Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Wednesday, May 24, 2023

3:00 p.m. – 5:00 p.m.

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

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

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows. Note: Livestreaming for the public is listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 (323) 705-3950
    Phone Conference ID: 420 775 326#

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, May 23, 2023 to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to five minutes.
    b. In person, from an Alliance County office, during the meeting when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

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

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

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

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

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

A. Board members may provide comments and announcements.

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

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

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

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

- Reference materials: Executive Summary from the CEO; and Local Health Plans of California Memo: May Revision 2023-24.

Pages 5-01 to 5-15

6. **Accept Alliance Dashboard for Q1 2023.**

- Reference materials: Alliance Dashboard – Q1 2023.

Pages 6-01 to 6-02

7. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the third month ending March 31, 2023.**

- Reference materials: Financial Statements as above.

Pages 7-01 to 7-09

Appointments: (8A.)

8A. **Approve appointment of Ms. Candi Walker, Mr. Humberto Carrillo and Ms. Yaneth Virgen Venegas to the Member Services Advisory Group.**

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

Page 8A-01

Minutes: (9A. – 9D.)

9A. **Approve Commission meeting minutes of April 26, 2023.**

- Reference materials: Minutes as above.

Pages 9A-01 to 9A-07

9B. **Accept Compliance Committee meeting minutes of March 15, 2023.**

- Reference materials: Minutes as above.

Pages 9B-01 to 9B-04

9C. **Accept Continuous Quality Improvement Committee meeting minutes of January 26, 2023.**

- Reference materials: Minutes as above.

Pages 9C-01 to 9C-07

9D. **Accept Whole Child Model Family Advisory Committee meeting minutes of March 13, 2023.**

- Reference materials: Minutes as above.

Pages 9D-01 to 9D-04

Reports: (10A. – 10H.)

10A. **Authorize the Chairperson to sign the agreement between the Alliance and the Monterey County In-Home Supportive Services (IHSS) Public Authority (Public Authority) to provide covered services to eligible and enrolled IHSS providers for the period July 1, 2023 through June 30, 2024.**

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

Page 10A-01

10B. **Approve revised 2023 Alliance Board meeting schedule.**

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

Page 10B-01

10C. **Approve Compensation Philosophy Adjustment: Living Wage Standard.**

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

Pages 10C-01 to 10C-02

10D. **Accept Quality and Performance Improvement Program Annual Report for 2022.**

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

Pages 10D-01 to 10D-13

10E. **Accept Quality Improvement Systems Workplan Report for Q4 2022.**

- Reference materials: Staff report and recommendation on above topic; and Quality Improvement System Workplan Q4 2022.

Pages 10E-01 to 10E-24

10F. **Accept Quality Improvement Health Equity Transformation (QIHET) Workplan for 2023.**

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

Pages 10F-01 to 10F-21

10G. **Approve revisions to Alliance Policy 401-1201 – Quality Improvement Health Equity Committee.**

- Reference materials: Staff report and recommendation on above topic; and Policy 401-1201 – Quality Improvement Health Equity Committee.

Pages 10G-01 to 10G-11

10H. **Accept Utilization Management Workplan Report for Q4 2022 and approve Utilization Management Workplan Template for 2023.**

- Reference materials: Staff report and recommendation on above topic; and Utilization Management Workplan Template for 2023.

Pages 10H-01 to 10H-20

Regular Agenda Items: (11. – 13.): 3:15 p.m.

11. Consider accepting audited financial statements and management letters for Alliance's fiscal year ending December 31, 2022 from Moss Adams LLP, independent auditors. (3:15 – 3:45 p.m.)

A. Moss Adams staff will present and Board will consider accepting audited financial statements and findings of independent auditors for FY 2022.

- Reference materials: Audited Financial Statements: FY 2022.

Pages 11-01 to 11-55

12. Consider approving proposed changes to Alliance's Care-Based Incentives (CBI) for 2024. (3:45 – 4:15 p.m.)

A. Dr. Dianna Diallo, Medical Director, will review and Board will consider approving proposed changes to Alliance CBI for 2024.

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

Pages 12-01 to 12-04

13. Discuss Provider Payment Strategy Part 1: Current State Assessment. (4:15 – 4:45 p.m.)

A. Ms. Lisa Ba, Chief Financial Officer, will review and Board will discuss provider payment strategy.

- Reference materials: Staff report on above topic.

Pages 13-01 to 13-02

Information Items: (14A. – 14E.)

Announcements:

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

- Finance Committee
  Wednesday, June 28, 2023; 1:30 – 2:45 p.m.
- Member Services Advisory Group
  Thursday, August 10, 2023; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, June 1, 2023; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [*In-person and remote teleconference*]
  Thursday, June 15, 2023; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [*In-person and remote teleconference*]
  Monday, July 10, 2023; 1:30 – 3:00 p.m.

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

The next regular meeting of the Commission, after this May 24, 2023 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, June 28, 2023; 3:00 – 5:00 p.m.
  Locations: Videoconference from Alliance offices in Scotts Valley, Salinas and Merced

Locations for the meeting:

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

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

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

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

Members of the public interested in attending should call the Alliance at (831) 430-5523 to verify meeting dates and locations prior to the meetings.

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

DATE: May 24, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

County Expansion: San Benito and Mariposa Counties. Staff continue efforts to prepare for the expansion of Alliance services to Medi-Cal beneficiaries in San Benito and Mariposa Counties effective January 1, 2024, including provider network development, community and member engagement, and preparations for initiating the new five county Commission at an inaugural meeting on October 25, 2023. To that end, staff have been working with Board members in existing counties and the Health Directors from San Benito and Mariposa counties to identify participants and plan for appointments by the respective Boards of Supervisors. Additionally, staff are meeting on operational readiness activities with leadership from relevant divisions within the Department of Health Care Services (DHCS) including Capitated Rate Development, Managed Care Operations and Managed Care Quality and Monitoring. Staff anticipate bringing a provider payment policy to your Board for consideration at the June 28, 2023 meeting.

2023-24 State Budget: May Revision. The Governor released the May Revision to his January budget proposal on May 12, 2023 projecting a $31.5B deficit up from what was a previously projected $22.5B shortfall in January. Despite the growing deficit, the May Revise continues to maintain most spending commitments from previous years on health and human services and related programs. This includes a continued commitment to expand Medi-Cal to all undocumented Californians by January 1, 2024 when full scope Medi-Cal will be expanded to the remaining undocumented individuals ages 26 to 49. The Alliance anticipates adding nearly 30,000 new members across all five counties in January 2024 through this expansion. The May Revise also maintains existing funding for major behavioral health initiatives and funding for housing and homelessness programs. A significant adjustment in funding is found in changes to the Managed Care Organization (MCO) tax model proposed in January which is detailed further below. *(For additional detail on the May Revise proposals see the attachment following this report for a summary that includes relevant highlights from the Governor's May Revision drafted by staff from the Local Health Plans of California.)*

Managed Care Organization Tax. The May Revise included an update to the Governor's January proposal to renew the MCO Tax, which expired at the end of CY22. The MCO tax program is a tax on managed care plans with the proceeds from the tax used to leverage federal funds to support the Medi-Cal program. The May Revise proposes to begin the MCO tax on April 1, 2023, which is nine months earlier than previously proposed, resulting in an additional $3.7B in general fund revenue than accounted for in the January budget. The Administration's updated tax model includes a commitment to invest additional funds in Medi-Cal to improve access and equity and proposes an increase in base rates for providers including Primary Care, Maternity Care and non-specialty mental health services. In addition, DHCS will collaborate with key stakeholders focusing on equitable access to care and determining long-term rate augmentations that will deliver the greatest benefit to improving the Medi-Cal delivery system.

Recommendations from this process will be put forward in the Governor's budget proposal for State FY 2024-25. The Alliance is engaged in discussions on the MCO tax and the larger budget proposal through the Local Health Plans of California and will advocate for a final MCO tax that includes appropriate adjustments to managed care plan revenue to support providers in the Alliance's service area.

Community Involvement. On May 11, 2023, I attended the Health Improvement Partnership of Santa Cruz County (HIPSCC) Council Meeting. I attended the DHCS Managed Care Small Workgroup meeting and HIPSCC Executive Committee meeting on May 18, 2023. On May 22, 2023, I attended the Ad Hoc DHCS CEO/CFO meeting to discuss DHCS' vision for the second year of the CalAIM transformation.

Health Services

The Health Services Division priorities in May include getting providers with lower performing metrics to engage in the Care-Based Quality Improvement Program, finalizing the Managed Care Accountability Set (MCAS) audit for 2022, continued development of the Population Health Program interventions, increasing member enrollment in Enhanced Care Management/Community Supports and developing the new Medi-Cal benefits including Doula and Dyadic Care.

Quality Improvement and Population Health

Healthcare Effectiveness Data and Information Set/Managed Care Accountability Set Report 2023. The medical records review has been completed and the MCAS audit team is finalizing submission to the auditors. Additional improvement over the Minimum Performance Level (MPL - Medicaid 50th percentile) has been found for several metrics in Merced following the medical record review.

Care-Based Quality Improvement Program. Provider Services and Quality Improvement staff are reaching out to providers that have not yet signed up for Care-Based Quality Improvement funding. The goal is to engage all providers with metrics below the MPL to engage in the performance improvement effort.

Population Health. Work continues to develop the Population Health Management Program in anticipation of 2024 requirements for identified populations of focus to have interventions in place. A gap analysis has been completed and indicates that progress is on rack.

Health Education. The Quality and Health Programs team has been conducting member workshops in multiple modalities in Q1 through Q2 including:

- Telephonic Healthier Living Program workshop series. One telephonic series was completed in English and one telephonic series was completed in Spanish.
- Virtual Healthier Living Program workshop series in English was completed.
- In-person Healthier Living Program workshop series in Spanish at the Merced Alliance office is in progress.
- Virtual Healthy Weight for Life Program workshop series in English is in progress.

The Healthier Living Program workshops are available for members experiencing a chronic illness. The Healthy Weight for Life Program workshops are available for parents of children at risk for childhood obesity.

Utilization Management

Inpatient and Emergency Department (ED). Increases in inpatient admissions seen over 2022 have not yet been reflected in Q1 2023 data, with March totals reflecting fewer inpatient authorizations across all three counties, and authorization data currently in the range for inpatient activity seen in 2021. This may be an early reflection of the plan's increased population health management and transitional care activity but could also be attributed to delays in authorization and claims submissions, as March and April did see a larger number of post service inpatient authorization submissions.

In addition to overall decreases in inpatient authorizations received, Q1 reflects a potentially decreased average length of stay, with a general lower acuity noted in inpatient stays and fewer delays in discharges due to increased opportunities for placement as facilities have opened additional beds for skilled nursing and long-term care needs.

ED utilization similarly reflects decreased activity over Q1 2023, with reduced rates noted across the three counties. Rates for 2023 appear to be trending lower than data noted in 2022 with consistent activity for each county when assessing monthly patterns for January, February, and March.

The Required Preadmission Screening and Resident Review (PASRR) program went live on May 1, 2023, and requires general acute care hospitals to submit the PASRR prior to transfer to Long Term Care and Skilled Nursing Facilities (LTC/SNF). The Alliance continues work with acute care and LTC/SNF facilities across the counties as this new requirement is operationalized.

Prior Authorization. Prior authorization determination metrics remained at or above target goal for 2023, with March authorization activity higher than seen in prior months and an all-time high for outpatient prior authorization requests. Increases in authorizations for durable medical equipment, rehabilitation therapies, diagnostic services and surgeries were noted. Though prior authorization rates showed an increase, when considering historical data, a similar utilization pattern was seen in 2022, with an isolated increase specific to March. Prior Authorization activity has reduced in April but remains higher than seen in prior months. Increases in authorization activity are potentially a reflection of continued increased member access and the public health emergency unwinding. Impacts of the plan's increased proactive transitional care activities may also be a contributor.

Member Benefits. Configuration efforts are underway for further automation of specialty in network Authorized Referrals. Additional configurations are additionally in progress to support member self-referrals for Medication Assisted Therapy, allowing members to access treatment without authorization or referral. Coverage has been expanded to allow self-referral for alcohol use disorder treatment and other substance use disorder treatment, in alignment with widening DHCS initiatives. Community Health Worker and doula benefits have been operationalized and work is underway to establish these networks and further develop these programs.

Pharmacy

Drug Utilization Review (DUR) Program. Opioid Total Daily Morphine Milligram Equivalent (MME) Dose DUR: Per Centers for Disease Control and Prevention Clinical Practice Guideline for Prescribing Opioids for Pain, 2022, the benefits of high-dose opioids for pain are not well established. At the same time, risks for serious harm related to opioid therapy, including opioid

misuse, overdose, and death, increase at higher opioid dosage. The Pharmacy department conducted a retrospective analysis of 2022 pharmacy claims to identify members at increased risk due to high opioid dosages. Members' risk was assessed based on average MME of their opioid's total daily dose. Out of 23,266 Alliance members with one or more claims for an opioid during 2022, only 0.5% members were found to be at highest risk due to the high dosage of ≥ 100 MME. Majority of the members on an opioid therapy (69%) were at the lower risk doses of 20-49 MME per day. Additionally, members on ≥90 MME receiving opioids from five or more different prescribers were identified and analyzed. No concerns were found.

There were 4,183 opioid prescribers identified and analyzed based on the number of members they prescribed for MME dosage they prescribed and their specialty. No concerning prescribing patterns were detected. An educational article will be published in Provider Digest, and a targeted educational outreach will be made via fax to the eight family and internal medicine providers that have two or more members on ≥ 90 MME. The educational material will include information on how to prepare for tapering conversations with the patient, importance of shared decision making to establish a patient-centered plan, patient education and clinical pearls on how to individualize tapering and address withdrawal symptoms.

Pharmacist-Led Academic Detailing (PLAD) Program. The PLAD Program covering diabetes, hypertension and asthma has been advertised in several Alliance driven platforms such as the Provider Bulletin on Men's Health and Provider Digest. One clinic has expressed interest in selecting PLAD Diabetes Program as one of the options for the Care-Based Quality Improvement Program.

Community Care Coordination

Complex Care Management. The second phase of the CalAIM Population Health Management (PHM) Program work began this month. The focus of this project will be to utilize the information gained in the prior project's gap analysis and to further development and implementation based on DHCS and National Committee for Quality Assurance requirements. Some of the DHCS requirements have not been finalized so this project will close the gap identified from the Population Health Management (PHM) readiness assessment in addition to new work by DHCS. PHM is a cyclical improvement model; this project will implement a basic first iteration that will be improved in future years.

Enhanced Care Management (ECM)/Community Supports (CS). In less than six weeks, the Alliance will initiate ECM services for two new populations of focus: Children and Youth enrolled in CCS WCM with additional needs beyond their CCS condition, as well as Children and Youth involved with the Child Welfare System. Additionally, two new CS services will be added: Personal Care and Homemaker Services and Respite Services for Caregivers. The Alliance plans to have six new ECM and CS providers contracted to provide the benefit for these new populations of focus and CS services across the service area. In addition, there are five existing ECM contracted providers who are going to be able to provide ECM to children/youth beginning in July.

DHCS has begun providing pre-decisional guidance related to the January 2024 go-live for ECM for individuals transitioning from incarceration. Alliance staff are participating and providing feedback to DHCS to support the implementation of ECM to this new population. Efforts are also underway to collaborate with community providers and correctional facilities to better understand the needs of these members.

Behavioral Health (BH)

Following executive turnover at our managed behavioral health organization Carelon (formerly Beacon), the Alliance team was introduced to new Account Executive, Kim Van Der Ham. Upon completing her orientation and onboarding, Ms. Van Der Ham will be the primary leadership support assigned to the Alliance and has begun attending key meetings.

The BH team partnered with Human Resources to conduct recruitment activities for the new Program Manager role, culminating in a job offer and acceptance to a highly qualified candidate, Rebecca McMullen who will join the Alliance team on May 30, 2023 based in Merced, where she has spent more than a decade in leadership positions with community based BH organizations. We look forward to Ms. McMullen's contributions to improving equitable access as well as other key initiatives. The next objective for BH staffing is to begin the recruitment process for an FTE analyst, which is approved in the 2023 budget effective July 1, 2023.

As part of completing the landscape assessment and gap analysis, the BH Director received a proposal from a community-based consultant regarding exploration of future state options. Following endorsement by the Board on April 26, 2023, next steps will be to onboard the consultant through a sole source justification. The consultant can then be onboarded utilizing the existing budgeted allotment for 2023 to support exploratory efforts.

Program Development. The Program Development Department moved from Strategic Development to Health Services in January 2023. In April, the department became fully staffed with a team comprised of one Director, one Manager, two Senior Program Development Analysts, one Program Development Specialist, and one Administrative Assistant.

DHCS Incentive Programs. CalAIM Incentive Payment Program (IPP): The aim of this program is to increase capacity of ECM and CS providers through increased care management capabilities, community supports infrastructure, information technology and data exchange, and workforce capacity. Thus far, $10,849,620 has been earned and received from DHCS (100% of total possible available funds to date). Of this, $7,801,248 has been allocated to ECM providers. Progress report Submission 2B was submitted to DHCS in March 2023, and is associated with an additional $10,849,620 possible allocation; decision and payment will be received by June 2023. Alliance staff are currently working to finalize the IPP Program Year 2 funding strategy and plan to begin executing additional IPP letters of agreements in the coming months.

Housing and Homelessness Incentive Program (HHIP). The aim of this program is to address homelessness and housing through collaborative plan and implementation of services and supports. Thus far, $7,012,656 has been earned and received from DHCS (100% of total possible allocation). Of this, $5,721,416 has been allocated to housing and homelessness community partners. Progress report Submission 1 was submitted to DHCS in March 2023, and is associated with an additional $16,362,863 possible allocation; decision and payment will be received by June 2023. Alliance staff are currently working to finalize the HHIP Program Year 2 funding strategy and plan to begin executing additional HHIP letters of agreement in the coming months.

Student Behavioral Health Incentive Program (SBHIP). The aim of this program is to increase access to preventative early intervention and behavioral health services by school-affiliated providers for TK-12 public school students. Thus far, $6,710,523 has been received (100% of total possible allocation). Of this, $3,708,000 has been allocated to five Local Education

Agencies (LEAs; School District partners), three County Offices of Education (COEs), and three County Offices of Behavioral Health (COBHs). Progress report #1 is due from the Alliance to DHCS on June 30, 2023, and is associated with an additional $1,437,273 possible total allocation; decision and payment will be received by August 2023. Alliance staff are currently executing letters of agreement to execute on SBHIP Program Year 2-3 with LEA, COE, and COBH partners, Participating SBHIP LEA partners include Atwater Elementary School District and Los Banos Unified School District (Merced County); Alisal Unified School District and Soledad Unified School District (Merced County); and Pajaro Valley Unified School District in partnership with Pajaro Valley Prevention and Student Assistance (Santa Cruz County).

Employee Services and Communications

Alliance Workforce. As of April 24, 2023, the Alliance has 549.4 budgeted positions of which our active workforce number is 531 (active FTE and temporary workers). There are 29 positions in active recruitment, and we are 95.6% staffed. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets. Human Resources partners with Finance to ensure alignment in this area and provides a bi-weekly workforce dashboard to all Directors and Chiefs for transparency regarding our workforce statistics.

Competencies and Career Development. This project continues to move forward with the approval of core, leadership, and director level competencies. Human Resources is currently working with each department, validating competencies by classification, and populating the new platform. We expect this work to run through the end of August 2023. Once this body of work is complete, Training & Development will begin work on the navigation and career development module, with education and training sessions scheduled to start in September and October 2023. Training and Human Resources will provide a status update to Operations Committee on May 10, 2023.

Quarterly Goal Check-in. The organization has completed its first quarterly goal check-in. Human Resources has implemented a new quarterly goal check-in process. With a focus on goal attainment across the organization, supervisors are in the process of goal check-in meetings with their staff to ensure we are progressing as needed to complete and meet assigned goals.

Onboarding Reboot. Training & Development has completed a new onboarding experience for all new employees joining the Alliance. The Alliance Onboarding Program is built on a foundation of inclusivity and belonging from day one. In addition, the program is designed to support unique onboarding processes for staff, leadership, and temporary employees to ensure each are set up for success from day one.

Facilities and Administrative Services.

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

Collaborative Office Space Survey. While the Alliance has transitioned to a hybrid, work-from-home environment, there are still organizational needs for departments and staff to meet and collaborate onsite in an Alliance office. A survey was created to get input from staff to

determine and evaluate business needs, desires, and ideas for the use of technology in collaborative spaces such as conference rooms and auditoriums.

Winter Storm Clean Up and Mitigation. Facilities is continuing efforts to clean up, repair, and mitigate areas impacted by flooding in the Scotts Valley location due the unprecedented rainfall in January 2023. Construction is underway and will be completed before the end of May 2023.

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

Communications. The member texting pilot is continuing, with the expectation that we will wrap up the feasibility report by the end of June. Later this month, we will begin sending targeted texts to members who are up for redetermination and who have received packets from the county.

A paid campaign promoting redetermination launched March 26, 2023 and will run through the end of the month. Tactics include website copy, social media ads, Member Bulletin articles, The Beat articles, mobile ads, and bus ads. To date, metrics are as follows:

- Website views: 14k English; 7k Spanish (Hmong views did not meet Google threshold for measurement)
- Facebook: 32k views in Spanish; 28 views in English
- Mobile ads: 461k impressions in Spanish; 363k impressions in English

To support enhanced awareness of the new Healthy Start program (rewards program for well checks and immunizations), we are launching a paid media campaign on May 8, 2023 that will run for eight weeks. Messaging will encourage people to see their doctor for checkups and to remain on track with vaccinations. The bilingual paid media campaign will run in all three counties and will include internal and exterior bus ads, mobile ads, Facebook ads, clinic ads, Peachjar ads (flyers to 72 schools), website copy and newsletter articles.

Operations

Claims. The first four months of the new HSP Platform audit have been completed (January through April). Our results for April were the best so far, achieving our quality targets in all three categories. We continue to work with Change Healthcare on implementing the new Other Health Coverage (OHC)/Coordination of Benefits (COB) payment integrity process. By implementing the OHC/COB payment integrity process, we will avoid paying primary in error, as well as be able to recover overpayments for circumstances where we have paid as primary in error. We are targeting an end of July go-live.

Member Services. As the continuous coverage requirement has now ended, the Member Services Department continues to actively collaborate with our county partners to share member information regarding address updates and redetermination dates. In May, the Alliance will use data obtained from our county partners to conduct targeted text and live outreach to members with redetermination packets due in June. Our call center is prepared for increased member calls related to the redetermination process. We have also implemented notifications in the Provider Portal to alert providers as to when a member's redetermination is due. Member Services is coordinating internal communication and training to ensure member-

facing staff understand the impacts to our members and reiterate the importance of completing the redetermination process for continuous coverage.

Provider Services. The Provider Services team is engaged in recruitment for San Benito and Mariposa expansion counties. Building out the network in these two new service areas is instrumental to ensuring member access. The team is also working to build out the ECM and CS providers for the July 1, 2023 new Populations of Focus. The team continues to engage with primary care providers for the Quality Improvement Program.

Community Engagement Santa Cruz/Monterey/Merced. The Community Engagement team have been working with community-based organizations in San Benito County through meet and greets held with the Community Foodbank of San Benito County, Aging & Disability Resource Connection, San Benito Health Foundation WIC staff, San Andreas Regional Center staff, and a few others. These initial conversations have positioned our staff to have conversations on best ways to serve county Medi-Cal recipients and to collaborate with existing organizations in the county. Future work in the expansion counties will include outreach to community members and coordination of townhall events to inform future members and community partners on the Alliance services.

County expansion work is continuing in Mariposa County with concerted community engagement efforts including sponsorship of the Mariposa Butterfly Festival. Introductory meetings and training for Mariposa County staff are currently underway. Key to these activities is establishing relationships with our community partners.

Q1 2023 Organizational Dashboard Results. The Q1 2023 Alliance Dashboard is comprised of 147 metrics monitoring 64 health plan core, support, and managerial processes. These 64 health plan processes are rolled-up to 13 top-level (Level 1) processes for Board monitoring using a composite methodology. Results for 9 of 13 Level 1 processes met or exceeded 95% of target. Key exceptions to the 95% standard and other notable performance are as follows:

Level 1 Process	Q1 Results	Qtr over Qtr Change	Key Drivers
Optimize the Alliance Workforce	93.6%	-2.5 percentage points	The process of recruiting new staff was impacted due to availability of candidates and hiring panels during the winter months. Turnover for staff with the Alliance less than 12 months continues to be a challenge and is being reviewed by Human Resources.
Manage Organizational Communications and Branding performance	91.7%	-7.7 percentage points	Community engagement on social media was below threshold, however, the overall reach of communication was higher than in previous quarters. Communications continues to refine the content to remain relevant and engaging.
Enhance Operational Effectiveness	90.8%	-2.8 percentage points	Timely completion of a couple projects was impacted by competing priorities and the complex nature of the work. The Operational Excellence team has identified

			gaps in process measurement and is working to ensure all key processes are measured and tracked.
Manage Alliance Compliance Commitments	71.7%	-18.7 percentage points	Corrective action and workplans have been put in place to address late reporting to Compliance, timely response to failed audits, and adequate correction of audit findings.

Attachments.

1. Local Health Plans of California Memo: May Revision 2023-24

To: Board of Directors & Plan Staff

From: LHPC Staff

Subject: Highlights from Governor's May Revision for 2023-24

Date: May 12, 2023

This memo includes highlights from the May Revision for FY 2023-24, specifically health and human services proposals of relevance to local plans. See the May Revision Budget Summary, DHCS Budget Highlights, and the DHCS Medi-Cal Estimate 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 with any questions.

State Budget Overview

The following highlights provide a snapshot of California's overall State Budget:

- ***Total Budget***: $306 billion total fund ($224 billion General Fund) in 2023-24
- ***Reduced Revenues and Budget Shortfall****:* There is an additional $9.3 million dollar shortfall from the Governor's January Budget resulting in a FY 2023-24 budget shortfall of $31.5 billion. The Governor presented a balanced budget by proposing the following solutions to fulfill the shortfall:
    - **$8.1 billion total in Funding Delays** – Additional $695 million across the multi-year without reducing the total amount of funding through the same period. Including $295 million moved into the out-years for the Foreclosure Intervention Housing Prevention Program.
    - **$6.7 billion total in Reductions/Pullbacks** – Additional $1.1 billion reduction in spending through reversions of unused funds, rather than cuts to programs.
    - **$7.5 billion total in Funding Shifts** – Additional $3.3 billion in shifts of spending commitments from the General Fund to other funds.
    - **$3.9 billion total in Trigger Reductions** – The May Revision does not include additional trigger reductions from the Governor's January Budget.
    - **$4.9 billion total in Limited Revenue Generation and** *Borrowing* – Including the additional $2.5 billion from the MCO tax beginning in calendar year (CY) 2023 and $1.2 billion in additional special fund loans to the General Fund.
    - **$450 million Safety Net Reserve Withdrawal**

- ***Budget Reserves****:* Reserved increased by $1.6 billion to $37.2 billion in budgetary reserves, the reserves include:

  - $22.3 billion in the Rainy Day Fund (Budget Stabilization Account)
  - $450 million in the Safety Net Reserve, which decreased the fund by half
  - $10.7 billion in the Public School System Stabilization Account, and increase of $2.2 billion
  - $3.8 billion in the state's operating reserve (Special Fund for Operating Uncertainties)

The Rainy Day fund continues to remain at the constitutional maximum which requires $2.3 billion to be dedicated for infrastructure investments. In order to access the Rainy Day fund, the Governor would need to declare a fiscal emergency, and any withdrawal is limited to no more than 50 per cent of the fund balance for any given fiscal year. While the May Revision does not project a recession, the administration has highlighted general fiscal uncertainty and forecasts revenues could decrease by $40 billion based on a moderate recession scenario driven largely by losses in personal income tax.

As required by Proposition 2, the budget accelerates the paydown of payments for state's retirement liabilities and includes an additional $2.3 billion in 2023-24 and approximately $5.1 billion over the next three years.

Based on the current revenue forecast, the Governor's budget focused on sustaining prior key investments such as:

- Transitional Kindergarten, Child Care Availability and Affordability, and Universal School Meals
- Maintaining Higher Education Commitments
- Advancing Climate Agenda
- Expanding Health Care Access and Delivery Transformation
- Expanding the Behavioral Health Continuum, Mental Health and Substance Use Disorder Supports
- Investments in Infrastructure, Housing, Homelessness, and continued Workforce Development

Reference: Budget Summary, pp. 1-7

Significant Medi-Cal Budget Items

Overall Medi-Cal Budget

- *2023-24 Budget estimate*: **$151.2 billion** ($37.6 billion General Fund) (DHCS Budget Highlights, p.15).
  - The 2023-24 budget estimates are $12.3 billion higher than the Governor's January Budget projection of $138.9 billion ($38.7 billion General Fund)

- *Total projected enrollment*: **The 2023-24 updated projected average monthly caseload is 14.2 million, a decrease of 1.4% from the Governor's Budget.** (DHCS Budget Highlights, p. 12)

The May Revision Medi-Cal caseload projections reflect impacts of California's PHE Unwinding plan and continuous coverage requirements that were not included in the Governor's January Budget.

- Medi-Cal beneficiaries will begin to lose coverage beginning in July 2023. The Medi-Cal caseload is projected to grow through June 2023 and then decline to a projected 12.8 million beneficiaries by July 2024 following the redetermination activities.
    - The federal Consolidated Appropriations Act, 2023 provides a step down of federal participation.
        - 6.2% enhanced match through March 31, 2023
        - 5.0% enhanced match April 1, 2023 through June 30, 2023
        - 2.5% enhanced match July 1, 2023 through September 30, 2023
        - 1.5% enhanced match October 1, 2023, through December 31, 2023

Reference: DHCS Budget Highlights, pp. 12-15

MCO Tax

The MCO Tax Model

The May Revision proposes increasing the MCO tax substantially above what was budgeted in the January Budget. While the January Budget assumed an MCO tax period of three years and total revenue of $6.5 billion, the May Revision assumes an extended tax period of three years and three quarters (effective retroactively to April 1, 2023 through CY 2026) and **total revenue over the tax period of $19.4 billion**. Prior to the release of the May Revision, DHCS released trailer bill language and a fact sheet outlining their proposal. Additional details are below.

MCO tax model summary:

- The proposed model assumes an **annual net state benefit of $5 billion** ($19.4 billion over the life of the tax as stated above).
- For the tax to be **effective retroactively to April 1, 2023**, DHCS must submit it to CMS by June 30th. This means the tax must be agreed upon and passed by the Legislature by June 15th.
- The **trailer bill includes the details of the model, including the tax tiers and amounts, and parameters for DHCS making changes to either enrollment or the tax model** for purposes of obtaining federal approval. The trailer bill also includes language authorizing a "Provider Payment Reserve Fund." More details are summarized below.

MCO spending proposal:

- The Administration proposes **$8.3 billion of the MCO tax revenue be utilized to support a balanced budget (General Fund offset) over the three and three-quarter years of the tax.** Specifically:
    - **$3.4 billion** in 2023-24
    - The remaining amount proposed as General Fund offset is $4.9 billion. If this is evenly distributed over FY 2024-25, FY 2025-26, and the first half of FY 2026-27, approximately $2 billion would be dedicated to the General Fund on an annual basis (with FY 2026-27 being a half year as the tax expires after December 31,

2026). These dollar amounts are not explicitly stated in the Budget documents, so LHPC will seek clarity from the Administration about its proposal.

- The Administration **proposes to establish a special fund for provider investments to improve access, quality, and equity total $11.1 billion over an 8 to 10 year period**.
- Of the proposed $11.1 billion to be dedicated to provider investments, the only specific proposal in the May Revision is provider rate increases for certain services up to **87.5% of Medicare rates** (primary care, maternity care, and non-specialty MH services).
    - These rate increases will be effective January 1, 2024 and in FY 2023-24 are estimated at **$98 million GF** ($237 million total funds).
    - Note that this proposal **includes Proposition 56 funding** and elimination of historical AB 97 rate reductions.
    - Our understanding is that while most, if not all, of the rates associated with the Proposition 56 codes are at or above the 87.5% threshold currently, this proposal will not decrease these rates. Rather, the **new base rate will be the calculation of the current base rate plus the supplemental payment.**
    - **We have not yet seen the specific codes** that will be attached to the rate increase but believe it will be the same as those DHCS proposed in the January Budget related to the federal approval of DSHP funding via the 1115 waiver.
- The Administration proposes to **develop additional specific proposals related to provider investments over the summer and fall** for inclusion in the Governor's January Budget for FY 2024-25.
- LHPC will continue to work closely with our members and the MCO Coalition to advocate for a spending plan that will provide meaningful investments to the Medi-Cal program.
- LHPC's press release in response to the May Revision can be found here.

Reference: Budget Summary, p. 49; DHCS Budget Highlights, pp. 5-6

Medi-Cal Eligibility Expansion to Undocumented Individuals

The May Revision maintains the funding levels for expansion of full-scope Medi-Cal coverage to all income-eligibility adults aged 26 through 49 regardless of immigration status, beginning January 1, 2024. Moreover, it reflects an **increase of $1.6 billion General Fund for FY 2023-24 and an estimated $2.4 billion General Fund ongoing annually**, for the expansion populations of adults 50 and older and 26-49. The increases are due to updated managed care rates, higher share of cost-only costs, higher caseloads due the continuous coverage requirement, and higher acuity members based on experience.

Reference: DHCS Budget Highlights, p. 7

Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule TPA

The May Revision includes **$10 million General Fund in FY 2023-24** to develop and implement a statewide infrastructure that will centralize provider management functions, including credentialing and quality oversight, and manage billing and claims for behavioral health services by school-based and school-linked providers, under the CYBHI fee schedule.

DHCS and DMHC are convening a **small CYBHI fee schedule workgroup consisting of LHPC, CAHP and several plan representatives beginning May 2023**. This workgroup will continue meeting monthly through the end of 2023 to discuss policy and operational considerations for implementing the statewide all-payer fee schedule as part of CYBHI.

Reference: DHCS Budget Highlights, p. 9

Forthcoming Whole Child Model Trailer Bill Language

DHCS will be amending existing trailer bill language to **remove Single Plan counties from the WCM expansion**; leaving in only those COHS counties who are expanding geographically and operate WCM today.

Reference: DHCS Budget Highlights, p. 11

Doula Services Implementation Evaluation Trailer Bill Language

Through the May Revision, DHCS is proposing trailer bill language extending the timelines for this workgroup to examine the implementation of the doula benefit through June 30, 2025.

Reference: DHCS Budget Highlights, p. 10

Other Health Proposals

Distressed Hospital Loan Program

The May Revise includes **$150 million General Fund one-time over 2022-23 and 2023-24** to provide interest-free cashflow loans to not-for-profit hospitals and public hospitals in significant financial distress or to governmental entities representing a closed hospital, for purposes of preventing the closure of, or facilitating the reopening of, those hospitals.

Reference: Budget Summary p. 59

Behavioral Health

- *Behavioral Health Community-Based Organized Network of Equitable Care and Treatment (BH-CONNECT) Demonstration (formerly CalBH-CBC)*
    - The May Revision provides for **$480 million in funding for a new workforce initiative in each year of the five-year demonstration**, totaling $2.4 billion dollars comprised of federal funds and the non-federal share is funded through DSHP and portion of MHSA state directed revenues. The workforce initiative is targeted at long and short term investments in behavioral health workforce, strengthening the pipeline of behavioral health professionals needed, and improving short-term recruitment and retention efforts.

      Reference: DHCS Budget Highlights, pp. 6-7

- *CARE Act Funding Increases*
    - Increases to account for additional activities required in draft rules released by the Judicial Council, changes in the hourly rates assumed for each activity performed by counties, and updates to the length of time in hearings.
        - $67.3 million General Fund, an increase of $800,000 from the Governor's January Budget for FY 2023-24
        - $121 million General Fund, an increase of $12.5 million from the Governor's January Budget for FY 2024-25 and ongoing
    - $15 million General Fund one-time start-up funding to Los Angeles County given their December 1, 2023 implementation

      Reference: Budget Summary pp. 49-50; DHCS Medi-Cal Estimate p. 7

- *998 Suicide and Crisis Lifeline*
    - The May Revision includes **$15 million one-time 988 State Suicide and Behavioral Health Crisis Services Fund in 2023-24** to support eligible 988 call center behavioral health crisis services, for a total of $19 million in 2023-24 and $12.5 million in 2024-25 and ongoing.

      Reference: Budget Summary p. 50

- *Behavioral Health Budget Solutions*
    - Behavioral Health Bridge Housing Program and CalHOPE funding is shifted, at least in part, from the General Fund to the Mental Health Services Fund. This shifting effectively eliminates the delay of $250 million General Fund for the Behavioral Health Bridge Program.

      Reference: Budget Summary p. 50

Home and Community Based Services (HCBS) Spending Plan

The 2021 Budget Act appropriated funds made available through the American Rescue Plan (APR) Act to enhance, expand, and strengthen HCBS. The ARP required HCBS funding to be spent by March 31, 2024 and that has been extended until March 31, 2025.

The May Revise proposes allowing certain initiatives, included in the approved HCBS Spending Plan, additional time to fully expend the funds and complete initiative objectives. One initiative of note is DHCS's Eliminating Assisted Living Waiver Waitlist. This will allow funds to be spent until March 2024.

Reference: DHCS Budget Highlights p. 8

Alliance Dashboard

Quarter 1, 2023

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

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

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

Core Processes

Deliver value to our members, providers and community

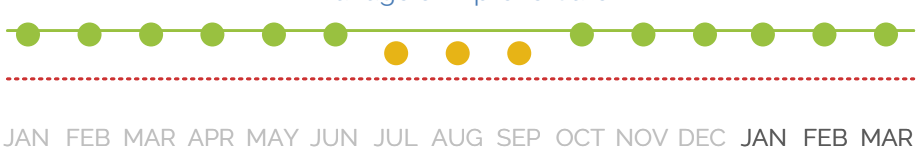
Engage & Support Members

97.3% Of Target

SUBPROCESSES
- 96.8 Help Members Engage
- 98.2 Help Members Navigate
- 96.8 Member Experience

Manage & Improve Care

99.2% Of Target



SUBPROCESSES
- 98.5 Manage Care Use
- 100 Improve Care

Develop & Maintain the Provider Network

97.6% Of Target

SUBPROCESSES
- 98.2 Develop the Network
- 97.0 Maintain the Network

Pay Providers

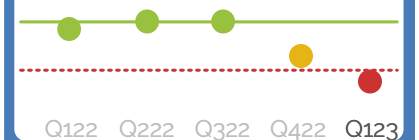
99.5% Of Target

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

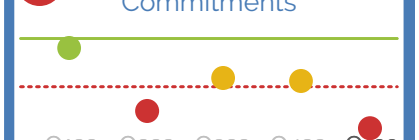
Managerial Processes

Guide the organization

90.8 Enhance Operational Effectiveness



71.7 Manage Compliance Commitments

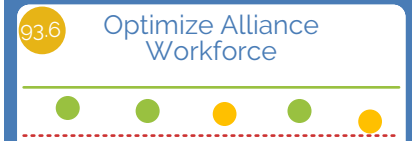


99.5 Manage Finances

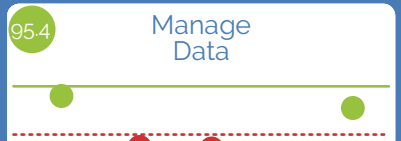
97.6 Manage Governmental & Community Relations

Support Processes *Enable organizational operations*

93.6 Optimize Alliance Workforce



95.4 Manage Data



98.3 Manage Technology

100 Provide Administrative Services

91.7 Communications & Organizational Branding

Back to Agenda

Alliance Dashboard – Board Metrics

Quarter 1, 2023

No.	Metric	Period	Target	Performance
1	Calls to Member Services answered within 30 seconds	Q123	80.0%	82.6%
2	New Member Welcome Call Completion Rate	Q422	30.0%	33.6%
3	Timely Resolution of Member Complaints	Q123	100.0%	99.0%
4	Members' Favorable Rating of Health Plan (CAHPS) (Medi-Cal)	2021	Child: 86.0% | Adult: 73.0%	Child: 87.8% | Adult: 76.8%
5	Members' Favorable Rating of Health Care (CAHPS) (Medi-Cal)	2021	Child: 84.5% | Adult: 70.5%	Child: 88.6% | Adult: 75.6%
6	Routine PCP Facility Site Reviews Completed Timely	Q123	100.0%	80.0%
7	Facility Sites Reviewed in Good Health	Q123	100.0%	100.0%
8	In Area PCP Market Share (all counties)	Q123	80.0%	87.0%
9	In Area Specialist Market Share (all counties)	Q123	80.0%	85.0%
10	Contracted PCP Open % (all counties)	Q123		57.3%
11	Overall Provider Satisfaction Rate	2022	88.0%	87.0%
12	Inpatient Bed Days/ 1,000 members/Year (Medi-Cal)	Q422	292.0	287.0
13	Admissions/1,000 Members/Year (Medi-Cal)	Q422	63.0	65.0
14	Total 30 Day All-Cause Readmissions %	Q422	11.0%	9.0%
15	Ambulatory Care Sensitive Admissions (Medi-Cal)	Q422	8.0%	6.4%
16	Average Length of Stay (Medi-Cal)	Q422	4.5	4.6
17	Emergency Department visits/1,000 members/year (all LOBs)	Q422	590.0	566.0
18	Avoidable Emergency Department visits (all LOBs)	Q422	18.0%	22.0%
19	Behavioral Health Utilization Rate by County (All Ages)	Q422	3.6%	SC: 13.2% | Mont: 6.9% | Merced: 6.5%
20	Routine Medical/Surgical Prior Authorizations Adjudicated Timely	Q123	100.0%	99.7%
21	Clean Claims Processed and Paid Within 30 Calendar Days	Q123	90.0%	94.7%
22	Employee Turnover Rate	Q222-Q123	10.0%	7.3%
23	Total Staffed Workforce	Q123	90.0%	95.5%
24	Board Designated Reserves Percentage	Q123	100.0%	116.1%
25	Net Income Percentage	Q123	1.0%	8.5%
26	Medical Loss Ratio	Q123	92.0%	88.2%
27	Administrative Loss Ratio	Q123	6.0%	5.4%

DATE: May 24, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Third Month Ending March 31, 2023

For the month ending March 31, 2023, the Alliance reported an Operating Loss of $1.8M. The Year-to-Date (YTD) Operating Income is $25.9M, with a Medical Loss Ratio (MLR) of 88.2% and an Administrative Loss Ratio (ALR) of 5.4%. The Net Income is $34.7M after accounting for Non-Operating Income/Expenses.

The budget expected a $39.8M Operating Income for YTD March. The actual result is unfavorable to budget by $13.9M or 34.9%, driven primarily by medical expenses.

	Mar-23 ($ In 000's)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*423,002*	*412,231*	*10,771*	*2.6%*
Revenue	136,117	131,070	5,047	3.9%
Medical Expenses	130,644	107,904	(22,740)	-21.1%
Administrative Expenses	7,294	8,434	1,141	13.5%
Operating Income	(1,821)	14,731	(16,552)	-100.0%
Net Income	5,312	12,047	(6,735)	-55.9%
MLR %	*96.0%*	*82.3%*	*-13.7%*	
ALR %	*5.4%*	*6.4%*	*1.1%*	
Operating Income %	*-1.3%*	*11.2%*	*-12.6%*	
Net Income %	*3.9%*	*9.2%*	*-5.3%*	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

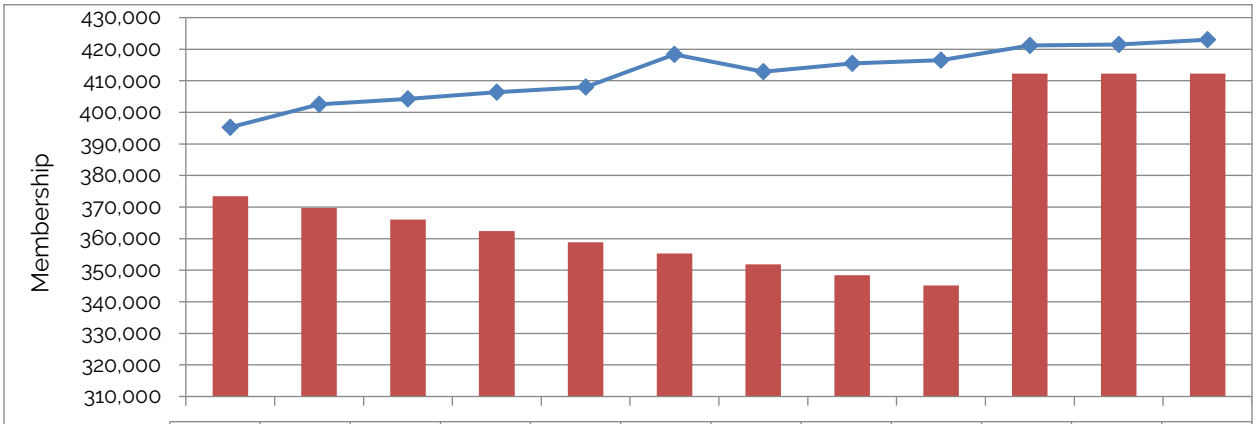
Mar-23 YTD (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*1,265,692*	*1,236,693*	*28,999*	*2.3%*
Revenue	407,385	393,209	14,176	3.6%
Medical Expenses	359,474	329,367	(30,106)	-9.1%
Administrative Expenses	22,038	24,078	2,040	8.5%
Operating Income/(Loss)	25,874	39,764	(13,890)	-34.9%
Net Income/(Loss)	34,650	31,711	2,939	9.3%
PMPM				
Revenue	321.87	317.95	3.92	1.2%
Medical Expenses	284.01	266.33	(17.68)	-6.6%
Administrative Expenses	17.41	19.47	2.06	10.6%
Operating Income/(Loss)	20.44	32.15	(11.71)	-36.4%
MLR %	88.2%	*83.8%*	*-4.5%*	
ALR %	*5.4%*	*6.1%*	*0.7%*	
Operating Income %	*6.4%*	*10.1%*	*-3.8%*	
Net Income %	*8.5%*	*8.1%*	*0.4%*	

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

At a PMPM level, YTD revenue is $321.87, which is favorable to budget by $3.92 or 1.2%. Medical cost PMPM is $284.01, which is unfavorable by $17.68 or 6.6%. The resulting operating income PMPM is $20.44, which is unfavorable by $11.71 compared to the budget.

Membership. March 2023 membership is favorable to budget by 2.6%. Please note that the 2023 budget assumed the Public Health Emergency (PHE) would end in January 2023, with membership beginning to decline in April 2023. The Health and Human Services Department announced that the PHE would end on May 11, 2023. The current Department of Healthcare Services (DHCS) states that the redetermination begins in April 2023 for the July 2023 renewal date, with the actual enrollment loss expected to begin in July 2023.

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



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Budget	373,452	369,700	366,008	362,379	358,808	355,301	351,849	348,456	345,117	412,231	412,231	412,231
Actual	395,252	402,517	404,261	406,414	407,983	418,380	412,859	415,506	416,529	421,212	421,478	423,002
Variance	21,800	32,817	38,253	44,035	49,175	63,079	61,010	67,050	71,412	8,981	9,247	10,771
Variance %	5.8%	8.9%	10.5%	12.2%	13.7%	17.8%	17.3%	19.2%	20.7%	2.2%	2.2%	2.6%

Revenue. The 2023 revenue budget was based on the current (DHCS) 2022 draft rate package and included a 1.2% rate increase. Furthermore, the budget assumed breakeven for Enhanced Care Management (ECM) and Community Supports (CS). Both were new programs in 2022. The prospective CY 2023 draft rates from DHCS (dated 12/8/2022, including Maternity) are favorable to the rates assumed in the CY 2023 budget by 0.7%.

March 2023 capitation revenue of $135.8M is favorable to budget by $5.0M or 3.8%, mainly attributed to higher enrollment of $3.4M and rate variances of $1.6M. March 2023 YTD capitation revenue of $406.3M is favorable to budget by $14.1M or 3.6%. Of this amount, $8.7M is from boosted enrollment, and $5.4M is due to rate variance.

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

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	83,559	83,744	(185)	969	(1,154)
Monterey	173,694	168,267	5,427	4,459	969
Merced	149,030	140,166	8,864	3,281	5,584
Total	**406,284**	**392,177**	**14,107**	**8,709**	**5,398**

Note: Excludes Mar-23 YTD In-Home Supportive Services (IHSS) premiums revenue of $1.1M.

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

March 2023 Medical Expenses of $130.6M are $22.7M or 21.1% unfavorable to budget. March 2023 YTD Medical Expenses of $359.5M are above budget by $30.1M or 9.1%. Of this amount, $22.4M is due to rate, and $7.7M is due to higher enrollment. Other Medical expense is unfavorable to budget by $5.9M or 12.4% due to higher utilization in behavioral health services, Allied Health, lab, and medical transportation. A general increase in respiratory-related expenses and overall claim volumes for typical services contributed to the Physician Services expenses.

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	141,605	123,178	(18,427)	(2,888)	(15,538)
Inpatient Services (LTC)	41,988	44,116	2,128	(1,034)	3,162
Physician Services	76,453	68,861	(7,592)	(1,615)	(5,977)
Outpatient Facility	45,905	45,609	(296)	(1,069)	774
Other Medical	53,523	47,603	(5,920)	(1,116)	(4,804)
Total	**359,474**	**329,367**	**(30,106)**	**(7,723)**	**(22,383)**

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

At a PMPM level, YTD Medical Expenses are $284.01, unfavorable by $17.68 or 6.6% compared to the budget. Please note that the rate (PMPM) is the unit cost for a service multiplied by the utilization.

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

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	111.88	99.60	(12.28)	-12.3%
Inpatient Services (LTC)	33.17	35.67	2.50	7.0%
Physician Services	60.40	55.68	(4.72)	-8.5%
Outpatient Facility	36.27	36.88	0.61	1.7%
Other Medical	42.29	38.49	(3.80)	-9.9%
Total	**284.01**	**266.33**	**(17.68)**	**-6.6%**

Administrative Expenses. March YTD Administrative Expenses are favorable to budget by $2.0M or 8.5% with a 5.4% ALR. Salaries are favorable by $0.4M due to savings from vacant positions and employee benefits. Non-Salary Administrative Expenses are favorable by $1.7M or 22.0% due to the timing of expenses versus the budget for projects in the new year.

Non-Operating Revenue/Expenses. March YTD Total Non-Operating Revenue is favorable to budget by $15.2M, attributed to $10.9M in unrealized gain on investments and $4.3M in interest income. Non-Operating Expenses are favorable by $1.6M due to the timing of grant expenses, resulting in a favorable Net Non-Operating income of $16.8M compared to the budget.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $34.7M, with an MLR of 88.2% and an ALR of 5.4%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Third Month Ending March 31, 2023
(In $000s)

Assets	
Cash	$392,076
Restricted Cash	300
Short Term Investments	683,440
Receivables	151,053
Prepaid Expenses	4,844
Other Current Assets	16,023
Total Current Assets	**$1,247,736**
Building, Land, Furniture & Equipment	
Capital Assets	$81,303
Accumulated Depreciation	(45,345)
CIP	733
Lease Receivable	2,539
Total Non-Current Assets	**39,230**
Total Assets	**$1,286,967**
Liabilities	
Accounts Payable	$24,294
IBNR/Claims Payable	526,752
Accrued Expenses	-
Estimated Risk Share Payable	17,500
Other Current Liabilities	7,010
Due to State	7,596
Total Current Liabilities	**$583,153**
Deferred Inflow of Resources	$2,437
Total Long-Term Liabilities	**$2,437**
Fund Balance	
Fund Balance - Prior	$666,727
Retained Earnings - CY	34,650
Total Fund Balance	**701,377**
Total Liabilities & Fund Balance	**$1,286,967**
Additional Information	
Total Fund Balance	**$701,377**
Board Designated Reserves Target	407,388
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	171,739
Total Reserves	**635,827**
Total Operating Reserve	**$65,550**

* MCGP includes Additional Contribution of $43.6M

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2023
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*423,002*	*412,231*	*10,771*	*2.6%*	*1,265,692*	*1,236,693*	*28,999*	*2.3%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$135,751	$130,726	$5,026	3.8%	$406,284	$392,177	$14,107	3.6%
Premiums Commercial	365	344	21	6.1%	1,102	1,032	69	6.7%
Total Operating Revenue	**$136,117**	**$131,070**	**$5,047**	**3.9%**	**$407,385**	**$393,209**	**$14,176**	**3.6%**
Medical Expenses								
Inpatient Services (Hospital)	$56,152	$40,353	($15,799)	-39.2%	$141,605	$123,178	($18,427)	-15.0%
Inpatient Services (LTC)	14,369	14,452	83	0.6%	41,988	44,116	2,128	4.8%
Physician Services	25,117	22,560	(2,557)	-11.3%	76,453	68,861	(7,592)	-11.0%
Outpatient Facility	17,828	14,942	(2,886)	-19.3%	45,905	45,609	(296)	-0.6%
Other Medical*	17,178	15,597	(1,581)	-10.1%	53,523	47,603	(5,920)	-12.4%
Total Medical Expenses	**$130,644**	**$107,904**	**($22,740)**	**-21.1%**	**$359,474**	**$329,367**	**($30,106)**	**-9.1%**
Gross Margin	**$5,473**	**$23,165**	**($17,693)**	**-76.4%**	**$47,911**	**$63,842**	**($15,930)**	**-25.0%**
Administrative Expenses								
Salaries	$5,560	$5,699	$139	2.4%	$16,113	$16,485	$372	2.3%
Professional Fees	170	229	59	25.8%	569	643	74	11.5%
Purchased Services	829	1,171	342	29.2%	2,423	2,993	570	19.0%
Supplies & Other	380	954	573	60.1%	1,791	2,821	1,030	36.5%
Occupancy	100	100	0	0.4%	338	302	(36)	-12.0%
Depreciation/Amortization	255	281	26	9.3%	802	833	32	3.8%
Total Administrative Expenses	**$7,294**	**$8,434**	**$1,141**	**13.5%**	**$22,038**	**$24,078**	**$2,040**	**8.5%**
Operating Income	**($1,821)**	**$14,731**	**($16,552)**	**-100.0%**	**$25,874**	**$39,764**	**($13,890)**	**-34.9%**
Non-Op Income/(Expense)								
Interest	$2,988	$1,025	$1,963	100.0%	$7,395	$3,074	$4,321	100.0%
Gain/(Loss) on Investments	5,181	(2,364)	7,546	100.0%	3,814	(7,093)	10,907	100.0%
Other Revenues	162	155	6	4.2%	452	465	(13)	-2.8%
Grants	(1,197)	(1,500)	302	20.2%	(2,885)	(4,499)	1,614	35.9%
Total Non-Op Income/(Expense)	**$7,133**	**($2,684)**	**$9,818**	**100.0%**	**$8,776**	**($8,053)**	**$16,829**	**100.0%**
Net Income/(Loss)	**$5,312**	**$12,047**	**($6,735)**	**-55.9%**	**$34,650**	**$31,711**	**$2,939**	**9.3%**
MLR	*96.0%*	*82.3%*			*88.2%*	*83.8%*		
ALR	*5.4%*	*6.4%*			*5.4%*	*6.1%*		
Operating Income	*-1.3%*	*11.2%*			*6.4%*	*10.1%*		
Net Income %	*3.9%*	*9.2%*			*8.5%*	*8.1%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2023
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*423,002*	*412,231*	*10,771*	*2.6%*	*1,265,692*	*1,236,693*	*28,999*	*2.3%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$320.92	$317.12	$3.81	1.2%	$321.00	$317.12	$3.88	1.2%
Premiums Commercial	0.86	0.83	0.03	3.4%	0.87	0.83	0.04	4.3%
Total Operating Revenue	**$321.79**	**$317.95**	**$3.83**	**1.2%**	**$321.87**	**$317.95**	**$3.92**	**1.2%**
Medical Expenses								
Inpatient Services (Hospital)	$132.75	$97.89	($34.86)	-35.6%	$111.88	$99.60	($12.28)	-12.3%
Inpatient Services (LTC)	33.97	35.06	1.09	3.1%	33.17	35.67	2.50	7.0%
Physician Services	59.38	54.73	(4.65)	-8.5%	60.40	55.68	(4.72)	-8.5%
Outpatient Facility	42.15	36.25	(5.90)	-16.3%	36.27	36.88	0.61	1.7%
Other Medical*	40.61	37.83	(2.78)	-7.3%	42.29	38.49	(3.80)	-9.9%
Total Medical Expenses	**$308.85**	**$261.76**	**($47.09)**	**-18.0%**	**$284.01**	**$266.33**	**($17.68)**	**-6.6%**
Gross Margin	**$12.94**	**$56.20**	**($43.26)**	**-77.0%**	**$37.85**	**$51.62**	**($13.77)**	**-26.7%**
Administrative Expenses								
Salaries	$13.14	$13.83	$0.68	4.9%	$12.73	$13.33	$0.60	4.5%
Professional Fees	0.40	0.56	0.15	27.7%	0.45	0.52	0.07	13.5%
Purchased Services	1.96	2.84	0.88	31.0%	1.91	2.42	0.51	20.9%
Supplies & Other	0.90	2.31	1.41	61.2%	1.42	2.28	0.87	38.0%
Occupancy	0.24	0.24	0.01	2.9%	0.27	0.24	(0.02)	-9.4%
Depreciation/Amortization	0.60	0.68	0.08	11.6%	0.63	0.67	0.04	6.0%
Total Administrative Expenses	**$17.24**	**$20.46**	**$3.22**	**15.7%**	**$17.41**	**$19.47**	**$2.06**	**10.6%**
Operating Income	**($4.30)**	**$35.74**	**($40.04)**	**-100.0%**	**$20.44**	**$32.15**	**($11.71)**	**-36.4%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Third Month Ending March 31, 2023
(In $000s)

	MTD	YTD
Net Income	$5,312	$34,650
Items not requiring the use of cash: Depreciation	216	763
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	5,478	19,727
Prepaid Expenses	531	(794)
Current Assets	(1,109)	(2,608)
Net Changes to Assets	**$4,900**	**$16,324**
Changes to Payables:		
Accounts Payable	(4,739)	(46,380)
Accrued Expenses	-	-
Other Current Liabilities	594	(699)
Incurred But Not Reported Claims/Claims Payable	227,082	244,384
Estimated Risk Share Payable	2,500	7,500
Due to State	2,550	2,550
Net Changes to Payables	**$227,988**	**$207,355**
Net Cash Provided by (Used in) Operating Activities	**$238,416**	**$259,093**
Change in Investments	(6,978)	(7,445)
Other Equipment Acquisitions	2,564	2,089
Net Cash Provided by (Used in) Investing Activities	**($4,415)**	**($5,356)**
Lease Interest Income	-	-
Net Cash Provided by (Used in) Financing Activities	**$0**	**$0**
Net Increase (Decrease) in Cash & Cash Equivalents	**$234,002**	**$253,737**
Cash & Cash Equivalents at Beginning of Period	**$158,074**	**$138,338**
Cash & Cash Equivalents at March 31, 2023	**$392,076**	**$392,076**

DATE: May 24, 2023

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Services Advisory Group: Member Appointment

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

Background. The Board established the MSAG authorized in the Bylaws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission.

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

Name	Affiliation	County
Candi Walker	Member	Santa Cruz
Humberto Carrillo	Member	Monterey
Yaneth Virgen Venegas	Community Partner	Monterey

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

Attachments. N/A

Meeting Minutes

Wednesday, April 26, 2023
10:00 a.m. – 2:30 p.m.

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

Commissioners Present:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Ms. Julie Edgcomb	Public Representative
Ms. Janna Espinoza	Public Representative
Supervisor Zach Friend	County Board of Supervisors
Dr. Charles Harris	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Ms. Mónica Morales	County Health Services Agency Director
Ms. Rebecca Nanyonjo	Director of Public Health
Supervisor Josh Pedrozo	County Board of Supervisors
Ms. Julie Peterson	Hospital Representative
Dr. Allen Radner	Provider Representative
Dr. Joerg Schuller	Hospital Representative
Mr. Rob Smith	Public Representative

Commissioners Absent:

Dr. Maximiliano Cuevas	Provider Representative
Ms. Leslie Abasta-Cummings	Provider Representative
Dr. James Rabago	Provider Representative

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Ms. Stephanie Sonnenshine	

Ms. Lisa Ba	Chief Financial Officer
Dr. Dale Bishop	Chief Medical Officer
Mr. Scott Fortner	Chief Administrative Officer
Ms. Jenifer Mandella	Chief Compliance Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
Ms. Jessie Dybdahl	Provider Services Director
Ms. Jessica Finney	Grants Director
Ms. Andrea Swan	Quality Improvement and Population Health Director
Ms. Shaina Zurlin	Behavioral Health Director
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Jimenez.

Commission Chairperson Jimenez called the meeting to order at 10:01 a.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

Chair Jimenez welcomed Mr. Michael Schrader, Alliance Chief Executive Officer. She also welcomed Ms. Leslie Abasta-Cummings and Ms. Julie Peterson to the Board.

Chair Jimenez recognized the Board service of Commissioners deGhetaldi and Weber.

2. Oral Communications.

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

No members of the public addressed the Commission.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

No comments or announcements from Commissioners at this time.

4. Comments and announcements by Chief Executive Officer.

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

Mr. Schrader reviewed the agenda and logistics for the day.

[Commissioner Morales arrived at this time: 10:04 a.m.]

[Commissioner Kalantari-Johnson arrived at this time: 10:05 a.m.]

He acknowledged the Board service of Dr. Larry deGhetaldi and Mr. Tony Weber and welcomed Ms. Julie Peterson and Ms. Leslie Abasta-Cummings to the Board.

The Alliance held an in-person All-Staff Assembly and luncheon on April 20, 2023 at the Cocoanut Grove in Santa Cruz County. Chair Jimenez opened the meeting and recognized and thanked Ms. Sonnenshine for her leadership and Mr. Schrader delivered his first State of the Alliance.

[Commissioner Molesky arrived at this time: 10:07 a.m.]

The Healthcare Effectiveness Data and Information Set Compliance Audit indicated no preliminary findings and the Department of Health Care Services Medical Survey resulted in zero findings for the Alliance for CY 2022.

[Commissioner Nanyonjo arrived at this time: 10:11 a.m.]

Work is underway to occupy a smaller footprint in Alliance offices and progress in underway to lease the vacant office space. Staff continue to work remotely and workstations have been set up for on-site use.

The deadline for providers to submit performance improvement projects to the Alliance for the Care-Based Incentive program was extended from April 28, 2023 to May 19, 2023. Additional content will be provided during the Alliance Quality Program discussion, regular agenda item #13.

With respect to the model change, in the fall two seats each from Merced, Monterey, and Santa Cruz counties are expected to be removed. Two seats are expected to be added for San Benito County, and one seat is expected to be added for Mariposa County. Staff are having conversations with each County for appointment by the respective Board of Supervisors. Staff may come forward with a recommendation in May to move the retreat from September to October to follow the Department of Health Care Services' readiness review for the model change.

Consent Agenda Items: (5. – 9H.): 10:20 a.m.

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

Chair Jimenez reminded the Board that in order to manage any risk of conflict, staff have separated the approval action for the Medi-Cal Capacity Grant Program: Funding Recommendation into two agenda items. Item 9G, Group A Grant applications that are not affiliated with Board members, which all Board members may discuss and vote on; and Item 9H Group B Grant applications that are affiliated with Board members which may have a conflict. Item 9H should be voted on separately from items 5-9G to facilitate two separate approval actions for Group A (applications not affiliated with Board members) and Group B (applications affiliated with Board members) so that the Board may have separate votes and Board members with a conflict may abstain from discussion and voting on item 9H.

MOTION: Commissioner Pedrozo moved to approve Consent Agenda items 5-9G, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Edgcomb, Espinoza, Friend, Harris, Jimenez, Kalantari-Johnson, Molesky, Morales, Nanyonjo, Pedrozo, Radner, Schuller, Smith.

Noes: None.

Absent: Commissioners Abasta-Cummings, Cuevas and Rabago.

Abstain: Commissioner Peterson.

Commissioner Pedrozo moved to approve Consent Agenda item 9H, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Edgcomb, Espinoza, Friend, Harris, Jimenez, Kalantari-Johnson, Molesky, Pedrozo and Smith.

Noes: None.

Absent: Commissioner Abasta-Cummings, Cuevas and Rabago.

Abstain: Commissioners Morales, Nanyonjo, Peterson, Rader and Schuller.

Regular Agenda Item: (10. - 16.): 10:22 a.m.

10. Annual Election of the Officers of the Commission. (10:22 – 10:24 a.m.)

The bylaws of the Santa Cruz – Monterey – Merced Managed Medical Care Commission require an annual election of the Chairperson and Vice Chairperson each year in April. Immediately following the election, the newly elected Chairperson facilitates the remainder of the April meeting.

Commissioner Conner nominated Chairperson Jimenez and Vice Chairperson Pedrozo to continue to serve as Chairperson and Vice Chairperson respectively for a successive year.

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

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Edgcomb, Espinoza, Friend, Harris, Jimenez, Kalantari-Johnson, Molesky, Morales, Nanyonjo, Pedrozo, Peterson, Radner, Schuller and Smith.

Noes: None.

Absent: Commissioners Abasta-Cummings, Cuevas and Rabago.

Abstain: None.

11. Consider approving new Medi-Cal Capacity Grant Program (MCGP) Funding Opportunities (2023 - Phase 2). (10:24 – 10:53 a.m.)

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

Ms. Jessica Finney, Grants Director, introduced the second of two phases of new grantmaking opportunities responsive to the grantmaking framework, priorities and goals adopted by the Board last year to ensure continued to contributions to capacity in the Medi-Cal delivery system. The first phase was approved at the March Board meeting.

Commissioners discussed and provided the following comment: focus on kids, anti-bullying and aging populations; member driven grants; outreach, equity learning, and web-based provider training (continuing education); consider best funding opportunities (allocations) for each county; patient access is critical; and using advertising and media channels to promote the Alliance.

MOTION: Commissioner Friend moved to approve recommendations for new MCGP funding opportunities and associated MCGP budget allocations. seconded by Commissioner Pedrozo.

ACTION: The motion passed with the following vote:

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

Noes: None.

Absent: Commissioners Abasta-Cummings, Cuevas, and Rabago.

Abstain: Commissioners Conner, Harris, Jimenez, Kalantari-Johnson, Morales, Nanyonjo, Peterson, Radner and Schuller.

12. Discuss Dual Eligible Special Needs Plans (D-SNPs) Operational Readiness and Governance Considerations. (10:53 – 11:43 a.m.)

Ms. Van Wong, Chief Operating Officer (COO) and Ms. Margaret Tatar, Managing Principal, Health Management Associates (HMA), oriented the Board to D-SNP readiness and governance considerations. Key findings and outcomes of the Operational Gap Assessment finalized by HMA in February 2023 were shared with the Board. Governance consideration for the Board under D-SNP and the Alliance's approach to respond to the Board's duty of care and next steps to prepare the Board for a June budget consideration were discussed.

Commissioners discussed and provided the following comment: level of readiness, analysis and community responsiveness by January 2024; additional staff may be required which may increase administrative expenses; and the vision for the provider network.

Mr. Schrader provided additional highlights and shared his perspective on D-SNP. The key difference is that dual-eligible Alliance members will have options for their Medicare coverage. They will have many of the same options as any Medicare consumer, dependent on their County of residence.

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

13. Discuss Alliance Quality Program. (11:50 a.m. – 12:37 p.m.)

Dr. Dale Bishop, Chief Medical Officer and Ms. Andrea Swan, Quality Improvement and Population Health Director, reviewed the quality metrics from the 2022 Managed Care Accountability Sets and Care-Based Incentives, described the 2023 quality improvement and

health equity transformation plan to address gaps in the 2022 report and discussed further developments of quality program readiness for 2024.

Commissioners discussed and provided the following comment: consider separate funding allocation for each county; concern with lack of primary care provider capacity; augment funding for community healthcare workers; opportunities for clinics through the grant program; effective school based initiatives; and additional resources and community outreach in Merced County.

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

[Commissioner Friend departed at this time: 1:11 p.m.]

14. Discuss State of the Alliance Network. (1:12 – 1:44 p.m.)

Ms. Wong, COO and Ms. Jessie Dybdahl, Provider Services Director, reviewed the Alliance's access framework including the concept of realized access, reviewed indicators of success and Alliance performance relative to network adequacy and realized access, shared the Alliance's approach on ensuring realized access as part of health equity for our members and discussed the outlook for county expansion and D-SNP focused efforts into 2023 and beyond.

[Commissioner Kalantari-Johnson departed at this time: 1:39 p.m.]

Commissioners discussed and provided the following comment: credentialing is a big obstacle; urgent care benefit is win/win; developing an access dashboard would be helpful; getting primary care providers into the system is a challenge and retention is an issue.

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

15. Discuss Behavioral Health Program: Gaps and Opportunities. (1:44 – 2:18 p.m.)

Dr. Shaina Zurlin, Behavioral Health Director, provided an overview of the current landscape of behavioral health services that are available to Medi-Cal members within and beyond the Alliance and discussed future considerations towards improving behavioral health services and systems to inform the Board's future discussions and actions on how the Alliance administers its behavioral health program.

Commissioners discussed and provided the following comment: consider forward thinking opportunities toward bringing behavioral health services in-house.

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

16. Discuss Key Takeaways and Next Steps. (2:18 – 2:28 p.m.)

Mr. Schrader, CEO, reviewed the key takeaways from the presentations and Board discussion which included: support for conversation toward reviewing the Alliance's provision of behavioral health services to determine any appropriate future state recommendations; dashboard/metric report on access; building primary care provider access and capacity; health equity within the MCGP and consideration for separate funding allocations for each County.

[Commissioner Morales departed at this time: 2:26 p.m.]

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

The Commission adjourned its regular meeting of April 26, 2023 at 2:28 p.m. to the regular meeting of May 24, 2023 at 3:00 p.m. via videoconference from Alliance offices in Scotts Valley, Salinas and Merced unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, March 15, 2023
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Arti Sinha	Application Services Director
Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Dale Bishop	Chief Medical Officer
Danita Carlson	Government Relations Director
Dave McDonough	Legal Services Director
Gordon Arakawa	Medical Director
Jessie Dybdahl	Provider Services Director
Jimmy Ho	Accounting Director
Kate Knutson	Compliance Manager (Chair)
Kay Lor	Payment Strategy Director
Lilia Chagolla	Community Engagement Director
Lisa Ba	Chief Financial Officer
Lisa Artana	Human Resources Director
Luis Somoza	Member Services Director
Michelle Stott	Quality Improvement and Population Health Director
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Ryan Markley	Compliance Director
Scott Fortner	Chief Administrative Officer
Shaina Zurlin	Behavioral Health Director
Stephanie Sonnenshine	Chief Executive Officer
Tammy Brass	Utilization Management Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Dianna Diallo	Medical Director

Committee Members Excused:

Adam Sharma	Operational Excellence Director
Jenifer Mandella	Chief Compliance Officer
Jennifer Mockus	Community Care Coordination Director
Linda Gorman	Communications Director

Ronita Margain	Community Engagement Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director

Ad-Hoc Attendees:

Ka Vang	Compliance Specialist II
Kat Reddell	Compliance Specialist II
Rebecca Seligman	Compliance Supervisor
Sara Halward	Compliance Specialist II

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

   Chairperson Kate Knutson called the meeting to order at 9:02 a.m.

2. **Review and Approval of February 15, 2023 Minutes.**

   COMMITTEE ACTION: Committee reviewed and approved minutes of February 15, 2023 meeting.

3. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Regulatory and All Plan Letter Updates**
   3. **Open APLs**

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. **Regular Agenda**

   1. **Program Integrity Quarterly Report**

   Seligman, Compliance Supervisor, presented the Q4 2022 Program Integrity Activity Report and reviewed select Matters Under Investigation (MUIs). Seligman reported that 38 concerns were referred to Program Integrity in Q4 2022, 20 of which resulted in the opening of a MUI. There were 59 active MUIs in Q4 2022.

   Seligman reviewed referral trends for the period noting that 4 were provider specific, 15 were member specific, and 1 was a State Request.

   Seligman began her review of the Q4 2022 Compliance Dashboard by noting that a formula error was identified in the data tables used to calculate the Annual Investigative Duration Average. This error was found to date back to the inception of the plan dashboard. Seligman informed the Committee that the error was corrected in all prior dashboards, which resulted in an overall longer investigative duration.

   Seligman reviewed performance of the Program Integrity metrics from the Q4 Alliance Dashboard noting that both quality and efficiency metrics met target performance while the efficiency metric did not.

   Seligman reviewed 2 exemplar cases, highlighting investigative measures taken and next steps for completion of MUI investigation. This included resolution of an MUI reported in

Q3 2020 related to over-utilization of level 5 E&M codes, in which ongoing monitoring identified that Program Integrity's intervention had resulted in behavior change on the provider's part. Also reviewed was the closure of an MUI reported in Q2 2022 related to an Alliance NEMT provider potentially falsifying transportation records. During investigation the SIU was notified that Department of Healthcare Services (DHCS) had opened an investigation into the provider, and while the plan's subsequent Corrective Action Plan (CAP) has been satisfied and the MUI closed, SIU continues to cooperate with DHCS investigators upon request.

Seligman reviewed Q422 Program Integrity Financial Reporting noting the total requested recoupment was $1,537.00 and completed recoupment was $20,882.87 during the period.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2022 Program Integrity Quarterly Report.

2. Internal A&M Quarterly Report

Halward, Compliance Specialist III, presented the Q4 2022 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 2 internal audits were conducted, and both received a passing score. Halward reviewed one exemplar internal audit related to P&T Committee membership and specific Conflict of Interest requirements to highlight Compliance staff's review activities and departmental activities.

Halward reviewed Q4 2022 Targeted Audits Dashboard metrics related to internal audits, noting that the quality metric met its established threshold, and the efficiency metric was not applicable for the time period as there were no failed audits. Halward then reviewed outcomes of the monitoring of 31 Alliance Dashboard metrics related to regulatory requirements, noting that 30 metrics met their established thresholds in Q4 2022

Halward presented the 2023 Internal Audit & Monitoring workplan, which incorporates existing risks from the 2022 workplan and inclusion of potential new risks, including newly implemented requirements and audit findings by regulators during 2022. The 2023 Internal A&M workplan includes 34 planned focused reviews, of which 12 are high risk areas, 14 are medium risk areas and 3 are low risk areas, in addition to 5 planned one-time audits. The 2023 workplan also includes implementing a quarterly review of the risks on the workplan and reprioritization of audit work as needed.

Halward reviewed external audit activities, reporting on potential uncorrected findings of the 2023 DMHC Follow Up Survey and reviewed potential findings of the 2023 DHCS Medical Audit conducted February 6-17.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2022 Internal A&M Quarterly Report.

3. Dignity/CommonSpirit Pre-delegation Assessment

Knutson, Compliance Manger, presented the Dignity/CommonSpirit Pre-Delegation Assessment. Dybdahl, Provider Services Director, reported that staff obtained and reviewed requested documentation from Dignity/CommonSpirit and found that they met Alliance requirements. Staff recommend approval of delegation of Provider Credentialing to Dignity/CommonSpirit.

COMMITTEE ACTION: Committee reviewed and approved the delegation of Credentialing activities to Dignity/CommonSpirit.

4. Review of MCAS Sanctions Final Amount

Bishop, Chief Medical Officer, reviewed the Final outcomes and the amount of monetary sanctions issued to the Plan for failure to meet minimum performance levels for Medi-Cal Managed Care Accountability Set (MCAS) performance measures. Bishop reported that Alliance staff met with DHCS to discuss process improvements and restrictions to vaccine clinics in Merced County. Upon review of this information, DHCS reduced the Plan's sanction amount from $88,000.00 to $57,000.00.

The meeting adjourned at 9:36 a.m.

Respectfully submitted,

Robin Sihler
Compliance Administrative and Data Reporting Assistant

Continuous Quality Improvement Committee (CQIC)

Meeting Minutes
Thursday, January 26, 2023
12:00 – 1:30 p.m.

Virtual Meeting / Web Conference

Committee Members Present

Dr. Caroline Kennedy	Physician Representative
Dr. Eric Sanford	Physician Representative
Dr. Minoo Sarkarati	Physician Representative
Dr. Stephanie Graziani	Physician Representative
Ms. Cheri Collette	Provider Representative
Ms. Stacey Kuzak	Provider Representative

Committee Members Absent:

Dr. Amy McEntee	Physician Representative
Dr. Casey Kirkhart	Physician Representative
Dr. Madhu Raghavan	Physician Representative
Dr. Oguchi Nkwocha	Physician Representative
Ms. Susan Harris	Provider Representative

Guests Present:

Dr. Villarama	Physician Representative
Adam Sharma	Operational Excellence Director
Alex Sanchez	Quality Improvement Program Advisor III
Georgia Gordon	Quality Improvement Project Specialist

Alliance Committee Members Present:

Dr. Gordon Arakawa	Chair, Medical Director
Dr. Dianna Diallo	Medical Director
Ms. DeAnna Leamon	Quality Improvement Nurse Supervisor
Ms. Deborah Pineda	Quality and Health Programs Manager
Ms. Hilary Gillette-Walch	Clinical Decision Quality Manager
Ms. Jacqueline Van Voerkens	Administrative Specialist
Ms. Jennifer Mockus	Community Care Coordination Director
Ms. Jessie Dybdahl	Provider Services Director
Ms. Lilia Chagolla	Community Engagement Dir., Monterrey
Ms. Linda Gorman	Communications Director
Mr. Luis Somoza	Member Services Director
Ms. Mao Moua	Quality and Health Programs Supervisor
Ms. Michelle Stott	QI/ Population Health Director
Ms. Navneet Sachdeva	Pharmacy Director
Ms. Ronita Margain	Community Engagement Dir., Merced
Ms. Sarah Sanders	Grievance and Quality Manager
Ms. Shaina Zurlin	Behavioral Health Director
Ms. Tammy Brass	Utilization Management Director
Ms. Viki Doolittle	UM/Complex Case Management Manager

1. Call to Order by Dr. Gordon Arakawa, Medical Director

Dr. Gordon Arakawa called the meeting to order at 12:05 PM, and welcomed all members present.

Dr. Arakawa announced that the Department of Health Care Services (DHCS) will conduct its annual audit at the Alliance February 6 – 17th .

2. Consent Agenda

Dr. Arakawa introduced the consent agenda.

October 27, 2022 CQIC Meeting Minutes

Dr. Arakawa presented the October 27, 2022 CQIC Minutes. There were no edits requested at this time.

Dr. Villarama inquired about the provider portal accuracy noted in the minutes. Michelle Stott, RN indicated that there were concerns about accuracy of the information that was in the provider portal when pulling the reports. A meeting is in place with the analytics team just to ensure that all the reports are accurate.

Dr. Kennedy inquired if the Alliance is still denying NIPT, the prenatal screening for serious genetic and congenital disorders (Down syndrome). Dr. Kennedy's understanding is there is presently an injunction against the state of California. Tammy Brass indicated that most of the frequent denials for genetic testing is the large panel whole exome sequencing.

Action: Tammy Brass will research Dr. Kennedy's question and provide the information offline. (Action complete)

Dr. Kennedy inquired about DME requests. Tammy Brass noted the overall denial rate is exceptionally low. Even though DME appears in the higher end, it is extremely low when it comes to the DME complex requests. The Alliance contracts with Periscope, which is a team that does in-home evaluations to identify the most appropriate DME, or if there are additional DME needs for that member, to ensure a comprehensive evaluation. The denials for DME are usually add-on specialty items that are not for specialty referrals.

Committee Decision: Minutes were approved as written.

Subcommittee/Workgroup Meeting Minutes

- Continuous Quality Improvement Workgroup – Interdisciplinary (CQIW - I) Minutes
- Continuous Quality Improvement Workgroup (CQIW) Minutes
- Pharmacy and Therapeutic (P&T) Committee - Minutes
- Utilization Management Workgroup (UMWG) Minutes

Workplans:

- Q3 2022 Utilization Management Work Plan
- Q3 2022 Utilization Management Work Plan Executive Summary
- Q3 2022 Quality Improvement System (QIS) Work plan
- Q3 2022 QIS Workplan Executive Summary

Policies Requiring CQIC Approval:

Require Approval		
Policy Number	**Title**	**Significant Changes**
401-1301	Potential Quality Issue	Minimal changes were made.
401-1306	Corrective Action Plan for Quality Issues	Significant changes were made to the policy based on CAP Process improvement work with OpEx.
401-1508	Facility Site Review Process	Significant changes were made to the policy based on APL 22-107 – Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review
401-1510	Medical Record Review and Requirements	Significant changes were made to the policy based on APL 22-107 – Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review
401-4101	Cultural and Linguistic Services Program	Updated policy in response to 2024 DHCS. Contract Deliverable request and AIR findings. A summary of the edits include: • Added language regarding member timely access to care, no cost translation for members, update language to C&L services, noted C&L services are based on PNA findings. • Updated language to specifically included provisions noted in 5.2.11.A.7 in the 2024 Medi-Cal Managed Care Contract.
401-4103	Interpreter Services	Updated policy in response to 2024 DHCS Contract Deliverable request and AIR findings. Added the following language, along with other required edits: • to specifically include that, "Member's timely access to care will note be delayed due to any lack of interpreter services." • to specifically include/define what medical and non-medical care settings are. • to specifically include that C&L staff assess the performance of our contracted interpreter service vendors. • around auxiliary aids.
Informational		
Policy Number	**Title**	**Significant Changes**
401-1524	County FSR Collaboration	• Significant changes were made to the policy based on APL 22-107 – Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review
401-1705	Care Based Incentive	• Health Equity was added as a value. • 2023 Health Equity measure was described. • Portal reports and resources listings were updated

401-4102	Translation of Alliance Documents	Updated policy in response to 2024 DHCS Contract Deliverable request and AIR findings. . A summary of added language • members have access to full and immediate translations at no cost. • CFR section provisions and W&I Code as part of critical member information that must be translated. • The Alliance mitigate any C&L gaps identified during our quality control reviews on translations.

Delegate Oversight Report: The VSP Q3 2022 and the Beacon Q4 2022 quarterly delegate oversite summary included in consent agenda meeting packet.

QIPH Reports
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Audit Q2 2021
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Audit Q4 2021
- IHA Audit Findings Q2 2022

Committee Decision: Consent Agenda was approved as written.
Action:
a. UM/CCM Administrative Assistant will submit the UM Workplan and Executive Summary to the Executive Assistant for the February Board meeting packet for approval.
b. QIPH Administrative Specialist will submit the CQIC minutes, QIS Workplan and QIS WP Executive Summary to the Executive Assistant for the February Board meeting packet for approval.
c. QIPH Administrative Assistant will submit the policies to Policy Hub for approval.

3. Regular Agenda

a. Quality Improvement Health Equity Transformation (QIHET)
Michelle Stott presented on the Quality Improvement System, Strategic Plan Alliance Interventions, and Quality Improvement Health Equity Transformation. Population Health is also being built out, and the present focus is working on NCQA standards and ensuring compliance. Health Equity work involved pediatric disparities in all 3 counties, with a large focus in Merced. The focus if for children to achieve the 90th percentile. The Pediatric Equity Task Force was created, which meets bi-weekly to achieve this goal and review the Pediatric Equity Roadmap. The Committee discussed the Health Equity Pediatric measures and clarified the goals.

Committee discussed women's preventive screenings and services. Members discussed the access issue of scheduling mammograms; presently they are being scheduled 4 – 5 months out, then some members forget they have the appointment. Michelle Stott indicated that Alliance health educators recently successfully participated in an intervention for Merced for scheduling provider appointments, and might be able to look into doing something similar for mamograms. Hilary Gillette-Walch suggested having standing orders for mammograms for members that are eligible.

Committee also discussed the transportation issues members are experiencing getting to these appointments. Natividad has taxis vouchers.

Committee discussed the CBI measure for Chlamydia.

Michelle Stott asked the Committee how they would like to see the CQIC transforming into the Quality Improvement and Health Equity Committee (QIHEC)? Dr. Kennedy would like to see the Committee learn from experts and from the State on what works. Have external expert present information.

Dr. Sanford would like to see data on interventions that are successful, versus data on equity; review data that the Alliance can make an impact on.

Dr. Sarkarati would like to see root causes, breakdowns, and reason of the measures/patient level data.

b. Community Health Workers (CHW) and Provider Engagement
Jessie Dybdahl, Provider Services Director, presented on the Community Health Workers Benefit. The Committee reviewed the DHCS mandates /CalAIM system transformation and the Health Equity/Person Centered Delivery System Transformation Strategic Plan 2022-2026 goals in which this benefit was created. An overview of CHW roles was reviewed. The Health Care Affordability and Information (HCAI) Department is leading the certification and trainings for efforts and stakeholder sessions. An overview of the Strategy Development for CHW Network and Engagement was presented. This included focus points for building a provider network, workforce development, and community dialogue / information sharing.

Dr. Kennedy mentioned the issue of trainings.
Action: Jessie Dybdahl will provide Dr. Kennedy with online free programs.
Action: Complete

Action: Dr. Kennedy will check with the appropriate person at the Monterey County Clinic regarding the Community Health Workers application.
Action: Complete

The Alliance is working on a grant program to financially support the CHW certifications.

Dr. Sanford mentioned that there is a group at the Center for Community Advocacy in Salinas, and the Public Health Department in Monterey, who would be interested in these positions.

c. Dyadic Care
Shaina Zurlin, Behavioral Health Director, presented on Dyadic Care. Dyadic Care is a form of treatment that targets family well-being as a mechanism to support healthy child development and mental health. Dyadic Care is a new benefit intended to address developmental and behavioral health (BH) conditions as soon as they are identified in primary pediatric care.

DHB Well Child Visits, Dyadic Services, Family Therapy, and the Dyadic Care implementation were shared with the Committee. The group discussed making referrals.

d. Member Satisfaction and Experience
Alex Sanchez presented on the 2022 Medi-Cal CAHPS® survey results. Key takeaways, survey outcomes and next steps were reviewed.

The survey was fielded between 3/29/2022 and 6/23/2022. Response rate for the adult survey slightly decreased from 18.6% to 15.4% and child survey decreased from 18.6% to 17.0%. Adult members rating of specialists improved by 7.9% in 2022, going from 77.8% to 85.7%. Medi-Cal Adult timeliness of care was significantly lower (73.4%) compared to 2021 (84.5%), with routine and urgent care appointments taking longer than the previous year.

"Getting needed care" declined amongst child respondents from 83.4% to 79.2% in 2022, falling below the 25th percentile nationally. No significant findings related to disparities in care based on answers to three supplemental questions, keeping in mind sampling only included those who speak either English or Spanish. Merced County Adult sample responses fall below the national and NCQA All-plans benchmarks for all composites and measures.

e. Utilization Management Criteria:
    a. Utilization Review: 2022 NTR Codes
    Utilization of the No Tar Required (NTR) codes were consistent throughout 2022, with increased utilization from 2019. CPAP supplies making up larger utilization numbers. Improved member compliance. Non-CPAP codes reflect minor increases. The top 5 new codes were reviewed. Annual utilization trends were reviewed.

    b. UM Member Benefit Updates Q1 2023
    The CPT/HCPCS updates for Q1 2023 (effective 1/1/2023) were presented including the evaluation of codes and authorization requirements. Many codes do not have authorization requirements. The surgery codes require authorization but will continue to be reviewed, and updates will continue to be brought to the committee.

f. Future Topics

No new topics were suggested at this time. Committee members are encouraged to submit items for discussion, at any time, to Michelle Stott or Tammy Brass.

Next Meeting: Michelle Stott announced that the title of future meetings will change to Quality Improvement Health Equity Committee (QIHEC) . Ms. Stott reviewed the 2023 schedule and announced that the cadence of the QIHEC meeting will change but will remain on Thursdays. The schedule will be distributed after the meeting.

The meeting adjourned at 1:30 p.m.

Minutes respectfully submitted by,

Jacqueline Van Voerkens
Administrative Specialist

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 13, 2023

1:30p.m. – 3:00p.m.

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

Chairperson: Janna Espinoza, WCM Family Member, WCMFAC Chair

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

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

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

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

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

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

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 13, 2023

1:30p.m. – 3:00p.m.

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

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 13, 2023

1:30p.m. – 3:00p.m.

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

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, March 13, 2023

1:30p.m. – 3:00p.m.

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

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

DATE: May 24, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Contract with Monterey County In-Home Services Public Authority

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Recommendation. Staff recommend the Board authorize the Chairperson to sign the agreement between the Alliance and the Monterey County In-Home Supportive Services (IHSS) Public Authority (Public Authority) to provide covered services to eligible and enrolled IHSS providers for the period July 1, 2023 through June 30, 2024.

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, 2023 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 and per member per month premiums. County staff are preparing the agreement for final review. Upon execution by your Board, the contract will go to the Monterey County Board of Supervisors for final approval prior to execution and implementation.

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

Attachments. N/A

DATE: May 24, 2023

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Revised 2023 Alliance Board Meeting Schedule

Recommendation. Staff recommend the Board approve the revised Alliance Board meeting schedule for the remainder of calendar year 2023.

Background. At the Board's December 7, 2022 meeting the 2023 schedule for the Board meetings was set. Meetings are held from 3:00 – 5:00 p.m. (fourth Wednesdays) from each of the three Alliance County offices via videoconference and are open to the public.

Discussion. Due to schedule conflicts with the proposed date for the Alliance's Board retreat in September, and to follow the Department of Health Care Services' readiness review for the model change and implementation of the new five-county Commission, staff propose the following revised Board meeting schedule for the remainder of 2023 to include a regular meeting in September and a half-day, in-person meeting in October.

- June 28, 2023 (3:00 – 5:00 p.m.) – via videoconference
- July 2023 (No Board Meeting)
- September 27, 2023 (3:00 – 5:00 p.m.) – via videoconference
- October 25, 2023 (10:30 a.m. – 2:00 p.m.; Location: TBD)
- November 2023 (No Board Meeting)
- December 6, 2023 (3:00 – 5:00 p.m.) – via videoconference

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

Attachments. N/A

DATE: May 24, 2023

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Compensation Philosophy Adjustment: Living Wage Standard

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Recommendation. Staff recommend the Board approve the adoption of a living wage standard as a component of the Alliance's compensation philosophy, effective for fiscal year 2023.

Summary. A "living wage" is defined as "what one full-time worker must earn on an hourly basis to help cover minimum basic needs where they live while still being self-sufficient." As part of a recent review of the Alliance compensation structure, it was determined that 15 employees are currently compensated at a rate of pay that is below their local living wage standard for a single adult with no children.

Background. In 2018, the Alliance's Board adopted a compensation philosophy which established competitive pay practices for staff recruitment and retention. This philosophy was adopted to create communication and transparency regarding a compensation strategy which is market-driven, performance-oriented, flexible and adaptable, consistent and fair, and aligns with the marketplace. The key elements of the Alliance compensation philosophy are clarified below:

- The Alliance will strive to pay its employees "fairly" and in a manner that is commensurate with an employee's performance, contributions, experience and level of skill and competency.
- The midpoint of ranges will be approximated off the 50th percentile of the relevant labor markets in order to attract, engage and retain talented staff.
- The Alliance will recognize that it competes for talent in differing labor markets (e.g., general industry, other health plans).
- Employee pay will be managed through the use of pay ranges, each of which will have a midpoint that will represent an approximation of the market rate. The pay ranges will be updated to ensure alignment with changing market pay levels.

Discussion. There is an additional opportunity to ensure the Alliance is competitive in workforce recruitment and selection strategies. While salary ranges are based on the local labor market as determined by external compensation consultants, there are situations where a portion of a small number of ranges fall below local living wage standards, according to the M.I.T. Living Wage Calculator. There are currently a small number of Alliance staff members who are paid slightly below the local living wage.

Staff recommend the Board approve the addition of a fifth bullet point to our compensation philosophy that states, "The Alliance will ensure that no employee is paid below the local living wage standard (single adult, no children)."

With the addition of a living wage standard to the Alliance compensation philosophy, the Board will be ensuring that all staff members earn a rate of pay that would enable them to earn income to meet minimum standards of living in our communities and meet basic needs. It would also further strengthen the ability of the Alliance to recruit and retain qualified staff.

Financial Impact. Adoption of the proposed living wage standard will have a financial impact of approximately $35,000.00, resulting from increasing pay for the 15 staff members currently compensated below the local living wage standard for a single adult with no children.

Attachments. N/A

DATE: May 24, 2023

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

FROM: Dale Bishop, MD, Chief Medical Officer

SUBJECT: Quality and Performance Improvement Program Annual Report for 2022

Recommendation. Staff recommend the Board accept the Quality and Performance Improvement Program (QPIP) Annual Report for 2022.

Summary. This informational report provides the 2022 activities for the Alliance's contractually required Quality Improvement System report or QPIP and an evaluation of the Quality Improvement System workplan. A written description of activities is reflected in the QIS workplan, as evidenced by goals and objectives reviewed quarterly and evaluated on an annual basis. These activities are approved by the Quality Improvement and Health Equity Committee (formerly Continuous Quality Improvement Committee) and ultimately, the Alliance Board.

Background. The Alliance is contractually required by the Department of Healthcare Services (DHCS) to maintain a QPIP to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. Each year, the Alliance's QPIP focuses upon areas with actionable challenges and significant clinical outcomes that relate to a large proportion of members. The intent is to evaluate the activities related to quality and develop future interventions for improvements in care delivery and ultimately, the health status of members. The 2022 QIS workplan outcomes and evaluation are described in further detail in the report.

Discussion.

2022 QIS Workplan Outcomes and Evaluation

Member Experience

- Member engagement rate of Member Outreach Campaigns:
    - Resumed in-person outreach activities in Merced, Monterey, and Santa Cruz Counties. Attended 119 community events and served over 13,000 members. Of those, 46 were new community events. The Alliance also co-hosted two community clinics at its Salinas location in Monterey County in partnership with VIDA Monterey County, VNA, Monterey County Health Department and United Way Monterey County. These clinics provided no-cost COVID-19 and flu vaccines to anyone in the community. The face-to-face outreach target was 35% of those attending events and the 2022 average was over 45% of attendees who were reached at each event.
- Health Services Division Member Outreach and Engagement Campaigns:
    - During 2022, Health Services staff worked closely to outreach and engage members in a few different campaigns. As we developed each successive

campaign, the teams became more closely collaborative and detailed in case documentation and integration of data collection into our case management systems. Our first goal was met with all ad hoc outreach and engagement campaigns documented and outcomes shared with key stakeholders. By the last quarter of 2022, we had a well-honed process and brought together staff from multiple departments to work together on member outreach. In five business days three staff were able to phone 341 members and schedule 22 of them for care. While training, materials, documentation and translation went smoothly, the lesson learned was the use of rosters built from claims data alone were not effective because it is important to identify members who were recently seen by the clinic, and the Alliance had not yet received and processed claims and removed those members who are scheduled. Already being seen at the clinic or currently scheduled was the most common reason the callers declined to be scheduled. Therefore, this step of reconciliation is particularly important because many facilities have long wait times for preventive services currently; perhaps impacting a large cohort of members.

- Member Support:
    - In 2022, the Member Services Call Center saw a larger than expected volume of member calls, as well as in increase in member walk-ins. To ensure that the Call Center could continue to provide strong and efficient services to our members, several actions where implemented to decrease member wait time to speak to an Alliance representative. This included onboarding additional staff to support the call volume, as well as engaging a vendor to provide additional customer service training for staff to maximize efficiency. Further, the Alliance engaged our current transportation vendor to explore taking on the intake and scheduling of member requests for transportation services. As our transportation vendor supported this work for many large health plans in California, they had the capacity and experience to provide high quality service to our members while meeting established call center service levels. As of January 1, 2023, the Alliance transitioned the intake and scheduling of member requests for transportation services to our current Non-Medical Transportation vendor. Member Services leadership continues to monitor the impact of this transition on our members, and as of February 2023, the transition has been smooth and the impact to members has been minimal.
- Cultural and Linguistics (C&L) Services and Population Needs Assessment Education:
    - In Q4 2022, while we saw a significant increase in utilization of our face-to-face interpreting services, there was a decrease in telephonic interpreting services.
    - A total of 6,015 telephonic interpreting services calls were reported for measuring Q4 2022 across the Alliance's service areas. This is a 6% decrease when compared to Q4 2021 (6,417).
    - A total of 1,166 face-to-face interpreting services requests were coordinated in Q4 2022 across the Alliance's service areas. This is a 141% increase when compared to Q3 2021 (483).
    - Overall trends we saw when compared to 2021 included: unplanned inclement stormy weather changes that impacted access/connectivity to telephonic and face-to-face interpreting services, decrease utilization in our telephonic and face-to-face interpreting services for indigenous languages, increase utilization in face-to-face interpreting services in all three service areas and increased face-to-face interpreting service requests for appointments in specialty care, behavioral health, and physical therapy.

  - The C&L team will focus on promoting our interpreting services through various Alliance communication outlets (i.e. Member Newsletter, Provider Bulletin, Alliance website posts, Provider Flash and presentations). We will feature an article around accessing our interpreting services in the 2023 March Member Newsletter and Provider Bulletin. We will also conduct provider and staff cultural competency trainings in late 2023, which will also focus on accessing interpreting services.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS):
  - For the Medi-Cal Adult surveys and comparison against national benchmarks, there was an increase to 91.5% (25-50th), health plan customer service at 91.1% (75th-90th), and rating of specialists at 85.7% (50-75th). Global ratings of health care: 75.6% (25th-50th) and health plan: 76.8% (75th-90th). Access metrics decreased for getting needed care at 82.9% (50th-75th) and getting care quickly (below 25th). For the Medi-Cal Child surveys, increases were noted in getting care quickly at 84.5% (25-50th), health plan customer service at 92% (above 90th), rating of personal doctor at 93.4% (above 90th), and rating of specialist at 93.4% (above 90th). For getting needed care, the rates decreased to 79.2% (below 25th) and slightly for rating of health plan to 87.8%. For how well doctors communicate, although increases noted, adult ratings were at 91,1% (25th-50th) and child ratings were at 93.1% (25th-50th). For augmented sample for Spanish speakers, measures above the 90th were in rating of personal doctor, rating of specialist, and rating of health plan. The areas of opportunity at 25th-50th percentile, were in getting care quickly at 78.2% and how well doctors communicate at 92.4%. In addition, supplemental questions focused on possible disparities in care and cultural humility were surveyed, and there were positive experiences for adults and children overall with rates ranging from 90.8% ("never" treated unfairly at doctor's office due to language barrier to 95.2% ("never" treated unfairly at doctor's office due to cultural differences). There were responses that indicated "always" to "sometimes" treated unfairly or misunderstanding of culture. For member experience overall, results will be reported internally and further analysis and/or additional surveying may be considered to uncover any hidden disparities to continue to improve services.

Quality of Service

<u>Access and Availability</u>

- Annual Access Plan:
  - The third annual Access Plan launched in April 2022 with the goal of promoting the development of a provider network that meets member needs through the strategic focus on areas of network expansion. The Network Development Steering Committee (NDSC) identified the following areas of focus for the 2022 Access Plan:
    1. Improve member access to care through ensuring that the Alliance network adequately meets regulatory requirements.
       a. Recruitment to meet all Annual Network Certification specialty care requirements within time and distance standards.
       b. Recruitment to secure network of new Medi-Cal provider types, specifically doulas and community health workers,
       c. Ensure sufficient capacity for contracted Enhanced Care Management (ECM) and Community Support (CS) services.

2. Expand access to contracted Non-Emergency Medical Transportation (NEMT) services.
    a. Support successful recruitment of NEMT service providers through rate enhancements.
    b. Recruit additional NEMT providers to serve each county of the Service Area.
    c. Enhance Provider Relations support of contracted NEMT providers.

Measures that required provider recruitment were challenged, most significantly due to a limited number of providers available for recruitment in the rural areas targeted and many providers identified were not eligible for recruitment, or unwilling or unable to entertain recruitment conversations due to their own staffing issues and resultant pressure on clinic capacity. The goal to recruit doulas and community health workers was challenged due to a lack of clarity on requirements as All Plan Letters and subsequent operationalization of internal processes occurred late in the year or into early 2023. However, this work continues as an organizational priority through a separate and dedicated project team.

In contrast, recruitment of ECM and CS providers was successful. However, many ECM/CS providers are small organizations who may find that their capacity to support large volumes of members is not feasible. The organization is now looking at ways to significantly increase provider capacity.

Ongoing monitoring of access-related metrics will continue to inform opportunities for improving access to care for Alliance members, and Provider Services has incorporated lessons learned into the planning process for the 2023 Access Plan. Potential Access Plan focus areas will be discussed by the NDSC in February of 2023. Provider Services also recommends that the 2023 Access Plan integrate work to address the Emerging Access Issues tracker developed and monitored through NDSC in 2022.

- Provider Choice: In-Area Market Share:
    - In-area market share for primary care and specialist providers is monitored quarterly and tends to fluctuate by less than 0.5%. From Q1 2022 through Q4 2022, primary care market share for the entire service area as a whole increased slightly from 86% to 86.5% and specialist market share decreased slightly from 86.5% to 85.5%.

<u>Provider Experience</u>

- Provider Satisfaction:
    - The Alliance conducts an annual Provider Satisfaction Survey in order to assess contracted providers' overall satisfaction with core health plan operations. Results are used to inform future initiatives and educational opportunities for the provider network, and in conjunction with other health plan data, provide insight into where the Alliance can focus improvement efforts.

      The survey measures overall provider satisfaction with the Alliance, with the top two responses on a five-point scale indicating that a provider is satisfied. In 2022, the Alliance's overall satisfaction rate (87%) decreased by two percentage points compared to the year prior. This performance change was not determined to be significantly lower, and remained significantly higher than the

Medicaid plan average comparative rating. 80% of PCPs responded they were satisfied with the Alliance, compared to 90% of specialists. Monterey and Merced County respondents reported the highest overall satisfaction at 89% and 88% respectively, followed by Santa Cruz at 78%.

The Survey also measures satisfaction with specified categories of core health plan operations. While satisfaction with Alliance core health plan services has historically landed in the top quartile of SPH Analytics' Medicaid BOB respondents, MY 2022 rankings all fall at or above the 95th percentile with the exception of Network/Coordination of Care, which ranks at the 92nd percentile.

Survey outcomes should be assessed as one of many inputs to measuring the effectiveness of health plan services and access to care. The 2022 outcomes will be assessed in partnership with other measures of access and quality, as well as member satisfaction, to gain a more holistic view of Alliance performance in 2022.

Quality of Clinical Care

Quality Measures: HEDIS/MCAS

- The Alliance had nine high performance levels in Santa Cruz/Monterey and four in Merced, and nine minimum performance levels (MPLs) in the women's (breast cancer screening, chlamydia screening) and children's domain (well-visits and immunizations), with one in Santa Cruz and eight MPLs primarily in Merced County. The Alliance was originally sanctioned $88,000 and following a meeting with DHCS, the sanction was reduced to $57,000. A pediatric disparities assessment was done to identify root causes and opportunities for improvement, which included a tour of Merced County and stakeholder input. It was recognized that Merced County has health disparities related to geography/poverty that will require additional attention and resources in order to improve quality scores in Central Valley. In addition, for rapid cycle improvements and to promote an organizational wide strategy for the children's measures, a Pediatric Equity Roadmap and a Pediatric Equity Taskforce was established with operational and health services leadership that meets bi-weekly. Across all counties, cross-cutting objectives to address health disparities were identified that included addressing workforce shortage, provider enablement, member and family activation, communication strategy, community engagement, and data procurement to improve HEDIS/MCAS rates. The strategies for the women's domain (activate resuming care for women's screenings) and children's domain (address health disparities and root causes for improvement) included these objectives as a framework to plan the work ahead for 2023.

Utilization

- Under/Overutilization:
    - Under and over utilization is closely monitored and Utilization Management investigates identified cases, develops interventions, and works closely with other departments such as Program Integrity, Quality Improvement, and Provider Services.

      As authorization codes are waived as part of the Authorization Reduction Project, efforts have been made to monitor these codes to ensure the waived codes do not result in inappropriate over utilization. Auto approved or no TAR

required (NTR) utilization volumes have been monitored through the Utilization Management Work Group.

The following monitored categories were approved in the April Continuous Quality Improvement Committee meeting, and were intended to be reviewed as part of the Quarterly Utilization Management Work Plan:

- Categories to be monitored for possible over utilization:
  - Electromyography (EMG)
  - Emergency Room Visits
  - Any Auth Redesign/NTR code identified from emerging utilization analysis results
- Categories to be monitored for possible underutilization:
  - Initial Health Assessment (IHA)
  - Breast Cancer Screening
  - Colon Cancer Screening
  - Lead Screening
  - Adverse Childhood Experience (ACE) Screening

Lack of consolidated over/under utilization reporting mechanisms has led to delays in centralized monitoring for the approved categories listed above. An underutilization report has been developed but not yet tested; anticipate a full review of 2022 data in Q1 2023.

Additional work is underway linking reporting from multiple sources. An underutilization report was developed in late Q3 2022; consolidation and report development is underway for over utilization reporting systems with a plan to provide annual review in Q1 2023 and quarterly thereafter.

- Physician Administered Drugs (PAD) Utilization Review:
  - Site of Care Program: In Q4 2022, the Alliance Pharmacy Department implemented a new program called Site of Care, with the goal of improving member care and access to medication infusions. The program proactively offers home infusion services to members who are currently receiving their infusion in the hospital outpatient setting. Switching to home infusion is not required and is voluntary. Both the member and the prescriber need to agree to transition to home infusion. Initial outreach was performed to members receiving vedolizumab infusions, who are 18 years of age or older, and on a consistent dose for an FDA-approved indication. Members were excluded if they are not a suitable candidate for home infusion or if they have been hospitalized in the past year. In 2023, the program will expand to include members on infliximab, IVIG and any other medications approved by Pharmacy and Therapeutics (P&T) Committee.
  - PAD Prior authorization (PA) requirement review: Over 200 PAD Healthcare Common Procedure Coding System (HCPCS) codes were reviewed against Medi-Cal guidelines. Restrictions were eased for drugs with high PA approval rates to improve timely access to PADs and reduce provider burden. Retrospective PAD utilization review was postponed until analytics reports are updated with additional HCPCS codes.
- Medication Reconciliation:
  In Q2 2022, the Pharmacy Department initiated the Medication Reconciliation Project in order help reduce hospital readmissions among the high-risk and very high-risk members. Medication Reconciliation is the formal process for creating the most complete and accurate list of patient's current medications by comparing discharge

medications to those in patient records or medication orders. The project goal was to review 50% of recently hospitalized members within 30 days of hospitalization. The list was narrowed down to members with diagnoses of asthma/COPD, hypertension, heart failure, and diabetes. Minors and members admitted to the hospital for surgeries, deliveries, and substance use disorders were excluded from review. Alliance Pharmacists reviewed the member's list of discharge medications for appropriateness and opportunity for possible intervention. The discharge medication list was compared to member's medication history to ensure accuracy.

- Alliance Pharmacists reviewed 122 members which is 88% of total eligible cases; it exceeded our goal of 50%. We performed 97 interventions on 78 members.
- 44 out of 122 members (36%) were not readmitted within three months as of January 3, 2023. Data is still to be determined for another 12% of members.
- Some of the interventions included addressing medication non-adherence, duplication of therapy, medications requiring prior authorization, and other barriers to medication access. Our partners and different points of contact included providers, pharmacists in the community, Medi-Cal Rx, Case Management and Enhanced Care Management/Community Services.
- The biggest cause for concern found during the project was medication non-adherence. Targeting and improving medication adherence could help reduce readmissions. We could also work on streamlining our processes within the Alliance so we can collaborate and increase efficiency.

<u>Adult Preventive Care Services</u>

- Health Education and Disease Management:
  - In Q4 the Quality and Health Programs (QHP) team completed two in-person Healthier Living Program (HLP) workshop series. This was the first time offering in-person workshops since the Pandemic began in March 2020.
  - Barriers in Q4 include members needing to travel to attend the workshops in-person. Members that participate in HLP are also experiencing chronic condition(s) and might have to miss sessions due to doctor's appointments and/or experiencing unexpected illness due to the condition(s) they have.
  - In 2022 a total of 37 Alliance member participated in the HLP workshops throughout the year. Of the 37 members 31 completed half the program (three sessions) or the full program (six sessions) and received a Target gift card.
  - Next steps for Q1 2023: the QHP team will offer the HLP workshops telephonically and virtually to allow members to participate that cannot attend activities in-person.
- Controlling Blood Pressure
  - The aim of this project was to improve hypertension control by improving the accuracy of blood pressure (BP) measurement, increase the number of members that are accurately identified as having hypertension, and learning how to promote best practice and change behaviors in a busy clinic practice. The Alliance partnered with Santa Cruz County HSA Clinics and targeted patients that were 18 years old and older, who were Alliance members and diagnosed with hypertension.
  - Using visual cues to remind staff to recheck elevated BP measurements was the intervention selected. Rechecking elevated BPs is considered best practice, and helps to reduce potentially falsely elevated BP readings from being recorded and used in management of hypertension. Each clinic selected different visual cues to test, but the one that was most popular was to notate on the whiteboard outside the exam room that the BP needed rechecking.

  - To assess the impact and performance of the intervention we selected an outcome and process metric.
    - By January 31, 2023, BPs "in control" will improve from 50% to 55% after implementing the new BP rechecking process, where a second BP reading is taken when the first BP reading is greater than 140/90.
    - By January 31, 2023, BP recheck rate will improve from 25% to 35% after implementing the new BP rechecking protocol, where a second BP reading is taken when the first BP reading is greater than 140/90.
  - The project was kicked off by participating in the annual skills day and providing the MA BP Measurement in-service training in June. Once exact visual cue was selected by each clinic and adequate BP measurement and project supplies were verified, visual cues were tested at Watsonville Health Center, Emeline Clinic, and the Homeless Persons Health Project Clinic on August 1, 2022, September 1, 2022, and October 3, 2022, respectively.
  - The project does not end until Jan of 2023. However, as of December 2022 our goals were partially ment.
    - BPs "in control" improved to 51.91%, a close to 2-percentage point increase.
    - BP recheck rate improved to 52.7%, a 27-percentage point increase.
  - Between November and December, the team brainstormed how to improve the BP recheck rate to closer to 90%. The QI team conducted surveys and also did a one week audit to better understand what was preventing staff from rechecking elevated BPs.
  - Next steps are to finish the final one-week BP recheck audit at the Emeline Clinic and review the data to highlight areas for improvement and possibly further staff training. If no further impact to outcome measures are made by the increase in BP recheck rate, we will pivot to look at other interventions to test that will improve hypertension control.
- Diabetes HbA1c >9% (poor control):
  - Initially, staff planned outreach to a clinic to work on identified goals but due to ongoing COVID-19 disease activity and staffing shortages, staff pivoted to working with members with diabetes through the Population Health Management Program and Care Management staff. Following implementation of risk scoring and stratification (RSS) of all members, staff successfully piloted outreach to our high-risk members with diabetes. The Pediatric CM team outreached to all members with a diabetes flag who was considered high risk, the Adult CM team outreached to all high-risk members with diabetes and who had an elevated HbA1c value >9%. The pilot was successful in that we reached 53 members and 37 (70%) enrolled in services. It was important to validate that the members identified as high risk through our RSS process was accurate in identification of high-risk members and found those members amenable to enrolling into care management services.
- Preventive Care Measure: Colorectal Cancer Screening (HEDIS):
  - Staff have worked through 2022 for the measurement of colorectal cancer screening in the Medi-Cal population. 2023 will be the first year that where NCQA includes the Medicaid (Medi-Cal) population in the annual survey. Data was tracked through the year; the measure was also added to the Care Based Incentive (CBI) Program for 2023. Overall screening for adults 45-75 years of age runs about 27% overall for the network. Providers will now be able to start submitting data through the Provider Portal's Data Submission Tool (DST) as well. Depending on the type of screening we are collecting data on testing up to

10 years ago, which really emphasizes the importance of the DST for data collection from the PCP's records and not being reliant on claims data alone to accurately measure our rates. This measure was highlighted in the CBI webinar in Q3 of 2022 and ongoing education is planned, include a Provider article will be released about the measure and data collection next quarter.

Maternal and Children's Preventive Care

- Maternal and Children's Preventive Care (HEDIS):
    - This topic area had five aggressive goals for the maternal child population's health. In regard to measures in the Children's Domain required to meet the minimum performance level or 50th percentile, the Santa Cruz-Monterey County reporting unit remains above the 50th percentile for all measures: well child visits, well infant visits (both w30-6+ and W30 2+), Childhood Immunization Status (Combo 10) and Immunizations for Adolescents. Merced County reporting unit remains below the 50th percentile for all measures in the Children's Domain. Data collection for 2022 is being finalized now that all data is available for the calendar year. Maternal depression was not measured in 2022, and adolescent depression has not been disaggregated from the CBI depression screening measure. Finally, in February we will look again at our performance in maternity care for Black and Native American persons. Starting in 2023 we will have prenatal and postpartum depression screening measures available for routine monitoring.

Performance Improvement Projects (State Mandated)

- Breast Cancer Screening Plan Do Study Act (PDSA):
    - We completed the fourth and fifth PDSA cycles in the first two quarters of 2022 as a requirement from DHCS; previous cycles were completed in 2021. For the fourth cycle QIPH partnered with Dignity Health Medical Group (DHMG) in Merced. QIPH provided the clinic with a list of members 50-74 years of age who were due for their breast cancer screening. DHMG reviewed the member list for contraindications that would require a member to be removed from the project, and submitted referrals to the DHMG imaging center. QIPH and DHMG met bi-weekly to discuss obstacles and to address any barriers. The project concluded by surpassing the predictive 10% goal to achieve a rate of 20%. We expect this already high performing provider's overall compliance rate to shift from 69% to 75% as a direct result of this active intervention.

      For the fifth cycle, QIPH partnered with Dr. Long Thao's office with a focused intervention on the linked Hmong members. This was after identifying a large disparity in this population in completing their breast cancer screenings. The QIPH team identified 68 members who were due for their screenings and provided this list to Dr. Thao's office to review for any contraindications. Upon Dr. Thao's clinic review, they delivered the referrals to El Portal Imaging to ensure that all were received. El Portal Imaging provided the Alliance with time blocks on their schedule, and the Alliance Health Educators contacted the members to assist in scheduling screenings using interpreting services. El Portal Imaging was responsible for placing the reminder calls and offered Alliance transportation services at that time. QIPH corresponded internally weekly, as well as outreach to El Portal Imaging for weekly updates. As a result of this outreach, seven of the 68 members scheduled with QIPH and completed their breast cancer screening. QIPH submitted the final information to Dr. Thao's office, noting the success of the intervention and that a few members felt more comfortable scheduling with their PCP. Dr. Thao's office completed another

round of outreach to the members, and an additional four members scheduled and completed their screenings. The final result of this intervention resulted in 11 out 68 members receiving their screenings (16.18%).

After the completion of cycle five of the Breast Cancer PDSA and seeing significant improvements in our efforts, DHCS has assigned QIPH to conduct a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis on breast cancer screenings. This is an effort to increase breast cancer screening rates to encourage members to resume preventative screenings post COVID-19 pandemic. QIPH is also continuing to promote breast cancer screening through the Care-Based Incentive (CBI) program.

- COVID-19 Quality Improvement Plan:
  - Three strategies were implemented in the first two quarters of 2022 as a requirement from DHCS. The first strategy was to target prenatal and postpartum members as part of the Healthy Mom and Health Babies program. All members who completed the Postpartum Follow-up Assessment in the HMHB were provided with contact information to Beacon for behavioral health support. 9.9% of members who completed the Postpartum Follow-up Assessment (N=81) in the HMHB program engaged with Beacon for behavioral health support.
  - Our second strategy was to target teens ages 11-13 years of age needing well care using letters. The first round of adolescent letters went out on February 18, 2022 reaching members who had upcoming birthdays falling in March and April. Given the ongoing staff shortages and waves of respiratory disease, we are delaying any further letter campaigns until 2023.
  - The final strategy was to issue a member incentive for those 7-24 months of age who receive their second flu shot. The requirement of two flu doses by the child's first birthday is the factor that limits improvement in the overall rate of Childhood Immunization Status (Combo 10). Unfortunately, in all three counties, the monthly vaccine rate has slightly dropped since the start of the year. We started in Santa Cruz and Monterey Counties in January 2022 at 48.9% and Merced County at 19.5%, and ended in December at 47.8% and 17.4% respectively. Additional assessment around family reluctance to vaccinate infants and toddlers with flu vaccine needs to be conducted in order to make progress on this measure.
- Childhood Immunizations:
  - Alliance 2020-2022 PIP topic focused on the HEDIS metric Childhood Immunization Status (CIS) and partnered with Castle Family Health Center (CFHC) in Merced County to work on this project.
  - The aim was to improve the percentage of children who have completed the Combination 10 vaccine series by age two in Merced County. Full compliance for Combination 10 includes four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three Haemophilus influenzae type B (HiB); three hepatitis B (HepB), one varicella (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.
  - The outcome goal was by December 31, 2022, CFHC will increase their percentage of children compliant with the CIS combo 10 HEDIS measure from a baseline of 12.22% to 19.51%.

  - Early in the project the team identified the flu vaccine as the limiting vaccine preventing the clinic from achieving a higher CIS rate; therefore, we specifically focused on improving flu vaccine compliance.
  - For the first half of 2022 the PIP team experienced challenges engaging with the clinic. However, in June we proposed a point-of-service member incentive ($25 gift card) that they were interested in testing. The PIP team then ascertained approval from QI Leadership, Health Programs, CBI Workgroup, Finance, and DHCS. Once approval was received, an LOA was executed and marketing materials were created. Between September 14 and December 30, 2022, the gift cards were ready to be distributed and the clinic received monthly spreadsheets to help schedule flu vaccine appointments and track all gift cards distributed. The Alliance mailed letters to eligible members and CFHC texted members informing them about the new point-of-service member incentive.
  - Despite the new member incentive, by the end of December, the CIS rate was trending back down to 12.84%. Interestingly, Merced County overall was experiencing a similar decrease in CIS rates.
  - Reviewing reasons why members were not scheduling visits, two major barriers uncovered were 1) flu vaccine hesitancy was over 50% and 2) members not able to be contacted by clinic staff was over 30%. This was due to a lack of phone numbers, disconnected numbers, wrong numbers, no voicemail, etc. In November after discussing the challenges the clinic was facing scheduling appointments, the team pivoted from scheduling flu vaccine visits to well child visits and would defer to the PCP to make strong recommendations for the flu vaccine.
- Child and Adolescent Well Care Visits:
  - Our PIP goal was to increase the percentage of child and adolescent members 3-17 years of age, linked to Golden Valley Health Center - Los Banos Clinic, who receive at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the intervention period, from 32.65% to 48.56% by December 31, 2022. We started 2022 at 35.35% and hit our goal rate in July 2022 at 49.20%. We ended the month of November at 59.96%. December/Q4 data is not available yet, but we anticipate the rate to be above 60.0%.
  - In June (Q2) we started a recall intervention. The Alliance provided a monthly list to the Los Banos Clinic with members who were non-compliant for them to do outreach and schedule them for a well care visit. The Los Banos Clinic staff continued with recall efforts through December 31, 2022.
  - DHCS approved the Alliance to offer a pilot point of service member incentive for this PIP (first of its kind). Alliance members linked to GVHC Los Banos Clinic ages 3-17 who completed their well care visit during October 1. 2022 through December 31, 2022 received a $25 Target gift card that was handed to them at the clinic site after their visit. A total of 147 gift cards were issued from October 1, 2022 through December31, 2022.
  - Barriers identified in 2022 were staffing challenges and member no shows. The clinic faced challenges with staffing due to the pediatrician calling out several days a month, clinic staff having to rotate to other Golden Valley sites for coverage, and clinic staff out sick. The clinic continues to have member no shows, despite efforts to confirm appointments ahead of time.
  - The PIP cycle officially concluded on December 31, 2022. The last Module is due to DHCS in Q2 2023. The PIP team will continue to meet in Q1 2023 to gather information and data needed to complete the Module 4 requirements.

Behavioral Health

- Adverse Childhood Experiences (ACEs):
  - ACEs screenings were operationalized in Q4 2022 via the CBI Program. The QI team has been monitoring implementation progress through reconciliation of attestations and billing. This has included problem solving around some claim denials and the revision of clinic workflows to ensure claims are reimbursable. Ongoing needs for this project include removal of barriers related to provider qualifications, CBO reimbursement for screenings and partnering with health information exchange to pursue data sharing possibilities. Information about ACEs screenings will also be shared in the March 2023 Member Newsletter to ensure members are informed of the need.
- Eating Disorders:
  - With the completion of the Eating Disorder (EDO) Workbook, both Alliance and county staff are preparing for a pilot project in 2023 to streamline administrative functions and remove access barriers for members. The Alliance, Beacon and Santa Cruz County will be building a robust interagency workflow to pilot and refine. Upon determination of a strong workflow, the model will be expanded and replicated in other service counties. To maximize quality in the interim, the teams conduct collaborative bi-weekly clinical case reviews with our MBHO. During 2022, the updated MOU was further completed to support EDO work, outlining responsibilities of both the managed care plan and mental health plans. Continued challenges to EDO workflows to address in 2023 include staff turnover, gaps in treatment opportunities and difficulty with shared cost reimbursement.

Clinical Safety

- Grievance and Potential Quality Issue (PQI) Management:
  - For Grievance and PQI management, the team reviewed 2,478 member grievances, with 410 (17%) requiring additional PQI review for potential quality of care (QoC) issues. 567 PQIs were closed this year compared to 545 in 2021. This number includes PQIs from member grievances, internal referrals, Provider Preventable Conditions, and QI RN quality reviews.

    All member grievances opened as PQIs in 2022 were closed within Grievance's regulatory timeframe of 30 days or less (N=410). To ensure all member grievances related to QoC are appropriately routed to the Medical Director for PQI oversight, a Medical Director inter-rater reliability review (IRR) of QI RN resolved member grievances is conducted quarterly. For year-end (YE) 2022, the IRR resulted in 100% Medical Director approval, indicating that potential QoC cases are being appropriately routed to the Medical Director for oversight.

    Examples of PQIs include member falls while inpatient, failure to follow through on lab results, and inappropriate opioid prescribing that injure the member. A Medical Director peer-to-peer IRR of PQIs is conducted quarterly to ensure PQIs are closed consistently between multiple medical directors. For YE 2022, the peer-to-peer IRR resulted in 100% Medical Director agreement, indicating Medical Directors are resolving PQIs with a consistent methodology for severity rating and follow-up actions to the case.

    The program's challenges include staffing shortages due to turnover, onboarding new staff, and ongoing program development. With reduced staff to process PQIs, regulatory cases (member grievances) were prioritized, resulting in some internally referred PQIs closing outside the 90-day timeframe (N=86).

As the program evolves, changes include reporting to the California Department of Public Health, collaboration with the Special Investigative Unit and Provider Services for substantial cases, weekly RN case-study groups, and updating the Corrective Action Plan (CAP) policy. These changes have increased overall transparency to the Peer Review Credentialing Committee and allowed additional follow-up for high-risk providers.

- Facility Site Review (FSR) Management: The FSR team monitors all primary care providers within the network to ensure that facilities provide accessible care that is evidence-based, prevention-focused and safe care for our members. During the COVID-19 Public Health Emergency, the team continued using remote methods with provider FSR and Medical Record Review (MRR). Per DHCS guidance, the FSR team returned to on-site audits in early 2022.

  The FSR team set out to achieve all operational goals at 100% compliance for 2022. Forty-two sites, or 91% (N=46), completed a periodic site review within three years of the last FSR. When Critical Element (CE) CAPs were issued at a review, four out of five sites (80%) had the CAP resolved within ten business days. CE CAPs require near-immediate resolution, including items like infection control practices. Of the clinics that were issued a CAP, 34 or 83% (N=41) could submit a CAP plan within 45 calendar days to the Alliance, and 35 or 97% (N=36) provided evidence of CAP implementation within 90 calendar days.

  Providers experienced challenges meeting FSR timelines. The provider challenges reported include limited staff due to the PHE, personal health concerns, and other urgent personal matters causing the scheduled reviews to be postponed past a three-year cycle or the CAP to exceed the due dates. In addition, in July 2022, DHCS implemented the expanded FSR and MRR audit tool to include new and updated criteria, thereby increasing the review length and the CAP size. To prepare providers for this update, the QI FSR team developed and distributed an educational video in collaboration with Health Improvement Partnership with tips to improve performance on FSR scores. The team also developed and distributed a crosswalk of the 2012 and 2022 FSR/MRR guidelines to highlight new criteria and encourage compliance.

Conclusion. Despite the pandemic that continued in 2022, there were active interventions across all the QPIP domains of member experience, quality of care, quality of service, and clinical safety. The Alliance had challenges in workforce both at the provider offices and internally to address priorities related to COVID-19 and new regulatory mandates requiring implementation. The Alliance is committed to meeting the strategic prioirities of health equity and person-centered transformation, and many of the topics in 2022 will carry over to 2023 for continued planning and improvement.

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

Attachments. N/A

DATE: May 24, 2023

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

FROM: Dale Bishop, MD, Chief Medical Officer

SUBJECT: Quality Improvement System Workplan Report for Q4 2022

Recommendation. Staff recommend the Board accept the Q4 2022 Quality Improvement Systems (QIS) Workplan report for Q4 2022.

Summary. This report provides pertinent highlights, trends, and activities from the Q4 2022 QIS Workplan.

Background. The Alliance is contractually required to maintain a Quality and Performance Improvement Program (QPIP) to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (the 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 QIS Workplan, with review and input from QIHEW.

The 2022 QIS Workplan was developed to align with the Alliance Strategic Plan of Member Wellness, Access to Care, and Promotion of Value. This is accomplished through the initiatives described below.

Section I: Member Experience	**Status**
A. Member Experience	
1. Member engagement rate of Member Outreach Campaigns	**Goal Met**
2. Health Services Division Member Outreach & Engagement Campaigns	**Goal Met**
3. Member Support	**Goal Not Met**
4. Cultural and Linguistics (C&L) Services & Population Needs Assessment Education	**Goal Met**
5. CAHPS: How Well Doctors Communicate, Global rating of health care	**Goal Partially Met**
Section II: Quality of Service	
B. Access and Availability	
1. Annual Access Plan	**Goal Met**
2. Provider Choice: In-Area Market Share	**Goal Met**
3. CAHPS Survey: Access Measures	**Goal Partially Met**
C. Provider Experience	
1. Provider Satisfaction	**Goal Met**

Section III: Quality of Clinical Care	
D. Utilization	
1. Under / Overutilization	**In Progress**
2. Physician Administered Drugs (PAD) utilization review	**Goal Met**
3. Medication Reconciliation	**Goal Met**
E. Adult Preventive Care Services	
1. Health Education and Disease Management	**Goal Met**
2. Controlling Blood Pressure	**Goal Partially Met**
3. Diabetes HbA1c >9% (poor control)	**Goal Partially Met**
4. Preventive Care Measure: Colorectal Cancer Screening (HEDIS)	**In Progress**
F. Maternal and Children's Preventive Care	
1. Maternal and children's preventive care (HEDIS)	**In Progress**
G. Performance Improvement Projects (State Mandated)	
1. Breast Cancer Screening PDSA	**Goal Met**
2. COVID-19 QIP	**Goal Met**
3. Childhood Immunizations	**Goal Not Met**
4. Child and Adolescent Well Care Visits	**In progress**
H. Behavioral Health	
1. Adverse Childhood Experiences (ACE)	**Goal Partially Met**
2. Eating Disorders	**Goal Partially Met**
Section IV: Clinical Safety	
I. Clinical Safety	
1. Grievance and PQI Management	**Goal Partially Met**
2. Facility Site Review (FSR) Management	**Goal Partially Met**

Discussion.

Q4 2022 QIS Workplan Outcomes and Evaluation

Member Experience:

- Member engagement rate of Member Outreach Campaigns: Staff attended face-to-face events in the community. Due to a lack of volunteers, this inhibits full attention to the participants. Events have successfully gained the attention of over 1,000 attendees. Recruitment for volunteers to attend as many events as possible will continue.
- Health Services Division Member Outreach and Engagement Campaigns: During Q4, Health Services with the support of Member Services staff outreached to 341 members to schedule pediatric preventive services, with 22 members successfully scheduled for care. The script, data collection tool and training were developed and led by the Health Education Supervisor, Desirre Herrera. A template for future outreach was developed; however, with critical lessons learned about having the outreach roster carefully reconciled against the electronic medical records to ensure members with recent visits and those scheduled are removed from the roster to target efforts more accurately. Similar outreach efforts may be contemplated in the future if additional planning is made with the provider on the member roster.

- Member Support: The Call Center experienced excessive absenteeism due to increase in staff COVID-19 cases and sick callouts. We saw a decrease in call volume in October and increases in November and December. Additionally, there was an increase in internal promotions which led to tenured staff leaving the call center. We did receive help from temporary workers that were hired in Q3 but because they are so new to the role, they are not able to answer as many calls a day as more seasoned staff.
- Cultural and Linguistics (C&L) Services & Population Needs Assessment Education: A total of 6,015 telephonic interpreting services calls were reported for measuring Q4 2022 across the Alliance's service areas. This is a 6% decrease when compared to Q4 2021 (6,417). A total of 1,166 face-to-face interpreting services requests were coordinated in Q4 2022 across the Alliance's service areas. This is a 141% increase when compared to Q3 2021 (483). As 2022 closes, we saw that utilization in face-to-face interpreter services has increased significantly from 2021, more so in non-American Sign Languages (foreign languages). Furthermore, utilization increased in all three of our service areas: Merced County (215%), Monterey County (20%), and Santa Cruz County (404%). Also, due to inclement stormy weather, our interpreting service vendors experienced connectivity and technical issues. In response, the C&L team posted information on the website and sent a provider fax via the Provider Flash to remind providers to use telephonic interpreting services.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) (Member Experience Survey): How Well Doctors Communicate; Global Rating of Health Care, Global Rating of Health Plan, Access metrics: Survey results were received in October and will be presented to the Quality Improvement committees once final analysis are completed.

Quality of Service

Access and Availability:

- Annual Access Plan: Measures that required provider recruitment were challenged, most significantly due to a limited number of providers available for recruitment in the rural areas targeted and many providers identified were not eligible for recruitment, or unwilling or unable to entertain recruitment conversations due to their own staffing issues and resultant pressure on clinic capacity. The goal to recruit doulas and community health workers was challenged due to a lack of clarity on requirements as All Plan Letters and subsequent operationalization of internal processes occurred late in the year or into early 2023. However, this work continues as an organizational priority through a separate and dedicated project team. In contrast, recruitment of Enhanced Care Management (ECM) and Community Supports (CS) providers was successful. However, many ECM/CS providers are small organizations who may find that their capacity to support large volumes of members is not feasible. The organization is now looking for ways to significantly increase provider capacity.

- Provider Choice: In-Area Market Share: From Q1 to Q4 2022, primary care market share for the entire service area as a whole increased slightly from 86% to 86.5% and the specialist market share decreased slightly from 86.5% to 85.5%.

- Provider Satisfaction: Results were received in September 2022 and will be presented to NDSC in November. In MY 2021, 89% of surveyed providers reported that they were satisfied with the Alliance.

Quality of Clinical Care

Utilization:

- Under/Overutilization: The Utilization Management (UM) Workgroup continues to closely monitor under and over utilization and continues to investigate identified cases, develop interventions, and work closely with other departments such as Program Integrity, QIPH, and Provider Services. As authorization codes are waived as part of the authorization reduction project, there will be monitoring to assure there is no resulting inappropriate over utilization. Auto approved or no TAR required (NTR) utilization will be monitored when an increase/decrease of 30% from the previous reporting quarter is identified. All monitored categories are reported out in the quarterly UM Workplan.
- Physician Administered Drugs (PAD) Utilization Review: The Site of Care Program has been initiated. Member inclusion and exclusion criteria were approved by the Pharmacy and Therapeutics (P&T) Committee. The program will initially target three infusion medications (vedolizumab, infliximab, and IVIG). Three members on vedolizumab were selected for the first outreach, and notifications were sent to identified members and their providers. For PAD review, ten new Healthcare Common Procedure Coding System (HCPCS) codes were reviewed against Medi-Cal guidelines and presented to the P&T Committee.
- Medication Reconciliation: The project was continued through November 4, 2022. A total of 182 cases were selected by the pharmacist from August to November. 122 cases were completed within 30 days of member discharge, which is 88% of eligible cases. Sixteen cases could not be completed due to time constraints and staffing problems, 44 cases were ineligible to be reviewed, such as minors, members with other health coverage, and multiple readmissions. Data was further analyzed based on outreaches that included providers, pharmacies, Medi-Cal Rx, Case Management and ECM/CS. Seventy-eight members needed an intervention for their medications. A total of 98 outreaches were made for the 78 members. Among the total 122 eligible members, 63 of them were readmitted within three months of hospitalization, 44 were not readmitted and 15 were too early to determine.

Adult Preventive Care Services

- Health Education and Disease Management: In Q4 the QHP team completed two in-person Healthier Living Program (HLP) workshop series. This was the first time offering in-person workshops since the pandemic began in March 2020. Please note, data results for Q4 include members that participated in the virtual HLP during Q3, but surveys were delayed and included in the Q4 data.
- Controlling Blood Pressure (BP): Monitored monthly BP recheck rates. Staff were reminded during huddles about BP protocol and importance of rechecking elevated BPs. A week-long audit of BPs was started to identify root causes of why elevated BPs were not being rechecked after implementing visual aids at WHC. HPHP and Emeline is scheduled to conduct their BP audits in January and February of 2023, respectively.

- Diabetes HbA1c >9% (poor control): Due to limited staffing, the team has pivoted to focus the Population Health pilot on adult high-risk members with the highest HbA1c values. QIPH will partner with CCC and Pediatric CM teams to test risk levels of members as scored by the BI tool and other methods. This will allow clinical staff to focus on this target population while testing the proposed methodology and workflows of the Population Health program.
- Preventive Care Measure: Colorectal Cancer Screening (HEDIS): During Q4, the tip sheet for this exploratory Care-Based Incentive (CBI) Measure was published. https://thealliance.health/for-providers/manage-care/quality-of-care/care-based-incentive/care-based-incentive-resources/ for provider's reference. Our data submission tool has also been updated and validated for providers to start submitting data for this CBI 2023 measure.
- Maternal and Children's Preventive Care (HEDIS): The first goal has two Performance Improvement Projects in progress, one for CIS and the other for Well Care Visits (WCV) both in Merced. Planning for a study of pediatric disparities has begun, with initial activities planned for Q3 2022 in Merced County. During Q3 and early Q4, we were able to initiate point of service incentives at both sites. Initial response to the WCV project has been very good but are experiencing a slow uptake of influenza vaccine at Castle Clinic despite offering a member incentive.
- The second goal's WCV disparities are being addressed by the CBI program 2023 to start. Data will be shared with providers through their CBI profiles quarterly but will need to continue to monitor and in some cases address this with clinics.
- Staff met with BabyScripts, a program that can be implemented by providers that support early pregnancy identification, data collection, and virtual monitoring that decreases preterm delivery and shortens the time until preeclampsia is diagnosed among other positive outcomes.

Performance Improvement Projects (State Mandated):

- Childhood Immunizations: In Q4, updated rosters were provided for clinics to conduct outreach at the beginning of each month. Clinics scheduled flu vaccine visits and distributed gift cards to eligible members who received their flu shots. Call scripts and flu vaccine resources were provided to the Castle team. HSAG approved Module 3 (flu vaccine incentive intervention). Due to the high volume of parents declining to schedule the flu vaccine visit, staff pivoted to prioritizing those due for a WCV + flu shot and provided a list of members to prioritize who are turning two in the current and subsequent month. Castle completed the texting campaign and the Alliance mailed flyers.
- Child and Adolescent Well Care Visits: In Q4, testing of the recall intervention continued. Staff continued to provide the Los Banos Clinic a monthly list of members who were non-compliant to be outreached and scheduled. The clinic has continued to do an amazing job at doing outreach in Q4. The goal rate was achieved in the month of July, ending the month at 49.20% and continued to trend upward in Q4. Implemented the pilot point of service member incentive for Alliance members linked to Golden Valley Health Centers (GVHC) Los Banos clinic ages 3-17 who completed a well care visit from October 1, 2022 through December 31, 2022. The go live date in the clinic was October 14, 2022. Meetings were held with the GVHC Los Banos clinic team one to two times a month for progress check-ins and updates. A total of 147 gift cards were issued to

members who went in and completed a well care visit from October 1, 2022 through December 31, 2022. This current performance improvement plan cycle with the Department of Health Care Services (DHCS) has officially ended as of December 31, 2022. The last module with findings is due on Q2 2023.

Behavioral Health:

- Adverse Childhood Experiences (ACEs): In Q4, ACE screenings was operationalized via the CBI Program. This included educating providers on the new CBI incentives during the CBI workshops, updated CBI materials and provider education. The DHCS ACEs report is not capturing ACEs that are done by behavioral health specialists as it is monitoring ACE screening by PCPs. There is an opportunity to continue to work with providers to increase ACE screenings, particularly in Merced. The QI team continues to reconcile clinic's provider lists to ensure their providers are showing up as attested for completing the ACE training and to begin billing for this service. The QI team also began doing a deep analysis as to why ACE screening claims are being denied and contacted Provider Relations Representatives to reach out to clinics to assist in ensuring the providers complete their attestation. QI is also partnering with ACE Overcomers to assist in training Merced providers on ACE screenings. Clinics are starting to change their workflows to have their clinic staff (MA, NP, PCPs) complete the ACE screenings.
- Eating Disorders: The Alliance has an established external collaborative bi-weekly behavioral health case review process with the Managed Behavioral Healthcare Organization (MBHO) to support members and collaborating with County Mental Health Plans. In Q2, the Alliance provided internal educational presentations to the social services department, utilization review director, and community care coordination director to address the increasing need and acuity levels of eating disorders. In Q3 the Alliance communicated a plan to create a workflow pilot with one county to improve processes and drafted an eating disorder workbook for use by all partners in the treatment of members. In Q4 Beacon and counties were able to review the workbook and prepare for building workflows in 2024.

Clinical Safety

Grievance and PQI Management:

The following summary of activities took place:

- Q4 Accomplishments: 1) The quarterly MD IRR of member complaints resolved by RNs resulted in 100% approval, indicating that cases are being appropriately routed to MD for oversight; 2) MD peer to peer IRR of Prevention Quality Indicators (PQIs) resulted in 100% agreement, indicating Medical Directors are resolving cases with consistent methodology; 3) all member grievances opened as PQIs in Q4 2022 were closed within Grievance's timeframes (30 days or less). N=90; 4) a new PQI referral form and referral criteria was developed for application in Q1 2023; and 5) the Clinical QoC CAP process is currently in the implementation phase in partnership with Operational Excellence.
- Q4 Summary: Member Grievances routed to QI for oversight reduced this quarter by 44% from Q3 2022 which allowed the team to focus on PQI process improvement efforts. The team performed several SWOT analyses and were able to modify PQI communication practices with providers and redesign the PQI referral form to streamline internal referrals. These changes reduce administrative tasks involved in processing PQIs and ensures providers are made aware of severe PQIs and quarterly trends as

needed. 100% of member grievances opened as PQIs were closed within Grievance's timeframe of 30-days or less (N=90), as required by the State. There was an increase in internally referred PQIs closed in 90-days or less (84%) this quarter, up from only 53% in Q3. Process changes made this quarter should lead to further increases in compliance in Q1 2023. The PQI team is close to completing the hiring of an additional FTE Registered Nurse by Q1 2023 which will bring team back to 100% staffing since mid-2022.

- Facility Site Review (FSR) Management: Developed and distributed a crosswalk of the 2012 and 2022 FSR/medical record review (MRR) guidelines to providers to highlight new criteria and encourage compliance. Continue to adjust the FSR MRR Corrective Action Plan (CAP) template to include additional provider resources for common site deficiencies. Collaborating with Alliance Application Services and DHCS to create an interface to upload FSR/MRR data to DHCS' new database is in development. Continue to meet with DHCS in the biweekly statewide MCP workgroup meetings and monthly FAQ Committee meetings to ensure we are continuing to follow recommendations around new guidelines as well as leniency for CAP due dates and site review scheduling according to each sites' impact of public health emergency related barriers.

Conclusion. There were active interventions in Q4 with 76% (19/25) meeting/partially meeting the project goals. In some cases, there were staff shortages to advance the work; however, barriers were addressed, or activities were prioritized. The Alliance will continue to monitor progress across the projects and report updates though the various quality improvement system committees.

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

Attachments.

1. Quality Improvement System Workplan – Q4 2022

Q4 2022 QIS Workplan

Topic	CAHPS: How Well Doctors Communicate
Status	Goal Partially Met
Topic	CAHPS: Global rating of Health Care
Status	Goal Partially Met
Topic	CAHPS: Global rating of Health Plan
Status	Goal Partially Met
Topic	Health Services Member Outreach & Engagement Campaigns
Status	Goal Met
Topic	Member Support
Status	Goal Not Met
Topic	Member engagement rate of Member Outreach Campaigns
Status	Goal Met
Topic	Cultural and Linguistics (C&L) Services & Population Needs Assessment Education
Status	Goal Met
Topic	CAHPS Survey: Access Measures
Status	Goal Partially Met
Topic	Annual Access Plan
Status	Goal Met
Topic	Provider Choice: In-Area Market Share
Status	Goal Met
Topic	Provider Satisfaction Survey
Status	Goal Met
Topic	Physician Administered Drugs (PAD) utilization review (Prelude to Site of Care Program)
Status	Goal Met
Topic	Medication Reconciliation
Status	Goal Met
Topic	Under / Overutilization
Status	In Progress
Topic	Health Education and Disease Management
Status	Goal Met
Topic	Diabetes HbA1c >9% (poor control)
Status	Goal Partially Met
Topic	Preventive Care Measure: Colorectal Cancer Screening (HEDIS)
Status	In Progress
Topic	Controlling Blood Pressure
Status	Goal Partially Met
Topic	Maternal and children's preventive care (HEDIS)
Status	Goal Not Met
Topic	Well Child Visits
Status	In Progress
Topic	COVID-19 QIP
Status	Goal Met
Topic	Childhood Immunizations
Status	Goal Not Met
Topic	Breast Cancer Screening PDSA
Status	Goal Met
Topic	Adverse Childhood Experiences (ACE)
Status	Goal Partially Met
Topic	Eating Disorders
Status	Goal Partially Met
Topic	Grievance and PQI Management
Status	Goal Partially Met
Topic	Facility Site Review (FSR) Management
Status	Goal Partially Met

PROGRESS SUMMARY

80%

Percent Complete

Composite Score

4

Sections above target

Q4 2022 QIS Workplan

SECTION 1: MEMBER EXPERIENCE

A: MEMBER EXPERIENCE

CAHPS: Global Rating of Health Care

Domain	Member Experience
Priority	Regulatory
Committee	MSEC, CQIW
Goals	1. Achieve x% in Members Global Rating of Health Care (CAHPS)- Child
Results Q4	88.60%
Opportunities for Improvement	1) Assess CAHPS surveys administered in 2022 and identify any improvements if the threshold/targets are not met

Summary of Quarterly Activities Narrative	Child rating of health care improved from 2021 to 2022.
Known Barriers/Root Cause(s) (as applicable)	Continued low response rate to survey.
Next Steps	Meet with internal stakeholders and discuss steps for improvement.

CAHPS: Global Rating of Health Plan

Domain	Member Experience
Priority	Regulatory
Committee	MSEC, CQIW
Goals	1. Achieve x% in Members Global Rating of Health Plan (CAHPS)- Adults
Results Q4	75.6
Opportunities for Improvement	1) Assess CAHPS surveys administered in 2022 and identify any improvements if the threshold/targets are not met

Summary of Quarterly Activities Narrative	Adult rating of health care decreased from 2021 to 2022.
Known Barriers/Root Cause(s) (as applicable)	Continued low response rate to survey.
Next Steps	Meet with internal stakeholders and discuss steps for improvement.

Member Engagement Rate of Member Outreach Campaign

Domain	Member Experience
Priority	Alliance Operating Plan
Committee	Member Support and Engagement Committee (MSEC)
Goals	Composite metric that rolls up normalized engagement rates from the outreach methods: Drive-through, Phone calls, Virtual, and Face to face to calculate an average member engagement rate across all outreach methods and attempts
Results Q4	48%
Opportunities for Improvement	Equally weights the four methods of engagement and averages the normalized performance of each method.

Summary of Quarterly Activities Narrative	Staff attended face to face events in the community
Known Barriers/Root Cause(s) (as applicable)	When at events we are not able to speak to all attendees due to lack of volunteers. At times YHM staff attend events alone or with only one staff volunteer. These events sometimes have over 1000 attendees.
Next Steps	Continue to recruit volunteers and attend as many events as possible

HS Member Outreach & Engagement Campaigns

Domain	Member Experience · Quality of Care · Quality of Service
Priority	Alliance Operating Plan
Committee	Continuous Quality Improvement Workgroup (CQIW), MSEC
Goals	1) In 2022, track and monitor all ad hoc member outreach and engagement campaigns 2) Track each campaigns intervention, percentage of successful calls (information provided/LVM) vs unsuccessful calls, and member counts
Results Q4	The Peds CM team, Health Education and QIPH staff worked together on outreach to pediatric members linked to a family practice clinic in Merced County. This summary elaborates further on what was described in the Q3 results. The request for assistance was at the request of the practice. Outreach occurred between October 10-14th for well child visits and vaccine visits. Three staff were trained in how to make calls, verify correct contact, use of translation service as needed and documentation. Outcomes: 341 members were phoned. 131 (38%) left voicemail, 62 (18%) their phone was disconnected, 54 (16%) there was No Answer/No voicemail available, 72 (21%) declined assistance with scheduling clinic appointment, and 22 (7%) agreed to appointments being scheduled. The primary reason for parent/guardian declination of appointment was that the appointment was already scheduled or completed (n=27, 38%). The next most common reason was that the parent preferred to contact the clinic directly (n=13 (18%)). Staff learned that use of rosters built from claims data alone were not effective because it is important to identify members who were recently seen by the clinic and the Alliance had not yet received and processed claims and second remove those members who are scheduled. This is particularly important because there are extensive wait times for preventive services at this time; perhaps impacting a large cohort of members. Otherwise, staff from various departments worked well to efficiently reach a large group of members in just a few business days. Furthermore, they tracked the outcome of each call and reason for declination which makes learning from this project more meaningful.
Opportunities for Improvement	1) Coordinated collaboration with multiple sources in the development of member written materials and staff talking points 2) Development of member roster lists with the verification if there is more than one member in the same household on the list 3) Identification of the right level of staff to support these outreach campaigns (i.e., clinical vs. non-clinical) 4) Coordinated approach for documenting, tracking, and reporting the outcome of each outreach call 5) Develop enough time to train staff on talking points and new outreach campaigns
Summary of Quarterly Activities Narrative	Q4 Health Services with the support of Member Services staff outreach to 341 members to schedule for pediatric preventive services, with 22 members successfully scheduled for care. The script, data collection tool and training were succinct and led by our Health Education Supervisor, Desirre Herrera. We have a model for future outreach but with critical lessons learned about having the outreach roster carefully reconciled against the electronic medical records to ensure members with recent visits and those scheduled are removed from the roster to more accurately target efforts.
Known Barriers/Root Cause(s) (as applicable)	1.) Need to pull from multiple departments to secure adequate staff for outreach. 2.) Core work is also impacted when deploying other teams to support outreach campaigns. 3.) Staff were able to mobilize, but it did take about 3-4 business days to identify staff and complete training before initiating calls. 4.) It's important for clinics requesting support to reconcile claims report against health records.
Next Steps	Discuss with multiple internal stakeholders the feasibility for outreach projects like the one completed in Q3. Success of outreach calls was impacted by lack of timely claims, no reconciliation with the clinic's appointment and electronic medical record systems against the Portal report which is primarily populated by claims and registry data [27 members contacted declined because they had a recent visit or have an appointment scheduled]. Also identified need to support parents with newborns with navigating to the linked PCP, confirming that they want to use that PCP and how to schedule well child visits.

Member Support

Domain	Member Experience
Priority	Regulatory
Committee	MSEC
Goals	1) 95% of Calls to Member Services Answered Before Being Abandoned; 2) 80% of Calls to Member Services Answered Within 30 Seconds
Results Q4	1) 85% 2) 45%
Opportunities for Improvement	2) Identify additional barriers to being able to continuously meet this requirement.
Summary of Quarterly Activities Narrative	The Call Center experienced excessive absenteeism due to increase in staff COVID cases and sick callouts. We saw a decrease in call volume in October and increases in November and December. Additionally, there was an increase in internal promotions which led to tenured staff leaving the call center. We did receive help from temps that were hired in Q3 but because they are so new to the role, they are not able to answer as many calls a day as more seasoned staff.
Known Barriers/Root Cause(s) (as applicable)	Not enough staff to support the call volume
Next Steps	Call the Car delegation that will take place will provide a substantial decrease in incoming call volume and will make it more manageable for the call center.

C&L Services & Pop. Needs Assessment Education

Domain	Member Experience, Quality of Care, Quality of Service
Priority	Regulatory
Committee	CQIW
Goals	To measure the performance of the Alliance C&L Services program and to make improvements accordingly (measure utilization per County). 1) Increase Provider Utilization of the Alliance Language Assistance Services program by 5% when compared to the previous year 2) Increase the Alliance network provider's familiarity with the Alliance Language Assistance Services Program (annual provider satisfaction survey)
Results Q4	6015
Opportunities for Improvement	Increase promotion of the Alliance Language Assistance Services with: 1.) Our external network providers through provider communication modalities, such as the Provider Flash (as needed), Provider Bulletin, and providing updated information to the Provider Services Network Team. 2.) Our members through member communication modalities, such as the Member Newsletter and providing updated information to member facing teams.
Summary of Quarterly Activities Narrative	Q4: A total of 6,015 telephonic interpreting services calls were reported for measuring Q4 2022 across the Alliance's service areas. This is a 6% decrease when compared to Q4 2021 (6,417). A total of 1,166 face-to-face interpreting services requests were coordinated in Q4 2022 across the Alliance's service areas. This is a 141% increase when compared to Q3 2021 (483). As 2022 closes, we saw that utilization in face-to-face interpreter services has increased significantly from 2021, more so in our Non-American Sign Languages (foreign languages). Furthermore, utilization increased in all three (3) of our service areas: Merced County (215%), Monterey County (20%), and Santa Cruz (404%). Also, due to inclement stormy weather, our interpreting service vendors experience connectivity and technical issues. In response, the C&L team posted on our website and sent a provider fax via the Provider Flash to promote as well as remind providers to use our telephonic interpreting services.
Known Barriers/Root Cause(s) (as applicable)	Q4: We lost our main indigenous interpreting vendor (that provided both telephonic and face-to-face interpreting services) at the beginning of Q2 and had to onboard a new vendor. This greatly impacted utilization in telephonic interpreting services for the indigenous languages due to unfamiliarity of how to access this service for these languages. Furthermore, our vendors experienced interruption with their services due to inclement stormy weather changes.
Next Steps	Q4: The C&L team will continue to promote our interpreting services for both telephonic and face-to-face through various Alliance communication outlets, such as, but not limited to quarterly Member Newsletter and Provider Bulletin, Provider Flash, and presentations. For the March 2023 Member Newsletter and Provider Bulletin, we will feature an article around accessing our interpreting services. In addition, the Alliance will conduct provider and staff trainings around cultural competency, which will also focus on accessing interpreting services in late 2023.

CAHPS: How Well Doctors Communicate

Domain	Member Experience, Quality of Care, Quality of Service
Priority	Regulatory
Committee	MSEC, CQIW
Goals	1. Achieve x% in How Well Doctors Communicate - Child 2. Achieve x% in How Well Doctors Communicate - Adult
Results Q4	Adult: 91.5%; Child: 93.1%
Opportunities for Improvement	Assess CAHPS surveys administered in 2022 and identify any improvements if the threshold/targets are not met
Summary of Quarterly Activities Narrative	Q4: Received data. Adult scores improved and child scores decreased.
Known Barriers/Root Cause(s) (as applicable)	Low response rate from members to the survey.
Next Steps	Meet with internal stakeholders and discuss steps for improvement.

SECTION 2: QUALITY OF SERVICE

B: ACCESS & AVAILABILITY

Annual Access Plan

Domain	Member Experience, Quality of Service
Priority	Regulatory
Committee	NDSC
Goals	The Annual Access Plan focus areas and improvement goals are established in January of each year and are solidified by the NDSC. The 2022 Access Plan goals will be finalized in January 2022.
Results Q4	Access plan completed, closeout report reviewed by NDSC at January 2023 meeting.
Opportunities for Improvement	The Access Plan will articulate identified areas within the Alliance provider network where targeted activities can increase or enhance choice and/or access. The 2022 improvement opportunities will be identified in January 2022.
Summary of Quarterly Activities Narrative	Measures that required provider recruitment were challenged, most significantly due to a limited number of providers available for recruitment in the rural areas targeted and many providers identified were not eligible for recruitment, or unwilling or unable to entertain recruitment conversations due to their own staffing issues and resultant pressure on clinic capacity. The goal to recruit doulas and community health workers was challenged due to a lack of clarity on requirements as All Plan Letters and subsequent operationalization of internal processes occurred late in the year or into early 2023. However, this work continues as an organizational priority through a separate and dedicated project team. In contrast, recruitment of ECM and CS providers was successful. However, many ECM/CS providers are small organizations who may find that their capacity to support large volumes of members is not feasible. The organization is now looking ways to significantly increase provider capacity.
Known Barriers/Root Cause(s) (as applicable)	Barriers to achieving Access Plan goals usually include faulty/inaccurate data, staff resource constraints, and provider's unwillingness to expand or contract for services.
Next Steps	Ongoing monitoring of access-related metrics will continue to inform opportunities for improving access to care for Alliance members, and Provider Services has incorporated lessons learned into the planning process for the 2023 Access Plan. Potential Access Plan focus areas will be discussed by the NDSC in February of 2023. Provider Services also recommends that the 2023 Access Plan integrate work to address the Emerging Access Issues tracker developed and monitored through NDSC in 2022.

Provider Choice: In-Area Market Share

Domain	Quality of Service
Priority	Regulatory
Committee	NDSC
Goals	In Area PCP Market Share (all counties) In Area Specialist Market Share (all counties)
Results Q4	PCP 86% Specialist 86%
Opportunities for Improvement	Credential non-credentialed providers practicing at contracted locations. Engage providers who have historically declined to contract.
Summary of Quarterly Activities Narrative	From Q1-Q4 2022, primary care market share for the entire service area as a whole increased slightly from 86% to 86.5% and specialist market share decreased slightly from 86.5% to 85.5%.
Known Barriers/Root Cause(s) (as applicable)	Difficulty obtaining timely credentialing applications for new or existing providers, priority to engage new entities in contracting over credentialing providers at existing contracted sites
Next Steps	

CAHPS Survey: Access Measures

Domain	Member Experience; Quality of Service
Priority	Regulatory
Committee	NDSC, CQIW, CQIW-I
Goals	1. Achieve xx% in Getting Care Quickly for Child and Adult CAHPS 2. Achieve xx% in Getting Needed Care for Child and Adult CAHPS
Results Q4	Getting Care Quickly: Adult - 73.4%; Child - 84.5% Getting Needed Care: Adult - 82.9%; Child - 79.2%
Opportunities for Improvement	Assess CAHPS surveys administered in 2022 and identify any improvements if the threshold/targets are not met
Summary of Quarterly Activities Narrative	Q4: Adults scores decreased for both measures, Child score increased in Getting Care Quickly, but decreased in "Getting Care Needed Care".
Known Barriers/Root Cause(s) (as applicable)	Mixed response to questions year over year
Next Steps	Meet with internal stakeholders and discuss steps for improvement.

C: PROVIDER EXPERIENCE

Provider Satisfaction Survey

Domain	Quality of Service
Priority	Regulatory
Committee	NDSC
Goals	Target of 88% of surveyed providers who are satisfied with the Alliance (annual measure based on Satisfaction Survey); lower threshold is 79.2%.
Results Q4	Results final, presented to NDSC and CQIW-I in December.
Opportunities for Improvement	In MY 2021, 89% of surveyed providers reported that they were satisfied with the Alliance.
Summary of Quarterly Activities Narrative	Results final, presented to NDSC and CQIW-I in December.
Known Barriers/Root Cause(s) (as applicable)	Provider satisfaction with the Alliance may be influenced by satisfaction with the health care system as a whole; difficult to specifically target action items to increase satisfaction for each respondent.
Next Steps	

SECTION 3: QUALITY OF CLINICAL CARE

D: UTILIZATION

Under / Overutilization

Domain	Clinical Safety; Quality of Care; Quality of Service
Priority	Regulatory
Committee	UMWG, CQIW, CQIC, Program Integrity/Compliance Committee
Goals	An interdepartmental over/underutilization report will be developed by December 31, 2022.
Results Q4	N/A
Opportunities for Improvement	Coordinated collaboration with all sources of monitoring for over and underutilization. Linking reporting from multiple sources to ensure compliance with monitoring.
Summary of Quarterly Activities Narrative	Under and over utilization is closely monitored and UM investigates identified cases, develops interventions and works closely with other departments such as Program Integrity, QI and Provider Services. As authorization codes are waived as part of the Auth Reduction Project, there will be monitoring to assure there is no resulting inappropriate over utilization. Auto approved or no TAR required (NTR) utilization will be monitored when an increase/decrease of 30% from the previous reporting quarter is identified. All monitored categories are reported out in the quarterly UM Work Plan and the following was approved in the April CQIC meeting: Categories to be monitored for possible over utilization: Electromyography (EMG) Emergency Room Visits Any Auth Redesign/NTR code identified from emerging utilization analysis results Categories to be monitored for possible under utilization: Initial Health Assessment (IHA) Breast Cancer Screening Colon Cancer Screening Lead Screening Adverse Childhood Experience (ACE) Screening Mental Health Visits Q4 Currently monitored in UMWG
Known Barriers/Root Cause(s) (as applicable)	Lack of consolidation of all efforts toward oversight of over /under utilization has led to delays in centralized reporting of the approved categories listed above. Underutilization report developed but not yet tested; anticipate full review of 2022 data in Q1 2023.
Next Steps	Auto approved or no TAR required (NTR) utilization volumes have been monitored through reporting to the Utilization Management Work Group (UMWG) to ensure that waived codes do not result in inappropriate over utilization. Lack of consolidation of all efforts toward oversight of over /under utilization has led to delays in centralized reporting of the approved categories listed above. Underutilization report developed but not yet tested; anticipate full review of 2022 data in Q1 2023.

PAD Utilization Review

Domain	Quality of Service
Priority	Operating Plan
Committee	Pharmacy and Therapeutics Committee
Goals	Perform PAD utilization review on a quarterly basis and present to P&T Committee PA criteria and formulary inclusion input
Results Q4	100%
Opportunities for Improvement	Remove PA requirement for PAD with high approval rate. Educate providers on more cost-effective products. Prelude to Site of Care program.
Summary of Quarterly Activities Narrative	Q4: Site of Care Program has been initiated. Member inclusion and exclusion criteria were approved by Pharmacy and Therapeutics (P&T) Committee. The program will initially target three infusion medications (vedolizumab, infliximab, and IVIG). Three members on vedolizumab were selected for the first outreach, and notifications were sent to identified members and their providers. For PAD review, 10 new HCPCS codes were reviewed against Medi-Cal guidelines and presented in the P&T Committee.
Known Barriers/Root Cause(s) (as applicable)	Some pharmacy staff resource constraints due to staff changes. For Site of Care Program, it is difficult to find the best contact information for providers. Tableau reports needed to be modified multiple times to identify eligible members. Administrative tasks such as setting up member/provider letters and referrals are time consuming. For PAD review, Tableau reports need to be updated to account for additional HCPCS codes. Currently waiting for Analytics to update the reports before performing PAD utilization review.
Next Steps	Site of Care in 2023: Send referrals to the home infusion pharmacy for member outreach. Expand member selection to the second target medication, infliximab. Notify provider- and member-facing teams about the program. Continue to refine workflow and processes. Train additional pharmacists and technicians on the processes. Start PAD utilization review once Tableau reports are updated by Analytics.

Medication Reconciliation

Domain	Clinical Safety, Member Experience, Quality of Care
Priority	Regulatory
Committee	Pharmacy and Therapeutics Committee, CQIW
Goals	Perform Medication Reconciliation for 50% of high-risk members within 30 days of discharge from acute setting.
Results Q4	88%
Opportunities for Improvement	(Not being done at the Alliance, and not being done at Transition of Care at all sites)
Summary of Quarterly Activities Narrative	Q4: Project was continued through Nov 4th, 2022. Total of 182 cases were selected by the pharmacist from August to November. 122 cases were completed within 30 days of member discharge, which is 88% of eligible cases. 16 cases could not be completed due to time constraints and staffing problems. 44 cases were ineligible to be reviewed, such as minors, members with other health coverage, and multiple readmissions. Data was further analyzed based on outreaches that included providers, pharmacies, Medi-Cal Rx, Case Management and Enhanced Care Management/Community Support. 78 members needed an intervention for their medications. Total 98 outreaches were made for the 78 members. Among the total 122 eligible members, 63 of them were readmitted within 3 months of hospitalization, 44 were not readmitted and 15 were too early to determine.
Known Barriers/Root Cause(s) (as applicable)	Some pharmacy staff resource constraints due to LOA and staff changes. Currently, the pharmacy staff does not have a member-facing role. Interventions would need to be performed by providers or case management teams. However, case management teams also have resource constraints and competing priorities. Missing PCP and member contact information are significant barriers for effective outreaches and interventions. Pharmacists have EMR access to some hospitals only and have difficulty or delay in obtaining discharge notes. Access to additional key hospitals will improve the comprehensiveness of the medication reconciliation. There were technological constraints that reduced efficiency, such as delay in updates to Essette CM module and Tableau report modifications.
Next Steps	Present results and analyses to P&T Committee and other internal departments.

E: ADULT PREVENTIVE CARE SERVICES

Health Education and Disease Management

Domain	Member Experience; Quality of Care; Quality of Service
Priority	Regulatory
Committee	CQIW
Goals	To increase member self-efficacy in performing self-management behaviors by having members participate in the Alliance Healthier Living Program. (Chronic Disease Self-Management Program) 1) By December 31, 2022, at least 50% of participants in the Healthier Living Program will have scored "Good/Very Good/Excellent" for their ability to manage their chronic health conditions after the workshop 2) Overall increasing improvements of the scores (i.e., poor to fair)
Results Q4	100%
Opportunities for Improvement	1) Increase member awareness of the Healthier Living Program workshop by collaborating with internal departments. 2) Continue to offer multiple options for participation including telephonic, virtual, and in-person workshops.
Summary of Quarterly Activities Narrative	In Q4 the QHP team completed two in-person Healthier Living Program (HLP) workshop series. This was the first time offering in-person workshops since the pandemic began in March 2020. Please note, data results for Q4 include members that participated in the virtual HLP during Q3 but surveys were delayed and included in Q4 data.
Known Barriers/Root Cause(s) (as applicable)	Barriers in Q4 include members needing to travel to attend the workshops in-person. Members that participate in HLP are also experiencing chronic condition(s) and might have to miss sessions due to doctor's appointments and/or experiencing unexpected illness due to the condition(s) they have.
Next Steps	Next steps for Q1 2023 the QHP team will offer the HLP workshops telephonically and virtually to allow members to participate that cannot attend activities in-person.

Controlling Blood Pressure

Domain	Quality of Care
Priority	Regulatory
Committee	CQIW
Goals	AIM: Improve hypertension control by improving the accuracy of blood pressure measurement by reducing potential false positives of elevated blood pressure readings. 1) By January 31, 2023, BPs in control will improve from 50% to 55% after implementing the new BP rechecking protocol, where a second BP reading is taken when the first BP reading is greater than 140/90. (this metric is measured by SCC and includes all of their pts on HTN registry) 2) Implement visual reminders to alert staff and patient when a BP recheck should be considered. 3) By January 31, 2023, BP recheck rate will improve from 25% to 35% after implementing the new BP rechecking protocol, where a second BP reading is taken when the first BP reading is greater than 140/90.
Results Q4	1) Goal not met - Santa Cruz HSA Clinic BP in control rate in Dec = 51.91%. 2) Goal met - Visual alerts implemented: WHC (8/1/22); Emeline (9/1/22); HPHP(10/3/22). 3) Goal met - Santa Cruz HSA Clinic BP recheck rate in Dec = 52.7%
Opportunities for Improvement	1) Increase members that are accurately identified as having hypertension. 2) For those members with hypertension established accurate readings support the clinical management of the patient. 3) Establish this best practice in a busy ambulatory care center.
Summary of Quarterly Activities Narrative	Q4: Monitored monthly BP recheck rates. Reminded staff during huddles about BP protocol and importance of rechecking elevated BPs. Started a week-long audit of BPs to identify root causes of why elevated BPs were not being rechecked after implementing visual aids at WHC. HPHP and Emeline is scheduled to conduct their BP audits in Jan and Feb of 2023, respectively.
Known Barriers/Root Cause(s) (as applicable)	Results from BP recheck audit (audited 45 elevated BPs): 1) Forgot to recheck elevated BP 8 (57%) 2) MA did not know needed to follow BP protocol for specialty visits 2 (14%) 3) Per provider no need to repeat BP at threshold (e.g. BP=140/74) 2 (14%) 4) Per provider no need to repeat BP; pt has not been compliant with medications 1 (7%) - appropriate reason 5) Forgot to document 2nd reading 1 (7%)
Next Steps	Conduct additional 1-week audit at Emeline Clinic. Will aggregate results and target most common root cause to focus the next intervention to test to improve elevated BP recheck rates.

Diabetes HbA1c >9% (poor control)

Domain	Quality of Care
Priority	Regulatory
Committee	CQIW
Goals	1). Identify a health care system willing to partner with the Alliance team in implementing an evidenced based practice for members with Diabetes Type II (Community Guide) 2. Establish a team of clinic staff and technical support staff from the Alliance to champion the program and support selection of an intervention. 3. Set an objective that identifies a target number of members that are able to decrease HbA1c values to below 7.5.
Results Q4	Completed Population Health Diabetes Mellitus pilot with 53 members ages 5-64 years old. During the pilot, 37 enrolled in services (70%) between Aug 18th- Nov. 18th into these programs: 18 Adult CCM, 7 Peds CCM, 11 Peds CC, 1 Adult CC. Five are potentially experiencing complications from diabetes and 5 members had IP admissions in the last 13 months. 18 (of 53) members with “other” issues including cardiac, pregnancy, dietary management, arthritis and vision concerns. There were 3 Members referred to Health Programs and 5 Members referred for Beacon services due to depression/ challenges coping.
Opportunities for Improvement	1) Few services available to members to support self management of diabetes. Members with diabetes need ongoing support to maintain A1c values that indicate good control. 2) Once new staff are on board, will explore opportunities to engage with a practice with a cohort of members with DM and interest in improving and/or expanding services to these members. 3) There are opportunities to not just manage blood glucose, but support adoption of healthy choices, tobacco use, increase physical activity and monitoring of blood pressure. 4) Until January 2023, continuous blood glucose monitoring was not available, this is a valuable tool that needs to be more widely implemented, including use of newer medications that can support members in managing their blood glucose levels.
Summary of Quarterly Activities Narrative	Due to limited staffing, the team has pivoted to focus the Population Health pilot on adult high risk members with the highest HbA1c values. QIPH will partner with CCC and Pediatric CM teams to test risk levels of members as scored by the BI tool and other methods. This will allow clinical staff to focus on this target population while testing the proposed methodology and work flows of the Population Health program.
Known Barriers/Root Cause(s) (as applicable)	1) Clinics are currently struggling to maintain staff and continue to care for members with COVID. Members needing a new PCP or access to a/their endocrinologists are challenged with getting appointments. 2) Alliance members have few resources, may be limited to not having safe areas for physical activity or support to prepare healthy meals. 4) Continue to assess population for root causes that challenge members to manage their diabetes well. Access to mental health care is a clear need and may take outreach to make that connection for members with diabetes. 5. Quest data has not been parsed correctly in the HL7 format. IT staff are working now to correct this issue so that we can ingest HbA1c files correctly. Ideally will clean out current data and replace with correct values for 2022.
Next Steps	1. Essette Population Health task implemented in Q4 to support evaluation and monitoring of all members introduced to services via the stratification process. 2. Ongoing monitoring and evaluation of the risk scoring process, ensure workflows are developed to support staff. 3. Ongoing work to ensure accurate HbA1c data is available to support CM staff.

Preventive Care: Colorectal Cancer Screening-HEDIS

Domain	Quality of Care
Priority	Regulatory
Committee	CQIW
Goals	Assess baseline rates for colorectal cancer screening and determine future interventions
Results Q4	As of November 2022, the overall rate of colorectal cancer screening for adults was 27.6%. Merced County was 23.8%, Monterey 29.5%, and Santa Cruz County at 29.9%.
Opportunities for Improvement	Data has not been analyzed at this time. Preliminary conversations with providers reveal that recommendations for routine colorectal screening are not well known, specifically acceptable methods and frequency. This is a new measure for Medicaid, we will be learning in 2023 about our baseline performance. In the meantime, we are collecting available data.
Summary of Quarterly Activities Narrative	During Q4, the tip sheet for this exploratory CBI Measure was published. https://thealliance.health/for-providers/manage-care/quality-of-care/care-based-incentive/care-based-incentive-resources/ for provider's reference. Our data submission tool has also been updated and validated for providers to start submitting data for this CBI 2023 measure.
Known Barriers/Root Cause(s) (as applicable)	1) New measure to Medicaid in 2022. Measure has a long look back period for data. 2) Need to prioritize resources to be dedicated to this measure against others for 2023.
Next Steps	Continue to promote best practices for colorectal cancer screening.

Well Child Visits

Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)
Committee	CQIW
Goals	By December 31, 2022, increase the percentage of child and adolescent members 3-17 years of age, linked to Golden Valley Health Center - Los Banos clinic, who receive at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the intervention period, from 32.65% to 48.56%.
Results Q4	Q4 2022 Rate is currently not available yet due to data validation in progress. Rate for the month of November was 59.96%.
Opportunities for Improvement	• Improve access by increasing the number of in-person well care visit appointment slots per week. • Prioritize health equity strategies by increasing outreach to populations with lower rates. • Promote member incentives to encourage members to complete their well-care visits.
Summary of Quarterly Activities Narrative	In Q4, we continued to test our recall intervention. We continued to provide the Los Banos Clinic a monthly list of members who were non-compliant to be outreached and scheduled. The clinic has continued to do an amazing job at doing outreach in Q4. We hit our goal rate in the month of July, ending the month at 49.20% and continued to trend upward in Q4. This quarter we also worked on implementing the pilot point of service member incentive for Alliance members linked to GVHC Los Banos clinic ages 3-17 who completed a well care visit from October 1, 2022 – December 31,2022. Our go live date in the clinic was October 14, 2022. We continued to meet with the GVHC Los Banos clinic team 1-2 times a month for progress check-ins and updates. A total of 147 gift cards were issued to members who went in and completed a well care visit from October 1, 2022 -December 31, 2022. This current PIP cycle with DHCS has officially ended as of December 31, 2022. Last Module with findings is due in Q2 2023.
Known Barriers/Root Cause(s) (as applicable)	Staffing challenges due to Provider and clinic staff being out due to sickness, covering other site, and time off. Staff not being able to allocate extra time to do outreach Member no shows and parents not wanting to schedule during school hours has also been an issue in Q4.
Next Steps	Monthly meetings with the PIP team will continue through Q1 2023 as we gather information and data needed to submit Module 4 in Q2 2023.

Maternal and children's preventive care (HEDIS)

Domain	Quality of Care
Priority	Department of Health Care Services (Bold goals 50 x 2025)
Committee	Continuous Quality Improvement Workgoup (CQIW)
Goals	1) Ensure all health plans exceed the 50th percentile for all children's preventive care measures; 2) Close racial/ethnic disparities in well-child visits and immunizations by 50%: • *Child and adolescent WCV • Childhood immunizations • Adolescent immunizations 3) Improve maternal and adolescent depression screening by 50%; 4) Close maternity care disparity for Black and Native American persons by 50%: • *Prenatal and postpartum care • Perinatal and postpartum depression screening
Results Q4	1. Children's measures in Merced: -W15 -W30-2 -WCV -CIS -IMA (implied but not required for SWOT) (-LSC suggested but not required for SWOT) 2. Racial/ethnic disparities - Assessed for measures covering children less than 3 years. Using the NCQA racial-ethnic and spoken language groupings we assessed the 2021 data and found that Black, Hawaiian, Native American, Alaskan Native, Arabic and Hmong members had the lowest rates of preventive services for this age group in Merced. 3. Maternal and adolescent depression screening, preparing for MCAS 2023. Adolescent and Adult depression screening rates remain low as measured by CBI program. 4. a. Prenatal care rates in Merced continued to drop and were 81.0% for December 2022, below the 50th percentile, Santa Cruz-Monterey is just at the 50th percentile with a rate of 85.8%. Postpartum care rates for Merced are at 70.1%, and Santa Cruz-Monterey at 86.9%. b. The Racial/ethnic disparities - not assessed during the quarter.
Opportunities for Improvement	1) We continue to struggle to get children's preventive measures above the 50th percentile in Merced County: members with well-child visits at 15 months, 30 months, 3-21 years, and Well Child Care (Nutrition & Physical Activity) and Childhood Immunizations. Santa Cruz-Monterey has just one measure that remains below the 50th percentile (WCV 15 months 6+ visits). 2) Close racial/ethnic disparities in well-child visits and immunizations by 50%. Child and adolescent WCV, Childhood immunizations, and Adolescent immunizations all have racial/ethnic disparities in all three counties. WCV disparities are being addressed by the CBI program to start, Child and adolescent immunizations remain in the CBI program but need additional analysis and planning. 3) We have completed chart reviews in the past that review maternal and adolescent depression screenings in the past and we know that reporting of screening is underreported by claims. 4) Disparities for Prenatal and Postpartum care have been reviewed but requires planning, perinatal and postpartum depression screening needs further analysis and planning.
Summary of Quarterly Activities Narrative	1) We have two Performance Improvement Projects in progress, one for CIS and the other for WCV both in Merced. Planning for a study of pediatric disparities has begun, with initial activities planned for Q3 2022 in Merced County. During Q3 and early Q4, we were able to initiate Point of service incentives at both sites. Initial response to the WCV project has been very good but are experiencing a slow uptake of influenza vaccine at the Castle Clinic despite offering a member incentive. 2) WCV disparities are being addressed by the CBI program 2023 to start. data will be shared with providers through their CBI profiles quarterly, but will need to continue to monitor and in some cases address with clinics. 3) Not started. 4) Met with BabyScripts, a program that can be implemented by providers that supports early pregnancy identification, data collection, and virtual monitoring that decreases preterm delivery, shortens the time until preeclampsia is diagnosed among other positive outcomes.
Known Barriers/Root Cause(s) (as applicable)	1) Clinics are currently struggling to maintain staff and continue to care for members with COVID. Incidence of COVID has increased since last report and is high in 2/3 counties. Recent feedback from providers suggests that there is significant resistance to pediatric flu vaccine from many families, especially in the Merced area. 2) Limited capacity at many primary care offices to review charts or reports to recall members that are missing preventive services as described in 1-2. The GVHC project has demonstrated that applying resources to recall has a positive impact on their WCV rates.
Next Steps	1. Continue to support and engage clinics in Merced, discuss and engage providers to collect lessons learned. Had a pediatrician from GVHC join the Pediatric Equity Task Force meeting. 2. Continue to explore potential health leadership in Merced County that could gather and lead conversations about health care systems, including ways to address vaccine hesitancy. 3. Continue to collect member voice and experience as they experience the health care system and barriers experienced. This disparity analysis is being built into the SWOT's first round of activities between January and May 2023. 4. Prepare to implement new measures that will provide insight into depression screening during the perinatal period. 5. Ongoing education about coding of screenings, like depression and other measures to clinicians.

G: PERFORMANCE IMPROVEMENT PROJECTS (STATE MANDATED)

Breast Cancer Screening PDSA

Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)
Committee	CQIW
Goals	1) By January 30, 2022, complete PDSA cycle 4 intervention to improve the breast cancer screening rate at Dignity Health Medical Group in Merced. 2) By May 30, 2022, complete PDSA cycle 5 intervention to improve the breast cancer screening rate at Dr. Thao's clinic.
Results Q4	1) 10% 2) 16.18%
Opportunities for Improvement	1) Application of standing orders for mammogram screening at provider offices. 2) Retrospective referral process of eligible members and member outreach by the imaging center.
Summary of Quarterly Activities Narrative	The QIPH provided Dignity Health Medical Group (DHMG) in Merced with a list of members 50-74 years of age who were due for their breast cancer screening. DHMG reviewed the member list for contraindications that would require a member to be removed from the project, and submitted referrals to the DHMG imaging center. QIPH and DHMG met bi-weekly to discuss obstacles and address any barriers. The project concluded by surpassing the predictive 10% goal to achieve a rate of 20%. We expect this already high performing provider's overall compliance rate to shift from 69% to 75% as a direct result of this active intervention. For our cycle 5 BCS intervention project, QIPH worked with Dr. Long Thao's office. The intervention focused on the linked Hmong members after identifying a large disparity in this population in completing their breast cancer screenings. The QIPH team identified 68 members who were due for their screenings and provided this list to Dr. Thao's office to review for any contraindications. Upon Dr. Thao's clinic review, they delivered the referrals to El Portal Imaging to ensure all were received. El Portal Imaging confirmed receipt of the referrals and provided the Alliance with time blocks on their schedule. The Alliance Health Educators contacted the members to schedule screenings using interpreting services. El Portal Imaging was responsible for placing the reminder calls and offered Alliance transportation services at that time. QIPH corresponded internally at least once a week, as well as reaching out to El Portal Imaging for weekly updates. As a result of this outreach, 7 of the 68 members scheduled with QIPH and completed their breast cancer screening. QIPH submitted the final information to Dr. Long Thao's office, noting the success of the intervention and that a few members felt more comfortable scheduling with their PCP. Dr. Thao's office completed another round of outreach to the members, and an additional 4 members scheduled and completed their screenings. The final result of this intervention resulted in 11 out 68 members receiving their screenings (16.18%). After the completion of cycle 5 of the Breast Cancer PDSA and after seeing significant improvements in our efforts, DHCS has assigned QIPH to conduct a SWOT analysis on breast cancer screenings. This is an effort to increase breast cancer screening rates to encourage members to resume preventative screenings post the COVID pandemic. After the completion of the analysis, it was determined to promote breast cancer screening through the Care-Based Incentive (CBI).
Known Barriers/Root Cause(s) (as applicable)	1) This is a high performing clinic and they have been actively working on increasing their breast cancer screening rates through the pandemic. As a result, the list of members that QIPH provided to DHMG were the patients that had already no-showed, not scheduled or canceled. This added a complexity to the project, but the project proceeded to be fruitful in the end. 2) The intervention with Dr. Long Thao's office identified that the majority of the Hmong population linked to Dr. Thao's office relies heavily on family members to assist in scheduling and taking this population to their appointments. The team also found that a portion of the members were not comfortable in scheduling with the Alliance and preferred to talk with the PCP office.
Next Steps	Next steps include continuing to monitor both underperforming and high performing breast cancer screening rate trends and target eligible, non-compliant members where opportunities for intervention activities are present. This 5th cycle concluded the breast cancer screening intervention series, and will continue to promote Breast Cancer Screenings through the Care-Based Incentive (CBI) Program. The CBI team will continue to promote best practices from this intervention series.

COVID-19 QIP

Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)
Committee	CQIW
Goals	1) By March 31, 2022, complete the follow up COVID-19 QIP submission
Results Q4	N/A
Opportunities for Improvement	• Member incentive for those 7-24 months of age who receive their second flu shot. • Adolescent well care letters for members 11-13 years of age. • Outreach to prenatal and postpartum members as part of the Healthy Mom and Healthy Babies program.
Summary of Quarterly Activities Narrative	N/A
Known Barriers/Root Cause(s) (as applicable)	Barriers to vaccine acceptance in Merced County remain higher than in Santa Cruz and Merced Counties despite attempts to partner with local community leaders, use of financial incentives and other interventions.
Next Steps	N/A

Childhood Immunizations

Topic	Childhood Immunizations
Domain	Quality of Care
Priority	Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)
Committee	CQIW
Goals	By December 31, 2022, Castle Family Health Center will increase Childhood Immunization Status (CIS) Combo 10 rates among the three targeted sites from a baseline of 12.22% to 19.51%
Results Q4	12.84%
Opportunities for Improvement	• For those providers who indicated that they do not have a member recall process for immunizations (Provider Access Survey), provide practice coaching to empower the clinic to develop a sustainable system. • Prioritize health equity strategies by increasing outreach to populations with lower rates. • Promote member incentives to encourage members to complete their immunizations.
Summary of Quarterly Activities Narrative	9/14/22 - 12/30/22: Provided updated rosters for clinics to conduct outreach at the beginning of each month. Clinic scheduled flu vaccine visits and distributed gift cards to eligible members who received their flu shots. 10/4/22 - Call scripts and flu vaccine resources were provided to Castle team. 10/24/22 - HSAG approved Module 3 (flu vaccine incentive intervention). 12/5/22 - Due to high volume of parents declining to schedule the flu vaccine visit, pivoted to prioritizing those due for a WCV + flu shot. Also provided list of members to prioritize who are turning 2 in the current and subsequent month. 12/9/22 - Castle completed texting campaign and CCAH mailed flyers.
Known Barriers/Root Cause(s) (as applicable)	1) Limited clinic PIP team engagement due to conflicting priorities 2) Staffing challenges (i.e. dedicated staff working on the project leaving organization or time was limited working on the project) 3) Parent vaccine hesitancy for child to receive flu vaccine 4) Data management challenges with using GC tracking and Outreach tracking spreadsheets
Next Steps	1) Continue with the member incentive until the end of flu season in May. 2) Complete Module 4 and submit to DHCS/HSAG to complete the 2020 - 2022 PIP Cycle.

Adverse Childhood Experiences (ACE)

Domain	Quality of Care
Priority	Divisional Goal, Diversity Leadership Program (DLP)
Committee	CQIW, CQIC
Goals	1) By 12/31/22, assess the current landscape in Merced County to address any barriers or factors to complete ACE screening. 2) By 12/31/22, promote education and best practices among providers and clinic staff to conduct the screening. 3) By 12/31/22, support a network of care with experts in the community (providers, community-based organizations, other experts).
Results Q4	3528
Opportunities for Improvement	1) Minimal ACE screenings in Merced County
Summary of Quarterly Activities Narrative	In Q4 we began operationalizing the ACE screenings via the CBI Program. This included educating providers on the new CBI incentives during the CBI workshops, updated CBI materials and provider education. The QI team continues to reconcile clinic's provider lists to ensure their providers are showing up as attested for completing the ACE training and are able to begin billing for this service. The QI team also began doing a deep analysis as to why ACE screening claims are being denied and contacted Provider Relations Representatives to reach out to clinics to assist in ensuring the providers complete their attestation. QI is also partnering with ACE Overcomers to assist in training Merced providers on ACE screenings. We are now seeing clinics changing their workflows to have the clinic staff (MA, NP, PCPs) complete the ACE screenings.
Known Barriers/Root Cause(s) (as applicable)	In Q4 QIPH continues to see the same barriers as in Q1, Q2 and Q3. It was determined that by Alliance stakeholders that providers can't be paid retroactively for ACE screenings if they showed proof of completing the training. The Alliance is paying claims based on attestation date, noted in the APL. Providers are to go through provider dispute process if they chose. QIPH identified that FQHCs do not qualify for the CHW benefit, and Alliance staff had been promoting this benefit to assist in completing screenings. CBO's also have the opportunity to complete screenings and there is a gap as to how the Alliance will receive this information if they are billing through the Alliance.
Next Steps	In 2023 QIPH will continue to promote and educate providers on the CBI Incentives, ACE training and attestation. QIPH will also partner with SCHIO to see if they can be a billing resource for CBO's and if data sharing is possible, as well as to see if SCHIO can house the screening data for Santa Cruz County. QIPH will continue to partner with ACEsINC and ACEs Overcomers to assist in training providers. QIPH will also continue to partner with Merced and Santa Cruz Counties to provide support with the PRACTICE grants. ACEs article will be included in the March 2023 Member Newsletter informing members on ACE screenings, as we anticipate an increase of screenings in 2023 with the new CBI incentives. QIPH will work with Beacon to review why ACE screening claims are being denied and provide feedback to clinics.

Eating Disorders

Domain	Clinical Safety, Member Experience, Quality of Care, Quality of Service
Priority	Alliance Operating Plan
Committee	UMWG, CQIC, Beacon Oversight Committee, Health Services Finance Committee
Goals	By 12/31/22 develop a pathway process for referrals and escalation. Develop a processes for mild to moderate and severe mental illness care coordination. Establish clear contact information for all levels of behavioral health interventions to increase timely access to care
Results Q4	Eating Disorder Workbook is being reviewed by Beacon and county partners to inform development of workflows. As this work was delayed given staffing shortages in BH, the pilot project to design and field test a new workflow with one county, and then scale it to all service areas, will resume in 2023.
Opportunities for Improvement	1) Establish a clear collaborative referral process with County Mental Health Plans 2) Establish a clinical referral outline biopsychosocial background for review of cases for authorization 3) Establish contact information for all levels of behavioral health interventions to increase timely access to care.
Summary of Quarterly Activities Narrative	The Alliance has an established external collaborative bi-weekly behavioral health case review process with our MBHO to support and address members with eating disorders, substance use disorders, biopsychosocial barriers in care, and co-occurring disorders. The Alliance is proactively collaborating with County Mental Health Plans to coordinate appropriate levels of care for eating disorder treatment, provide TAR authorizations, and arrange reimbursement for the cost of treatments. In Q2, the Alliance has provided internal educational presentations to the social services department, utilization review director, and community care coordination director to address the increasing need and acuity levels of eating disorders. In Q3 the Alliance communicated a plan to create a workflow pilot with one county to improve processes and drafted an Eating Disorder Workbook for use by all partners in the treatment of members. In Q4 Beacon and counties were able to review the workbook and prepare for building workflows in 2024.
Known Barriers/Root Cause(s) (as applicable)	1) Staffing changes 2) Continued education on the prevalence, impact, cost, and levels of treatment are needed to support care for eating disorders. 3) Gaps in appropriate levels of care needed and treatment.
Next Steps	Since completion of the Eating Disorder Workbook, counties and Beacon partners have had the opportunity to review and provide feedback. Upon hiring a new BH Manager, the workflow pilot project will begin with Santa Cruz County with the intention of refining and scaling the process.

SECTION 4: CLINICAL SAFETY

I: CLINICAL SAFETY

Grievance and PQI Management

Domain	Clinical Safety
Priority	Regulatory
Committee	CQIW
Goals	1) By December 31, 2022 100% of Potential Quality Issues (PQI) completed within 90 calendar days of receipt. 2) By December 31, 2022 Quality Improvement (QI) nurse to route 100% of grievances related to medical quality of care issues to the Medical Director. Conduct an inter-rater reliability audit on a quarterly basis.
Results Q4	Q4 Data as of 1/4/2023: 1.) 116/121 (96%) PQIs were closed within timeframe this quarter: a. 90/90 (100%) of member grievances opened as PQIs were closed within 30-days or less. b. 26/31 (84%) of internally referred PQIs were closed within 90-days or less. 2.) 67/67 (100%) of member grievances received by QI related to potential medical quality of care issues shall be referred to the Medical Director. YE 2022 Data as of 1/20/2023: 1) 496/567 (87%) PQIs were closed within timeframe this year: a. 410/410 (100%) of member grievances opened as PQIs were closed within 30-days or less. b. 86/157 (55%) of internally referred PQIs were closed within 90-days or less. 2) 410/410 (100%) of member grievances received by QI related to potential medical quality of care issues shall be referred to the Medical Director.
Opportunities for Improvement	1) Maintain adequate staffing of program; expedite training of new hires. 2) Continue work with OpEx regarding Corrective Action Plan workflow and methods.
Summary of Quarterly Activities Narrative	Q4 Accomplishments: 1. The quarterly MD IRR of member complaints resolved by RNs resulted in 100% approval, indicating that cases are being appropriately routed to MD for oversight; and 2. MD peer to peer IRR of PQIs resulted in 100% agreement, indicating Medical Directors are resolving cases with consistent methodology; and 3. All member grievances opened as PQIs in Q4-2022 were closed within Grievance's timeframes (30 days or less). N=90; and 4. A new PQI referral form and referral criteria was developed for application in Q1-23; and 5. Clinical QoC CAP Process is currently in the implementation phase in partnership with Operational Excellence. Q4 Summary: Member Grievances routed to QI for oversight reduced this quarter by 44% from Q3-22 which allowed the team to focus on PQI process improvement efforts. The team performed several SWOT analyses and were able to modify PQI communication practices with providers and redesign the PQI referral form to streamline internal referrals. These changes reduce administrative tasks involved in processing PQIs and ensures providers are made aware of severe PQIs and quarterly trends as needed. 100% of member grievances opened as PQIs were closed within Grievance's timeframe of 30-days or less (N=90), as required by the State. There was an increase in internally referred PQIs closed in 90-days or less (84%) this quarter, up from only 53% in Q3. Process changes made this quarter should lead to further increases in compliance in Q1-23. PQI Team is close to completing the hiring of an additional FTE RN by Q1-23 which will bring team back to 100% staffing since mid-2022.
Known Barriers/Root Cause(s) (as applicable)	1. Hiring RN FTE to assist in processing member grievances and PQIs is in process, however finding qualified candidates remains a challenge.
Next Steps	1. Proceed with hiring RN FTE; and 2. Continue collaborations with OpEx.

Facility Site Review Management

Domain	Clinical Safety
Priority	Regulatory
Committee	CQIW
Goals	1) By December 31, 2022 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date. 2) By December 31, 2022 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. 3) By December 31, 2022 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) By December 31, 2022 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by the FSR team.
Results Q4	1) 73% (11 of 15) of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date. 2) 50% (1 of 2) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. 3) 67% (8 of 12) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 100% (8 of 8) of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by the FSR team.
Opportunities for Improvement	1) Update the plan to ensure the smooth transition from Policy Letter 14-004 to All Plan Letter 20-006; 2) In a pilot of the new FSR/MRR tools, it was found that 90% of surveys prompted a Corrective Action Plan (CAP). This is a significant impact, since 2021, where only 33% of audits prompted a CAP. This is a concern considering implementation occurred on July 1, 2022. 3) Collaborate with Practice Coaching and Provider Services to prepare for an influx in Corrective Action Plans (CAPs) due to the new FSR requirements.
Summary of Quarterly Activities Narrative	1. Developed and distributed a crosswalk of the 2012 and 2022 FSR/MRR guidelines to providers to highlight new criteria and encourage compliance. 2. Continue to adjust the FSR MRR Corrective Action Plan (CAP) template to include additional provider resources for common site deficiencies. 3. Collaborating with Alliance Application Services and DHCS to create an interface to upload FSR MRR data to DHCS' new database in development, MSRP. 4. Continue to meet with DHCS in the biweekly state wide MCP workgroup meetings and monthly FAQ Committee meetings to ensure we are continuing to follow recommendations around new guidelines as well as leniency for CAP due dates and site review scheduling according to each sites' impact of public health emergency related barriers.
Known Barriers/Root Cause(s) (as applicable)	1. Staff shortages continue in response to the public health emergency, such as sick leave, absence for childcare, high staff turnover, difficulty in hiring new staff, and managers shifting to patient care positions to cover shortages. 2. New hybrid FSR/MRR process that led to delayed MRR audits is being revised to ensure timely completion of reviews.
Next Steps	1. Continue to meet with DHCS in the biweekly state wide MCP workgroup meetings and monthly FAQ Committee meetings to ensure we are following the most up to date recommendations around new guidelines, leniency for CAP due dates and site review scheduling according to each site's impact of public health emergency related barriers. 2. Continue to work with Alliance Application Services and DHCS to create an interface to upload FSR MRR data to DHCS' new database in development, MSRP. 3. Create new initiatives to proactively help sites meet new FSR MRR guidelines prior to site audit. 4. Quality Improvement Project Specialist to assist FSR team in improving CAP process.

DATE: May 24, 2023

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

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

SUBJECT: Quality Improvement Health Equity Transformation Workplan for 2023

Recommendation. Staff recommend the Board approve the Quality Improvement Health Equity Transformation (QIHET) Workplan for 2023.

Background. This informational report provides a summary of the activities planned for the 2023 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.

Discussion. The Alliance is contractually required by the Department of Healthcare Services to maintain a quality improvement system to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. This is monitored through an annual 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.

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

Attachments.

1. Quality Improvement Health Equity Transformation Workplan 2023

Quality Improvement Health Equity Transformation (QIHET) Workplan
2023

INITIAL WORKPLAN & EVALUATION APROVAL	FINAL WORKPLAN & EVALUATION APROVAL
Submitted and approved by:	Submitted and approved by:
QIHET-W Date:____2/23/2023 ___	QIHET-W Date: _____ ___
QIHET-C Date:_____	QIHET-C Date:_____
Board Date:_____	Board Date:_____
Dale Bishop, MD, CMO Date	Dale Bishop, MD, CMO Date
Medical Director Date	Medical Director Date
Andrea Swan, RN Date Quality Improvement & Population Health Director	Andrea Swan, RN Date Quality Improvement & Population Health Director

Quality Improvement System Workplan

Section I: Member Experience

- A. Member Experience
  - Health Care Collaboratives
  - Health Services Division Member Outreach & Engagement Campaigns
  - Member Support – Call Center
  - Cultural and Linguistics (C&L) Services & Population Needs Assessment Education
  - CAHPS: How Well Doctors Communicate

Section II: Quality of Service

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

Section III: Quality of Clinical Care

- D. Utilization
  - Under / Overutilization
  - Site of Care
  - Drug Utilization Review (DUR)

Section III: Quality of Clinical Care (Continued)

- E. Adult Preventive Care Services
  - Health Education and Disease Management
  - Controlling Blood Pressure
  - Diabetes HbA1c >9% (poor control)
- F. Performance Improvement Projects (State Mandated)
  - Women's Health Domain SWOT
  - Children's Domain SWOT
  - Childhood Immunizations
  - Child and Adolescent Well-Care Visits in Merced County
  - Well-Child Visits in the First 30 Months of Life; Well-Child Visits in the First 15 Months – Six or More Well Child Visit W30-6) Measure
  - Follow-Up After Emergency Department Visit for Mental Illness – 30 Day Follow-Up; Total and Follow-Up After Emergency Department Visit for Substance Use; 30 ay Follow-Up - Total
- G. Behavioral Health
  - Eating Disorders

Section IV: Clinical Safety

- H. Clinical Safety
  - Grievance and PQI Management
  - Facility Site Review (FSR) Management

Quality Improvement Health Equity Transformation (QIHET) Workplan
2023

The Alliance strategic priorities include 1) Health Equity and 2) Person-Centered Delivery System Transformation. The QIHETP activities that may have connection points with the Strategic Goals through activities of assessment, planning, monitoring, or interventions for improved member outcomes.

Strategic Priority #1: Health Equity

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

- Pediatric Equity Roadmap
- CAHPS Survey (Child): Access Measures, How Well Doctors Communicate
- Childhood Immunizations – Combo 10 (HEDIS)
- Eating Disorders

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

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

Strategic Priority #2: Person-Centered Delivery System Transformation

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

- Eating Disorders*

*As above, for children and youth

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

- Drug Utilization Review (DUR)
- Site of Care
- Over/under utilization
- Preventive Care:
  - Health Education & Disease Management
  - Controlling Blood Pressure (HEDIS)
  - Diabetes A1c > 9% Poor Control (HEDIS)
  - PIPs: Breast Cancer Screening SWOT (HEDIS), Childhood Immunizations

Quality Improvement Health Equity Transformation (QIHET) Workplan
2023

Section I: Member Experience

A: Member Experience

Topic: Health Care Collaboratives - feedback from community engagement **Domain:** Member Experience **Priority:** Alliance Operating Plan	**Committee:** Member Support and Engagement Committee (MSEC) **Responsible Person(s):** Lilia Chagolla, Community Engagement Director	**Goals:** Determine baseline performance by calculating the number of ideas acted upon by the organization (as defined by: assessing feasibility of, starting, or completing a project, taking direct action) against of ideas brought back to the organizations by Community Engagement Team from Health Care Collaborative meetings. **Opportunities for Improvement:** None identified. **Known Barrier(s)/Root Cause(s):** Adequate staff to perform activities.
Topic: Health Services Division Member Outreach & Engagement Campaigns **Domain:** • Member Experience • Quality of Service • Quality of Care **Priority:** Core	**Committee:** • QIHEW • Member Support and Engagement Committee (MSEC) **Responsible Person(s):** • Desirre Herrera, Interim Quality and Health Programs Manager	**Goals:** Member outreach is critical to inform, foster dialogue, and support at risk Alliance members. Member outreach will consist of calling members impacted by the emergent issues, impact on access to care, and member voice assessments. Mobilize an internal team to identify members, develop scripting and information of appropriate resources and health education, and conduct telephonic outreach to high-risk, vulnerable members. Activities: 1. In 2023, track and monitor all ad hoc member outreach and engagement campaigns. 2. Track each campaigns intervention, percentage of successful calls (information provided/LVM) vs. unsuccessful calls, and member counts.

		Opportunities for Improvement: 1. Coordinated collaboration with multiple sources in the development of member written materials and staff talking points. 2. Development of member roster lists with the verification if there is more than one member in the same household on the list. 3. Identification of the right level of staff to support these outreach campaigns (i.e., clinical vs. non-clinical) 4. Coordinated approach for documenting, tracking, and reporting the outcome of each outreach call. 5. Develop enough time to train staff on talking points and new outreach campaigns. **Known Barrier(s)/Root Cause(s):** Adequate staff and planning time are required to support outreach activities. Core work is also impacted when deploying other teams to support outreach campaigns.
Topic: Member Support – Call Center **Domain:** Member Experience **Priority:** Regulatory (DHCS)	**Committee:** Member Support and Engagement Committee (MSEC) **Responsible Person(s):** • Luis Somoza, Member Services Director • Gisela Taboada, Call Center Manager	**Goals:** 1. 95% of Calls to Member Services Answered Before Being Abandoned 2. 80% of Calls to Member Services Answered Within 30 Seconds **Opportunities for Improvement:** Identify additional barriers to being able to continuously meet this requirement. **Known Barrier(s)/Root Cause(s):** 1. Lack of sufficient staffing levels to meet goals. 2. Increase in transportation calls-NMT call delegation to vendor effective 1/1/2023. Delegation will decrease call volume in this area.

Quality Improvement Health Equity Transformation (QIHET) Workplan
2023

Topic: Cultural and Linguistics (C&L) Services & Population Needs Assessment Education **Domain:** • Member Experience • Quality of Service • Quality of Care **Priority:** Regulatory (DHCS)	**Committee:** QIHEW **Responsible Person(s):** • Desirre Herrera, Interim Quality and Health Programs Manager, • Ivonne Munoz, Interim Quality and Health Programs Supervisor	**Goals:** To measure the performance of the Alliance C&L Services program and to make improvements accordingly (measure utilization per County). 1. Increase Provider Utilization of the Alliance Language Assistance Services program by 5% when compared to the previous year. 2. Increase the Alliance network provider's familiarity with the Alliance Language Assistance Services Program **Opportunities for Improvement:** Effective communication is critical for our members to ensure understanding, empowerment and provide high-quality care. The Alliance Language Assistance Services program ensures that Alliance members receive high-quality and appropriate language services by reducing health disparities related to language/cultural barriers. 1. Explore the effectiveness of cultural competency services provided by the Alliance in ensuring that members receive high-quality, person-centered care and identifying opportunities for improvement where necessary. 2. Monitor telephonic interpreting, face-to-face interpreting, translations, and readability requests. 3. Monitor member and provider complaints and PQIs. 4. Develop a Health Literacy Tool kit for the organization (PNA) 5. Collaborate with PS in the development and launching of provider cultural competency training (PNA) 6. Implement audio interpreting services for Telehealth visits. 7. Promote the Alliance Language Assistance Services with our external network providers (i.e., quarterly fax blasts, training videos to support providers on how to use the services) (PNA)

		Known Barrier(s)/Root Cause(s): 1. Not enough C&L staffing to support core work. 2. The volume of work for C&L services continues to increase over time significantly. Required timelines met by shifting a few tasks to the Heath Educators. This was done to assist with the increased demand for interpreting and translation services. 3. Not enough time for Providers to receive training; currently impacted with COVID-19 and resuming care.
Topic: CAHPS: How Well Doctors Communicate **Domain:** Member Experience **Priority:** Regulatory (DHCS)	**Committee:** • QIHEW Member Support and Engagement Committee (MSEC) **Responsible Person(s):** • Kristen Rohlf, MPH, Interim Quality and Population Health Manager • Alex Sanchez, MPH, Quality Improvement Program Advisor III	**Goals:** 1. Achieve xx% in How Well Doctors Communicate - Child 2. Achieve x % in How Well Doctors Communicate - Adult **Opportunities for Improvement:** Assess CAHPS surveys administered in 2022, determine thresholds and targets, and identify any improvements. **Known Barrier(s)/Root Cause(s):** TBD

Section II: Quality of Service

B: Access & Availability

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

Topic: Annual Access Plan **Domain:** • Quality of Service • Quality of Care • Member Experience **Priority:** • Regulatory (meeting regulatory obligations for timely and geographically accessible access to care); • Core Operational work	**Committee:** Network Development Steering Committee (NDSC) **Responsible Person(s):** Rachaelle Schultze, Provider Quality and Network Development Manager	**Goals:** The Annual Access Plan focus areas and improvement goals are established in January of each year and are solidified by the NDSC. The 2023 Access Plan goals will be finalized in January 2023. **Opportunities for Improvement:** The Access Plan will articulate identified areas within the Alliance provider network where targeted activities can increase or enhance choice and/or access. The 2023 improvement opportunities will be identified in January 2023. **Known Barrier(s)/Root Cause(s):** TBD
Topic: Provider Choice: In-Area Market Share **Domain:** • Quality of Service • Member Experience **Priority:** • Regulatory (meeting regulatory obligations for timely and geographically accessible access to care); • Core Operational work	**Committee:** Network Development Steering Committee (NDSC) **Responsible Person(s):** Rachaelle Schultze, Provider Quality and Network Development Manager	**Goals:** 1. 80% Market Share (PCP and Specialist) target with 75% lower threshold 2. Market Share stability with a no more than 5% decrease annually. **Opportunities for Improvement:** 1. Credential non-credentialed providers practicing at contracted locations. 2. Engage providers who have historically declined to contract. **Known Barrier(s)/Root Cause(s):** Difficulty obtaining timely credentialing applications for new or existing providers, priority to engage new entities in contracting over credentialing providers at existing contracted sites.

Topic: CAHPS Survey: Access Measures **Domain:** • Quality of Service • Member Experience **Priority:** Regulatory (DHCS)	**Committee:** • Network Development Steering Committee (NDSC) • QIHET-W • QIHET-C **Responsible Person(s):** • Kristen Rohlf, MPH Interim Quality and Population Health Manager • Alex Sanchez, MPH, Quality Improvement Program Advisor III	**Goals:** 1. Achieve xx% in Getting Care Quickly for Child and Adult CAHPS 2. Achieve xx% in Getting Needed Care for Child and Adult CAHPS **Opportunities for Improvement:** Assess CAHPS surveys administered in 2022, determine thresholds and targets, and identify any improvements. **Known Barrier(s)/Root Cause(s):** TBD
C: Provider Experience		
Topic: Provider Satisfaction **Domain:** Quality of Service **Priority:** Regulatory; Core Operational work	**Committee:** Network Development Steering Committee (NDSC) **Responsible Person(s):** Rachaelle Schultze, Provider Quality and Network Development Manager	**Goals:** Target of 88% of surveyed providers who are satisfied with the Alliance (annual measure based on Satisfaction Survey); lower threshold is 79.2%. **Opportunities for Improvement:** Engage more providers in responding to the annual survey; continue to explore new or evolved questions to best inform the Alliance as to feedback in targeted areas. **Known Barrier(s)/Root Cause(s):** None

Section III: Quality of Clinical Care

D: Utilization

***The Utilization Management Program is monitored through the Utilization Management Workplan**

Topic: Under / Overutilization **Domain:** • Quality of Care (QOC) • Quality of Service (QOS) • Clinical Safety (CS) **Priority:** Regulatory	**Committee:** • Utilization Management Workgroup (UMWG) • QIHET-W • QIHET-C • Program Integrity / Compliance Committee • Claims • Advanced Analytics • Health Services Finance Collaborative • PS / HS Collaborative **Responsible Person(s):** • Tammy Brass, Director of UM / CCM • Medical Directors	**Goal(s):** An interdepartmental over/underutilization report will be developed by December 31, 2023. **Opportunities for Improvement:** 1. Coordinated collaboration with all sources of monitoring for over and underutilization. 2. Linking reporting from multiple sources to ensure compliance with monitoring. **Known Barrier(s)/Root Cause(s):** Lack of consolidation of all efforts toward oversight of over /utilization.
Topic: Site of Care **Domain:** • Quality of Care • Member Experience • Clinical Safety **Priority:** Organizational Tactic	**Committee(s):** • Pharmacy and Therapeutics Committee (P&T) • Continuous Quality Improvement Committee (CQIC) **Responsible Person(s):** • Navneet Sachdeva, PharmD, Pharmacy Director • Yasuno Sato, PharmD, Clinical Pharmacy Manager	**Goals:** 1. Perform Site of Care outreach to 50% of Site of Care eligible members on targeted drugs in a form of informational letter and infusion provider phone calls. 2. Determine any barriers for Site of Care transition from members, prescribing providers, and infusion providers perspective. **Opportunities for Improvement:** 1. Improve access to home infusions and outpatient infusion center infusions for members.

		2. Develop infusion provider and member relationship, which can eventually improve medication adherence and health outcomes. **Known Barrier(s)/Root Cause(s):** 1. Pharmacy staffing 2. Insufficient Home infusion and outpatient infusion contracted providers. 3. Hospital contract limiting transition of infusions out of Hospital based outpatient infusions center.
Topic: Drug Utilization Review (DUR) **Domain:** • Quality of Care • Member Experience • Clinical Safety **Priority:** Regulatory	**Committee(s):** • Pharmacy and Therapeutics Committee (P&T) • QIHET-W **Responsible Person(s):** • Navneet Sachdeva, PharmD, Pharmacy Director • Yasuno Sato, PharmD, Clinical Pharmacy Manager	**Goals:** 1. Perform retrospective drug utilization review on a quarterly basis, to assure that drug utilization is appropriate, medically necessary, and not likely to result in adverse events. 2. Based on DUR, provide active and ongoing outreach to educate providers on common drug therapy problems (e.g., new prescribing guidelines and advisories) with the goals of improving prescribing and dispensing practices, increasing medication compliance, and improvement of over-all member health. **Opportunities for Improvement:** Improve awareness among members on providers on any drug utilization is not in line with current clinical guidelines. **Known Barrier(s)/Root Cause(s):** Limitation in report generation

E: Adult Preventive Care Services		
Topic: Health Education and Disease Management **Domain:** • Quality of Service • Member Experience • Quality of Care **Priority:** Regulatory (DHCS)	**Committee:** QIHEW **Responsible Person(s):** • Desirre Herrera, Interim Quality and Health Programs Manager	**Goals:** To increase member self-efficacy in performing self-management behaviors by having members participate in the Alliance Healthier Living Program. (Chronic Disease Self-Management Program) 1. By December 31, 2023, at least 50% of participants in the Healthier Living Program will have scored "Good/Very Good/Excellent" for their ability to manage their chronic health conditions after the workshop. 2. Overall increasing improvements of the scores (i.e., poor to fair) **Opportunities for Improvement:** 1. Increase participation in the Healthier Living Program workshop by prompting the member incentive and offering different format options. (Telephonic, virtual, and in-person) 2. Coordinated collaboration with multiple sources to ensure to expand the quality improvement system in the community by having a greater presence and promoting Alliance quality initiatives related to wellness and health promotion. **Known Barrier(s)/Root Cause(s):** 1. Technology resources constraints (i.e., phone/network systems not working, 2. MS Teams connectivity issues, increasing power outages).
Topic: Controlling Blood Pressure **Domain:** Quality of Care	**Committee:** QIHEW **Responsible Person(s)**: • Kristen Rohlf, MPH, Interim Quality and Population Health Manager	**Goals:** 1. Support the Pharmacy Team in initiating the Pharmacist-Led Academic Detailing Hypertension Program which will decrease the percentage of members with uncontrolled blood pressures (or BP greater than or equal to 140/90). 2. Identify a health care system willing to partner with the Alliance team in implementing an evidenced based practice for members with Hypertension.

Priority: Regulatory: DHCS Health Equity Goals, HEDIS	• Yasuno Sato, PharmD, Clinical Pharmacy Manager • Jo Pirie, Quality Improvement Program Advisor II • Naomi Kawabata, RN, Sr Quality Improvement Nurse	3. By 12/31/2023, the Santa Cruz County Clinics proportion of patients with BP at goal (or less than 140/90) will increase from 52% to 57%. **Opportunities for Improvement:** 1. Improving accurate BP readings will allows clinical interventions such as the Pharmacists-Led Academic Detailing Hypertension Program to be more effective in improving BP control in members with uncontrolled hypertension. 2. Increase members that are accurately identified as having hypertension. 3. For those members with hypertension established accurate readings support the clinical management of the patient. 4. Establish this best practice in a busy ambulatory care center. **Known Barrier(s)/Root Cause(s):** 1. Clinician and staff turnover limits clinics from participating in improvement activities. 2. New process may be slowly adopted, will need to focus on education and job aids.
Topic: Diabetes HbA1c >9% (poor control) **Domain:** Quality of Care **Priority:** Regulatory: DHCS Health Equity Goals, HEDIS	**Committee:** QIHEW **Responsible Person(s)**: • Kristen Rohlf, MPH, Interim Quality and Population Health Manager • Yasuno Sato, PharmD, Clinical Pharmacy Manager • Vera Eichenbaum, PharmD, Clinical Pharmacist • Naomi Kawabata, RN, Sr Quality Improvement Nurse	**Goals:** 1. Identify a health care system willing to partner with the Alliance team in implementing clinical practice recommendations on the latest pharmacologic recommendations for managing members with Diabetes Type II (ADA 2023: Pharmacologic Approaches to Glycemic Treatment) 2. Support the Pharmacy Team in initiating the Pharmacist-Led Academic Detailing Diabetes Program which will decrease the percentage of members with uncontrolled diabetes (or A1c > 9%). **Opportunities for Improvement:** 1. Opportunities to engage with a practice with a cohort of members with DM and interest in improving and/or expanding services to these members.

		2. For those clinics who do not have a member recall process for routine diabetes care follow-up, provide practice coaching to empower the clinic to develop a sustainable system. 3. Opportunity to connect members to Diabetes Self-Management Education (DSME) and grow our network of Certified Diabetes Educators. 4. Opportunity to not just manage blood glucose, but support adoption of healthy choices, tobacco use, increase physical activity. **Known Barrier(s)/Root Cause(s):** 1. Clinics are currently struggling to maintain staff and continue to care for members with COVID. 2. Limited capacity at many primary care offices to adopt a new initiative. 3. Limited network of accessible Certified Diabetes Educators. 4. Alliance members have few resources, may be limited to not having safe areas for physical activity or support to prepare healthy meals.
F: Performance Improvement Projects (State Mandated)		
Topic: Women's Health Domain SWOT **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Performance	**Committee:** QIHEW **Responsible Person(s):** • Charley Aebersold, CSSBB, Quality Improvement Program Advisor IV • Britta Vigurs, Quality Improvement Program Advisor II	**Goals:** To increase Breast Cancer Screening, Cervical Cancer Screening, and Chlamydia Screening rates by providing practice coaching and learning collaboratives to support provider implementation of QI Interventions, and supporting providers through Alliance member recall and health education. 1. By 11/11/2022 Submission 1 Technical Assistance PRN. 2. By 1/30/2023 Strategies, measurable action items and short-term objectives. 3. By 5/30/2023 Progress on strategies and action items. 4. By 9/30/2023 Progress on strategies and action items.

		Opportunities for Improvement: Incentivization of the BCS measure. **Known Barrier(s)/Root Cause(s):** TBD
Topic: Children's Domain SWOT **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Performance	**Committee:** QIHEW **Responsible Person(s):** • Eleni Pappazisis, Quality Improvement Program Advisor III • Alex Sanchez, MPH, Quality Improvement Program Advisor III	**Goals:** Outreach to high-risk racial ethnic groups in Merced County who are deficient in CIS and/or W30 to address barriers to care and connect member with PCP. Provide education on children's preventative services to Merced County clinics to support clinic staff in becoming subject matter experts (SME) for their clinic. Support practices in maximizing Electronic Medical Record (EMR) and data optimization through the Alliance Portal to prompt providers to order all recommended preventative services. 1. By 11/11/2022 Submission 1 Technical Assistance PRN. 2. By 1/30/2023 Strategies, measurable action items and short-term objectives. 3. By 5/30/2023 Progress on strategies and action items. 4. By 9/30/2023 Progress on strategies and action items. **Opportunities for Improvement:** Incentivization of the BCS measure. **Known Barrier(s)/Root Cause(s):** TBD

Quality Improvement Health Equity Transformation (QIHET) Workplan 2023

Topic: Childhood Immunizations **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)	**Committee:** QIHET-W **Responsible Person(s):** Naomi Kawabata, Sr. QI Nurse	**Goals:** 1. By April 21, 2023, complete final modules for DHCS PIP and summarize outcomes. 2. CIS PIP SMART Goal: By December 31,2022, CFHC will increase CIS rates among the three targeted sites from a baseline of 12.22% to 19.51%By December 31, 2022, CFHC will increase CIS rates among the three targeted sites from a baseline of 12.22% to xx **Opportunities for Improvement:** 1. For those providers who indicated that they do not have a member recall process for immunizations (Provider Access Survey), provide practice coaching to empower the clinic to develop a sustainable system. 2. Flu vaccinations are the limiting vaccine in CIS compliance; therefore, conducting focus groups to further understand the root causes of flu vaccine hesitancy in Merced County may help to develop more effective interventions. **Barrier(s)/Root Cause(s):** 1. Due to the pandemic and flu vaccine hesitancy amongst parents, rates were inadvertently impacted. 2. Staffing shortages in the clinic resulted in inconsistent engagement by the provider.
Topic: Child and Adolescent Well-Care Visits in Merced County **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP)	**Committee:** QIHET-W **Responsible Person(s):** Veronica Lozano, MBA, CHES, Quality Improvement Program Advisor II	**Goals:** 1. By April 21, 2023, complete final modules for DHCS PIP and summarize outcomes: 2. WCV PIP SMART Goal: By December 31, 2022, use key driver diagram interventions to increase the percentage of child and adolescent members who receive at least one child and adolescent well-care visit with a PCP or OB/GYN practitioner during the intervention period among MCO members ages 3-17 years old, linked to Golden Valley Health Centers - Los Banos, from 32.65% to 48.56% (rate of peer benchmark [Taylor Farms Family

		Health & Wellness Center – Gonzales, CA] in Monterey/reference county). **Opportunities for Improvement:** 1. Providers need to block out time for dedicated staff to do recall outreach and schedule members who are non-compliant for a well care visit. 2. Prioritize health equity strategies by increasing outreach to populations with lower rates. **Barrier(s)/Root Cause(s):** Due to the pandemic and staff shortages in the clinic, inconsistent engagement by the provider. Parents not able or wanting to bring member in.
Topic: Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30–6) measure **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Clinical Performance Improvement Project (PIP) 2023-2026	**Committee:** QIHET-W **Responsible Person(s):** Kristen Rohlf, MPH, Interim Quality and Population Health Manager, and designee(s)	**Goals:** Reduce disparity in well-child visits in the first 15 months among Hispanic Population living in Merced County. 1. By quarter 3 2023, complete first modules for DHCS PIP. **Opportunities for Improvement:** 1. Prioritize health equity strategies by increasing outreach to populations with lower rates. **Barrier(s)/Root Cause(s):** TBD

Topic: Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total and Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total **Domain:** Quality of Care **Priority:** Statewide Department of Healthcare Services (DHCS) Non-Clinical Performance Improvement Project (PIP) 2023-2026	**Committee:** QIHET-W **Responsible Person(s):** Kristen Rohlf, MPH, Interim Quality and Population Health Manager, and designee(s)	**Goals:** By quarter 3 2023, complete first modules for DHCS PIP. **Opportunities for Improvement:** 1. Improve the percentage of provider notifications for members with SUD/SMH diagnoses following or within 7 days of emergency department (ED) visit. 2. Increase data sharing to Behavioral Health Delegate. **Barrier(s)/Root Cause(s):** Patient privacy concerns for protected health information created barriers for notifications.
G: Behavioral Health		
Topic: Eating Disorders **Domain:** • Quality of Care • Quality of Service • Member Experience • Clinical Safety **Priority:** Operating Plan	**Committee:** • Utilization Management Workgroup (UMWG) • Continuous Quality Improvement Committee (CQIC) • Beacon Oversight Committee • Health Services Finance Committee **Responsible Person(s):** • Tammy Brass, UM /CCM Director • Shaina Zurlin, LCSW, PsyD. Behavioral Health Director, • Medical Directors	**Goals:** By December 21, 2023, improve workflow process for coordinating and expediting eating disorder referrals to Behavioral Health through pilot project and then scaling results to all counties. **Opportunities for Improvement:** 1. Establish and maintain clear workflows for specialty and non-specialty level care with counties and Beacon. 2. Provide specific pathways for referrals and escalation processes within the Alliance. 3. Delineate processes for mild to moderate and severe mental illness care coordination in collaboration with Beacon and county systems. 4. Establish clear contact information for all levels of behavioral health interventions to increase timely access to care. **Known Barrier(s)/Root Cause(s):** 1. Eating disorders post pandemic have increased significantly. Unclear pathways have caused delays in treatment. 2. Gaps in handoffs between levels of care.

Section IV: Clinical Safety		
H: Clinical Safety		
Topic: Grievance and PQI Management **Domain:** Clinical Safety (CS) **Priority:** Regulatory	**Committee:** QIHET-W **Responsible Person(s):** • DeAnna Leamon, FNP, Clinical Safety Quality Manager	**Goals:** 1. By December 31, 2023, 100% of Potential Quality Issues (PQI) are completed within 90 calendar days of receipt. 2. By December 31, 2023, 100% member grievances opened as PQIs are closed within 30-days or less per regulatory requirement. 3. By December 31, 2023, quarterly MD IRR of QoS grievances shall be in 100% agreement, indicating QI RNs are resolving cases with consistent methodology. Quarterly MD IRR shall be a 10% sample of QoS Grievances resolved by QI RN. **Opportunities for Improvement:** Maintain adequate staffing of program; expedite training of new hires. **Known Barrier(s)/Root Cause(s):** Retaining qualified and well-trained staff.

Quality Improvement Health Equity Transformation (QIHET) Workplan 2023

Topic: Facility Site Review (FSR) Management **Domain:** Clinical Safety (CS) **Priority:** Regulatory	**Committee:** QIHEW **Responsible Person(s):** • DeAnna Leamon, FNP, Clinical Quality Safety Manager	**Goals:** 1. By December 31, 2023 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date. 2. By December 31, 2023 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. 3. By December 31, 2023 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4. By December 31, 2023 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by the FSR team. **Opportunities for Improvement:** 1. Create a plan to ensure the smooth transition from Policy Letter 14-004 to All Plan Letter 20-006; 2. Collaborate with Provider Services to ensure that all providers are updated on the new USPSTF requirements that will be implemented in the FSR and MRR tool in January; 3. Collaborate with Practice Coaching and Provider Services to prepare for an influx in Corrective Action Plans (CAPs) due to the new FSR requirements. **Known Barrier(s)/Root Cause(s):** 1. Large PCP offices with a large amount of staff must conduct many small trainings to address CAPs to prevent large staff gatherings in

		compliance with reducing risk of COVID transmission. 2. Staff shortages in response to COVID, such as turnover and absence for childcare, delayed the provider's implementation of CAPs. 3. Supply chain shortages, including international Oxygen shortages. 4. Practices adopting new Electronic Medical Records.

DATE: May 24, 2023

TO: Santa Cruz-Monterey-Merced 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. Alliance Policy 401-1201 – Continuous Quality Improvement Committee was renamed to the Quality Improvement Health Equity Committee (QIHEC). 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 (the 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.

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	**Policy Hub Approval Date:**
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 Pharmacy and Therapeutics (P&T) Committee, Utilization Management Workgroup (UMWG), Continuous Quality Improvement Workgroup (CQIW) Interdisciplinary, and 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:

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 – C*ultural and Linguistic Services Program*

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 an Alliance Medical Director (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, 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 (defined as not being under active investigation by the Special Investigations Unit nor having an open Corrective Action Plan for Quality Issues).

3.d. Core Alliance staff membership includes the Chief Medical Officer, Medical Director(s), QIPH Director, QIPH Managers, Quality and Health Programs (QHP) Manager, QIPH Nurse Supervisor, Pharmacy Director, Community Care Coordination Director (CCC), Utilization Management and Complex Case Management Director (UM/CCM) Director, Provider Services (PS) Director, Regional Operations Directors, and Member Services (MS) Director or designees. 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 Annual Report[19] is submitted to the QIHEC for review, approval and submission to the Alliance Board, and subsequent submission to DHCS. The QIHE Annual Report includes:

3.j.2.a. A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions;

3.j.2.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.2.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.2.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.2.e. Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and behavioral health care services;

3.j.2.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.2.g. Population Health Management (PHM) activities and findings as outlined in Exhibit A, Attachment III, Section 4.3 (Population Health Management);

3.j.2.h. Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

3.j.2.i. An assessment of subcontracting entities performance of delegated QIHE activities.

3.j.2.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: CEO, CMO, Medical Director(s), QIPH Director, QIPH Managers, QIPH Nurse Supervisor, UM/CCM Director, UM/CCM Managers, CCC Director, Pharmacy Director, QHP Manager, Medical Directors, MS Director, Grievance and Quality Manager, PS Director, Provider Quality and Network Development Manager, Claims Director, Analytics Director, Communications Director, Community Engagement Director(s), Strategic Development Director (or Grants Programs Manager), and Compliance Director or designees from the departments. 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 CMO (or designee) chairs the CBIW. Core membership includes: QIPH Director, QIPH Program Advisors, QIPH 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:

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity `Committee	
Original Date: 02/01/1996	**Policy Hub Approval Date:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Community Care Coordination
Pharmacy
Provider Services
Utilization Management
Member Services
Community Engagement
Compliance

Regulatory:
California Evidence Code §1157
California Code of Regulations Title 28, Chapter 2, Article 7, Section 1300.70

Legislative:

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

DHCS All Plan or Policy Letter:
DHCS All Plan Letter 19-017

NCQA:

Supersedes:

Other References:

Attachments:

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

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
12/01/1998	12/01/1998	Barbara Flynn, RN	Barbara Flynn, RN
01/01/2000	01/01/2000	Barbara Flynn, RN	Barbara Flynn, RN
02/01/2003	02/01/2003	Barbara Flynn, RN	Barbara Flynn, RN
02/01/2004	02/01/2004	Barbara Flynn, RN	Barbara Flynn, RN
01/01/2005	01/01/2005	Barbara Flynn, RN	Barbara Flynn, RN
03/01/2006	03/01/2006	Barbara Flynn, RN	Barbara Flynn, RN
01/01/2008	01/01/2008	Richard Helmer, MD	Richard Helmer, MD
11/01/2008	11/01/2008	Andres Aguirre	Andres Aguirre
03/01/2010	03/01/2010	Kaite McGrew	Richard Helmer, MD

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity `Committee	
Original Date: 02/01/1996	**Policy Hub Approval Date:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Reviewed Date	Revised Date	Changes Made By	Approved By
01/23/2012	01/23/2012	David Altman, MD	David Altman, MD
02/06/2013	02/06/2013	Herschel Leland, Sr. Compliance Specialist	David Altman, MD
06/12/2013	06/12/2013	Steven Slack, MD, AMD	CQIW
01/10/2014	01/10/2014	Dale Bishop MD CMO	CQIW
04/21/2014	04/21/2014	Dale Bishop MD CMO	CQIW
01/20/2015	01/20/2015	Julio Porro, MD, Medical Director	CQIW
01/20/2016	01/20/2016	Julio Porro, MD, Medical Director	CQIW
01/26/2017	01/26/2017	Sitara Cavanagh, Accreditation Specialist	CQIC
12/29/2017	12/29/2017	Chris Morris, Quality & Performance Improvement Manager	CQIW
02/01/2018	02/01/2018	Sitara Cavanagh, Quality Improvement Coordinator	CQIC
01/16/19	01/16/19	Amit Karkhanis, Quality & Performance Improvement Manager	CQIW
01/24/2019	01/24/2019	Amit Karkhanis, Quality & Performance Improvement Manager	CQIC
07/17/2019	07/17/2019	Michelle Stott, RN Quality Improvement Director	CQIW
07/25/2019	07/25/2019	Michelle Stott, RN, Quality Improvement Director	CQIC
01/15/2020	01/15/2020	Oscar Sanchez, Quality Improvement Administrative Assistant	CQIW
01/23/2020	01/23/2020	Oscar Sanchez, Quality Improvement Administrative Assistant	CQIC
01/28/2021	01/28/2021	Michelle Stott, RN, Quality Improvement and Population Health Director	CQIC
01/19/2022	01/19/2022	Amit Karkhanis, Quality & Performance Improvement Manager	CQIW
04/28/2022	04/28/2022	Amit Karkhanis, Quality & Performance Improvement Manager	CQIC
01/27/2023	1/27/2023	Michelle N. Stott, Quality Improvement & Population Health Director	QIHEW

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity `Committee	
Original Date: 02/01/1996	**Policy Hub Approval Date:**
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Reviewed Date	Revised Date	Changes Made By	Approved By
03/30/2023		Dale Bishop, MD, Chief Medical Officer	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
[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 24, 2023

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

FROM: Tammy Brass, RN, Utilization Management Director

SUBJECT: Utilization Management Workplan Report for Q4 2022 and Utilization Management Workplan Template for 2023

Recommendation. Staff recommend the Board accept the Utilization Management Workplan (UMWP) Report Summary for Q4 2022 and approve the Utilization Management (UM) Workplan Template for 2023.

Summary. This document provides an overall summary of the UMWP activities for Q4 2022, end of year highlights and annual program review. Overall Q4 2022 utilization of inpatient, emergency department (ED) visits, long-term care (LTC), and outpatient services have shown increased activity across the counties in several areas. Increases in California Children's Services (CCS) eligibility were also observed in Q4 2022, continuing the trends noted in 2021 wherein improvements have been made in identification and referrals of CCS eligible members. Care coordination services and pilot programs continued, and progress was made in development and utilization of Enhanced Case Management (ECM) and Community Support (CS) services.

Background. The Utilization Management Workgroup (UMWG) provides guidance and direction to the UM Program and operates under the authority of the Quality Improvement Health Equity Committee. This quarterly summary continues to reflect the outcomes of the changes to the UMWP established for Q4 2022. In addition, projects and initiatives carried forward from 2021 continue to be monitored and updated for progress toward goals. Variances in goal achievement are documented in the quarterly UMWP with evaluation of issues influencing outcomes. In areas where interventions are adjusted or changed, documentation is described in the quarterly recommendations.

Q4- 2022 Workplan Outcomes and Evaluation

Project and Initiative Outcomes

> Pediatric Case Management. Total eligibility in Q4 2022 noted at 8,137 CCS members (increased from 8,068 in Q3). Santa Cruz county reflected a 3.2% increase in CCS eligibility over prior quarter, with Monterey and Merced showing smaller increases. Continued development of Annual Medical Redetermination (AMR) processes continue across the counties, with challenges noted when external hardcopy records are needed versus portal view due to provider office delays in submission of hard copy records for AMR review.

System Transformation Development: Enhanced Case Management and Community Care Coordination. Q4 2022 efforts included planning for an Alliance ECM dashboard to monitor provider capacity, member enrollment, and how the network development compares to Department of Health Care Services (DHCS) estimates of ECM expansion/enrollment in 2023. Additionally, identification and contracting and credentialing of new ECM and CS providers was completed in this quarter to prepare for the implementation of two additional ECM populations of focus that were added to the benefit, in alignment with DHCS guidelines, for January 2023. A new CS will be added for members in the Alliance service area as well, Environmental Accessibility Adaptations, also known as Home Modifications.

Reducing Readmissions Initiative. Enrollment into the Alliance's CS Medically Tailored Meals service continues. Moving into 2023, the Alliance intends to provide this service to all members who meet DHCS' eligibility criteria, including women at risk during pregnancy.

Plans are underway to modify existing initiative efforts in preparation for the implementation of Population Health Management's (PHM) Complex Care Management and Transitional Care Services. With the implementation of PHM, the Alliance will be adding additional care management elements to align with National Committee for Quality Assurance standards of Complex Care Management. Staff continued to modify their CCM practice with implementation in Q4. The Alliance will also be aligning with PHM standards and providing transitional care services to high-risk members beginning January 2023.

Recuperative Care Program. The Recuperative Care Program was fully transitioned to a CS service in Q3 for the Alliance's service area. Oversight of the program continued throughout Q4 through ECM/CS.

Operational Performance Outcomes. Operational Performance includes regulatory performance monitoring metrics that are reported on the organizational dashboard in addition to the UMWP. These include the following:

Authorization Turn Around Times. Authorization volumes 29,496 of 29,605 authorizations completed timely for a turnaround (TAT) rate of 99.6% (consistent with prior quarters). A twice daily Tableau report is in place for assessing turnaround times and authorization assignments for near 100% rate, continued cross training and SME development and ongoing review for process improvement and overall authorization reduction opportunities continue into 2023.

Goal: 100%
Results: 99.6%

Prior Authorization Request Determination Metrics. Overall denial rate remains low at less than 2% (n=1.5), reflecting an opportunity in 2023 to consider further authorization configurations for low risk, historically low denial categories. Q4 appeal rates reflect consistent findings in this category: (Q3 noted at 5%) 6% denials resulting

in appeals, 68% denials upheld, 32% denials overturned in appeal. When considering overall authorization volumes, less than 1% authorizations result in an appeal.

Denial rate for the year averaging at 1.7%, with opportunity in 2023 for further authorization optimization and reduction for codes with historical low denial rates. When considering appeal activity, 6.8% of denials resulting in appeals, with a consistently low volume (1.7%) being overturned in appeal, frequently a result of new information submitted at time of appeal.

Top 10 Prior Authorization Requests Resulting in Medical Necessity Denials. Q4 medical necessity denial activity remains consistent as seen in prior quarters with genetic testing making up five of the top ten categories, though overall denial volumes remain low, with highest volume denial category reflecting a total of 28 denials. Consultation requests also noted within the top ten denial category rates, as seen in prior quarters, and a reflection of redirection opportunities within network. Overall top denial categories in Q4 are low and evenly distributed across previously seen denial categories.

Inter-rater Reliability Review-Nurses. Annual internal rate of return rates at 100% for nurses, physicians and pharmacy teams. 100% of staff in these categories who review authorization requests for medical necessity, scored 90% or higher on the MCG care guidelines Inter-rater Reliability Case Studies to ensure proper understanding and application of MCG care guidelines.

Utilization Performance Outcomes

Inpatient Utilization. Q4 totals for inpatient utilization reflect slight increases in activity comparative to Q3, with an increase in total membership by 7% from 2021. Overall readmission rates decreased in Q4 by 1% (n=11%) with an average of 12% for the year. Reduced CCS and Ambulatory care sensitive admission (ACSA) bed days noted in 2022 as compared to 2021. Average length of stay (ALOS) reduced from 5.1 noted in 2021 to an average of 4.7 in 2022. Continued readmission reduction and transition of care work and program development throughout Q4 with reductions made in both ALOS and readmissions in 2022 with a 7% increase in overall membership.

Readmissions for Medi-Cal Seniors and Seniors and Persons with Disabilities (SPD) populations decreased in Q4 to 15% from a Q2 high of 18%, while Q4 CCS admissions increased to 20%, likely a reflection of increased RSV and Covid activity. The BD/K/Y for this population came in under target goal at 1295, with overall admit/K/Y under the 2021 state average. (Of note, the Alliance uses bed-days per K/Y. The bed-days per K/Y goal was established by utilizing the historic average length of stay (ALOS) as a multiplier.)

Goal: Bedday per thousand/per year (PKPY) 292
Results: 287 PKPY

Ambulatory Care Sensitive Admission (ACSA). ACSA rates in Q4 met the goal in all three counties. Q4 reflects slight increases across the counties, with each county coming in lower than highs seen in prior quarters. Sustained metrics below the target goal suggests that members are receiving improved access for chronic illness in the county, given that ACSA are admissions for chronic conditions such as COPD, CHF and diabetes that aren't managed well in the outpatient arena.

Goal: Dashboard target goal is 8.0
Results: Santa Cruz: 5.3%, Monterey 6.2% and Merced 6.6%.

Readmissions. The target goal was achieved in Q4, with overall readmission rates noted at 11%, a decrease from a Q1 high of 13%. The 11% average is in line with rates seen in 2021, and when assessed by county, rates of 12% are noted in Merced, with Santa Cruz totals at 10.98% and Monterey at 10.71%. Higher readmission rates are noted in the over 55 age groups, with 2022 readmission rates consistently over 15% for Merced County in this category.

Continued collaboration with hospitals with prioritization of post discharge care is in flight. Monitoring for early discharge with recent transition to diagnostic-related group (DRG) contracts will be evaluated as a possible factor.

Goal: Dashboard target 11%,
Results: 11%

Alternatives to Acute Inpatient Days – Skilled Nursing Facilities (SNF) and Short Term Rehabilitation (STR). There was a significant increase in the utilization of STR in Q4 2022 as compared to Q3 with an increase of 29% in STR bed days. Overall total number of STR for Q4 was stable at 258, slightly higher than Q3 (n=257) and lower than the peak seen in Q2 (n=334). While the number of members in STR remains stable, the increase in bed days is due to the increased LOS related to COVID-19 recovery resulting in longer stays. STR readmits after discharge were slightly increased in Q4, but lower than the peak noted in Q1 (n=53 vs 72).

UM/CR is closely monitoring LOS to ensure ELOS are medically necessary and have returned to face-to-face meeting in the facilities to monitor LOS more closely. UM/CR has additionally implemented an IDT process to identify and provide resources to SNF members discharged who are readmitted within 30 days. Examples of transition of care strategies include utilizing Recuperative Care Programs, Medically Tailored Meals, as well as other Community Supports, Enhanced and Complex Case management and Care Coordination resources.

Long Term Care (LTC). Number of Q4 2022 new admissions to LTC increased significantly over Q3 by 25%. Total number of Medi/Medi stable in Q4 and continues to comprise 84% of the LTC population. Overall total numbers of CCAH members in LTC reduced in Q4 to 179, down from a total of 261 noted in Q3.

New admissions to LTC increased significantly in Q4 2022, most likely due to the resolution of the current Covid surge that closed facilities to new admissions.

Emergency Department Utilization Metric. Q4 2022 avoidable visits increased in all three counties compared to Q3 2022 averages. Rates for the three counties reflected Q4 ranges of 18-25% avoidable visits across the three counties, with Monterey reflecting the highest increases at 25%. Total number of ED visits also increased across the three counties, with Visits/K/Y ranging from 468 (Santa Cruz) - 618 (Monterey) and variances from prior quarter ranging from 10-18%.

Increases in Q4 are nearing 2019 ED utilization rates and reflect the need for improvements in urgent and primary care access.

Pharmacy Utilization. With the Medi-Cal pharmacy carve-out of outpatient medications to DHCS and Magellan, Pharmacy Utilization now includes Physician Administered Drugs (PAD).

Medical Necessity Pharmacy Denials Per Quarter. In Q4 2022, 1,443 authorization requests for PAD were received and 129 authorizations (8.9%) were denied. It is similar to the previous quarter. Overall denial rate for 2022 was similar to 2021, when only looking at physician-administered drugs. We will continue to monitor the denial rate.

Top five physician administered drugs that result in medical necessity denial hyaluronic acid and non-preferred iron injections (ferric carboxymaltose, ferumoxytol) continue to be the top denied drugs. Outreach was performed to two providers with the highest number of hyaluronic acid denials, to educate on prior authorization criteria and required information for prior authorization review.

Out of Network (OON) Specialist Utilization Metric. OON volumes increased in Q4, with corresponding higher volume of voided/canceled submissions (n=27%), typically representative of duplicate submissions and provider withdrawals. Overall, OON denials remain low (n-2.8%), with total approvals lower than activity seen in prior quarters, a reflection of successful redirection efforts in network (n=54% vs 74%). Routine Provider Services/Utilization Management collaborative meetings are in place to monitor overall network adequacy and outreach for further network development where members are seen OON routinely and redirection to specialists in network is a challenge.

Under/Over Utilization Tracking and Reporting. Utilization monitoring of EMG screening continued in Q4 2022 with no increases noted in comparison to prior reporting periods. Monitoring of ED utilization continues as well, with work to build internal Alliance member supports to promote wellness care and further reduce ED utilization. ED and avoidable ED utilization have increased, and although trends do not indicate overutilization, overall, ED utilization has returned to 2019 levels. An opportunity to improve urgent care access is recognized to improve avoidable ED

evaluation and removal of authorization requirements for codes related to low-cost DME and supplies as well as codes with very high approval rates continued in Q4, with monitoring of utilization trends relative to 2019-2021 baseline from claims

reports for overutilization. Monitoring of newly implemented NTR codes reflects utilization patterns consistent over prior pre-pandemic quarters,

NTR codes have remained consistent throughout 2022 with utilization patterns reflecting increased membership and members' continued engagement in and access to care. Top Claim counts are also reflective of increased primary care access and wellness services. Continued monitoring of increases in nonemergency medical transportation (NEMT) access that have newly emerged in Q4 is warranted and is also reflective of increased communication of the NEMT benefit as well as a reflection of ongoing NEMT network development.

Underutilization monitoring continued in Q4 for initial health assessment, mammography, colon cancer screening, lead screening, adverse childhood experiences (ACEs) screening, and mental health visits. Underutilization parameters remain as in Q1 with opportunities in all counties to increase ACE screening, colon cancer screening IHA and lead screening. Development of additional over/under reporting is underway in Q4 to support further analysis and intervention in these areas.

Emerging Under/Over Utilization Analysis. In traditional utilization analysis, a particular service/benefit is first identified, and its utilization pattern is then monitored moving forward. The results here reflect a different analytical process that seeks to identify the ("emerging") services/benefits that are highly utilized or under-utilized over a given time period. Using this method, services/benefits can be flagged for further monitoring and assessment. As the emerging analysis continues to be developed, we expect to see trends identified there to inform future utilization monitoring. Additionally, work is in progress to more collaboratively identify and track both over- and under-utilization.

The Q4 top five average claims for codes with authorization requirements removed:

1. T1000-T5999, not valid for Medicare (487)
2. 95905-95913, Nerve Conduction Tests (295)
3. A6000-A6412, Dressings (270)
4. 94010-94799, Pulmonary Diagnostic Testing/Rehab/Therapies (191)
5. Z4300 - Z5999, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (146)

Utilization for these codes has remained consistent with baseline and data seen in Q1. Utilization rates have not fully returned to 2019 (pre pandemic) volumes.

The top five average services reflecting higher utilization rates for all claim counts in Q4 are as follows:

1. 36415 (8,558) Collection of Venous Blood by Venipuncture
2. H2019 (7,774) Therapeutic Behavioral Services, per 15 minutes
3. 99173 (5,879) Screening Test of Visual Acuity, Quantitative
4. S5102 (5,373) Day Care Services, Adult; Per Diem
5. 1160F (4,060) Review of All Medications by a Prescribing Practitioner

Utilization for these codes reflects increased population and member engagement in primary care services.

Delegate Oversight Outcomes

Behavioral Health

Delegated Oversight Quarterly Report Summary. In Q4 2022, penetration rates met or exceeded expectations for ages 0-12 and 13-18, as was the trend throughout the year. In the adult bracket of 19+, members in Santa Cruz well exceeded the 4.5% to 6.5% target with 10.55% utilization. The same adult group fell short of the minimums in Monterey with 4.31% and Merced with 3.9%. The Q4 file audit is in progress, with our delegate Carelon (formerly Beacon) having submitted data on 3/22.

Beacon UM and MedImpact UM File Audits. MedImpact was 100% in compliance. Turnaround time for five prior authorization requests were reviewed according to MedImpact criteria in a timely manner.

2023 Utilization Management Workplan Template – Summary of Changes (by section)

Projects and Initiatives.

- System Transformation Development/Community Care Coordination: Updates made to reflect ECM and CS program objectives and assessments.
- Reducing Readmissions Initiative: Updates made for assessment of transitional care activities and evaluation of overall readmission rates.

Operational Performance. No changes

Utilization Performance.

- Inpatient Utilization: Updates made to meet or exceed State admissions averages and bed-day goals.
- Emergency Utilization: Updated State averages and goals.
- Pharmacy: No changes.
- Under/Over Utilization Tracking and Reporting: Added language to description for Auto Authorization/No Tar Required (NTR) monitoring.
- Emerging Under/Over Utilization: Added field for Auto Authorization/NTR reporting.

Utilization Management Delegated Oversight.

- Updated name from Beacon to Carelon; UM file audit from 15/10 to 10/3 files

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

Attachments.

1. Utilization Management Workplan Template 2023

Central California Alliance for Health
2023 Utilization Management Work Plan and Evaluation

I. Projects and Initiatives
- A. Pediatric Case Management
- B. System Transformation Development / Community Care Coordination
- C. Reducing Readmissions Initiative

II. Operational Performance
- A. Routine Prior Authorization Turn Around Time
- B. Prior Authorization Request Determination Metrics
- C. Top 10 Prior Authorization Medical Necessity Denials
- D. Inter-Rater Reliability - Nurses/MDs/Rx

III. Utilization Performance
- A. Inpatient Utilization
- B Ambulatory Care Sensitive Admissions (ACSA)
- C Readmissions
- D Alternatives to Acute Inpatient Days
- E Long-term Care
- F Emergency Department Utilization
- G Pharmacy Utilization
- H Out-of-Network Specialist Utilization Metric
- I Under / Over Utilization Tracking and Reporting
- J. Emerging Under / Over Utilization Analysis

IV. UM Delegate Oversight
- A. UM Delegate Oversight Quarterly Report Summary-complete
- B. Medi-Cal Mental Health Utilization Rates
- C. Beacon UM File Audit

INITIAL WORK PLAN AND EVALUATION APPROVAL

Submitted and approved by UMWG Date: 5/10/2023

Submitted and approved by QIHEC Date: 5/10/2023

Submitted and approved by Board Date:

Dale Bishop, MD, Chief Medical Officer Date:

Tammy Brass, RN, Utilization Management Director Date:

FINAL EVALUATION APPROVAL:

Submitted and approved by UMWG Date:

Submitted and approved by CQIC Date:

Submitted and approved by Board Date:

Date:

Dale Bishop, MD, Chief Medical Officer Date:

Tammy Brass, RN, Utilization Management Director Date:

Back to Agenda

I. Projects and Initiatives

A. Pediatric Case Management

The Pediatric Case Management Program serves to optimize care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions. The goal of the program is to support comprehensive treatment of the whole child, including the child's full range of needs through early identification and referral for CCS eligibility and appropriate risk stratification. Data derived from DHCS WCM Tableau Report.

2023 Evaluation								
Time Period	Total # of Eligible members by County	# Newly Eligible by County	# Aged Out by County	# Approved NICU/PICU by County	# High Risk Members	# Low Risk Members	# ICPs	Comments/Recommendations
1st Quarter								
2nd Quarter								
3rd Quarter								
4th Quarter								
Year End								

B. System Transformation Development / Community Care Coordination

Execution of Enhanced Case Management (ECM) and Community Supports (CS)

2023 Evaluation					
Time Period		Objective	Contracted Providers By County: Total Numbers and Capacity	Member Enrollment Totals by County	Comments/Recommendations
1st Quarter		Support the ongoing development of contracted providers capacity to provide ECM core services, including for new populations of focus.			
2nd Quarter		Align with PS dept to support the contracting and development of new providers to be prepared to support the incoming pediatric populations and 2 new Community Supports (CS) services for 7/1/23.			
3rd Quarter		Support the ongoing development of contracted providers capacity to provide ECM core services.			
4th Quarter		Align with PS dept. to provide contracted and noncontracted potential ECM and CS providers with information about the new populations of focus for 2024. Support the expansion of the ECM/CS network to assist these new populations of focus in 2024.			
Year End					

C. Reducing Readmissions Initiative

To support reducing hospital readmissions, UM and CCC will track and evaluate the impact of Population Health Management and Transitions of Care activities as it relates to reductions in readmissions for members participating in these services.

2023 Evaluation							
Time Period	Number Interfacility IDTs	UM Transitions of Care	Merced County 30 day Readmissions	Monterey County 30 day Readmissions	Santa Cruz County 30 day Readmissions	Total 30 day Readimssion	Comments/Recommendations
1st Quarter							
2nd Quarter							
3rd Quarter							
4th Quarter							
Year End							

Back to Agenda

II. Operational Performance

A. Routine Prior Authorization Turn Around Time

Percent of routine prior authorizations completed within 5 business days (excludes extended or deferred authorizations).

2023 Evaluation				
Time Period	**Goal**	**Results**	**Assessment & Interventions**	**Recommendation for Future**
1st Quarter	**100%**			
2nd Quarter	**100%**			
3rd Quarter	**100%**			
4th Quarter	**100%**			

B. Prior Authorization Request Determination Metrics

Monitoring of prior authorization volume, volume and % of electronic submissions, and appeals.–TAT goal for Knox Keene LOB NOA's: denial letters sent within 2 business days. Auth reduction impact to be monitored through PA volume review.

2023 Evaluation						
Time Period	**#PA Volume**	**# Medical Necessity Denials**	**# Appeals**	**#Appeals Upheld**	**# Overturned**	**Assessment & Interventions**
1st Quarter						
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End						

C. Top 10 Prior Authorization Requests that result in Medical Necessity Denials

List of the top 10 prior authorization medical necessity denials, by volume.

2023 Evaluation		
Time Period	**List Denials**	**Assessment & Interventions**
1st Quarter		
2nd Quarter		
3rd Quarter		
4th Quarter		

Back to Agenda

D. Inter-rater Reliability Review – Nurses

100% of nurses (RN and LVN) staff who review authorization requests for medical necessity, will score 90% or higher on the MCG care guidelines Inter-rater Reliability Case Studies to ensure proper understanding and application of MCG care guidelines.

2023 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**			

F. Inter-rater Reliability Review – Physicians

100% of physicians will score 90% or higher on the MCG care guidelines inter-rater Reliability Case Studies to ensure proper understanding and application of Milliman Care Guidelines.

2023 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**			

G. Inter-rater Reliability Review – Pharmacists

100% of pharmacists will score 90% or higher on the MCG care guidelines inter-rater Reliability Case Studies to ensure proper understanding and application of MCG care guidelines.

2023 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**			

Back to Agenda

III. Utilization Performance

A. Inpatient Utilization

The goals per line of business and by Medi-Cal aid category groupings were developed using Alliance historical performance, and DHCS state benchmarks. Of note; the state benchmarks reflect admissions per thousand per year (K/Y), while the Alliance uses bed-days per K/Y. A weighted average was used to calculate state averages based on total Medi-Cal population groupings. The bed-days per K/Y goal was established by utilizing the historic average length of stay as a multiplier, without the weighted average. The Alliance Bed Ambulatory Care Sensitive Admissions (ACSA) and 30-day Readmissions tracked per line of business and region.

IHSS							Goal						
Time Period	2022 Admit/K/Y Reported	2023 Admit/K/Y	Admit/K/Y State Average	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance		ACSA %	Readmits %	Assessment	Interventions
1st Quarter	60		N/A				200						
2nd Quarter	69		N/A				200						
3rd Quarter	62		N/A				200						
4th Quarter	56		N/A				200						
YTD/Year End	63		N/A				200						

Medi-Cal Child and Family Aid Codes							Goal						
Time Period	2022 Admit/K/Y Reported	2023 Admit/K/Y	Admit/K/Y State Average 06/22	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	40		58				170						
2nd Quarter	44		58				170						
3rd Quarter	45		58				170						
4th Quarter	50		58				170						
YTD/Year End	45		58				170						

Medi-Cal Seniors and Persons with Disabilities Aid Codes							Goal						
Time Period	2022 Admit/K/Y Reported	2023 Admit/K/Y	Admit/K/Y State Average 06/22	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	224		418				1300						
2nd Quarter	246		418				1300						
3rd Quarter	227		418				1300						
4th Quarter	237		418				1300						
YTD/Year End	234		418				1300						

New Medicaid Expansion Members (i.e. former LIHP, as well as new M aid code and 7U/7W aid code members)							Goal						
Time Period	2022 Admit/K/Y Reported	2023 Admit/K/Y	Admit/K/Y State Average 06/22	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	71		77				375						
2nd Quarter	73		77				375						
3rd Quarter	76		77				375						
4th Quarter	72		77				375						
YTD/Year End	73		77				375						

Back to Agenda

A. Inpatient Utilization (Continued)

Total Medi-Cal Inpatient Utilization: Total Medi-Cal Inpatient Utilization goal was calculated using a weighted average of the individual bed days/thousand/year goal for each aid code/population subset (SPD, Child and Family, and Medicaid Expansion members).

							Goal					
Time Period	2022 Admit/K/Y Reported	2023 Admit/K/Y	Admit/K/Y State Average 06/22	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	57		147				290					
2nd Quarter	62		147				290					
3rd Quarter	62		147				290					
4th Quarter	65		147				290					
YTD/Year End	62		147				290					

B. Ambulatory Care Sensitive Admissions (ACSA) (%)

Ambulatory Care Sensitive Admissions (ACSA) per region.

Time Period	Santa Cruz ACSA %	Monterey ACSA %	Merced ACSA %	Assessment	Interventions
1st Quarter					
2nd Quarter					
3rd Quarter					
4th Quarter					
YTD/Year End					

C. Readmissions (%)

*30-day Readmissions per region

	Santa Cruz %					Monterey %					Merced %					
Time Period	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	Assessment & Interventions
1st Quarter																
2nd Quarter																
3rd Quarter																
4th Quarter																
YTD/Year End																

D. Alternatives to Acute Inpatient Days - Skilled Nursing Facility

Appropriate inpatient utilization involves identification of hospitalized patients that do not require an acute inpatient level of care but cannot be discharged home safely. These patients should be transferred/discharged to a facility where they can receive a lower, more appropriate level of care or determined to be at an "admin" level in the hospital as appropriate discharge is secured. STR readmissions are tracked to evaluate trends in hospital readmissions occurring after placement at the LOC.

Time Period	#SNF Beddays (Updated #)	PKPY SNF SPD (Updated #)	PKPY IPT Beddays SPD (Updated #)	Total # STR	STR Readmits After Discharge	Assessment	Interventions
1st Quarter							
2nd Quarter							
3rd Quarter							
4th Quarter							
YTD/Year End							

Back to Agenda

E. Long-term Care

New admissions are monitored for continued appropriateness of placement. Appropriate long-term care utilization involves identification of members who continue to meet Title 22 as well as members that no longer require long-term level of care.

Time Period	# of New Admissions	# of LTC	Total # of Members in LTC	Total # of Medi/Medi	Assessment	Interventions
1st Quarter						
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End						

F. Emergency Department

The ED utilization goals by Medi-Cal aid category groupings were developed using Alliance historical performance, industry benchmarks (including MCG actuarial projects) and comparison to other County Organized Health Systems (COHS) data. Performance is assessed against goals and State benchmark of DHCS reporting on ED visits/K/Y. Total ED visits and Avoidable ED visits tracked per line of business and region.

IHSS				Goal				
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average	Assessment	Interventions
1st Quarter				N/A		N/A		
2nd Quarter				N/A		N/A		
3rd Quarter				N/A		N/A		
4th Quarter				N/A		N/A		
YTD/Year End				N/A		N/A		

Medi-Cal Child and Family				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 06/22	% CCS Visits	Assessment	Interventions
1st Quarter				400		333			
2nd Quarter				400		333			
3rd Quarter				400		333			
4th Quarter				400		333			
YTD/Year End				400		333			

Back to Agenda

F. Emergency Department (Continued)

Medi-Cal Seniors and Persons with Disabilities				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 06/22	% CCS Visits	Assessment	Interventions
1st Quarter				900		975			
2nd Quarter				900		975			
3rd Quarter				900		975			
4th Quarter				900		975			
YTD/Year End				900		975			

Medicaid Expansion (i.e. former LIHP, as well as new M aid code and 7U/W aid code members)				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 06/22	% CCS Visits	Assessment	Interventions
1st Quarter				500		543			
2nd Quarter				500		543			
3rd Quarter				500		543			
4th Quarter				500		543			
YTD/Year End				500		543			

ED Visits per County								
Time Period	Santa Cruz Avoidable Visits %	Santa Cruz Total Visits/K/Y	Monterey Avoidable Visits %	Monterey Total Visits K/Y	Merced Avoidable Visits %	Merced Total Visits K/Y	Assessment	Interventions
1st Quarter							Note: weighted average goal for total Medi-Cal ED visits for 2022 (in Alliance Dashboard) is 590	
2nd Quarter								
3rd Quarter								
4th Quarter								
YTD/Year End								

Back to Agenda

G. Pharmacy

Medical Necessity Pharmacy Denials Per Quarter

Monitoring of Pharmacy prior authorization volume, appeals, and State Fair Hearings (SFH). Outcomes of the SFH included in the narrative.

Time Period	# Auth Volume	# Denials	# Appeals	# Appeals Upheld	# Overturned	#SFH	Assessment	Interventions
1st Quarter								
2nd Quarter								
3rd Quarter								
4th Quarter								
Year End								

Top 5 Physician Administered Drugs that Result in Medical Necessity Denial

List top 10 Pharmacy prior authorization medical necessity denials, by volume.

Time Period	List of drugs	Comments	Interventions
1st Quarter			
2nd Quarter			
3rd Quarter			
4th Quarter			
Year End			

Back to Agenda

H. Out of Area / Out of Network Specialist Utilization Metric

Appropriate use of network specialist and out-of-network specialist is monitored for provider and member access. Review of referral practice by county provides opportunity for improved network development. Data derived from DHCS Out Of Network Tableau Report.

Time Period	Total Auths	Approvals	Denials	Voided / Canceled	Top 5 Specialty Types by County	Assessment & Interventions
1st Quarter					Merced: Monterey: Santa Cruz:	
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End						

I. Under / Over Utilization Tracking and Reporting

Under-over utilization is closely monitored and UM investigates identified cases, develops interventions and works closely with other departments such as Program Integrity, QI and Provider Services. As authorization codes are waived as part of the Auth Reduction Project, we will monitor to assure there is no resulting inappropriate over utilization. Auto approved or no TAR required (NTR) utilization will be monitored when an increase/decrease of 30% from the previous reporting quarter is identified in the emerging analysis (see Section J).

2023 Evaluation				
Time Period	Monitored Category	Over or Under	Assessment	Interventions
1st Quarter	1.EMG 2. Auth Redesign Codes (As identified) 3. IHA 4. Breast Cancer Screening 5. Colon Cancer Screening 6. Lead Screening 7. ACE Screening 8. Mental Health Visits 9. ED Utilization	1.Over 2. Over 3. Under 4. Under 5. Under 6. Under 7. Under 8. Under 9. Over		
2nd Quarter				
3rd Quarter				
4th Quarter				

J. Emerging Under / Over Utilization Analysis

Provision of services that were not clearly indicated or provision of services that were indicated in either excessive amounts or in a higher-level setting than appropriate. True over and under results may be reported in Section I of this work plan for formal monitoring.

Time Period	Top 5 Over	Top 5 Under	Service / Benefit Type	Top 5 Auto Approved/NTR Codes	Assessment
1st Quarter	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.	
2nd Quarter					
3rd Quarter					
4th Quarter					

Back to Agenda

IV. UM Delegate Oversight

A. UM Delegate Oversight Quarterly Report (Analysis Summary)

Time Period	Delegate	Report Due Date	Reports Received	Reports Required	Follow-up Plan
Q4-22: Reported - Q1-23	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q1-23: Reported - Q2-23	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q2-23: Reported - Q3-23	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q3-23: Reported - Q4-23	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	

Back to Agenda

B. Medi-Cal Mental Health Utilization Rates

Carelon is contracted with CCAH to provide mild to moderate mental health services. Carelon supplies this data in a quarterly report that is presented in quarterly meetings with each County Behavioral Health Department. Utilization percentage rates for children and adolescents and for adults are reported by for each county managed by CCAH. Utilization rates reflect a rolling 12 month measurement ending at the Quarter. Utilization percentage is calculated by dividing the number of unique members in each age cohort within each County into the number of members that have received Carelon services from that same County and age cohort within each quarter. Utilization percentage goals were developed by Carelon and are based on best reviewing data from other states, national benchmark data, historical data on county mental health utilization, and the structure of the California delivery system. The goals are in a mature market of 3 years of operation (market maturity: lower rates are expected in new markets and higher ranges are typical for mature markets with 3-5 years of Carelon presence).

Time Period	Santa Cruz	Monterey	Merced	GOAL	Assessment	Interventions
1st Quarter						
0-12				2.5% - 4%		
13-18				2.5% - 4%		
19+				4.5% - 6.5%		
2nd Quarter						
0-12				2.5% - 4%		
13-18				2.5% - 4%		
19+				4.5% - 6.5%		
3rd Quarter						
0-12				2.5% - 4%		
13-18				2.5% - 4%		
19+				4.5% - 6.5%		
4th Quarter						
0-12				2.5% - 4%		
13-18				2.5% - 4%		
19+				4.5% - 6.5%		

C. Carelon UM File Audit

Review occurring every quarter that looks at previous quarter UM work. For review, ~~15~~ 10 files are randomly selected. If the first 3 ~~8~~ files pass, no further review is conducted. If any of the first 3 ~~8~~ fail. All 10~~15~~ files are reviewed. While 100% is expected, 90% is the juncture at which a corrective action plan would be apprised if needed. Non-compliance with any of the elements require follow up analysis and correction by the vendor. Categories for review include: timeliness of decisions and notifications, appropriate practitioner review of denials, relevant information used for decisions, appeal rights communications to member, evidence of transitional care planning.

Time Period	% Compliance	Summary of Non-Compliance	Follow-up Actions
1st Quarter			
2nd Quarter			
3rd Quarter			
4th Quarter			

Back to Agenda

D. MedImpact UM File Audit

Review occurring every quarter that looks at previous quarter UM work. For review, 5 files are randomly selected. While 100% is expected, 90% is the juncture at which a corrective action plan would be apprised if needed. Non-compliance with any of the elements require follow up analysis and correction by the vendor. Categories for review include: timeliness of decisions and notifications, appropriate practitioner review of denials, relevant information used for decisions, appeal rights communications to member, evidence of transitional care planning.

Time Period	% Compliance	Summary of Non-Compliance	Follow-up Actions
1st Quarter			
2nd Quarter			
3rd Quarter			
4th Quarter			

Line of Business	Per Month (PMPM) Cost							Change from 2021
	2021	2022 Q1	2022 Q2	2022 Q3	2022 Q3	2022 Q4	2022 YTD	
IHSS								

MedImpact Medical Necessity Pharmacy Denials Per Quarter

Monitoring of Pharmacy prior authorization volume and appeals.

Time Period	# Auth Volume	# Denials	# Appeals	# Appeals Upheld	# Overturned	Assessment
1st Quarter						
2nd Quarter						
3rd Quarter						
4th Quarter						
Year End						

Back to Agenda

Communication with
the Commissioners

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)

December 31, 2022

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Communication with the Commissioners

To the Commissioners
Santa Cruz-Monterey-Merced Managed Medical Care Commission
d.b.a. Central California Alliance for Health

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health (the "Alliance") as of and for the year ended December 31, 2022 and have issued our report thereon dated April 27, 2023. 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 Managed Medical Care Commission d.b.a. Central California Alliance for Health's internal control over financial reporting. Accordingly, we considered Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health'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.

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 Managed Medical Care Commission d.b.a. Central California Alliance for Health are described in Note 2 to the financial statements. During fiscal year 2022, the Alliance adopted GASB 87, *Leases*, under the restrospective approach, and GASB 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32* for the fiscal year 2022. 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 of the discount rate, useful lives, lease terms related to the lease assets and deferred inflow of resources. 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 Auditor'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 27, 2023.

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 Managed Medical Care Commission d.b.a. Central California Alliance for Health, 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 27, 2023

April 27, 2023

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, 2022 and 2021 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 $2,500,000 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 27, 2023.

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.

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.

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, 2022 and 2021. 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, 2022 and 2021 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, 2022 and 2021, 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, 2022 and 2021:

    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. 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, 2022 and 2021, respectively.

Memorandum:

44. 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.

45. We have reviewed and evaluated the impact of adopting GASB 87, *Leases*, as discussed in Note 1 of the financial statements. Our adoption of GASB 87 encompasses all arrangements that meet the definition of leases under GASB 87.

46. 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
F24301267686423

Lisa Ba, CFO

DocuSigned by:
8413AE9CEC4C43E...

Jimmy Ho, Director of Accounting


MOSSADAMS

Report of Independent Auditors and
Financial Statements with Supplementary Information

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)

December 31, 2022 and 2021

MOSSADAMS

Table of Contents

Management's Discussion and Analysis

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Management's Discussion and Analysis
Years Ended December 31, 2022, 2021, and 2020

The intent of the management's discussion and analysis of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health (the Alliance) is to provide readers with an overview of the Alliance's financial activities for the fiscal years ended December 31, 2022, 2021, and 2020. 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 2022, 2021, and 2020:

Key operating indicators	Fiscal years ended December 31 2022	2021	2020	2022-2021 Change	2021-2020 Change
Members (at end of fiscal period):					
Medi-Cal program	415,668	386,535	364,613	29,133	21,922
IHSS program	654	517	540	137	(23)
Average member months:					
Medi-Cal program	403,315	377,585	349,674	25,730	27,911
IHSS program	623	514	568	109	(54)
Total revenues (in millions)	$ 1,710.7	$ 1,732.7	$ 1,474.6	$ (22.0)	$ 258.1
Capitation revenue (in millions)	$ 1,721.5	$ 1,733.1	$ 1,467.6	$ (11.6)	$ 265.5
Investment and other income (in millions)	$ (10.8)	$ (0.4)	$ 7.0	$ (10.4)	$ (7.4)
Operating expenses (in millions):					
Medical expenses (in millions)	$ 1,358.9	$ 1,360.9	$ 1,222.0	$ (2.0)	$ 138.9
Administrative expenses (in millions)	$ 257.0	$ 243.6	$ 224.5	$ 13.4	$ 19.1
Increase (decrease) in net assets (in millions):	$ 83.9	$ 118.2	$ 13.8	$ (34.3)	$ 104.4
Total revenues per member per month	$ 352.9	$ 381.9	$ 350.9	$ (29.0)	$ 31.0
Operating expenses per member per month:					
Medical expenses per member per month	$ 280.3	$ 299.9	$ 290.8	$ (19.6)	$ 9.2
Administrative expenses per member per month	$ 53.0	$ 53.7	$ 53.4	$ (0.7)	$ 0.3
Increase (decrease) in net assets per member per month	$ 17.3	$ 26.1	$ 3.3	$ (8.7)	$ 22.8
Medical loss ratio	78.9 %	78.5 %	83.3 %	0.40 %	(4.80) %
Administrative expense ratio	15.0 %	14.1 %	15.2 %	0.90 %	(1.10) %
Administrative expense ratio (excluding premium tax)	4.8 %	4.9 %	5.6 %	(0.10) %	(0.70) %

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, 2022 and 2021. The basic financial statements of the Alliance, including the statements of net position, statements of revenues, expenses, and changes in net position; statements of cash flows, represent the combined accounts and transactions of the two programs – Medi-Cal and 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 addresses the Alliance's overall program activities. The Medi-Cal program accounted for approximately 99.8% of the Alliance's annual revenues during fiscal years 2022, 2021, and 2020.

Financial Highlights Fiscal Year 2022

- Total assets at year-end were $1,045.0 million and exceeded liabilities by $666.7 million.
- Net position increased by $83.9 million or 14.4% during fiscal year 2022.

Financial Highlights Fiscal Year 2021

- Total assets at year-end were $983.8 million and exceeded liabilities by $582.8 million.
- Net position increased by $118.2 million or 25.4% during fiscal year 2021.

Condensed Statements of Net Position as of December 31 (dollars in thousands) are as follows:

Financial position	As of December 31			2022-2021 Change		2021-2020 Change	
	2022	2021 (As restated)	2020	Amount	Percentage	Amount	Percentage
Assets:							
Current assets	$ 618,962	$ 546,201	$ 451,649	$ 72,761	13.3 %	$ 94,552	20.9 %
Capital assets, net	39,544	42,236	49,929	(2,692)	(6.4)	(7,693)	(15.4)
Board-designated investments and restricted deposit	384,662	394,098	331,862	(9,436)	(2.4)	62,236	18.8
Lease receivable - noncurrent	1,792	1,277	-	515	40.3	1,277	-
Total assets	$ 1,044,960	$ 983,812	$ 833,440	$ 61,148	6.2 %	$ 150,372	18.0 %
Liabilities:							
Current liabilities	$ 375,796	$ 399,006	$ 368,850	(23,210)	(5.8) %	$ 30,156	8.2 %
Deferred inflow of resources	2,437	2,013	-	424	21.1	2,013	-
Total liabilities and deferred inflow of resources	378,233	401,019	368,850	(22,786)	(5.7)	32,169	8.7 %
Net position:							
Invested in capital assets	39,544	42,236	49,929	(2,692)	(6.4) %	(7,693)	(15.4) %
Restricted	300	300	300	-	-	-	-
Unrestricted	626,883	540,257	414,361	86,626	16.0	125,896	30.4
Total net position	666,727	582,793	464,590	83,934	14.4 %	118,203	25.4 %
Total liabilities and net position	$ 1,044,960	$ 983,812	$ 833,440	$ 61,148	6.2 %	$ 150,372	18.0 %

Capital Assets Fiscal Year 2022

Capital assets, net decreased from $42.2 million to $39.5 million, or by $2.7 million, in 2022 compared to the previous year. This decrease is mainly the net result of $0.6 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 additions and in furniture and equipment.

Capital Assets Fiscal Year 2021

Capital assets, net decreased from $49.9 million to $42.2 million, or by $7.7 million, in 2021 compared to the previous year. This decrease is the net result of $5.5 million in capital additions, $7.4 million in disposals, and $5.8 million in depreciation expense. Capital additions included $4.3 million in construction in process, which was subsequently transferred and reflected in building additions and in furniture and equipment.

Liquidity Fiscal Year 2022

At December 31, 2022, the Alliance maintained a working capital ratio, including board-designated investments, of 2.67. The increase of $86.5 million in working capital in 2022 compared to the prior year is primarily due to the change in net position.

During 2022, board-designated investments decreased by $9.4 million from the prior year. The decrease is due to a slight decrease in revenues and non-capitated revenues are excluded from board-designated reserve calculation.

Liquidity Fiscal Year 2021

At December 31, 2021, the Alliance maintained a working capital ratio, including board-designated investments, of 2.36. The increase of $126.6 million in working capital in 2021 compared to the prior year is primarily due to the change in net position.

During 2021, board-designated investments increased by $62.2 million from the prior year. The increase is due to improved revenues in 2021.

Leases

During the fiscal year ended December 31, 2022, the Alliance retrospectively adopted Governmental Accounting Standards Board ("GASB") Statement No. 87, *Leases*. The Alliance as a lessor, recognized a deferred inflow of resources corresponding to the lease receivable amount, and it is defined as an acquisition of net position by the Alliance that is applicable to future reporting periods. Deferred inflow of resources balance were $2.4 million and $2.0 million as of December 31, 2022 and 2021, respectively. The impact to beginning net position was not significant. See Note 8 in the notes to the financial statement.

Results of Operations

The Alliance's fiscal year 2022 operations resulted in a $83.9 million increase in net position compared to a $118.2 million increase in net position in fiscal year 2021. The Alliance's fiscal year 2020 operations resulted in a $13.8 million increase in net position.

The following table shows revenues, expenses, and changes in net position for the three most recent years:

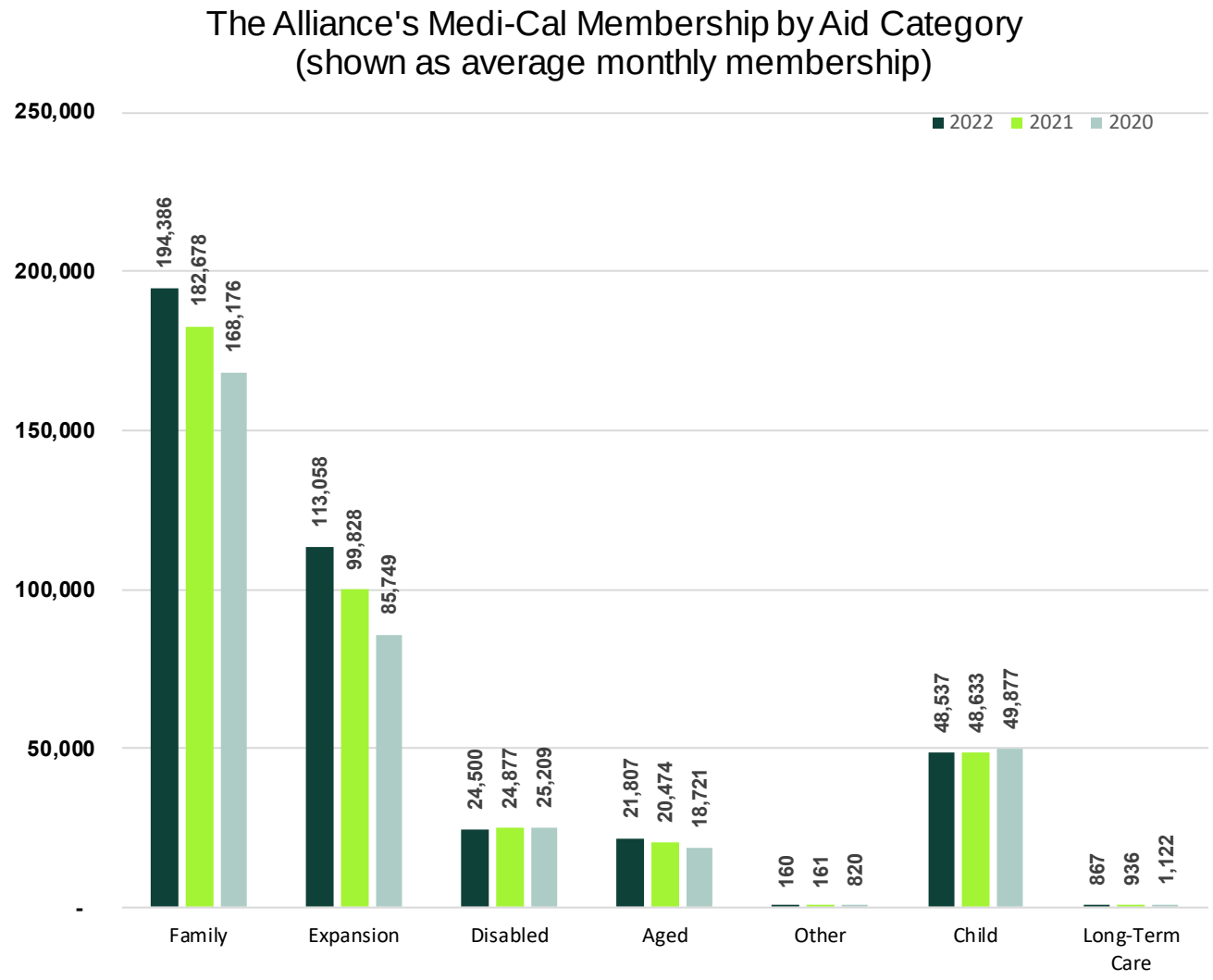
Condensed revenues, expenses, and changes in net position for the years ended (in thousands):

Results of operations	2022	2021	2020	2022-2021 Change Amount	2022-2021 Change Percentage	2021-2020 Change Amount	2021-2020 Change Percentage
Capitation revenue, investment (loss) income, including net realized and unrealized gains and losses, and other income	$ 1,710,652	$ 1,732,733	$ 1,474,585	$ (22,081)	(1.3) %	$ 258,148	17.5 %
Expenses:							
Total medical expenses	1,358,877	1,360,894	1,222,017	(2,017)	(0.1)	138,877	11.4
Total administrative expenses	257,007	243,570	224,508	13,437	5.5	19,062	8.5
Grants	10,834	10,066	14,245	768	7.6	(4,179)	(29.3)
Total expenses	1,626,718	1,614,530	1,460,770	12,188	0.8	153,760	10.5
Increase (decrease) in net position	83,934	118,203	13,815	(34,269)	(29.0)	104,388	755.6
Total net position, beginning of year	582,793	464,590	450,775	118,203	25.4	13,815	3.1
Total net position, end of year	$ 666,727	$ 582,793	$ 464,590	$ 83,934	14.4 %	$ 118,203	25.4 %

Enrollment

During fiscal 2022, the Alliance served an average of 403,940 members per month compared to an average of 377,585 members per month in 2021. This increase in membership is primarily due to the continuation of the Public Health Emergency (PHE) declaration, which temporarily freezes the eligibility redetermination process. Under the Governor's orders, Counties cannot reduce or terminate Medi-Cal benefits during PHE. During fiscal 2021, the Alliance served an average of 377,585 members per month compared to an average of 349,674 members per month in 2020. 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 2022, 2021, and 2020:



Operating Revenues Fiscal Year 2022

Revenues in 2022 slightly decreased over 2021. Even though revenue increased due to Medi-Cal membership growth as well as increased capitation rates from the Department of Health Care Services ("DHCS"), the increase was offset against the reduction in revenue due to pharmacy carve out.

Operating Revenues Fiscal Year 2021

Revenues in 2021 increased over 2020 mostly due to increased Medi-Cal capitation rates from the Department of Health Care Services (DHCS). Membership also increased in 2021 over 2020.

Medical Expenses Fiscal Year 2022

Overall, medical expenses decreased by 0.1% in 2022, totaling $1,358.9 million compared to $1,360.9 million in 2021. The Alliance's medical expenses, as a percentage of capitation revenues, was 78.9% in fiscal year 2022, compared to 78.5% in fiscal year 2021. The Alliance's average medical costs per member per month decreased by 6.5% in 2022. Medical expenses include the following:

- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $43.3 million in 2022 compared to $38.6 million in 2021. The increased cost is attributable to a small increase in membership.
- Hospital inpatient and long-term care expenses increased by $115.9 million, or 20.3%, in 2022. The increased cost of care is due to increased membership.
- Expenses related to physicians, outpatient facilities, and allied health providers increased by $66.0 million, or 13.5%, in 2022. Most of the increase is due to increased rates paid to providers. Increased membership also contributed to the increase in expenses.
- Other medical increased by $17.5 million or 55% in 2022 primarily due to the new CalAIM Incentive program of $10 million. In addition, higher utilization in lab and behavioral health services contributed the year over year increase.
- Prescription drugs expenses decreased by $206.7 million or 93.1% during 2022. The decrease was due to the prescription drug services carve out and transfer to State Pharmacy Rx program. The remaining $15.3 million is related to Physician Admin Drugs, which is not part of the pharmacy carve out to the State.
- Alliance Care IHSS program expenses increased by $1.1 million. The increase was due to an increase in membership.
- Net reinsurance expense decreased by $674 thousand compared to 2021 due to a decrease in recoveries as well as an increase in premiums.

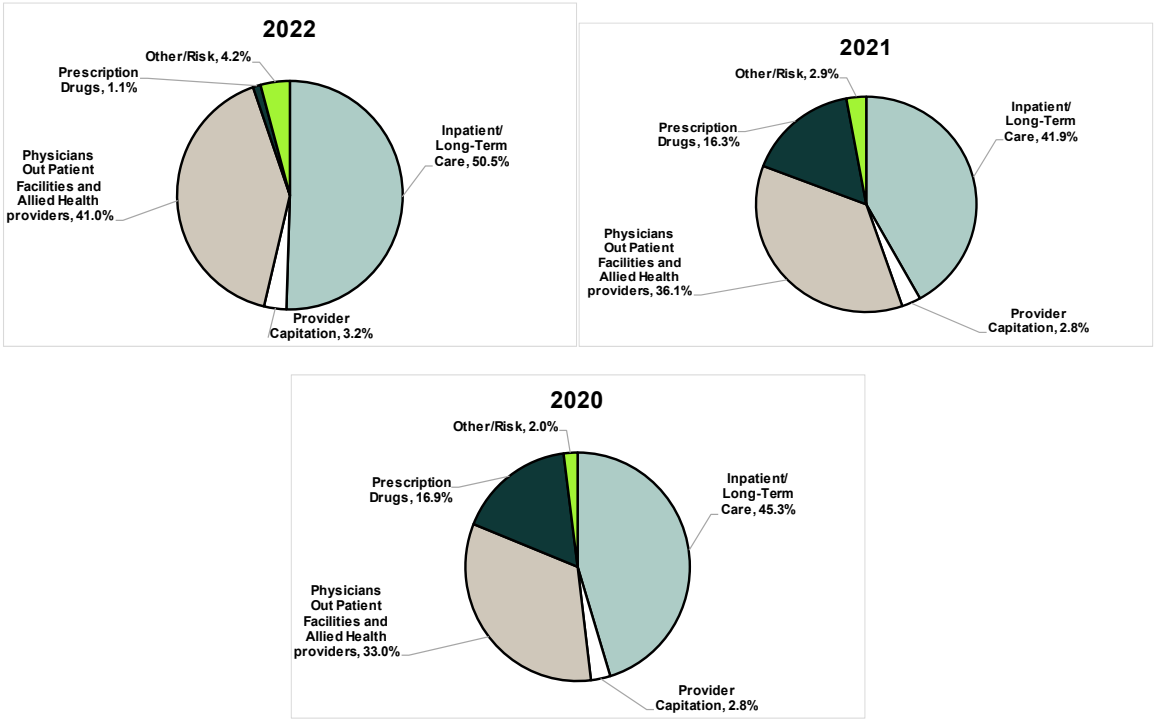
Medical Expenses Fiscal Year 2021

Overall, medical expenses increased by 11.4% in 2021, totaling $1,360.9 million compared to $1,222.0 million in 2020. The Alliance's medical expenses, as a percentage of capitation revenues, was 78.5% in fiscal year 2021, compared to 83.3% in 2020. The Alliance's average medical costs per member per month increased by 3.2% in 2021. Medical expenses include the following:

- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $38.6 million in 2021 compared to $35.0 million in 2020. The increased cost is attributable to a small increase in membership.
- Hospital inpatient and long-term care expenses increased by $21.0 million, or 3.8% in 2021. The increased cost of care is due to increased membership.
- Expenses related to physicians, outpatient facilities, and allied health providers increased by $86.3 million, or 21.3%, in 2021. Most of the increase is due to increased rates paid to providers. Increased membership also contributed to the increase in expenses.
- Other medical decreased by $7.1 million or 28.7% in 2021 primarily due to increased allocation of salaries to medical as well as expenses related to COVID vaccination member incentive expenses.

- Prescription drugs expenses increased by $13.2 million or 6.3% during 2021. The increase was due to increased prescription drug pricing.
- Alliance Care IHSS program expenses decreased by $400 thousand. The decrease was due to a decrease in membership.
- Net reinsurance expense increased by $8.0 million compared to 2020 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 2022, 2021, and 2020:



Administrative Expenses Fiscal Year 2022

Total administrative expenses were $257.0 million in 2022 compared to $243.6 million in 2021, for a net increase of $13.4 million or 5.52%. This increase is primarily due to an increase of $16.6 million in premium taxes in 2022. Premium taxes were $174.6 million in 2022, compared to $157.9 million in 2021. Supplies, occupancy, insurance and other decreased $5.3 million or 32.9%, compared to $16.1 million in 2021. In 2022, salaries and benefits expenses were $56.3 million, an increase of $5.3 million compared to 2021.

Overall, professional fees, purchased services and depreciation decreased $3.2 million or 17.4% in 2022. Purchased services expenses, behavioral health fees, and consulting costs were up in 2022, offset by reductions in pharmacy benefit management fees, depreciation, and supplies expenses.

Administrative Expenses Fiscal Year 2021

Total administrative expenses were $243.6 million in 2021 compared to $224.5 million in 2020, for a net increase of $19.1 million or 8.5%. This increase is primarily due to an increase of $16.6 million in premium taxes in 2021. Premium taxes were $157.9 million in 2021, compared to $141.3 million in 2020. Supplies, occupancy, insurance and other increased $6.9 million or 74.2%, compared to $9.2 million in 2020. In 2021, the Alliance recognized $7.4 million from loss on disposal of capital assets. Offsetting these increases, salaries and benefits expenses were $51.0 million, a decrease of $4.6 million compared to 2020. Salary expense increased in 2021 due to an increase in salary expenses attributable to medical costs.

Overall, professional fees, purchased services and depreciation increased $0.2 million or 1.2% in 2021. Pharmacy benefit management fees, behavioral health fees and consulting costs were up in 2021, offset by reductions in depreciation and purchased services expenses.

Economic Factors

The Public Health Emergency (PHE) that was declared by Health and Human Services back in 2020 continued to get extended throughout 2022. Additionally, effective May 1, 2022, the State extended eligibility to adults ages 50 and above, regardless of immigration status. As a result, the Alliance experienced an increase in revenue due to the enrollment increase of 7.5% compared to the prior year. The increase in revenue from membership growth was offset by the Pharmacy carve-out, which the State assumes coverage for all Medi-Cal members. The utilization was suppressed in 2020 but recovered gradually in 2021 and returned to the pre-pandemic level by December 2022. However, the increased enrollment diluted the costs at per member level. As the PHE comes to an end and the redetermine resumes, the Alliance expects a decrease in enrollment and an increase in per member cost in 2023.

In 2022, the Alliance implemented Enhanced Care Management (ECM) and Community Supports (CS). These programs are part of the State's California Advancing and Innovating Medi-Cal (CalAIM) initiatives. CalAIM is a multi-year plan to transform California's Medi-Cal programs to integrate more seamlessly with other social services with the goal of improving outcomes for Medi-Cal members. Some of the additional services will provide additional revenues as well as costs to the Alliance.

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):

	2022	2021	2020
TOTAL ASSETS	$ 46,796	$ 52,893	$ 36,117
TOTAL LIABILITIES	-	-	-
TOTAL FIDUCIARY NET POSITION	$ 46,796	$ 52,893	$ 36,117
TOTAL ADDITIONS, NET	$ (2,684)	$ 11,206	$ 9,953
TOTAL DEDUCTIONS	3,413	1,469	1,788
(DECREASE) INCREASE IN FIDUCIARY NET POSITION	(6,097)	9,737	8,165
FIDUCIARY NET POSITION - BEGINNING OF YEAR	52,893	43,156	27,952
FIDUCIARY NET POSITION - END OF YEAR	$ 46,796	$ 52,893	$ 36,117

Total fiduciary fund net position as of December 31, 2022, decreased by $6.0 million from December 31, 2021 due to a decrease in fair value of investments and contributions. Total fiduciary fund net position as of December 31, 2021, increased by $9.7 million from December 31, 2020 due to an increase in fair value of investments and contributions.

MOSSADAMS

Report of Independent Auditors

The Commissioners
Santa Cruz-Monterey-Merced Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)

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 Managed Medical Care Commission d.b.a. Central California Alliance for Health, as of and for the years ended December 31, 2022 and 2021, and the related notes to the financial statements, which collectively comprise Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health'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 Managed Medical Care Commission d.b.a. Central California Alliance for Health as of December 31, 2022 and 2021, 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 Managed Medical Care Commission d.b.a. Central California Alliance for Health 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 Managed Medical Care Commission d.b.a. Central California Alliance for Health'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 Managed Medical Care Commission d.b.a. Central California Alliance for Health'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 Managed Medical Care Commission d.b.a. Central California Alliance for Health'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.

Emphasis of Matter – New Accounting Standard

As discussed in Note 1 to the financial statements, Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health's adopted Government Accounting Standards Board No. 87, *Leases*, as of January 1, 2021. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 9 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 Managed Medical Care Commission d.b.a. Central California Alliance for Health's basic financial statements. The supplementary schedules of revenues and expenses by program and changes in net position for the years ended December 2022 and 2021, on pages 38 and 39 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 is 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, 2022 and 2021, are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Moss Adams LLP

San Francisco, California
April 27, 2023

Financial Statements

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Net Position
December 31, 2022 and 2021
(in thousands)

	2022	2021 (As restated)
Assets		
Current assets		
Cash and cash equivalents	$ 13,085	$ 2,313
Short-term investments	416,886	279,301
Capitation receivable from the Department of Health Care Services (DHCS)	168,097	242,183
Prepaid expenses and other assets	20,147	21,668
Lease receivable - current	747	736
Total current assets	618,962	546,201
Capital assets, net		
Nondepreciable	8,076	7,778
Depreciable, net of accumulated depreciation	31,468	34,458
Capital assets, net	39,544	42,236
Lease receivable - noncurrent	1,792	1,277
Board-designated investments	384,362	393,798
Restricted deposits	300	300
Total assets	$ 1,044,960	$ 983,812
Liabilities, Deferred Inflow of Resources, and Net Position		
Current liabilities		
Medical claims liability	$ 282,211	$ 226,063
Directed payments payable	157	110,988
Provider incentives payable	10,000	10,000
Accounts payable	3,415	3,032
Accrued liabilities	80,013	48,923
Total current liabilities	375,796	399,006
Deferred inflow of resources	2,437	2,013
Net position		
Invested in capital assets	39,544	42,236
Restricted	300	300
Unrestricted	626,883	540,257
Total net position	666,727	582,793
Total liabilities, deferred inflow of resources, and net position	$ 1,044,960	$ 983,812

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2022 and 2021
(in thousands)

	2022	2021
Operating revenues		
Capitation revenue	$ 1,721,476	$ 1,733,131
Operating expenses		
Medical expenses		
Medi-Cal		
Provider capitation	43,308	38,600
Claim payments to providers	1,242,624	1,060,662
Prescription drugs	15,286	221,921
Other medical	49,164	31,701
Alliance Care: In Home Supportive Services (IHSS) program	3,711	2,552
Reinsurance and other, net of (recoveries) expense	4,784	5,458
Total medical expenses	1,358,877	1,360,894
Administrative expenses		
Premium tax expense	174,563	157,938
Salaries, wages, and employee benefits	56,342	51,007
Supplies, occupancy, insurance, and other	10,786	16,083
Professional fees	3,491	2,047
Depreciation and amortization	3,333	5,759
Purchased services	8,492	10,736
Total administrative expenses	257,007	243,570
Total operating expenses	1,615,884	1,604,464
Operating income	105,592	128,667
Investment (loss) income, including net realized and unrealized gains and losses	(12,565)	(1,782)
Other income	1,741	1,384
Grants	(10,834)	(10,066)
Increase in net position	83,934	118,203
Net position, beginning of year	582,793	464,590
Net position, end of year	$ 666,727	$ 582,793

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Cash Flows
Years Ended December 31, 2022 and 2021
(in thousands)

	2022	2021
Cash flows from operating activities:		
Capitation and other revenue	$ 2,043,723	$ 2,141,313
Payments to providers	(1,643,770)	(1,721,600)
Payments to vendors	(180,474)	(188,916)
Payments to employees	(55,932)	(51,208)
Net cash provided by operating activities	163,547	179,589
Cash flows from capital and related financing activities:		
Purchases of capital assets	(641)	(5,497)
Net cash used in capital and related financing activities	(641)	(5,497)
Cash flows from noncapital financing activities:		
Grants	(10,834)	(10,066)
Net cash used in noncapital financing activities	(10,834)	(10,066)
Cash flows from investing activities:		
Purchases of investments	(266,018)	(377,033)
Sales of investments	137,869	205,918
Cash received from investment income	(13,151)	(1,770)
Net cash used in investing activities	(141,300)	(172,885)
Net change in cash and cash equivalents	10,772	(8,859)
Cash and cash equivalents, beginning of year	2,313	11,172
Cash and cash equivalents, end of year	$ 13,085	$ 2,313
Reconciliation of increase in net position to net cash provided by operating activities:		
Increase in net position	$ 83,934	$ 118,203
Adjustments to reconcile decrease in net position to net cash provided by operating activities:		
Depreciation and amortization	3,333	5,759
Investment income	12,565	1,782
Loss on disposal of capital assets	-	7,431
Grants	10,834	10,066
Changes in assets and liabilities:		
Capitation receivable from the DHCS	74,086	2,176
Prepaid expenses and other assets	2,004	4,017
Medical claims liability	61,194	37,649
Directed payments payable	(110,831)	(11,414)
Provider incentives payable	-	(10)
Accounts payable	384	(89)
Accrued liabilities	26,044	4,019
Net cash provided by operating activities	$ 163,547	$ 179,589

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Fiduciary Net Position
December 31, 2022 and 2021
(in thousands)

	2022	2021
ASSETS		
Investments, at fair value		
Stable value/cash management	$ 6,339	$ 5,861
Bond	1,577	2,444
Guaranteed lifetime income	335	310
Balanced/asset allocation	28,197	31,422
U.S. stock	6,480	8,517
International/global stock	1,275	1,626
Specialty	1,252	1,567
Total investments, at fair value	45,455	51,747
Receivables		
Notes receivable from participants	1,341	1,146
Total receivables	1,341	1,146
NET POSITION AVAILABLE FOR BENEFITS	$ 46,796	$ 52,893

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2022 and 2021
(in thousands)

	2022	2021
Additions to net position attributed to Investment income		
Net (depreciation) appreciation in fair value of investments	$ (7,653)	$ 6,010
Total investment (loss) income	(7,653)	6,010
Interest income on notes receivable from participants	46	46
Contributions		
Employer and employee contributions	4,787	4,646
Rollover contributions	136	504
Total contributions	4,923	5,150
Total additions, net	(2,684)	11,206
Deductions from net position attributed to		
Benefits paid to participants	3,647	1,504
Miscellaneous credits	(234)	(35)
Total deductions	3,413	1,469
(Decrease) increase in net position	(6,097)	9,737
Net position available for benefits		
Beginning of year	52,893	43,156
End of year	$ 46,796	$ 52,893

See accompanying notes.

Note 1 – Organization

The Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health (the Alliance) is a Regional County Organized Health System serving Medi-Cal eligible persons in Santa Cruz, Monterey, and Merced Counties, 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.

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, 2022.

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, 2022 and 2021.

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 21-member Santa Cruz-Monterey-Merced-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 U.S. generally accepted accounting principles 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 Statement No. 72), effective January 1, 2016. GASB Statement No. 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 Statement No. 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 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 to 15 years
Furniture and equipment	3 to 5 years
Software	3 to 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 another 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.

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, 2022 and 2021, the Alliance had accumulated board-designated investments of $384.4 million and $393.8 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:

	2022	2021
Proposition ("Prop") 56 liability	$ 62,961	$ 47,245
Other program payable	19,752	10,221
Medical claims liability	199,498	168,597
	$ 282,211	$ 226,063

Other program payable – In 2022 and 2021, 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 2022, $27 million in revenue and $21 million in incentive expense was recognized. In 2021, $1.6 million in revenue and $1.8 million in expenses was recognized.

Directed payments payable – Included in directed payments payable in the statement of net position are payables related to the Intergovernmental Transfer (“IGT”) program for Medi-Cal managed care capitation rates and the capitation rate ranges Hospital Qualify Assurance Fee (“HQAF”) payable pursuant to Senate Bill 239 and Proposition 52, as well as Directed Payments comprising of 1) Private Hospital Directed Payment (PHDP); 2) Designated Public Hospital Enhanced Payment Program (EPP-FFS and EPP-CAP); and 3) Designated Public Hospital Quality Incentive Pool (QIP). (1). During the year ended December 31, 2022, approximately $110.8 million of these payables were paid out.

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 2022, the Board allocated $10.0 million to the PCP Medi-Cal Program CBI incentive budget. For 2021, the Board allocated $10.0 million to the PCP Medi-Cal Program CBI incentive budget. During the years ended December 31, 2022 and 2021, respectively, $10.0 million and $10.0 million were paid out. Accrued annual incentive program as of December 31, 2022 and 2021 is $10.0 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:

	2022	2021
Managed Care Organization ("MCO") tax liability	$ 67,180	$ 41,563
Other accrued liabilities	7,787	7,360
Enhanced Care Management ("ECM") risk corridor reserves	5,046	-
	$ 80,013	$ 48,923

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 Managed Care Organization 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 Managed Care Organization (MCO) tax, effectively renewing the program effective January 1, 2020. The premium tax expense totaled $174.6 million and $157.9 million for the years ended December 31, 2022 and 2021, respectively.

ECM risk corridor reserve – Effective January 1, 2022, California launched a multi-year initiative called California Advancing and Innovating Medi-Cal (CalAIM) to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program, and payment reforms across the Medi-Cal program. CalAIM initiatives include the delivery of new Enhanced Care Management (ECM) benefits. DHCS has implemented two-sided risk corridors on ECM services as of January 1, 2022, under which managed care plans are fully at risk for losses up to 95% and gains over 105% on applicable ECM services. Managed care plans will owe a remittance to the State or be owed a payment from the State if gains or losses exceed 5 percent of the applicable ECM rates received. The CalAIM risk corridor reflects the potential amount due to the State for ECM gains in excess of the 105% risk corridor. During the year ended December 31, 2022, the reduction of capitation revenue related to ECM risk corridors was $5.0 million.

Medi-Cal Expansion (MCE) medical loss ratio (MLR) reserve – Effective with the enrollment of the Adult Expansion Population per the Affordable Care Act on January 1, 2014, the Alliance is subject to DHCS requirements to meet a minimum of 85% medical loss ratio for this population. Specifically, the Alliance will be required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by DHCS. In the event the Alliance expends less than the 85% requirement, the Alliance will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. Conversely, if the MLR is over 95 percent, the state reimburses the MCP the portion of the medical expenses in excess of the 95 percent limit. The contract periods subject to reserve are for January 1, 2014 to June 30, 2015; July 1, 2015 through June 30, 2016; July 2016 through June 30, 2017; and July 2017 through June 30, 2018. Based on final determination letters received from the State in 2020, as of December 31, 2022 and 2021, the Alliance is owed approximately $9.1 million by the State, relating to reporting period July 1, 2017 – June 30, 2018, as included in prepaid expenses and other assets in the statements of net position.

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, 2022 and 2021.

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 are 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 In Home Supportive Services 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 health-care 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, 2022 and 2021, a total of $10.8 million and $10.1 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 2022 and $350,000 for 2021) 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 $11.3 million and $10.3 million are included in reinsurance and other expense in 2022 and 2021, respectively. In 2022 and 2021, there is a total of $6.5 million and $4.8 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 2017, the GASB issued Statement No. 87, *Leases* ("GASB Statement No. 87"), which is effective for financial statements for periods beginning after December 15, 2019. GASB Statement No. 87 is meant to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. GASB Statement No. 87 increases the usefulness of governments' financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB Statement No. 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. Under GASB Statement No. 87, a lessee is required to recognize a lease liability and an intangible right-to-use lease asset, and a lessor is required to recognize a lease receivable and a deferred inflow of resources, thereby enhancing the relevance and consistency of information about governments' leasing activities. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance* ("GASB 95"), which extends the effective date of GASB Statement No. 87 to fiscal years beginning after June 15, 2021, and all reporting periods thereafter. The Alliance adopted GASB Statement No. 87 as of January 1, 2022 and retrospectively applied it to January 1, 2021. The Alliance evaluated contracts that were formerly accounted for as operating leases to determine whether they meet the definition of a lease as defined in GASB Statement No. 87. As lessor, the Alliance's adoption of GASB Statement No. 87 resulted in recognition of lease receivable and deferred inflow of $2.0 million as of December 31, 2021. The impact to beginning net position was not significant. See Note 8. The Alliance recognized a lease receivable of $2.5 million and deferred inflow of resources of $2.4 million as of December 31, 2022.

In June 2020, the GASB issued Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans – an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32* ('GASB Statement No. 97'). GASB Statement No. 97 amends the criteria for reporting governmental fiduciary component units – separate legal entities included in a government's financial statements. GASB Statement No. 97 clarifies rules related to reporting of fiduciary activities under Statements No. 14 and No. 84 for defined contribution plans and to enhance the relevance, consistency, and comparability of the accounting and financial reporting of IRC Code section 457 plans that meet the definition of a pension plan. The Alliance adopted GASB Statement No. 97 for the fiscal year ending 2022. The adoption had no 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, 2022 and 2021, consist of the following (in thousands):

	2022	2021
Cash and cash equivalents	$ 13,085	$ 2,313
Short-term investments	416,886	279,301
Restricted deposits	300	300
Board-designated investments, at fair value	384,362	393,798
Total cash, cash equivalents, and investments	$ 814,633	$ 675,712

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.

	2022		2021	
	Carrying Amount	Bank Balance	Carrying Amount	Bank Balance
Insured	$ 450	$ 450	$ 450	$ 450
Collateralized	12,935	14,809	2,163	4,623
Total cash and restricted deposits (in thousands)	$ 13,385	$ 15,259	$ 2,613	$ 5,073

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 Statement No. 72, fair value hierarchy disclosure is not required for these external pooled investments.

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):

	2022				
Investment type	Total	Investment Exempt from Fair Value	Level 1	Level 2	Level 3
Corporate bonds	$ 109,866	$ -	$ 109,866	$ -	$ -
State & local agency bonds	33,865	-	33,865	-	-
U.S. agency bonds	18,200	-	18,200	-	-
Money market funds	135,715	135,715	-	-	-
	297,646	$ 135,715	$ 161,931	$ -	$ -
External Investment Pool					
LAIF	74,975				
CalTrust	428,627				
	$ 801,248				

	2021				
Investment type	Total	Investment Exempt from Fair Value	Level 1	Level 2	Level 3
Corporate bonds	$ 74,322	$ -	$ 74,322	$ -	$ -
State & local agency bonds	6,158	-	6,158	-	-
U.S. agency bonds	15,311	-	15,311	-	-
Money market funds	166,756	166,756	-	-	-
	262,547	$ 166,756	$ 95,791	$ -	$ -
External Investment Pool					
LAIF	74,095				
CalTrust	336,457				
	$ 673,099				

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, 2022, 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	$ 109,866	$ -	$ 109,866
State and local agency bonds	33,865	-	33,865
U.S. agency bonds	18,200	-	18,200
Money market funds	135,715	135,715	-
CalTrust	428,627	428,627	-
LAIF	74,975	74,975	-
	$ 801,248	$ 639,317	$ 161,931

As of December 31, 2021, 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	$ 74,322	$ -	$ 74,322
State and local agency bonds	6,158	-	6,158
U.S. agency bonds	15,311	-	15,311
Money market funds	166,756	166,756	-
CalTrust	336,457	336,457	-
LAIF	74,095	74,095	-
	$ 673,099	$ 577,308	$ 95,791

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).

As of December 31, 2022, 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+
Money market fund	$ 135,715	$ 135,715	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	109,866	-	5,483	11,061	39,232	-	29,050	22,109	973	1,958
F.F.C.B.	2,134	-	-	2,134	-	-	-	-	-	-
Federated Government Obligations Fund	1,870	-	-	-	1,870	-	-	-	-	-
Federal Home Loan Mortgage	10,615	-	-	10,615	-	-	-	-	-	-
State and local bonds	33,865	6,191	7,684	3,282	15,779	-	929	-	-	-
United States Treasury Notes	3,581	3,581	-	-	-	-	-	-	-	-
LAIF	74,975	74,975	-	-	-	-	-	-	-	-
CalTrust	428,627	428,627	-	-	-	-	-	-	-	-
Total	$ 801,248	$ 649,089	$ 13,167	$ 27,092	$ 56,881	$ -	$ 29,979	$ 22,109	$ 973	$ 1,958

As of December 31, 2021, 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+
Money market fund	$ 166,756	$ 166,756	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	74,322	-	5,106	8,155	5,105	8,574	18,409	23,863	2,049	3,061
F.N.MA	11,809	-	-	11,809	-	-	-	-	-	-
Federal Home Loan Mortgage	3,502	-	-	3,502	-	-	-	-	-	-
State and local bonds	6,158	-	-	2,011	4,147	-	-	-	-	-
LAIF	74,095	74,095	-	-	-	-	-	-	-	-
CalTrust	336,457	336,457	-	-	-	-	-	-	-	-
Total	$ 673,099	$ 577,308	$ 5,106	$ 25,477	$ 9,252	$ 8,574	$ 18,409	$ 23,863	$ 2,049	$ 3,061

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 2022	2021
Money market funds		16.9 %	24.8 %
U.S. government securities	Federal Home Loan Mortgage	1.3	0.5
	United States Treasury Notes	0.4	-
	Federal Farm Credit Bond	0.3	-
	Federal Government Obligations Fund	0.2	-
F.N.M.A.	Federal National Mortgage Association	-	1.8
Corporate bonds	Various	13.7	11.0
State and local bonds	Various	4.2	0.9
LAIF	State of California	9.3	11.0
CalTrust	CalTrust JPA	53.5	50.0
		100 %	100 %

Note 4 – Capital assets

Capital assets – Capital assets activity in 2022 consists of the following (in thousands):

	December 31, 2021	Increases	Decreases/ Transfers	December 31, 2022
Capital assets not being depreciated:				
Land	$ 7,564	$ -	$ -	$ 7,564
Construction in process	215	641	(344)	512
Total capital assets not being depreciated	7,779	641	(344)	8,076
Capital assets being depreciated:				
Buildings and building equipment	42,657	-	299	42,956
Furniture and equipment	16,568	-	45	16,613
Software	16,657	-	-	16,657
	75,882	-	344	76,226
Less accumulated depreciation for:				
Buildings and building equipment	12,597	1,518	-	14,115
Furniture, equipment, and software	28,828	1,815	-	30,643
	41,425	3,333	-	44,758
Total capital assets being depreciated, net	34,457	(3,333)	344	31,468
Total capital assets, net	$ 42,236	$ (2,692)	$ -	$ 39,544

Capital assets activity in 2021 consists of the following (in thousands):

	December 31, 2020	Increases	Decreases/ Transfers	December 31, 2021
Capital assets not being depreciated:				
Land	$ 7,564	$ -	$ -	$ 7,564
Construction in process	2,481	2,555	(4,821)	215
Total capital assets not being depreciated	10,045	2,555	(4,821)	7,779
Capital assets being depreciated:				
Buildings and building equipment	45,177	89	(2,609)	42,657
Furniture and equipment	14,472	2,853	(757)	16,568
Software	16,657	-	-	16,657
	76,306	2,942	(3,366)	75,882
Less accumulated depreciation for:				
Buildings and building equipment	11,079	1,518	-	12,597
Furniture, equipment, and software	25,343	4,241	(756)	28,828
	36,422	5,759	(756)	41,425
Total capital assets being depreciated, net	39,884	(2,817)	(2,610)	34,457
Total capital assets, net	$ 49,929	$ (262)	$ (7,431)	$ 42,236

During the year ended December 31, 2021, certain constructions related to the Capitola Manor project were terminated, resulting in write offs of previously capitalized cost. The resulting loss on disposal of fixed assets of approximately $7.4 million was included in supplies, occupancy, insurance and other in the statements of revenues, expenses, and changes in net position for the year ended December 31, 2021.

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, 2022 and 2021 (in thousands):

	2022	2021
Beginning balance	$ 226,063	$ 200,716
Incurred:		
Current year	1,298,237	1,352,287
Prior years	32,936	(16,771)
Total	1,331,173	1,335,516
Paid:		
Current year	1,039,964	1,138,285
Prior years	235,061	171,884
Total	1,275,025	1,310,169
Ending balance	$ 282,211	$ 226,063

Medical claims payable increased by $56 million in comparison to the previous year. $28 million of this increase is 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, an increase of $16 million from the accruals and payments of State directed Proposition 56 supplemental payments.

Amounts incurred related to prior years represent changes from previously estimated liabilities. In 2022, amounts incurred related to prior year results from claims being adjudicated and paid for amounts were more than originally estimated due to adverse claims experience and higher than expected acuity for high-dollar medical services. Liabilities at any year-end are continuously reviewed and reestimated as information regarding actual claims payments and expected payment trends become known. Negative amounts reported for incurred related to prior years result from claims being adjudicated and paid for amounts less than originally estimated.

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.

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 $60.6 million and $60.4 million at December 31, 2022 and 2021, respectively. The Act also requires the Alliance to maintain $300,000 restricted deposits, which is displayed as a restricted deposit in the accompanying statements of net position. As of December 31, 2022 and 2021, total net position was $666.7 million and $582.8 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 $4.9 million and $5.2 million of retirement plan expense during 2022 and 2021, 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.

Investments by fair value level include the following as of December 31 (in thousands):

Description	2022	Level 1	Level 2	Level 3
Investments by fair value level	$ -	$ -	$ -	$ -
	-	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
Collective investment trusts - at NAV	45,455			
Total investments	$ 45,455			

Description	2021	Level 1	Level 2	Level 3
Investments by fair value level	$ -	$ -	$ -	$ -
	-	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
Collective investment trusts - at NAV	51,747			
Total investments	$ 51,747			

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 thirty 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, 2022 and 2021, the rates of interest on outstanding loans with Mission Square was 3.4% and 3.75%, 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, 2022 and 2021 were $1.34 million and $1.15 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, 2022 and 2021, the cumulative rate of return for the 401(a) plan was -14.5% and 13.5%, respectively.

Note 8 – Leases

The Alliance is a lessor for noncancellable leases of multiple leases. Lease revenue from the lease arrangements were $1.3 million and $1.05 million for the years ended December 31, 2022 and 2021, 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 $102,000 for the year ended December 31, 2022, and was included in other income in the statements of revenues, expenses, and changes in net position.

Note 9 – 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 10 – 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 11 – 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

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Schedule of Revenues and Expenses by Program and Changes in Net Position
Year Ended December 31, 2022
(in thousands)

	Medi-Cal					
	Santa Cruz County	Monterey County	Merced County	IHSS Program	Administrative	Total
Operating revenues						
Capitation revenue	$ 360,781	$ 738,301	$ 618,173	$ 4,221	$ -	$ 1,721,476
Operating expenses						
Medical expenses						
Medi-Cal						
Provider capitation	6,607	19,602	17,099	-	-	43,308
Claim payments to providers	270,502	546,371	425,751	-	-	1,242,624
Prescription drugs	6,102	5,901	3,283	-	-	15,286
Other medical	12,418	21,494	15,252	-	-	49,164
Alliance Care: IHSS program	-	-	-	3,711	-	3,711
Reinsurance and other, net of (recoveries) expense	999	2,021	1,764	-	-	4,784
Total medical expenses	296,628	595,389	463,149	3,711	-	1,358,877
Administrative expenses						
Premium tax expense	-	-	-	-	174,563	174,563
Salaries, wages, and employee benefits	-	-	-	-	56,342	56,342
Supplies, occupancy, insurance, and other	-	-	-	-	10,786	10,786
Professional fees	-	-	-	-	3,491	3,491
Depreciation and amortization	-	-	-	-	3,333	3,333
Purchased services	-	-	-	-	8,492	8,492
Total administrative expenses	-	-	-	-	257,007	257,007
Total operating expenses	296,628	595,389	463,149	3,711	257,007	1,615,884
Operating income (loss)	64,153	142,912	155,024	510	(257,007)	105,592
Investment income, including net realized and unrealized gains and losses	-	-	-	-	(12,565)	(12,565)
Other income	-	-	-	-	1,741	1,741
Grants	-	-	-	-	(10,834)	(10,834)
Increase (decrease) in net position	$ 64,153	$ 142,912	$ 155,024	$ 510	$ (278,665)	83,934
Net position, beginning of year						582,793
Net position, end of year						$ 666,727

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Schedule of Revenue and Expenses by Program and Changes in Net Position
Year Ended December 31, 2021
(in thousands)

	Medi-Cal					
	Santa Cruz County	Monterey County	Merced County	IHSS Program	Administrative	Total
Operating revenues						
Capitation revenue	$ 382,415	$ 752,172	$ 595,257	$ 3,287	$ -	$ 1,733,131
Operating expenses						
Medical expenses						
Medi-Cal						
Provider capitation	5,225	16,904	16,471	-	-	38,600
Claim payments to providers	239,000	456,414	365,248	-	-	1,060,662
Prescription drugs	54,887	94,606	72,428	-	-	221,921
Other medical	5,938	14,282	11,481	-	-	31,701
Alliance Care: IHSS program	-	-	-	2,552	-	2,552
Reinsurance and other, net of (recoveries) expense	1,515	2,873	1,070	-	-	5,458
Total medical expenses	306,565	585,079	466,698	2,552	-	1,360,894
Administrative expenses						
Premium tax expense	-	-	-	-	157,938	157,938
Salaries, wages, and employee benefits	-	-	-	-	51,007	51,007
Supplies, occupancy, insurance, and other	-	-	-	-	16,083	16,083
Professional fees	-	-	-	-	9,806	9,806
Depreciation and amortization	-	-	-	-	5,759	5,759
Purchased services	-	-	-	-	2,977	2,977
Total administrative expenses	-	-	-	-	243,570	243,570
Total operating expenses	306,565	585,079	466,698	2,552	243,570	1,604,464
Operating income (loss)	75,850	167,093	128,559	735	(243,570)	128,667
Investment income, including net realized and unrealized gains and losses	-	-	-	-	(1,782)	(1,782)
Other income	-	-	-	-	1,384	1,384
Grants	-	-	-	-	(10,066)	(10,066)
Increase (decrease) in net position	$ 75,850	$ 167,093	$ 128,559	$ 735	$ (254,034)	118,203
Net position, beginning of year						464,590
Net position, end of year						$ 582,793


MOSSADAMS

DATE: May 24, 2023

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

FROM: Dr. Dianna Diallo, Medical Director and Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Care-Based Incentive Program 2024

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

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

Proposed changes to 2024 programmatic measures are:

- Add Lead Screening in Children
- Retire Body Mass Index (BMI) Assessment: Children & Adolescent

Proposed changes to Fee-For-Service (FFS) measures are:

- Add $200 FFS measure for Diagnostic Accuracy and Completeness Training
- Add $200 FFS measure for Cognitive Health Assessment Training and Attestation
- Add $1000 FFS measure for submission of Social Determinants of Health (SDOH) ICD-10 Z-Codes
- Add $1000 FFS measure for participation in Quality Performance Improvement Projects including the Pharmacist-Led Academic Detailing Diabetes Program Participation

Proposed changes to 2024 exploratory measures are:

- Add Well-Child Visits for Age 15 Months–30 Months
- Retire Immunizations: Adults

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

Historically, CBI has aligned with many DHCS mandated reported measures, but other state policies have also impacted measure selection including the California State Auditor's reports, DHCS All Plan Letters, California Governor directives, and directives during the Public Health Emergency. Measure selection for CBI has also taken into consideration preventive service measure gaps with a focus on health equity in alignment with the DHCS

Quality Strategy and the Alliance Strategic Plan as a way to support the Medi-Cal population.

Discussion. For 2024 programmatic Care Coordination - Hospital & Outpatient and Care Coordination - Access measures, staff recommend no change.

Measure Category	Measure Name
Care Coordination – Access Measures	Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents
	Application of Dental Fluoride Varnish
	Developmental Screening in the First 3 Years
	Initial Health Assessment
	Post-Discharge Care
Care Coordination – Hospital & Outpatient Measures	Ambulatory Care Sensitive Admissions
	Plan All-Cause Readmission
	Preventable Emergency Visits

The proposed 2024 programmatic Quality of Care measures will add Lead Screening in Children, transitioning from an exploratory to a programmatic status, and change the Screening for Depression and Follow-up Plan CMS Adult Core measure to the NCQA Depression Screening and Follow-up for Adolescent and Adults to align with MCAS reporting. The following are recommended to remain unchanged: Breast Cancer Screening, Cervical Cancer Screening, Child and Adolescent Well-Care Visit, Diabetic HbA1c Poor Control (>9%); Immunizations: Adolescents, Immunizations: Children (Combo 10), and Well-Child Visit in the First 15 Months. BMI Assessment: Children & Adolescent is recommended for retirement following removal from MCAS reporting by DHCS, starting in reporting year 2023.

Measure Category	Measure Name
Quality of Care Measures	Breast Cancer Screening
	Cervical Cancer Screening
	Child and Adolescent Well-Care Visits (3-21)
	Diabetic HbA1c Poor Control >9.0 %
	Immunizations: Adolescents
	Immunizations: Children
	Lead Screening in Children
	Screening for Depression and Follow-up Plan
	Well-Child Visit in The First 15 Months

For 2024, it is recommended that the Health Equity: Child and Adolescent Well-Care Visit measure, will set aside approximately 5% of the overall CBI payment, to be distributed if we achieve the health plan challenge to improve well child visit rates for all ethnicities with special attention to races/ethnicities with rates below the 50th percentile. Credit will be awarded for each race/ethnicity that improves by 5% with additional credit for 10% improvement. Weighting will also be given for improvement in races/ethnicities with a starting point below the 50th percentile.

FFS measures that are recommended include a $200 measure for completion of a Diagnostic Accuracy and Completeness Training, $200 for the DHCS Cognitive Health Assessment Training and Attestation, $1,000 for inclusion of the 25 accepted Social Determinants of Health (SDOH) ICD-10 Z-Codes, and $1,000 per clinic for participation and completion in quality improvement of the Pharmacist-Led Academic Detailing Diabetes Program.

- The Diagnostic Accuracy and Completeness training payment is intended to provide compensation for the time spent in completing training that will support improved provider diagnostic coding in preparation for upcoming rate adjustments dependent on diagnostic accuracy and completeness in Medi-Cal and future Medicare D-SNP program participation. The payments for the coding and assessment training will be per clinician, and the Alliance will pay for each CBI group in which the clinician practices.

- The payment for addition of SDOH (z-codes) is intended to support development of Alliance health equity and population health programs. The SDOH codes will aid in the coordination of services based on member health and social needs, as well as close gaps in reporting.

- Payment for participation in Cognitive Health Assessment training will reward providers for completion of training needed to be qualified to submit claims for cognitive health assessment which is a new Medi-Cal benefit recommended for all members over age 65 annually. These payments would be retroactive for all rendering providers who have already completed their training and attestation with the state and received through confirmation to the Alliance.

- Because it is anticipated that there will be continuing need for Quality Improvement Project support in 2024 following the current 2023 Care-Based Quality Improvement Project effort, a payment for participation in quality improvement programs is proposed. Practices with metrics that are below the minimum performance level, measured at the 50th percentile for the 2023 year programmatic payment will qualify for the 2024 Quality Improvement Projects, which will include our Pharmacist-Led Academic Detailing Diabetes Program.

The downward payment adjustment for Quality of Care metrics below the minimum performance threshold (Medicaid 50th percentile) is proposed to remain in place for 2024 with the change that metrics that remain below the minimum performance threshold will not be included in the payment adjustment if the CBI group shows a 10% improvement from the prior year. This will recognize the effort providers have made to improve low performing metrics and that achieving significant improvement removes the penalty.

Tier	Performance <50th Percentile	CBI Programmatic Payment Adjustment
1	1-3 measures between 25th and 49th and no metrics <25th	Payment reduction of 25%
2	4 or more measures between 25th and 49th and no metrics <25th	Payment reductions of 50%
3	1-3 measures <24th	Payment reduction of 75%
4	4 or more measures <24th	No CBI Payment

The CBI program includes a linked-member diagnosis severity adjustment that can result in increased payments. The adjustment increases CBI payment for providers that have membership with complex medical conditions that depend on diagnostic accuracy and completeness in claims received. The adjustment is currently calculated using the Alliance business intelligence software program. In 2024, the plan is to transition to the adjustment program called CDPS Rx which will be used by DHCS for severity adjustment for future plan payments.

Recommended additions to exploratory measures include Well-Child Visits for Age 15 Months - 30 Months. Recommendations for retirement are the Immunizations: Adults.

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

Attachments. N/A

DATE: May 24, 2023

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Provider Payment Strategy Part 1: Current State Assessment

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

Summary. A Managed Care Plan (MCP) is designed to manage costs and improve the quality of care. In the managed care environment, providers are typically paid through various payment models that incentivize efficiency and quality of care. This report describes the current Alliance payment models and their constraints and opportunities.

Background. The Alliance accumulated a substantial reserve fund between 2014 to 2017 primarily due to the influx of Affordable Care Act (ACA) Medi-Cal expansion members and the higher revenue rates attributed to this population. In 2016, to ensure network adequacy and member access, the Board approved an increase in provider payment rates. The increase was subsidized using Alliance reserves gained via ACA Medi-Cal expansion revenue rates. As the Department of Health Care Services (DHCS) gained more experience with the ACA Medi-Cal expansion population, they reduced the revenue rate to align with the observed inpatient cost. Higher provider reimbursement rates, coupled with an increase in utilization, resulted in a $200M loss over 36 months from October 2017 to September 2020. To ensure that provider payments were in line with revenue from DHCS, the Alliance Board approved a Cost Containment Plan in June 2020 and set a payment policy requiring provider payment to align with revenue rates, utilization trends, and industry benchmarks.

Discussion. Staff analyzed provider payments for hospitals, primary care physicians, and specialists. Staff incorporated the various Alliance incentive programs, such as the Care-Based Incentive, Specialty Care Incentive, and Hospital Quality Incentive Program. In addition, staff included the various payments our providers received from the State. Under Medi-Cal Financing, providers receive additional directed payments or supplemental payments for serving Medi-Cal members. The Alliance payment strategy is to avoid duplicating the State funding programs but to look for other opportunities for our providers.

The analysis showed that the Alliance's hospital payment in aggregate is at 140% Medi-Cal APR-DRG or 120% Medicare. After accounting for various directed payments, the overall hospital compensation is at 266% Medi-Cal APR-DRG, or 221% Medicare. The Alliance payments on average account for 55% of hospitals' revenue for serving Medi-Cal members, and various directed payments accounts for the remaining 45%. Our primary care physicians, excluding Federal Qualified Health Centers, received Proposition 56 payments that account for 17% of the total compensation, making the total reimbursement at 200% Medi-Cal and 95% Medicare. The specialists are reimbursed at 100% Medicare.

Overall, the Alliance payment is above Medi-Cal and Medicare fee schedules and higher than our sister plans in nearby geographic areas. The current level of payment will negatively impact the Alliance's financial performance when DHCS implements the regional

rates, where DHCS will compare the cost of services and improve efficiency across all managed care plans. In addition, the higher-than-Medicare payment level will make it challenging for the Alliance to break even in the Dual Eligible Special Needs Plans line of business in 2026.

Due to the above constraints, staff have little room to increase the base fee-for-service reimbursement model as the costs will not be recognized in the revenue rate-setting process.

However, many opportunities exist to improve provider revenue through Value-Based Payment (VBP) models. VBP is a broad set of performance-based payment strategies linking financial incentives to providers' quality and resource use efficiency performance.

Staff will come back to the Board with VBP recommendations in June.

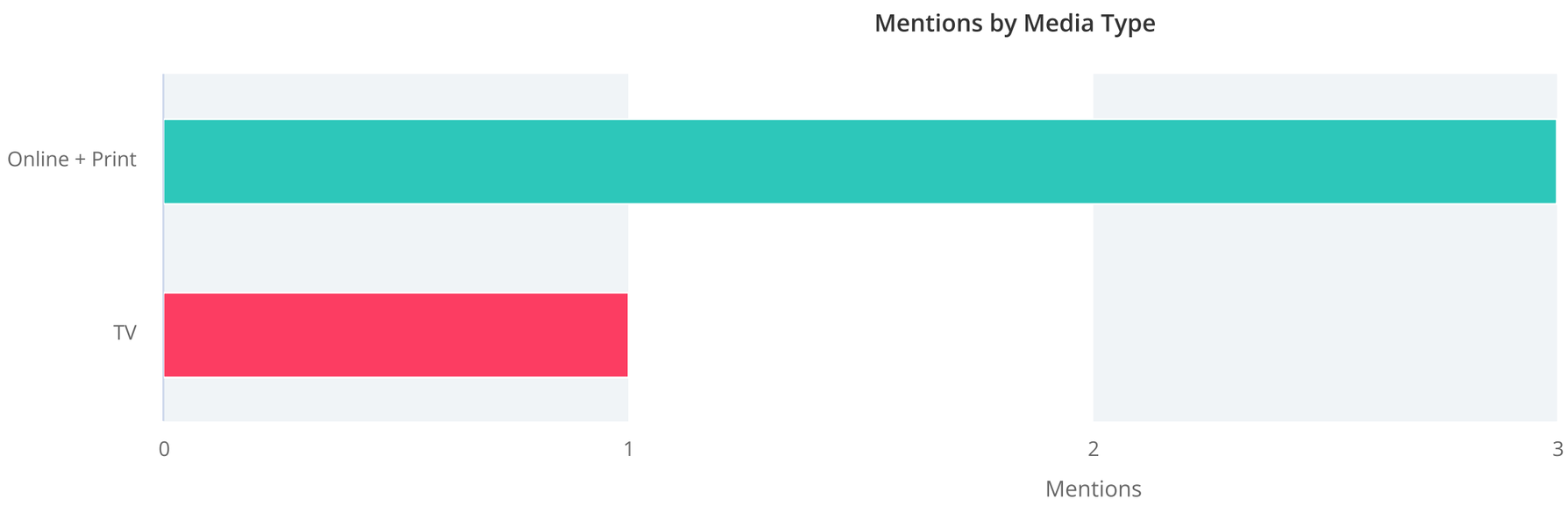
Fiscal Impact. There is no fiscal impact associated with this agenda item.

Attachments. N/A

Information Items: (14A. – 14E.)

May 2023 Board Report

Mention Analytics



Total National TV Audience
22,933

Total National TV Publicity
USD $2,510

Total Local TV Audience
22,933

Total Local TV Publicity
USD $2,510

Total Online News Audience
34,779

Total Online News Publicity
USD $468

Total Number of Clips 4

Farmers market opens for season at Ramsay Park

1

Date Collected Apr 27, 2023 7:07 PM EDT
Category Digital News
Source Register Pajaronian
Author Tarmo Hannula

Est. Audience 1,630
Est. Publicity Value USD $38
Market Watsonville, CA
Language English

... Pajaro Valley who received two major grants totaling nearly $400,000 to address food insecurity in the Pajaro Valley. Funds from the U.S. Department of Agriculture's Agricultural Marketing Service will help build the capacity of El Mercado by supporting the producer-to-consumer market. Funds from **Central Coast Alliance for Health** will support the refinement of VeggieRx, CHT's produce prescription program and serves as a VeggieRx redemption site. Those eligible can use a credit card at the Manager's Booth to purchase tokens valid at every El Mercado vendor.

Liz Medina, program manager, said local residents who are Medi-Cal ...

Central California Alliance for Health announces Michael Schrader as their new CEO

2

KSBW Action News 8 at 5

Time Apr 17, 2023 8:26 PM EDT
Local Broadcast Time 5:26 PM PDT
Category News
Call Sign KSBW (NBC)
Market DMA: 127 Monterey, CA
Language English

Est. National Audience 22,933
Est. National Publicity Value USD $2,510

Est. Local Audience 22,933
Est. Local Publicity Value USD $2,510

products. they also want more federal funding for tobacco prevention programs. ## **Central California Alliance for Health** announced Michael Schrader as their new CEO today... the Alliance is a nonprofit health plan that provides care to over 400- thousand people in Monterey, Santa Cruz and Merced counties.. in a statement, Schrader said, "my desire is to foster an uplifting culture that affords caring and compassionate service for members." Schrader previously worked in similar health plan nonprofits... and has experience in Medi- cal, Medicare and other programs. ## researchers say they have developed a vaccine against the bird flu that could work on humans. they plan to test it on chickens this spring. the most recent outbreak of bird flu was the deadliest the u.s. has ever seen. more than 58 million birds on farms were impacted and... it has even killed 6 endangered condors in arizona. the goal is to have the

Back to Agenda

The Rising Need for Quality Healthcare Services At Home drives U.S. Hospice Market Growth by 2030

3

Date Collected Apr 10, 2023 6:15 AM EDT
Category Digital News
Source Express Press Release

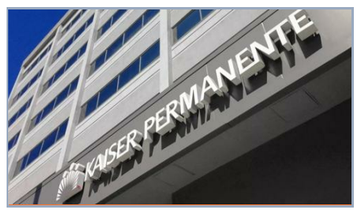
Est. Audience 33,149
Est. Publicity Value USD $430
Market United States
Language English

— /EPR Network/ —

U.S. Hospice Industry Overview

The U.S. hospice market size was valued at USD 32.1 billion in 2021 and is expected to expand at a compound annual growth rate (CAGR) of 8.20% over the forecast period. The rising geriatric population coupled with the increasing prevalence of chronic as well as age-associated diseases is anticipated to boost the market growth. According to the Population Reference Bureau, the U.S. population aged 65 years and above is expected to reach 95 million by 2060 from 52 million in 2018. The high prevalence of cancer, dementia, and respiratory,...

...The growing importance of telemedicine is also expected to drive the market. The technology is marking its presence to extend its care to outpatient settings to improve care coordination. The Hospice of Santa Cruz County is launching a telehealth program for palliative and hospice services that would enable medication management, virtual visits, and other services with the help of a grant it received from the **Central California Alliance for Health**....



In the Public Interest: Examining Kaiser's deal with Santa Cruz County

4

Date Collected Apr 3, 2023 8:09 AM EDT
Category Digital News
Source Lookout Santa Cruz
Author Source, Over The Past Decade, Christopher Neely Has Built A Diverse Journalism Résumé, Spanning The East Coast To Texas, Most Recently, California S Central Coast.

Market United States
Language English

... health plans. By not partnering with the local Medi-Cal alliance nor committing to serve a certain number of Medi-Cal patients, deGhetaldi contends Kaiser will take the path of most business sense: choose the healthier and thus less-expensive Medi-Cal patients.

Linda Gorman, spokesperson for the **Central California Alliance for Health**, which oversees the system of local Medi-Cal patients, says the county's agreement leaves a big question mark on how Medi-Cal patients will be served.

"Neither the State Department of Health Care Services nor Kaiser have made the Alliance aware of how many Medi-Cal patients Kaiser will serve," ...

Alliance Fact Sheet
April 2023

ABOUT THE ALLIANCE

The Alliance is an award-winning regional non-profit health plan, established in 1996, with **over 27 years** of successful operation. Using the State's County Organized Health System (COHS) model, we currently serve **423,069 members** in Merced, Monterey and Santa Cruz counties. We work in partnership with our contracted providers to promote prevention, early detection and effective treatment, and improve access to quality health care for those we serve. This results in the delivery of innovative community-based health care services, better medical outcomes and cost savings. The Alliance is governed with local representation from each county on our Board of Commissioners.

Quick Facts[2]

1996
Year Established

523
Number of Employees

$4.07M
YTD Revenue

5.4%
Spent on Administration

Service Area:
Merced, Monterey and Santa Cruz counties.

Membership by Program

Total Membership: **423,069**[3]

422,424
Medi-Cal

645
Alliance Care IHSS

OUR VISION

Healthy People,
Healthy Communities.

OUR MISSION

Accessible, quality health care guided by local innovation.

WHAT WE DO

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

WHO WE SERVE

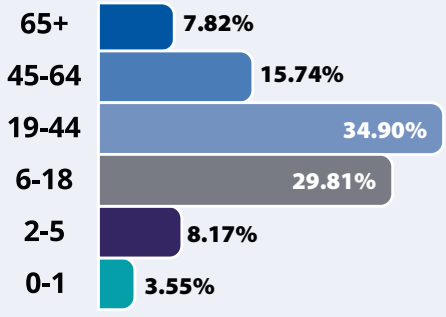
Our members represent 43 percent[1] of the population in Merced, Monterey and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income mothers and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled, and low-income, childless adults ages 19–64.

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

PROVIDER PARTNERSHIPS

The Alliance partners with more than 11,565 providers to form our provider network, with 87 percent of primary care physicians and 85 percent of specialists within our service area contracted to provide services to our members. The Alliance also partners with more than **3,432** providers to deliver behavioral health and vision services.

Membership by Age Group



EXECUTIVE LEADERSHIP

Michael Schrader
Chief Executive Officer

Lisa Ba
Chief Financial Officer

Dale Bishop, MD
Chief Medical Officer

Scott Fortner
Chief Administrative Officer

Cecil Newton
Chief Information Officer

Jenifer Mandella,
Chief Compliance Officer

Van Wong
Chief Operating Officer

GOVERNING BOARD

The Alliance's 21-member governing board, the Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan.

- **Leslie Abasta-Cummings,** Chief Executive Officer, Livingston Community Health
- **Supervisor Wendy Root Askew,** County of Monterey
- **Dorothy Bizzini,** Public Representative
- **Leslie Conner,** Executive Director, Santa Cruz Community Health Centers
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas
- **Larry deGhetaldi,** MD, Provider Representative
- **Julie Edgcomb,** Public Representative
- **Janna Espinoza,** Public Representative
- **Supervisor Zach Friend,** County of Santa Cruz
- **Charles Harris,** MD, Chief Executive Officer, Natividad Medical Center
- **Elsa Jimenez,** Director of Health, Monterey County Health Department - Alliance Board Chairperson
- **Shebreh Kalantari-Johnson,** Public Representative
- **Michael Molesky,** Public Representative
- **Monica Morales,** Health Services Agency Director, County of Santa Cruz Health Services Agency
- **Rebecca Nanyonjo,** Director of Public Health, Merced County, Department of Public Health
- **Supervisor Josh Pedrozo,** County of Merced – Alliance Board Vice Chairperson
- **Julie Peterson,** Chief Financial Officer, Watsonville Community Hospital
- **James Rabago,** MD, Merced Faculty Associates Medical Group
- **Allen Radner,** MD, Salinas Valley Memorial Healthcare System
- **Joerg Schuller,** MD, Vice President Medical Affairs, Mercy Medical Center
- **Rob Smith,** Public Representative

AWARDS

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

State Quality Awards:

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

DHCS 2021

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

2019

- Outstanding Performance for Medium-sized Plan

2018

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

Customer Service Honors:

- DHCS 2011 Gold Quality Award for Outstanding Service and Support

Employer Workplace Distinctions:

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

[1]County population data source: U.S. Census Bureau 2021 population estimate (as of Jul. 1, 2021). Membership percentage by county: Merced (53 percent); Monterey (43 percent); Santa Cruz (30 percent). [2]Fact sheet data as of April 1, 2023. [3]Fact sheet data as of April 1, 2023.

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

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

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

April 28 2023

Maximiliano Cuevas, MD, FACOG, CEO
Clinica de Salud del Valle de Salinas
55 Plaza Circle, Suite C, Salinas, CA 93901
E-Mail: mcuevas@csvs.org

RE: Application for Health Center Program Service Expansion - School Based Site

Dear Dr. Cuevas;

The Central California Alliance for Health (the Alliance) is pleased to support Clinica de Salud del Valle de Salinas (CSVS') application for funding to create a new primary care and behavioral services in collaboration with the Salinas City Elementary School District.

CSVS is one of the area's largest providers of primary and behavioral health services in our District. Established as a free clinic for Salinas Valley farm workers, it has grown into a network of comprehensive primary care centers distinguished by both a JCAHO accreditation and a top 10% HRSA audit. It provides access to high quality primary care, dental, optometry and behavioral health services to over 50,000 low-income residents, effectively covering the entire Salinas Valley and the coastal areas of Monterey County, CA. CSVS operates 14 clinics including one mobile unit, and two temporary vaccine sites.

The Alliance is a Medi-Cal managed care plan, established in 1996, using the State's County Organized Health System (COHS) model. The Alliance currently serves over 420,000 members in Merced, Monterey and Santa Cruz counties. CSVS has been a critical partner with the Alliance as a contracted provider since our inception in Monterey County in 1999. We work in partnership with our contracted providers to promote prevention, early detection and effective treatment, and improve access to quality health care for those we serve. This results in the delivery of innovative community-based health care services, better medical outcomes and cost savings

There is a clear need for increased screening, preventive and resiliency programming, and site-based primary care providers and community health workers specializing in behavioral health will address a wide array of unmet needs. We are happy to offer our support for CSVS in this important work so the patients we share with CSVS benefit from increased school-based health programming.

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209-381-5300

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The Alliance is pleased to offer our support for CSVS' application to expand these services through this funding opportunity.

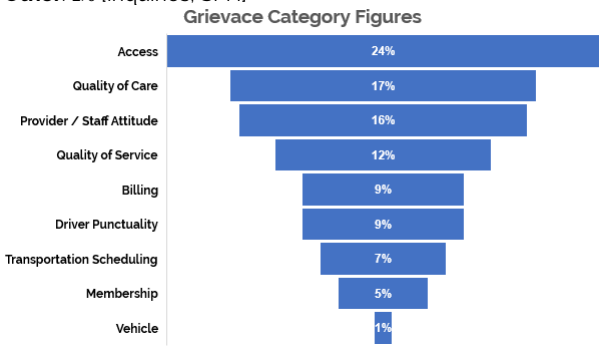
Sincerely,

Michael Schrader
Chief Executive Officer

Member Appeals and Grievance Report
Q1, 2023

Q1 2023 Appeals and Grievances: 1,244* including Beacon (aka Carelon)

Appeals: 4% [73% in favor of Plan; 27% in favor of Member]
Exempt: 46%
Grievances: 49%
Other: 1% [Inquiries, SFH]



Analysis and Trends
- Access issues regarding provider availability in MRY continue.

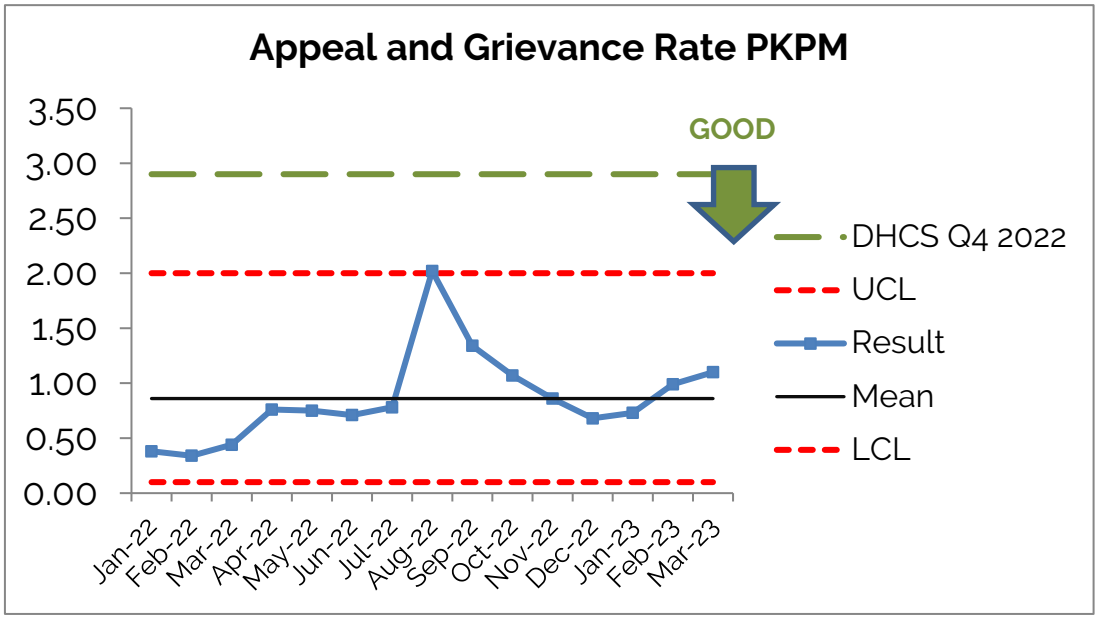
Highest Grievances Filed by County
1. Monterey: 43%
2. Merced: 33%
3. Santa Cruz: 24%

Behavioral Health Beacon (Carelon) Grievances: 54
- Member Grievances: 43 Exempt Grievances: 11
- **Monterey**: 27
- Santa Cruz: 18
- Merced: 9

IHSS Summary:
- Member Grievances: 7

☒ **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	July	Aug	Sep	Oct	Nov	Dec
2022 Enrollment	**390,340**	**391,463**	**393,336**	395,725	403,174	404,952	407,139	408,758	411,137	413,199	415,510	416,851
A&G Issues	**150**	**132**	**174**	301	302	286	318	824	549	441	359	282
Rate PKPM*	**0.38**	**0.34**	**0.44**	0.76	0.75	0.71	0.78	2.02	1.34	1.07	0.86	0.68
2023 Enrollment	**420,144**	**421,735**	**423,067**									
A&G Issues	**307**	**416**	**467**									
Rate PKPM*	**0.73**	**0.99**	**1.10**									

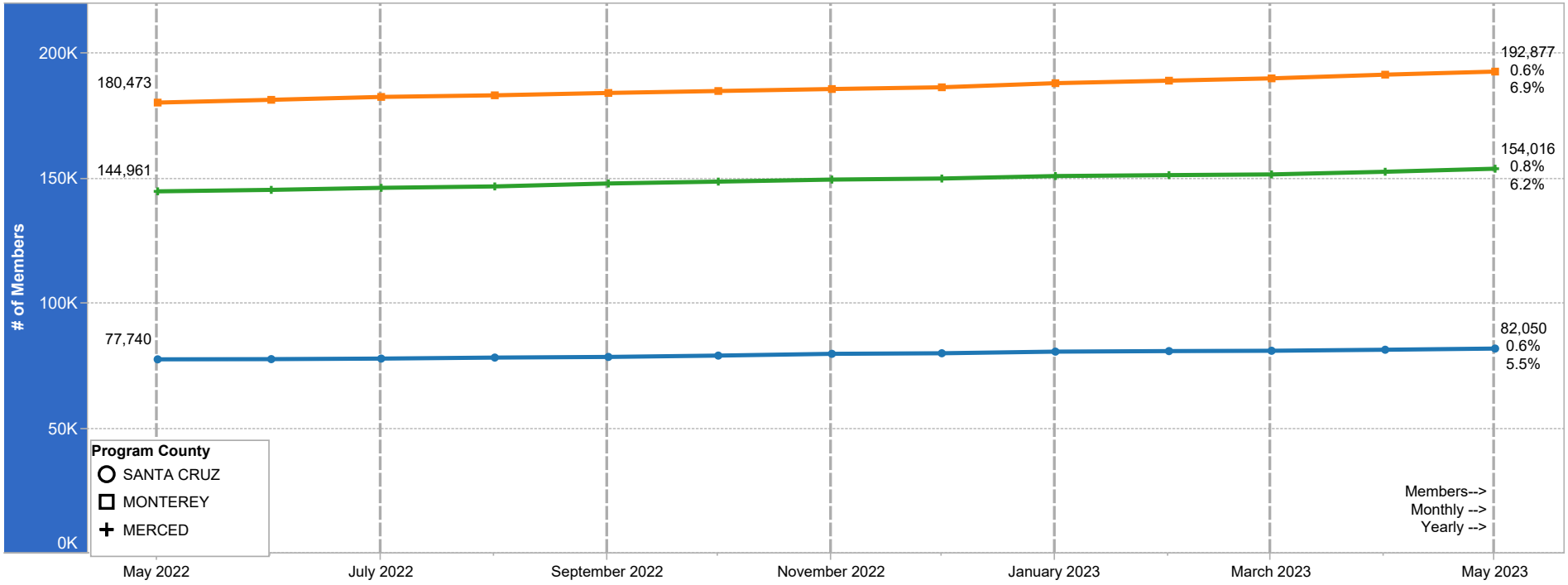
*Grievances Per 1,000 Member Month

Enrollment Report

Year: *2022 & 2023* **County:** *All* **Program:** *AIM, IHSS, Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *5/2/2023*

StaticDate
5/1/2022 12:00:00 AM to 5/31/2023 11:59:59 PM

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



Program..	ProgramCo..	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023
Medi-Cal	SANTA CRUZ	77,740	77,822	78,040	78,443	78,703	79,237	79,945	80,171	80,822	81,039	81,170	81,579	82,050
	MONTEREY	179,823	180,924	182,085	182,726	183,672	184,453	185,243	185,941	187,589	188,596	189,519	191,002	192,222
	MERCED	144,961	145,549	146,360	146,929	148,104	148,855	149,666	150,085	151,081	151,449	151,732	152,797	154,016
IHSS	MONTEREY	650	657	654	660	658	654	656	654	652	651	646	648	655
Total Members		**403,174**	**404,952**	**407,139**	**408,758**	**411,137**	**413,199**	**415,510**	**416,851**	**420,144**	**421,735**	**423,067**	**426,026**	**428,943**