children.
- Analyzes pharmacy data for potential fraud and abuse cases and reports cases as required. The Pharmacy department reports any potential quality issues to Quality department and partners

with them in implementing any interventions. The Pharmacy department acts as subject matter expert on any medication related PQIs referred to QI.
- Develops, implements, and maintains policies and procedures specific to pharmacy management in compliance with Federal and State requirements and regulations.
- The Pharmacy Department provides clinical and quality oversight of Med Impact and Medi-Cal Rx to ensure medication access and appropriateness.

Utilization Management and Care Management

The QIHE Program provides data to profile practitioners/providers; identifies opportunities for improving authorization and referral processes, including guideline/criteria development, modification of existing guidelines, benefit interpretations, and the development of disease management programs.

Utilization Management is responsible for:
- Conducting pre-certification, concurrent and retrospective analysis of appropriateness of care and services.
- Tracking and trending utilization data.
- Completing an annual evaluation of utilization management activities
- Tracking and analyzing data regarding over and under-utilization of services.

Case Management is responsible for:
- Overseeing case management activities including those for high-risk members and members with complex health needs.
- Tracking and analyzing data regarding clinical outcomes.
- Ensuing outreach and care coordination activities for identified members.
- Fostering continuity and coordination of care.

Community Grants

The Alliance makes investments to health care and community organizations in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties through the Medi-Cal Capacity Grant Program (MCGP) 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.
- Addressing social drivers that influence health and wellness in our communities.

The MCGP furthers the strategic priority of health equity through a variety of investments:
- Healthcare Workforce: Strengthen and expand the provider workforce to address provider shortages. Increase the number of providers who reflect the diversity of the Alliance's membership and provide culturally and linguistically competent care. Close care gaps, increase quality scores and improve members' overall health.
- Healthcare Delivery System Infrastructure: Invest in new and expanded health care facilities and technology to improve access to high quality care, care coordination and data sharing.
- Parent/Child Health & Wellness: Empower parents and caregivers through education and support, ensuring access to timely prenatal and postnatal care, preventative health services, and community resources.

- Community Education and Engagement: Invest in trusted, community-based organizations serving historically marginalized communities to educate and engage members about Medi-Cal services, improve access to health care and supportive resources, promote the importance of preventative care and regular screenings and create supportive networks and environments.
- Social Drivers of Health: Invest in strategies that reduce health disparities, support healthy and active lifestyles and reduce risk of chronic disease, including access to nutritious food, safe spaces for recreation, and permanent supportive housing.

Communications

The QIHE Program provides aggregate data to the Communications Department regarding the effectiveness of practitioner/provider outreach strategies and processes as part of customer engagement. Communications is responsible for:

- Communicating the Alliance's value proposition as it relates to local access, diverse provider network and other services and programs available to members.
- Engaging members and potential members at outreach events to answer questions on member benefits and advising on how to contact their state agency for enrollment information.
- Engaging with new members to provide an understanding and overview of benefits and services and provide information on how to choose a doctor and how to use their Alliance card. Reaching and engaging members through omnichannel messaging on digital, print and other communications channels.
- Messages include information they need to be as healthy as possible, including messaging on the Nurse Advice Line, transportation benefits, the importance of well-checks and vaccines, information on important health screenings, behavioral health services, language assistance services, information on upcoming vaccine clinics and more.
- Maintaining content strategy across all communications channels, ensuring an aligned communications approach across member, provider, and community audiences.
- Overseeing the publication and delivery of print and digital newsletters and bulletins for members, providers, and communities. These include the Member Bulletin, The Provider Bulletin, Provider Digest, Provider Flash and The Beat.
- Overseeing the text messaging (SMS) program to communicate and engage with members directly on a variety of topics related to their overall health and wellness and the benefits and services available to them.
- Executing paid media campaigns targeted to members and the public, promoting various messaging on well checks and vaccines.

Data Analytics

The QIHE Program works with the Data Analytics Services Department under ITS to understand the data and statistics to assist in developing the standard methodologies to achieve targeted and accurate results. The Data Analytics Department are responsible for:

- Provides quantitative and qualitative analyses or evaluation on a variety of complex and diverse strategic and operation issues.
- Collaborates with Business Intelligence, Finance and Contracting for data compilation.
- Measures rates and analyzes patterns of utilization to aid in quality improvement projects. Providing technical support for the provider incentive programs, ad hoc data requests, and report generation. Produces dashboards that are used to measure quality improvement projects, effectives of care, utilization and to provide data for comparison.

Analytical Resources

CCAH dedicates staff and information systems to analyzing and reporting clinical and service quality data. Employed and contracted staff include Bachelors and Master's level prepared personnel with statistical analysis training and experience conducting quantitative and qualitative analysis of health care data.

Software resources include but are not limited to the claims systems, HEDIS software, Provider Network Management Systems, Microsoft products, Business Intelligence Tools, SQL server reporting software (SSRS), Toad database management toolset, statistical analysis software, care management software, and other systems to support the QIHE Program.

Clinical Quality Improvement

CCAH's Quality Improvement Department adheres to all DHCS standards in accordance with Title 22, CCR, Section 53860 (d) and Title 42, USC, Section 1396a(30)(C) for quality performance reporting. In addition to the CCAH works with the External Quality Review Organization (EQRO) in the annual MCAS review process for quality performance measures and health equity measures identified by DHCS. CCAH uses standard data collection and analysis to track clinical issues that are relevant to our population. This is primarily based on the audited MCAS results that are reported to NCQA and the State. CCAH sets the goal to exceed the DHCS established minimum performance level (MPL) and meet health disparity reduction targets for specific populations and measures as identified by DHCS. Alliance staff evaluates the Plan's performance against these goals at the end of the fiscal year. Based on the findings, CCAH identifies and prioritizes areas for improvement by developing quality improvement projects and supporting providers through the CBI program resources and Alliance Provider Portal reports. CCAH also developed a Quality Outreach Program for practitioners and their office staff, Provider Partnership Program. This includes provider reports and site visits to build collaborative relationships with the providers and clinics. The QM program will also monitor areas of over and underutilization of services to improve appropriate utilization of services. The over and underutilization measures will be based on HEDIS and other internally developed utilization measures.

The QIPH Department implements opportunities to improve quality of care by developing and implementing quality improvement activities/interventions. These interventions align patient and provider engagement programs and may include but are not limited to:

- Developing and adopting clinical standards, practice guidelines or administrative standards, with subsequent dissemination of the standards to physicians, members, or staff as appropriate.

Additional Quality Improvement Program Structure

The Quality Improvement and Population Health Department is a multi-faceted department with multiple functional areas, and programs.

Accountability

Alliance Board: The **Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission** (Alliance Board) promotes, supports, and has ultimate accountability and authority for a comprehensive and integrated QIHETP. Alliance Board responsibilities include:

1. Annual review and approval of the QIHETP and applicable QIHETP reports
   - Appointment of an accountable entity or entities to provide oversight of the QIHETP.
   - Routine review of written progress reports from the QIHEC

- Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and DHCS Comprehensive Quality Strategy.
- The Alliance Board has delegated direct supervision, coordination, and oversight of the QIHETP by the Quality Improvement Health Equity Committee (QIHEC), with the Chief Executive Officer (CEO) and Alliance Quality Improvement and Population Health (QIPH) Department under the supervision of the Chief Medical Officer (CMO) in collaboration with the Chief Health Equity Officer or designee. The CMO regularly provides QIHETP operational reports to the Alliance Board.

The Board assigns the authority and responsibility to implement the Quality Improvement Health Equity Transformation Program to the Chief Medical Officer who chairs the QIHEC Committee. The QIHEC is charged with overseeing implementation of the Quality Improvement Health Equity Transformation Program.
The Board Meeting agendas include presentations of CCAH committees and sub-committee reports for review, recommendations, and approval. The Commission meetings are widely publicized, open to the public, and meet the conditions of the Ralph M. Brown Act.

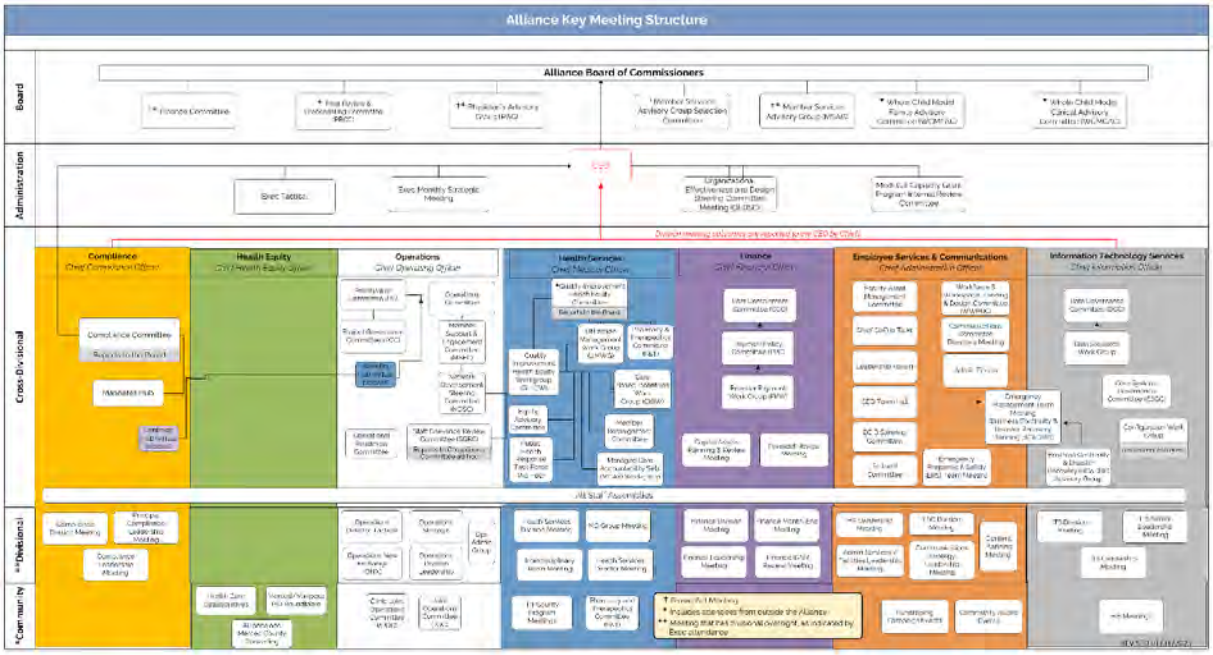
- The Board (Commission) shall consist of a maximum of 25 voting members whom, except for the director or designee of the Health Department (or Health Services Agency) who shall work in the respective county and be appointed by the respective Board of Supervisors,
- shall be legal residents of the County of Santa Cruz appointed by the Board of Supervisors of
- Santa Cruz County, legal residents of Monterey County appointed by the Board of Supervisors
- of Monterey County, legal residents of Merced County appointed by the Board of Supervisors of Merced County, legal residents of San Benito County appointed by the Board of Supervisors of San Benito County, and legal residents of Mariposa County appointed by the Board of Supervisors of Mariposa County. The Commission shall be generally representative of the diverse skills, backgrounds, interests, and demography of persons residing in each county.

The key to CCAH's quality management success is integration of information. CCAH's committees may function separately, but it is an expectation that data and information be readily available to and from all who are actively involved in CCAH's performance improvement processes. Committee information and data are validated, coordinated, aggregated, communicated, reported, and acted upon in a timely, expedient manner to ensure success with all performance improvement and quality initiatives. Regular meetings are held by each respective committee during the year. Written minutes are maintained by each Committee for each meeting. Primary responsibilities of the committee members include the following:

- Committee members are required to sign a conflict-of-interest statement.
- Committee members cannot vote on matters where they have an interest and must abstain until the issue has been resolved.
- Committee members are expected to provide expertise and assistance in directing the QI Program activities.

Organizational Structure

CCAH's organizational structure is the framework for QIHETP activities. The organizational structure is described in the following section.



Chief Medical Officer (MD)

- CCAH provides executive management and leadership of the Alliance Health Services Division, which includes the Quality Improvement and Health Equity, Pharmacy, Utilization Management, and Community Care Coordination Departments, with duties including but not limited to: Approving subordinate budget recommendations and working with executive administration to create an annual budget, including providing clinical insight and guidance on medical budget.
- Monitoring legislative and legal changes related to Alliance functions and ensuring appropriate.
- communication of same
- Provides executive management and leadership of the Alliance Health Services Division, which includes the Quality Improvement and Health Equity, Pharmacy, Utilization Management and Complex Case Management, and Community Care Coordination Departments
- Serves as Chair of the Quality Management and Utilization Management (QIHEC), Peer Review & Credentialing (PR&C) and Physician Advisory Committees.
- Developing and evaluating the Quality Improvement Program and plan to ensure the provision of and the continuous improvement towards high quality services for Alliance members.
- Ensures that effective collaborative work and problem solving is maintained between assigned departments, and other internal and external stakeholders.
- Oversees accreditation and compliance activities to ensure agreed upon and mandated standards are met.
- Identifies medical delivery system quality issues; develops and oversees implementation of corrective action plans.
- Serving as main staff liaison regarding medical issues to physician and provider committees and advisory groups

- Developing and evaluating the Utilization Management Plan and program, and reporting outcomes
- Oversees the provision of medical management for safe and effective health care services, including behavioral healthcare services in conjunction with the Medical Director, and the Pharmacy Director.
- Serving as main staff liaison regarding medical issues to physician and provider committees and advisory groups
- Establishes prioritization of QM issues and improvement activities based on effect customer impact, safety, and available resources.
- Reviews and approves Quality Management policies and procedures.

Chief Health Equity Officer (MD)

CCAH provides Provide leadership to ensure health equity is prioritized and health inequities are addressed within the QIHETP. This role acts as part of the Regional Quality and Health Equity team but not limited to:

- Consulting on and facilitating the development and implementation of strategies and targeted interventions designed to identify, address and eliminate health inequities, such as systemic racism, social drivers of health, and infrastructure barriers through understanding root causes and utilizing relevant quantifiable metrics to track and evaluate the results of targeted interventions
- Establishing the Alliance's health equity and population health framework
- Developing initiatives, policies, and practices to prevent structural health disparities and social injustices in health and social services
- Monitoring and reporting on DEIB strategic plan initiatives aimed at improving health equity and reducing health disparities
- Ensuring all policies and procedures for promotion of health equity where possible, such as marketing strategy, medical and other health services policies, member and provider outreach, community advisory committees, quality improvement activities including delivery system reforms, grievance and appeals, and utilization management
- Assisting and advising on National Committee for Quality Assurance (NCQA) accreditation regarding health equity standards
- Ensuring procedures and practices are in alignment with the Alliance's vision and mission and are designed to promote health equity
- Accessing, evaluating, and reporting on confidential data which may include members' protected health information and personally identifying information
- Developing, monitoring, and maintaining analytic reports and performance metrics related to strategic goals and projects
- Responsible for overseeing employee performance appraisal, hiring, salary administration, training and development, performance management. and discipline
- Working with executive administration to create annual budget and approving subordinate budget recommendations as appropriate and necessary
- Interacting with external entities, such as health networks, legal counsel, and state and federal regulatory agencies

Medical Director(s) (MD)

CCAH Provides clinical leadership within one or more of the Health Services functional areas including, but not limited to: Utilization Management, Quality Improvement, Pharmacy, and Care Management Develops and improves relationships with internal and external stakeholders, including the

- professional medical community and maintains and enhances communications with similar Health Plan organizations. Providing clinical leadership for medical decisions regarding hospital Concurrent Review on
- Alliance inpatient members.
- Coordinating and consulting with department Directors regarding the clinical direction of programs, studies, activities, processes.
- Taking a leadership role in strategic planning, Clinical Effectiveness and Quality Initiatives and other operational programs.
- Evaluating physician requests for member reassignment
  Reviewing Authorization Requests as referred by Utilization Management staff for approval or denial of requested services.
  CCAH Directing and interpreting data based on utilization analysis, including overutilization, underutilization, and cost trending in key areas (inpatient, pharmacy, Emergency Department (ED) use, etc.)
- Assessing requirements and needs for mandatory, and optional, health promotion programs · Recommending study design, oversight, and feedback mechanisms for quality improvement projects.
- Identifying fraud, waste, and abuse and working with the Alliance Compliance Program to address those issues.
- CCAH Participating in the development, implementation, and monitoring of the Alliance drug formulary · Providing clinical support and leadership to the Pharmacy Department drug utilization management process including practitioner interface as appropriate and overseeing appropriate denials · Assisting in the Pharmacy Benefit Manager (PBM) and pharmacy consulting services relationships including the PBM Request for Proposal (RFP) process.
- Participating in the Alliance's internal committees, Hubs, and workgroups, such as: Clinical Quality Improvement Committee (CQIC), Quality Improvement Work Group (CQIW), Utilization Management Work Group (UMWG), Reassignment Committee, Staff Grievance Review (Appeals and Grievances) Committee, Compliance Committee, etc.
- Attending and/or chairing local medical meetings and committees, such as Hospital Joint Operating Committee, Physicians Advisory Group (PAG), Peer Review and Credentialing Committee (PRCC)
- Participating in information sharing, discussions, and problem-solving meetings with other Health Care organizations and community agencies ·
- Evaluating disputes regarding Primary Care Physician performance ·
- Informing and educating the professional community about the Alliance and its programs ·
- Participating in academic detailing outreach to providers regarding Care-Based Incentives (CBI), Quality Improvement Programs, Utilization Management best practice and Care Management Programs
- Serving as a liaison for network physicians who have questions, suggestions, feedback and/or complaints.

Health Equity Program Manager

Develops and manages the operationalization of health equity strategies and performs program planning and design and operational program management, with duties including but not limited to:

- Supporting and collaborating with the Chief Health Equity Officer in the planning, design, development, and implementation of programs that support health equity and DEIB initiatives across the organization
- Operationalizing concepts and developing tactics to achieve strategic program objectives
- Monitoring program activities, including performance metrics, for continuous improvement
- Tracking and analyzing trends in healthcare disparities, recognizing the implications of diverse cultural, language, economic, education, and health status needs of members, and supporting efforts to address inequities
- Evaluating data related to identified disparities and making recommendations related to prioritization
- Ensuring that the Health Equity Program and related processes adhere to regulatory and contractual requirements, laws, accreditation standards, and regulations, including Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC)
- Assisting with research, preparation, and revision of policies, procedures, and program materials
- Participating in the evaluation of program goals to ensure alignment with departmental and organization-wide goals
- Preparing narrative and statistical reports, correspondence, communications content, and other program materials
- Providing updates to Alliance leadership and staff, making presentations, and developing related materials
- Working with the Chief Health Equity Officer to prepare and deliver reports for executive leadership and the Board
- Working with the Compliance Department to monitor compliance with regulations and contract provisions
- Cultivating partnerships with a broad range of professional and community partners and leading the development of engagement opportunities that incorporate community voices and solutions into health equity programs and projects
- Networking, establishing affiliations, and maintaining relationships with community-based organizations (CBOs) to gather information about health disparities to inform the Alliance's health equity work
- Working collaboratively with external stakeholders and CBOs to address identified priority disparities

Community Engagement Director

Acts as the health plan's regional community liaison, representing the Alliance and its programs, services and operations in assigned counties and regions, with duties including but not limited to:

- Planning, implementing, and evaluating new programs, services and lines of business
- Ensuring existing programs, services and lines of business for the assigned geographical area align with community needs
- Planning, developing, implementing, and evaluating the community relations program

- Identifying and analyzing quality and customer service issues and overseeing the implementation of recommended improvements to programs, services, and lines of business
- Acting as the primary liaison between community partners and the Alliance, including Clinic Joint Operational Committees and Hospital Joint Operational Committees, while maintaining a strong presence in the local community
- Representing the Alliance with local, state, and federal government entities and community agencies
- Participating in various community meetings, forums, events, and providing leadership within the health care community
- Serving as liaison to community advisory committees, collaboratives, and commissions
- Promoting the health plan's services within the counties of responsibility
- Identifying, planning, and leading community engagement activities to develop and promote Alliance community presence, improve social determinants of health, and promote health equity and brand awareness
- Recommending, planning, developing, implementing, and evaluating goals and objectives for the community engagement program within the framework of overall organizational goals and objectives, in collaboration with the Chief Operating Officer
- Recommending, planning, developing, implementing, and evaluating member and community engagement and community partnership goals and objectives, including overseeing member outreach initiatives and community committee planning and projects, in collaboration with department leadership across the organization
- Participating in organizational strategic planning and overseeing implementation of community engagement related projects
- Advising Alliance leadership and other appropriate staff of community collaboration opportunities within the service area**.**

Community Grants Director
Directs the planning, development, implementation, and ongoing operation of the Alliance's Medi-Cal Capacity Grant Program in collaboration with the governing board and Alliance executive team, with duties including but not limited to:

- Developing, maintaining, and refining the policy framework, goals and selection criteria for grant program investments in collaboration with the Chief Executive Officer (CEO) and Alliance Board
- Developing and monitoring a multi-year plan for grant program investments and adjusting the plan to address emerging needs and priorities
- Researching, analyzing and reporting on potential investments in relation to the plan's strategic goals, expected outcomes, estimated costs, feasibility issues, legal issues, and regional and county-specific business factors
- Designing new grant programs and working with key Alliance staff and external partners to implement
- Evaluating merits of grant proposals, conducting due diligence, and recommending proposals that meet selection criteria and align with program goals
- Ensuring grantee compliance with multi-year grant requirements
- Managing ongoing vendor and grantee relations
- Receiving, analyzing and reporting grant program performance data and comparing to goals
- Making recommendations for program improvements or changes based on program evaluations and grantee feedback

- Working with the CEO and CFO to budget funds for the Community Grants Department and the Medi-Cal Capacity Grant Program, and managing and monitoring various grant program budgets on an ongoing basis
- Preparing and presenting reports to Alliance management and Board
- Developing contracts or other legal documents in collaboration with staff and attorneys
- Overseeing the development of communications materials to promote the grant program and Alliance investments in the community
- Staying informed about current research, policy activities, and trends related to Alliance priorities in order to identify new opportunities for grant program development
- Developing and evaluating new programs and projects and presenting to staff and the Board of Commissioners, as directed by the Chief Executive Officer (CEO)
- Preparing reports for the Board of Commissioners package for review by the CEO
- Providing support to the CEO on strategic projects and operational initiatives related to grant funding in the community

Quality Improvement and Population Health Director
Provides strategic management oversight in implementing, directing, and monitoring the Alliance's Quality Improvement and Population Health Department functions, with duties including but not limited to:
The QIPHD reports to the CMO.

- Designing, developing, and managing Quality Improvement and Population Health Department services and deliverables, including clinical programs related to quality improvement, population health, clinical safety, and other Health Services initiatives.
- Overseeing the development and implementation of the population health program, in collaboration with other Alliance Departments and with assistance from the Quality and Population Health Manager, including initiatives for targeted interventions in alignment with the Alliance's vision and mission.
- Overseeing the Quality Improvement Health Equity Transformation Program for Managed Care, including the Medi-Cal Managed Care Accountability Set (MCAS)/Health Effectiveness Data and Information Set (HEDIS), Health Programs, and Care-Based Incentive (CBI) programs, and ensuring compliance with regulatory reporting requirements.
- Providing organizational-wide leadership for the Alliance's QIHETP through monitoring, evaluating, and taking effective action on any needed improvements in the quality of care delivered.
- Overseeing delegated oversight for quality improvement activities, including overseeing pre-delegation evaluations and ongoing evaluations of delegate or subcontractors to ensure compliance with Alliance standards, and implementation of corrective action plans.
- Overseeing the investigation of suspected clinical quality of care issues and trends and ensuring that identified issues are promptly corrected through monitoring and corrective action plans in collaboration with the Compliance Department, Provider Services Department, and Chief Medical Officer (CMO) or designee.
- Developing, implementing, and maintaining programs, policies, and procedures to meet Alliance goals and ensure regulatory and contractual compliance.
- Coordinating relationships with clinical and social service agencies and documenting protocols for agency communications and referrals pertaining to quality improvement activities including Memorandums of Understanding.
- Attending and providing support to clinical committee meetings.

- Assisting the Medical Director in managing QIHETP, including MCAS/HEDIS and quality study research, and ensuring compliance with related regulatory reporting requirements.
- Participating in the Alliance's Grievance system by incorporating a continuous quality improvement process related to grievance resolution.
- Advising executive leadership on strategic issues involving the QIHETP.
- Participating in the general administration of the Alliance as a member of the executive management team by providing input into the problem-solving and decision-making process.
- Participating in strategic planning and implementation of the Quality Improvement and Population Health Department operational goals related to the growth and development of Alliance business operations.
- Ensuring that Quality Improvement and Population Health Department goals and activities are in alignment with the Alliance strategic plan.
- Preparing narrative and statistical reports and making presentations.
- Developing performance measures related to strategic goals and new projects and presenting to staff and the Board of Commissioners, as directed by the CMO.
- Preparing reports for the Board of Commissioners package for review by the CMO.
- Overseeing the preparation and maintenance of records, reports, and related documents.
- Overseeing, coordinating, and participating in a variety of committees, including the Quality Improvement Health Equity Committee (QIHEC), both Quality Improvement Health Equity Workgroups (QIHEW), Peer Review and Credentialing Committee (PRCC), and other committees relevant to the QIHETP.
- Developing and managing the Quality Improvement and Population Health Department operations and budget.
- Providing support to the CMO, including leading or supporting activities within the Health Services Division as directed, such as monitoring and tracking of Health Services analytics, clinical analytics and reporting, and performance improvement.

Quality and Performance Improvement Manager(s) (QPIM)
The QPIM reports to the QIPH Director and leads quality improvement initiatives to improve quality measures performance with the network providers and local communities, with duties including but not limited to:

- Supporting the development, management, and implementation of performance improvement program activities to achieve established benchmarks for quality measures performance, such as HEDIS/MCAS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Department of Managed Health Care (DMHC) health equity measures, and Centers for Medicaid and Medicare (CMS) quality measures.
- Managing a data-driven strategy for quality measures performance through dashboards, data stratification, analysis, and action plans.
- Developing and implementing provider education strategies and tools, monitoring provider performance, and facilitating technical assistance for providers that perform below quality Benchmark.
- Participating in the development of risk adjustment or value-based payment programs that deliver measurable, actionable solutions and outcomes across the health care system.
- Planning, implementing, and evaluating quality initiatives based on key performance metrics, return on investment analysis, and other outcomes to determine effectiveness of interventions.

- Monitoring, tracking, and ensuring completion of administrative QIPH Department activities in an organized, systematic, and on-going basis and developing plans for improvement.
- Overseeing the accurate execution of the QIPH work plan, dashboard, quarterly and annual QIPH summary, and operational trackers maintained by the QIPH Department.
- Developing and recommending plans to utilize internal resources and techniques to improve clinical outcomes, such as practice coaching, process improvement tools or academic detailing.
- Leading clinical initiatives designed to build a culture of high performance through learning sessions, webinars and on-going collaboratives with multiple network providers and community-based organizations
- Remaining current and knowledgeable of applicable mandates from oversight agencies, such as DHCS, CMS, DMHC, NCQA and other regulatory/accrediting bodies as applicable.
- Manages quality improvement projects, initiatives and activities including NCQA Accreditation.
- Is responsible for compliance with NCQA and regulatory standards.
- Managing and supervising staff, setting goals and objectives, delegating, and assigning work.
- Identifying, overseeing, and assisting with objectives, priorities, assignments, and work-related tasks and reviewing work products as needed

Quality and Population Health Manager (QPHM)
The QPHM reports to the QIPHD and manages, leads, acts as a subject matter expert, and provides guidance on unit functions and department operations, including regarding clinical health outcomes related to population health management, clinical data management and retrieval, reporting standards, and State policy and procedure implementation, with duties including but not limited to:

- Leading, planning, and improving clinical health outcomes through coordination of data from Alliance information systems, qualitative and quantitative information, clinical assessments, business intelligence tools, and other relevant sources.
- Overseeing and conducting research and complex analysis for clinical programs, including MCAS/ HEDIS and Care-Based Incentive (CBI) programs, developing recommendations for improvements, and presenting recommendations to Health Services leadership
- Manages the coordination, planning and implementation of the annual MCAS project; participates in HEDIS activities and interventions as required.
- Developing and assisting with implementation of population health initiatives consistent with the Alliance strategic plan, utilizing data-driven approaches to study the health status and determinants of specific populations.
- Monitoring and managing operational changes mandated by the DHCS, DMHC, and other governmental entities.
- Participating in the design, development, testing and implementation of new projects and changes to existing projects or other strategic programs in collaboration with Alliance Departments
- Evaluating options for clinical data retrieval specifically addressing reporting tools, functionality, and criteria to meet the needs for reporting of the MCAS/HEDIS
- Directing the technical specifications that enable population health measurement and the implementation and evaluation of clinical outcomes and programs
- Conducting analysis and interpretation of complex clinical data, issues, trends, and relationships and translating into effective strategies and action plans ·

- Communicating recommendations and providing guidance on alternatives to stakeholders · Identifying, investigating, and working with Information and Technology Services to implement solutions for data analytics and technology
- Providing updates to Alliance leadership, making presentations, supporting, and training end users on Quality Improvement and Health Equity policies and procedures, and developing related materials.
- Maintaining knowledge of applicable State and Federal laws and regulations, monitoring legislative and legal changes related to Alliance functions, and ensuring compliance with same.
- Providing support to the Quality Improvement and Population Health Director and may act for the Director in the Director's absence.
- Overseeing or conducting staff training, including the development and maintenance of training materials, in conjunction with the Training and Development team
- Identifying training gaps and opportunities for improved performance

Clinical Safety Quality Manager (CSQM)
The CSQM reports to the QIPHD and CCAH manages and leads clinical quality safety initiatives to enhance the Quality Improvement and Health Equity Transformation (QIHET) and improve performance for the provider network, with
duties including but not limited to:

- Supporting improved performance management and implementation of clinical safety program requirements, such as Facility Site Reviews/Medical Record Reviews and Potential Quality Issues, in the community clinics.
- Performing and participating in delegation oversight activities as contractually required for the QIHET program, such as on-going review of policies and procedures, workplans, and related performance reports with reporting to relevant QIHET committees.
- Participating in the Corrective Action Plan (CAP) process for quality issues by reviewing CAPs for appropriateness, monitoring CAP progress, completion, and closure within defined timelines
- Developing and recommending plans to utilize internal resources and techniques to improve clinical safety outcomes, such as practice coaching, process improvement tools or academic detailing.
- Monitoring, tracking, and ensuring completion of administrative QIPH Department activities in relation to clinical safety in an organized, systematic, and on-going basis and developing plans for improvement.
- Contributing to the accurate execution of the QIHE work plan, dashboard, annual QIHE reports.
- Acting as a resource on regulatory, contractual and accreditation activities within the scope of clinical safety for the QIHET Program.
- Remaining current and knowledgeable of applicable mandates from oversight agencies, such as California Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), Department of Managed Health Care (DMHC), NNCQA and other regulatory/accrediting bodies as applicable.
- Researching, interpreting, and assessing the impact of applicable regulatory, contractual and accreditation requirements within the scope of clinical safety for the QIHET Program
- Managing and supervising staff, setting goals and objectives, delegating and assigning work
- Collaborating with department Director in developing staff training plans, career pathways and routine individual staff performance reviews.

- Overseeing or conducting staff training, including the development and maintenance of training materials, in conjunction with the Training and Development team.
- Identifying training gaps and opportunities for improved performance.

Clinical Safety Supervisor

The Clinical Safety Supervisor unit, acts as a subject matter expert, and provides guidance on clinical safety functions, with duties including but not limited to:

- Conducting research and analysis related to clinical safety strategies
- Preparing narrative reports and making presentations
- Interpreting and analyzing statistical reports to ensure accuracy of data and make recommendations
- Drafting, recommending, and implementing administrative policies and procedures related to Quality Improvement and Population Health Department operations
- Developing, recommending, implementing, and ensuring compliance with department policies and procedures
- Attending and participating in internal and external meetings related to Quality Improvement and Population Health Department activities
- Overseeing the preparation and maintenance of records, reports, and related documents
- Providing support to the Clinical Safety Quality Manager and may act for the Manager in the Manager's absence
- Providing mentoring, coaching, and development and growth opportunities to assigned staff
- In conjunction with Clinical Safety Quality Manager, interviewing and participating in the selection of staff
- Evaluating employee performance, providing feedback to staff, and coaching and counseling or disciplining staff when performance issues arise
- Orienting new staff to the Quality Improvement and Population Health Department functions
- Conducting training related to Quality Improvement and Population Health functions for all Alliance staff, including the development and maintenance of training materials, in conjunction with the Learning and Development team
- Assisting with program planning, development, implementation, and evaluation
- Reviewing medical records, investigating, and making recommendations for PQIs
- Ensuring strong and timely communication regarding PQIs to Grievance, Provider Services, and other departments, as appropriate
- Leading PQI case review, investigation and resolution with Quality Improvement and Population Health nurses assigned to PQI
- Collaborating with Medical Directors on FSR/MRR/PAR/PQI Corrective Action Plans (CAPs)
- Monitoring and reporting Provider Preventable Conditions (PPC) as mandated by statute
- Working with department leadership to conduct process and outcome evaluation of the Department's programs
- Ensuring that policies, procedures, and workflows are current and reflect Alliance practice and industry standards, including Department of Health Care Services requirements
- Accurately documenting audit information using Medi-Cal Managed Care Division (MMCD) tools and guidelines and maintaining an organized FSR/MRR/PAR file system
- Issuing CAPs for any deficiencies found in audits and following up with providers to ensure timely correction of deficiencies
- Managing workflows for all CAPs related to FSR/MRR/PAR/PQI

- Attending and participating in the monthly Staff Grievance Review Committee and updating nurse colleagues on meeting outcomes and actions

Facility Site Review Supervisor
The Facility Site Review Supervisor supervises the FSR clinical safety team, acts as a subject matter expert, and provides guidance on clinical safety functions, with duties including but not limited to:

- Interpreting and analyzing statistical reports to ensure accuracy of data and make recommendations
- Drafting, recommending, and implementing administrative policies and procedures related to Quality Improvement and Population Health Department operations
- Developing, recommending, implementing, and ensuring compliance with department policies and procedures
- Attending and participating in internal and external meetings related to Quality Improvement and Population Health Department activities
- Providing input related to budget development and assisting with budget monitoring and purchasing functions
- Supporting and training end users, and developing related materials
- Staying informed of current and new developments in the field and sharing updates with staff
- Overseeing the preparation and maintenance of records, reports, and related documents
- Providing support to the Clinical Safety Quality Manager and may act for the Manager in the Manager's absence
- Supervising and participating in the development, management, and measurement of a comprehensive healthcare strategy in alignment with Department of Health Care Services (DHCS) standards of care and in collaboration with internal stakeholders and network providers to promote evidence-based practices and improve member health outcomes
- Acting as the primary liaison with DHCS regarding FSR/MRR/PAR issues and implementation of related regulations
- Supervising, conducting, and completing full scope Facility Site Review (FSR), Medical Record Review (MRR) and Physical Accessibility Review (PAR) audits, based on standards set by DHCS, to ensure patient safety
- Overseeing and participating in education sessions with network providers to prepare them for the FSR/MRR audit process
- Encouraging providers to optimize participation in the Care Based Incentive Program to enhance quality healthcare to members and reward evidence-based practice
- Supervising and participating in local, regional, and state audits and initiatives to measure, analyze and improve member health outcomes
- Collaborating with the Quality Improvement and Population Health Department Team and other departments to evaluate and report observed and/or measured trends in individual and group provider performance

Quality and Health Equity Supervisors
The Quality Improvement and Health Equity Supervisors supervises a team within the Quality Improvement and Health Equity Department, acts as a subject matter expert, and provides guidance on Quality Improvement and Health Equity programs, with duties including but not limited to:

- Overseeing the daily operations performed by a team within the Quality Improvement and Health Equity Department
- Monitoring the day-to-day work of staff to ensure compliance with program guidelines

- Conducting regular staff meetings and ensuring staff is informed of program updates in a timely manner
- Creating, running, and analyzing a variety of statistical and activity reports and providing these to the Quality Improvement and Health Equity Managers within specified timeframes
- Conducting regular in-service training for staff to ensure that accurate information is provided to members, providers, and the community
- Participating in continuous quality improvement activities, including sitting in on Quality Improvement Program Advisors' meetings with providers to enhance and improve the quality of the work and customer service provided by staff
- Drafting, recommending, and implementing administrative policies and procedures related to Quality Improvement and Health Equity operations
- Developing, recommending, implementing, and ensuring compliance with department policies and procedures
- Preparing narrative and statistical reports and overseeing the preparation and maintenance of records and related documents
- Providing input related to budget development and assisting with budget monitoring and purchasing functions
- Making presentations, supporting and training staff, and developing related materials
- Providing support to the Quality Improvement and Population Health Managers and acting for the Manager in the Manager's absence
- Overseeing Healthcare Effectiveness Data and Information Set (HEDIS) or the Alliance's pay-for-performance (Care-Based Incentive) program
- May be assigned to oversee other improvement or regulatory activities
- Overseeing Provider performance improvement plans, Provider Partnership, Equity Practice Transformation (EPT), member satisfaction and programs that support provider performance improvement and ensure alignment with regulatory requirements
- Overseeing and participating in regular on-site provider visits and education
- Overseeing staff responsible for QI projects that include population health, and/or quality performance, and/or health equity
- Overseeing staff responsible for acquiring, analyzing and synthesizing programmatic information in order to make recommendations to leadership regarding program modifications
- Ensuring timely and accurate communication with program stakeholders
- Ensuring that staff accurately complete documentation, reports, and technical and statistical assessments in a timely manner

Quality Improvement Nurses (QIN)

The Quality Management Nurse is a Registered nurse licensed by the State of California. The QMN reports to the Clinical Safety Manager and performs QIPH activities related to HEDIS, FSR, and complaint/grievance resolution.

- Develops and measures a comprehensive preventive healthcare strategy in collaboration with the internal stakeholders and network providers to promote best evidence-based practices and improve member health outcomes.
- Collaborates with Quality Improvement and Population Health Department Team and other departments to evaluate and report observed and/or measured trends in individual and group provider performance. CCAH Evaluates patient safety and quality issues by promoting an environment of transparency with internal stakeholders, network providers and community partners.

- Coordinating communication regarding PQI to Grievance, Provider Services and other departments as indicated.
- Developing and delivering presentations on the PQI process and providing data, analysis, and trends to various internal and external audiences
- Identifies opportunities for improvement through monitoring and analysis of clinical and satisfaction data.
- Ensuring patient safety through Facility Site Review (FSR), Medical Record Review (MRR) and Physical Accessibility Review (PAR) audits and documenting all potential safety or quality issues at the time of audit.
- Closely collaborating with Provider Services in coordinating communication with providers and in timely reporting of FSR/MRR /PAR completion
- Educating and preparing network providers for the FSR/MRR audit by conducting interim educational visits ·
- Developing and delivering presentations on the FSR/MRR/PAR process and providing data, analysis, and trends to various internal and external audiences
- Oversees and monitors assigned administrative functions including annual program descriptions, work plans, evaluations, as well as maintenance of up-to-date definitions and organization charts related to:
    - Potential Quality Issue (PQI).
    - Facility Site Review
    - Quality Improvement.
    - Medical Record Review.
    - Physical Accessibility Review.
- Issuing Corrective Action Plan (CAP) for any deficiencies found in audits and following up with providers on timely correction of deficiencies.
- Participates in maintaining compliance with NCQA and regulatory standards.
- Leading PQI weekly meetings with Quality Improvement and Population Health Department staff and Medical Director

Quality and Health Programs Manager (QHPM)
The QHPM reports to the QIPHD manages all aspects of the Health Programs unit, including Health Education/Disease Management programs and Cultural and Linguistic services, with duties including but not limited to:

- Managing and coordinating health promotion and chronic disease management programs within the health plan
- Developing and implementing health promotion and disease management programs to meet the needs of members in multiple lines of business.
- Identifying the health education and cultural and linguistic needs within the member population
- Investigating potential project areas and recommending appropriate intervention
- Collaborating with internal staff, including Quality Improvement and Population Health Director,
  Medical Directors, and Chief Medical Officer to identify members that may qualify for Health Programs services.
- Collaborating with providers and other external customers to develop interventions for high-risk members.

- Preparing health and disease management program promotional materials, including newsletter articles, pamphlets, and brochures in collaboration with the Communications Department
- Preparing promotional materials for the Alliance's Cultural and Linguistic services
- Coordinating Health Education/Disease Management and Cultural and Linguistic activities with Utilization Management and Complex Case Management, Quality Improvement and Population Health, and Community Care Coordination staff to improve health outcomes and promote appropriate use of resources.
- Directing Health Programs staff activities and mentoring staff in Health Programs
- Maintaining Health Programs policies and procedures to meet Alliance goals and ensure regulatory/contractual compliance.
- Performing ongoing monitoring of Health Programs and activities to evaluate plan's effectiveness and determine follow-up needed.
- Maintaining current knowledge of regulatory requirements pertinent to health education/disease management and cultural and linguistic services (DHCS, CMS, DMHC)
- Tracking, analyzing, and developing strategies to address outlier performance of Health Programs metrics.
- Maintaining and coordinating relationships with clinical and social service agencies as needed (County Health Departments, community health organizations, etc.)
- Assisting in Quality Improvement activities, including annual HEDIS studies and CBI
- Participating in preparation of DHS/DMHC Audit and Investigation audits for all aspects of health education/disease management and cultural and linguistic services

Quality and Health Programs Supervisors
Supervises a team within the Quality and Health Programs Unit, acts as a subject matter expert, and provides guidance on Quality and Health Programs functions, including Health Education and Disease Management Programs or Cultural and Linguistic Services, with duties including but not limited to:

- Overseeing the daily operations performed by a team within the Quality and Health Programs Unit
- Monitoring the day-to-day work of staff to ensure compliance with program guidelines.
- Conducting regular staff meetings and ensuring staff is informed of program updates in a timely manner.
- Creating, running, and analyzing a variety of statistical and activity reports and providing these to the Quality and Health Programs Manager within specified timeframes
- Conducting regular in-service training for staff to ensure that accurate information is provided to members and the community.
- Coordinating assignment and distribution of Alliance provider and Alliance staff referrals to staff
- Participating in continuous quality improvement activities, including call monitoring, to enhance and improve the quality of the work and customer service provided by staff.
- Drafting, recommending, and implementing administrative policies and procedures related to Quality and Health Programs Unit operations.
- Developing, recommending, implementing, and ensuring compliance with department policies and procedures
- Overseeing Cultural and Linguistic (C&L) program activities, including supervising initiatives and projects designed to advance the Alliance's health equity strategies and ensure alignment with C&L regulatory requirements.

- Overseeing health education and disease management program activities, including supervising initiatives and projects designed to advance the Alliance's health equity strategies and ensure alignment with health education regulatory requirements.
- Working with the Quality and Health Programs Manager and assigned staff to conduct process and outcome evaluation of the Quality Improvement and Population Health Department's programs.
- Developing partnerships with community agencies and programs to allocate additional resources that support member's efforts to improve their overall health status.
- Ensuring that policies, procedures, and workflows are current and reflect Alliance practice and industry standards.
- Working with the Quality and Health Programs Manager and assigned staff to identify training opportunities for the department on topics such as chronic diseases, cultural competency, outreach strategies, program evaluation, software, customer service, and team building.
- Working with the Training and Development team to develop and implement training opportunities, coordinating, and participating in staff training activities, and tracking staff participation.
- Supervising the C&L staff in the delivery of the Alliance Cultural and Linguistic Services in specified health services areas, such as telephonic, face-to-face, and audio interpreting, and translations services, such as readability, suitability, and translation
- Supervising the Health Education staff in the delivery of the Alliance health education and disease management programs in specified health services areas, such as chronic health conditions, adult and pediatric weight management, pediatric preventative health care, and parental and postpartum care

Health Educators

The HE reports to the Quality and Health Programs Supervisor and conducts telephonic and in-person outreach and education to members identified as eligible for the Alliance's Quality and Health Program activities, with duties including but not limited to:

- Working in partnership with the Quality and Health Programs Supervisor, and Quality Improvement and Population Health (QIPH) team to develop, implement and maintain health education and disease management initiatives and programs.
- Providing health education information and referrals over the telephone or in-person to health plan members identified and referred with high-risk conditions on health education topics such as diabetes, asthma, adolescent/adult weight management, and prenatal and postpartum care.
- Assisting with the evaluation of health education and disease management initiatives and programs
- Preparing and developing training materials using a variety of formats
- Maintaining appropriate record keeping in internal care tracking systems, including a caseload of referred members, required documentation, and referrals.
- Assisting members with questions or issues that arise related to health program benefits.
- Ensuring that assigned health education and outreach activities meet QIPH goals and objectives.
- Answering general health information questions for members calling the Alliance Health Education Line or referring members to the appropriate Alliance department
- Assisting the Quality and Health Programs Supervisor with special projects, as assigned
- Conducting outreach and education to parents and members referred to the Alliance's adolescent weight management, prenatal, and postpartum programs.

- Conducting outreach and education to members referred to the Alliance's chronic disease management programs.
- Conducting community workshops based upon evidence-based and evidence-informed curricula for eligible Alliance members.
- Ensuring adherence to evidence-based and evidence-informed curricula when conducting workshops with members
- Collaborating with the Quality and Health Programs Manager, Quality and Health Programs Supervisor, and the QIPH team to develop and implement evidence-based health promotion interventions and ensuring that such interventions are culturally and linguistically appropriate for the Alliance's diverse membership.
- Identifying and promoting low cost, low health-literacy, culturally and linguistically appropriate health education materials
- Coordinating telephonic member referrals to external programs such as Women, Infants and Children (WIC), and other social and community services.

Care Coordinators I

The Care Coordinators reports to the Quality and Health Programs Supervisors and assists with the coordination of health education activities and/or health education activities linguistic services for Alliance members, with duties including but not limited to:

- Conducting telephone interviews with members, significant others, and family members to determine if care needs are being met or if additional services are needed.
- Intake and processing of provider requests for C&L or Health Education services with follow up to ensure coordination of services.
- Creating new cases, thoroughly documenting, and monitoring clear case notes in the Alliance computer system, in alignment with National Committee for Quality Assurance (NCQA) standards.
- Answering phone calls through the department's Automatic Call Distributor line
- Gathering information from providers, internal stakeholders, and members to assign cases appropriately to the team.
- Responding to internal and external providers' referrals and determining eligibility for C&L or Health Education services in a timely manner.
- Performing administrative duties to track, organize, monitor and follow-up on case work · Tracking receipt, assignment, enrollment, and disenrollment of cases.
- Establishes and maintains effective working relationships with provider offices, County departments and other community agencies related to care coordination for members, disease management, and/or health education
- Recommends and implements program improvements that strengthen member access and health outcomes

Quality and Health Programs Program Advisors

The Quality and Health Programs team Program Advisors report to the Quality and Health Programs Manager and lead projects and activities with duties including but not limited to:

- Coordinating programmatic support to advance the Alliance's health equity strategies related to C&L, Health Education and Member Incentive programs.
- Serving as a consultant in internal and external stakeholder meetings.
- Responding to operational issues and questions from Alliance staff and Alliance network providers related to C&L, Health Education and Member Incentive programs.

- Reaching out to primary care providers, specialists, community agencies, and Alliance staff in order to maximize C&L and Health Education program participation.
- Establishing relationships with internal and external stakeholders to gain a clear understanding of provider and member needs.
- Providing subject matter expertise and knowledge of regulatory requirements related to C&L, Health Education and Member Incentive programs, including monitoring contractual, legal, and regulatory requirements.
- Coordinating the implementation of new C&L, Health Education and Member Incentive program regulatory requirements, including interventions in response to member needs
- Providing operational guidance to ensure alignment with Medi-Cal, Knox-Keene, and other regulatory and accreditation standards.
- Preparing, reviewing, and updating policies and procedures, program descriptions, evaluation reports, ongoing monitoring reports, and other administrative documents
- Collaborating with the Quality and Health Programs leadership team on C&L, Health Education and Member Incentive programs improvement, planning, implementation, and evaluation to ensure alignment with departmental work plans, organizational goals, regulatory requirements, and state policies.
- Overseeing services performed by vendors for C&L, Health Education and Member Incentive programs.
- Reviewing reports from vendors and providing an aggregate summary of vendor performance and compliance to Quality and Health Programs leadership, monitoring vendor performance, providing feedback to vendors, and facilitating on-going vendor relationships
- Supporting investigations into alleged violations of federal or state non-discrimination laws, and quality assurance concerns related to C&L and Health Education services.
- Conducting research related to a variety of C&L, Health Education and Member Incentive program issues, analyzing information and data, and preparing summaries and reports.
- Collaborating with internal and external stakeholders to identify and address health disparities and gaps in care to support health equity measures and improve health outcomes.
- Coordinating member outreach efforts to gather member feedback, evaluating feedback, and providing results and recommendations to the Quality and Health Programs leadership team.
- Preparing narrative and statistical reports, including developing reports and dashboards to perform on-going monitoring of C&L, Health Education and Member Incentive programs.
- Supporting Alliance reports related to Health Equity and Population Health, including coordinating member surveys, analyzing data, and preparing summaries and reports.
- Managing large datasets, such as quality health indicators and analyzing data for health disparities
- Implementing structure, process, and governance related to reviewing member communications to ensure that materials meet DHCS readability, suitability, and translations requirements and to ensure compliance with Health Education and C&L standards.

Quality Improvement Program Advisor IV
Manages and leads the planning, implementation, and management of select Quality Improvement (QI) programs, such as HEDIS, Performance Improvement, and the Alliance's pay-for-performance (CBI) program, with duties including but not limited to:

- Acting as the QI key knowledge holder on process changes as they relate to the National Committee for Quality Assurance's (NCQA) HEDIS process HEDIS teams.

- Ensuring necessary steps are taken to achieve a successful year over year improvement of HEDIS measures, including working with internal and vendor resources on process improvement initiatives.
- Identifying preventative care areas with declining or plateauing compliance rates over time, including conducting statistical and root cause analysis of contributing factors
- Taking proactive and strategic actions to plan, design and oversee research and analytical projects that support HEDIS, CBI, and QI projects.
- Conducting analysis and providing strategic recommendations to executives and professional clients related to improving health care quality, provider satisfaction and member health outcomes.
- Developing new algorithms and modifying existing algorithms related to QI projects to address complicated business problems, such as stratification, provider benchmarking, and program evaluations.
- Transforming business goals into hypotheses and tangible QI data mining goals
- Pulling and integrating data from disparate sources, such as claims and clinical data.
- Utilizing data visualization tools to produce data that is easily interpreted by non-technical audiences.
- Using data to demonstrate program performance and opportunities for improvement.
- Maintaining audit readiness through ongoing training, competency assessment, auditing, monitoring of metrics, and development of corrective action plans, as needed
- Setting expectations and goals for program inputs, processes, and outputs
- Developing, implementing, monitoring, and improving programmatic process and outcome metrics to ensure continuous quality improvement.
- Acquiring, analyzing, and synthesizing programmatic information to make recommendations to leadership regarding program modifications.
- Taking the lead in assigning and coordinating work and monitoring work assignments
- Acting as a technical resource to staff
- Providing mentoring and coaching to staff
- Conducting staff training, including the development and maintenance of training materials
- Acting as a subject matter expert in healthcare quality, efficiency, and value-based payment models · Maintaining and updating work process, policy, and reference documents

Quality Improvement Program Advisor III
Leads the planning, implementation, and management of select Quality Improvement (QI) programs, such as HEDIS, Performance Improvement, and the Alliance's pay-for-performance (Care-Based Incentive) program, with duties including but not limited to:

- Leading or participating in the development of expectations and goals for QI program inputs, processes, and outputs
- Developing, implementing, monitoring, and improving programmatic process and outcome metrics to ensure continuous quality improvement.
- Ensuring timely and accurate communication with program stakeholders
- Identifying preventative care areas with declining or plateauing compliance rates over time, including conducting root cause analysis of contributing factors
- Monitoring and ensuring the validity of data and accuracy of data analyses.
- Analyzing large claim data sets to develop conclusions about data integrity, accuracy, and general relationships, and making related recommendations.

- Analyzing large claim data sets to develop conclusions about data integrity, accuracy, and general relationships, and making related recommendations.
- Investigating and analyzing database and data processing issues in relation to HEDIS and CBI in order to identify causes and recommend solutions.
- Identifying QI business issues and challenges, forming hypotheses, planning, and conducting interviews and whiteboard sessions, and performing reporting and analysis to synthesize conclusions, develop solutions and make recommendations.
- Identifying reporting and quality improvement opportunities
- Providing day-to-day consultation to business users and participating in and contributing to cross-functional project teams
- Managing assigned workflows and ensuring reliability, integrity, and timeliness of end products
- Developing project plans and strategies and executing assigned project plans to deliver solutions.
- Gathering information regarding customer expectations to develop goals and meet expectations.
- Collaborating with Lead QI Program Advisors and supervisor and requesting review as needed to ensure reliability, integrity, and timeliness of end products.
- Summarizing findings to develop and propose appropriate solutions to QI program and project challenges.
- Preparing and delivering formal presentations of work to customers

Quality Improvement Program Advisor II
Supports Quality Improvement (QI) and Population Health Department leadership and higher-level Quality Improvement Program Advisors with program administration, with duties including but not limited to:

- Coordinating and submitting convenience and over read samples to the External Quality Review Organization (EQRO) to ensure quality data.
- Submitting Interactive Data Submission System (IDSS) data to National Committee for Quality Assurance (NCQA)
- Acting as a resource on HEDIS technical specifications and training staff in the use of HEDIS certified software
- Collaborating with other County Organized Health Systems (COHS) regarding joint HEDIS activities and reporting
- Serving as point person for HEDIS staff regarding correct Health Insurance Portability and Accountability Act (HIPAA) protocols related to transporting Protected Health Information (PHI)
- Maintaining HEDIS member exclusion data
- Maintaining a problem log of certified HEDIS software issues
- Reviewing and validating accurate location and contacts for medical record requests
- Participating in on-site visits for Physical Accessibility Reviews (PAR) with providers, in collaboration with QI nurse
- May assist FSR Team engagement with providers, including scheduling reviews and monitoring visits related to Medical Record Review (MRR), FSR and PAR
- Performing outreach to providers for corrective action plan (CAP) follow-up
- Preparing documentation and provider-specific reports to assist QI nurses with providing educational information and assistance with CAP completion to providers.

- Act as practice coach to providers to improve effectiveness of health care delivery through various modalities such as on-site support, trainings, analysis, and one-on-one coaching.
- Develop, participate in, and lead provider collaboratives across counties including but not limited to, in-person events and virtual meetings.
- Develop and support provider improvement plans and programs.
- Responding to inquiries from internal stakeholders regarding regulatory and accreditation activities by researching, summarizing, and presenting findings and recommendations
- Coordinating Health Services (HS) Division continuous audit readiness program efforts
- Coordinating production of pre-audit deliverables and conducting review and analysis of various data sources to determine potential audit focal points.

Quality Improvement Program Advisor I

Supports Quality Improvement (QI) and Population Health Department leadership and higher-level Quality Improvement Program Advisors with program administration, with duties including but not limited to:

- Maintaining Health Effectiveness Data and Information Set (HEDIS) member exclusion data
- Maintaining a problem log of certified HEDIS software issues
- Reviewing and validating accurate location and contacts for medical record requests
- Working with supplemental data sources such as immunization registries and lab vendors
- Collaborating with practices to integrate their electronic medical record data into vendor software.
- Compiling and analyzing Facility Site Review (FSR) and Potential Quality Issue (PQI) data to assist with evaluation of quality of clinical care and member safety.
- Participating in the coordination of Health Services (HS) Division continuous audit readiness program efforts
- Assisting with or coordinating production of pre-audit deliverables and conducting review and analysis of various data sources to determine potential audit focal points.
- Assisting with or conducting the more routine gap analyses between operational activities and contractual requirements and collaborating with stakeholders on contract requirements and related operational modifications
- Acting as liaison to Compliance Department audit leads to coordinate and execute on-site audit logistics, coordinate document requests with relevant subject matter experts and stakeholders and may assist with the coordination of required CAP (Corrective Action Plan) activities, development of narrative CAP rebuttals, and supporting implementation of operational modifications to correct deficiencies.
- Assisting with researching and coordinating health plan accreditation standards, such as NCQA
- Performing routine review and interpretation of accreditation standards and guidelines, regulatory and contractual requirements, policies and procedures, and trends and best practices, and making recommendations based on findings
- Participating in HS Division quality improvement efforts to promote operational alignment with accreditation, regulatory and contractual standards, guidelines and/or requirements.
- Participating in the coordination of annual facilitation, analysis, and dissemination of the Alliance member experience surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, including coordinating with the Alliance's third-party survey administrator and internal stakeholders

Quality Improvement Project Specialist
Coordinates, leads, supports, and participates in Quality Improvement and Population Health Department projects and serves as a liaison for interdepartmental and company-wide initiatives, with duties including but not limited to:

- Documenting and communicating action items to staff assigned to QI-related projects.
- Coordinating between the Care-Based Incentive (CBI) and HEDIS programs, acting as a liaison between HEDIS vendors and provider offices, and coordinating and scheduling HEDIS audit activities.
- Assisting leadership with planning and implementing training, education, and awareness activities for internal and external audiences
- Representing the department in various interdepartmental committees and workgroups and acting as a liaison
- Assisting with the development of policies and procedures specific to area of expertise and educating/training others on new processes and procedures
- Developing and creating a variety of materials in collaboration with department leadership and other staff
- Assisting with the development of communications materials in collaboration with department leadership and other staff
- Composing basic content, copy editing, proofreading, and auditing communications to ensure compliance with Alliance marketing, communication, and information strategies for all media formats.
- Assigning Provider Bulletin articles to internal subject matter experts, working with the
- Communications Department to finalize content and ensuring that publication deadlines are met.
- Acting as the Quality Improvement and Populations Health Department liaison to the Communications Department, attending Communication Committee meetings, and reporting back to Quality Improvement and Population Health Department leadership and staff regarding communications activities
- Creating clear and concise materials for internal and external presentations and training programs
- Assisting with the development and execution of the department's Communication Plan and coordinating related activities
- Applying accepted project management methodologies and ensuring compliance with the organization's project, policy, and procedural standards
- Developing, revising, and executing project work plans to ensure timely and efficient completion of assigned projects.
- Overseeing and tracking tasks, timelines, and resources needed to meet project objectives.
- Monitoring project status, identifying and resolving or escalating issues, delivering progress reports on projects, and communicating updates to project stakeholder.

Coding Resource Specialist
Acts as the clinical coding expert across all departments with duties including but not limited to:

- Researching all relevant regulations, and representing the Quality Improvement and Population Health Department in the internal committees
- Reviewing new and updated OILs (Operating Instruction Letter) to determine the potential impact upon the Health Effectiveness Data Information Set (HEDIS), CBI and other Quality Improvement and Population Health initiatives.

- Working directly with stakeholders in analyzing current and future systems configuration to ensure coding methodology and modifier rules are appropriately applied for proper reimbursement while adhering to applicable regulations.
- Preparing quality assurance and performance improvement reports to verify program and data integrity.
- Maintaining and managing a procedure code listing for all lines of business.
- Serving as the primary consultant for HEDIS and CBI programs and annually updating code sets using state and national code sets
- Utilizing consultative skills by maintaining excellent interpersonal relationships in various departments and with network providers
- Serving as a resource to internal departments including Claims, Contracts, Analytics and Technology Services (ATS), Provider Services and other units within Health Services Division
- Presenting at provider workshops or assisting with provider training in regard to regulations for coding of medical bills and documentation required to support claims submission and prompt accurate payment to providers.
- Advising stakeholders regarding system configuration and contractual billing requirements based on coding standards.
- Collaborating with departments in identifying coding interface enhancements, development of changes, and implementation of these functions throughout the Alliance
- Performing medical chart review to validate codes for quality monitoring, reporting, and analysis of internal databases.
- Working across departments regarding conflicting, ambiguous, or non-specific medical documentation

Administrative Specialist
The administrative specialist reports to the QIPH Director and Performs multiple, high-level administrative functions in support of a Chief Officer or Department Director, with duties including but not limited to:

- Performing duties and tasks related to specific departmental business needs and activities.
- Providing administrative assistance to management staff on program activities and special projects.
- Supporting, coordinating and/or completing departmental and organizational projects, such as those related to reports, presentations, newsletters, departmental metrics, staff communications, and special event administration.
- Gathering, coordinating, and preparing materials in support of responses to internal and external audits and the preparation of regulatory reports
- Assisting with the development, documentation, implementation and maintenance of administrative support procedures and processes.
- Composing correspondence, performing general research, creating, and updating spreadsheets, building, and maintaining files and databases, and preparing written reports.
- Coordinating and scheduling training, conferences, retreats, and travel for department staff.
- Creating, preparing, and producing presentation materials for internal and external presentations Providing administrative support to department leadership in the development and maintenance of the department budget.
- Ordering office supplies and preparing and submitting purchase orders and expense request forms for department purchases.

- Processing vendor contracts and invoices and communicating with vendors.
- Tracking petty cash expenditures, reconciling balances, and submitting a monthly final detailed accounting report.
- Assisting with the development and maintenance of department pages and information on the intranet.
- Developing and maintaining filing systems, maintaining accurate records, and coordinating records retention/destruction projects in consultation with department leadership.
- Answering, directing, and placing telephone calls and scheduling telephone and video conference calls.
- Representing the department at internal and external meetings.
- Assisting with the development of departmental training and resource materials and assisting with training staff, as assigned.
- Coordinating departmental facilities maintenance requests.
- May coordinate the work of other departmental clerical/support staff and assist with training and developing procedures and guidelines for clerical/support staff.
- May assist with processing personnel and payroll records and resolving related issues.

Utilization Management Director

The UM Director reports to the Health Services Officer and leads and shapes the Utilization Management (UM) Strategy for the Alliance, while providing management oversight in implementing, directing, and monitoring the Alliance's Utilization. Management Department functions, including prior authorizations, concurrent review, medical claims review, appeals and grievances, with duties including but not limited to:

- Leading development of UM strategy by leveraging the use of data/analytics to inform and technology solutions to streamline operational efficiencies while also building a cost-benefit methodology to rationalize decisions on UM reviews to be performed based upon staffing costs, productivity, and projected medical cost savings.
- Identifying opportunities to create efficiencies in the UM program and activities, incorporating innovative approaches and solutions, and leading process redesign work necessary to implement improvements.
- Directing the utilization management, concurrent review, prior authorizations medical claims review, appeals and grievances functions.
- Providing leadership in the design and implementation of UM policies, processes and procedures needed to meet National Commission on Quality Assurance (NCQA) and Utilization
- Review Accreditation Commission (URAC) accreditation requirements for both a Medi-Cal and Medicare line of business (D-SNP)
- Establishing and measuring productivity metrics in order to support workforce planning methodology and rationalization of services to perform UM reviews.
- Developing approach to auto-approvals where appropriate and partnering with the Provider Services team to implement strategies to reduce unnecessary administrative burden for Alliance care delivery partners related to UM processes.
- Developing and maintaining protocols for Treatment Authorization Request (TAR) authorization criteria
- Designing, developing, implementing, and maintaining programs, policies and procedures in order to meet regulatory, contractual, accreditation, and performance standards.
- Evaluating and overseeing the implementation recommendations on program changes relative to covered services.

- Maintaining knowledge of the UM software program functionality and leading the clinical team responsible for advising on replacement, upgrades, and user testing
- Advising and collaborating with the Chief Medical Officer (CMO) and Medical Directors on strategic issues involving Utilization Management Department programs
- Developing and maintaining collaborative working relationships with clinical and social service agencies in the community
- Collaborating with Community Care Coordination, Quality Improvement/Population Health, Pharmacy, and Health Programs to improve health outcomes and promote appropriate use of resources.
- Maintaining knowledge of regulatory and accreditation agencies and related requirements pertinent to case management and integrated behavioral health, such as Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), Department of Managed Health Care (DMHC), and Knox Keene
- Ensuring that staff advocates for members within the scope of the role of the health plan by arranging for, or directly reaching out to, Primary Care Providers (PCPs), specialists, hospitals, local mental health services, the managed care behavioral health organization (MCBHO), local care management programs, and community agencies in order to maximize program participation and outcomes.
- Assisting with quality improvement activities, including annual HEDIS studies
- Drafting, recommending, and implementing administrative policies and processes and procedures related to Utilization Management Department operations.
- Maintaining current knowledge of relevant Federal and State laws, policies and directives, and organizational policies and procedures, including regulatory requirements pertinent to population health, case management and disease management (DHCS, CMS, DMHC, and Major Risk Medical Insurance Board), communicating changes to staff, and ensuring that all requirements are met.
- Monitoring legislative and legal changes related to Alliance functions and ensuring appropriate communication of same
- Reviewing and assessing overall department functions, core work, goals, and structure, developing and implementing short- and long-term planning to achieve strategic objectives, and completing an annual department assessment.

Case Management Director

The CMD provides strategic management oversight in implementing, directing, and monitoring the Alliance's Care Management functions, including Behavioral Health, Care Coordination, Care Management (Adult Complex Case Management and Pediatric Case Management inclusive of California Children's Services), in alignment with Medi-Cal, Knox-Keene and other regulatory and accreditation standards, with duties including but not limited to:

- Designing, developing, implementing, and maintaining programs, policies, and procedures in order to meet regulatory, contractual, accreditation, and performance standards
- Designing, developing, and maintaining Behavioral Health (BH) policies and procedures that relate to Care Management
- Leading the development and oversight of Alliance Care Management efforts including those required by the Medi-Cal CalAIM initiative and the Alliance's Strategic Plan
- Advising and collaborating with the Health Services Officer (HSO), Chief Medical Officer (CMO), and Medical Directors on strategic issues involving Care Coordination and Care Management programs

- Participating in development and implementation of electronic systems and modules that support case management and best practice and accreditation standards
- Collaborating with all departments, within Health Services and across the organization, to improve health outcomes and promote appropriate use of resources
- Tracking, analyzing, and developing strategies to address outlier performance of care management metrics and reporting on metrics at a regular cadence
- Preparing reports for the Board of Commissioners package for review by the HSO and/or CMO
- Developing performance measures related to strategic goals and new projects and presenting to staff and the Board of Commissioners, as directed by the HSO and/or CMO
- Drafting, recommending, and implementing administrative policies, processes and procedures related to Care Management Department operations
- Maintaining current knowledge of relevant federal and state laws, policies and directives, and organizational policies and procedures, including regulatory requirements pertinent to case management and disease management issued by Department of Health Care Services, Centers for Medicare and Medicaid Services, Major Risk Medical Insurance Program, or Department of Managed Health Care, communicating changes to staff, and ensuring that all requirements are met

Pharmacy Director

The Pharmacy Director is a pharmacist with an unrestricted license issued by the State of California. The PD reports to the Health Services Officer and is responsible for overseeing the strategic management oversight in implementing, directing, and monitoring the Alliance's Pharmacy functions, with duties including but not limited to:

- Developing and maintaining protocols for Treatment Authorization Request (TAR) authorization criteria
- Ensuring contractual turnaround times are met by staff, and performing duties associated with
- Prior Authorization, as needed, which includes reviewing and making determinations of pharmacy authorization requests.
- Performing complex pharmacy utilization and authorization review using applicable policies and guidelines
- Interfacing with the Pharmacy Benefits Manager (PBM) including ensuring that formulary changes are processed appropriately by the PBM.
- Advising in the resolution of disputed or questionable claims relative to medications
- Reviewing and overseeing the implementation of appropriate pricing of drug and supplies claims
- Reviewing and reporting out on Utilization Review (UR) trending
- Ensuring quality of pharmacy services through UR, review of medical records and provider education, identifying training opportunities and trends
- Evaluating and overseeing the implementation of cost-effective delivery of pharmacy services (e.g., generic drug contract, rebate, Code I drug, provider education, etc.)
- Evaluating and overseeing the implementation recommendations on program changes relative to covered pharmacy services.
- Participating in strategic planning and implementation of the Pharmacy Department operational goals related to the growth and development of Alliance business operations.
- Ensuring that Pharmacy Department goals and activities are in alignment with the Alliance strategic plan · Conducting complex research and analysis related to Pharmacy strategies.
- Assisting in formulating strategic plans and goal setting in support of Alliance programs

- Modeling and promoting effective interdepartmental communication · Preparing narrative and statistical reports and making presentations.
- Preparing reports for the Board of Commissioners package for review by the Health Services Officer and the Chief Medical Officer (CMO)
- Developing performance measures related to strategic goals and new projects and presenting to staff and the Board of Commissioners, as directed by the Health Services Officer and the CMO
- Drafting, recommending, and implementing administrative policies, processes and procedures related to Pharmacy Department operations.
- Maintaining current knowledge of relevant federal and state laws, policies and directives, and organizational policies and procedures
- Monitoring legislative and legal changes related to Alliance functions and ensuring appropriate communication of same
- Reviewing and assessing overall department functions, core work, goals, and structure, developing and implementing short- and long-term planning to achieve strategic objectives, and completing an annual department assessment.
- Overseeing the preparation and maintenance of records, reports, and related documents
- Developing and managing the Pharmacy Department operations, work plans, and budget
- Attending and participating in internal and external meetings related to Alliance business operations.
- Providing support to the Health Services Officer and CMO

Behavioral Health Medical Director

The BH Medical Director reports to the Health Services Officer and Provides strategic management oversight in planning, implementing, directing, and monitoring the Alliance's Behavioral Health functions, with duties including but not limited to:

- Oversees MBHO delegated utilization management, quality improvement and care management activities.
- Directing and organizing planning of the Behavioral Health program with the MBHO and the Care Management team.
- Leading and participating in meetings about proposed mental health administrative models through Department of Health Care Services (DHCS), tracking developments, and keeping organization informed.
- Designing, developing, implementing, and managing behavioral health program performance to align with existing and future needs of Alliance members.
- Planning for and directing the service delivery components for members' behavioral health needs, considering current and future integration needs, not limited to mental health and/or substance use disorder.
- Developing and maintaining policy and procedures in order to meet regulatory, contractual, and accreditation standards.
- Overseeing the development of new Medi-Cal behavioral health benefits within the Alliance and providing executive level oversight of Alliance behavioral health projects.
- Collaborating with other Alliance departments on behavioral health initiatives/activities to improve health outcomes and appropriate use of resources Oversee the development of programming to support the education of the health services division, providers, members and their families on behavioral health issues including symptoms, relapse prevention, stress reduction, lab work, and healthy lifestyle choices.

- Tracking, analyzing, and developing strategies to address outlier performance in behavioral health metrics.
- Tracking, analyzing, developing, and reporting on Administrative Quality Indicators (AQI's) pertaining to behavioral health initiatives.
- Participating in strategic planning and implementation of the Behavioral Health Department's operational goals related to the growth and development of Alliance business operations.
- Ensuring that Behavioral Health Department's goals and activities are in alignment with the Alliance strategic plan.
- Conducting complex research and analysis related to behavioral health strategies.
- Assisting in formulating strategic plans and goal setting in support of Alliance programs.
- Modeling and promoting effective interdepartmental communication.
- Preparing narrative and statistical reports and making presentations Developing performance measures related to strategic goals and new projects and presenting to staff and the Board of Commissioners, as directed by the Chief Medical Officer (CMO).
- Preparing reports for the Board of Commissioners package for review by the CMO.
- Drafting, recommending, and implementing administrative policies, and processes and procedures related to Behavioral Health Department operations.
- Maintaining current knowledge of relevant Federal and State laws, policies and directives, and organizational policies and procedures.
- Monitoring legislative and legal changes related to Alliance functions and ensuring appropriate communication of same.
- Overseeing the preparation and maintenance of records, reports, and related documents.
- Overseeing and coordinating meetings to promote effective communication between the Alliance, MBHO, County Behavioral Health Departments, Regional Centers, and Community Partners.

Chief Compliance Officer
The CO reports to the CEO and is responsible for establishing and implementing an effective Compliance Program, including Fraud, Waste and Abuse, to prevent illegal, unethical, or improper conduct consistent with applicable laws, regulatory and accreditation standards, and the plan's policies.

- Directing and controlling activities of a broad functional division through Department Directors
- Making decisions on operational matters and ensuring effective achievement of objectives
- Responsible for overseeing employee performance appraisal, hiring, salary administration, training and development, performance management, and discipline.
- Ensuring Department Directors set goals, objectives and standards and monitor and evaluate department performance.
- Reviewing and assessing overall division function, including the core work, goals and structure of each department, and overseeing directors' development and implementation of short- and long-term planning to achieve strategic objectives and completion of annual department strategic planning related activities.
- Approving subordinate budget recommendations and working with executive administration to create the annual budget.
- Maintaining current knowledge of relevant federal and state laws, policies and directives, and organizational policies and procedures

- Developing, recommending, and implementing plans, policies, programs, and projects
- Ensuring development of clear scope and work plans for new efforts
- Ensuring the establishment of clear and measurable objectives for plans, policies, programs, and projects
- Ensuring the development of training programs to ensure staff are aware of statutory and regulatory requirements and ensuring that Compliance Program training of all Alliance staff, board members and contractors is conducted as required.
- Ensuring effective processes are in place to allow two-way communication between the Compliance Division and other Alliance staff such that staff are aware of new and changing requirements and are knowledgeable about how to report noncompliance, suspected fraud, waste or abuse, or other misconduct without fear of retaliation.
- Ensuring suspected non-compliance is promptly investigated and that identified issues are fully corrected in a timely manner.
- Ensuring organizational projects support contractual, regulatory, statutory, or other compliance related requirements.
- Ensuring appropriate disciplinary measures and corrective actions are taken when staff violate Alliance policies and procedures.
- Maintaining a direct reporting relationship with the Alliance Board of Commissioners, based upon the Chief Compliance Officer's ultimate responsibility to the Board, and routinely reporting Compliance Program metrics and updates to the Board.

Quality Improvement and Health Equity Committee and Subcommittees

Quality Improvement Health Equity (QIHEC) Committee

The Alliance maintains a Quality Improvement and Health Equity Transformation Program (QIHETP), as described in Alliance Policy 401-1101 – Quality Improvement and Health Equity Transformation Program (QIHETP). The Santa Cruz-Monterey-Merced –San Benito-Mariposa Managed Medical Care Commission (Alliance Board) delegates oversight and performance responsibility of the QIHETP to the QIHEC, excluding credentialing/recredentialing activities, which are directed by the Peer Review and Credentialing Committee.

The QIHEC is designated by, and accountable to, the Alliance Board, supervised by the Chief Medical Officer or designee, in collaboration with the Chief Health Equity Officer. The activities, findings, recommendations, and actions of the QIHEC are reported to the Alliance Board on a scheduled basis.

The QIHEC oversees the QI activities of the organization, Pharmacy and Therapeutics (P&T) Committee, Utilization Management Workgroup (UMWG), and Quality Improvement Health Equity Workgroup (QIHEW). The QIHEC partners with the Compliance Committee to meet delegate oversight requirements. Primary duties of the QIHEC include the following:

- Annually reviewing and approving the draft Quality Improvement and Health Equity and Utilization Management Work Plans (QIHEWP and UMWP).
- Quarterly reviewing progress against active QIHEWP and UMWP goals.
- A written summary of QIHEC activities, as well as QIHEC activities of its fully delegated subcontractors and downstream fully delegated subcontractors, findings, recommendations, and actions are prepared after each meeting.
- Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the

findings of the activities of other committees such as the Community Advisory Committee (CAC)

- Institute actions to address performance deficiencies, including policy recommendations.
- Ensure appropriate follow-up of identified performance deficiencies.
- Providing leadership and oversight in the implementation of quality improvement principles and activities in the daily operations of the Alliance.
- Facilitating communication on the status and progress of Alliance QIHETP activities to the Alliance Board on a scheduled basis.
- Participating in the development and/or adoption of specific utilization management criteria and benefit parameters.
- Monitoring the activities of, and providing direction to, all QIHEC subcommittees/ workgroups.
- Stimulating the highest degree of commitment to quality health care and to the goal of continuous improvement.
- Recommending and approving changes to select QIHETP related Alliance policies, practice guidelines, and subcommittees' proposed action plans.
- Overseeing the QIHETP and UM Program policies (Alliance Policies 401-1101 and 404-1101 respectively), and the QIHEWP and UMWP for annual submission to the Alliance Board.
- Reviewing, approving, and submitting the Quality Improvement and Health Equity (QIHE) Annual Report to the Alliance Board.
- Reviewing and advising on QIHETP related Corrective Action plans (CAP), not including credentialing/recredentialing oversight related CAPs. Individual provider issues may be referred to the PRCC and/or Program Integrity Unit depending on the nature of the issue.
- Reviewing standards of care guidelines, as described in Alliance Policy 401-1501 – Standards of Care.
- Oversight of language assistance and interpreter services as described in Alliance Policy 401-4101 – Cultural and Linguistic Services Program
- Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and the DHCS Comprehensive Quality Strategy
- For fully delegated subcontractors and downstream fully delegated subcontractors, ensure maintenance of a QIHEC and reporting to the Alliance on a quarterly basis, at a minimum; and
- Partnering with the Compliance Committee to meet QIHETP delegate oversight requirements.

Core membership consists of Alliance network providers, including but not limited to hospitals, clinics, county partners, fully delegated subcontractors ensuring representation of all required specialties as outlined below and downstream subcontractors. They are representative composition of the provider network and provide health care services to members affected by health disparities, limited English proficiency (LEP), children with special health care needs (CSHCN), seniors and persons with disabilities (SPDs) and persons with chronic conditions (e.g., diabetes, asthma, and congestive heart failure). QIHEC core members actively participate on the QIHEC or medical subcommittee that reports to the QIHEC. A network behavioral health practitioner also attends QIHEC and or other subcommittees to discuss transitions of care. Committee members must be in good standing with the Alliance.

Core Committee Members (voting) External to CCAH

- Medical Director, Santa Cruz Community Health Centers, Santa Cruz County
- Family Medicine Physician, Watsonville County Health, Santa Cruz County
- Pediatrician, Salud Para la Gente, Santa Cruz County

- Clinical Director of Quality, County of Santa Cruz Health Services Agency, Santa Cruz County
- Doctor of Osteopathic Medicine, Dignity Health–Dominican, Santa Cruz County
- Medical Director, Monterey County Department of Health, Monterey County
- Chief Medical Officer, Clinica De Salud Del Valle, Monterey County
- Director of Nursing, Golden Valley Health Centers, Merced County
- Chief Operating Officer, Merced Faculty Associates, Merced County
- Medical Director, Carelon Behavioral Health

Core CCAH Staff:

- Chief Medical Officer (Chair), Chief Executive Officer, Chief Administrative Officer, Chief Health Equity Officer, Health Services Officer, Medical Director(s), QIPH Director, QIPH Managers, Quality and Health Programs (QHP) Manager, QIPH Nurse Supervisor, Care Management Director (CM), Communications Director, Enhanced Health Services Director, Member Services (MS) Director or designees, Pharmacy Director, Program Services Director, Provider Services (PS) Director, Regional Operations Director Utilization Management (UM) Director, , Behavioral Health Director (BH), Administrative Specialist, and Ad-hoc (non-core) membership varies as topics mandate.

There are three subcommittees that report to the QIHEC committee. They are:

- Pharmacy and Therapeutics (P&T) Committee
- Utilization Management Work Group (UMWG)
- Quality Improvement Health Equity Workgroup (QIHEW)

Pharmacy and Therapeutics (P&T) Committee

The P&T Committee is chaired by the Alliance Medical Director and is comprised of in-house and network pharmacists, primary care physicians and specialists. The P&T Committee meets quarterly and reports to the QIHEC Committee

The P&T Committee:

- Examine and update the utilization management of Physician-Administered Drugs (PADs) to reflect the evolving standard of practice of medicine relative to drug therapy.
- Evaluate PADs on their therapeutic merits, avoiding duplication of therapeutically equivalent drugs.
- Evaluate PADs with new Healthcare Common Procedure Coding System (HCPCS) billing codes.
- Review and update policies and procedures of pharmaceutical management annually to promote the clinically appropriate use of pharmaceutic ng codes.
- Evaluate new drugs, drugs with new or changing indications, and changing economic factors involving drug therapy in a systematic manner.
- Review policies and procedures that guide the use of cost-effective drug therapy.
- Conduct focused reviews of high-cost therapy classes or drugs as indicated by utilization trend reports.
- Implement drug utilization review projects and offer strategies for improving the quality of practitioner prescribing.
- Utilize newsletters and the Alliance website to distribute drug information to prescribers and communicate drug policy decisions made by the P&T Committee.
- Participate in quality assurance activities related to drug prescribing, adverse drug reactions, and drug interactions.

Utilization Management Work Group (UMWG)

The UMWG operates under the authority of the QIHEC. UMWG is co-chaired by an Alliance Medical Director and the UM Director. UMWG membership includes representatives from all major areas of Health Services (HS), including the CMO, Medical Directors, UM Managers, and Supervisors, QIHE Director, Pharmacy Director, and CM Director, and other staff or delegates as needed. The UMWG meets, at a minimum, 12 times a year and once a quarter, and as needed. UMWG activities and recommendations are reported to the QIHEC quarterly. The UMWG provides guidance and direction to the Program. UMWG activities include, but are not limited to:

- Reviewing and making recommendations to the Program policy annually.
- Reviewing and approving the UM Work Plan and Evaluation quarterly.
- Approving and ensuring implementation of utilization management criteria and UM policies.
- Analyzing summary data and making recommendations for action.
- Recommending medical policy, protocol, and clinical practice guidelines.
- Monitoring delegated utilization management activities through regular reports as described in Alliance policy *105-0004 – Delegate Oversight*.

Quality Improvement Health Equity Workgroup

The QIHEW, under the direction and guidance of the QIHEC, is responsible for addressing high-priority and emerging quality and health equity trends requiring organization-wide and/or cross-departmental response, including, but not limited to, topics related to provider capacity, grievances, member access and satisfaction, and QIHET program activities. The QIPH Director, or designee, chairs the QIHEW. Ad-hoc membership varies as topics mandate.

Core membership includes: CMO, Medical Director(s), QIPH Director (chair), Chief Compliance Officer, Chief Health Equity Officer, Chief Operating Officer, Health Services Officer, Care Management Director, Claims Director, Community Engagement Director, Community Grants Director, Compliance Director or designees from the departments, Data Analytics Director, Enhanced Health Services Director, Grievance and Quality Manager, Marketing and Communications Director, Medicare Executive Director, MS Director, Pharmacy Director, Program Development Director, PS Director, Provider Quality and Network Development Manager, UM Director, Behavioral Health Manager, QIPH Managers, QHP Manager, and UM Managers.

The workgroup meets quarterly. Ongoing review and approval of the QIHEWP, including refining interventions to address barriers and incorporate feedback from the QIHEC, and the QIHE Annual Report

- Annual review and approval of various QIPH policies and related processes and functions.
- Analysis of HEDIS/Managed Care Accountability Set (MCAS) measures and the development of strategies to improve performance.
- Development of QIHETP related provider and member communications.
- Development of disease management initiatives.
- Ongoing oversight of delegated QIHE activities of subcontractors.
- Review of language assistance and interpreter services as described in Alliance Policy 401-4101 – C*ultural and Linguistic Services Program*

- Review and analysis of provider and member survey results; and
- Review and approval of QIHETP-related standing reports, and state mandated PIPs.

Subcommittees that report to the Quality Improvement Health Equity Workgroup (QIHEW)

- Care-Based Incentives Work Group (CBIWG)
- Member Reassignment Committee
- Network Development Steering Committee
- Staff Grievance Review Committee

Care-Based Incentives Work Group (CBIWG)

The Care-Based Incentives Workgroup (CBIWG) purpose is to provide oversight of CBI program to meet timelines for incentive evaluation, contractual requirements, payment/build schedules, and address issues that may impact the program. A Medical Director chairs the CBIWG.

Core membership includes: QIPH Director, Medical Directors, Quality and Health Programs Manager, Cultural and Linguistics Program Advisor, Quality Improvement Program Advisors, Quality and Population Health Manager, Quality and Performance Improvement Manager, Coding Resource Specialist, QI Project Specialist, Provider Relations Supervisor, Senior Provider Services Contract Analyst, Provider Payment Analyst, Health Informatics Analyst, Health Equity Program Manager, Data Scientist IV, Senior Provider Relations Representative.

Member Reassignment Committee

The Member Reassignment Committee is chaired by a Medical Director. Reassignment requests are not automatically approved. They are presented to the Reassignment Committee for review and discussion, and determination is made by the Medical Director (MD) during regularly scheduled Reassignment Meetings. A PCP may request that the Alliance reassign a member linked to their practice to another PCP based on the following criteria:

- Alleged/Actual Member Fraud or Theft **-** The PCP alleges that the member fraudulently sought or received covered services for him or herself or another party. The PCP alleges that the member has committed theft from the practice.
- Request for Non-Medically Necessary Medication **-** A member repeatedly requests medication that the PCP determines is not medically necessary.
- Alleged Abusive/Disruptive Behavior by Member **-** The PCP alleges that the member behaves in a threatening, abusive, or disruptive manner to provider or office personnel.
- Violation of Medication Management Agreement - A member violates the Medication Management Agreement s/he has agreed to with the PCP and which the PCP has submitted to the Alliance.
- Non-Compliance with Treatment Plan - The member refuses to comply with the PCP's case management or recommended treatment and the PCP believes the refusal endangers the health of the member or significantly aggravates a medical condition.
- Ineffective Relationship – There has been an irremediable breakdown of the physician/patient relationship such that ongoing effective communication and patient care is impossible.
- Failure to Keep Appointment **-** The member fails to keep three or more scheduled appointments with the PCP within a 12-month period.
- Other **-** Other circumstances, supported by documentation, not identified herein which the PCP believes justify the reassignment of the member from their practice to a different PCP.

Network Development Steering Committee

The Network Development Steering Committee (NDSC) is comprised of a cross-functional team of Alliance leaders whose insights and areas of focus serve as inputs to assessing the strength of the Alliance provider network in meeting member needs and informing potential network development opportunities. The NDSC monitors and evaluates member access to care through comprehensive, coordinated, and regular review of access inputs, including but not limited to survey outcomes, regulatory compliance, and process-related information; and supports improved member access to care through oversight of the development and execution of an annual provider network Access Plan. The Provider Services Director and/or the Provider Quality and Network Development staff will prepare a quarterly regular agenda item for the QIHEW, a report which will reflect trends, access plans, and other relevant information discussed at the NDSC in the preceding quarter.

The Alliance SGRC meets regularly to review and monitor compliance with the Alliance Grievance Process. The SGRC monitors the processing of all Grievance and Appeal cases for statutory, regulatory, and contractual compliance to monitor quality of care and to provide a mechanism for continuous operational process and quality improvement.

Management and supervisory staff responsible for operational areas which may be the subject of Grievance cases participate in the SGRC to investigate and ensure appropriate resolution of cases, communicate actions and results of grievance review, and to inform operational improvements when required.

The SGRC monitors the Grievance and Appeal cases to identify emergent or systemic issues with grievance and/or patterns of improper service denials. The committee also monitors potential issues and barriers to care and formulates policy changes and procedural improvements in Plan administration, where indicated.

The SGRC meets regularly and reviews:

- A Member Grievance and Appeal log which includes exempt, 24 hour and 30-day Grievances, Appeals and State Fair Hearing requests.
- Any patterns and trending identified through the resolution of Grievance cases, quarterly.

The Chief Operations Officer (COO) is the Officer of the plan with primary responsibility of the grievance system. Grievance reports and selected SGRC content are submitted to the Quality Improvement Health Equity Workgroup (QIHEW). The COO continuously reviews the operation of the Grievance and Appeal system to identify any emergent or systemic issues with grievance and appeals and/or patterns of improper service denials through participation in the QIHEW.

Patient Safety

CCAH is committed to a culture of "patient safety" as a high-level priority. On an ongoing basis, CCAH fosters a Patient Safety culture that is communicated throughout the organization. CCAH is committed to developing and implementing activities to improve patient safety and clinical practice. CCAH aims to engage with both members and provider to promote and implement safety practices.

The first goal of our patient safety initiative is to: avoid injuries to our members from the care that is intended to help them. CCAH defines Patient Safety as "freedom from accidental injury caused by

errors in medical care". Medical errors refer to unintentional, preventable mistakes in the provision of care that have actual or potential adverse impact on our members.

The second goal of our patient safety initiative is to: establish and maintain a blame-free environment where members, their families, practitioners, providers, and CCAH staff, are able to report errors or close calls without fear of reprisal and where errors can be viewed as opportunities for improvement.

CCAH'S commitment to patient safety is demonstrated though the identification and planning of appropriate patient safety initiatives. The patient safety initiatives promote safe health practices through education and dissemination of information for decision-making and collaboration between our practitioners and members and through:

- Evaluation of pharmacy data for provider alerts about drug interactions, recall, and pharmacy over and under-utilization.
- Education of members regarding their role in receiving safe, error free health care services through the member newsletter and the CCAH web site.
- Education of members and providers regarding the availability and use of clinical practice guidelines.
- Education of providers regarding improved safety practices in their practice through the provider newsletter, member profiles and the CCAH web site.
- Evaluation for safe clinic environments during Facility Site Reviews (FSR) and dissemination of information regarding FSR findings and important safety concerns to members and providers.
- Education to members regarding safe practices at home through health education and incentive programs.
- Intervention for safety issues identified through case management, social worker management, care management and the grievance and clinical case review processes.
- Evaluation and analysis of data collected regarding hospital activities relating to member safety, including but not limited to the rate of hospital-acquired infections and all cause readmissions within 30 days of discharge.
- Collaboration and exchanges of admission notes and discharge summary between hospital and Primary Care Provider (PCP) when members are admitted to the acute care facility.
- Dissemination of information to providers and members regarding activities in the network related to safety and quality improvement.
- Monitor Hospital Safety Scores using publicly reported Leapfrog data: http://www.leapfroggroup.org/cp
- COVID-19 pandemic -related services

CCAH receives information about actual and potential safety issues from multiple sources including, member and practitioner grievances, potential quality issues, and pharmacy data such as, poly pharmacy occurrences, as well as, through FSR Corrective Action Plans.

Facility Site Reviews

Facility Site Reviews (FSR) audits is to ensure that all primary care provider sites utilized by CCAH for delivery of services to members have sufficient capacity to:

- Provide appropriate primary healthcare services.
- Carry out processes that support continuity and coordination of care.
- Maintain patient safety standards and practices; and
- Operate in compliance with all applicable federal, state, and local laws and regulations.

In compliance with the California statute (Title 22, section 56230) that requires all primary are provider sites contracted with the CCAH Medi-Cal Managed Care Program to have both initial and periodic site inspections regardless of the status of other accreditation and/or certifications, the FSR serves as the standard for conducting the initial and subsequent periodic reviews of PCP sites. A full scope FSR consists of:

- Facility Site Review (FSR)
- Medical record Review (MRR)
- Physical Accessibility Review Survey (PARS)

CCAH, per DHCS All Plan Letter 22-017, ensures that FSRs are conducted by a Certified Site Reviewer (CSR), trained, and certified by the health plan's Master Trainer (MT) provides necessary education and support to primary care providers and their office staff to facilitate successfully passing the initial and periodic FSR. Technical assistance is provided to PCPs and their staff on identified deficiencies needing improvement or corrections. CCAH also performs various monitoring reviews to ensure that standards are maintained on areas of care. These are also done to keep PCPs abreast with latest updates or changes in the guidelines. These monitoring platforms consist of:

- All primary care provider (PCP) sites are monitored between required three-year Facility Site Reviews (FSRs) to maintain patient safety standards and practices and operate in compliance with applicable federal, state, and local laws and regulations.
- An Interim Review form are sent to all PCP sites mid-way between the periodic full scope reviews (at 18 months). The Interim Review form is faxed to the provider office. It contains a checklist of the nine critical elements and requires the provider verify that all nine are either in place or are not applicable. Onsite verification is done depending on a PCP's compliance and history of previous audit standing.
- Focused reviews for critical element or repetitive deficiencies identified during Facility Site Review (FSR) impact patient health and safety.
- Corrective Action Plans for sites that receive a Conditional Pass (80-89%, or 90% and above with critical element deficiencies and/or deficiencies in pharmacy, infection control. A CAP is required to be established, that addresses each of the noted deficiencies. CAP documentation shall identify the following:
  - the specific deficiency
  - corrective action(s) needed.
  - re-evaluation timelines/dates,
  - responsible person(s),
  - problems in completing corrective actions,
  - education and/or technical assistance provided by the Health Plan,
  - evidence of the correction(s), completion/closure dates and name/title of reviewer

All CAPS are placed and followed up based on strict timelines determined by MMCD standards and CCAH's internal policy.

Collaborative CCAH Quality Initiatives

The Provider Partnership Program

The Provider Partnership Program was launched in 2024 by CCAH with the main purpose of increasing the delivery of preventive services and disease management services to its members through close collaboration with providers. The program will begin as a pilot, with five sites identified for participation, and will focus on Merced County. Additional purposes include:

- To build a partnership aimed at improving low performing measures, and to build a strong collaborative relationship between CCAH and our providers.
- The sharing and application of NCQA and Health Plan identified MCAS best practices for improvement within domains of care detailed below.
- Review of provider performance to initiate focus areas of performance to help reduce gaps in care.
- Support an interdisciplinary team approach by engaging all key staff in the quality improvement process.

Goals of this program include:

- Improve targeted MCAS measure compliance rates for low performing CBI practices to reach Minimum Performance Level (MPL) by the end of 2024.
- Improve the delivery of preventive and treatment services to members.
- Improve the administrative communication between CCAH and the physician's office.

The core of this program revolves on performance measurement of the following areas, with a focus placed on women and children's measures:

- HEDIS measures
- Access/Availability of Care
- Effectiveness of Care
- Utilization
- MCAS measures
- Children's Health Measures
- Women's health measures
- Acute and Chronic Disease Management Measures
- Behavioral Health Measures

The Provider Partnership Program has a multidisciplinary team for provider support that includes:

- Provider Services Representatives
- Quality Improvement Program Advisors
- Coding Specialist
- Quality Improvement and Population Health Director
- Quality and Performance Improvement Manager
- Medical Director – Health Services
- Clinical Safety Quality Manager and Quality Improvement Nursing staff (FSR Nurses)

Additional elements of the Provider Partnership program will include participation in two secondary processes:

- Clinical Joint Operations Committee (cJOC): Quarterly meetings between CCAH leadership and practice leadership
- Practice Coaching - Monthly brainstorming sessions with practice staff and CCAH Quality Improvement Program Advisors to review any short-term projects focused on process change and improvement.

As the program continues to evolve, the long-term aim is to expand efforts and welcome new providers, big or small, who are open to working hand-in hand with CCAH under the program's purpose and goals.

Practice Coaching

In 2024, CCAH began to offer educational opportunities set-up under the "Practice Coaching" umbrella in collaboration with work implemented through Provider Partnerships.

- Lunch & Learns: One-hour sessions open to all CCAH providers that will focus on one theme identified by looking at the lowest performing, or most challenging, MCAS measures in Merced County. The sessions will be a structured presentation and include guest presenters.

Clinical Quality Improvement

CCAH's Quality Improvement Department adheres to all DHCS standards in accordance with Title 22, CCR, Section 53860 (d) and Title 42, USC, Section 1396a(30)(C) for quality performance reporting. In addition to the CCAH works with the External Quality Review Organization (EQRO) in the annual MCAS review process. CCAH uses standard data collection and analysis to track clinical issues that are relevant to our population. This is primarily based on the audited MCAS results that are reported to NCQA and the State. CCAH establishes goals and benchmarks for these measures and evaluates the Plan's performance against these goals at the end of the fiscal year. Based on the findings, CCAH identifies and prioritizes areas for improvement by developing quality improvement projects, and supports data driven information sharing through the Alliance Provider Portal reports, and the CBI program for PCPs. CCAH also developed a Quality Outreach Program for practitioners and their office staff, Provider Partnership Program. This includes provider reports and site visits to build collaborative relationships with the providers and clinics. The UM program will also monitor areas of over and underutilization of services to improve appropriate utilization of services. The over and underutilization measures will be based on HEDIS and other internally developed utilization measures.

The QIPH Department implements opportunities to improve quality of care by developing and implementing quality improvement activities/interventions. These interventions align patient and provider engagement programs and may include but are not limited to:

- Developing and adopting clinical standards, practice guidelines or administrative standards, with subsequent dissemination of the standards to physicians, members, or staff as appropriate.
- Educating physicians and clinic staff about clinical standards and practice guidelines.
- Providing feedback reports to physicians and clinic staff on their current performance.
- Providing health promotion and health education programs to members and educate them on how to improve their health.
- Improving internal functions to improve quality of care, accessibility, and service. This is a key issue for the Plan for the coming year.

Access to Care

CCAH has established standards and mechanisms to assure the accessibility of primary care, specialty care, and behavioral health. The Plan will continue to work with providers and clinics to develop interventions to improve access. The Plan will also monitor access to care, based on the following standards, as outlined by DMHC:

- Availability of Practitioners (PCP, Specialists and Behavioral Health providers)
- Appointment access (routine and urgent appointments)
- Availability of PCPs by Language

- Language Assistance Services (In-Person Interpreter, Language Line and Hearing Impaired)
- Telephone access
- After-hours access to care
- Health Reach 24/7 Nurse Advice Line
- Transportation services
- Availability of Practitioners via Telehealth

Continuity and Coordination of Care

The Alliance ensures medical and mental health Continuity of Care (C.O.C) and continued access to care for specified newly eligible members, who make a request for C.O.C. for up to 12 months with an out-of-network Medi-Cal provider. The Alliance also ensures C.O.C. for existing members with a terminating provider. The Alliance is exempt from authorizing C.O.C. if the provider was terminated for exclusionary reasons related to a medical disciplinary action, fraud, abuse, or other conduct that prohibits the provider from participating in the Medi-Cal program. At the member's request, the Alliance is required to approve completion of covered services for the following conditions: acute, serious chronic, pregnancy, terminal illness, the care of a newborn child between birth and age 36 months, and performance of a surgery or other procedure that is authorized by the Alliance as a part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member

Delegation Oversight

CCAH delegates responsibility of the utilization management, credentialing, rights and responsibilities, member engagement, and grievance and appeals and quality to selected organizations. CCAH maintains accountability and ultimate responsibility for the associated activities by overseeing performance for the delegated functions. CCAH retains the right to revoke any delegated function if compliance with standards is not met. CCAH has a process in place to assess and ensure delegated entities have the ability to perform the delegated functions. All delegates, which are not NCQA accredited are required to pass an initial pre-delegation audit, and an annual delegation oversight audit are required to pass an initial pre-delegation audit and an annual delegation oversight audit. An initial assessment is conducted pre-contractually to determine the organization's ability to provide delegated services and at least annually thereafter. CCAH attains all these through its DOC's:

- Review and approve the CCAH Delegation Oversight program charter, policies, and procedures at least annually, or more frequently depending upon business needs or changes to the Delegation Oversight Program requirements.
- Designate the staff that will participate in Delegates' audits.
- Review and approve the results of Delegates' annual audits.
- Review and approved pre-delegation audit results of prospective Delegates and make delegation recommendations.
- Review and approve scope of annual oversight audits.
- Make recommendations for conducting ad hoc audits.
- Review and approve sources of industry standard and guidelines use to evaluate Delegates' compliance with the Delegation Agreement.
- Review recommendations for monitoring activities.
- Participate in the review of corrective action plans, monitor, and evaluate their implementation.
- Escalate recurrent cases of non-compliance to the Compliance Committee.
- Make penalty recommendations when delegates do not consistently meet requirements.

- Report oversight activities to Compliance Committee and QIHE Committee.
- Provide annual audit report to QIHE Committee

The QIHEC continuously monitors delegated entities and reviews their performance on a quarterly basis. The Committee has the authority to place any delegated entity on a corrective action plan for deficiencies in performance. CCAH has a collaborative, supportive, relationship with its contracted delegates and meets with them at least quarterly to review reports and performance.

Member Satisfaction

In addition to HEDIS clinical measures, the QIHE program supports company-wide efforts to improve the member's experience with the plan's services and the provider network. CCAH uses Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores to evaluate member experience.
The plan contracts with NCQA certified vendors to conduct an annual CAHPS to monitor members' satisfaction with health care services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member satisfaction and the processes, which impact satisfaction. CCAH will conduct CAHPS surveys at least annually and the results will be presented to the QIHEC committees. CCAH will evaluate the survey results to develop an improvement plan to address areas identified. The report will include a drill down analysis of the CAHPS survey results at the clinic level to identify high and low performing clinics. This analysis will help CCAH to learn best practices form high performing groups and work with low performing groups to improve performance.

In addition to the CAHPS survey, CCAH also has a robust grievance process that monitors patient satisfaction with the Plan's services and providers on an ongoing basis. The plan will be working will be working with the internal departments involved to collaborate on methods to improve member satisfaction and to focus on any findings from grievances for resolution.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The QI program supported companywide efforts to improve the member's experience with our service and our provider network. CCAH uses Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores to evaluate member experience. Providers are evaluated against the following CAHPS measures:

- Rating of the health Plan
- Customer Service
- Getting Care Needed
- Getting Care Quickly

Providers are evaluated against the following CAHPS measures:

- Rating of Personal Doctor
- Rating of Health care quality
- Grievance and Appeals
- Access and availability

Provider Performance Results

In line with CCAH's mission of continuously improving the health of the community, the health plan's QIHE program aims to:

- Improve the quality and efficiency of health care provided to CCAH members.
- Improve members' experiences with services and care received.

- Improve members' health outcomes.
- Provide culturally sensitive and linguistically appropriate services.
- Promote the safety of all members in all treatment settings.
- Ensure timely access and availability of services for all members, including those with complex or special needs, including physical or developmental disabilities, multiple chronic conditions, and severe mental illness.
- Promote processes to ensure the availability of "safe, timely, effective, efficient, equitable, patient centered care" and provide oversight within the network.

The following strategies are being adapted to achieve above goals:

- Focus on managing chronic conditions by adhering to and providing best practices in the care of their condition(s)
- Focus on improving patient safety by ensuring that evidenced-based clinical practice guidelines are followed in providing care and best practices are implemented at inpatient care settings.
- Focus on preventive health for the members by ensuring that they get access to preventive services in a timely manner and by adopting evidence-based medicine in prevention and health promotion.
- Focus on improving performance of different quality measures during the measurement year including, but not limited to:
- NCQA HEDIS Measures – CCAH utilizes select HEDIS measures to monitor and implement quality improvement projects for NCQA health plan and health equity accreditation
- Managed Care Accountability Set (MCAS) - CCAH's goal is to calculate the rates required for MCAS, stratify DHCS-selected MCAS measures, and exceed the minimum performance level (MPL) as determined by DHCS.

Initial Health Appointment

CCAH recognizes the importance of improving Initial Health Appointments (IHA) rate as a key initiative to providing better care to members. CCAH has developed training for providers on IHA requirements that are conducted during the new provider in-service. To effectively monitor the accuracy of completed IHAs, CCAH has also identified the appropriate claims and encounter codes used to identify initial health appointments. In addition, the Coding Resource Specialist conducts a medical record audit twice yearly to ensure that providers are accurately completing and documenting all the elements required as part of the IHA in the medical records. The QIPH department will track and trend the IHA rates and findings from the medical record audit and develop interventions as necessary to improve quality of care. IHA's are also tracked and addressed during the Facility Site Review (FSR) and Medical Records Review (MRR) onsite visit of the Providers office by our QM nurses.

Member Engagement Standards

CCAH has established Health and Wellness Programs to provide the members with a variety of opportunities to improve health. The purpose of the health and wellness programs is to provide opportunities for members to improve their health by participating in wellness activities available to them. The Health and Wellness Programs are available to all members that are enrolled with CCAH. Members have access to all the tools, activities, programs, and incentives that are part of the Health and Wellness Programs. All members are informed about the Health and Wellness Programs at the time of enrollment and at least annually thereafter. CCAH also promotes the Health and Wellness Programs on the website. The program is evaluated annually for effectiveness.

CCAH rewards its members for taking steps to be healthier with the Health Rewards program – an incentive program that rewards members for getting routine care, managing chronic conditions, adopting healthy lifestyle habits through raffles and direct incentives. Through this program, members that complete the requirements for the incentive will earn a Target Gift Card, the values vary. CCAH identifies eligible winners two ways: 1. Monthly list of eligible winners for each incentive is created using claims and supplemental data. 2. Attendance records for completion of workshops. CCAH will work with its internal finance team to mail out gift cards to raffle winners and workshop attendees. Our direct incentives are managed by a vendor, CCAH sends a list of eligible members, and the vendor mails out the gift cards. CCAH Health Rewards program incentivizes the following services:

- Well Visits for 0-15 months of age, 30 months of age, and 18-21 years of age.
- Immunizations: Childhood Immunizations (CIS-10), Flu Second Dose, and Adolescent Immunizations {IMA-2)
- Prenatal & Postpartum visits
- Use of Nurse Advice Line
- Healthier Living Program workshop series.
- Live Better with Diabetes Program workshop series.
- Healthy Weight for Life workshop series

- Comprehensive Member Portal
  CCAH has worked in driving its members more to use the health plan's portal through developing a comprehensive website where member related information and updates can be seen. CCAH Member Portal offers the following:
  - Member Tools
  - Customer Service
  - Creating an Account
  - Provider Directory
  - Medical EOC
  - Formulary

- Member Information
  - Benefits and Services
  - Grievance and Appeals
  - Medi-Cal Redetermination
  - Medi-Cal Eligibility
  - Rights and Responsibilities
  - Case Management
  - Member Portal information are being constantly updated to deliver the latest, most valuable information that may serve its members. For better CCAH experience, there is also the MyCCAH App that members can download from the APP store or Android Market.

- Social Media Platform
  - CCAH also facilitates the sharing of ideas, thoughts, and information via Facebook, where its members can follow for identity, conversations, sharing, relationships, presence, and support.

- Diversity, Equity, Inclusion and Belonging Committee

- In view of the current national awareness on racial equality, CCAH is working with a consultant to form a permanent working group for this committee to achieve inclusion and belonging through implementing and maintaining DEIB best practices. Our goal is to develop a framework by partnering with consultants with expertise in Diversity, Equity Inclusion, and Belonging to influence and sustain DEIB practices within the organization. A comprehensive and clear framework is needed to address DEIB comprehension and review our policies and practices to support an inclusive culture. In addition to promoting equity, this framework will help our workforce develop the skills needed to support health equity in our diverse membership. Additionally, this committee will work toward providing ongoing: Provider education and Training.
- Member support and programs
- Employee training and activities.

- Provider Engagement
  - CCAH's QIHE program works hand in hand with the plan's Provider Services Department for provider involvement/engagement. This department has representatives for providers. This team helps ensure that network providers are engaged through:
  - Soliciting provider input to the health plan for the development and implementation of health plan's policies and standards,
  - Identification of provider needs and gaps.
  - Assistance on other areas in which provider input and engagement are critical.
  - Coordination of provider feedback on matters relevant to health plan and quality improvement activities that impact providers.
  - Educate providers on member benefits and available programs.

- QIHE program's Strategies for Provider Engagement includes:
  - Provider Partnership and Coaching opportunities
  - Provider Incentives
  - Care-Based Incentive (CBI) for PCPs
  - Hospital Incentive
  - Data Sharing Incentive
  - Specialty Care Incentive (SCI)
  - Clinic JOC (clinic and hospital)
  - Provider Satisfaction Survey
  - HEDIS Provider Awards
  - Provider Portal

- CCAH has worked on driving its network providers more to use the health plan's portal through developing a CCAH Provider Portal offers the following:
  - Home Page
    - Important Information for Providers
    - Portal News
    - Provider News
    - Quick Links
    - Provider Events Calendar

- Main
    - Claims Search
    - Overpayment Letters Search
    - Eligibility Search
    - Provider Directory
    - Prescription History
    - Data Submissions

- Auths and Referrals
    - Jiva (Care Management Software)
    - Procedure Code Lookup
    - Authorization/Referral Search – Prior to 7/15/2024

- Reports
    - Linked Member List
    - Quality Reports
    - Care Based Incentives (CBI)
    - HEDIS (MCAS) Reports

- The Alliance Website offers provider related information, updates, and resources:
    - Manage Care
    - Behavioral Health
    - California Children's Services
    - Clinical Resources
    - Cultural and Linguistics Services
    - Enhanced Care Management and Community Supports
    - Health Education and Disease Management
    - Pharmacy
    - Quality of Care
    - Provider Incentives
    - Health Assessments
    - HEDIS
    - Immunization Resources
    - Member Incentives
    - Site Reviews

- Resources
    - COVID-19
    - Claims
    - Forms
    - Provider Credentialing Applications and Policies
    - News
    - Provider Directory
    - Provider Manual
    - Timely Access to Care
    - Webinars and Training
    - Emergency Preparedness
    - Provider Portal

Annual Quality Improvement and Health Equity Evaluation

An evaluation of the QIHET Program is completed at the end of each calendar year. The annual evaluation is conducted by the QIPH staff in conjunction with designated department leaders. The evaluation includes:

- A description of completed and ongoing QIHE activities.
- Trending of measures to assess performance in quality and safety of clinical care and quality and safety of service.
- Assessment of barriers and/or limitations when performance does not meet goals.
- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Analyses of demonstrated improvements, including assessing whether there was meaningful improvement in a measure.
- An analysis of the overall effectiveness of the program, including progress toward influencing network-wide safe clinical practices.
- An evaluation of delegated activities, if any.
- Recommendations for changes to be incorporated into the subsequent QIHE Program Description and annual QIHE work plan.

Quality Improvement and Health Equity Workplan

The QIHE work plan is the schedule of activities for the QIHEC Programs. The QIHEC work plan includes the main tasks that cover the scope of the QIHE Program including quality of clinical care, quality of service, and safety of clinical care; yearly objectives; yearly planned activities; time frames for completion of each task; the person responsible for the task; monitoring of previously identified issues; and scheduled evaluation of the quality improvement program. It is prepared as a calendar with a rolling schedule. At any point in time a full year of activities is visible. QIHE activities and indicators are ongoing and continuous. They are not discontinuous at the end of the year.

The QIHEC work plan is not a static document. It is approved annually by the QIHEC Committee but is revised and developed more fully in response to the analysis of performance data, interventions, remeasurement timeframes and the addition and deletion of indicators on an ongoing basis.

DATE: May 28, 2025

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

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

SUBJECT: Policy Revision – 401- 1201 Quality Improvement Health Equity `Committee

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Recommendation. Staff recommend the Board approve revisions to Alliance Policy 401-1201 – Quality Improvement Health Equity Committee (QIHEC)

Background. To define the role and responsibilities of the Alliance's Quality Improvement Health Equity Committee (QIHEC), as contractually required by the 2024 Medi-Cal Contract.

Discussion. The Alliance maintains a Quality Improvement and Health Equity Transformation Program (QIHETP), as described in Alliance Policy 401-1101 – *Quality Improvement and Health Equity Transformation Program (QIHETP)*. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board) delegates oversight and performance responsibility[i] of the QIHETP to the QIHEC, excluding credentialing/recredentialing activities, which are directed by the Peer Review and Credentialing Committee.

The Alliance Quality Improvement Health Equity Committee policy language was minorly modified to update the structure, committee membership, reporting, subcommittee information, and to include notations of actions which fulfill NCQA requirements.

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

Attachments.

1. Alliance Policy 401-1201 – Quality Improvement Health Equity Committee

[i] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity `Committee	
Original Date: 02/01/1996	**Date Published:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Purpose

To define the role and responsibilities of Quality Improvement Health Equity Committee (QIHEC), Central California Alliance for Health's (the Alliance) contractually required quality improvement health equity committee[1].

Policy

The Alliance maintains a Quality Improvement and Health Equity Transformation Program (QIHETP), as described in Alliance Policy 401-1101 – *Quality Improvement and Health Equity Transformation Program (QIHETP)*. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board) delegates oversight and performance responsibility[2] of the QIHETP to the QIHEC, excluding credentialing/recredentialing[3] activities, which are directed by the Peer Review and Credentialing Committee.

Definitions[4]

1. Corrective Action: Specific identifiable activities or undertaking of the Alliance that address program deficiencies or problems.
2. Managed Care Accountability Set (MCAS): A set of measures based on the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets selected by DHCS for evaluation of health plan performance.
3. Performance Improvement Projects (PIP)[5]: Studies selected by the Alliance, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes.

Procedures

The QIHEC conducts oversight and manages performance of the QIHETP as outlined below.

1. Structure
   The QIHEC is designated by, and accountable to, the Alliance Board, supervised by the Chief Medical Officer or designee, in collaboration with the Chief Health Equity Officer. The activities, findings, recommendations, and actions of the QIHEC are reported to the Alliance Board on a scheduled basis[6]. The QIHEC oversees the activities of the organization, Pharmacy and Therapeutics (P&T) Committee, Utilization Management Workgroup (UMWG), and Continuous Quality Improvement Workgroup (CQIW).. The QIHEC partners with the Compliance Committee to meet delegate oversight requirements[7].

2. Responsibilities
   Primary duties of the QIHEC[8] include the following:

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2.a. Annually reviewing and approving the draft Quality Improvement and Health Equity and Utilization Management Work Plans (QIHEWP and UMWP);
2.b. Quarterly reviewing progress against active QIHEWP and UMWP goals;
2.c. A written summary of QIHEC activities, as well as QIHEC activities of its fully delegated subcontractors and downstream fully delegated subcontractors, findings, recommendations, and actions are prepared after each meeting;
2.d. Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings of the activities of other committees such as the Community Advisory Committee (CAC);
2.e. Institute actions to address performance deficiencies, including policy recommendations;
2.f. Ensure appropriate follow-up of identified performance deficiencies;
2.g. Providing leadership and oversight in the implementation of quality improvement principles and activities in the daily operations of the Alliance;
2.h. Facilitating communication on the status and progress of Alliance QIHETP activities to the Alliance Board on a scheduled basis;
2.i. Participating in the development and/or adoption of specific utilization management criteria[9] and benefit parameters;
2.j. Monitoring the activities of, and providing direction to, all QIHEC subcommittees/ workgroups;
2.k. Stimulating the highest degree of commitment to quality health care and to the goal of continuous improvement;
2.l. Recommending and approving changes to select QIHETP related Alliance policies, practice guidelines, and subcommittees' proposed action plans;
2.m. Overseeing the QIHETP and UM Program policies (Alliance Policies 401-1101 and 404-1101 respectively), and the QIHEWP and UMWP for annual submission to the Alliance Board;
2.n. Reviewing, approving, and submitting the Quality Improvement and Health Equity (QIHE) Annual Report[10] to the Alliance Board;
2.o. Reviewing and advising on QIHETP related Corrective Action plans (CAP), not including credentialing/recredentialing oversight related CAPs. Individual provider issues may be referred to the PRCC and/or Program Integrity Unit depending on the nature of the issue;
2.p. Reviewing standards of care guidelines, as described in Alliance Policy 401-1501 – *Standards of Care*;
2.q. Oversight of language assistance and interpreter services as described in Alliance Policy 401-4101 – *Cultural and Linguistic Services Program*

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2.r. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and the DHCS Comprehensive Quality Strategy

2.s. For fully delegated subcontractors and downstream fully delegated subcontractors, ensure maintenance of a QIHEC and reporting to the Alliance on a quarterly basis, at a minimum; and

2.t. Partnering with the Compliance Committee to meet QIHETP delegate oversight requirements[11].

3. Requirements

3.a. Frequency: The QIHEC meets at least quarterly, but as frequently as necessary to demonstrate follow-up on all findings and required actions[12].

3.b. Chair: The QIHEC is chaired by the Alliance Chief Medical Officer (or designee)[13] in collaboration with the Chief Health Equity Officer.

3.c. Membership: Core membership consists of Alliance network providers, including but not limited to hospitals, clinics, county partners, fully delegated subcontractors ensuring representation of all required specialties as outlined below and downstream subcontractors. They are representative composition of the provider network and provide health care services to members affected by health disparities, limited English proficiency (LEP), children with special health care needs (CSHCN), seniors and persons with disabilities (SPDs) and persons with chronic conditions[14]. Committee members must be in good standing with the Alliance. Good standing is defined as:

3.c.1. Having an unrestricted license to practice medicine or osteopathic medicine in the state of California; and,

3.c.2. Not having an open accusation or disciplinary action by any state licensing board; and,

3.c.3. Not having any ongoing or unresolved program integrity corrective action plans (CAPs).

▪

3.d. Core Alliance staff membership includes the Chief Medical Officer, Chief Executive Officer, Chief Administrative Officer, Chief Health Equity Officer, Health Services Officer, Medical Director(s), QIPH Director, QIPH Managers, Quality and Health Programs (QHP) Manager, QIPH Nurse Supervisor, Care Management Director (CM), Communications Director, Enhanced Health Services Director, Member Services (MS) Director or designees Pharmacy Director, Program Services Director, Provider

Services (PS) Director, Regional Operations Directors, Utilization Management Director (UM), and Behavioral Health Manager. Ad-hoc (non-core) membership varies as topics mandate.

3.e. Voting: Voting rights are afforded to all core QIHEC members.

3.f. Quorum: A majority of core QIHEC members constitutes a quorum[15].

3.g. Term: Alliance subcontractor QIHEC members are appointed for a renewable one-year term. Membership forms are completed by each Alliance subcontractor member annually.

3.h. Attendance: QIHEC members are required to attend a minimum of two of the four quarterly meetings in order to remain in good standing. Meetings may be held virtually or in-person; members preferring to attend at an alternate Alliance office may do so.

3.i. Minutes: QIHEC minutes are reviewed by the Alliance Board on a routine basis[16]. QIHEC minutes are submitted to DHCS[17] upon Alliance Board review and approval and made publicly available on the Contractor's website at least on a quarterly basis.

3.j. Reporting:

3.j.1. Quarterly: The activities, findings, recommendations, and actions of the QIHEC relative to the QIHETP are submitted to the Alliance Board in writing on a quarterly basis[18].

3.j.2. Annually: The QIHE Program Description is submitted to the QIHEC for review, and approval and submission to the alliance Board, and subsequent submission to DHCS and NCQA. The purpose of the QIHEW Program Description is to describe the structure and framework of the organization and ensure continuous assessment, planning, implementation, evaluation, and improvements in the quality of care and services rendered by our network providers received by our members and participants.

3.j.3. Annually: The QIHE Annual Program Evaluation[19] is submitted to the QIHEC for review, approval and submission to the Alliance Board, and subsequent submission to DHCS and NCQA. The QIHE Annual Program Evaluation includes:

3.j.3.a. A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions;

3.j.3.b. A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies;

3.j.3.c. An analysis of actions taken to address any recommendations in the annual External Quality Review (EQR) technical report and specific evaluation reports;

3.j.3.d. An analysis of the delivery of services and quality of care and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review, and the results of consumer satisfaction surveys;

3.j.3.e. Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and behavioral health care services;

3.j.3.f. A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Alliance utilizes the information from this engagement to inform policies and decision-making;

3.j.3.g. Population Health Management (PHM) activities and findings as outlined in Exhibit A, Attachment III, Section 4.3 (Population Health Management);

3.j.3.h. Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives;

3.j.3.i. An assessment of subcontracting entities performance of delegated QIHE activities;

3.j.3.j. Copies of all final reports of non-governmental accrediting (e.g., National Committee for Quality Assurance [NCQA]) if relevant, including any CAPs developed to address noted deficiencies, and an assessment of subcontractor performance of delegated quality improvement activities.

3.k. Confidentiality[20]:

3.k.1. All members of the QIHEC will agree to the terms of the Confidentiality Agreement;

3.k.2. Peer review committee whose activities, information and records are protected from disclosure under California Evidence Code Section 1157; and

3.k.3. All QIHEC members must agree to respect and maintain the confidentiality of all QIHEC discussions, deliberations, records, and other information generated in connection with these activities and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of QIHEC business.

3.l. Conflict of Interest[21]:

3.l.1. All members of the QIHEC will agree to the terms of the Conflict of Interest Agreement;

3.l.2. All members of the QIHEC who have a conflict of interest with respect to any matter being brought before the QIHEC shall report the conflict of interest to the chairperson of the QIHEC;

3.l.3. A QIHEC member with a conflict of interest will refrain from casting a vote on any related issue and will abstain from any proceedings of the QIHEC in which such issues are raised for consideration; and

3.l.4. A QIHEC member is deemed to have a conflict of interest if there is any potential for personal, professional, or financial gain in the item being presented, or any other involvement in the matter which may impair the member's objectivity in considering the matter.

4. Other Committees

4.a. P&T Committee: The P&T Committee operates under the authority of the QIHEC as described in Alliance Policy 403-1104 – *Mission, Composition and Functions of the Pharmacy and Therapeutics Committee.*

4.b. UMWG: The UMWG operates under the authority of the QIHEC as described in Alliance Policy 404-1101 – *Utilization Management Program.*

4.c. Quality Improvement Health Equity Workgroup (QIHE-W): The QIHE-W, under the direction and guidance of the QIHEC, is responsible for addressing high-priority and emerging quality and health equity trends requiring organization-wide and/or cross-departmental response, including, but not limited to, topics related to provider capacity, grievances, member access and satisfaction, and QIHET program activities. The QIPH Director or designee chairs the QIHE-W. Core membership includes: CMO, Medical Director(s), QIPH Director, Chief Compliance Officer, Chief Health Equity Officer, Chief Operating Officer, Health Services Officer, Care Management Director, Claims Director, Community Engagement Director, Community Grants Director, Compliance Director or designees from the departments, Data Analytics Director, Enhanced Health Services Director, Grievance and Quality Manager, Marketing and Communications Director, Medicare Executive Director, MS Director, Pharmacy Director, Program Development Director, PS Director, Provider Quality and Network Development Manager, UM Director, Behavioral Health Manager, QIPH Managers, QHP Manager, and UM Managers. Ad-hoc membership varies as topics mandate. The QIHE-W is responsible for activities, including but not limited to:

4.c.1. Ongoing review and approval of the QIHEWP, including refining interventions to address barriers and incorporate feedback from the QIHEC, and the QIHE Annual Report[22];
4.c.2. Annual review and approval of various QIPH policies and related processes and functions;
4.c.3. Analysis of HEDIS/Managed Care Accountability Set (MCAS) measures and the development of strategies to improve performance;
4.c.4. Development of QIHETP related provider and member communications;
4.c.5. Development of disease management initiatives;
4.c.6. Ongoing oversight of delegated QIHE activities of subcontractors;
4.c.7. Review of language assistance and interpreter services as described in Alliance Policy 401-4101 – *Cultural and Linguistic Services Program;*
4.c.8. Review and analysis of provider and member survey results; and
4.c.9. Review and approval of QIHETP-related standing reports, and state mandated PIPs.

4.d. Care Based Incentives Workgroup (CBIW): The Care Based Incentives Workgroup (CIWG) purpose is to provide oversight of the Care-Based Incentive program to meet timelines for incentive evaluation, contractual requirements, build schedules, and address issues that may impact the program. The CMO (or designee) chairs the CBIW. Core membership includes: QIPH Director, QIPH Program Advisors, QIPH

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Managers, QHP Manager, QIPH Project Specialist, QIPH Coding Resource Specialist, Medical Directors, Pharmacy Director (or designee), PS Director (or designee), Contracts Manager, and Analytics Director (or designee)

5. Delegate Oversight[23]
   Oversight and performance responsibility of the Alliance's delegated QIHE functions, including UM/CCM, are maintained and monitored by the QIHEC, in collaboration with the Compliance Committee, as described in Alliance Policy 105-0004 – *Delegate Oversight.*

References:

Alliance Policies:
- 105-0004 – Delegate Oversight
- 401-1101 – Quality Improvement and Health Equity Transformation Program
- 401-1501 – Standards of Care
- 401-4101 – Cultural and Linguistic Services Program
- 403-1104 – Mission, Composition and Functions of the Pharmacy & Therapeutics Committee
- 404-1101 – Utilization Management Program

Impacted Departments:
- Community Care Coordination
- Community Engagement
- Compliance
- Member Services
- Pharmacy
- Provider Services
- Utilization Management

Regulatory:
- California Evidence Code §1157
- California Code of Regulations Title 28, Chapter 2, Article 7, Section 1300.70

Legislative:

Contractual (Previous Contract):

Contractual (2024 Contract):
- 2024 Medi-Cal Contract A.3.2.2-A.3.2.2.1

DHCS All Plan Letter:
- APL 19-017 – Quality and Performance Improvement Requirements

NCQA:

Supersedes:

Other References:

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity `Committee	
Original Date: 02/01/1996	**Date Published:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Attachments:

Lines of Business This Policy Applies To

☐ DSNP
☒ Medi-Cal
☒ Alliance Care IHSS

LOB Effective Dates

(01/01/2026 – present)
(01/01/1996 – present)
(07/01/2005 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
11/02/2023	11/02/2023	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEW
11/30/2024	11/30/2023	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEW
12/11/2023	12/11/2023	Jenifer Mandella, Chief Compliance Officer	Andrea Swan
03/11/2024	03/11/2024	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEW
04/25/2024	04/25/2024	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEC
02/19/2025	02/19/2025	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEW
04/02/2025		Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEC

[1] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[2] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1
[3] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12

[5] DHCS All Plan Letter 19-017; and DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[6] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.2
[7] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 3.1.4
[8] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[9] DHCS State Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.D
[10] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8
[11] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6

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	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity `Committee	
Original Date: 02/01/1996	**Date Published:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

[12] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[13] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[14] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[15] Consistent with *Bylaws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission* (April, 2009)
[16] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[17] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[18] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[19] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[20] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[21] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3
[22] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[23] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.5

DATE: May 28, 2025
TO: Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
FROM: Andrea Swan, RN, Quality Improvement and Population Health Director
SUBJECT: Quality Improvement Health Equity Transformation Workplan – Q4 2024

Recommendation. Staff recommend the Board accept the Q4 2024 Quality Improvement Health Equity Transformation (QIHET) Workplan report.

Summary. This report provides pertinent highlights, trends, and activities from the Q4 2024 QIHET Workplan.

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

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

Discussion:

QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION

Reporting purpose is to: To develop a comprehensive evaluation of all Quality Improvement activities for 2024.

Report Previously Identified Issues /Highlights: Barriers identified in data collection related to Grievance and Appeal data.

Report Changes/Updates: All workplan updates submitted quarterly with all information reviewed and approved by QIHEC. Evaluation on track to be written during QI 2025.

PROGRAM DESCRIPTION

Reporting purpose is to: Finalize 2024 Program Description for presentation to QI stakeholders, and develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS, and NCQA requirements.

Report Previously Identified Issues /Highlights: Delay in approval of final Program Description as additional areas needed review to ensure program description met all required elements.

Report Changes/Updates: The Program Description reviewed in September 2024 by NCQA team and has met all required elements.

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

Report Previously Identified Issues /Highlights: No previously identified issues or highlights to report.

Report Changes/Updates: Quarter 3 updates presented and approved at QIHEW and QIHEC. Q4 activities completed pending updates at Q1 2025 QIHEW and QIHEC.

QUALITY OF CLINICAL CARE
MCAS Intervention:
Reporting purpose is to:

1. Provider Partnership program shows improvement across all 5 provider sites and 9 of the 10 measures of focus.
2. Develop a comprehensive MCAS workgroup to capture, plan, and discuss quality improvement activities which will improve DHCS required MCAS measures, and NCQA HEDIS prioritized measures.

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

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

Report Previously Identified Issues /Highlights: In Q4, met with almost all departments to discuss interventions for the last planned activity, except one department due to changes in leadership. MCAS workgroup discussions on health fair, barriers in member contact, quality withhold, and MCAS portal reports.

Report Changes / Updates: Not changes or updates to report: Of the tracked measures, as of December 2024 monthly data, Child and Adolescent Well-Care Visits, Immunizations for Adolescents - Combo 2, Lead Screening in Children, Well-Child Visits in the First 15 Months—Six or More Well-Child Visits, Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits met the strategic priority percentile goal of a 5 percentile improvement over the previous year. Chlamydia Screening in Women, and Breast Cancer Screening met the goal to reach the 50th percentile based on the MY23 percentiles. Childhood Immunizations - Combo 10 is the only measure that did not reach the goal.

Care Base Incentive
Reporting purpose is to: Enhance monthly quality provider portal report data and functionality.

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

Increase access to introductory CBI program information for network providers.

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

Report Previously Identified Issues: No previously identified issues or highlights to report.

Report Changes / Updates: Final evaluations to workplan updated. No additional action taken in Q4 2024.

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

Report Previously Identified Issues /Highlights: No previously identified issues or highlights to report.

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

- **Q4 progress**: A total of 5 presentations on Health Education services and Member Health Rewards were coordinated and completed in Quarter 4. This included internal and external audiences.

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

- **Q4 progress:** The project team included 1 article in the December 2024 Member Newsletter informing members of health resources and self-management tools. Additionally, the Health Educators completed 1,318 outgoing calls to members to offer health and wellness programs.

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

- **Q4 progress:** A total of 60 surveys were collected in Q4 to collect member experiences participating in chronic disease management and wellness programs. Highlights include that 92% of members reported they were satisfied/highly satisfied with the HLP/chronic disease management program. 100% reported they were highly satisfied with the HWL/childhood obesity prevention program.

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

- **Q4 progress:** A total of 8 member workshops were completed during the reporting period. Virtual and telephonic workshops were completed.

SAFETY OF CLINICAL CARE

Facility Site Review and Potential Quality Issues

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

Facility Site Review:
Report Previously Identified Issues /Highlights:
Identified Issues: To ensure adequate staffing levels, the organization has approved two new positions, and one backfill position for an FSR nurse who resigned in Q3.

Goal Results:

1. 5/6 or 83% (goal: 80%) of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.
2. 6/6 or 100% (goal: 100%) of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.

Report Changes / Updates: Two new hires began in January 2025, and an additional new hire is currently in process with HR approval and an offer pending, with a potential start date in February.

Potential Quality Issues
Report Previously Identified Issues /Highlights:
Identified Issues: Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals, CAP management, collaborative efforts, and quality studies to enhance the quality of care for members.

Goal Results:

1. 112/112 or 100% (goal: 100%) of member grievances received by QI concerning potential medical quality of care issues are resolved within the regulatory timeframes for Member Grievances.
2. 40/53 or 75% (goal: 80%) of non-grievance related PQIs are completed within 90 calendar days.

Report Changes / Updates: PQI observed a 2% improvement in closing internal referrals within 90 days from Q3 to Q4 2024. In December 2024, Policy 401-1301 ("Potential Quality Issues") was updated to extend the turnaround goal from 90 to 120 days, effective Q1 2025. This operational change is expected to further enhance performance on this key metric. However, the team continues to face challenges with managing non-regulatory PQI referrals, timely CAP management, quality studies, and collaborative work to enhance the quality of care for members. In Q1 2025, processes will be examined and areas for process improvement pinpointed.

Grievance and Appeals

Reporting purpose is to: To provide an update and review of AG performance, trends, and activities for the Appeals and Grievance Program during Q4 2024.

Report Previously Identified Issues /Highlights:
Identified Issues:

1. Staffing deficiency.
2. System testing continued to resolve identified issues for new CMSR system (Jiva). While training and familiarity helped to close the gap with learning curves, regulatory performance still below targets.
3. Category reconciliations.
4. Grievance trends with provider availability (access), provider and plan attitude, and appeal trends with medically tailored meals.

Results:

1. Completed recruitment to stabilize staffing which improved regulatory performance. New staff member began in November 2024.
2. Regulatory performance declined but did not exceed established parameters during Q42024. This was due to both performance and learning curve with the new Care Management System (Jiva) along with ongoing staffing deficiencies.
3. Coaching and cascading examples of errors to improve accuracy with categorizations.
4. Provider Relations staff close communications to clinics about staffing challenges, recruitment grants, after hours scheduling and customer service skills. For appeals, medically tailored meals policy under review for appropriate policy adjustments.

Report Changes / Updates: No changes or updates to report.

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

Report Previously Identified Issues /Highlights:

- Lack of accessible in person appointments within 10 business days for many BH providers/members not having first appointment within 10 business days
- Discovery of pending BHT referrals through Carelon not linked to services in a timely manner back in Q1.
- BH team informed by BH providers of difficulty with credentialing timelines and referral questions.
- From Q4 2023 to Q3 2024, Merced County Membership for CCAH reduced by just under ~2000 members.
- Local EDs lacking engagement and awareness of most appropriate referral options for BH care.
- Local ED having turnover in leadership.

Report Changes / Updates:

- BH Manager presented on BH benefits to MSAG and WCM advisory committee.
- BH Manager and QI team presented at PAG in 5/2024 on current BH measures, including discussion from providers related to BH benefit.
- BH Managers invited to several of the hospital JOC meetings, where psychiatric hospitalizations (FUA FUM measures) were discussed.
- Weekly meetings with Carelon to review data on BHT referrals and linkage to care.
- BH Managers met with Monterey group of pediatricians, along with other alliance and Carelon staff, in 7/2025 and 9/2025 to discuss BH services and referral process and barriers.
- Outreach events attended by BH manager in the 2 new counties (San Benito and Mariposa).
- Workgroup started with Merced BHRS in 6/2024 on high utilizers and ED visits and in person collaborative occurred with Merced BHRS to discuss interventions.
- BH Manager attended 2 outreach events in Merced County in 2024.

MEMBER EXPERIENCE
Member Satisfaction Survey – CAHPS
Reporting purpose is to: Update the group on the progress of CAHPS work.

Report Previously Identified Issues /Highlights: The team previously identified that CAHPS surveys were not fielded timely which led to delayed results and challenges implementing relevant interventions.

Report Changes / Updates: No changes or updates to report: In Q4 2024 the CAHPS Medicaid surveys benchmark and county level data was received. The data was analyzed and the development of 2025 goal recommendations to share at Q1 2025 QIHEW and Operations Committee meetings for feedback was created. Additionally, a CAHPS article was created for the January 2025 employee newsletter to help build awareness and attended the November 2024 Member Services Advisory Group to elicit feedback on CAHPS results from Members.

QUALITY OF SERVICE

Access and Availability

Reporting purpose is to: Comply with DMHC Timely Access Survey Requirements and review provider member ratios.

Report Previously Identified Issues /Highlights: No previously identified issues or highlights to report.

Report Changes / Updates: Currently in progress for the PAAS survey for timely access, awaiting results, and monitoring of provider ratios are in compliance, except for IM & Allergy and Immunology.

Geo Access

Reporting purpose is to: Comply with time and distance requirements in accordance with DHCS timelines.

Report Previously Identified Issues /Highlights: No previously identified issues or highlights to report.

Report Changes / Updates: GeoAccess Reports submitted to DHCS. Awaiting feedback on outcomes. All alternative access points have been accepted.

Provider Satisfaction Survey

Reporting purpose is to: Monitor Provider Satisfaction annually.

Report Previously Identified Issues /Highlights: No previously identified issues or highlights to report.

Report Changes / Updates:

Overall satisfaction by Provider type has increased to 89%, previously 88%.
Satisfaction by county:

- Merced- 90%
- Monterey- 90%
- Santa Cruz- 85%

Behavioral Health (NPMH) provider satisfaction- 79%, previously 72%

Telephone Access

Reporting purpose is to: To ensure timely assistance for members when connecting with the plan, through Member Services Call Center.

Report Previously Identified Issues /Highlights:

- Goals were met for Q4, Service level target average of 80%. The call center was impacted by low staffing and high call volume increase. SLA will continue to improve for 2025 due to the addition of 10 temporary staff. The abandonment rate remains low for the busy call center at 3%, this is under the 5% target goal.

- Small decrease in Walk-ins, 1,071 Walk-in members were assisted. The Merced office continues to have the highest member walk-in volume. SV assisted 38 member walk-ins for Q4- this location received a higher average of member than the Mariposa location.

Report Changes / Updates: Addition of FTE onboarding successful. The team remains focused on implementing a workforce Management Tool to increase efficiencies.

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

Report Previously Identified Issues /Highlights: No previously identified issues or highlights to report.

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

- **Q4 progress:** A total of 2 presentations on C&L services were completed in Quarter 4.

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

- **Q4 progress:** An article was included in the December 2024 Member Newsletter. The article informed members of their rights to have written information in alternative formats (Alternative Format Selection/AFS).

Goal 3:
On a quarterly basis, collect member feedback on their experience with language assistance services in a clinical setting.

- **Q4 progress:** A total of 26 member experience surveys were collected in Q4. According to the member feedback collected for language assistance services in a clinical setting:
    - Over 96% of members reported the highest rating of satisfaction with the interpreter at their doctor visit.
    - 100% reported they would use the interpreting services again.
    - When asked for recommendations to improve the experience 96% of members reported no improvements needed. 4% shared recommendations such as training all interpreters to provide the same quality of service as high performing interpreters.

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

- **Q4 progress – phone interpreting services:**
  There was a total of 6,815 calls in Q4 by provider sites. This reflects an increase of 38% compared to Q4 in 2023.
- **Q4 progress – Face-to-Face (F2F) interpreting services:**
  There was a total of 1,764 requests in service counties for F2F. This reflects an increase of 35% compared to Q4 in 2023.

- Santa Cruz County had 710 requests in Q4. This was an 8.2% increase compared to Q4 2023.
- Merced County had 470 requests in Q4. This was a 20.2% increase compared to Q4 2023.
- Monterey County had 580 requests in Q4. This was a 123.9% increase compared to Q4 of 2023.
- San Benito County had 4 requests in Q4. This is a new service county and there was no comparison for 2023.
- Mariposa County had 0 requests in Q4. This is a new service county and there was no comparison for 2023.

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

Report Previously Identified Issues /Highlights: No previously identified issues or highlights to report.

Report Changes / Updates:

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

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

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

Attachments.
1. Q4 2024 Quality Improvement and Population Health Transformation Program Workplan.

2024 QIPH Work Plan

SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To develop a comprehensive evaluation of all Quality Improvement activities for 2024.	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements. *Correction-This section notes the QI evaluation goals and objectives. 1. Ensure all data is tracked through the work plan each quarter as these updates will ensure completion of the evaluation timely.	1/1/2024-12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	All workplan updates submitted quarterly with all information reviewed and approved by QIHEC. Evaluation on track to be written during QI 2025.	1: Barriers identified in data collection related to Grievance and Appeal data.	1. Reporting was created to accurately capture needed categories of grievance data moving forward.	☑ Yes ☐ No	Please add QI evaluation link
2.	2.						☐ Yes ☐ No	
3.	3.				2:	2:	☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

PROGRAM DESCRIPTION (ANDREA SWAN)

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

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3. Develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS, and NCQA requirements.	3. Review all DHCS, and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2024-12/31/2024	Andrea Swan, Quality Improvement & Population Health Director	2nd update: 9/2024 workplan reviewed by NCQA team and has met all required elements.	2: Delay in approval of final PD as additional areas needed review to ensure program description met all required elements.	2: With all elements finalized, and system developed to ensure Business owner completion, and stakeholder review the QI program description going forward the program description for 2025 will be launched in December prior to the measurement year to ensure timely completion, and committee review and approval.	☑ Yes ☐ No	encountered due to understanding of additional requirements needed to meet all area which led to the final program description not being presented at QIHEC however the QI workplan was used in its place to outline and report the QI program and al activities to stakeholders. 2025 workplan was launched late 2024 and is on track to be presented to QIHEC QI 2024.
4.	4.						☐ Yes ☐ No	

ANNUAL WORKPLAN (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To executes a QI program annual work plan that reflects ongoing activities throughout the year and addresses all required DHCS, and NCQA requirements	1. Create a workplan that captures yearly activities, time frame for each activity's completion, staff members responsible for each activity, monitoring of previously identified issues, and evaluation of QI program.	1/1/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1: Workplan successfully completed, and approved at QIHEW, and QIHEC in the 1st quarter of 2024. 1st quarter updates have been completed pending presentation to QIHEW and QIHEC. Qtr. 2 Quarter 1 updates presented and approved at QIHEW and QIHEC. Q2 updates completed pending update at QIHEW in August, and QIHEC in Sept. Qtr. 3: Quarter 2 updates presented and approved at QIHEW and QIHEC. Q3 activities completed pending update at QIHEW in August, and QIHEC in Sept. Qtr. 4: Quarter 3 updates presented and approved at QIHEW and QIHEC. Q4 activities completed pending updates at Q1 2025 QIHEW and QIHEC.	1: Current workplan needed to be updated to meet DHCS and NCQA requirements which was successfully completed. 2: With the presentation of workplan goals within the QIPH committee feedback included in the need to establish clear baselines, and timeframes. The workplan was updated, and presented with changes, and approved.	1: Continue to work with business owners for timely submission and ensuring work plan updates meet requirements and reflect progress towards goals.	☑ Yes ☐ No	Workplan updated to meet NCQA requirements with accurate timely reporting updates achieved.
2. Ensure all workplan elements are properly documented and reflect appropriate follow up by each business owner.	2. Regular quarterly check-ins to review workplan entries, with regular feedback provided to business owners when applicable.	3/31/204,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director				☑ Yes ☐ No	
3. Review and approval of workplan quarterly by QIHEC	3. Review of all workplan entries prior to each committee to ensure appropriate documentation.	3/31/204,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director		3: N/A	2. Continue to work with Business owner on timely accurate submissions of each area.	☐ Yes ☐ No Yes	
4.	4.						☐ Yes ☐ No	

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SECTION 2: QUALITY OF CLINICAL CARE

MEDI-CAL MANAGED CARE SET (MCAS) INTERVENTION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Establish and launch Provider Partnership program	1. Sign up 4 providers by 3.31.24. 2. Do onsite meetings and observations by 4.31.24. 3. Develop and implement interventions for 1-2 MCAS measures at each site by 6.30.24. 4. Monitor and adjust interventions and MCAS rates 9.30.24	1/1/24-3/31/24 3/31/24-4/31/24 4/1/24-6/30/24 7/1/24-9/30/24	Sarina King, Quality and Performance Improvement Manager	Five practices enrolled by April 2024. 2 Focused measures selected per site, with project charters completed. Monthly practice coaching sessions and quarterly data review meetings began in April 2024. Data as of Sept. 2024 shows upward trends in 9 of the 10 selected measures for the 5 sites.	Difficulty scheduling and meeting with providers, slow start to interventions.	Continue to support practice with Care Gap closure reports and funding for additional clinic time.	☑ Yes ☐ No	The Alliance provider liaisons and leadership team were persistent in their support, education and outreach to our Provider Partners. This persistence resulted in regular coaching meetings with our sites and appropriate escalations and support with interventions. The result is improved performance across MCAS measures with 9 of 10 tracked measures showing year over year improvement and 4 of 10 reaching MPL.
2. Develop a comprehensive MCAS committee to capture, plan, and	1. Create project charter and project tracker.	1/1/2024-3/31/2024	Britta Vigurs, Quality Improvement Program Advisor	In Q1 2024 we drafted the MCAS Workgroup Meeting Charter and	The previous cross-departmental workgroup to	This meeting will reoccur monthly.	☑ Yes ☐ No	This MCAS committee

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discuss quality improvement activities that will improve DHCS required MCAS measures, and NCQA HEDIS prioritized measures. Overall strategic goal is to improve Merced County Pediatric Measures by a 5 percentile increase over MY 22 each year through 2026. In addition to children's health measures sanctioned in Merced there were there are two women's health measures that also fell below the minimum performance level (MPL) held to the 50th percentile. Goal is to reach the following: • Child and Adolescent Well-Care Visits (WCV) - 48.0% (45th percentile) • Childhood Immunizations - Combo 10 (CIS-10) - 24.5% (14th percentile). • Immunizations for Adolescents - Combo 2 (IMA–2) - 35.2% (50th percentile). • Lead Screening in Children (LSC) - 53.2% (25th percentile). • Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6)- (16th %ile) • Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 60.8% (28th %ile) • Breast Cancer Screening (BCS) - 52.6% (50th percentile). Chlamydia Screening in Women (CHL-Tot) - 56.04% (50th percentile).	2. Establish regular monthly check-in with committee to monitor activities. 3. Evaluation current intervention strategies against finalized audited measurement year (MY) MY2023 MCAS measure rates. 4. Request direction of interventions from.	3/1/2024-6/30/2024 6/17/23-8/31/2024 4/1/24-12/31/2024		identified stakeholders across the Alliance to attend future meetings as core attendees or ad hoc. Topic tracker has been drafted to assist identifying standing agenda items and future topics based on priorities. MCAS Measurement Year (MY) 2023 rates (Report Year 2024) in Merced County show improvements in all measures but Immunizations for Adolescents (IMA-2). Child and Adolescent Well-Care Visits (WCV), Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6+), Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits (W30-2+), and Breast Cancer Screening met 2023 Target Goals. WCV, W30-6+ and BCS are on track for 2024. In Q2 the MCAS Workgroup discussed tracking of all projects/initiatives that may impact MCAS measures. QIPH interviewed key stakeholders across the organization to assess impact, and track information for further discussion in the MCAS Workgroup. In Q3 the MCAS Workgroup discussed barriers and improvement activities for servicing Alliance members in rural communities to close gaps in care. Assessment for projects/initiatives for MCAS measures continues with stakeholders across the organization.	address MCAS measures during the pandemic was structured more for reporting out, rather than allowing active work within the meeting to identify and flag barriers in projects. In Q3 MCAS workgroup meetings were canceled due to competing hi-priority meetings and will work to see if meeting schedule should be modified for 2025.			meeting is structured to be an interdisciplinary workgroup to review and approve interventions, as well as serve as working sessions to problem solve barriers. There were a number of new quality improvement projects within the provider network last year in 2023, which would have helped drive improvements in targeted measures like BCS and W30-6+.

CARE-BASED INCENTIVE (CBI) (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Enhance Provider Portal reports to streamline access to reports and increase availability of functions and measures monthly.	1. Create business requirements for a roll-up function that allows multiple clinics sites to see a combined monthly rate for measures available monthly on the Provider Portal Quality Report. 2. Develop workflow to extract and generate additional columns that	1/1/2024-3/31/2024 1/1/2024-6/30/2024	Alex Sanchez, Quality Improvement Program Advisor, Magdalena Kowalska, Quality Improvement Program Advisor, Shannon Fletcher, Quality Improvement Program Advisor, Annecy Majoros, Quality Improvement Program Advisor	1. Roll-up function has been deployed on the Provider Portal Quality Reports in Q1 2024. 2. Work for business requirements completed in Q2 2024.	Competing priorities for staff, and limited staffing available to build and test reports. Limited visual and report functionalities of the provider portal.	1. No further action required. 2. Awaiting ticket assignment, portal development, and testing.	☑ Yes ☐ No	Initial reports with target dates in Q1 were successfully completed with no issues after collaborating on the easiest technological

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	note members meeting continuous enrollment specifications to applicable monthly Provider Portal Quality reports. 3. Create business requirements to add trending graphs to monthly quality reports. 4. Create business requirements to add a Gaps in Care report. 5. Create business requirements to generate email reminders for portal reports for providers.	6/30/2024-12/31/2024 4/1/2024-12/31/2024 4/1/2024-12/31/2024 1/31/2024-3/31/2024		3. Business requirements completed and submitted to ITS in Q1 2023. 4. Work to start in Q2 2024. 5. Completed draft language in Q1 2024.		3. Awaiting ticket assignment, portal development, and testing. 4. QA by QIPH and portal release. 5. Continued discussions with staff from Provider Services and Quality Improvement and Population Health on portal feature development, then development and testing of the function		solution. Anticipate potential bandwidth challenges for the rest of the report enhancements due to regulatory and non-regulatory alliance projects for programming.
2. Increase access to introductory CBI program information for network providers.	1. Record a CBI 2024 introductory video. 2. Create survey for feedback on training content. 3. Published video on the Alliance Webinars and Training website. 4. Advertise video to network providers, with additional targeting for newly added Mariposa and San Benito County providers. 5. Create Data Submission Tool (DST) training video. 6. Create and record coding training material for MCAS/CBI.	4/1/2024-5/30/2024. 4/1/2024-5/30/2024. 6/1/2024-6/30/2024 7/1/2024-7/31/2024 6/1/2024-8/31/2024 6/1/24-8/31/24	Annecy Majoros, Quality Improvement Program Advisor, Juan Velarde, Quality Improvement Program Advisor, Britta Vigurs, Quality Improvement Program Advisor, Tera Mendoza, Coding Resource Specialist	Work completed for CBI Introduction video in Q2 2024. Coding Introduction video completed and posted to Alliance website in Q3.	Bandwidth of staff to complete the training videos in competition with regulatory and other project obligations.		☑ Yes ☐ No	Planned activities were updated to combine the training videos for the CBI introduction, DST and provider portal reports into one training video for ease of use by provider clinics. Coding Introduction video will continue to be advertised in CBI forensics visits and at the CBI 2025 Workshop.

BASIC POPULATION HEALTH MANAGEMENT (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal department staff that interact with members to increase awareness of Health Education services and health rewards available for members.	1. The project team will reach out to internal departments that interact with members. Examples of teams: a. Health Education team b. Member Services team c. Care Coordination team d. Community Engagement team 2. Schedule presentations 3. Deliver Health Education and Member Health Rewards services presentation. 4. Request input regarding presentation content and any	3/31/2024, 6/30/2024 9/30/2024, 12/31/2024	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	A total of **5 presentations** on Health Education services and Member Health Rewards were coordinated and completed in Quarter 4. Presentations were delivered to the following audiences: • Alliance Community Grants Team • Merced County Office of Education • Merced Maternal Wellness Coalition	No issues to report in Q4.	The project team will continue to coordinate presentations for internal teams and external community partners in Q4.	☑ Yes ☐ No	This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members.

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2. A minimum of 2 presentations will be conducted per quarter.	member needs that they have encountered regarding Health Education services.			• A Community Counteracting Tobacco (ACCT) Coalition • ECM Provider (ClinNEXUS)				
3. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.	1. The project team will conduct outreach and education activities to inform members of services available to them via: a. Member outreach calls b. Member workshops c. Member mailings d. Member newsletter articles e. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	The following activities were completed in Q3 to inform members of Health and Wellness programs: • <u>Member Newsletter:</u> The project team included 1 article in the December 2024 Member Newsletter informing members of health resources and self-management tools. • <u>Member outreach calls:</u> The Health Education team completed 1**,318 outgoing outreach calls** in Q4 to offer members health and wellness programs.	No issues to report in Q4.	The project team will continue to conduct member informing activities in 2025.	☑ Yes ☐ No	The member newsletters result in higher calls to the Health Education Line regarding programs included in the newsletter. In Q4 the Health Education Line received **751 incoming calls** from members, providers and the community regarding Quality and Health Programs services. Additionally, the Health Educators received **178 PCP referrals** to health education services in Q4.
4. On a quarterly basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact.	1. The project team will conduct satisfaction surveys with members to evaluate: a. Information about the overall program b. Usefulness of the information shared. c. Percentage of members indicating that the program helped them achieve health goals. 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Member feedback was collected regarding chronic disease management and wellness programs. • **Member Satisfaction Surveys:** The project team completed a total of **<u>60 surveys</u>**.	No issues to report in Q4.	The project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.	☑ Yes ☐ No	According to the member feedback collected for chronic disease management programs: 92% of members reported they were satisfied with the HLP/chronic disease management program. 96% reported they were satisfied with the staff that provided HLP. 88% reported HLP helped them

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								achieve health goals. 96% reported the information received in HLP was useful. According to the member feedback collected for wellness programs: 100% of members reported the highest rating of satisfaction with the HWL/childhood obesity prevention program. 100% reported they were satisfied with the staff that provided HWL. 100% reported HWL helped them achieve health goals. 100% reported the information received in HLP was useful.
4. On a quarterly basis increase the number of member workshops provided by the Health Education Team in comparison to 2023 baseline. In 2023 there were on average 2 workshops scheduled per quarter. In 2024 the team will double this number and offer at minimum 4 workshops per quarter.	1. The Health Educators will conduct a minimum of 4 member workshops per quarter. 2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs. 3. Health Educators will lead.	3/31/2024, 6/30/2024, 9/30/2024, 12/31/2024	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	A total of **8 member workshops** were coordinated in Q4. The following workshop modalities and languages were provided: • 1 virtual Healthier Living Program (HLP) group in English. • 2 virtual Live Better with Diabetes (LBD) group, 1 English, 1 Spanish. • 2 virtual Healthy Weight for Life (HWL) groups, 1 English, 1 Spanish. • 3 telephonic Healthier Living Program (HLP) groups, 1 Spanish, 2 English.	No issues to report in Q4.	The project team will continue to schedule workshops in 2025.	☑ Yes ☐ No	The project team continues to experience high interest in member workshops.

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SECTION 3: SAFETY OF CLINICAL CARE

FACILITY SITE REVIEW (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.	1. Enhance provider scheduling support by onboarding three additional QI RNs dedicated to conducting facility site reviews. 2. Implement proactive planning by reviewing all upcoming site reviews one quarter in advance. 3. Streamline scheduling by offering provider sites a selection of review dates two months before the review due date. 4. Maintain continuous communication with provider sites until a review date is confirmed.	10/01/2024-12/31/2024	Joana Castaneda, Quality Improvement Program Advisor, Tisha Criswell Senior Quality Improvement Nurse	1. Achieved goal with a result of 5 out of 6 reviews completed (83%). 2. Recruitment is underway for three FSR positions. 3. Q1 reviews were proactively assessed during Q4 for planning. 4. Initial communications have been sent to providers regarding Q1 reviews.	To ensure adequate staffing levels, the organization has approved two new positions, and one backfill position for an FSR nurse who resigned in Q3 2024.	Ongoing collaboration with HR to recruit three QI RN positions for FSR. Maintain communication with providers with site reviews due in Q1 2025, ensuring follow-up on date selection until each review date is confirmed.	☑ Yes ☐ No	Two new hires began in January 2025, and an additional new hire is currently in process with HR approval and an offer pending, with a potential start date in February.
2. 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.	1. Enhance CAP management support by onboarding three additional QI RNs for facility site reviews. 2. Send email reminders to provider sites regarding upcoming CAP due dates. 3. Directly contact non-responsive providers via phone, involving PRRs as necessary.	10/01/2024-12/31/2024	Tisha Criswell Senior Quality Improvement Nurse	1. Achieved goal results of 6 out of 6, or 100%. 2. Currently in the recruitment phase for three FSR positions. 3. Reminders regarding upcoming due dates have been sent to providers with CAPs.	To ensure adequate staffing levels, the organization has approved two new positions, and one backfill position for an FSR nurse who resigned in Q3 2024.	1. Ongoing collaboration with HR to recruit three QI RN positions for FSR. 2. Maintain consistent communication with providers regarding CAP due dates. Follow up with non-responsive providers through direct phone calls involving PRRs as needed.	☑ Yes ☐ No	Two new hires began in January 2025, and an additional new hire is currently in process with HR approval and an offer pending, with a potential start date in February.

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POTENTIAL QUALITY ISSUES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 100% of member grievances received by QI concerning potential medical quality of care issues are resolved within the regulatory timeframes for Member Grievances.	2. Establish due dates in SharePoint for PQIs that allow sufficient time for investigation, translation needs (if applicable), and for the Grievance Coordinator to resolve the case. 3. Promptly request medical records necessary for the PQI investigation upon case assignment to the QI RN. 4. Ensure timely coordination of discussions if the case requires MD guidance or potential P2/P3 recommendations.	10/01/2024-12/31/2024	Emily Kaufman, Clinical Safety Supervisor, Eleni Pappazisis, Quality Improvement Program Advisor, Naomi Kawabata, Senior Quality Improvement Nurse, Katie Lutz, Senior Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, Bethany Fung, Quality Improvement Nurse, and Karen De Leon, Quality Improvement Nurse	1. Achieved goal results of 100%, with all 112 cases closed on time. 2. Due dates have been established in SharePoint to facilitate the closure of regulatory PQIs. 3. The QI RN requested medical records promptly for PQI investigations. 4. Timely discussions were conducted with MDs regarding P2/P3 cases.	1. Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals, CAP management, collaborative efforts, and quality studies to enhance the quality of care for members.	1. Continue establishing due dates in SharePoint to prioritize promptly closing regulatory-based PQIs. 2. Maintain the practice of requesting medical records as needed for investigations to ensure timely case closures. 3. Conduct weekly MD meetings to discuss potential P2/P3 cases requiring guidance, ensuring that these discussions do not hinder timely case resolution.	☑ Yes ☐ No	Regulatory PQI work is on track, with current initiatives meeting established timelines and quality standards. Efforts in this area continue to progress as planned, ensuring that regulatory requirements are consistently met.
1. 80% of non-grievance related PQIs are completed within 90 calendar days.	2. Triage and prioritize incoming internal referrals for the following case types: a. Known provider to tracking and trending. b. Provider on a CAP or involved in an open Quality Study c. LTSS member	10/01/2024 – 12/31/2024	Eleni Pappazisis, Quality Improvement Program Advisor, Naomi Kawabata, Senior Quality Improvement Nurse, Emily Kaufman, Senior Quality Improvement Nurse, Katie Lutz, Senior Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, Bethany Fung, Quality Improvement Nurse, and Karen De Leon, Quality Improvement Nurse	1. Achieved goal results of 73%, with 24 out of 33 cases closed on time. 2. The team effectively triaged and prioritized incoming internal referrals for the following case types: • Known providers for tracking and trending. • Providers on a CAP or involved in an open Quality Study. • LTSS members.	1. Ensure staffing levels are adequate to balance regulatory PQIs, internal PQI referrals, collaborative efforts, and quality studies to enhance the quality of care for members.	2. Triage incoming 90-day referrals promptly. 3. Temporarily decline collaborative work and be selective about participating in Quality Studies until the team can achieve 100% compliance in closing regulatory and internal referral PQIs.	☐ Yes ☑ No	PQI observed a 2% improvement in closing internal referrals within 90 days from Q3 to Q4 2024. In December 2024, Policy 401-1301 ("Potential Quality Issues") was updated to extend the turnaround goal from 90 to 120 days, effective Q1 2025. This operational change is expected to further enhance performance on this key metric. However, the team continues to face challenges with managing non-regulatory PQI referrals, timely CAP management, quality studies, and collaborative work to enhance the quality of care for members. In Q1 2025,

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								processes will be examined and areas for process improvement pinpointed.

GRIEVANCE & APPEALS REVIEW (SARAH SANDERS)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide grievance updates to interdisciplinary groups including SGRC and QIHEW.	a. Monitor and process concerns within regulatory timeframes. b. Provide internal communications on appeal and grievances trends and outcomes. c. Track and trend grievance data by demographics including language to analyze disparities. d. Identify actionable opportunities for improvement	04/01/2024-6/30/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q4: June staffing deficiency	Q3: Staffing deficiency impacted regulatory timeframes.	Continue monitoring regulatory compliance and trends. Active staffing recruitment planned for Q3-24 to ensure appropriate staffing to support regulatory compliance.	☑ Yes ☐ No	Close monitoring, communications and tracking of AG occurred
2. Support Members by resolving issues of dissatisfaction with the Alliance.	a. Ensure that where appropriate, corrective action is implemented and effective in improving identified problems. b. Track grievance and appeals for access/QOC trends, system issues, and identify actionable corrections needed.	04/01/2024 – 06/30/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q4: System testing continued to resolve identified issues for new CMSR system (Jiva). While training and familiarity helped to close the gap with learning curves, regulatory performance still below targets.		QI action and monitoring for responsiveness	☑ Yes ☐ No	
3. Quality Data: External Report requirements are met 100% of the time.	a. Monitor timely data and state submissions to ensure completeness. b. Evaluate and identify opportunities to improve the data accuracy of AG information.	04/01/2024 – 06/30/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q3: Category reconciliations.	Q3: n/a	Monitor for data to ensure new benefit types pulled for required MCPD reporting.	☑ Yes ☐ No	New benefits added to the tableau reporting suite.
4. Ongoing monitoring of AG results to support that appropriate action is taken when occurrences of poor performance are identified. Identify and track allegations of discrimination.	a. Identify and, when appropriate, act on substantiated issues in a timely manner. Monitor and report findings bi-monthly. Complete audits for allegations of discrimination to monitor, prevent and identify any discriminatory practices.	04/01/2024 – 06/30/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager	Q4: Grievance trends with provider availability (access), provider and plan attitude, and appeal trends with medically tailored meals.	Q3: n/a	Monitor outliers	☑ Yes ☐ No	Results Achieved.

COC OF MEDICAL & BEHAVORIAL HEALTH (REBECCA MCMULLEN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase Utilization of BH benefit overall by 2.5% within the Behavioral health network in Merced County, from a baseline of 4.07% by	-At minimum, annual BH team member attendance at PAG and QIHEC meetings to discuss BH services	By 10/31/2024	- Rebecca McMullen, BH Manager and/or Shae Redwine, BH Analyst	Q4 update: -BH Manager presented on BH benefits to MSAG and WCM advisory committee.	-Lack of accessible in person appointments within 10 business days for many BH providers/members not	-BH services will be insourced in 7/2025 with goal to increase utilization and member and provider experience, ensuring	☐ Yes X No	The reason why goal was not met is due to several factors related to lack of education of BH benefit to members and

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12/31/2024, by increasing provider and member education about BH benefits offered.	-At minimum, annual BH team member attendance at MSAG or other similar member forums to discuss BH services such as WCM advisory committee -increase in provider outreach and education via provider newsletters -Promotion of BH services at outreach activities (at least 3) in Merced County annually. -Meet with Delegate (Carelon) monthly and MHPs at minimum quarterly to track and discuss appropriate referrals and transitions to the NSMHS benefit. Outreach and engage local Merced Eds in collaboration on referrals to BH care.	Attended by 2/8/2024 Ongoing, started 5/1/2024 By 12/31/2024 Ongoing, started in 5/1/2024 Ongoing, started 1/1/2024 By 12/31/2024	- Communications department manager, Provider Services Manager, Member Services Manager	-BH Manager and QI team presented at PAG in 5/2024 on current BH measures, including discussion from providers related to BH benefit. -BH Managers invited to several of the hospital JOC meetings, where psychiatric hospitalizations (FUA FUM measure) were discussed. -Weekly meetings with Carelon to review data on BHT referrals and linkage to care, specifically. - BH Managers met with Monterey group of pediatricians, along with other Carelon staff on 7/2025 and 9/2024 to discuss BH services and referral process and barriers. -Outreach events attended by BH manager in our 2 new counties. -Workgroup started with Merced BHRS in 6/2024 on high utilizers and ED visits and in person collaborative occurred with Merced BHRS to discuss interventions. -BH Manager attended 2 outreach events in Merced County in 2024. -Engagement with BH providers by the plan in preparation for insourcing 7/1/25 began in Q3/Q4. -Carelon to provide the BH service until 6/30/25.	having initial appointment occur within 10 business days - Discovery of pending BHT referrals through Carelon not linked to services in a timely manner -BH team informed by BH providers of difficulty with credentialing timelines and referral questions -Local Eds lacking engagement and awareness of most appropriate referral options for BH care. -From Q4 2023 to Q3 2024, Merced County Membership for CCAH reduced by 2000 members. -Local Ed having turnover in leadership.	appropriate representation of providers in the Merced County area. -Annual communication to members and providers via a "NSMHS outreach and education plan" draft completed and will be posted on external website for members and providers by DHCS. -BH Manager to continue ongoing monthly collaboration with Merced BHRS to discuss BH interventions at local ED. -BH team will present at on BH benefits and/or BH coordination of care at QIHEC and PAG Q1 2025, and MSAG in Q2 2025. -BH Manager to meet monthly with Merced BHRS team to discuss Coordination of care for ED members and engage with local ED on outreach and referrals for BH care. -BH team doing a presentation to providers at "Lunch and Learn" in May 2025.		providers, lack of available providers in the BH space, difficulty referring members to the BH benefit and lack of follow through on referrals submitted incorrectly or with insufficient information.
							☐ Yes ☐ No	

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SECTION 4: MEMBER EXPERIENCE

MEMBER SATISFACTION SURVEY – CAHPS (SARINA KING)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start& end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. CAHPS survey fielded timely, and results reported out to internal stakeholders within 8 weeks of receiving results	1. CAHPS workflows, processes, and timelines documented and reviewed in Q1 2024, and steps are taken to begin MY2023 surveys.	2/8/24 – 12/31/24	Sarina King, Quality and Performance Improvement Manager	In Q4 CG CAHPS fielding occurred. We also received MY2023 Quality Benchmark data as well as breakdowns by county. Confirmed sample frames and supplemental questions for MY24 Medi-Cal CAHPS so that fielding could be done timely in 2025.	Previously fielding was not always completed in a timely manner which led to delayed results.	• Review and analyze CG CAHPS results • Ensure MY24 Medi-Cal CAHPS are fielded timely • Update workflows and processes to reflect any changes to work.	☑ Yes ☐ No	Creating the workflows and timelines and coordinating with all involved parties led to do timely fielding of the Medi-Cal and CG CAHPS surveys.
2. Increase organizational awareness of what CAHPS is and current what current rates are	2. Present MY 2022 CAHPS rates to targeted and appropriate stakeholders Begin outreach to chiefs/admins to present CAHPS overview and high-level rates to organization at all-staff or division meetings.	3/1/2024 – 12/31/24 3/1/2024 – 12/31/24	Sarina King, Quality Performance Improvement Manager	In Q4 2024, we analyzed MY23 and created a presentation to share with the organization in Q12025. We will present to both QIHEW in Ops Committee to share results and get input on interventions and goals for 2025. A CAHPS article for the January employee newsletter was created and set to be published. Attended Member Services Advisory Group on 11/7/2024 to get feedback on CAHPs results.	Current issues that we are working through involve getting organizational involvement and alignment on CAHPS interventions based on previous MY results.	Develop CAHPS goals and interventions for 2025.	☑ Yes ☐ No	We have continued to lay the groundwork for organizational support and alignment to focus on CAHPS interventions. Now that we have MY23 results, we will be sharing the results out organizationally and within QIHEW to develop goals and interventions.

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SECTION 4: QUALITY OF SERVICE

ACCESS & AVAILABILITY (AA) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with DMHC Timely Access Survey Requirements	1. Ensure 90% of After-hours triage compliance in Timely Access Survey. (Provider Appointment Availability Survey [PAAS]). 2. Ensure 75% Urgent and routine appointment access compliance, as well as next available follow up appointment for non-physician mental health care, within required time frames. 3. PAAS work begins in the summer with vendor engagement and finalization of the project plan and contact lists. The survey is launched from August to November/December. Results are available in Q1 of the subsequent year.	7/1/2024-12/31/2024	Jessie Dybdahl, Provider Service Director	Q4: complete PAAS survey and report outcomes once available.	none	Receive results from Vendor (Mid-March 2025) and compile data to report out.	☐ Yes ☑ No	PAAS vendor survey is complete-awaiting results.
2. Quarterly review of provider to member ratios for PCPs and High-volume/high-impact Specialties. To ensure all ratios meet regulatory requirements.	1. Ensure provider to member ratios are w/in compliance and mitigate if out of compliance on a quarterly basis. 2. Tableau report is monitored no less than quarterly to ensure provider to member ratios are met for each required provider type.	7/1/2024 - 12/31/2024	Jessie Dybdahl, Provider Service Director	Q4: Review ratios and any outcomes. Based on the policy standards, are well within compliance for provider to member ratios for all provider types, minus two. Those that we are not within compliance with, we will continue to monitor quarterly and work with necessary departments to address.	none	- Inform Grants of specialties where we aren't in compliance. - Inform Network Develop Team of necessary new specialties for recruitment.	☑ Yes ☐ No	Current metrics are in line with requirements, except Allergy & Immunology and Internal Medicine.

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						- Continue monitoring quarterly for compliance.		

GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with Time or Distance Standards set forth by DHCS	1. Ensure the network meets time or distance standards in compliance with DHCS requirements when a provider is available. 2. Monitor areas where no provider is available and ensure alternative access requests are in place on a quarterly basis. 3. Evaluate the non-contracted provider network to determine if recruitment might remedy access gaps. Launch recruitment efforts as applicable.	7/1/2024 - 12/31/2024 7/1/2024 - 12/31/2024	Jessie Dybdahl, Provider Service Director	Q4: The Alliance has submitted the Network Certification Report to DHCS and DHCS is reviewing and will provide outcomes.	none	Continue to monitor any gaps as they arise with in network and recruit as feasible.	☐ Yes ☑ No	Completed submission of the reports. Awaiting DHCS.
2.	2.						☐ Yes ☐ No	
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provider Satisfaction Survey	1. Monitor Provider Satisfaction annually. Ensure no less than 5% decrease in overall satisfaction with the plan from prior year. 2. The Provider Satisfaction Survey (PSS) is launched in the summer with vendor engagement in spring. Contact lists are sent for primary care, specialty care, and non-physician mental health care. The survey is launched from July to August. Results are available in quarter 4.	7/1/2024 - 12/31/2024	Jessie Dybdahl, Provider Service Director	Overall satisfaction by Provider type has increased to 89%, previously 88%. Satisfaction by county: - Merced- 90% - Monterey- 90% - Santa Cruz- 85% Behavioral Health (NPMH) provider satisfaction- 79%, previously 72%	none	Discuss county specific results	☑ Yes ☐ No	none
2.	2.						☐ Yes ☐ No	
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

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TELEPHONE ACCESS (VERONICA OLIVARRIA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of calls to Member Services answered within 30 seconds.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. Improvement efforts slated for 2024: o The adoption of a Workforce Management Tool to assist with call forecasting and representative scheduling, ensuring we have appropriate levels of staff supporting the queues at any given time/day. o Call Audit Optimization: We are developing formal call audit guidelines and defined audit methodology to ensure staff is adhering to Alliance updates and processes. o Developing additional call circles (queues) to: o Optimize resource availability. o Improve speed to answer. o Reduce representative training time. o Increase member satisfaction. o Computer Telephone Enhance HSP/Finesse by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time on phone for the MSR and will make each call more efficient. Integration: 2. Assess staffing needs due to increase in membership	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Olivarria, MS Call Center Manager Lilia Chagolla, Member Services Director	Goal not met (63%). The call center has hired additional staff to support the calls and member walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Assign staff to support offices to assist member walk-ins. Eliminate unnecessary meetings and focus meetings/training on business needs. Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules. Trainings coordinated in small teams to maximize service level.	Q1 is the busiest time of the year in the Call center, the company was also in a Common Spirit negotiation that impacted 7600 members and the Call center was short staffed. Q2- we hired an additional 5 MSR's that helped maximize coverage and increase service level to 90% and higher monthly. Q3- We hired 2 Call Center Supervisors, 2 FTE's and onboarded 2 Temps Reps to back fill for staff who recently promoted to other departments. Q4- Additional temp were hired to back fill for 2 staff promotions out of the department and 3 MSR's out on LOA.	The Call Center team will continue to ensure we are fully staffed by continuing to review the needs of our callers and ensure our staff have the most current resources and/or trainings.	☐ Yes ☑ No ☑ Yes ☐ No ☑ Yes ☐ No ☑ Yes ☐ No	This goal has been successful in increasing every month by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members. We are currently in the process of reviewing a new phone system and a Workforce management tool. Call center Supervisors are focused on coaching real time, ensuring resources are available and HSP updates are current to allow staff to focus on the needs of the caller.

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2. Call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	2. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. (Same as above)	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Olivarria, MS Call Center Manager Lilia Chagolla, Member Services Director	Goal not met (63%) The call center has hired additional staff to support the calls and member walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Assign staff to support offices to assist member walk-ins. Eliminate unnecessary meetings and focus meetings/training on business needs. Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules. Trainings coordinated in small teams to maximize service level.	Q1 is the busiest time of the year in the Call center, the company was also in a Common Spirit negotiation that impacted 7600 members and the Call center was short staffed. Q2- we hired an additional 5 MSR's that helped maximize coverage and increase service level to 90% and higher monthly. Q3- Onboarded 2 Call Center Supervisors, 2 FTE's and 2 Temps Reps to back fill for staff who recently promoted to other departments. Q4 - The call center focused on ensuring the queue was covered to meet the needs of our callers. We did experience multiple staff out on leave and several staff promoted out of the department. However, we successfully met all call center metrics.	Working on additional FTEs and moving call quality auditing to MS Ops team, WFM tool to be implemented with new phone system.	☐ Yes ☑ No ☑ Yes ☐ No ☑ Yes ☐ No ☑ Yes ☐ No	This goal has been successful in increasing every month by ensuring we are fully staffed to meet the needs of our membership and ensuring Alliance staff are informed and trained about the services available to members. We are currently in the process of reviewing a new phone system and a Workforce management tool. Call center Supervisors are focused on coaching real time, ensuring resources are available and HSP updates are current to allow staff to focus on the needs of the caller.
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

CULTURE & LINGUISTICS (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide at least 1 C&L services presentations to Alliance internal department staff that interact with members to increase awareness of C&L services available for members.	1. The C&L team will reach out to internal departments that interact with members. Examples: a. QIPH new hire orientation b. Member Services team c. Care Coordination team d. Community Engagement team 2. Schedule C&L services presentation 3. Deliver C&L services presentation. 4. Request input regarding presentation content and any	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	A total of 2 **presentations** on C&L services were coordinated and completed in **Quarter 4**. Presentations were delivered to the following audiences: • Alliance Community Grants teams • Clinica de Salud del Valle de Salinas (CSVS)	No issues to report in Q4.	The project team will continue to coordinate presentations for internal departments and external partners in Q1 2025.	☑ Yes ☐ No	This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members. Increased awareness of C&L

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	member needs that they have encountered regarding C&L services.							Services allows Alliance staff to share information on a broader scale with members they are working with in day-to-day operations.
2. On a quarterly basis, inform members of C&L Services available to them in 2024 utilizing at least 1 member informing modality.	1. The C&L team will conduct outreach and education activities to inform members of services available to them via: a. Member newsletter articles b. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor	The following activities were completed in **Q4** to inform members of C&L Services: **December Member Newsletter article**– the article in the newsletter informed members of their rights to have written information in alternative formats (Alternative Format Selection/AFS).	No issues to report in Q4.	The project team will continue to coordinate presentations for internal departments and external partners in Q1 2025.	☑ Yes ☐ No	This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members. Increased awareness of C&L Services allows Alliance staff to share information on a broader scale with members they are working with in day-to-day operations.
3. On a quarterly basis, collect member feedback on their experience with language assistance services in a clinical setting.	1. The project team will conduct satisfaction surveys with members to evaluate: a. Individual ratings of access to language services. b. Overall rating of interpretation services. c. Access to language services at a health care encounter. d. Gather individual experiences with the services. 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	The following activities were completed in **Q4** to collect member feedback regarding language assistance services in a clinical setting. • **Member Satisfaction Surveys:** The project team completed a total of 26-member experience surveys.	No issues to report in Q4.	The project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.	☑ Yes ☐ No	According to the member feedback collected for language assistance services in a clinical setting: 1. Over 96% of members reported the highest rating of satisfaction with the interpreter at their doctor visit. 2. 100% reported they would use the interpreting services again. 3. When asked for recommendations to improve the experience 96% of members reported no improvements needed. 4% shared recommendations such as training all

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								interpreters to provide the same quality of service as high performing interpreters. The C&L team will take this input and share feedback with the interpreting services vendors to work on these recommendations.
4. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2023 baseline utilization data.	1. The project team will track utilization for the following services: • Phone interpreting services. • Face-to-Face (F2F) interpreting services. 2. Use quarterly utilization data to identify potential need to training of provider network on language assistance services.	3/31/2024 6/30/2024 9/30/2024 12/31/2024	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor	**Provider Utilization for Q4** was as follows: **Phone interpreting services:** There was a total of **6,815 total calls in Q4** by provider sites. This reflects an **increase of 38%** compared to Q4 in 2023. **Face-to-Face (F2F) interpreting services:** There was a total of **1,764 requests in all service counties for F2F in Q4**. This reflects an **increase of 35%** compared to Q4 in 2023. • **Santa Cruz County** had **710 requests** in **Q4.** This was an 8.2% **increase** compared to Q4 2023. • **Merced County** had **470 requests** in **Q4**. This was a 20.2% **increase** compared to Q4 2023. • **Monterey County** had **580 requests** in **Q4.** This was a 123.9**% increase** compared to Q4 of 2023. • **San Benito County** had **4 requests** in **Q4**. This is a new service county and there was no comparison for 2023. • **Mariposa County** had **0 requests** in **Q4**. This is a new service county and there was no comparison for 2023.	No issues to report in Q4.	The utilization data from Q1-Q4 reflects very low to no utilization of in-person/F2F interpreting services in the new expansion counties. The C&L team will reach out to the Provider Relations team to share this information and inquire how to best support the providers in the expansion counties with language assistance services access.	☑ Yes ☐ No	There continues to be increases in utilization of language assistance services by providers in 2024 compared to 2023.

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DELEGATION OVERSIGHT (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations.	1. Quarterly review of delegate reports to ensure compliance, and identification of any issues.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	1. All delegate reports for the 1st quarter were received and reviewed with no gaps identified.	No previous issues identified	Continue with quarterly review	☑ Yes ☐ No	All areas delegated within QI were received, reviewed, and reported timely.
2. Ensure oversight of all delegated activities by governing board.	2. Present quarterly updates of all reviewed activities with identification of any issues to the governing board for review, and feedback.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	3. All delegate reports for the 2nd quarter were received and reviewed with no gaps identified. 4. No issues with delegate reports. QIPH is working with Compliance to ensure all delegate reports meet NCQA requirements. 5. No issues with delegate reports as well close out Q4.	No previous issues identified	Continue with quarterly review	☑ Yes ☐ No	In 2024, no identified issues with QI Delegated entities.
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

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Communications with
the Commissioners

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

December 31, 2024

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MOSSADAMS

Communications with the Commissioners

To the Commissioners

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (the Alliance) as of and for the year ended December 31, 2024, and have issued our report thereon dated April 25, 2025. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated October 20, 2022, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's internal control over financial reporting. Accordingly, we considered Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The required supplementary information and supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated October 20, 2022, and communicated to management on December 2, 2024.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission are described in Note 1 to the financial statements. During the year ended December 31, 2024, the Alliance adopted GASB Statement No. 101, *Compensated Absences*. There were no other changes in the application of existing policies during 2024. We noted no transactions entered into by the Alliance during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management's estimate of the liability for incurred but unreported claims expense is based on historical claims experience and known activity subsequent to year end. We evaluated the key factors and assumptions used to develop the incurred but unreported claims expense in determining that they are reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the capitation receivable and revenue for eligible program beneficiaries is based upon a historical experience methodology using contracted rates and member counts. We evaluated the key factors and assumptions used to develop the capitation receivable in determining that they are reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the fair market values of 401a plan investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.

- Management's estimates include key assumptions such as discount rates, useful lives, and contract terms for leases and subscription-based IT arrangements. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were related to medical claims liability and capitation revenue.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the Alliance's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the Alliance's financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. No such disagreements arose during the course of our audit.

*Circumstances that Affect the Form and Content of the A**uditor's** Report*

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected and uncorrected misstatements whose effects, as determined by management, were material, both individually or in the aggregate, to the financial statements taken as a whole

Management Representations

We have requested certain representations from management that are included in the management representation letter dated April 25, 2025.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Alliance's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Commissioners and management of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, and is not intended to be, and should not be, used by anyone other than these specified parties.

Moss Adams LLP

San Francisco, California
April 25, 2025

April 25, 2025

Moss Adams LLP
101 2nd Street, Suite 900
San Francisco, California, 94105

We are providing this letter in connection with your audits of the financial statements of Central California Alliance for Health (the "Alliance"), which comprise the statements of net position, statements of revenues, expenses, and changes in net position, cash flows, statements of fiduciary net position, and statements of changes in fiduciary net position as of December 31, 2024 and 2023 and for the years then ended, and the related notes to the financial statements, for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $3,750,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of April 25, 2025.

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated October 20, 2022, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.

2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

3. We acknowledge our responsibility for the design, implementation, and maintenance of internal controls to prevent and detect fraud.

4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

5. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.

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6. All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.

7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.

Information Provided

8. We have provided you with:

   a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation, and other matters;

   b. Minutes of the meetings of commissioners, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared;

   c. Additional information that you have requested from us for the purpose of the audit;

   d. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

9. All transactions have been properly recorded in the accounting records and are reflected in the financial statements.

10. We have retained copies of all information we provided to you during the engagement and have been provided copies of all necessary financial and non-financial schedules, memos, data, and other information related to all services performed by you, such that in our opinion our records are complete, including our records supporting our financial statements and all related accounting policies and positions. Furthermore, you do not act as the sole host of any financial or non-financial information system for us, nor do you provide any electronic security or back-up services for our data or records.

11. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

12. We have no knowledge of any fraud or suspected fraud that affects the entity and involves—

    a. Management,

    b. Employees who have significant roles in internal control, or

    c. Others when the fraud could have a material effect on the financial statements.

13. We have no knowledge of any allegations of fraud or suspected fraud affecting the entity's financial statements communicated by employees, former employees, analysts, regulators, or others.

14. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

15. We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the financial statements.

16. We have disclosed to you the identity of all the entity's related parties and all the related party relationships and transactions of which we are aware.

17. There are no—

    a. Violations or possible violations of laws or regulations, such as those related to the Medicare antifraud and abuse statutes, including but not limited to the Anti-Kickback Act, Limitations on Certain Physician Referrals (commonly referred to as the "Stark law"), and the False Claims Act, in any jurisdiction whose effects should be considered for disclosure in the financial statements or as basis for recording a loss contingency other than those disclosed or accrued in the financial statements.

    b. Possible illegal acts brought to the attention of management.

    c. Unasserted claims or assessments that our lawyer has advised us are probable of assertion and must be disclosed in accordance with GASB 62 section 1500, *Reporting Liabilities*, paragraph .114 and section C50, *Claims and Judgments*, paragraph .115.

    d. Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB 62 section 1500 paragraph .114 and section C50 paragraph .115.

18. The Alliance has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral, except as disclosed to you and reported in the financial statements.

19. The Alliance has complied with all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance.

20. The Alliance has been in compliance with the requirements of licensure under the Knox-Keene Health Care Service Plan act of 1975.

21. Capitation revenue as disclosed in Note 2 of the financial statements is fairly stated in accordance with GAAP.

22. We have complied with all restrictions on resources and all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance.

23. We have disclosed to you any change in the Alliance's internal control over financial reporting that occurred during the Alliance's most recent fiscal year that has materially affected, or is reasonably likely to materially affect, the Alliance's internal control over financial reporting.

24. We have responded fully and truthfully to all inquiries made to us by you during your audits.

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25. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the financial statements or on the disclosure in the notes to the financial statements.

26. We have made available to Moss Adams all known reviews, surveys and inquiries from Federal, State and local regulatory authorities completed or ongoing. We confirm that we are not aware of any non-compliance with laws and regulations.

27. No violations or possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements. This is including, but not limited to, the anti-kickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law), and the False Claims Act.

28. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning the investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.

29. We have appropriately reconciled our books and records (e.g., general ledger accounts) underlying the financial statements to their related supporting information (e.g. sub ledger or third-party data). All related reconciling items considered to be material were identified and included on the reconciliations and were appropriately adjusted in the financial statements. There were no material un-reconciled differences or material general ledger suspense account items that should have been adjusted or reclassified to another account balance. There were no material general ledger suspense account items written off to a statement of net position account, which should have been written off to an income statement account and vice versa.

30. Medical claims liability, including amounts for incurred but not reported claims and estimated recoveries for salvage and subrogation have been determined using appropriate estimated ultimate costs of settling the claims (including the effects of inflation and other societal and economic factors), considering past experience adjusted for current trends and any other factors that would modify past experience. The estimated liability is to the best of our knowledge and belief, an accurate estimate of our incurred but unreported health claims liability as of December 31, 2024 and 2023. The data used in projecting the ultimate unpaid claims and claims adjustment expense is complete and accurate, and is reconciled to the underlying accounting records.

31. Management has no knowledge of a large pool of impending claims outstanding at December 31, 2024 and 2023 that would materially affect the estimate for liability for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims.

32. All reinsurance transactions entered into by the Alliance are final and there are no side agreements with reinsurers, or other terms in effect, which allow for the modification of term under existing reinsurance arrangements. Furthermore, the Alliance's reinsurance arrangements meet the risk transfer provisions or are accounted for as deposits.

33. Pay for performance, provider incentive, withhold, capitation and other arrangements with providers wherein the Alliance is obligated to provide for a settlement of accounts with providers have been calculated in accordance with the existing arrangements and are included in the statement of net positions at net realizable value, giving consideration to all amounts due under arrangements. We believe provider incentives payable is fairly stated as of December 31, 2024 and 2023, respectively.

34. Board designated reserves have been approved by the Alliance's Board and is complete and accurate.

35. Financial instruments include cash and cash equivalents on deposit with financial institutions, the balances of which frequently exceed federally insured limits. If any of the financial institutions with whom the Alliance does business were placed into a receivership, the Alliance may be unable to access the cash on deposit with such institutions in order to operate its business without adverse effect.

36. The Alliance has accepted the following responsibilities related to the non-attest services provided related to the drafting the financial statements and related footnotes as of December 31, 2024 and 2023:

    a. Make all management decisions and perform all management functions.

    b. Designate an individual with suitable skill, knowledge, and / or experience to oversee the non-attest services.

    c. Evaluate the adequacy and results of the non-attest services performed.

    d. Accept responsibility for the results of the non-attest services performed.

    e. Establish and maintain internal controls including monitoring ongoing activities.

37. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by third-party organizations or other regulatory agencies.

38. We have the intent and ability to commit the necessary resources to become compliant with the laws and regulations contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") by the required compliance deadlines. We have no information that indicated that a significant vendor may be unable to sell to the Alliance; a significant customer may be unable to purchase from the Alliance; or a significant service provider may be unable to provide services to the Alliance, in each case because of their respective inability to comply with HIPAA.

39. We have reviewed all recently released accounting pronouncements and have evaluated those that may have an effect on the Alliance in the current and subsequent periods and disclosed as appropriate in the financial statements.

40. We are not aware of any reason that Moss Adams LLP would not be considered to be independent for purposes of the Alliance's audit.

41. To our knowledge, there are no instances where any officer or employee of the Alliance has an interest in a company with which the Alliance does business that would be considered a "conflict of interest." Such an interest would be contrary to the Alliance's policy.

42. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the financial statements of the Alliance are properly disclosed.

43. During the year ended December 31, 2024, the Alliance adopted GASB Statement No. 101, Compensated Absences. The adoption had no material impact to the Alliance's financial statements.

44. We have performed an analysis of expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under our contracts. We have determined that expected costs do not exceed anticipated revenues. Based on our analysis, we believe no premium deficiency reserves are necessary at December 31, 2024 and 2023, respectively.

45. We acknowledge our responsibility for presenting the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position, in accordance with accounting principles generally accepted in the United States of America and we believe the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position are measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.

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46. To the best of our knowledge and belief, as of December 31, 2024 and 2023, there are no liabilities associated with our contract with DHCS for the Adult Expansion, Medical Loss Ratio (MLR) corridor for the periods beyond June 30, 2017.

47. The Alliance recorded an estimated reduction in receivable and revenue for expected acuity adjustment liability. The DHCS informed managed care plans of an upcoming acuity adjustment factor, resulting from extension of the DHCS re-determination, which impacted rates due to lower acuity of population that may already have other health coverage and/or lower utilization. Management recorded an estimated liability of $29.1 million, as of December 31, 2024 and 2023

48. There have been no known or suspected breaches of sensitive information caused by cyber-attack or other means where the breach could have a material effect on the financial statements.

49. To the best of our knowledge and belief, no events have occurred subsequent to the balance sheet date and through the date of this letter that would require adjustment to or disclosure in the aforementioned financial statements.

DocuSigned by:
Lisa Ba
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Lisa Ba, CFO

DocuSigned by:

Jimmy Ho, Director of Accounting

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Report of Independent Auditors and
Financial Statements with Supplementary Information

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

December 31, 2024 and 2023

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Management's Discussion and Analysis

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Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Management's Discussion and Analysis
Years Ended December 31, 2024, 2023, and 2022

The intent of the management's discussion and analysis of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (the Alliance) is to provide readers with an overview of the Alliance's financial activities for the fiscal years ended December 31, 2024, 2023, and 2022. Readers should review this summation in conjunction with the Alliance's financial statements and accompanying notes to the financial statements to enhance their understanding of the Alliance's financial performance.

Key Operating Indicators – Proprietary Fund

The table below compares key operating indicators for the Alliance for the fiscal years 2024, 2023, and 2022:

Key operating indicators	Fiscal years ended December 31 2024	2023	2022	2024-2023 Change	2023-2022 Change
Members (at end of fiscal period)					
Medi-Cal program	442,498	405,325	415,668	37,173	(10,343)
IHSS program	693	697	654	(4)	43
Average member months					
Medi-Cal program	449,301	420,338	403,315	28,963	17,023
IHSS program	712	669	623	43	46
Total revenues (in millions)	$ 2,802.3	$ 2,132.4	$ 1,710.7	$ 669.9	$ 421.7
Capitation revenue (in millions)	$ 2,747.8	$ 2,085.9	$ 1,721.0	$ 661.9	$ 364.9
Capitation revenue, net of premium tax (in millions)	$ 1,996.8	$ 1,709.5	$ 1,546.4	$ 287.3	$ 163.1
Investment and other income (in millions)	$ 54.5	$ 46.5	$ (10.3)	$ 8.0	$ 56.8
Operating expenses (in millions)					
Medical expenses (in millions)	$ 1,861.1	$ 1,483.5	$ 1,358.9	$ 377.6	$ 124.6
Administrative expenses (in millions)	$ 107.1	$ 91.3	$ 82.4	$ 15.8	$ 8.9
Premium tax expenses (in millions)	$ 751.0	$ 376.4	$ 174.6	$ 374.6	$ 201.8
Increase in net assets (in millions)	$ 56.4	$ 168.0	$ 83.9	$ (111.6)	$ 84.1
Total revenues per member per month	$ 518.9	$ 422.1	$ 352.9	$ 96.8	$ 69.2
Operating expenses per member per month					
Medical expenses per member per month	$ 344.6	$ 293.6	$ 280.3	$ 51.0	$ 13.3
Administrative expenses per member per month	$ 19.8	$ 18.1	$ 17.0	$ 1.8	$ 1.1
Increase in net assets per member per month	$ 10.4	$ 33.3	$ 17.3	$ (22.8)	$ 15.9
Medical expenses as a percentage of capitation revenue	67.8 %	71.1 %	78.9 %	(3.30) %	(7.80) %
Medical expenses as a percentage of capitation revenue, net of MCO tax revenues	93.2 %	86.8 %	87.9 %	6.44 %	(1.10) %
Administrative expenses as a percentage of capitation revenue, net of MCO tax revenues	5.4 %	5.3 %	5.3 %	0.10 %	- %
Premium tax as a percentage of total revenues	26.8 %	17.7 %	10.2 %	9.10 %	7.50 %

Overview of the Financial Statements

This annual report consists of the basic financial statements of the business-type activities and the aggregate remaining fund information of the Alliance, and the related notes to those statements, which reflect the Alliance's financial position and results of its operations for the fiscal years ended December 31, 2024 and 2023. The basic financial statements of the Alliance, including the statements of net position, statements of revenues, expenses, and changes in net position, and statements of cash flows, represent the combined accounts and transactions of the two programs—Medi-Cal and the Alliance Care IHSS program—operated by the Alliance.

- The statements of net position include all of the Alliance's assets and liabilities, using the accrual basis of accounting, as well as an indication about which assets are utilized to fund obligations to providers and which are restricted or designated as a matter of the Alliance's board of directors' policy.

- The statements of revenues, expenses, and changes in net position present the results of operating and nonoperating activities during the respective fiscal years and the resulting decrease or increase in net position.

- The statements of cash flows report the net cash provided by operating activities, as well as other sources and uses of cash from investing and capital and noncapital related financing activities.

- The statements of fiduciary net position include all of the Alliance's assets and liabilities for the 401(a) Money Purchase Plan and Trust, using the accrual basis of accounting.

- The statements of changes in fiduciary net position, present the results of activities during the respective fiscal years and the resulting decrease or increase in fiduciary net position.

The following discussion and analysis address the Alliance's overall program activities. The Medi-Cal program accounted for approximately 99.8% of the Alliance's annual revenues during fiscal years 2024, 2023, and 2022.

Financial Highlights Fiscal Year 2024

- Total assets at year end were $1,867.1 million and exceeded liabilities by $891.2 million.

- Net position increased by $56.4 million or 6.8% during fiscal year 2024.

Financial Highlights Fiscal Year 2023

- Total assets at year-end were $1,629.7 million and exceeded liabilities by $834.7 million.

- Net position increased by $168.0 million or 25.2% during fiscal year 2023.

Condensed Statements of Net Position as of December 31 (dollars in thousands) are as follows:

Financial position	As of December 31			2024-2023 Change		2023-2022 Change	
	2024	2023	2022	Amount	Percentage	Amount	Percentage
Assets							
Current assets	$ 1,330,773	$ 1,167,011	$ 624,707	$ 163,762	14.0 %	$ 542,304	86.8 %
Capital assets, net	36,441	36,303	39,544	138	0.4	(3,241)	(8.2)
Board-designated investments and restricted deposit	483,572	413,502	384,662	70,070	16.9	28,840	7.5
Lease receivable - noncurrent	3,120	2,385	1,792	735	30.8	593	33.1
Subscription assets, net of accumulated amortization	13,214	10,510	4,680	2,704	25.7	5,830	100.0
Total assets	$ 1,867,120	$ 1,629,711	$ 1,055,385	$ 237,409	14.6 %	$ 574,326	54.4 %
Liabilities							
Current liabilities	$ 964,657	$ 786,427	$ 384,579	$ 178,230	22.7 %	$ 401,848	104.5 %
Subscription liabilities, net of current portion	7,386	5,578	1,642	1,808	32.4	3,936	100.0
Deferred inflow of resources	3,899	2,933	2,437	966	32.9	496	20.4
Total liabilities and deferred inflow of resources	975,942	794,938	388,658	181,004	22.8	406,280	104.5
Net position							
Invested in capital assets	36,441	36,303	39,544	138	0.4 %	(3,241)	(8.2) %
Restricted	304	300	300	4	1.3	-	-
Unrestricted	854,433	798,170	626,883	56,263	7.0	171,287	27.3
Total net position	891,178	834,773	666,727	56,405	6.8	168,046	25.2
Total liabilities and net position	$ 1,867,120	$ 1,629,711	$ 1,055,385	$ 237,409	14.6 %	$ 574,326	54.4 %

Capital Assets Fiscal Year 2024

Capital assets, net, increased from $36.3 million to $36.4 million, or by $0.1 million, in 2024 compared to the previous year. This increase is mainly the net result of $3.5 million in capital additions, and $3.3 million in depreciation expense. Capital additions are all included in construction in process, which was subsequently transferred and reflected in building improvements, software, and equipment.

Capital Assets Fiscal Year 2023

Capital assets, net decreased from $39.5 million to $36.3 million, or by $3.2 million, in 2023 compared to the previous year. This decrease is mainly the net result of $2.5 million in capital additions, $2.6 million of capital sale or disposal, and $3.1 million in depreciation expense. Capital additions are all included in construction in process, which was subsequently transferred and reflected in building additions and in furniture and equipment.

Liquidity Fiscal Year 2024

At December 31, 2024, the Alliance maintained a working capital ratio, including board-designated investments, of 1.88. The increase of $55.6 million in working capital in 2024 compared to the prior year is primarily due to the change in net position.

During 2024, board-designated investments increased by $70.1 million from the prior year. The increase is due to a slight increase in revenues and noncapitated revenues are excluded from board-designated reserve calculation.

Liquidity Fiscal Year 2023

At December 31, 2023, the Alliance maintained a working capital ratio, including board-designated investments, of 2.01. The increase of $169.3 million in working capital in 2023 compared to the prior year is primarily due to the change in net position.

During 2023, board-designated investments increased by $28.9 million from the prior year. The increase is due to a slight increase in revenues and noncapitated revenues are excluded from board-designated reserve calculation.

Results of Operations

The Alliance's fiscal year 2024 operations resulted in a $56.4 million increase in net position compared to a $168.0 million increase in net position in fiscal year 2023. The Alliance's fiscal year 2022 operations resulted in a $83.9 million increase in net position.

The following table shows revenues, expenses, and changes in net position for the three most recent years:

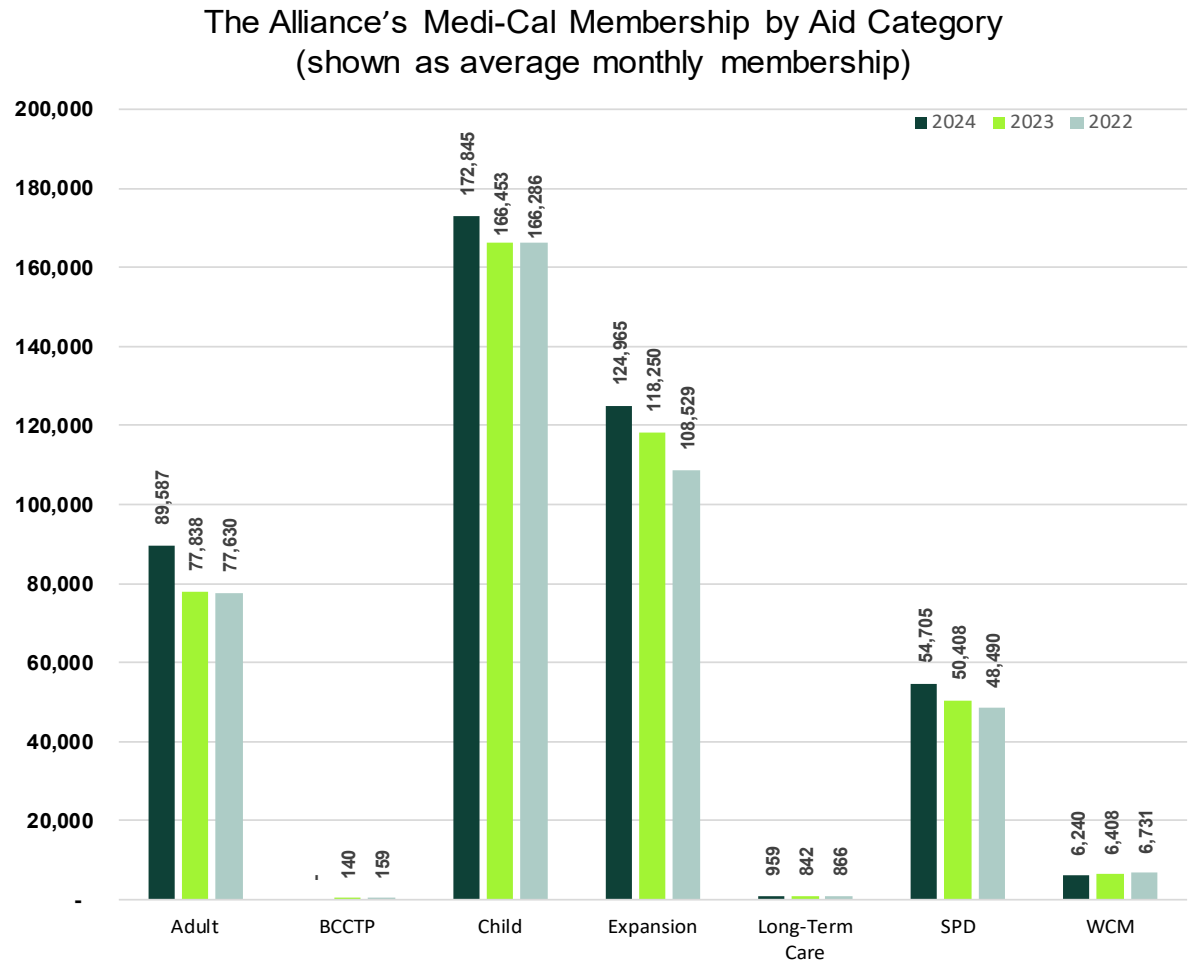
Condensed revenues, expenses, and changes in net position for the years ended (in thousands):

Results of operations	2024	2023	2022	2024-2023 Change		2023-2022 Change	
				Amount	Percentage	Amount	Percentage
Capitation revenue, investment (loss) income, including net realized and unrealized gains and losses, and other income	$ 2,802,273	$ 2,132,397	$ 1,710,652	$ 669,876	31.4 %	$ 421,745	24.7 %
Expenses							
Total medical expenses	1,861,068	1,483,504	1,358,877	377,564	25.5	124,627	9.2
Total administrative expenses	107,143	91,259	82,444	15,884	17.4	8,815	10.7
Premium tax expense	750,982	376,406	174,563	374,576	99.5	201,843	115.6
Grants	26,675	13,182	10,834	13,493	102.4	2,348	21.7
Total expenses	2,745,868	1,964,351	1,626,718	781,517	39.8	337,633	20.8
Increase in net position	56,405	168,046	83,934	(111,641)	(66.4)	84,112	100.2
Net position, beginning of year	834,773	666,727	582,793	168,046	25.2	83,934	14.4
Net position, end of year	$ 891,178	$ 834,773	$ 666,727	$ 56,405	6.8 %	$ 168,046	25.2 %

Enrollment

During fiscal 2024, the Alliance served an average of 450,013 members per month compared to an average of 421,007 members per month in 2023. The Public Health Emergency (PHE) declaration officially ended on May 11, 2023. Disenrollment was lower than forecast, resulting in a higher average member month compared to the prior year. The Alliance also expanded into Mariposa and San Benito Counties. During fiscal 2023, the Alliance served an average of 421,007 members per month compared to an average of 403,940 members per month in 2022. This increase in membership is primarily due to the PHE declaration.

The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2024, 2023, and 2022:



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Operating Revenues Fiscal Year 2024

Revenues in 2024 increased over 2023. Revenue increased despite the PHE period which ended in May of 2023. The increase in Medi-Cal membership was due to redeterminations and the expansion into San Benito and Mariposa counties.

Operating Revenues Fiscal Year 2023

Revenues in 2023 increased over 2022. Revenue increased despite the PHE period which ended in May of 2023. The decrease in Medi-Cal membership was lower than anticipated from the redeterminations, offset by increases in capitation rates from the DHCS.

Medical Expenses Fiscal Year 2024

Overall, medical expenses increased by 25.5% in 2024, totaling $1,861.2 million compared to $1,483.5 million in 2023. The Alliance's medical expenses, as a percentage of capitation revenues, was 67.7% in fiscal year 2024, compared to 71.1% in fiscal year 2023. Managed Care Organization (MCO) tax revenues, which increased in fiscal year 2024 compared to fiscal year 2023, are included in capitation revenue, resulting in lower medical expenses to capitation revenue percentages. The Alliance's medical expenses, as a percentage of capitation revenues, net of MCO tax revenues, was 93.2% in fiscal year 2024, compared to 86.8% in fiscal year 2023. The Alliance's average medical costs per member per month increased by 17.4% in 2024. Medical expenses include the following:

- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $111.9 million in 2023 compared to $51.8 million in 2023. The increased cost is attributable to increased enrollment and utilization of ECM benefits.

- Hospital inpatient and long-term care expenses increased by $84.1 million, or 12.4%, in 2024. The increased cost of care was due to enrollment increases and higher utilization.

- Expenses related to physicians, outpatient facilities, and allied health providers increased by $216.2 million, or 33.8%, in 2024. Most of the increase was due to membership increases and acuity.

- Other medical increased by $11.6 million, or 10.6% in 2024 primarily due to the ramp up of medical allocation invoices received for the preparation of the DNSP line of business and bringing behavioral health services in-house. Additionally, there was an increase in medical salaries and temp services allocated to medical costs for DSNP and behavioral health.

- Alliance Care IHSS program expenses increased by $0.5 million. The increase was due to an increase in membership.

- Net reinsurance expense increased by $5.1 million compared to 2023 due to a decrease in recoveries as well as an increase in premiums.

Medical Expenses Fiscal Year 2023

Overall, medical expenses increased by 9.2% in 2023, totaling $1,483.5 million compared to $1,358.9 million in 2022. The Alliance's medical expenses, as a percentage of capitation revenues, was 71.1% in fiscal year 2023, compared to 78.9% in fiscal year 2022. The Alliance's medical expenses, as a percentage of capitation revenues, net of MCO tax revenues, was 86.8% in fiscal year 2023, compared to 87.9% in fiscal year 2022. The Alliance's average medical costs per member per month increased by 4.7% in 2023. Medical expenses include the following:

- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $51.8 million in 2023 compared to $43.3 million in 2022. The increased cost is attributable to a small increase in membership.

- Hospital inpatient and long-term care expenses decreased by $8.9 million, or 1.3%, in 2023. The decreased cost of care was due to enrollment increases offset by delays in the state's redetermination processes, and lower utilization.

- Expenses related to physicians, outpatient facilities, and allied health providers increased by $129.6 million, or 26.4%, in 2023. Most of the increase was due to membership increases and acuity.

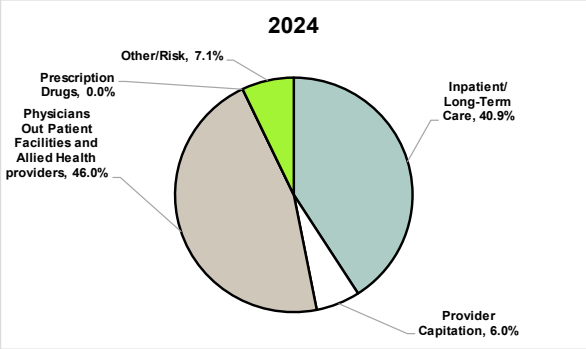
- Other medical increased by $59.8 million or 121% in 2023 primarily due to the State Incentive programs of $39 million and internal Care Based Incentive program of $15 million. In addition, there was also hospital quality incentives increase of $5 million.

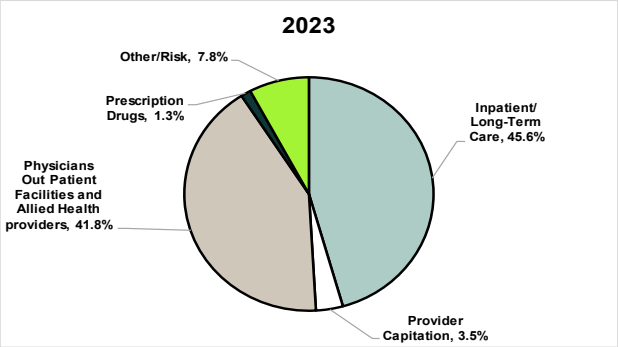
- Prescription drugs expenses increased by $3.5 million or 23.2% during 2023. The increase was related to Physician Admin Drugs, which is not part of the pharmacy carve out to the State.

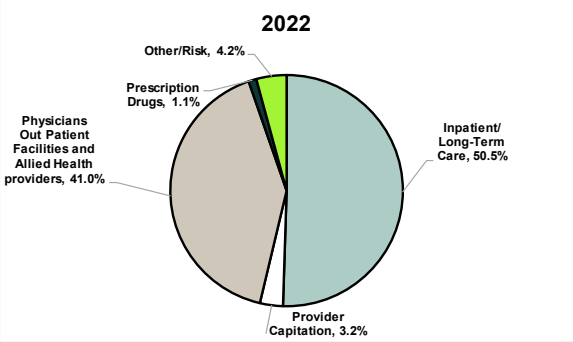
- Alliance Care IHSS program expenses increased by $0.6 million. The increase was due to an increase in membership.

- Net reinsurance expense decreased by $2.5 million compared to 2022 due to a decrease in recoveries as well as an increase in premiums.

Below is a side-by-side comparison of medical expenses by major category and their respective percentages of the overall medical expenses in fiscal years 2024, 2023, and 2022:







Administrative Expenses Fiscal Year 2024

Total administrative expenses were $107.0 million in 2024 compared to $91.3 million in 2023, for a net increase of $15.9 million or 17.4%. This increase is primarily due to increases in salaries and benefits expenses. Supplies, occupancy, insurance, and other increased $4.5 million or 60.4% compared to $7.4 million in 2023. In 2024 salaries and benefits expenses were $70.2 million, an increase of $6.8 million compared to 2023. Overall, professional fees, purchased services, and depreciation increased $4.6 million or 22.4% in 2024.

Administrative Expenses Fiscal Year 2023

Total administrative expenses were $91.3 million in 2023 compared to $82.4 million in 2022, for a net increase of $8.8 million or 10.7%. This increase is primarily due to salaries and benefits expenses Supplies, occupancy, insurance and other decreased $1.5 million or 16.8%, compared to $8.9 million in 2022. In 2023 salaries and benefits expenses were $63.4 million, an increase of $7.1 million compared to 2022. Overall, professional fees, purchased services and depreciation increased $3.3 million or 19.0% in 2023. Purchased services expenses and consulting costs were up in 2023, offset by reductions in legal fees.

Premium taxes

Premium taxes were $751.0 million in 2024, compared to $376.4 million in 2023. In 2022, premium taxes were $174.6 million. The increase is primarily due to the modified tax structure approved for the premium tax due to the Department of Health Care Services (DHCS) for 2024.

Economic Factors

Potential legislative changes to Medi-Cal or the ACA could impact membership and revenue. In January 2024, the Alliance officially expanded into two new counties, San Benito and Mariposa, which added new membership and revenue for the calendar year. The additional membership from the two new counties helps offset the decrease in membership from the unwinding period of the redetermination. The Plan is working on other initiatives such as Behavioral Health In-house by July 2025, Quality and Health Equity in the new expansion counties, National Committee for Quality Assurance (NCQA) Accreditations, and Medicare (Dual-Eligible Special Needs Plan) D-SNP by January 2026. The initial capital and staffing costs to implement these initiatives and increased medical costs will likely impact the bottom line in the coming years.

Although management believes the Plan is well-positioned to meet its obligations, it is important to note that information significantly contradicting the going concern assumption would include scenarios such as an inability to continue meeting obligations as they become due without substantial asset dispositions outside the ordinary course of operations, restructuring of debt, or reliance on fiscal oversight bodies. While no such indicators are currently present, the Plan remains vigilant in identifying and addressing potential threats to its financial health. These considerations are actively integrated into the Plan's long-term financial strategy to support continued sustainability and mission fulfillment.

FINANCIAL HIGHLIGHTS – FIDUCIARY FUND

The table below is a summarized comparison of the assets, liabilities, and fiduciary net position of Central California Alliance for Health 401a Qualified Retirement Plan as of December 31, and the changes in fiduciary net position for the years ended December 31 (in thousands):

	2024	2023	2022
Total assets	$ 65,677	$ 57,806	$ 52,893
Total liabilities	-	-	-
Total fiduciary net position	$ 65,677	$ 57,806	$ 52,893
Total additions, net	$ 13,146	$ 12,850	$ 11,206
Total deductions	5,275	1,840	1,469
Increase in fiduciary net position	7,871	11,010	9,737
Fiduciary net position, beginning of year	57,806	46,796	43,156
Fiduciary net position, end of year	$ 65,677	$ 57,806	$ 52,893

Total fiduciary fund net position as of December 31, 2024, increased by $7.88 million from December 31, 2023, due to an increase in fair value of investments and contributions. Total fiduciary fund net position as of December 31, 2023, increased by $11.0 million from December 31, 2022, due to an increase in fair value of investments and contributions.

MOSSADAMS

Report of Independent Auditors

The Commissioners
Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission as of and for the years ended December 31, 2024 and 2023, and the related notes to the financial statements, which collectively comprise Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements present fairly, in all material respects, the respective financial position of the business-type activities and aggregate remaining fund information of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission as of December 31, 2024 and 2023, and the respective changes in net position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

***Auditor's** Responsibilities for the Audit of the Financial Statements*

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audits were conducted for the purpose of forming an opinion on the financial statements that comprise the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's basic financial statements. The supplementary schedules of revenues and expenses by program and changes in net position for the years ended December 31, 2024 and 2023, are presented for purposes of additional analysis and are not a required part of the basic financial statements. The supplementary schedules of revenues and expenses by program and changes in net position are the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary schedules of revenues and expenses by program and changes in net position for the years ended December 31, 2024 and 2023, are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

San Francisco, California
April 25, 2025

Financial Statements

Back to Agenda

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Statements of Net Position
December 31, 2024 and 2023
(in Thousands)

	2024	2023
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 14,209	$ 21,770
Short-term investments	857,436	615,943
Capitation receivable from the Department of Health Care Services (DHCS)	446,834	515,011
Prepaid expenses and other assets	11,281	13,588
Lease receivable, current	1,013	699
Total current assets	1,330,773	1,167,011
CAPITAL ASSETS, net		
Nondepreciable	5,627	6,070
Depreciable, net of accumulated depreciation and amortization	30,814	30,233
Capital assets, net	36,441	36,303
SUBSCRIPTION ASSETS, net of accumulated amortization	13,214	10,510
LEASE RECEIVABLE, noncurrent	3,120	2,385
BOARD-DESIGNATED INVESTMENTS	483,268	413,202
RESTRICTED DEPOSITS	304	300
Total assets	$ 1,867,120	$ 1,629,711

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Statements of Net Position
December 31, 2024 and 2023
(in Thousands)

	2024	2023
LIABILITIES, DEFERRED INFLOW OF RESOURCES, AND NET POSITION		
CURRENT LIABILITIES		
Medical claims liability	$ 402,758	$ 288,373
Voluntary rate range program payable	74,434	-
Provider incentives payable	43,459	40,000
Subscription liabilities, current portion	3,204	3,109
Accounts payable	8,763	7,912
Accrued liabilities	432,039	447,033
Total current liabilities	964,657	786,427
Subscription liabilities, net of current portion	7,386	5,578
Deferred inflow of resources	3,899	2,933
NET POSITION		
Invested in capital assets	36,441	36,303
Restricted	304	300
Unrestricted	854,433	798,170
Total net position	891,178	834,773
Total liabilities, deferred inflow of resources, and net position	$ 1,867,120	$ 1,629,711

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2024 and 2023
(in Thousands)

	2024	2023
OPERATING REVENUES		
Capitation revenue	$ 2,747,769	$ 2,085,911
OPERATING EXPENSES		
Medical expenses		
Medi-Cal		
Provider capitation	111,862	51,838
Claim payments to providers	1,616,492	1,316,137
Other medical	120,513	108,957
Alliance Care: In Home Supportive Services (IHSS) program	4,900	4,326
Reinsurance and other, net	7,301	2,246
Total medical expenses	1,861,068	1,483,504
Administrative expenses		
Salaries, wages, and employee benefits	70,222	63,405
Supplies, occupancy, insurance, and other	11,936	7,441
Professional fees	4,267	3,233
Depreciation and amortization	8,752	6,467
Purchased services	11,966	10,713
Total administrative expenses	107,143	91,259
Premium tax expense	750,982	376,406
Total operating expenses	2,719,193	1,951,169
Operating income	28,576	134,742
INVESTMENT INCOME, INCLUDING NET REALIZED AND UNREALIZED GAINS AND LOSSES	52,118	44,560
OTHER INCOME	2,386	1,926
GRANTS	(26,675)	(13,182)
INCREASE IN NET POSITION	56,405	168,046
NET POSITION, beginning of year	834,773	666,727
NET POSITION, end of year	$ 891,178	$ 834,773

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Statements of Cash Flows
Years Ended December 31, 2024 and 2023
(in Thousands)

	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation and other revenue	$ 3,492,206	$ 2,211,787
Payments to providers	(2,323,703)	(1,896,619)
Payments to vendors	(811,978)	(45,580)
Payments to employees	(67,885)	(61,487)
Net cash from operating activities	288,640	208,101
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(3,528)	(2,493)
Proceeds from sale of capital assets	-	3,015
Payments on subscription liabilities	(4,013)	(2,221)
Net cash from capital and related financing activities	(7,541)	(1,699)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITY		
Grants	(26,675)	(13,182)
Net cash from noncapital financing activity	(26,675)	(13,182)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of investments	(331,421)	(209,082)
Proceeds from sales of investments	69,436	24,546
Net cash from investing activities	(261,985)	(184,536)
NET CHANGES IN CASH AND CASH EQUIVALENTS	(7,561)	8,684
CASH AND CASH EQUIVALENTS, beginning of year	21,770	13,086
CASH AND CASH EQUIVALENTS, end of year	$ 14,209	$ 21,770

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Statements of Cash Flows
Years Ended December 31, 2024 and 2023
(in Thousands)

	2024	2023
RECONCILIATION OF INCREASE IN NET POSITION TO NET CASH FROM OPERATING ACTIVITIES		
Increase in net position	$ 56,405	$ 168,046
Adjustments to reconcile increase in net position to net cash from operating activities		
Depreciation and amortization	8,752	6,467
Investment income	(52,118)	(44,560)
Gain on disposal of capital assets	-	(369)
Grants	26,675	13,182
Changes in assets and liabilities		
Capitation receivable from the DHCS	68,176	(317,736)
Prepaid expenses and other assets	4,850	6,893
Subscription assets/liabilities	(2,254)	(2,165)
Medical claims liability	114,932	5,613
Voluntary rate range program payable	73,886	391
Provider incentives payable	3,459	30,000
Accounts payable	955	4,497
Accrued liabilities	(15,078)	337,842
Net cash from operating activities	$ 288,640	$ 208,101
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING AND FINANCING ACTIVITIES		
Noncash acquisition of subscription assets	$ 2,255	$ 7,045

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Statements of Fiduciary Net Position
As of December 31, 2024 and 2023
(in Thousands)

	2024	2023
ASSETS		
Investments, at fair value		
Stable value/cash management	$ 6,854	$ 6,755
Bond	1,379	1,740
Guaranteed lifetime income	290	420
Balanced/asset allocation	42,054	35,103
U.S. stock	9,970	9,037
International/global stock	1,805	1,658
Specialty	1,385	1,569
Total investments, at fair value	63,737	56,282
Receivables		
Notes receivable from participants	1,940	1,524
Total receivables	1,940	1,524
NET POSITION AVAILABLE FOR BENEFITS	$ 65,677	$ 57,806

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2024 and 2023
(in Thousands)

	2024	2023
ADDITIONS TO NET POSITION ATTRIBUTED TO INVESTMENT INCOME		
Net appreciation in fair value of investments	$ 7,113	$ 7,456
Total investment income	7,113	7,456
Interest income on notes receivable from participants	102	52
Contributions		
Employer and employee contributions	5,931	5,207
Rollover contributions	-	135
Total contributions	5,931	5,342
Total additions, net	13,146	12,850
DEDUCTIONS FROM NET POSITION ATTRIBUTED TO		
Benefits paid to participants	5,341	1,878
Miscellaneous credits	(66)	(38)
Total deductions	5,275	1,840
INCREASE IN NET POSITION	7,871	11,010
NET POSITION AVAILABLE FOR BENEFITS, beginning of year	57,806	46,796
NET POSITION AVAILABLE FOR BENEFITS, end of year	$ 65,677	$ 57,806

See accompanying notes.

Note 1 – Organization

The Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (the Alliance) is a Regional County Organized Health System serving Medi-Cal eligible persons in Santa Cruz, Monterey, Merced Counties, San Benito and Mariposa California (the Counties). The Alliance is a local public agency separate and distinct from the respective county governments. The Alliance began serving enrollees in Santa Cruz County, expanded the Alliance's services into Monterey County, and expanded again into Merced County. In 2024, service expanded into San Benito and Mariposa counties.

The Alliance has contracted with the California Department of Health Care Services (DHCS) to provide healthcare benefits to eligible County residents. In turn, the Alliance has contracted with various healthcare providers to provide or arrange hospital and medical services for its members. The Alliance's contract with DHCS extends through December 31, 2024, subject to annual renewals. Previous to the convening of the new board, the contract with DHCS was with the Santa Cruz-Monterey-Merced Managed Medical Care Commission. Subsequent to the convening of the new board, the contract with DHCS is with the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission.

The Alliance, in partnership with Monterey County In Home Supportive Services (IHSS) Public Authority, operates the Alliance Care IHSS program. Alliance Care IHSS provides comprehensive healthcare to IHSS caregivers in Monterey County.

The Medi-Cal program accounted for approximately 99.8% of the Alliance's revenues for the years ended December 31, 2024 and 2023.

The Alliance sponsors a 401(a) Money Purchase Plan and Trust (the Plan), which is a defined-contribution plan covering all of its employees. The Alliance also sponsors a voluntary 457 deferred compensation plan. See Note 7.

Note 2 – Summary of Significant Accounting Policies

Basis of presentation – The Alliance is a locally governed and operated public health plan governed by the 18-member Santa Cruz-Monterey-Merced-San Benito-Mariposa-Managed Medical Care Commission Board. The Alliance has no component units and is not reported as a component unit of any governmental entity.

Accounting standards – The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB). The activities of the Alliance are reported using the economic resources measurement focus and the accrual basis of accounting. Under this method, revenues are recorded when earned and expenses are recorded when the related liability is incurred. As permitted by GASB Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, the Alliance has elected to apply all Financial Accounting Standards Board Statements and Interpretations, Accounting Principles Board Opinions, and Accounting Research Bulletins issued after November 30, 1989, which have been codified under Accounting Standards Codification (ASC), except for those that conflict with or contradict GASB pronouncements.

Statements of net position – Net position is required to be classified for accounting and reporting purposes in the following categories:

Invested in capital assets – This component of net position consists of capital assets including capital assets, net of accumulated depreciation and amortization and reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of external constraints placed on net position by law. It also pertains to constraints imposed by constitutional provisions or enabling legislation.

Unrestricted – This component of net position consists of net position that do not meet the definition of "restricted" or "invested in capital assets." A portion of the unrestricted net position is board designated.

Use of estimates – The preparation of financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Significant items subject to estimates include claims incurred but not reported, which is reported in medical claims liability.

Cash and cash equivalents – The Alliance considers all highly liquid instruments purchased with an original maturity of three months or less to be cash equivalents.

Investments – The Alliance adopted GASB Statement No. 72, *Fair Value Measurement and Application* (GASB 72), effective January 1, 2016. GASB 72 requires the Alliance to use valuation techniques which are appropriate under the circumstances and are consistent with the market approach, the cost approach, or the income approach. GASB 72 establishes a hierarchy of inputs used to measure fair value consisting of three levels. Level 1 inputs are quoted prices in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. Level 3 inputs are unobservable inputs.

The Alliance adheres to the disclosure requirements of GASB Statement No. 40, *Deposits and Investment Risk Disclosures—An Amendment of GASB Statement No. 3 Deposits with Financial Institutions, Investments (including Repurchase Agreements and Reverse Repurchase Agreements)*.

Investments are stated at fair value in accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*. The fair value of investments is estimated based on quoted market prices for these or similar investments.

Capital assets – Capital assets are stated at cost. Significant additions, replacements, major repairs, and renovations to infrastructure and buildings and furniture, software, and equipment are capitalized if the cost exceeds $10,000 and a useful life of at least three years. The expenses of normal maintenance, repairs, and minor replacements are charged to operations when incurred.

Depreciation and amortization is calculated on a straight-line basis over the estimated lives of the assets, which are summarized as follows:

Building	39 years
Building equipment	5–15 years
Furniture and equipment	3–5 years
Software	3–5 years

The Alliance evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Lease receivable and deferred inflow of resources – Pursuant to GASB Statement No. 87, *Leases*, the Alliance as a lessor, recognized a lease receivable and a deferred inflow of resources in the statements of net position. A lease receivable represents the present value of future lease payments expected to be received by the Alliance during the lease terms. A deferred inflow of resources is recognized corresponding to the lease receivable amount and is defined as an acquisition of net position by the Alliance that is applicable to future reporting periods. Amortization of the deferred inflow of resources is based on the straight-line method over the terms of the leases.

The Alliance recognizes lease contracts or equivalents that have a term exceeding one year and the annual receipts on the contract exceed $25,000 for equipment and $75,000 for real estate that meet the definition of other than short-term lease. The Alliance uses the same interest rate it charges to lessee as the discount rate or that is implicit in the contract to the lessee. Short-term lease receipts and variable lease receipts not included in the measurement of the lease receivable are recognized as income when earned.

Subscription assets and liabilities – The Alliance has recorded subscription assets as a result of implementing GASB Statement No. 96, *Subscription-Based Information Technology Arrangements* (GASB 96). The subscription assets are initially measured at an amount equal to the initial measurement of the related subscription liability plus any contract payments made to the Subscription-Based Information Technology Arrangements (SBITA) vendor at the commencement of the subscription term, capitalizable initial implementation costs, less any incentive payments received from the SBITA vendor at the commencement of the subscription term. The subscription assets are amortized on a straight-line basis over the shorter of the subscription term or the useful life of the underlying assets.

The Alliance entered into various agreements for IT subscriptions. These agreements range with terms extending through 2029. Total lease payments were $5.3 million and $4.5 million for fiscal years 2024 and 2023, respectively. Variable payments based upon the use of the underlying IT asset are not included in the subscription liability because they are not fixed in substance—therefore, these payments are not included in subscription assets or subscription liabilities. The Alliance did not enter into any additional subscription agreements that have yet to commence as of December 31, 2024.

The following is a summary of changes in subscription liabilities, net for the years ended December 31 (in thousands):

2024	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
	$ 8,687	$ 5,916	$ 4,013	$ 10,590	$ 3,204

2023	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
	$ 3,863	$ 7,045	$ 2,221	$ 8,687	$ 3,109

Board-designated investments – The Board designated the establishment of certain reserve funds for contingencies. The desired balance for this fund is three times the average of monthly premium capitation revenue. As of December 31, 2024 and 2023, the Alliance had accumulated board-designated investments of $483.3 million and $413.2 million, respectively.

Medical claims liability – The Alliance establishes a medical claims liability based on estimates of the ultimate cost of claims in process and provision for claims incurred but not yet reported, which is determined based on historical claims payment experience and other statistics. Such reserves are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known; such adjustments are included in operations. Although considerable variability is inherent in such estimates, management believes that the medical claims liability is adequate and fairly stated; however, this liability is based on estimates and the ultimate liability may differ from the amount provided.

Also included in medical claims liability in the statements of net position are as follows at December 31 (in thousands):

	2024	2023
Proposition (Prop) 56 liability	$ 16,490	$ 57,330
Targeted Rate Increases (TRI) liability	66,418	-
State incentive liability	55,280	30,362
Other program payable	2,785	3,704
Medical claims liability	261,785	196,977
Total	$ 402,758	$ 288,373

Proposition 56 liability – Assembly Bill 120 appropriated Proposition 56 funds in the 2017-18 state fiscal year for specified DHCS supplemental payment expenditures. DHCS developed supplemental payment methodologies that the Alliance is required to execute. The liability was $16.5 million in 2024 compared to $57.3 million in 2023.

TRI liability – Pursuant to Welfare & Institutions Code Section 14105.201 (added by AB 118) DHCS developed primary care, obstetric, and non-specialty mental health services targeted provider rate increases (TRI) for providers in Medi-Cal effective for dates of service on or after January 1, 2024. These rate increases will apply to eligible providers in the Fee-For-Service delivery system, as well as eligible network providers contracted with Medi-Cal managed care plans through a minimum fee schedule directed payment. The liability was $66.4 million for 2024.

State incentive liability – In 2023 and 2022, DHCS implemented several State sponsored incentive programs related to behavior health integration, COVID vaccines, student behavior health, enhanced care management, community supports, and housing and homelessness. In 2024 and 2023, $43.3 million and $39 million, respectively, in incentive expense, was recognized. Outstanding liability as of December 31, 2024 and 2023 was $55.3 million and $30.4 million, respectively, as included in medical claims liability in the statements of net position.

Voluntary rate range program payable – The Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164 and 14301.4, provides a mechanism for public entities to use voluntary Intergovernmental Transfer (IGT) agreements to finance the non-federal share of the difference between the lower and upper bounds of Medi-Cal Managed Care Plans' (MCP) actuarially sound rate ranges, as determined by the DHCS. Governmental funding entities that are eligible in accordance with W&I Code section 14164 may voluntarily transfer funds to DHCS for use in this program. These funds, together with the applicable Federal Financial Participation, will be paid by DHCS to MCPs as part of the capitation rates. Funds are to be paid out to participating providers within 30 days of receipt from MCP. For 2024, $74.4 million in revenue was received and recorded in voluntary rate range program payable, and paid out in January of 2025.

Provider incentives – Under the terms of its provider agreements, the Alliance has agreed to incentive arrangements in the Medi-Cal line of business. All Primary Care Providers (PCP) incentive budgets are paid through the Care Based Incentives (CBI) program. For 2024, the Board allocated $15 million to the PCP Medi-Cal Program CBI incentive budget. During the years ended December 31, 2024 and 2023, $15.0 million and $15.0 million were paid out for CBI, respectively. For 2024, the Board allocated $10 million for Specialist Care Incentive (SCI) program. During the year ended December 31, 2024 $10 million was paid out of SCI. Additionally, for 2024 the Board allocated $18 million for a Hospital Quality Incentive Program (HQIP), and $4 million for a Data Sharing Incentive program. Accrued annual incentive program as of December 31, 2024 and 2023 was $43.5 million and $40.0 million, as included in provider incentives payable in the statements of net position.

Accrued liabilities – included in accrued liabilities on the statements of net position are the following at December 31 (in thousands):

	2024	2023
Managed Care Organization (MCO) tax liability	$ 374,576	$ 397,867
Acuity adjustment liability	29,177	29,177
Other accrued liabilities	11,616	9,288
Risk corridor reserves	16,670	10,701
Total	$ 432,039	$ 447,033

MCO tax liability – Effective July 1, 2013 until June 30, 2016, Senate Bill 78 added Revenue and Taxation Code Article 5 to impose a 3.9375% sales tax on sellers of Medi-Cal health care services subject to DHCS providing capitation payments that make the Alliance actuarially sound. In 2016, California's Senate Bill X2.2 enacted a new MCO tax, effective for a taxing period of July 1, 2016, through June 30, 2019. The approved tax structure is based upon enrollment between specified tiers that are assessed different tax rates. On April 3, 2020, the Centers for Medicare & Medicaid Services (CMS) approved a waiver for the broad-based and uniformity requirements related to the State of California's MCO tax, effectively renewing the program effective January 1, 2020, through December 31, 2022. On June 29, 2023, AB 119 (Chapter 13, Statutes of 2023) reimposed the MCO premium tax effective April 1, 2023, through December 31, 2026. The premium tax expense totaled $751.0 million and $376.4 million for the years ended December 31, 2024 and 2023, respectively.

Risk corridor reserves – The DHCS has implemented comprehensive risk corridor protections for Medi-Cal managed care plans in 2024, which include: (1) coverage for the Unsatisfactory Immigration Status (UIS) population across most counties, with enhanced protections for San Benito County's transition to mandatory enrollment; (2) adjustments for San Benito County's shift from voluntary to mandatory managed care; and (3) safeguards for Enhanced Care Management (ECM) services under the CalAIM initiative. These risk-sharing mechanisms use predefined thresholds to reconcile actual costs against projected capitation rates, through a two-sided risk corridor utilizing actual expenditures experienced. The corridors serve as temporary financial safeguards during periods of significant system transformation, with adjustments made through subsequent expenditure reconciliations. Management recorded a combined estimated liability for these risk corridors of $16.7 million and $10.7 million as of December 31, 2024 and 2023, respectively.

Acuity adjustment liability – DHCS informed managed care plans of an upcoming acuity adjustment factor, resulting from extension of the DHCS re-determination, which impacted rates due to lower acuity of population that may already have other health coverage and/or lower utilization. Management recorded an estimated liability of $29.1 million as of December 31, 2024 and 2023.

Premium deficiencies – The Alliance performs periodic analyses of its expected future medical expenses and maintenance expenses to determine whether such expenses will exceed anticipated future revenues under its contracts. Should expected expenses exceed anticipated revenues, a premium deficiency reserve is recorded. No premium deficiency reserve was needed at December 31, 2024 and 2023.

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Statements of revenues, expenses, and changes in net position – For purposes of display, transactions deemed by management to be ongoing, major, or central to the serving of their members in Santa Cruz, Monterey, and Merced Counties are reported as operating revenues and expenses. Peripheral or incidental transactions are reported as nonoperating revenues and expenses. These peripheral activities include investment income, changes in unrealized gains and losses on investments, and grant expenditures.

Revenue recognition – Revenue is recognized in the month in which the members are entitled to healthcare services. Capitation revenue is received from DHCS each month following the month of service based on estimated enrollment and capitation rates as provided for in the DHCS contract. Eligibility of beneficiaries is determined by the Counties of Merced, Monterey, and Santa Cruz and validated by the State. The State provides the Alliance the validated monthly eligibility file in support of capitation revenue for the month. Further, the Alliance receives monthly reconciliations reflecting retrospective enrollment amounts from DHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to DHCS for these retrospective adjustments. These estimates are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known; such adjustments are included in operations.

Eligibility for the Alliance Care IHSS program is determined by Monterey County IHSS Public Agency. A list of covered members is provided to the Alliance each month by the County of Monterey. Premiums are paid by the County to the Alliance in the month coverage is provided. Retroactive additions or deletions are not allowed under the agreement.

Grants – In December 2014, the Alliance Board approved $116.7 million in grant funding. An additional $106.3 million was approved in October 2016. The purpose of the grant program is to further the Alliance's mission by increasing member access to quality healthcare through strategic planning, program development, and responsive Medi-Cal capacity investments. In 2016, the grant program became fully operational. Grant expenditures are classified as nonoperating. For the years ended December 31, 2024 and 2023, a total of $26.7 million and $13.2 million, respectively, had been expended by the Alliance under this program.

Risk management – The Alliance is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Alliance carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Alliance's commercial coverage.

Medical reinsurance (stop-loss insurance) – The Alliance has entered into a reinsurance (stop-loss) agreement with a third party to limit its losses. Under the terms of the agreement, the third party will reimburse the Alliance certain proportions of claims in excess of specified deductibles ($350,000 for 2024 and 2023) for all lines of business for inpatient claims, which include hospital, sub-acute, skilled nursing, long-term care, and durable medical equipment, implants, orthopedics and prosthesis, limited to $1,000,000 in aggregate over all contract years per member. Stop-loss insurance premiums of $12.1 million and $11.6 million are included in reinsurance and other expense in 2024 and 2023, respectively. In 2024 and 2023, there is a total of $4.8 million and $9.6 million, respectively, in recoveries.

Professional liability insurance –The Alliance maintains insurance coverage for professional liability and errors and omissions insurance. The policy is an occurrence-based policy and designed to provide comprehensive professional liability insurance and errors and omissions insurance for Alliance employees. There have been no reductions in coverage or any claims that have exceeded coverage in any of the past three years.

Income taxes – The Alliance operates as a government unit under the purview of Internal Revenue Code Section 501(a) whose income is excluded from taxation under Internal Revenue Code Section 115 and corresponding provisions of the California Revenue and Taxation Code. As such, the Alliance is not subject to federal or state taxes on income.

Reclassifications – Certain amounts relating to prior year have been reclassified to conform with the current-year presentation.

New accounting pronouncements – In June 2022, the GASB issued Statement No. 101, *Compensated Absences* (GASB 101). The Statement updates the recognition and measurement guidance for compensated absences. This Statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used, and (2) leave that has been used but not yet paid, provided the services have occurred, the leave accumulates, and the leave is more likely than not to be used for time off or otherwise paid in cash or noncash means. In estimating the leave that is more likely than not to be used or otherwise paid or settled, a government should consider relevant factors such as employment policies related to compensated absences and historical information about the use or payment of compensated absences. The statement amends the existing requirements to disclose only the net change in the liability instead of the gross additions and deductions to the liability. The Alliance adopted this statement for the year ended December 31, 2024. The adoption did not result in a material impact to the financial statements.

Note 3 – Cash and Cash Equivalents, Short-Term Investments, and Board-Designated Investments

Cash and cash equivalents and investments as of December 31 consist of the following (in thousands):

	2024	2023
Cash and cash equivalents	$ 14,209	$ 21,770
Short-term investments	857,436	615,943
Restricted deposits	304	300
Board-designated investments	483,268	413,202
Total cash, cash equivalents, and investments	$ 1,355,217	$ 1,051,215

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Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure, the Alliance may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code (the Code) requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the State law. At year end, deposits were collateralized with securities held by the pledging financial institution's trust department or agent in the Alliance's name.

	2024		2023	
	Carrying Amount	Bank Balance	Carrying Amount	Bank Balance
Insured	$ 350	$ 350	$ 350	$ 350
Collateralized	14,163	14,985	21,720	23,728
Total cash and restricted deposits (in thousands)	$ 14,513	$ 15,335	$ 22,070	$ 24,078

Investments – The Alliance invests in obligations of U.S. government agencies, corporate notes, and instrumentalities. The Alliance's investment policy allows only high-quality investments as permitted by the Code and subject to the limitations of the Alliance's Annual Investment Policy (investment policy).

The Alliance also invests in the State of California Local Agency Investment Fund (LAIF). The Local Investment Advisory Board provides oversight for LAIF. The Board consists of five members as designated by statute. The chairman is the state treasurer or his designated representative.

Two members qualified by training and experience in the field of investment or finance, and the state treasurer appoints two members who are treasurers, finance or fiscal officers, or business managers employed by any county, city, or local district or municipal corporation of this state. The term of each appointment is two years or at the pleasure of the appointing authority. The recorded value of the Alliance's investments in LAIF is equal to the Alliance's share of the estimated fair value of the underlying assets.

In 2016, the Alliance invested in the Investment Trust of California (CalTrust) as one of its discretionary advisory partners. Blackrock Financial Management, a registered investment advisor, provides oversight for CalTrust pursuant to Joint Exercise of Powers Agreement. The Board of Trustees consists of ten Trustees, at least seventy-five percent are members of the governing body, officers, or personnel of the Members which are appointed by the initial Members and the Board. The Trustees and Officers currently serve without compensation but are reimbursed for reasonable expenses in connection with their duties. The Board is responsible for setting overall policies and procedures and for the retention and monitoring of all agents acting on behalf of CalTrust. The recorded value of the Alliance's investments in CalTrust is equal to the Alliance's share of the estimated fair value of the underlying assets.

LAIF and CalTrust are external investment pools. Per GASB 72, fair value hierarchy disclosure is not required for these external pooled investments.

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Government money market funds are required to invest at least 99.5% of their total assets in (i) cash; (ii) securities issued or guaranteed by the United States or certain U.S. government agencies or instrumentalities; and/or (iii) repurchase agreements that are collateralized fully. The Fund is exempt from requirements that permit money market funds to impose a liquidity fee and/or temporary redemption gates. Shares are not restricted as to when they may be redeemed.

The following is a summary of the fair value hierarchy of the Alliance's short-term investments and board-designated investments, as of December 31 (in thousands):

	2024				
Investment Type	Total	Investment Exempt from Fair Value	Level 1	Level 2	Level 3
Corporate bonds	$ 149,488	$ -	$ 149,488	$ -	$ -
State & local agency bonds	142,720	-	142,720	-	-
U.S. agency bonds	98,835	-	98,835	-	-
Money market funds	302,908	302,908	-	-	-
	693,951	$ 302,908	$ 391,043	$ -	$ -
External Investment Pool					
LAIF	74,470				
CalTrust	572,283				
	$ 1,340,704				

	2023				
Investment Type	Total	Investment Exempt from Fair Value	Level 1	Level 2	Level 3
Corporate bonds	$ 97,906	$ -	$ 97,906	$ -	$ -
State & local agency bonds	61,191	-	61,191	-	-
U.S. agency bonds	45,541	-	45,541	-	-
Money market funds	240,174	240,174	-	-	-
	444,812	$ 240,174	$ 204,638	$ -	$ -
External Investment Pool					
LAIF	73,225				
CalTrust	511,108				
	$ 1,029,145				

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Interest rate risk – In accordance with its investment policy, the Alliance manages its exposure to declines in fair value from increasing interest rates by matching maturity dates to the extent possible with the Alliance's expected cash flow draws. The policy of the Alliance limits maturities to five years. As of December 31, 2024, the Alliance's short-term and board-designated investments have the following related maturity schedule (in thousands):

Investment Type	Fair Value	Less Than 1 Year	1–5 Years
Corporate bonds	$ 149,488	$ -	$ 149,488
State and local agency bonds	142,720	-	142,720
U.S. agency bonds	98,835	-	98,835
Money market funds	302,908	302,908	-
CalTrust	572,283	572,283	-
LAIF	74,470	74,470	-
Total	$ 1,340,704	$ 949,661	$ 391,043

As of December 31, 2023, the Alliance's short-term and board-designated investments have the related maturity schedule (in thousands):

Investment Type	Fair Value	Less Than 1 Year	1–5 Years
Corporate bonds	$ 97,906	$ -	$ 97,906
State and local agency bonds	61,191	-	61,191
U.S. agency bonds	45,541	-	45,541
Money market funds	240,174	240,174	-
CalTrust	511,108	511,108	-
LAIF	73,225	73,225	-
Total	$ 1,029,145	$ 824,507	$ 204,638

Credit risk – The Alliance's investment policy is intended to conform to the Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments and by diversifying the investment portfolio, in accordance with the investment policy. The investment policy sets minimum acceptable credit ratings for investments from two nationally recognized rating services: Standard and Poor's Corporation (S&P) and Moody's Investor Service (Moody's). For an issuer of short-term debt, the rating must be no less than A-1 (S&P) or P-1 (Moody's), while an issuer of long-term debt shall be rated no less than an A (S&P or Moody's).

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As of December 31, 2024, the following are the credit ratings of short-term and board-designated investments (in thousands):

Investment Type	Fair Value	Unrated	Rating as of Year-End AAA	AA+	AA	AA-	A+	A	A-	BBB+	BBB
Money market fund	$ 302,908	$ 302,908	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	149,488	-	-	30,015	12,631	34,963	40,812	20,168	1,994	3,938	4,967
F.F.C.B.	7,632	-	-	7,632	-	-	-	-	-	-	-
F.H.L.B	56,713	-	-	56,713	-	-	-	-	-	-	-
Federal Home Loan Mortgage	7,440	-	-	7,440	-	-	-	-	-	-	-
State and local bonds	142,721	4,571	23,776	30,697	20,586	42,806	15,000	5,285	-	-	-
United States Treasury Notes	27,049	17,426	7,628	1,995	-	-	-	-	-	-	-
LAIF	74,470	74,470	-	-	-	-	-	-	-	-	-
CalTrust	572,283	572,283	-	-	-	-	-	-	-	-	-
Total	$ 1,340,704	$ 971,658	$ 31,404	$ 134,492	$ 33,217	$ 77,769	$ 55,812	$ 25,453	$ 1,994	$ 3,938	$ 4,967

As of December 31, 2023, the following are the credit ratings of short-term and board-designated investments (in thousands):

Investment Type	Fair Value	Unrated	Rating as of Year-End AAA	AA+	AA	AA-	A+	A	A-	BBB+	BBB
Money market fund	$ 240,174	$ 240,174	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	97,906	-	538	13,179	28,782	-	22,654	29,838	-	1,937	978
F.F.C.B	6,640	-	-	6,640	-	-	-	-	-	-	-
Federated Government Obligations Fund	1,924	-	-	-	1,924	-	-	-	-	-	-
Federal Home Loan Mortgage	21,171	-	-	21,171	-	-	-	-	-	-	-
State and local bonds	48,908	-	-	18,877	23,393	-	4,787	1,851	-	-	-
United States Treasury Notes	21,572	8,689	12,283	600	-	-	-	-	-	-	-
LAIF	79,742	73,225	6,517	-	-	-	-	-	-	-	-
CalTrust	511,108	511,108	-	-	-	-	-	-	-	-	-
Total	$ 1,029,145	$ 833,196	$ 19,338	$ 60,467	$ 54,099	$ -	$ 27,441	$ 31,689	$ -	$ 1,937	$ 978

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. The Alliance's investment policy limits to no more than 5% of the total market value investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises; no more than 20% may be invested in one money market fund. The investment policy places a diversification limit of 5% for all issuers other than anyone U.S. government agency, for which the policy allows 100%, and only one repurchase agreement counterparty, for which the policy allows 25% to 50% depending on the maturity. Medium Term Maturity Corporate Securities are limited to 30% and State and Local Obligations are limited to 25%. The dollar limit of investments in LAIF is $75.0 million.

Investment	Issuer	Percentage of Portfolio 2024	2023
Money market funds		22.6 %	23.3 %
U.S. government securities	Federal Home Loan Mortgage	0.6	2.1
	United States Treasury Notes	2.0	1.5
	Federal Farm Credit Bond	0.6	0.6
	Federal Home Loan Bond	4.2	-
	Federal Government Obligations Fund	-	0.2
Corporate bonds	Various	11.1	9.5
State and local bonds	Various	10.6	5.9
LAIF	State of California	5.6	7.1
CalTrust	CalTrust JPA	42.7	49.7
		100 %	100 %

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Note 4 – Capital Assets, Net

Capital assets – Capital assets activity in 2024 consists of the following (in thousands):

	December 31, 2023	Increases	Decreases/ Transfers	December 31, 2024
Capital assets not being depreciated				
Land	$ 4,961	$ -	$ -	$ 4,961
Construction in process	1,109	280	(723)	666
Total capital assets not being depreciated	6,070	280	(723)	5,627
Capital assets being depreciated				
Buildings and building equipment	43,697	591	365	44,653
Furniture and equipment	10,442	82	165	10,689
Software	20,302	2,575	88	22,965
	74,441	3,248	618	78,307
Less accumulated depreciation for				
Buildings and building equipment	15,729	1,592	-	17,321
Furniture, equipment, and software	28,479	1,693	-	30,172
	44,208	3,285	-	47,493
Total capital assets being depreciated, net	30,233	(37)	618	30,814
Capital assets, net	$ 36,303	$ 243	$ (105)	$ 36,441

For the year ended December 31, 2024, depreciation expense was $3.3 million as included in depreciation and amortization expense on the statements of activities and changes in net position. Depreciation and amortization expense for the year ended December 31, 2024 also includes $0.9 million attributable to medical-service-related assets.

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Capital assets activity in 2023 consists of the following (in thousands):

	December 31, 2022	Increases	Decreases/ Transfers	December 31, 2023
Capital assets not being depreciated				
Land	$ 7,564	$ -	$ (2,603)	$ 4,961
Construction in process	512	2,493	(1,896)	1,109
Total capital assets not being depreciated	8,076	2,493	(4,499)	6,070
Capital assets being depreciated				
Buildings and building equipment	42,956	-	741	43,697
Furniture and equipment	16,613	-	(6,171)	10,442
Software	16,657	-	3,645	20,302
	76,226	-	(1,785)	74,441
Less accumulated depreciation for				
Buildings and building equipment	14,115	1,552	62	15,729
Furniture, equipment, and software	30,643	1,535	(3,699)	28,479
	44,758	3,087	(3,637)	44,208
Total capital assets being depreciated, net	31,468	(3,087)	1,852	30,233
Capital assets, net	$ 39,544	$ (594)	$ (2,647)	$ 36,303

For the year ended December 31, 2023, depreciation expense was $3.1 million as included in depreciation and amortization expense on the statements of activities and changes in net position.

Note 5 – Medical Claims Liability

The following is a reconciliation of the medical claims liability, including loss adjustment expenses for the years ended December 31 (in thousands):

	2024	2023
Beginning balance	$ 288,373	$ 282,212
Incurred		
Current year	1,750,021	1,396,146
Prior years	(2,567)	11,725
Total	1,747,454	1,407,871
Paid		
Current year	1,370,266	1,139,785
Prior years	262,803	261,925
Total	1,633,069	1,401,710
Ending balance	$ 402,758	$ 288,373

Medical claims payable increased by $114.4 million in comparison to the previous year. $64.8 million of the fluctuation is related to an increase in the general medical claims payable reserves and is due to the changes between actual payments for medical services and estimated amounts in previous years. In addition, there was a decrease of $40.8 million from the accruals and payments of State directed Proposition 56 supplemental payments. The decreases were offset by other liabilities increase of $66.4 million for State Target Rate Increase liability (TRI), $55.2 million for increases in the State's Incentive payments programs liability and other pass thru incentive liabilities.

Amounts incurred related to prior years represent changes from previously estimated liabilities. In 2024, amounts incurred related to prior year results from claims being adjudicated and paid for were less than originally estimated. Liabilities at any year end are continuously reviewed and re-estimated as information regarding actual claims payments and expected payment trends become known.

Medical expenses in the statements of revenues, expenses, and changes in net position also include capitation payments to providers, reinsurance premiums, and other direct payments to providers, which do not flow through the medical claims liability.

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Note 6 – Restricted Net Assets and Tangible Net Equity

As a limited license plan under Knox-Keene Health Care Service Plan Act of 1975 (the Act), the Alliance is required to maintain a minimum level of tangible net equity, as determined by the State of California. The required tangible net equity level was approximately $75.5 million and $65.2 million at December 31, 2024 and 2023, respectively. The Act also requires the Alliance to maintain $300,000 restricted deposits, which is shown as a restricted deposit in the accompanying statements of net position. As of December 31, 2024 and 2023, total net position was $891.2 million and $834.8 million, respectively, which exceeded the minimum tangible net equity level for both years.

Note 7 – Central California Alliance for Health 401(A) Qualified Retirement Plan

The Alliance sponsors a 401(a) Money Purchase Plan and Trust (the Plan), which is a defined-contribution plan covering all its employees. Under the terms of the plan agreement after one year of service, the Alliance will contribute 10% of salaries and wages on behalf of each participant for the plan year. The Alliance has the authority to amend the Plan's provisions.

The Alliance also sponsors a deferred compensation plan created in accordance with Internal Revenue Service Code Section 457. This is an elective defined contribution plan in which employees with work schedules of at least 30 hours per week may participate. The Alliance does not make any contributions to this plan.

The Alliance incurred $5.9 million and $5.2 million of retirement plan expense during 2024 and 2023, respectively, included in salaries, wages, and employee benefits in the statements of revenues, expenses, and changes in net position.

Summary of Significant Accounting Policies

Basis of accounting – The Plan fiduciary financial statements are prepared using the accrual basis of accounting. The Plan's contributions are recognized in the period in which contributions are made. Benefits are recognized when due and payable in accordance with the terms of the Plan.

Investments – The Plan's investments are reported at fair value, including certain investments held in collective investment trusts. Investments held in each trust are maintained on a unit basis. The units represent a proportional ownership interest in each of the funds in which a participant is invested (net asset value, or NAV). The NAV of a unit is determined by adding the market value of each respective fund's investments, plus receivables and other assets, and then deducting liabilities. The balance, called net assets, is divided by the number of units outstanding. The value of a unit at any given time will depend on the investment performance of the particular fund's portfolio of investments. All earnings (interest, dividends, realized gains, unrealized gains), losses (realized and unrealized), and expenses are recorded and reflected in changes in the NAV. The NAV is calculated daily.

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Investments by fair value level include the following as of December 31 (in thousands):

Description	2024	Level 1	Level 2	Level 3
Investments by fair value level	$ -	$ -	$ -	$ -
		$ -	$ -	$ -
Investments not subject to fair value hierarchy				
Collective investment trusts - at NAV	63,737			
Total investments	$ 63,737			

Description	2023	Level 1	Level 2	Level 3
Investments by fair value level	$ -	$ -	$ -	$ -
		$ -	$ -	$ -
Investments not subject to fair value hierarchy				
Collective investment trusts - at NAV	56,282			
Total investments	$ 56,282			

Plan description – Participant data for the Plan, as of the measurement date for the year indicated, is as follows:

- All full-time, part-time, and per-diem employees of the Organization are eligible to participate in the Plan. Employees are eligible to receive employer contributions upon completion of one year of service, defined as working 12 months for a minimum of 1,000 hours.
- Participants will receive an employer contribution of 10% of compensation. Employees who wish to make elective contributions may do so through the agency's 457 plan.
- Participants are fully vested in employer contributions.

Employer contribution – The Alliance makes contributions based on the established funding practice.

Notes receivable from participants – Participants may borrow from their accounts a minimum of $1,000 up to a maximum equal to the lesser of $50,000 or 50% of their vested account balance. The maximum loan term is five years unless the loan term qualifies as a home loan, in which case the term of the loan is not to exceed 30 years.

Loans are secured by the balance of the participant's account and bear fixed, reasonable rates of interest, as determined by the custodians. Principal and interest are paid directly by the participant to the custodians through monthly ACH transactions. As of December 31, 2024 and 2023, the rates of interest on outstanding loans with Mission Square was 5.3% and 3.4%, respectively, with maturities extending up to five years. The interest rate is locked in for the term of the loan and established at the onset of the loan. The loan totals as of December 31, 2024 and 2023, were $1.9 million and $1.5 million, respectively.

Rate of return – The Plan is a defined contribution plan with investment returns varying per participant based on investment elections. On a cumulative basis for the years ended December 31, 2024 and 2023, the cumulative rate of return for the 401(a) plan was 12.3% and 15.9%, respectively.

Note 8 – Leases

The Alliance is a lessor for noncancelable leases of multiple leases. Lease revenue from the lease arrangements were $1.2 million and $1.5 million for the years ended December 31, 2024 and 2023, respectively, and were included in other income in the statements of revenues, expenses, and changes in net position. Interest revenue from the lease arrangements was $234,000 and $151,000 for the years ended December 31, 2024 and 2023, respectively, and was included in other income in the statements of revenues, expenses, and changes in net position.

Note 9 – Subscription Based Information Technology Arrangements

The Alliance has the following subscription asset activities as of December 31 (in thousands):

2024	Beginning Balance	Increase	Decrease	Ending Balance
Subscription assets	$ 14,679	$ 8,171	$ 1,185	$ 21,665
Less accumulated amortization	(4,169)	(5,467)	(1,185)	(8,451)
Subscription assets, net	$ 10,510	$ 2,704	$ -	$ 13,214

2023	Beginning Balance	Increase	Decrease	Ending Balance
Subscription assets	$ 6,402	$ 9,210	$ 933	$ 14,679
Less accumulated amortization	(1,722)	(3,380)	(933)	(4,169)
Subscription assets, net	$ 4,680	$ 5,830	$ -	$ 10,510

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For the years ended December 31, 2024 and 2023, the Alliance recognized $5.5 million and $3.3 million, respectively, in amortization expense included in depreciation and amortization expense on the statements of activities and changes in net position.

The future subscription payments as of December 31, 2024, were as follows (in thousands):

Years Ending December 31,	Principal	Interest	Total
2025	$ 3,204	$ 466	$ 3,670
2026	3,207	327	3,534
2027	3,330	186	3,516
2028	849	40	889
Total	$ 10,590	$ 1,019	$ 11,609

The Alliance evaluated the subscription assets for diminished service capacity and determined there were no impairment for the years ended December 31, 2024 and 2023.

Note 10 – Risks and Uncertainties

The Alliance primarily serves Medi-Cal eligible persons. Laws and regulations governing the Medi-Cal program are complex, and subject to interpretation. The Alliance believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medi-Cal programs.

Note 11 – Contingencies

The Alliance is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on the Alliance's financial position or results of operations.

Note 12 – Health Care Reform

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates or benefits. The ultimate outcome of these proposals, including the potential effects of, or changes to, health care reform that will be enacted cannot presently be determined.

Supplementary Information

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Santa Cruz-Monterey-Merced-San Benito-Mariposa
Managed Medical Care Commission
Schedule of Revenues and Expenses by Program and Changes in Net Position
Year Ended December 31, 2024
(in Thousands)

	Medi-Cal				
	Central California Region	San Benito Region	IHSS Program	Administrative	Total
OPERATING REVENUES					
Capitation revenue	$ 2,607,805	$ 134,483	$ 5,481	$ -	$ 2,747,769
OPERATING EXPENSES					
Medical expenses					
Medi-Cal					
Provider capitation	107,715	4,147	-	-	111,862
Claim payments to providers	1,528,219	88,273	-	-	1,616,492
Other medical	116,618	3,895	-	-	120,513
Alliance Care: IHSS program	-	-	4,900	-	4,900
Reinsurance and other, net	6,873	428	-	-	7,301
Total medical expenses	1,759,425	96,743	4,900	-	1,861,068
Administrative expenses					
Salaries, wages, and employee benefits	-	-	-	70,222	70,222
Supplies, occupancy, insurance, and other	-	-	-	11,936	11,936
Professional fees	-	-	-	4,267	4,267
Depreciation and amortization	-	-	-	8,752	8,752
Purchased services	-	-	-	11,966	11,966
Total administrative expenses	-	-	-	107,143	107,143
Premium tax expense	-	-	-	750,982	750,982
Total operating expenses	1,759,425	96,743	4,900	858,125	2,719,193
Operating income (loss)	848,380	37,740	581	(858,125)	28,576
Investment income, including net realized and unrealized gains and losses	-	-	-	52,118	52,118
Other income	-	-	-	2,386	2,386
Grants	-	-	-	(26,675)	(26,675)
INCREASE (DECREASE) IN NET POSITION	$ 848,380	$ 37,740	$ 581	$ (830,296)	56,405
NET POSITION, beginning of year					834,773
NET POSITION, end of year					$ 891,178

Santa Cruz-Monterey-Merced-San Benito-Mariposa
Managed Medical Care Commission
Schedule of Revenues and Expenses by Program and Changes in Net Position
Year Ended December 31, 2023
(in Thousands)

	Medi-Cal				
	Central California Region	San Benito Region	IHSS Program	Administrative	Total
OPERATING REVENUES					
Capitation revenue	$ 2,081,364	$ -	$ 4,547	$ -	$ 2,085,911
OPERATING EXPENSES					
Medical expenses					
Medi-Cal					
Provider capitation	51,838	-	-	-	51,838
Claim payments to providers	1,316,137	-	-	-	1,316,137
Other medical	108,957	-	-	-	108,957
Alliance Care: IHSS program	-	-	4,326	-	4,326
Reinsurance and other, net	2,246	-	-	-	2,246
Total medical expenses	1,479,178	-	4,326	-	1,483,504
Administrative expenses					
Salaries, wages, and employee benefits	-	-	-	63,405	63,405
Supplies, occupancy, insurance, and other	-	-	-	7,441	7,441
Professional fees	-	-	-	3,233	3,233
Depreciation and amortization	-	-	-	6,467	6,467
Purchased services	-	-	-	10,713	10,713
Total administrative expenses	-	-	-	91,259	91,259
Premium tax expense	-	-	-	376,406	376,406
Total operating expenses	1,479,178	-	4,326	467,665	1,951,169
Operating income (loss)	602,186	-	221	(467,665)	134,742
Investment income, including net realized and unrealized gains and losses	-	-	-	44,560	44,560
Other income	-	-	-	1,926	1,926
Grants	-	-	-	(13,182)	(13,182)
INCREASE (DECREASE) IN NET POSITION	$ 602,186	$ -	$ 221	$ (434,361)	168,046
NET POSITION, beginning of year					666,727
NET POSITION, end of year					$ 834,773

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DATE: May 28, 2025

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

FROM: Michael Schrader, Chief Executive Officer.

SUBJECT: May Revise and Federal Budget Proposals

Recommendation. This report is informational only.

Summary. The week of May 12th brought major developments in both Sacramento and Washington, DC., with key budget proposals released which will shape the future of Medi-Cal. On May 12, the House Energy and Commerce Committee released its markup including Medicaid provisions totaling $625B over ten years. Meanwhile, on May 14, Governor Newsom released his May Revise which included significant adjustments to Medi-Cal.

Discussion. Staff continue to monitor budget discussions in Washington, DC and Sacramento and provide a summary of the provisions included in both the federal and state budget proposals related to Medicaid/Medi-Cal.

House Budget proposal

The House Energy and Commerce Committee released its recommendations for federal budget reconciliation. Some of the more notable provisions include:

Federal Financing for States:

- Citizenship/Immigration Status. No federal match for people with UIS, effective October 1, 2026.
- FMAP Penalty. Reduces federal match by 10% for expansion states that provide Medicaid coverage under state-based program to people with UIS, effective October 1, 2027.
- Gender Services. No federal match for specified gender transition procedures for children under age 18, effective upon enactment.

Funding Mechanisms

- Future Provider Taxes. Freeze state provider tax rates; prohibit states from increasing and/or establishing new provider taxes, effective upon enactment
- Provider Tax Requirements. Tighten requirements for uniform taxes; requires states to modify models to comply with requirements, effective upon enactment, subject to transition period not to exceed three fiscal years
- State Directed Payments. Limit payments exceeding the total published Medicare payment rate, effective for rating periods beginning on/after enactment

Eligibility and Enrollment:

- Redeterminations. Require redeterminations for Medicaid Expansion adults every six months, effective October 1, 2027.
- Work / Community Engagement. Implement community engagement, as defined, requirement of 80 hours a month for Medicaid Expansion adults without children, with a list of exemptions, effective January 1, 2029.
- Assets. Establish a $1M ceiling for permissible home equity values, for long term care.
- Retroactive Coverage. Restrict retroactive coverage to one month before coverage.

May Revise

Governor Newsom unveiled the May Revise of California's State Budget, which includes proposed cuts to Medi-Cal for the upcoming fiscal year which begins July 1. Some of the more relevant proposals include:

Services for individuals with Unsatisfactory Immigration Status (UIS):

- Enrollment freeze for full-scope Medi-Cal, adults aged 19 and older, effective no sooner than January 1, 2026.
- Implementation of Medi-Cal $100 monthly premiums, adults 19 and older, effective January 1, 2027.
- Elimination of long-term care services and IHSS, adults 19 and older beginning January 1, 2026.
- Elimination of full-scope dental coverage, adults 19 and older beginning July 1, 2026.
- Reduction to payments for FQHC providers for services provided to the UIS population.

Medi-Cal program overall:

- Reinstatement of the Medi-Cal asset limit for seniors and disabled adults.
- Elimination of coverage for drugs for weight loss (GLP-1).
- Elimination of Acupuncture Optional Medi-Cal Benefit.
- Elimination of Over-the-Counter Drug Coverage for certain classes e.g., vitamins, antihistamines).

Medi-Cal funding:

- Implementation of the Proposition 35 Expenditure Plan which details the proposed uses of Managed Care Organization (MCO) Tax revenue for Medi-Cal program support and rates paid to Medi-Cal providers for specified services.

It is important to note the State budget proposals summarized above do not contemplate potential impacts of any, yet to be decided upon, federal budget changes. Should any federal actions result in funding reductions effective in the 2025-26 State fiscal year, mid-year budget adjustments could be necessary.

Fiscal Impact. N/A

Attachments.

1. Kaiser Family Foundation: Summary of Medicaid Provision in Energy and Commerce Committee Bill
2. LHPC memo: Highlights from Governor's Proposed Budget for 2025-26
3. Letters to Congressional Delegation

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Tracking the Medicaid Provisions in the 2025 Reconciliation Bill

Updated: May 14, 2025

On May 14, the House Energy and Commerce Committee advanced its portion of a budget reconciliation bill to meet spending targets aimed at funding President Trump's domestic priorities that includes significant changes to the Medicaid program. The Congressional Budget Office (CBO) estimates that the bill would decrease the federal deficit by more than the $880 billion over 10 years that was called for by the budget resolution passed by Congress in April. CBO preliminary estimates show that the Medicaid provisions would reduce the deficit by $625 billion over ten years and increase the number of people without health insurance by at least 7.6 million by 2034.

The following includes a summary of the Medicaid provisions included in the legislation approved by the Energy and Commerce Committee compared to current law.

Summary of Medicaid Provisions in Energy and Commerce Committee Bill

	Current Law	Energy and Commerce Draft Language	KFF Resources
Medicaid Expansion			
Expansion Coverage and Financing	The Affordable Care Act expands Medicaid eligibility to non-elderly adults with	• Eliminates the temporary incentive for states that newly adopt expansion.	5 Key Facts About Medicaid Expansion New Incentive for

	incomes up to 138% FPL based on modified adjusted gross income and provides 90% federal financing for the expansion population. The Supreme Court effectively made expansion an option for states. The American Rescue Plan Act (ARPA) added a temporary financial incentive for states that newly adopt expansion. Currently, 41 states, including DC, have implemented the Medicaid expansion.	Effective Date: January 1, 2026	States to Adopt the ACA Medicaid Expansion: Implications for State Spending Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates Medicaid Expansion Tracker
Cost Sharing	States have the option to charge premiums and cost-sharing for Medicaid enrollees within limits, and certain populations and services (emergency, family planning, pregnancy and preventive) are exempt from cost-sharing. Cost-	• Eliminates enrollment fees or premiums for expansion adults. • Requires states to impose cost sharing of up to $35 per service on expansion adults with incomes 100-138% FPL; maintains existing exemptions of	Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers

	sharing is generally limited to nominal amounts but may be higher for those with income above 100% of the federal poverty level (FPL). Out-of-pocket costs cannot exceed 5% of family income. States may allow providers to deny services for enrollees for nonpayment of copayments.	certain services from cost sharing and limits cost sharing for prescription drugs to nominal amounts. • Maintains the 5% of family income cap on out-of-pocket costs. Effective Date: October 1, 2028	
State Funded Coverage of Undocumented Immigrants	Under current law, undocumented immigrants are not eligible for Medicaid coverage. KFF data show that as of April 2025, 14 states and DC use state-only funds to provide health coverage to children regardless of immigration status, including 7 states that do so for at least some adults.	• Reduces the expansion match rate from 90% to 80% for states that use their own funds to provide health coverage or financial assistance to purchase health coverage for individuals who are not lawfully residing in the United States. Effective Date: October 1, 2027	Which States Would Be Affected by a House Proposal to Cut Federal Medicaid Funding for States That Cover Undocumented Immigrants? Key Facts on Health Coverage of Immigrants 5 Key Facts About Immigrants and Medicaid
Eligibility Policies			

Work Requirements	Current law prohibits conditioning Medicaid eligibility on meeting a work or reporting requirement. During the first Trump administration, 13 states received approval to implement work requirements through Section 1115 waivers. Work requirement waiver approvals were either rescinded by the Biden administration or withdrawn by states, and Georgia is the only state with a Medicaid work requirement waiver in place. Several states have recently submitted new 1115 waiver requests to implement work requirements.	• Requires states to condition Medicaid eligibility for individuals ages 19-64 applying for coverage or enrolled through the ACA expansion group on working or participating in qualifying activities for at least 80 hours per month. • Mandates that states exempt certain adults from the requirements. • Requires states to verify that individuals applying for coverage meet requirements for 1 or more consecutive months preceding the month of application and that individuals who are enrolled meet requirements for 1 or more months between the most	5 Key Facts About Medicaid Work Requirements Understanding the Intersection of Medicaid and Work: An Update Section 1115 Waiver Tracker Work Requirements Medicaid Work Requirements: Implications for Low Income Women's Coverage An Overview of Medicaid Work Requirements: What Happened Under the Trump and Biden Administrations?

		recent eligibility redetermination (at least twice per year). • These provisions cannot be waived, including under Section 1115 authority. Effective Date: January 1, 2029	
Eligibility Determinations	States must renew eligibility for Medicaid enrollees whose eligibility is based on modified adjusted gross income (MAGI), including children, pregnant individuals, parents, and expansion adults, every 12 months and must renew eligibility at least every 12 months for enrollees whose eligibility is based on age 65+ or disability. States are required to review eligibility within the 12-month period if they receive	• Requires states to conduct eligibility redeterminations at least every 6 months for Medicaid expansion adults. Effective Date: October 1, 2027	Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations Following the Unwinding of the Pandemic-Era Continuous Enrollment Provision Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage

	information about a change in a beneficiary's circumstances that may affect eligibility.		
Verifying Enrollee Address and Other Information	States are not required to take proactive steps to obtain updated enrollee contact information. The Eligibility and Enrollment final rule (see below) requires states to leverage reliable data sources to update enrollee address information, effective June 2025.	• Requires states to obtain enrollee address information using reliable data sources, including the National Change of Address Database and managed care entities. • Requires the Secretary to establish a system to share information with states for purposes of preventing individuals from being simultaneously enrolled in two states and requires states to submit monthly enrollee SSNs and other information to the system. • Requires states to	Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations Following the Unwinding of the Pandemic-Era Continuous Enrollment Provision

		review the Master Death File at least quarterly to determine if any enrolled individuals are deceased. Effective Date: January 1, 2027 for states to obtain contact information; October 1, 2029 to establish system to prevent enrollment in two states simultaneously; January 1, 2028 to review Master Death File	
Eligibility and Enrollment Final Rule	CMS issued two separate rules, collectively referred to as the Eligibility and Enrollment final rule. The first rule reduces barriers to enrollment in Medicare Savings Programs (MSPs), which provides Medicaid coverage of Medicare premiums and cost sharing for low-	• Delays implementation of both rules until January 1, 2035. Effective Date: Upon enactment	5 Things to Know: A Look at the Proposed Medicaid Eligibility & Enrollment Rule What Does the Medicaid Eligibility Rule Mean for Low-Income Medicare Beneficiaries and the Medicare Savings Programs (MSPs)?

	income Medicare beneficiaries. The second rule streamlines application and enrollment processes in Medicaid, aligns renewal policies for all Medicaid enrollees, facilitates transitions between Medicaid, CHIP, and subsidized Marketplace coverage, and eliminates certain barriers in CHIP. Implementation deadlines for states to vary across provisions, but many provisions are already in effect, and for others, states are already in compliance.		Potential Effects of the Proposed Medicaid Eligibility Rule for Newly Enrolled Medicare-Medicaid Enrollees
Immigrant Coverage	Undocumented immigrants are not eligible for federally-funded Medicaid coverage. Emergency Medicaid pays hospitals for the	• Eliminates the requirement for states to provide Medicaid coverage during a reasonable opportunity period but allows	5 Key Facts About Immigrants and Medicaid How States Verify Citizenship and Immigration Status in Medicaid

	costs of emergency department care for immigrants who would qualify for Medicaid, except for their immigration status. States verify immigration status through the DHS SAVE system which can provide automatic real-time verification. If the SAVE system cannot verify immigration status in real time, states are required to provide Medicaid benefits to applicants during a "reasonable opportunity period" of 90 days while their immigration status is being verified, if they meet all other eligibility criteria. Lawfully present immigrants must wait five years after obtaining qualified status before they may enroll in Medicaid; states	states to do so at state option. • Prohibits states from claiming federal matching funds during a reasonable opportunity period. Effective Date: October 1, 2026	

	may waive the five-year wait for children and pregnant individuals. Some states cover undocumented immigrants using only state funds.		
Retroactive Coverage	Under current law, states are required to provide Medicaid coverage for qualified medical expenses incurred for up to 90 days prior to the date of application for coverage.	• Limits retroactive coverage to one month prior to application for coverage. Effective Date: October 1, 2026	
Financing			
Provider Taxes	States are permitted to finance the non-federal share of Medicaid spending through multiple sources, including state general funds, health care related taxes (or "provider taxes"), and local government funds. Federal rules specify provider taxes must be broad-based and	• Prohibits states from establishing any new provider taxes or from increasing the rates of existing taxes. • Revises the conditions under which states may receive a waiver of the requirement that taxes be broad-based and uniform such that	5 Key Facts About Medicaid and Provider Taxes Medicaid Budget Survey 2024-2025 - Provider Rates and Taxes

	uniform (i.e., states can't limit provider taxes to only Medicaid providers) and may not hold providers "harmless" (i.e., guarantee providers receive their money back). The hold harmless requirement does not apply when tax revenues comprise 6% or less of providers' net patient revenues from treating patients (referred to as the "safe harbor" limit).	some currently permissible arrangements taxes, such as those on managed care plans, will not be permissible in future years. • Provision overlaps with a proposed rule released May 12, 2025. Effective Date: Upon enactment, but states may have at most 3 fiscal years to transition existing arrangements that are no longer permissible	
Disproportionate Share Hospital Payments (DSH)	Medicaid provides DSH payments to hospitals that serve a disproportionate percentage of low-income, uninsured and Medicaid patients. The payments can be used to cover unpaid costs of care for people who are uninsured and to supplement	• Delays the DSH reductions (of $8 billion per year) through September 30, 2028. • Extends Tennessee's DSH program through September 30, 2028.	Medicaid Financing: The Basics

	Medicaid payment rates that often do not fully cover provider costs. DSH payments totaled over $17 billion in federal FY 2023. Federal DSH spending is capped for each state and facility, but within those limits, states have considerable discretion in determining the amount of DSH payments to each DSH hospital. The Affordable Care Act (ACA) called for a reduction in federal DSH allotments starting in FY 2014 based on the anticipated reduction in uninsured rates stemming from the ACA implementation, but the cuts have been delayed several times and are currently delayed through September 30, 2025.	Effective Date: Upon enactment	

State Directed Payments	States are generally not permitted to direct how managed care organizations (MCOs) pay their providers. However, subject to CMS approval, states may use “state directed payments” (SDPs) to require MCOs to pay providers certain rates, make uniform rate increases (that are like fee-for-service supplemental payments), or to use certain payment methods. A 2024 rule on access to care in Medicaid managed care codified that the upper limit for SDPs is the average commercial rate for hospitals and nursing facilities, which is generally higher than the Medicare payment ceiling used for other Medicaid fee-for-service	• Directs HHS to revise state directed payment regulations to cap the total payment rate for inpatient hospital and nursing facility services at 100% of the total published Medicare payment rate. • Grandfathers state directed payments submitted for approval and approved prior to the legislation’s enactment. Effective Date: Upon enactment	10 Things to Know About Medicaid Managed Care 5 Key Facts about Medicaid and Hospitals Medicaid Budget Survey FY 2024-2025, Provider Rates and Taxes

	supplemental payments.		
Section 1115 Demonstration Waiver Budget Neutrality	Under long-standing policy and practice, Section 1115 demonstration waivers must be "budget neutral" to the federal government over the course of the waiver. Federal costs under an 1115 waiver may not exceed what they would have been for that state without the waiver. Typically, budget neutrality calculations are determined on a per enrollee basis—so, per enrollee spending over the course of the waiver (usually 5 years) cannot exceed the projected per enrollee spending calculated in the "without-waiver baseline." Budget neutrality calculations and	• Requires the HHS Secretary to certify 1115 demonstration waivers are not expected to result in an increase in federal expenditures compared to federal expenditures without the waiver and to specify a methodology for applying any budget neutrality "savings" in a waiver extension period. Effective Date: Upon enactment	Medicaid Section 1115 Waivers: The Basics

	the use of "savings" when expenditures decrease on account of the waiver are negotiated between states and CMS and the Office of Management and Budget).		
Good Faith Waiver for Payment Reduction Related to Certain Erroneous Medicaid Payments	Federal law directs CMS to recoup federal funds for erroneous payments made for ineligible individuals and overpayments for eligible individuals if the state's eligibility "error rate" exceeds 3 percent. CMS may waive the recoupment if the Medicaid agency has taken steps to demonstrate a "good faith" effort to get below the 3 percent allowable threshold.	• Requires HHS to reduce federal financial participation to states for identified improper payment errors related to payments made for ineligible individuals and overpayments made for eligible individuals. Effective Date: Beginning FY 2030	5 Key Facts About Medicaid Program Integrity – Fraud, Waste, Abuse and Improper Payments
Long-term Care			
Nursing Home Staffing Final Rule	A 2024 Biden-administration final rule requires long-	• Prohibits the Secretary of Health and Human	Texas Judge Overturns Controversial

	term care facilities (LTC) to meet minimum staffing levels (including a 24/7 RN on-site and a minimum of 3.48 total nurse staffing hours per resident day (HPRD)), requires state Medicaid agencies to report the share of Medicaid payments for institutional LTC that are spent on worker compensation, and provides funding for people to enter careers in nursing homes. On April 7, the US District Court for Northern Texas ruled to overturn the minimum staffing requirements, and it is expected that the Administration will not appeal that decision.	Services from implementing, administering, or enforcing the final rule. Effective Date: Upon enactment	Nursing Facility Staffing Rule A Closer Look at the Final Nursing Facility Rule and Which Facilities Might Meet New Staffing Requirements 10 Things About Long-Term Services and Supports (LTSS)
Home Equity Limits	Most Medicaid enrollees who qualify for Medicaid because they need	• Reduces the maximum home equity limits to $1,000,000	Medicaid Eligibility Levels for Older Adults and People with

	long-term care (LTC) are subject to limits on their home equity. In 2025, federal rules specified that states' limits on home equity must be between $730,000 and $1,097,000, and those amounts are updated each year for inflation.	regardless of inflation. • Allows states to apply different requirements for homes that are located on farms. Effective Date: January 1, 2028	Disabilities (Non-MAGI) in 2025
Access			
Free Choice of Provider	States must generally allow beneficiaries to obtain Medicaid services from any provider that is qualified and willing to furnish services. Managed care organizations (MCOs) may restrict enrollees to providers in the MCO's network, except that such plans cannot restrict free choice of family planning providers.	• Prohibits Medicaid funds to be paid to providers that are nonprofit organizations, essential community providers primarily engaged in family planning services or reproductive services, provide for abortions outside of the Hyde exception and received $1,000,000 or more in payments from Medicaid; this would affect	What's at Stake in the Supreme Court Case Medina v. Planned Parenthood South Atlantic? The Impact of Medicaid and Title X on Planned Parenthood

		Planned Parenthood and other Medicaid essential community providers. Effective Date: Upon enactment for 10 years.	
Streamlined Enrollment for Out-of-State Pediatric Providers	Medicaid only reimburses providers that are enrolled in the state's Medicaid program. To receive reimbursement for services provided to a Medicaid enrollee from another state, providers must generally enroll with that state's Medicaid program. However, states are required to pay for out-of-state necessary medical services if any of the following apply: they are needed because of a medical emergency, travel to the home state would endanger health, the services	• Requires states to establish a process for out-of-state providers to enroll as participating providers without further screening requirements if they are providing services to enrollees under age 21. • Specifies that enrollment of out-of-state providers is to last 5 years unless the provider is terminated or excluded from participation during that period. Effective Date: 4 years after enactment	

	are more readily available in another state, or general practice is for residents of a particular locality to use resources provided in another state.		
Gender Affirming Care	Under current law states have flexibility to determine coverage for gender affirming care in Medicaid. A number of states have imposed restrictions on such care in Medicaid and for other payers, many of which are subject of ongoing litigation.	• Prohibits federal matching funds for "gender transition procedures," defined to include puberty blockers, hormone treatment and surgery, for persons under age 18 enrolled in Medicaid and CHIP. • Prohibits "coverage of gender transition procedures" as an essential health benefit (EHB) for expansion adult coverage. Effective Date: Upon enactment	Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions
Medicaid Provider	Provider screening and enrollment is required for all	• Requires states to conduct checks at enrollment,	5 Key Facts About Medicaid Program Integrity – Fraud,

Screening Requirements	providers in Medicaid fee-for-service or managed care networks. Additionally, the ACA requires states to terminate provider participation in Medicaid if the provider was terminated under Medicare or another state program. CMS has multiple tools to assist states with provider screening and enrollment compliance, including leveraging Medicare data.	reenrollment, and on a monthly basis to determine whether HHS has terminated a provider or supplier from Medicare or another state has terminated a provider or supplier from participating in Medicaid or CHIP. • Requires states to conduct quarterly checks (in addition to at provider enrollment or reenrollment) of the Social Security Administration's Death Master File to determine whether providers enrolled in Medicaid are deceased. Effective Date: January 1, 2028	Waste, Abuse and Improper Payments
Prescription Drugs			
Prescription Drug Pricing and Rules for	States are not required to offer Medicaid	• Requires all retail pharmacies and certain non-retail	Prohibition of Spread Pricing in Medicaid MCO

Pharmacy Benefit Managers	prescription drug coverage, but all states do. States provide prescription drug benefits through either fee-for-service (FFS) Medicaid or through managed care organizations (MCOs). Under FFS, states often use the National Average Drug Acquisition Cost (NADAC) survey, which surveys pharmacies about their costs of acquiring prescription drugs, to inform their prescription drug payment rates. The survey is optional for pharmacies to complete and may overstate prescription drug costs. When MCOs provide prescription drugs, they often use	pharmacies to complete the NADAC survey and imposes penalties for non-completion. • Requires the Secretary of Health and Human Services to make data from the NADAC survey about prescription drug costs and pricing publicly available. • Establishes requirements for PBM payments to pharmacies, including that they be no less than what FFS payments would be. • Prohibits spread pricing and requires that payments to PBMs and similar entities reflect the pharmacies' costs and an administrative fee that is fair market value.	Contracts Medicaid Budget Survey 2024-2025 - Pharmacy Section

	Pharmacy Benefit Managers (PBMs) to administer pharmacy benefits. Some PBMs charge Medicaid MCOs for pharmacy costs that far exceed the actual costs of reimbursing pharmacies for drugs, a practice known as “spread pricing.” As of 2019, only 11 states had prohibited spread pricing in MCO contracts.	Effective Date: Starting 6 months after enactment for the Drug Acquisition Cost Survey, 18 months after enactment for the requirements governing PBMs	

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To: Board of Directors & Plan Staff

From: LHPC Staff

Subject: Highlights from Governor's Proposed Budget for 2025-26

Date: May 14, 2025

This memo includes highlights from Governor Newsom's Proposed Budget for 2025-26, specifically health and human services proposals of relevance to local plans. See the Governor's May Revision, DHCS FY 2025-26 May Revision Highlights, DHCS Medi-Cal Estimate and the Proposition 35 Spending Plan for CY 2025-26 for additional details (references and page numbers are provided throughout the memo). LHPC will continue to review and analyze Budget proposals impacting local plans and provide additional information as it becomes available. Please contact Rebecca Sullivan at rsullivan@lhpc.org, Katie Andrew kandrew@lhpc.org or Beau Bouchard bbouchard@lhpc.org with any questions.

State Budget Overview

The following highlights provide a snapshot of California's overall State Budget:

- ***Total Budget***:
  - May Revision Budget - $321.9 billion ($226.4 billion GF) a decrease of $400 million from the Governor's January Budget. (Reference: May Revision Summary Chart, p. 9).
- ***Increased Expenditures Outpacing Revenues:*** The FY 2025-26 May Revision budget anticipates a deficit of $12 billion compared to the Governor's January budget estimate of a $16.5 billion surplus. The Governor presented a balanced budget by proposing the following:
  - *May Revision Reserves Balance* - $15.7 billion, a decrease of $2.7 billion from Governor's January Budget
    - $11.2 billion in Budget Stabilization Account, an increase of $300 million from the Governor's January Budget
    - $4.5 billion in Special Fund for Economic Uncertainties, no change from the Governor's January Budget
    - $1.5 billion earmarked in the Governor's January Budget for the Public School System Stabilization Account is not reflected in the May Revision

The Budget Summary specifically calls out Medi-Cal as the key source of expenditure growth which results in a $12 billion dollar shortfall to balance the budget. General Fund revenues,

excluding transfers and loans, are downgraded by approximately $5.2 billion through 2025-2026. The Governor noted the impact of the administration's policies, specifically highlighting the impact of the on-again, off-again implementation of tariffs on state revenue which has caused a reduction in state corporate taxable profit growth in 2025 from 4% growth to a 2% decline. Other impacts to revenue noted include:

- $10 billion in reduced Capital Gains
- $2.5 billion in weaker corporate taxes
- $2 billion in lower wages and personal income tax withholdings
- $1.5 billion in reduced sales taxes

Reference: May Revision Summary, pp. 1-5

Significant Medi-Cal Budget Items
Overall Medi-Cal Budget

- *May Revision Budget estimate:*
  - $179 billion ($37.4 billion GF) in SFY 2024-2025, $4.4 billion increase from Governor's January Budget;
  - $194.5 billion ($44.6 billion GF) in SFY 2025-2026, a $6.4 billion increase (+3.4%) in total spending and a $2.5 billion increase in GF (+6%) from Governor's January Budget (DHCS May Revision Budget Highlights, p. 11-13).
  - Estimates that between 2024-2025 and 2025-2026 a Year-over-Year total spending increase of $15.5 billion (+8.7 %) and a GF spending increase of $7.2 billion (+19.2%).
- *May Revision Budget total projected enrollment:* Estimated average monthly caseload projections for 2024-2025 is 14.9 million, increase of 0.12% from November 2024 estimate; estimated average monthly caseload projections for 2025-2026 is 14.8 million, increase of 2.4% from November 2024 estimate (DHCS May Revision Budget Highlights, p. 8)

Expenditures in the Medi-Cal program have significantly increased and continue to outpace revenues. The May Revise Summary notes the $3.4 billion cash flow loan and the $2.8 billion GF appropriation to support Medi-Cal expenditures of $37.6 billion GF in 2024-2025, citing higher overall enrollment, pharmacy costs, and higher managed care costs. Specifically, major cost drivers for the estimated GF in 2024-2025 compared to the 2024 Budget Act include:

- $3.8 billion increase in costs for UIS members
- Base cost increases for non-UIS members due higher enrollment and utilization as a result of continuation of unwinding flexibilities include approximately $1.5 billion for managed care, $700 million for pharmacy, $300 million for FFS costs, and $180 million for dental services.
- $311 million to replay a Medical Providers Interim Payment Fund loan for 2023-2024.

- Over $2 billion offsetting reduction related to the MCO Tax. (DHCS May Revision Budget Highlights, p. 12)

Costs drivers for the increase in the Medi-Cal Estimate for 2025-2026 compared to the November 2024 Medi-Cal Estimate include:

- $5 billion increase in costs for UIS member, before accounting for budget solutions.
- Base cost increases for non-UIS members, before accounting for budget solutions, include approximately $1 billion related to pharmacy, $280 million related to managed care, $200 million related to other FFS costs, and $180 million related to dental costs.
- Other offsetting reductions in GF spending from budget solutions. (DHCS May Revision Budget Highlights, p. 13)

Additionally, the May Revise Summary notes that without the May Revision proposals to contain expenditure growth that the Medi-Cal GF costs would be approximately $10 billion higher across 2024-2025 and 2025-2026 compared to the Governor's January Budget.

Reference: May Revision Summary, p. 2-3; DHCS May Revision Budget Highlights, p. 4, p. 8, p. 11-14

Caseload Projections

Caseload projections show an increase of 348,200 Medi-Cal enrollees in 2025-26 compared to the Governor's January Budget. Medi-Cal base projections estimate 14.97 million eligibles in 2024-25, decreasing to14.83 million in 2025-26. Declining caseloads from 2024-25 to 2025-26 are due to a combination of the end of the COVID-19 pandemic unwinding flexibilities to sunset June 2025 and the implementation of proposed budget solutions, including those UIS enrollment freeze and elimination of the asset test.

- *COVID-19 Unwinding Flexibilities Sunset*— projected to decrease average monthly eligibles not in the base estimate by 239,156 in 2025-26.
- *Enrollment Freeze for UIS*— projected to decrease average monthly eligibles not in the base estimate by 32,261 in 2025-26. Additional details of this policy are noted below in a dedicated section on Changes to Eligibility for the Undocumented Population.
- *Elimination of the Asset Test*— projected to decrease average monthly eligibles not in the base estimate by 10,889 in 2025-26, resulting in coverage loss for about 112,000 beneficiaries by full implementation. The policy will be implemented no sooner than January 1, 2026 and would limit assets to $2,000 for an individual and $3,000 for a couple. *Estimated General Fund Savings*: $94 million in 2025-26, $540 million in 2026-27, and $791 million ongoing, inclusive of IHSS impacts.

Reference: May Revision Summary, pp. 35-36; DHCS Budget Highlights, pp. 5, 8-9, DHCS Medi-Cal Local Assistance Estimate, p. 113

Proposition (Prop) 35 - Managed Care Organization (MCO) Tax

Prop 35 was approved by the voters in November 2024 and requires DHCS to seek federal renewal and reauthorization of the MCO Tax to permanently continue the tax. It specifies permissible uses of the tax revenues, starting with the 2025 tax year. In addition, DHCS must consult with a stakeholder advisory committee to develop and implement the program. For FY 2025-26, the budget reflects $4.2 billion in MCO Tax revenue, a decrease of $200 million from the FY 2025-26 Governor's Budget and $2.8 billion for FY 2026-27, a decrease of $400 million from FY 2026-27 Governor's Budget. The amendments to the MCO Tax were approved by the federal government on December 20, 2024 and can be found here.

The budget reflects Prop 35 expenditures for calendar years 2025 and 2026 only. DHCS has issued their Prop 35 Spending Plan for CY 2025 and 2026 which outlines that DHCS intends to fund the non-federal share of the majority of Prop 35 domains and overall managed care capitation payment increases by "sweeping" the MCO Tax dollars intended to increase the domains outlined in Prop 35.In short, leveraging Prop 35 to fund the non-federal share of managed care capitation rates frees up general fund to help solve the budget problem. These rate increases in managed care are a result of caseload, utilization, and cost growth that is accounted for in setting plans' capitated rates; not new funding for providers as intended by Prop 35. The portion of the funding that we believe is being utilized more in alignment with Prop 35 are directed payments proposed to begin in certain categories effective January 1, 2026 in most cases. However, there are also questions about the interaction with the BH-CONNECT special terms and conditions, which are mentioned throughout DHCS' Prop 35 document as specifying rate increases in certain service categories. Below is a summary of how DHCS intends to leverage the MCO Tax for the Prop 35 domains:

- DHCS intends to implement a limited-term uniform dollar increase directed payment for Emergency Department Facilities and Physicians, beginning July 1, 2025, as well as Primary and Specialty Care Services, beginning January 1, 2026. These will be add-ons and treated similarly to Prop 56 payments.
- Existing Designated Public Hospital and Emergency Facility Services Directed Payments - DHCS intends to use these funds to support non-federal share of those existing programs. For the public hospitals, this program is currently self-financed, so Prop 35 funding will instead fund the non-federal share.
- Reproductive Health - DHCS intends to provide the funds to the Department of Health Care Access and Information (HCAI) to provide grants that address emergent needs in reproductive health including midwifery practitioner loan repayments and scholarships and expansion of education capacity for nurse midwives. This proposal is a full sweep of funding.
- Support for Safety Net Clinics – DHCS intends to increase the current Community Clinics Directed Payment by covering the non-federal share and increasing the pool amount, consistent with the intent of the Proposition.
- Ground Emergency Medical Transportation – DHCS intends to increase current FFS fee schedules, which will increase managed care GEMT add-on rates.

- Graduate Medical Education – DHCS intends to provide all of the funds to the UC to spend on expanding the GME program, consistent with the intent of Prop 35.
- Behavioral Health Facility Throughput - DHCS is proposing a portion of the funding be allocated to data sharing, consent management, and care coordination; and another portion for flexible housing subsidy pools. It is not clear how much of the funding is intended to support BH-CONNECT and county implementation, or specifically what will be supported by the first proposed bucket.
- Medi-Cal Workforce – DHCS intends to provide the funds to HCAI to support workforce but does not have a detailed proposal for specifically what types of providers or programs. HCAI will be invited to a future PAHCA-SAC meeting to discuss.

Reference: Governor's Budget Summary, p. 36, DHCS Budget Highlights, p. 4, DHCS Medi-Cal Local Assistance Estimate, p. 451 & 485

Changes to Eligibility for the Undocumented Population

Enrollment Freeze for Full-Scope (State-Only) Medi-Cal Expansion for UIS Adults 19+
Estimated General Fund Savings: $86.5 million in 2025-2026, increasing to $3.3 billion by 2028-2029

Effective no sooner than January 1, 2026, propose implementation of a freeze on new enrollment in full-scope, state-only Medi-Cal coverage for adults 19 years of age or older without satisfactory immigration status or are unable to establish satisfactory immigration status. The enrollment freeze excludes individuals that are Qualified Non-Citizens under the five-year bar, individuals claiming Permanently Residing Under Color of Law, and pregnant individuals.

Medi-Cal Premiums (State-Only) for UIS Adults 19+
Estimated General Fund Savings: $1.1 billion in 2026-2027, increasing to $2.1 billion by 2028-2029.

Effective no sooner than January 1, 2027, propose to implement state-only $100 monthly premiums for UIS individuals 19 years of age or older. DHCS stated on the CalHHS Secretary Stakeholder May Revise call that they anticipate an approximate 25% disenrollment of the targeted population as a result of this policy change.

Elimination of (State-Only) PPS Rates to FQHCs and Rural Health Clinics for UIS Individuals
Estimated General Fund Savings: $452.5 million in 2025-2026 and $1.1 billion in 2026-2027 and ongoing.

Propose to eliminate PPS rates to clinics for state-only-funded services for UIS population, and instead, reimburse at the Medi-Cal Fee Schedule rate if FFS delivery system and at the applicable negotiated rate between Medi-Cal managed care plans and clinics.

Elimination of (State-Only) Long-Term Care for UIS Individuals

Estimated General Fund Savings: $333 million in 2025-2026 and $800 million in 2026-2027 and ongoing.

Effective January 1, 2026, propose to eliminate state-only long-term care benefits for UIS individuals.

Elimination of Dental Benefits for UIS Adults 19+
Estimated General Fund Savings: $308 million in 2026-2027 and $336 million in 2028-2029 and ongoing.

Effective July 1, 2026, propose to eliminate full-scope, state-only dental coverage for UIS Medi-Cal members aged 19 years or older; however, will continue to have access to restricted-scope emergency dental coverage.

Institute a Pharmacy Rebate Aggregator for UIS Population
Estimated General Fund Savings: $300 million in 2025-2026 and $362 million ongoing.

Propose to implement a rebate aggregator to secure state rebates for UIS individuals.

Changes to Medi-Cal Minimum Medical Loss Ratio
The May Revision proposes to increase the minimum medical loss ratio for managed care plans beginning January 1, 2026. Although the May Revision does not specify what percentage the MLR will increase to, the information LHPC has received from DHCS indicates it will increase to 90%. This will require DHCS to develop new trailer bill language to update the MLR statute.
Estimated General Fund Savings: $200 million in SFY 2028-29 and ongoing.

Reference: May Revision Summary, p. 38; DHCS Budget Highlights, pp. 6-7

Changes to Provider Supplemental Payments

Elimination of Proposition 56 Supplemental Payments
Estimates General Fund Savings: Eliminate approximately $504 million in 2025-26 and $550 million ongoing for Proposition 56 supplemental payments to dental, family planning, and women's health providers.

Elimination of Skilled Nursing Facility Workforce and Quality Incentive Program *(SNF WQIP)*
Estimates General Fund Savings: $168.2 million in 2025-26 and $140 million ongoing.

Eliminates the SNF WQIP and suspends the requirement to maintain a backup power system for no fewer than 96 hours.

Increase in Pharmacy Expenditures & Budget Solutions
The Governor's January Budget projected an increase of $1.6 billion ($1.3 billion General Fund) in 2024-25 and a year-over-year increase of $1.2 billion ($215.2 million General Fund) in 2025-26 due to projected growth in Medi-Cal pharmacy expenditures. The May Revise does not

readily identify projections for total pharmacy increases in 2025-26 but does project increased spending of approximately $1 billion in 2025-26 for the non-UIS population.

The May Revise includes several policies aimed at addressing pharmacy costs, resulting in an estimated $638 million in 2025-26 collectively. The policies are primarily cost-containment measures in the Medi-Cal Rx program but does include coverage elimination of some over-the-counter drugs and GLP-1s for weight loss.

Pharmacy Drug Rebates

- *Estimated General Fund Savings:* $300 million in 2025-26 and $362 million ongoing. As noted above, the May Revise calls to implement a rebate aggregator for the UIS population to negotiate and execute contracts to allow Medi-Cal to secure state rebates for this population.

- *Estimated General Fund Savings:* $75 million in 2025- 26 and $150 million ongoing associated with minimum rebate for human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) and cancer drug rebates.

Elimination of Over-the-Counter Drug Coverage
Estimated General Fund Savings: $3 million in 2025-26 and $6 million in 2026-27 and ongoing through elimination of pharmacy coverage of certain drug classes, including: COVID-19 antigen tests, over-the-counter vitamins, and certain antihistamines.

Prescription Drug Utilization Management
Estimated General Fund savings: $25 million in 2025-26 and $50 million in 2026-27 and ongoing through implementation of utilization management and prior authorization policies for prescription drugs.

Step Therapy Protocols
Estimated General Fund Savings: $87.5 million in 2025-26 and $175 million ongoing through implementation of a step therapy strategy.

Prior Authorization for Continuation of Drug Therapy
Estimated General Fund Savings: $62.5 million in 2025-26 and $125 million in 2026-27 and ongoing through elimination of continuing care status under Medi-Cal Rx effective January 1, 2026. Prior authorization will be required for any drugs not or removed from Medi-Cal Rx CDL.

Elimination of GL-P1s
Estimated General Fund Savings: $85 million in 2025-26, growing to $680 million by 2028-29 and ongoing through elimination of coverage for weight loss.

Pharmacy Benefit Manager Licensure
Proposed statutory changes to establish licensure and reporting requirements for PBMs to increase transparency, understand cost drivers and develop approaches to improve affordability.

Reference: May Revision Summary, pp. 37-39; DHCS Budget Highlights, pp. 4-7

CalAIM

The May Revision estimates $2.4 billion in expenditures for CalAIM ECM and Community Supports, an increase of $1.2 billion from the Governor's January Budget. DHCS project 2025-26 increases of $728 million for Community Supports and $366 million for Enhanced Care Management compared to the Governor's January Budget. Transitional Rent is included in the May Revision and does not reflect increased cost estimates from the Governor's January Budget. However, there is $200 million of Proposition 35 funds to support Flexible Housing Pool rental assistance and housing supports over two years.

Governor's January Budget

	Total Fund	**General Fund**	**Federal Funds**
Community Supports	$231,000,000	$89,797,000	$141,203,000
Enhanced Care Management	$955,686,000	$374,369,000	$581,317,000
Transitional Rent	$31,276,000	$10,947,000	$20,329,000
Total for FY 2025-26	$1,217,962,000	$475,114,000	$742,848,000

May Revision Budget

	Total Fund	**General Fund**	**Federal Funds**
Community Supports	$1,049,181,000	$436,131,000	$613,050,000
Enhanced Care Management	$1,321,964,000	$580,079,000	$741,884,000
Transitional Rent	$31,276,000	$10,947,000	$20,329,000
Total for FY 2025-26	$2,402,421,000	$1,027,158,000	$1,375,263,000

Reference: DHCS Medi-Cal Local Assistance Estimate, p. 129, May Revision Budget Summary p. 49

Other Medi-Cal Proposals

- *Optional Benefit Elimination: Acupuncture*—May revision reflects General Fund savings of $54 million in 2025-26 and $13.1 million ongoing by eliminating acupuncture as an optional benefit.

- *Utilization Management Efficiencies: Hospice*—Implementation of prior authorization requirements for hospice services are projected to result in General Fund savings of $25 million in 2025-26 and $50 million ongoing.

- *Program of All-Include Care for the Elderly (PACE) Capitation Payments*—Estimated General Fund savings of $13 million in 2025-26 and $30 million ongoing through limiting payments to PACE providers to the midpoint of actuarial rate ranges. This proposal would exclude newly enrolled providers who will receive enhanced rates for the first two years.

Reference: DHCS May Revision Budget Highlights, p. 6

Behavioral Health

- *Behavioral Health Workforce Initiative*—Proposed $1.9 billion ($143 million Behavioral Health Services Fund, $808 million Designated State Health Program Funding, and $950 million federal funds) for HCAI to implement the Behavioral Health Workforce Initiative beginning in January 2026.

  Reference: May Revise Budget Summary, p. 45

Other Human Services Proposals

In-Home Supportive Services (IHSS)

The May Revision includes $28.3 billion ($10.3 billion General Fund) for the IHSS program in 2025-26. The May Revision includes several reductions impacting IHSS to address the budget shortfall.

- *Medi-Cal Eligibility Reductions Impacting IHSS*—A reduction of $22.5 million General Fund in 2025-26 to conform IHSS with the reinstate of the Medi-Cal asset limit. A reduction of $158.8 million General Fund in 2025-26 and ongoing to eliminate IHSS benefits for UIS population aged 19 and older.

- *Conform IHSS Residual Program with Medi-Cal Coverage*—A reduction of $110.6 million General Fund in 2025-26 to conform the IHSS Residual Program coverage, a program available to individuals who are not eligible for full-scope Medi-Cal, with the timing of Medi-Cal coverage.

- *Provider Overtime and Travel Hours*—A reduction of $707.5 million General Fund and ongoing to cap IHSS provider overtime and travel hours at 50 hours, a decrease from 60-70 hour cap, per week beginning in 2025-26.

- *Community First Choice Option Late Penalties*—A reduction of $81 million General Fund in 2025-26 to reflect the assumed costs for counties to cover the IHSS, Community First Choice Option reassessment late penalties.

Reference: May Revision Budget Summary, p. 42

Housing and Homelessness

Creating the California Housing and Homelessness Agency
The Administration is continuing to propose establishing a new California Housing and Homelessness Agency (CHHA) to create a more integrated and effective administrative framework for addressing the state's housing and homelessness challenges. CHHA will be responsible for coordinating state housing and homelessness efforts, which includes addressing the full spectrum of Californians' housing needs, from efforts to prevent and end homelessness, to supporting low-income renters and first-time homebuyers. The agency will also be responsible for safeguarding civil rights, including efforts to advance and enforce fair housing and equal employment protections.

The new CHHA will integrate housing programs, streamline policies, and simplify the administration of state affordable housing programs. Creating a state agency focused on overseeing policy development and the administration of state housing and homelessness resources will provide clear authority and accountability for addressing statewide priorities. The agency will include the following entities:

- Department of Housing and Community Development
- California Interagency Council on Homelessness
- California Housing Finance Agency
- Civil Rights Department
- Housing Development and Finance Committee

Reference: Governor's Budget Summary, pp. 47-48

Proposition 35 Flexible Housing Subsidy Pools
The May Revision reflects $200 million Proposition 35 funds (Behavioral Health Facilities domain) over two years for Flexible Housing Pool rental assistance and housing supports to help individuals with significant behavioral health conditions who are experiencing, or at risk of, homelessness, enter and maintain stable long-term housing.

Reference: Governor's Budget Summary, p. 49

TBL Section
The following list outlines trailer bill language of interest to local plans. LHPC will be monitoring for trailer bill language in the coming weeks and will share more information once available:

- Policy Changes Related to Individuals with Unsatisfactory Immigration Status
- Eliminate Prospective Payment System Reimbursement for State-Only Services
- Eliminate Medi-Cal Optional Benefit: Acupuncture Services
- Reinstatement of the Medi-Cal Asset Limit
- Medi-Cal Managed Care Plans Medical Loss Ratio Increase
- HIV and Cancer Drug Rebates Prior Authorization for Continuation of Drug Therapy
- Skilled Nursing Facility Workforce and Quality Incentive Program

- Suspension of Skilled Nursing Facility Backup Power Requirement
- Federal Final Rules (includes Eligibility, Managed Care and Access Final Rules)
- Non-Designated Public Hospital Supplemental Fund and Intergovernmental Transfer Programs
- Streamline Legislative Reporting Requirements

May 13, 2025

The Honorable Adam Gray
1230 Longworth House Office Building
Washington, DC 20515

Dear Congressman Gray,

Medicaid stands as a cornerstone of American strength and resilience, providing vital health coverage to 78.5 million Americans—including 15 million Californians. This program represents our nation's commitment to supporting families, protecting workers, and sustaining our world-leading healthcare system.

Central California Alliance for Health is a public Medicaid managed care plans operating directly in Santa Cruz, Monterey, Merced, San Benito and Mariposa counties, ensuring that our 440,000 Medicaid members have access to the vital health care services from a provider network that is fairly reimbursed for the care they provide. As a local health plan, we are community-based, locally governed and publicly accountable. As you consider budget reconciliation measures, we strongly urge you to safeguard Medicaid from significant funding reductions. While we support initiatives to enhance program efficiency and combat waste, fraud, and abuse, we are deeply concerned that proposed cuts would result in coverage losses, increased uncompensated care burdens, deteriorating health outcomes for working families, and economic damage to local communities.

The House Energy and Commerce Committee's proposed mark-ups released this week would cut an estimated $912 billion in spending—exceeding their $880 billion target—with $715 billion coming from Medicaid, Medicare, and health care marketplaces. Cuts of this magnitude will result in widespread loss of healthcare access, destabilize safety net systems, and negatively impact state economies. The Committee's Medicaid reduction proposals include a 10% penalty for states offering coverage to income-eligible undocumented residents, provider tax cuts, new work requirements (called community engagement), and cost-sharing burdens for individuals earning as little as $15,560 annually.

Before Congress acts on these measures, our Representatives must have a comprehensive analysis of how these proposed reductions would affect each state and the health and economic consequences nationwide. In California alone, preliminary estimates indicate the proposal would result in approximately $90-100 billion in cuts over the next decade. This magnitude of reduced federal funding will force difficult decisions by California policymakers and will lead to fewer Californians with health care coverage, poorer access to care, a negative impact on health outcomes in local communities, and harmful effects to California health care providers. The ripple effects of these cuts will be felt across the state in our local communities.

Medicaid's Critical Contributions

As you deliberate on Medicaid funding, we emphasize these essential benefits:

Medicaid Strengthens Our Workforce and Economy One in five American workers relies on Medicaid coverage, enabling them to remain productive members of society. These hardworking individuals serve in restaurants, retail establishments, construction sites, and countless other sectors. With reliable healthcare access, they can focus on their work without the shadow of medical bankruptcy or untreated illness.

A healthy workforce misses fewer workdays, maintains higher productivity, and contributes more substantially to national prosperity.

Medicaid Builds Strong American Families Our nation's foundation rests on family strength. Medicaid provides essential coverage to millions of children, seniors, and individuals with disabilities. Nearly half of all enrollees—approximately 37 million young Americans—receive the preventive care and medical treatment necessary for developing into healthy, productive citizens.

When parents have reliable healthcare, they don't have to worry about missing work or losing a job due to poor health, allowing them to meet their family responsibilities. Regular preventive care and chronic condition management keeps Americans across generations healthy and productive, upholding our national commitment to family values and inclusive care.

Medicaid Sustains America's Premier Healthcare Infrastructure America's healthcare system leads the world, with Medicaid playing a vital role in maintaining this excellence. The program supports hundreds of thousands of health care professionals and facilities nationwide. Rural hospitals especially depend on Medicaid to continue serving communities that would otherwise lack medical access.

By ensuring consistent patient flow and reliable payment, Medicaid helps maintain our healthcare infrastructure coast-to-coast, enabling continued American healthcare innovation that benefits people globally.

Medicaid: A Shield Against America's Uninsured Crisis

Prior to Medicaid expansion, our nation faced a healthcare access emergency—millions of hardworking Americans went without basic health coverage, leading to devastating personal financial collapses and emergency rooms functioning as primary care providers. The ripple effects strained our entire healthcare ecosystem as hospitals absorbed billions in unpaid care costs. Today's expanded Medicaid program has transformed this landscape, creating a safety net that protects both American families and health care providers. We now see communities where preventive care replaces emergency intervention, where medical bills no longer trigger household bankruptcies, and where hospitals stand on firmer financial ground. This remarkable turnaround represents effective governance addressing real-world challenges—a healthcare solution that strengthens both individual Americans and the institutions that serve them.

Medicaid Delivers Exceptional Value

In an era demanding fiscal restraint, Medicaid demonstrates government effectiveness—delivering comprehensive health care while saving American taxpayers substantially. The numbers tell a compelling story: providing care at 83 cents on the dollar compared to private insurance alternatives. This isn't merely good governance—it's smart economics that maximizes every federal dollar invested.

This remarkable efficiency hasn't gone unnoticed. Three-quarters of American voters across political divides recognize Medicaid's value proposition and support its continuation. They understand what detailed analyses have consistently shown: investments in Medicaid strengthen our economic foundation, enhance workforce productivity, preserve family stability, and maintain critical healthcare infrastructure.

As you navigate difficult budgetary decisions, we ask you to recognize Medicaid not as a mere expenditure but as a strategic investment in America's human capital and infrastructure. The program's demonstrated record of efficiency, combined with its measurable impacts on our healthcare system and economy, makes a compelling case for its protection. America prospers when its people are healthy enough to work, when families avoid financial collapse from medical events, and when our healthcare facilities remain viable in every community—outcomes that depend on Medicaid's continued strength.

Sincerely,

Michael Schrader
Chief Executive Officer

May 13, 2025

The Honorable Zoe Lofgren
1401 Longworth House Office Building
Washington, DC 20515

Dear Congresswoman Lofgren,

Medicaid stands as a cornerstone of American strength and resilience, providing vital health coverage to 78.5 million Americans—including 15 million Californians. This program represents our nation's commitment to supporting families, protecting workers, and sustaining our world-leading healthcare system.

Central California Alliance for Health is a public Medicaid managed care plans operating directly in Santa Cruz, Monterey, Merced, San Benito and Mariposa counties, ensuring that our 440,000 Medicaid members have access to the vital health care services from a provider network that is fairly reimbursed for the care they provide. As a local health plan, we are community-based, locally governed and publicly accountable. As you consider budget reconciliation measures, we strongly urge you to safeguard Medicaid from significant funding reductions. While we support initiatives to enhance program efficiency and combat waste, fraud, and abuse, we are deeply concerned that proposed cuts would result in coverage losses, increased uncompensated care burdens, deteriorating health outcomes for working families, and economic damage to local communities.

The House Energy and Commerce Committee's proposed mark-ups released this week would cut an estimated $912 billion in spending—exceeding their $880 billion target—with $715 billion coming from Medicaid, Medicare, and health care marketplaces. Cuts of this magnitude will result in widespread loss of healthcare access, destabilize safety net systems, and negatively impact state economies. The Committee's Medicaid reduction proposals include a 10% penalty for states offering coverage to income-eligible undocumented residents, provider tax cuts, new work requirements (called community engagement), and cost-sharing burdens for individuals earning as little as $15,560 annually.

Before Congress acts on these measures, our Representatives must have a comprehensive analysis of how these proposed reductions would affect each state and the health and economic consequences nationwide. In California alone, preliminary estimates indicate the proposal would result in approximately $90-100 billion in cuts over the next decade. This magnitude of reduced federal funding will force difficult decisions by California policymakers and will lead to fewer Californians with health care coverage, poorer access to care, a negative impact on health outcomes in local communities, and harmful effects to California health care providers. The ripple effects of these cuts will be felt across the state in our local communities.

Medicaid's Critical Contributions

As you deliberate on Medicaid funding, we emphasize these essential benefits:

Medicaid Strengthens Our Workforce and Economy One in five American workers relies on Medicaid coverage, enabling them to remain productive members of society. These hardworking individuals serve in restaurants, retail establishments, construction sites, and countless other sectors. With reliable healthcare access, they can focus on their work without the shadow of medical bankruptcy or untreated illness.

A healthy workforce misses fewer workdays, maintains higher productivity, and contributes more substantially to national prosperity.

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By ensuring consistent patient flow and reliable payment, Medicaid helps maintain our healthcare infrastructure coast-to-coast, enabling continued American healthcare innovation that benefits people globally.

Medicaid: A Shield Against America's Uninsured Crisis

Prior to Medicaid expansion, our nation faced a healthcare access emergency—millions of hardworking Americans went without basic health coverage, leading to devastating personal financial collapses and emergency rooms functioning as primary care providers. The ripple effects strained our entire healthcare ecosystem as hospitals absorbed billions in unpaid care costs. Today's expanded Medicaid program has transformed this landscape, creating a safety net that protects both American families and health care providers. We now see communities where preventive care replaces emergency intervention, where medical bills no longer trigger household bankruptcies, and where hospitals stand on firmer financial ground. This remarkable turnaround represents effective governance addressing real-world challenges—a healthcare solution that strengthens both individual Americans and the institutions that serve them.

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In an era demanding fiscal restraint, Medicaid demonstrates government effectiveness—delivering comprehensive health care while saving American taxpayers substantially. The numbers tell a compelling story: providing care at 83 cents on the dollar compared to private insurance alternatives. This isn't merely good governance—it's smart economics that maximizes every federal dollar invested.

This remarkable efficiency hasn't gone unnoticed. Three-quarters of American voters across political divides recognize Medicaid's value proposition and support its continuation. They understand what detailed analyses have consistently shown: investments in Medicaid strengthen our economic foundation, enhance workforce productivity, preserve family stability, and maintain critical healthcare infrastructure.

As you navigate difficult budgetary decisions, we ask you to recognize Medicaid not as a mere expenditure but as a strategic investment in America's human capital and infrastructure. The program's demonstrated record of efficiency, combined with its measurable impacts on our healthcare system and economy, makes a compelling case for its protection. America prospers when its people are healthy enough to work, when families avoid financial collapse from medical events, and when our healthcare facilities remain viable in every community—outcomes that depend on Medicaid's continued strength.

Sincerely,

Michael Schrader
Chief Executive Officer

May 13, 2025

The Honorable Tom McClintock
2256 Rayburn House Office Building
Washington, DC 20515

Dear Congressman McClintock,

Medicaid stands as a cornerstone of American strength and resilience, providing vital health coverage to 78.5 million Americans—including 15 million Californians. This program represents our nation's commitment to supporting families, protecting workers, and sustaining our world-leading healthcare system.

Central California Alliance for Health is a public Medicaid managed care plans operating directly in Santa Cruz, Monterey, Merced, San Benito and Mariposa counties, ensuring that our 440,000 Medicaid members have access to the vital health care services from a provider network that is fairly reimbursed for the care they provide. As a local health plan, we are community-based, locally governed and publicly accountable. As you consider budget reconciliation measures, we strongly urge you to safeguard Medicaid from significant funding reductions. While we support initiatives to enhance program efficiency and combat waste, fraud, and abuse, we are deeply concerned that proposed cuts would result in coverage losses, increased uncompensated care burdens, deteriorating health outcomes for working families, and economic damage to local communities.

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Michael Schrader
Chief Executive Officer

May 13, 2025

The Honorable Jimmy Panetta
200 Cannon House Office Building
Washington, DC 20515

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Sincerely,

Michael Schrader
Chief Executive Officer

DATE: May 28, 2025

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

FROM: Jenifer Mandella, Chief Compliance Officer

SUBJECT: Q3-4 2024 Compliance Program Report

Recommendation. Staff recommend the Board approve the Compliance Program Report for Q3-4 2024.

Summary. This report summarizes the Alliance's Compliance Program activities for Q3-4 2024 and includes a recommendation to approve the Compliance Program Report.

Background. The Alliance is required to implement an effective Compliance Program that meets the requirements set forth in 42 C.F.R. § 438.608. Modeled off the United States Federal Sentencing Guidelines' (FSG's) seven elements of an effective compliance program, and articulated in the Compliance Plan, the Alliance's Compliance Program takes a systematic and strategic approach to decreasing risk posed by non-compliance.

The FSG states "The organization's governing authority shall be knowledgeable about the content and operation of the compliance and ethics program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program." The Board has delegated authority for overseeing the Compliance Program to the Compliance Committee and receives updates on the efficacy of the Compliance Program through the routine submission of Compliance Committee minutes, the inclusion of key Compliance Program metrics in the Alliance Dashboard, and the receipt of bi-annual reporting from the Chief Compliance Officer.

Discussion. This report serves to inform the Board of the Alliance's Compliance Program activities for Q3-4 2024.

Key Accomplishments

- Led organizational efforts to obtain National Committee for Quality Assurance (NCQA) health plan and health equity accreditations, as required by the Department of Health Care Services (DHCS). Compliance staff led the project, overseeing the organization's implementation of NCQA-compliant processes, expanded member and provider data collection, and more targeted data reporting methodologies to ensure readiness for its April 2025 Survey. The Plan expects to receive the two NCQA accreditations in June of 2025.
- Supported efforts to launch a Medicare Dual Special Needs Plan (DSNP) product:
    - Timely submission of the Notice of Intent to Apply to the Centers for Medicare and Medicaid Services (CMS).
    - Assisted with developing the Alliance's Part C and Part D applications, which were timely submitted in early 2025.

    - Revised compliance program operations to align with Medicare program requirements. Significant revisions included formalizing the corrective action plan (CAP) process to ensure that any deficiencies identified within Alliance or delegate operations resulted in a formal CAP; developed a process to identify and risk rate first tier, downstream, and related entities (FDRs); and revised the contents and frequency of board reporting. Program changes will continue through 2025 to ensure a fully compliant program is in place by January 1, 2026.
    - In anticipation of increased volume and complexity resulting from additional regulatory scrutiny, modified the Compliance Department's structure to ensure sufficient staffing resources and leadership oversight are in place to meet requirements promulgated by DHCS, Department of Managed Health Care (DMHC), NCQA, and CMS.
- Supported insourcing of the behavioral health benefit via management of regulatory filings to secure necessary approvals.
- Identified and remediated two significant instances of suspected fraud, waste, or abuse (FWA), which resulted in overpayment recoveries and internal process improvements to mitigate risk of future issues:
    - Emergency COVID-19 Testing - staff discovered potentially fraudulent billing practices by non-contracted COVID-19 testing providers. Under the guise of California's emergency COVID-19 testing requirements, providers submitted a high-volume of inappropriate claims for reimbursement for COVID-19 tests, which the Alliance recovered as overpayments. Program Integrity staff continue to partner with the Alliance's Claims department to ensure these claims are flagged for further review to prevent inappropriate payments.
    - Medically Tailored Meals - staff found evidence that meals were not provided in alignment with regulatory requirements, including delivering food to ineligible members and lack of proper dietary assessments. Program Integrity staff recovered overpayments as required and continue to partner with organizational leadership to refine and oversee the delivery of this benefit.

Legal and Regulatory Updates

Compliance staff track and an analyze new requirements and manage a process to ensure the implementation of legislation, contract changes, and sub-regulatory guidance. A brief description of significant regulatory developments are included below for Board awareness.

- While the impact is still uncertain, Compliance staff are monitoring changes resulting from the 2024 election. Staff are reviewing relevant Executive Orders to determine impact, including identifying any mitigating factors such as litigation, injunctions, and conflicting state requirements. Potential impacts may include efforts to eliminate the Affordable Care Act's Medicaid expansion, cuts to federal funding through block grants or per-capita grants, changes to Medicaid eligibility criteria, and the introduction of new requirements for approving waiver requests from states.
- Regulators have issued implementation specifications for requirements issued in previous years, including:

    - Implementation specifications for the CMS' Managed Care Access, Finance, and Quality rule, which intends to increase access through establishing timely access studies; enhance quality through value-based purchasing agreements; and ensure transparency with medical loss ratio requirements and enhanced public reporting of plan performance.
    - Implementation specifications for provisions of the revised DHCS Medi-Cal contract that were not effective until 2025 or later, such as community reinvestment and emergency preparedness requirements.
    - Evolving requirements for the enhanced case management (ECM) and community supports (CS) benefits, which largely aim to ensure program integrity in the delivery of services.
- Significant proposed changes to security requirements in response to the increasing risk of breaches and cyberattacks across the healthcare industry, including the increasing prevalence of cyberattacks of business associates. In response, Health and Human Services (HHS) Office for Civil Rights (OCR) issued a proposed rule that would modify the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule in a way that removes existing flexibility to determine which requirements to implement based on a risk assessment. In addition, DHCS recently notified plans that as a state contractor, we are subject to the State Chief Information Officer's policies which specify that physical data centers must be within the continental United States and that remote access to data from outside the continental United States may only be provided with approval from the State Chief Information Security Officer. While neither rule is final yet, this signals that regulators are prioritizing the security of program data.

Regulatory Audits

The Alliance undergoes routine audits and examinations of its finances and operations by its regulatory oversight agencies, as well as by independent auditing firms. Following is a list of audits and examinations that the Alliance was involved in during Q3-4 2024, including the auditing entity and a description of the audit status.

- DHCS Targeted Behavioral Health and Transportation Audit – which is a statewide review conducted in 2022 to ensure that members are receiving support in coordinating care between the various systems responsible for providing mental health and substance use disorder services as well as a review of plan processes for ensuring transportation is provided to enable members to access covered services. In early 2024, the Alliance received 8 findings; 6 related to coordination of care between the Alliance, its managed behavioral health organization Carelon and the County Mental Health Plan (MHP) for members accessing specialty mental health, non-specialty mental health, and substance use disorder services; and two findings related to the provision of transportation services. Five of the findings have been closed and the remaining findings are pending DHCS' review of supporting documentation such as reports and workflows. Staff anticipate the closure of the remaining findings in early 2025.
- 2024 DMHC Medical Audit – which is a routine review of the Alliance's performance in providing health care benefits and meeting the health care needs of enrollees for the Alliance's Alliance Care In-Home Supportive Services (IHSS) line of business in the areas of: grievances and appeals, prescription drugs, utilization management

(UM), quality management, language assistance, continuity of care, access and availability, and access to emergency services and payment. The Alliance has not yet received the results of this survey.
- Health Services Advisory Group Network Adequacy Validation Audit – which is a review conducted by a DHCS-contracted organization to confirm the validity of the data, systems, and methods used by the Alliance to calculate results for its Annual Network Certification filing. The Alliance received findings indicating that all audited elements met requirements.

In addition, staff prepared for regulatory audits scheduled in early 2025, as follows.
- 2025 DMHC Financial Audit – which is a routine review of the Alliance's fiscal and administrative affairs, including an examination of the financial report and claims practices. The audit commenced in January of 2025 and remains ongoing.
- 2025 DHCS Medical Audit – the 2025 audit was limited in scope, covering UM, case management, coordination of care, access and availability of care, member rights, quality management, and administrative and organizational capacity. As of publication of this report, DHCS has not formally issued findings, however, feedback provided at the close of the interview sessions indicate the Alliance may expect findings related to resolution of quality grievance, oversight of grievance and appeals, and enhanced case management.

Regulatory Notices of Non-Compliance

The Alliance's regulators routinely monitor plan activities to confirm compliance with requirements. Where regulators have found the Alliance to be non-compliant, they may issue warning letters or notices of non-compliance, may implement corrective action plans (CAPs), and may impose sanctions (collectively referred to in this report as "notices of non-compliance"). Following is a list of active concerns addressed during Q3-4 2024.
- DMHC audit sanctions – As previously reported, DMHC imposed an Enforcement Action regarding four findings from the 2020 DMHC Medical Survey which remained uncorrected during the 2022 Follow-Up Survey. The results uncorrected deficiencies related to processing appeals and grievances, pharmacy denial notices, and communications to members regarding grievance resolution and utilization management denials. Notably, the latter two findings were issued because the Alliance erroneously underlined the DMHC's website in our member letters. The Department indicated a willingness to resolve the matter with the payment of a $100,000 administrative penalty. The Alliance continues to negotiate the administrative penalty with DMHC.
- DMHC timely access sanctions – DMHCS imposed an Enforcement Action for failure to submit two required documents with the measurement year (MY) 2019 timely access report, which was submitted in 2020. This was a result of staff oversight, which was corrected immediately when DMHC notified the plan; nevertheless, DMHC is pursuing financial penalties of $15,000 for this omission. The Alliance continues to negotiate the administrative penalty with DMHC.
- DHCS Primary Care Provider (PCP) ratio CAP – DHCS issued a CAP indicating that the Alliance had failed to meet the requirement to ensure the full-time equivalent ratio of one PCP to every 2,000 members in Monterey and Merced counties. Staff revised

network reporting procedures, which addressed the deficiency in Merced County. Staff continue to work collaboratively with DHCS to resolve the ratios in Monterey County as there appears to be a discrepancy in the network data DHCS is reviewing and internal reporting sources.

HIPAA

The Alliance maintains a comprehensive process to investigate suspected disclosures of protected health information (PHI) and report disclosures to relevant oversight bodies. The table below summarizes HIPAA Program activity for Q3-4 2024,

		Q3 2024	Q4 2024	Trend
Referrals Received		27	32	22% decrease
Investigation Outcome	Breach	0	0	n/a
	Incident	8	9	47% decrease
	Non-reportable	18	23	10% increase
	Pending	1	0	n/a
Members Impacted		196	229	82% increase

In the second half of 2024, referral volume normalized, with 27 referrals in Q3 and 32 referrals in Q4. 30% of referrals required DHCS notification pursuant to the DHCS Medi-Cal contract, a slight decrease from the first half of the year. Zero referrals were deemed breaches.

425 members were impacted by incidents, meaning that their PHI was disclosed to a covered entity that they did not have a treating relationship with. This is a significant increase from the first half of 2024 and is largely attributed to misconfigurations of the Alliance's new care management system, which resulted in inaccurate provider contact information in limited instances. As a routine practice, corrective action is put in place to prevent recurrence. Notably, staff have not identified any additional disclosures related to the care management system, indicating effective corrective action.

Compliance staff conduct root cause analysis on all referrals, whether a disclosure occurred or not. Incorrect selection/entry, lost/stolen wallets, and verbal disclosures are typically the main drivers of HIPAA referrals, and the first 2 of those 3 root causes are reflected in Q3-4 data. For this reporting period, 'other' replaced verbal disclosure as a top root cause. Examples of these include the afore-mentioned configuration errors and disclosures resulting from errors in the DHCS eligibility file, The chart below shows the root causes of suspected disclosures of PHI during Q3-4 2024.

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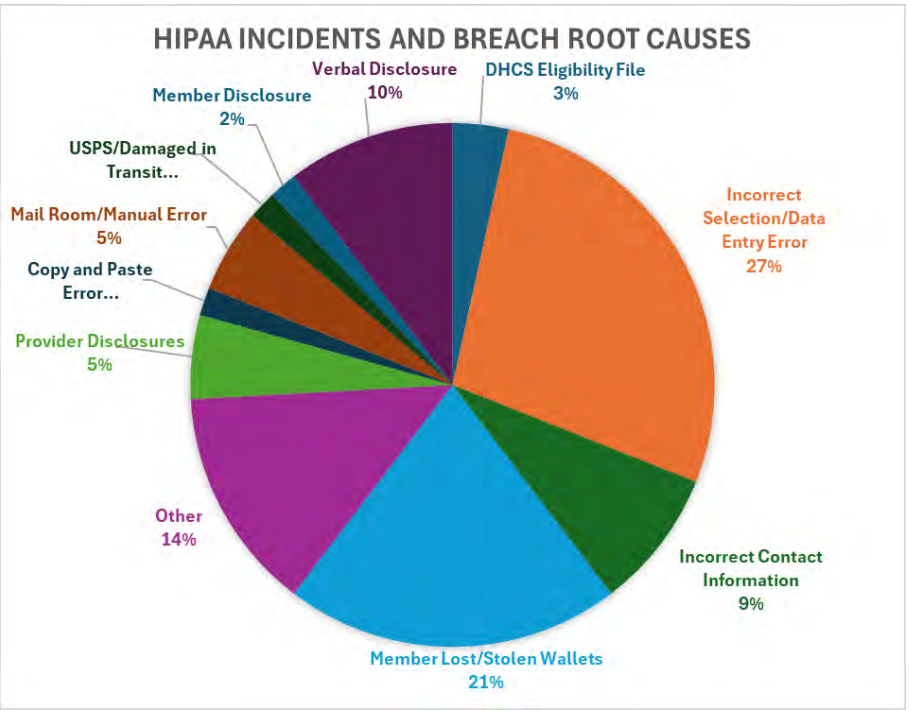

FWA Prevention, Detection, and Investigation
The Alliance Program Integrity function is responsible for ensuring the Plan has controls in place to prevent and detect FWA, and to investigate, report, and resolve suspected and/or actual FWA. In limited instances, Alliance delegates may conduct some FWA-related activities at the Plan's direction. These activities are represented in this report. The table below summarizes Program Integrity activity for Q3-4 2024,

	Q3 2024	Q4 2024	Trend
Referred	43	35	30%
Opened	15	42	16%
Reported	25	12	38%

Referral volume continued to trend down, with a 30% decrease in referrals and a 16% decrease in cases opened for investigation. Nevertheless, due to an increase in complexity of cases, the total number of cases worked during the time period remained high, with 89 cases active. 55% of referrals met the threshold for DHCS reporting pursuant to the DHCS Medi-Cal contract.

Where FWA is suspected, Plan staff prevents recurrence of the identified behavior by providing education, issuing CAPs, and/or implementing internal controls. Compliance's reporting indicates these corrective actions are effective as there were minimal repeat concerns during the reporting period.

Where the Alliance identifies overpayments, it is required to pursue those recoupments. The table below includes the Program Integrity-related claim recoveries for Q3-4 2024.

Recoupment	Alliance-initiated	Delegate-initiated
Requested Recoupment	$100,119.77	$7,065.28
Completed Recoupment	$103,182.68	

Provider-related concerns continued to make up the bulk of Program Integrity investigations, with concerns related to over-utilization, duplicate billing, and billing for services not rendered. As previously mentions (Key Accomplishments), significant cases related to billing for COVID-19 testing and medically tailored meals.

Program Integrity staff continue to attend California Department of Justice (DOJ) meetings to stay up to date on current trends and collaborate with regulators, law enforcement, and staff from other health plans. Where information shared may impact the Alliance, staff open referrals and/or work with relevant departments to implement internal controls, in line with standard process.

Delegate Oversight
Where plan functions are carried out by a subcontractor, the Alliance is obligated to ensure those operations are compliant. Prior to delegating any functions, the Alliance conducts a predelegation audit to ensure adequate procedures are in place, and oversees the performance of those core functions through annual desk audits and review of quarterly reporting. Where delegate documentation does not demonstrate full compliance, staff request clarification and/or implement CAPs, as indicated,

The Alliance contracts with 12 entities considered delegates for administrative functions like credentialing and claims processing and clinical functions such as UM. During the reporting period, 62 delegate reviews were initiated, and 71 were closed. In addition to managing ongoing oversight of delegates, Compliance staff oversaw delegate CAP completion, with 3 CAPs closed, one newly opened, and one ongoing. Details are in the table below.

Status	Entity	Concern
Closed	Carelon	Timely processing of credentialing and recredentialing applications
Closed	Carelon	Timely and complete support of contracted providers to ensure network adequacy
Closed	MedImpact	Clear, concise description of denial rationale in member communications related to formulary exclusion requests.
Ongoing	Carelon	Timely access to Behavioral Health Therapy (BHT) services
Opened	MedImpact	Extends clear, concise requirement to all member communications

During the latter half of 2024, staff began tracking and trend opportunities for improvement in delegate performance, as required by NCQA. Staff also began building tools and resources needed to comply with Medicare oversight requirements for FDRs. Staff

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conducted their first predelegation audit for our DSNP line of business, approving MedImpact for delegation to enable them to support development of the Part D application.

Internal A&M Program
The Alliance's Internal Audit & Monitoring (IA&M) Program proactively assesses compliance with regulatory and contractual obligations, ensures internal controls are in place to prevent and detect non-compliance, and implements corrective action when non-compliance is identified. The IA&M program includes conducting targeted audits of risk areas and routine monitoring of compliance-related metrics on the Alliance Dashboard.

As shown in the table below, staff are completing planned audits, although closure may lag due to the time needed to obtain corrective action from business units. Q3-4 audit activity focused on similar operational areas as the previous report, including grievance and UM as these are areas of high focus for our regulators; these areas were classified as medium risk. Low-risk areas scheduled for audit were transportation and translation.

During the second half of 2024, a total of 9 internal audits were assigned for review 7 audits were closed (77%). An audit is considered closed when results are shared with business units and a plan for correction is provided. For the two audits that were not closed, Compliance staff had issued findings and were awaiting management response prior to closing the audits. In Q4 2024, staff time was diverted from internal audit to preparation for the scheduled 2025 regulatory audits.

Risk levels and passing results for closed audits are provided in the table below.

		Q3 2024	Q4 2024
Total		3	4
Risk Level	High	0	0
	Medium	1	3

	Low	2	1
Result	Pass	3	2
	Fail	0	2
	Unable to Audit	0	0

2 audits received a failed result during the report period, with details as follows.

- Timeliness of Response to Continuity of Care (COC) Requests – which assessed the timeliness of COC processing, timeliness of member notification, and completeness of content for member notifications. Staff found that that COC requests are processed timely, however, member notification requirements are inconsistently applied, and system documentation to demonstrate compliance is variable.
- UM Authorizations Regulatory Notices - which reviewed UM notices to members and providers to ensure timeliness and required content. While the majority of notices contain the required content, provider notification of authorization decisions were not sent within the required timeframes.

For all aforementioned areas, Compliance staff ensured the implementation of corrective action – either through documented action plans or formal CAPs - and will assess the need to re-audit to confirm full remediation. Effective 01/01/2025, all failed internal audits will be mitigated via formal CAP.

Routine monitoring of compliance-related metrics on the Alliance Dashboard did not identify significant deficiencies. Three regulatory metrics did not meet threshold – timely reporting of HIPAA incidents, timely reporting of suspected FWA, and timely completion of facility site reviews for contracted PCP offices.

		Q3 2024 monitoring; Q2 2024 performance	Q4 2024 monitoring; Q3 2024 performance
Total Metrics Monitored		35	35
Result	Pass	33	34
	Fail	2	1

Confidential Reporting

In support of the requirement to ensure effective lines of communication from staff to the Compliance Officer, the Alliance maintains a confidential hotline, which Alliance staff may use to report compliance issues anonymously. During Q3-4 2024, two reports were received rough the hotline. One was an employee-related concern and managed by Human Resources; the other was a report that a member had threatened their provider. The latter report was responded to by the clinical team in contact with the provider with advice from Compliance staff.

The Alliance also maintains a reporting mechanism on its public website that allows members, providers, contractors, or any other person or entity to submit reports of non-compliance, including anonymous reports if desired. During the report period, Compliance

received a total of 4 reports of potential compliance concerns via this mechanism. Each report was subject to a preliminary review to determine the presence of non-compliance and appropriate next steps.

- 3 of the 4 reports did not identify any instances of non-compliance. These reports were subsequently forwarded to the appropriate department for further follow-up and resolution as needed.
- 1 report was initially identified as a potential HIPAA-related event and was processed accordingly. Upon further investigation, it was determined that the concern did not constitute a reportable event.

Training and Education

All Alliance staff receive web-based compliance training, which reviews FWA prevention, HIPAA policies and procedures, the Alliance's Compliance Plan and Code of Conduct, the Alliance's DHCS Medi-Cal contract, and mechanisms for reporting non-compliance. New hires must complete training within two weeks for staff-level positions, or four weeks for supervisory-level positions. Existing staff are enrolled in the web-based module annually as a refresher. New hires also receive supplemental training which provides a high-level overview of the content and structure of the Alliance's Medi-Cal Contract, regulatory audits, the Internal A&M Program, and HIPAA and FWA processes and reporting mechanisms. In Q3-4 2024, 145 of 146 (99%) of staff enrolled in training completed it timely. The one outstanding training has since been completed, outside the reporting period.

During the reporting period, Compliance staff conducted a routine review of our new hire and annual training content to ensure the content remains relevant and current. No changes were made to the training in 2024 as Compliance staff plan to make significant changes in 2025 to incorporate Medicare's provided training content into the Alliance's current web-based required training modules. All Alliance staff will be required to complete this expanded Medicare training prior to DSNP's planned go-live.

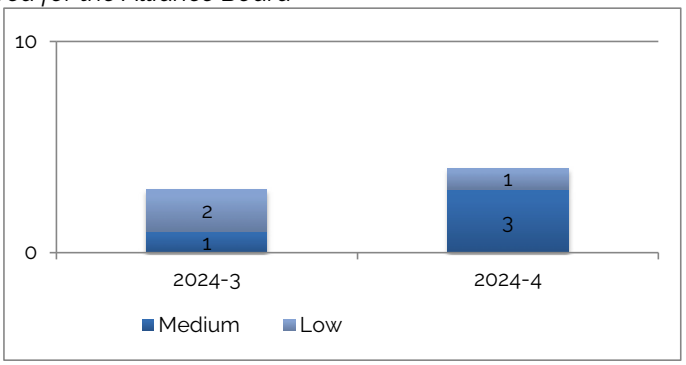
Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments.

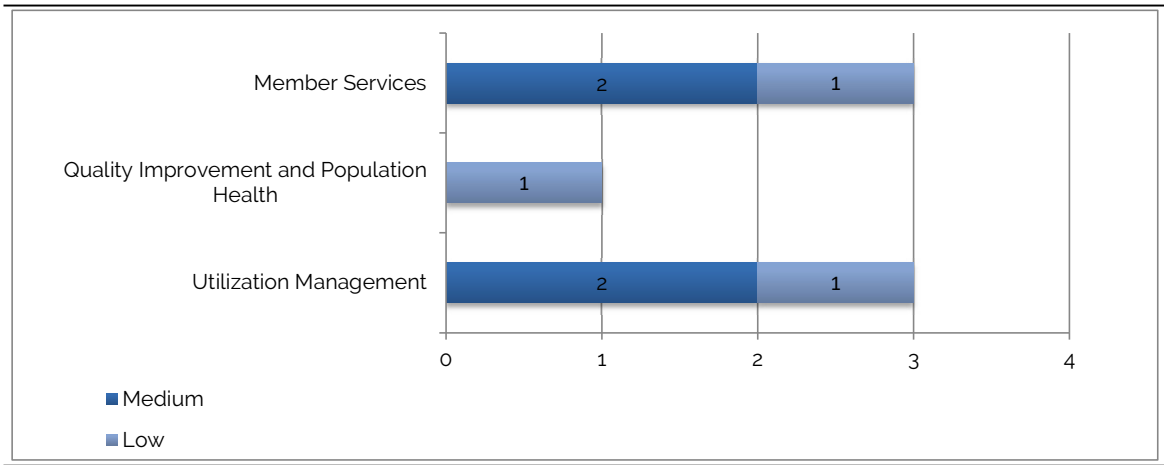
1. Q3-4 2024 Internal A&M Dashboard
2. Q3-4 2024 HIPAA Dashboard
3. Q3-4 2024 Program Integrity Dashboard

Compliance
Internal Audit Dashboard - Q3-Q4 2024
Prepared for the Alliance Board

Reviews Closed by Risk Level
Compliance closed a total of 7 risk-based internal reviews during Q3-Q4 2024. The internal audit program assesses and mitigates risk to ensure Plan readiness for regulatory audits and forthcoming accreditations. Items were selected for the work plan based on recent audit findings, new requirements, and regulatory sanctions.

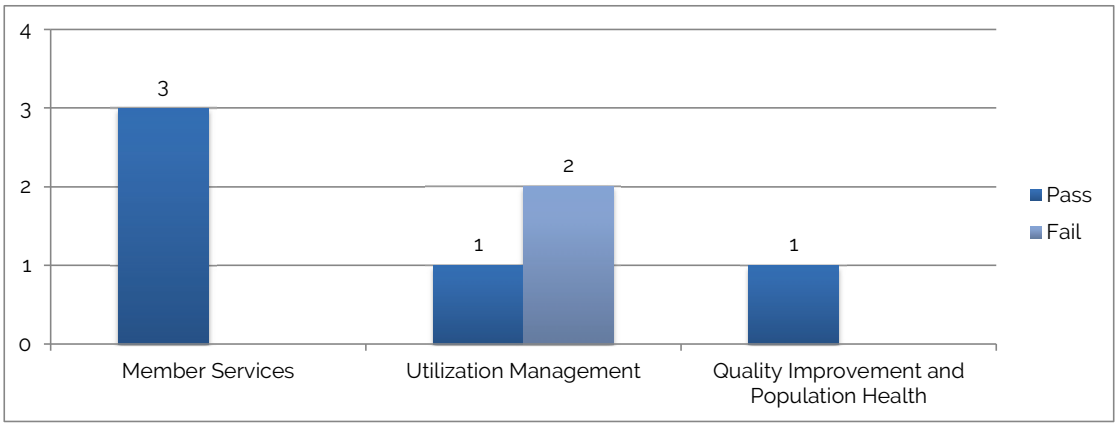


7 Total Reviews Closed in Q3-Q4 2024



Q3-Q4 Reviews by Operational Area & Risk Level
Each review is assigned to a SME department with oversight responsibility of the requirement. The reviews are assigned a risk level based on objective risk criteria such as impact and complexity. The chart shows the number of reviews conducted, separated by department within each risk level.

Q3-Q4 2024 Review Results by Operational Area
5 of 7 closed reviews received a passing score
2 of 7 closed reviews received a failing score

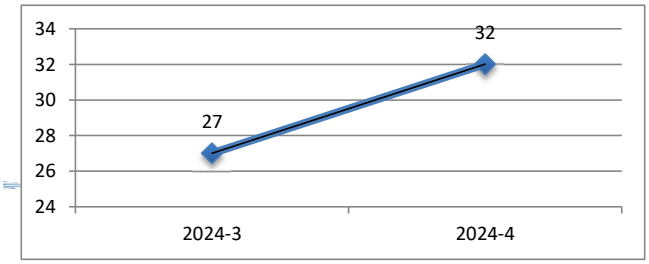


Mitigation for Failed Reviews
In response to failed reviews, Compliance partners with SME departments to ensure deficiencies are corrected through the following:
- Recommending process improvements
- Requesting action plans from departments to cure deficiencies
- Re-auditing to ensure correction

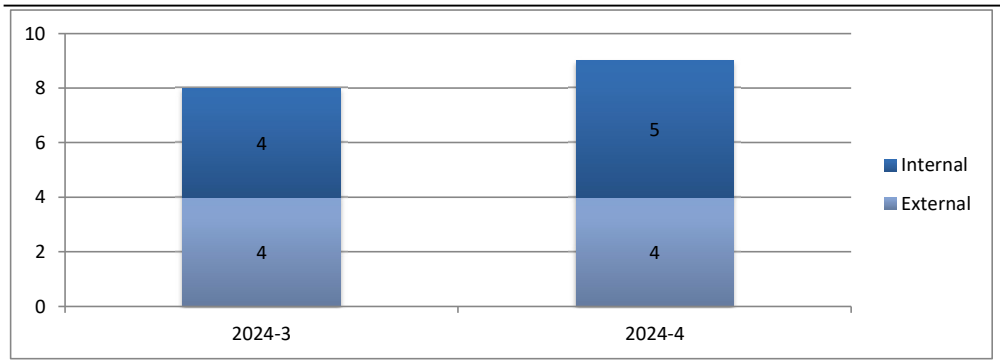
Back to Agenda

Compliance
HIPAA Dashboard - Q3-Q4 2024
Prepared for the Alliance Board

Reports of Suspected Disclosures
Compliance received a total of 59 reports of suspected unauthorized disclosures of Protected Health Information (PHI) during Q3-Q4 2024.
(This is all suspected events, whether or not they were deemed reportable upon investigation)

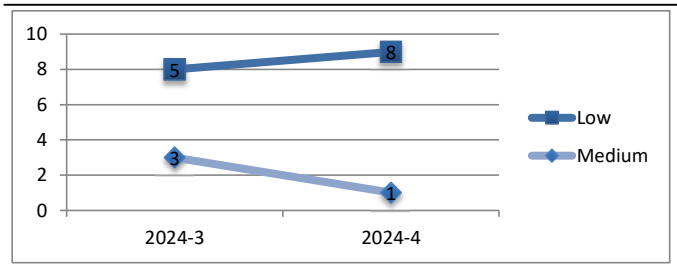


59 Total HIPAA Reports in Q3-Q4 2024



Sources of Disclosures:
Internal (Alliance) & External (Non-Alliance
Compliance tracks whether the disclosure was caused by internal Alliance departments or by external entities, including providers and delegat

**Excludes Non-Events, Duplicates and Non-Reportable Incide*

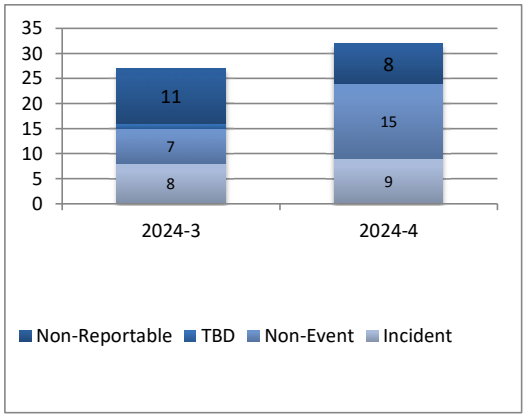


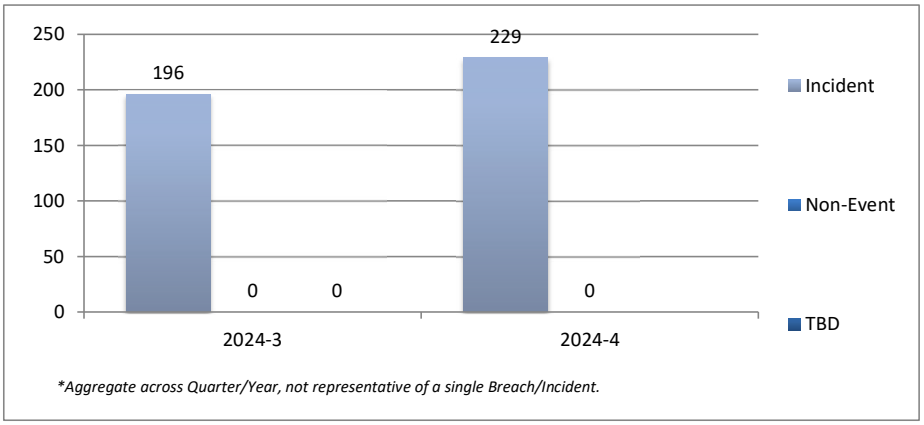
Impact of Events
(excludes Non-Events and Events Pending Investigation)
8 of 17 events had an impact of low;
9 of 17 had an impact of of medium;
0 of 17 had an impact of high.

Impact levels are determined by analyzing whether PHI was disclosed to a HIPAA covered entity, whetl the PHI has been destroyed or recovered, and the amount of time passed between discovery and

Final Classification
Breaches are unauthorized disclosures of PHI to a non-covered entity; Incidents are unauthorized disclosures to covered entities; Non-events are when the investigation reveals that no unauthorized disclosure of PHI occured; Mitigated incidents are when the Plan is able to mitigate the disclosure within the 24-hour reporting window.

Member Impact
425 members were impacted by HIPAA events in Q3-Q4 2024; all of which were classified as incidents. Ther were zero breaches.
An incident occurs when PHI has been compromised or has a high probabiliy of being compromised. A breach is whe has been compromised and can only be determined as such by the Alliance Privacy Officer.





**Aggregate across Quarter/Year, not representative of a single Breach/Incident.*

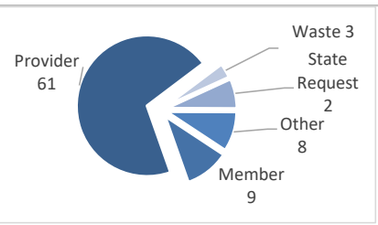
Back to Agenda

Program Integrity
Special Investigations Unit Dashboard - Q3-Q4-2024

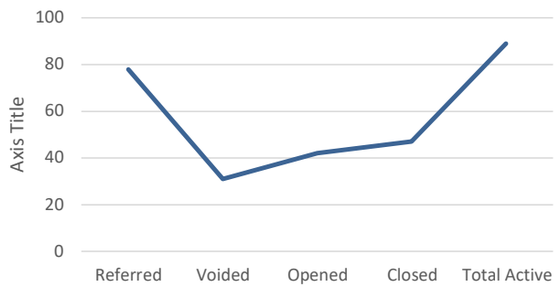
Prepared for the Alliance Board

Note: Unless otherwise indicated, statistics represent data for the quarter only.

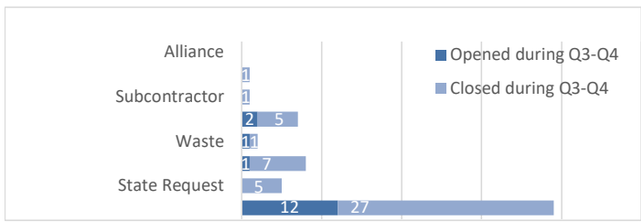
Matters Under Investigation (MUIs)
MUIs are classified by the target of the allegation/concern. ("Other" example: If a member alleges a non-Alliance member may be using his/her Alliance ID card to fraudulently obtain services.)



89
Total

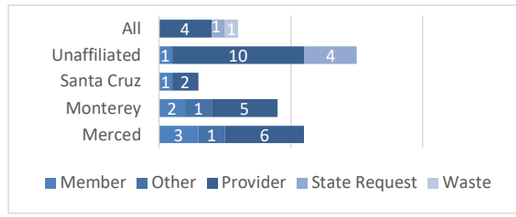


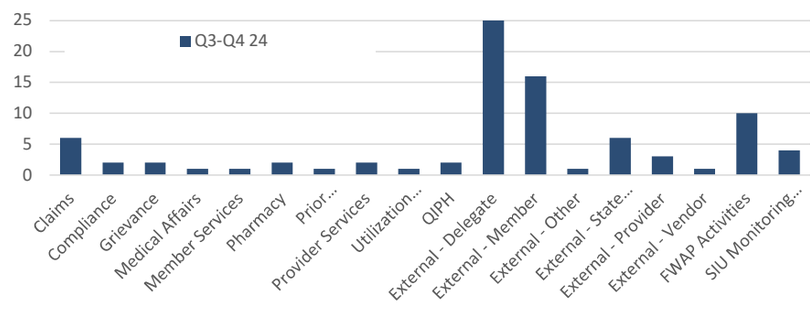
Referral Trends
Referrals come from various sources (internal, delegate, etc.) These referrals are either opened or voided depending on the scope of the referral. MUIs are closed when an investigaton is complete.



MUIs by Status
If MUIs undergo a status change in a single quarter, they are reported once under current status at end of quarter. MUIs by status does not account for MUIs not in an Opened or Closed status

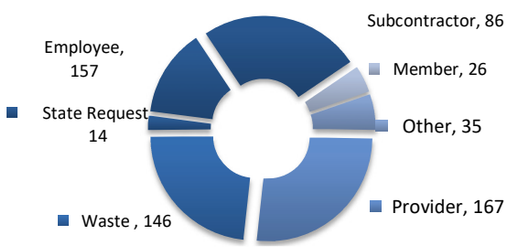
MUIs by County
Most MUIs are assigned a county affiliation. Where a provider serves multiple Alliance counties, or a member receives services in multiple Alliance counties, the county affiliation is identified by the billing address or mailing



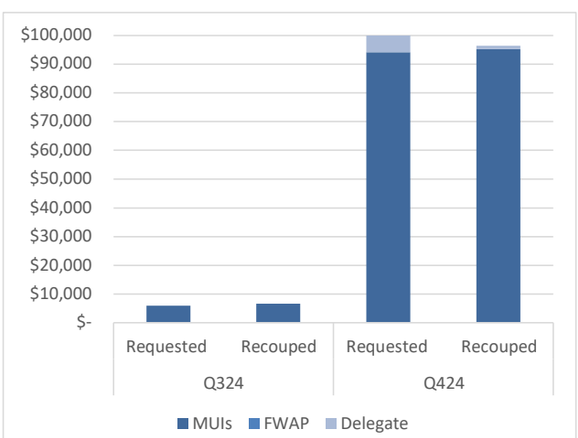


MUI Reporting Department
The referral source represents the origin of the referral, not the nature of the allegation/ concern.

Investigation Duration Average
- Statistics are in business days, excluding Alliance holidays.
- Statistics represent the average of all MUIs closed in previous 12 months.



98
Days



Financial Reporting

MUIs and FWAP: represent claims requested for recovery by the SIU during the review period, subsequent to the resolution of an MUI or a FWAP Program audit.

Recoupment: represent claims on which reoupment was completed during the review period.

Q3-Q424 Requested Recoupment:
- MUI: $100,119.77
- FWAP: $0
- Delegate: $7,065.28

Completed Recoupment:
- MUI/FWAP: $101,888.59
- Delegate: $1,294.09

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Information Items: (18A. – 18D.)

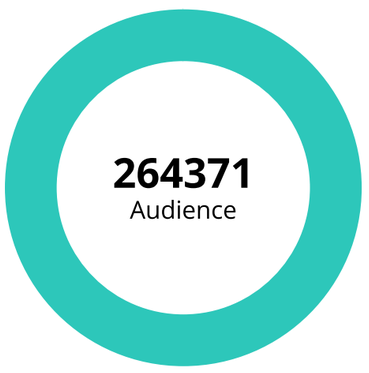
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

May 2025 Board Report

Mention Analytics

Mentions by Media Type

Audience by Media Type



Publicity by Media Type

Total Online + Print Audience
264,371

Total Online + Print Publicity
USD $1,267

Total Number of Clips 11

Back to Agenda

(Requires Critical Mention login)

California; Medicaid cuts may upend mental health plans

1

Powered by LexisNexis

Date Collected Apr 13, 2025 9:38 AM EDT
Category Print
Source Santa Cruz Sentinel (California)
Author Ana B. Ibarra ; CalMatters

Est. Audience 14,664
Est. Publicity Value USD $57
Market Santa Cruz, CA
Language English

... federal approval is set to expire at the end of 2026.

The Trump administration has not indicated whether it will renew the CalAIM permissions, but given the discussion of Medicaid funding cuts, it is creating some anxiety over the future of the program.

Michael Schrader, chief executive of the **Central California Alliance for Health**, the local Medicaid plan for people in Merced, Santa Cruz and neighboring counties, said he has been hearing concerns about this from providers in his network.

"Providers are wondering, 'Do we keep making investments in CalAIM?'" Schrader said.

"I've got clinics saying, 'I did what you asked me ...

Medicaid cuts could upend California's plans for improving mental health

2

Date Collected Apr 12, 2025 6:37 PM EDT
Category Digital News
Source Santa Cruz Sentinel

Est. Audience 28,259
Est. Publicity Value USD $119
Market Santa Cruz, CA
Language English

... federal approval is set to expire at the end of 2026.

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California has big plans for improving mental health. Medicaid cuts could upend them

3

Date Collected Apr 8, 2025 2:27 PM EDT
Category Digital News
Source LAist

Est. Audience 33,149
Est. Publicity Value USD $131
Market Carson, CA
Language English

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Mental health Medicaid cuts could upend CA plans to improve

4

Date Collected Apr 8, 2025 1:54 PM EDT
Category Digital News
Source LAist

Est. Audience 33,149
Est. Publicity Value USD $134
Market Carson, CA
Language English

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5

Date Collected Apr 8, 2025 11:51 AM EDT
Category Digital News
Source Press Democrat
Author ANA B. IBARRA

Est. Audience 59,778
Est. Publicity Value USD $431
Market Santa Rosa, CA
Language English

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California has big plans for improving mental health. Medicaid cuts could upend them

6

Date Collected Apr 8, 2025 9:17 AM EDT
Category Digital News
Source Lake County Record Bee
Author Ana B. Ibarra

Market United States
Language English

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7

Date Collected Apr 8, 2025 9:21 AM EDT
Category Digital News
Source Lake County Record Bee
Author Ana B. Ibarra

Est. Audience 4,076
Est. Publicity Value USD $16
Market Lakeport, CA
Language English

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(Requires Critical Mention login)

California has big plans for improving mental health. Medicaid cuts could upend them

8

Date Collected Apr 8, 2025 1:41 AM EDT
Category Digital News
Source CALmatters (CA)
Author Ana B. Ibarra

Est. Audience 45,648
Est. Publicity Value USD $191
Market United States
Language English

... federal approval is set to expire at the end of 2026.

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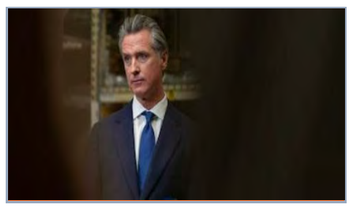

CA's Big Plans to Improve Mental Health Threatened by Possible Medicaid Cuts

9

Date Collected Apr 7, 2025 5:05 PM EDT
Category Digital News
Source San Jose Inside
Author Ana B. Ibarra, More This Author

Market United States
Language English

... federal approval is set to expire at the end of 2026.

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Online News

(Requires Critical Mention login)

California has big plans for improving mental health. Medicaid cuts could upend them

10

Powered by LexisNexis

Date Collected Apr 7, 2025 4:04 PM EDT
Category Print
Source CalMatters
Author Ana B. Ibarra

Market United States
Language English

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11

Date Collected Apr 7, 2025 2:36 PM EDT
Category Digital News
Source CALMatters
Author Kristen Hwang

Est. Audience 45,648
Est. Publicity Value USD $188
Market United States
Language English

... federal approval is set to expire at the end of 2026.

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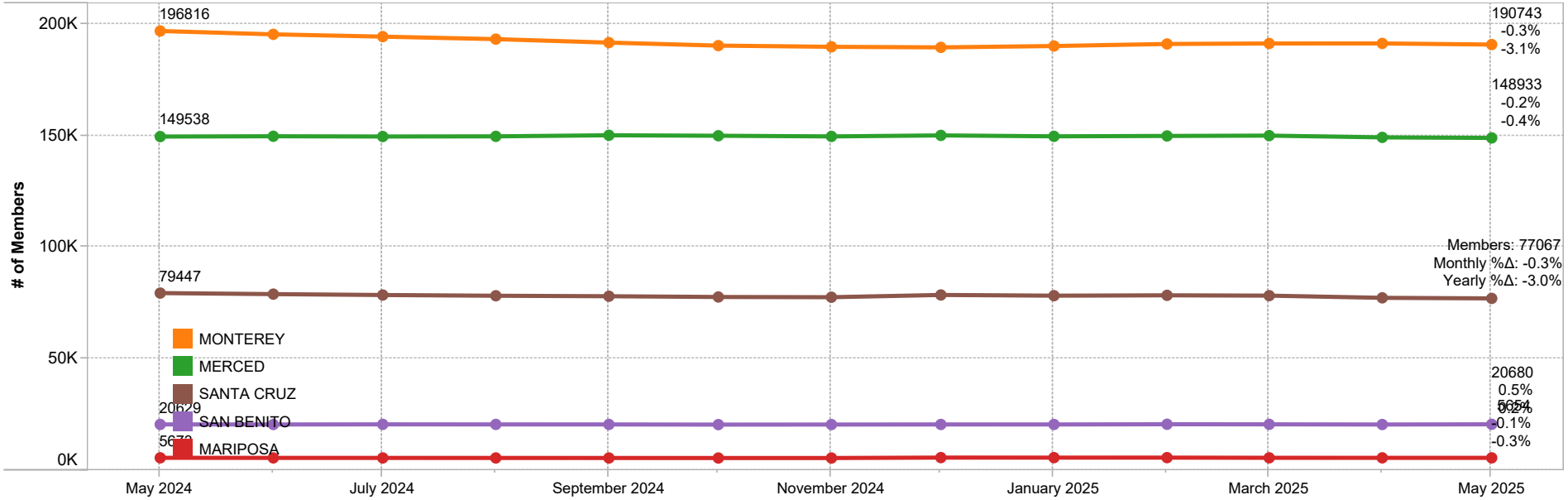
Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *5/2/2025 6:37:30 AM*

Enrollment Month
5/1/2024 to 5/31/2025

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



LOB	County	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025
Medi-Cal	SANTA CRUZ	79,447	78,980	78,576	78,251	78,032	77,697	77,600	78,604	78,285	78,444	78,302	77,318	77,067
	MONTEREY	196,091	194,587	193,564	192,451	190,898	189,564	189,035	188,787	189,408	190,329	190,549	190,584	190,089
	MERCED	149,538	149,678	149,560	149,639	150,114	149,907	149,606	150,060	149,647	149,816	149,967	149,174	148,933
	MARIPOSA	5,673	5,641	5,625	5,612	5,598	5,581	5,580	5,768	5,755	5,757	5,676	5,661	5,654
	SAN BENITO	20,629	20,595	20,656	20,631	20,615	20,546	20,572	20,611	20,609	20,701	20,666	20,584	20,680
IHSS	MONTEREY	725	731	729	723	717	709	702	693	684	680	675	663	654
Total Members		**452,103**	**450,212**	**448,710**	**447,307**	**445,974**	**444,004**	**443,095**	**444,523**	**444,388**	**445,727**	**445,835**	**443,984**	**443,077**

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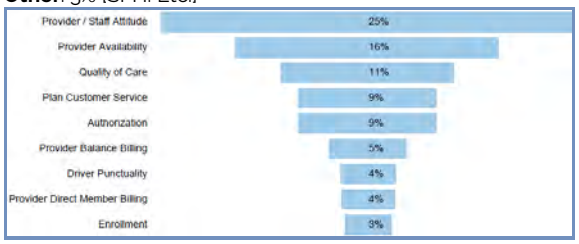
Member Appeals and Grievance Report
Q1, 2025

Q1 2025 Appeals and Grievances: 1499 * including Carelon.
Appeals: 11% [84% in favor of Plan; 16% in favor of Member]
Exempt: 36%
Grievances: 50%
Other: 3% [SFH. Etc.]



Analysis and Trends

- 2% increases for Provider/Staff Attitude, QOC and Provider Availability from Q424.
- Decreases in Plan Customer Service concerns and Authorization issues from Q424.
- Trend: Authorization issues involve Medically Tailored Meal (MTM) & Community Support benefits.

Highest Grievances Filed by County

1. **Monterey**: 39%
2. Merced: 33%
3. Santa Cruz: 20%
4. San Benito: 6%
5. Mariposa: 2%

Behavioral Health Carelon Grievances: 30

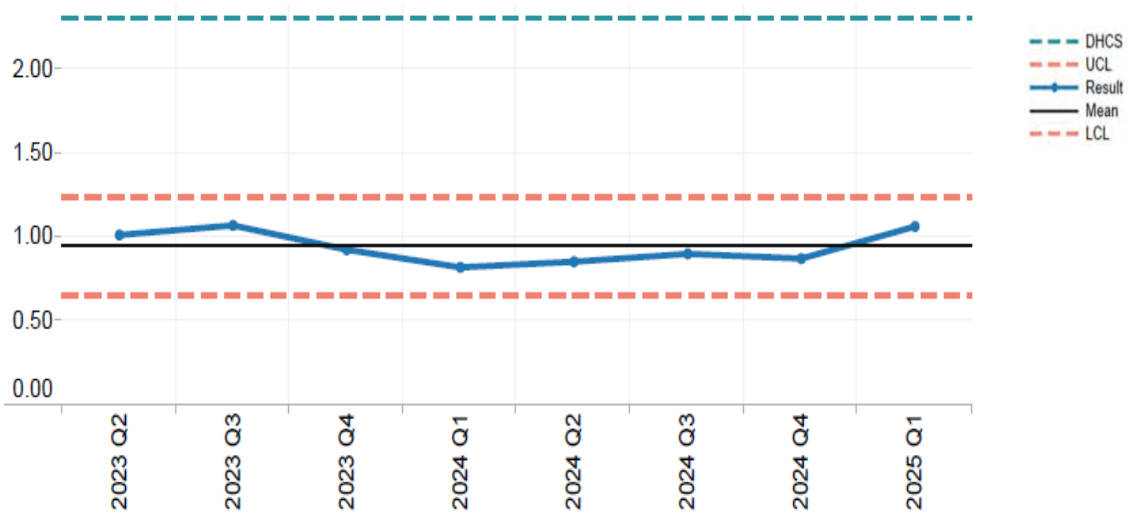
- **Monterey**: 12
- Santa Cruz: 9
- Merced: 7
- San Benito: 2

IHSS Summary: 8

- Member Grievances: 4
- Exempt Complaints: 4

☒ **In Control**
☐ **Not in Control**

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



		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2024	MemberMonths	458,093	456,832	456,667	455,038	452,106	450,218	448,721	447,314	445,984	444,010	443,115	444,546
	Case Count	394	386	345	399	427	333	416	409	384	421	395	356
	Case Count Per 1000 MM	0.86	0.84	0.76	0.88	0.94	0.74	0.93	0.91	0.86	0.95	0.87	0.80
2025	MemberMonths	444,421	445,806	445,968									
	Case Count	404	439	579									
	Case Count Per 1000 MM	0.91	0.98	1.30									

*Grievances Per 1,000 Member Month

Back to Agenda

Alliance Fact Sheet
Q2 2025

About the Alliance

The Central California Alliance for Health is an award-winning regional managed care health plan. The Alliance has provided trusted, no cost Medi-Cal health care from local teams to families since 1996. Using the State's County Organized Health System (COHS) model, we currently serve more than **443,373 members** in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We have a local presence in the communities we serve, so we understand the unique needs of these communities and our members. Together with our contracted providers, we work to promote prevention, early detection and effective treatment and to improve access to quality, equitable health care. The Alliance is governed with local representation from each county on our Board of Commissioners.

Quick Facts

1996
Year Established

642
Number of Employees

$2.09B[1]
Annual Revenue

5.7%[1]
Administrative Overhead

$46.4M[2]
Community Grants

VISION

HEALTHY PEOPLE.
HEALTHY COMMUNITIES.

MISSION

Accessible, quality health care guided by local innovation.

VALUES

Collaboration:
Working together toward solutions and results.

Equity:
Eliminating disparity through inclusion and justice.

Improvement:
Continuous pursuit of quality through learning and growth.

Integrity:
Telling the truth and doing what we say we will do.

What We Do

The Alliance is a local health ally for compassionate and trusted health care that supports the whole person. We ensure quality care for all ages and stages of life and for any health condition. We go beyond just providing health care, connecting our members to day-to-day resources.

Who We Serve

Our members represent 41%[3] of the population in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income parents and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled and low-income, childless adults ages 19–64.

Provider Partnerships

The Alliance partners with 100% of hospitals in our service areas and a network of approximately 13,830 providers (99% of primary care physicians and 99% of specialists within our service areas) to ensure members receive timely access to the right care, at the right time. The Alliance also partners with more than 4,650 providers to deliver behavioral health and vision services.

Our Members[4]

1 out of every 3
Mariposa County residents.

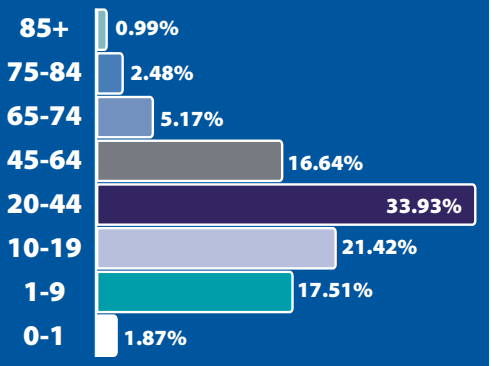
1 out of every 2
Merced County residents.

1 out of every 2
Monterey County residents.

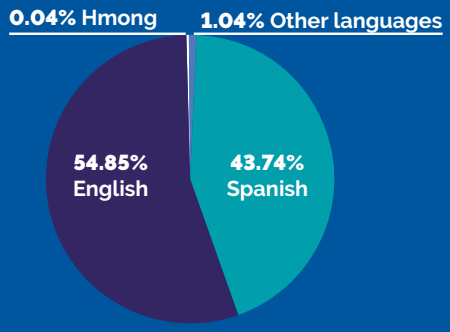
1 out of every 3
San Benito County residents.

1 out of every 3
Santa Cruz County residents.

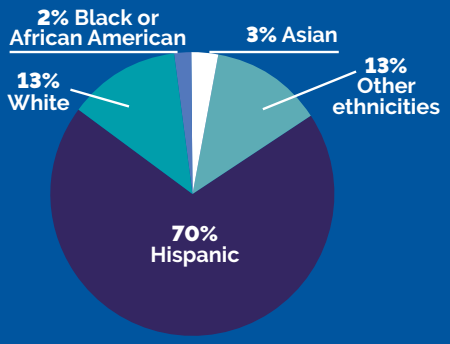
Membership by Age Group



Preferred Language



Race/Ethnicity



Executive Leadership

Michael Schrader
Chief Executive Officer

Lisa Ba
Chief Financial Officer

Jenifer Mandella
Chief Compliance Officer

Scott Fortner
Chief Administrative Officer

Cecil Newton
Chief Information Officer

Omar Guzmán, MD
Chief Health Equity Officer and Interim Chief Medical Officer

Van Wong
Chief Operating Officer

Governing Board

The Alliance's governing board, the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan.

In alphabetical order, current Board members are:

- **Leslie Abasta-Cummings,** Chief Executive Officer, Livingston Community Health, Alliance Board Vice Chairperson, At Large Health Care Provider Representative
- **Anita Aguirre,** Chief Executive Officer, Santa Cruz Community Health, At Large Public Representative
- **Ralph Armstrong,** DO FACOG, Hollister Women's Health, At Large Health Care Provider Representative
- **Wendy Root Askew,** Supervisor, County of Monterey, County Board of Supervisors Representative
- **Tracey Belton,** Health and Human Services Agency Director, San Benito County, County Health Department Representative
- **Dorothy Bizzini,** Public Representative
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas, Health Care Provider Representative
- **Kimberly De Serpa,** Supervisor, County of Santa Cruz, County Board of Supervisors Representative
- **Janna Espinoza,** Public Representative
- **Mark Hendrickson,** Assistant County Executive Officer/Acting Director of Public Health, Merced County Health Department Representative
- **Donaldo Hernandez, MD,** Health Care Provider Representative
- **Elsa Jimenez,** Director of Health Services, Monterey County Health Department, Alliance Board Chairperson, County Health Department Representative
- **Kristina Keheley, PhD,** Health and Human Services Agency Director, Mariposa County Health and Human Services Agency, County Health Department Representative
- **Michael Molesky,** Public Representative
- **Monica Morales,** Health Services Agency Director, County of Santa Cruz Health Services Agency, County Health Department Representative
- **Supervisor Josh Pedrozo,** County of Merced, County Board of Supervisors Representative
- **James Rabago, MD,** Merced Faculty Associates Medical Group, Health Care Provider Representative
- **Allen Radner, MD,** President/CEO, Salinas Valley Health, At Large Health Care Provider Representative

Unless otherwise stated, Fact Sheet data as of April 1, 2025.

[1]Amounts based on 2025 annual budget.

[2]Represents 2024 investments through the Alliance's Medi-Cal Capacity Grant Program.

[3]County population data source: U.S. Census Bureau 2023 population estimate (as of Jul. 1, 2023).

[4]Represents an approximate visual representation. Membership percentage by county: Mariposa (34 percent) Merced (51 percent); Monterey (44 percent); San Benito (30 percent); Santa Cruz (30 percent).