Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Wednesday, September 22, 2021

3:00 p.m. – 5:00 p.m.

(800) 700-3874
www.ccah-alliance.org

Teleconference Meeting

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

Important notice regarding COVID-19: Based on guidance from the California Department of Public Health and the California Governor's Office, in order to minimize the spread of the COVID-19 virus, Alliance offices will be closed for this meeting. The following alternatives are available to members of the public to view this meeting and to provide comment to the Board.

1. Members of the public wishing to join the meeting may do so as follows:
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 323-705-3950
    Phone Conference ID: 598 578 583#

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 items that are listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, September 21, 2021 to the Clerk of the Board at kstagnaro@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to five minutes.
    b. Public comment during the meeting, when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

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

---

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

A. Roll call; establish quorum.
B. Supplements and deletions to the agenda.
C. Welcome new Board member Charles Harris, MD, Hospital Representative, Monterey County.

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 2021-22 State Budget Summary.

Pages 5-01 to 5-15

6. Accept Alliance Dashboard for Q2 2021.

- Reference materials: Alliance Dashboard – Q2 2021.

Pages 6-01 to 6-02

7. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the seventh month ending July 31, 2021.

- Reference materials: Financial Statements as above.

Pages 7-01 to 7-09

Appointments: (8A.)

8A. Approve appointment of Dr. Salvador Sandoval to the Whole Child Model Clinical Advisory Committee.

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

Page 8A-01

Minutes: (9A. – 9G.)

9A. Approve Commission meeting minutes of June 23, 2021.

- Reference materials: Minutes as above.

Pages 9A-01 to 9A-06

9B. Accept Compliance Committee meeting minutes of June 16, 2021.

- Reference materials: Minutes as above.

Pages 9B-01 to 9B-04

9C. Accept Continuous Quality Improvement Committee meeting minutes of April 29, 2021.

- Reference materials: Minutes as above.

Pages 9C-01 to 9C-06

9D. Accept Member Services Advisory Group meeting minutes of May 13, 2021.

- Reference materials: Minutes as above.

Pages 9D-01 to 9D-03

9E. **Accept Physicians Advisory Group meeting minutes of June 3, 2021.**
- Reference materials: Minutes as above.

Pages 9E-01 to 9E-06

9F. **Accept Whole Child Model Clinical Advisory Committee meeting minutes of June 17, 2021.**
- Reference materials: Minutes as above.

Pages 9F-01 to 9F-05

9G. **Accept Whole Child Model Family Advisory Committee meeting minutes of July 12, 2021.**
- Reference materials: Minutes as above.

Pages 9G-01 to 9G-05

Reports: (10A. – 10H.)

10A. **Approve Alliance Donations and Sponsorship of Events and Organizations Policy.**
- Reference materials: Staff report and recommendation on above topic; and Alliance Donations and Sponsorship of Events and Organizations Policy.

Pages 10A-01 to 10A-05

10B. **Approve Alliance Policy 401-1101 – Quality and Performance Improvement Program revisions.**
- Reference materials: Staff report and recommendation on above topic; Quality and Performance Improvement Program Policy; Attachment A – QPIP Committee Structure; and Attachment B – Quality Improvement Department Organization Chart.

Pages 10B-01 to 10B-29

10C. **Approve Conflict-of-Interest Code of the Santa Cruz-Monterey-Merced Managed Medical Care Commission dba Central California Alliance for Health.**
- Reference materials: Staff report and recommendation on above topic; and Conflict-of-Interest Code of the Santa Cruz-Monterey-Merced Managed Medical Care Commission.

Pages 10C-01 to 10C-08

10D. **Approve recommendation for Alliance Formulary Changes for Q3 2021 as recommended by the Pharmacy and Therapeutics Committee.**
- Reference materials: Staff report and recommendation on above topic; and Resolution.

Page 10D-01

10E. **Accept decisions from the June 9, 2021 and September 9, 2021 meetings of the Peer Review and Credentialing Committee.**
- Reference materials: Staff report and recommendation on above topic.

Pages 10E-01 to 10E-02

10F. **Approve recommendation for Recuperative Care Pilot Funding and Criteria Adjustments.**
- Reference materials: Staff report and recommendation on above topic.

Pages 10F-01 to 10F-03

10G. **Accept Quality and Performance Improvement Program Workplan Report for Q1 2021.**
- Reference materials: Staff report and recommendation on above topic.

Pages 10G-01 to 10G-04

10H. **Accept Utilization Management Workplan Report for Q1 2021.**
- Reference materials: Staff report and recommendation on above topic.

Pages 10H-01 to 10H-05

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

11. Discuss COVID-19 State of the Pandemic in Alliance Service Areas and Alliance Offices, and consider approving Provider and Member Vaccine Incentive Program. (3:15 p.m. – 3:45 p.m.)

A. Dr. Dale Bishop, Chief Medical Officer and Mr. Scott Fortner, Chief Administrative Officer, will review and Board will discuss above topic.
B. Board will consider approval of Provider and Member Vaccine Incentive Program.
- Reference materials: Staff report and recommendation on above topic.

Pages 11-01 to 11-02

12. Discuss California State FY 2021-2022 Key Implementations. (3:45 p.m. – 4:15 p.m.)

A. Ms. Stephanie Sonnenshine, CEO, will review and Board will discuss above topic.

13. Consider approving Alliance 2022-2026 Strategic Plan. (4:15 p.m. – 5:00 p.m.)

A. Ms. Stephanie Sonnenshine, CEO, will review and the Board will consider approving Alliance 2022-2026 Strategic Plan.
- Reference materials: Staff report and recommendation on above topic; and Draft 2022-2026 Strategic Plan Framework.

Pages 13-01 to 13-07

Information Items: (14A. – 14G.)

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, October 27, 2021; 1:30 – 2:45 p.m.

- Member Services Advisory Group
  Thursday, November 4, 2021; 10:00 – 11:30 a.m.

- Physicians Advisory Group
  Thursday, December 2; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee (*by teleconference only*)
  Thursday, December 16, 2021; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee (*by teleconference only*)
  Monday, November 8, 2021; 1:30 – 3:00 p.m.

Locations for the above meetings, unless otherwise noticed:

In Santa Cruz County:
Central California Alliance for Health Auditorium
1700 Green Hills Road, Scotts Valley, CA

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

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

The next meeting of the Commission, after this September 22, 2021 meeting:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, October 27, 2021, 3:00 p.m. – 5:00 p.m.
  Locations: Videoconference from Alliance offices in Scotts Valley, Salinas and Merced. Due to the continued Public Health Emergency, the meeting will also be made accessible to the public via teleconference.

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

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

DATE: September 22, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

New Director of Department of Health Care Services. On September 10, 2021, Governor Gavin Newsom announced the appointment of Michelle Baass as Department of Health Care Services (DHCS) Director. Ms. Baass will fill the role held by outgoing Director William Lightbourne since June, 2020. Ms. Baass has been Undersecretary of the California Health and Human Services Agency (CHHSA) since 2018. Previously she held the position of Deputy Secretary of the Office of Program and Fiscal Affairs at CHHSA and Deputy Director and Principal Consultant at the California State Senate Committee on Budget and Fiscal Review from 2012 to 2017 as well as other leadership roles within the State government. The DHCS Director position requires confirmation by the Senate.

Recall Election. The recall election set for September 14, 2021, allowed voters to decide whether to allow Governor Newsom to continue his term as governor or to elect a new leader for the state. The recall effort was not successful and Governor Newsom will complete his term as the governor of California.

COVID-19 State of Emergency. The majority of California's statewide COVID-19 restrictions ended on June 15, 2021. However, the California state of emergency which Governor Newsom declared at the outset of the pandemic in March 2020 remains. The Governor's power to declare a state of emergency is provided under California law and is designed to help the government act quickly in times of crisis. The declaration provides the opportunity to obtain federal relief for pandemic-related expenses and provides the Governor with broad authority to suspend current law and impose new rules via Executive Order (EO). EOs issued by the Governor in March 2020 included additional flexibilities for Medi-Cal to ensure continued access for members as well as flexibilities for public entities, like the Alliance, regarding teleconferencing options for public meetings. These flexibilities end with the expiration of prior Executive Orders on June 30th and September 30th respectively. However, the legislature has approved AB 361 authored by Assembly member Robert Rivas which would provide authority for public agencies, such as the Alliance, to implement teleconferencing flexibilities during declared States of Emergency (SOE). This bill has been sent to the Governor's desk and, if approved, is effective immediately and will allow the board to meet via teleconferencing in October and through the end of the declared SOE.

2021-22 State Budget Update. The legislature adopted and the Governor signed a 2021-22 spending plan and accompanying budget trailer bill with language including the authority and funding for CalAIM priorities, the expansion of Medi-Cal to older undocumented adults and post-partum women, new children and youth behavioral health initiatives and new benefits including Doula and Community Health Worker services and Continuous Glucose

Monitors. See attachment for a summary of the most significantly impactful budget priorities for the Alliance. In addition, staff will provide an overview of these and other Medi-Cal priorities at the September meeting.

Legislative Session 2021. The 2021 legislative session came to an end at midnight on September 10, 2021 with a legislative deadline to adopt bills to send to the Governor. Staff continues to monitor legislation identified in the legislative areas of focus adopted by your board and presented at the April meeting. Staff will review final legislation signed by the Governor and report back at a future meeting.

San Benito and Mariposa County Expansion. Staff continue to work with County staff on necessary steps towards approval by DHCS of the expansion of the Alliance into San Benito and Mariposa counties which includes adoption of enabling Ordinance to form a multi-county commission reflective of your board's direction regarding governance structure for a January 1, 2024 implementation. Enabling ordinances in Santa Cruz, Monterey, Merced and San Benito counties are each scheduled for final adoption at their respective September 14, 2021 Board of Supervisors meeting. Mariposa County is scheduled to introduce the enabling ordinance at its September 15, 2021 meeting with final adoption on September 21, 2021. Approved ordinances are due to DHCS by October 10, 2021.

California Advancing and Innovating Medi-Cal (CalAIM). Planning for implementation of the CalAIM initiatives continues, with plans working in partnership with DHCS, counties, and associations to prepare for the new Enhanced Case Management (ECM) benefit and optional In Lieu of Services (ILOS) benefit effective January 1, 2022. Staff have received final program documents and deliverable requirements as well as draft ECM rates and are working on deliverable development and program implementation.

Community Involvement. I attended the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Executive Committee meeting on July 15, 2021. On July 19 and 20, 2021 I attended the Local Health Plans of California July meeting and Board Retreat in Napa and I attended the virtual Stakeholder Advisory Committee Meeting on July 29, 2021. On August 10, 2021 I presented to the Merced County Board of Supervisors. I attended the virtual HIPSCC Council meeting on August 12, 2021 and I attended the HIPSCC Executive meeting on August 19, 2021 as well as a virtual meeting with Merced County Health and Human Services related CEO and department directors. I presented to the San Benito County Board of Supervisors on August 24, 2021. On September 8, 2021 I attended the virtual All Plan CEO meeting and the virtual ACAP Equity Task Force meeting. On September 9, 2021 I attended the virtual HIPSCC Council meeting and I attended the virtual Medi-Cal Children's Health Advisory Panel meeting. On September 15, 2021 I participated in a virtual Community Health Needs Assessment conducted by Sutter Maternity & Surgery Center in partnership with Dignity Health Dominican Hospital in Santa Cruz County. On September 16, 2021 I presented on Cal-AIM and changes to Alliance programs and services at the virtual Hospital Council – Monterey Bay CEO Section meeting and I attended the virtual HIPSCC Executive Committee meeting. On September 15, 2021 I participated in an interview on the local Community Health Needs Assessment with Actionable Insights.

Health Services

Health Services Update. The Health Services Division current priorities include preparing for the Medi-Cal pharmacy carve-out (which is now scheduled for January 1, 2022), completing the Model of Care-2 submission and beginning the operational planning for the new CalAIM Enhanced Case Management/In Lieu of Services (ECM/ILOS) program, and planning for COVID vaccine promotion as part of a new proposed Medi-Cal Vaccine Incentive Program.

Inpatient / Emergency Department Utilization. Inpatient COVID-related admissions increased during the months of July and August, consistent with national trends related to the spread of the delta variant strain. These admissions were seen in the unvaccinated members in all three counties with Merced having a greater portion of the overall totals. This upward trend is being monitored daily for inpatient bed capacity in all three counties as well as surrounding areas. Development of flags in the medical review software is being established to indicate any known vaccination status of members. This will assist with the coordination of member contact post-discharge to educate and encourage vaccinations where indicated.

Emergency Department (ED) utilization in July and August has remained relatively stable from the second quarter. Utilization of the Nurse Advice Line has increased by 20% correlating with improvements in Alliance website member resource information.

Whole Child Model Program. During the peak of the pandemic, many Medical Therapy Program (MTP) services for Whole Child Model (WCM) members were transferred out to alternate providers due to MTP site closures and access limitations. With MTPs having resumed services following previous pandemic site closures, WCM project work in July and August included increased collaboration with the MTPs across the counties to reconnect members directly to MTP site services. WCM project work in Q2 was additionally focused on developing and refining reporting mechanisms to monitor California Children's Services (CCS) referral activity in all stages of the process as well as on the Age Out program including further development of member Age Out resource materials and direct member outreach. Monthly CCS/MTP meetings were held across the counties to further the collaborative work across the teams.

Prior Authorization. Authorization overall volumes have remained consistent for the last two months with trending towards stability as members continue to resume care.

The Authorization Redesign Project is on track with the 2021 roadmap. Approximately 6% of total authorization volume has been decreased to date. Significant progress has been made with the development of a portal solution for providers. A tool will allow providers to search for authorization requirements by code in addition to identifying when quantity or service limits apply. Expected completion of the portal configuration for this purpose is scheduled for the end of the third quarter.

To date 139 codes have been removed from requiring prior authorization. Plans are in place to remove authorization requirements for an additional 40 codes. Preparation for provider training for the new prior authorization look-up tool is in the planning stages. Providers who continue to send authorization requests where no longer needed will be identified for focused training and follow-up.

Non-Emergent Medical Transportation requests continue to increase due to COVID-related ride accommodations and for serious mental illness and substance use disorder members. Coordination with the County is in process to facilitate adequate information sharing between the Alliance and County case managers.

Medi-Cal Rx Update. DHCS received the conflict avoidance plan from Magellan on July 27, 2021 and determined the appropriate protections are in place to support the January 1, 2022 go live for Medi-Cal Rx. The project has been formally moved from "Hold" back to "Active" status. The Alliance has resumed all DHCS, all local associations, and internal meetings to resume the work for successful implementation of Medi-Cal Rx. To educate and inform members about the Medi-Cal Rx implementation date, the Alliance will issue 30-day notices to members, along with new member ID cards, by December 1, 2021. In addition, there are several website and print outreach efforts planned to inform and assist members in navigating this change. The Alliance member website will be updated with information regarding the transition, including links to the DHCS and Magellan PBM website.

Q2 2021 Pharmacy Trends.

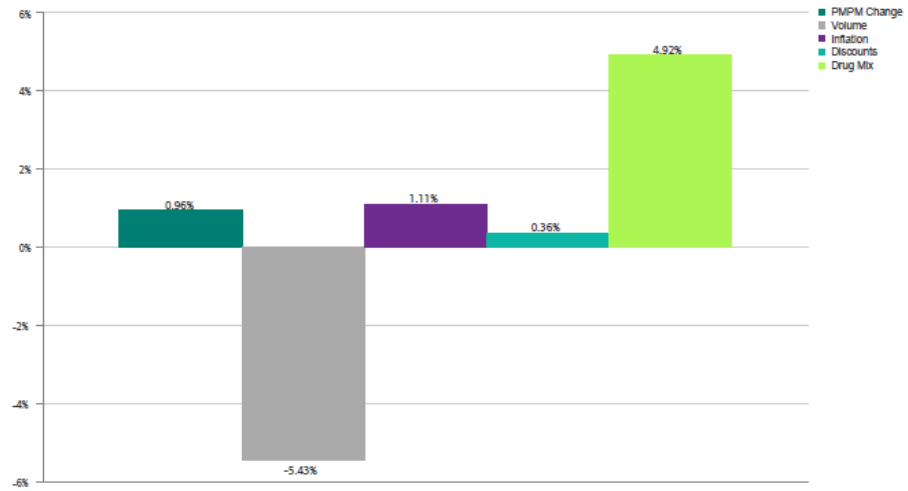
Report Period: 04/01/2021 to 06/30/2021 | Comparison Period: 04/01/2020 to 06/30/2020

The Q2 2021, per member per month (PMPM) of $45.82 is increased by 1% as compared to Q2 2020. This is lower than the Custom benchmark. Prescription utilization (PMPM) decreased 3.5%. Overall cost per Rx increased 4.6% this period, with cost for branded prescriptions increasing 7.0% and generic prescriptions decreasing 0.2%.

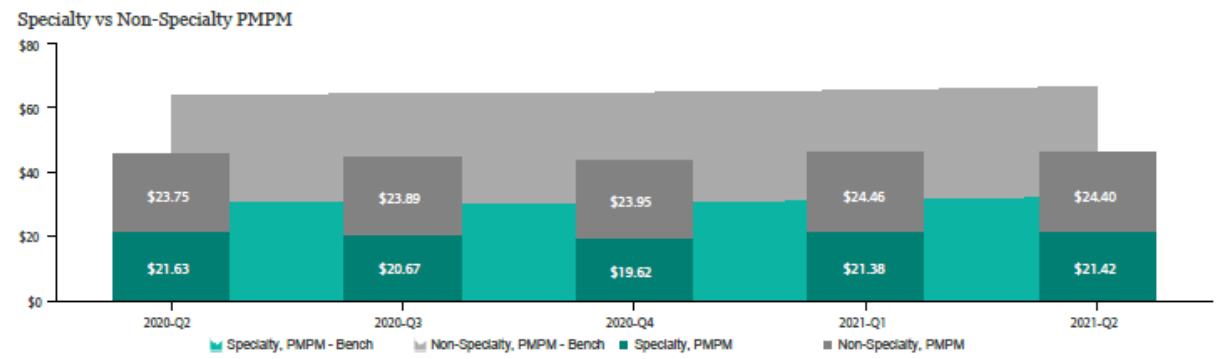
In comparison to Q2 2020, the Alliance's membership has increased by 8.9% and percentage of utilizing members has increased by 3.8% in Q2 2021.

Plan Paid PMPM Trend 1.0% ▲
Benchmark PMPM Trend 4.2% ▲

Drug Mix was the major driver of PMPM increase



The major driver of PMPM increase is drug mix (shift in therapy) for high cost drugs (Trulicity, Steglatro, Eliquis, Trikafta, Vyondys-53, Increlex, Taltz, Dupixent).



Back to Agenda

The percentage of the Specialty spent has decreased from 47.7% in Q2 2020 to 46.7% in Q2 2021. This is leading to decrease Specialty PMPM of $21.42 in Q2 2021.

Managed Care Accountability Set Performance Measures – DHCS 2021-2022 Improvement Plan Process. All health plans regardless of performance are required to submit a brief COVID-19 Quality Improvement Plan. The initial submission must include three strategies related to Managed Care Accountability set (MCAS) measure domains, one of which must address the behavioral health domain. The Alliance has identified the following three strategies to meet this requirement:

1. Member incentive for completing the second dose of the flu vaccine in children between the ages 7-months to 2-years to improve the CIS Combination 10 rate.
2. Reminder letters prior to the child's 11th, 12th and 13th birthday to improve adolescent well-care visits.
3. Leveraging the Healthy Mom and Healthy Babies program for BIPOC/low-rate populations to improve PPC – postpartum/maternal mental health.

Employee Services and Communications

Alliance Workforce. As of August 30, 2021, the Alliance has 519 budgeted positions of which our active workforce number is 493.7 (active FTE and temporary workers). There are 14.5 positions in active recruitment, and 34.8 positions are vacant. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets. Human Resources continues to partner with Budget & Reporting to ensure alignment in FTE goals.

Human Resources will be conducting an Employee Satisfaction Survey within the coming months. As in past surveys, we expect to gain valuable information to assist us in identifying areas in which employees are happy, engaged and satisfied. In addition, we will also identify any areas of opportunity for growth and enhancement. The organization is moving to an annual survey so that we can quickly measure, respond, and implement relevant changes as needed.

Human Resources is working with Pearl Meyer, our outside compensation consultant, to ensure alignment between our compensation ranges and the job market. This is an important evaluation process and best practice to ensure we are competitive in the market to attract and retain talent. This work provides an opportunity for us to review compensation data, pay structures, evaluate benchmarked positions, and provide a summary report and recommendations, if any, at the conclusion of this work. We expect this body of work to continue through early September and to assist and inform budget planning.

Facilities and Administrative Services. Capitola Manor: Construction is underway and the Office of Statewide Health Planning and Development (OSHPD) increment 1 permit has not yet been issued, but OSHPD will be following up by September 15, 2021. The project is currently 25% complete and scheduled to be finished in Q3 2022. The project is expected to exceed the current budget due to inflation. A revised budget for 2022 will be submitted.

The Facilities team is currently working with several prospective tenants interested in leasing space at the 1800 building in Scotts Valley.

Facilities has sold the aging Alliance vehicle fleet, via public auction.

Communications. The external website was redesigned and launched on July 1, 2021. The new website provides a professional, branded, mobile-responsive, accessible and compliant user experience, with easily digestible, searchable content. To support the launch, staff executed a comprehensive communications plan to inform members, providers, community stakeholders and other interested parties about the website's features and benefits. Staff also conducted trainings with key member and provider facing staff to ensure they understand the features and benefits of the new website. The website has a new, easy to remember and branded URL – www.thealliance.health and staff will be updating all print and digital materials with the new web address as needed. The previous URL and all extension pages automatically direct to the new URL, providing a seamless user experience. The new site also fully optimizes Google Analytics, so staff will review key web metrics and make updates to the site to enhance and streamline overall user experience.

Staff has been working on a fall flu campaign launching in September aimed at connecting with the emotional aspects of protecting those you love by getting a flu shot. The campaign includes paid and owned tactics across our footprint, including digital and print advertisements, radio public service announcements and streaming ads, website landing page, a home page banner ad, social media posts, member flyers in all three languages, and provider eNewsletter bulletins. In addition, staff collaborated with CareNet to deliver flu vaccine postcards to be delivered to all member households in mid-September and an additional 3,600 postcards will be printed for dissemination by Outreach staff at local events throughout flu season.

Operations

Claims Operational Performance. Claims inventory reduction has been a continued focus for the Claims Department. As of September, claims inventory is 38,206, which is 21.33% lower than August's average inventory. Inventory levels are expected to be back at target by September 17, 2021, reflecting staff's commitment to paying providers timely. Claims aging, or the timeframe from when a claim is received to when a claim is processed, is another area of focus, with improvements noted through a 72.83% reduction in claims 26 or more days aged in September over the month prior. Core claims performance will remain a continued focus in the coming months.

Member Services. In April, DHCS released new guidance regarding standards for determining threshold languages, nondiscrimination requirements, and language assistance services. The new guidance requires the Alliance to designate a Discrimination Grievance Coordinator and implement procedures to promptly and equitably investigate and resolve member grievances alleging any action prohibited by federal or state nondiscrimination laws. In response, the Member Services Department will implement Discrimination Grievance Coordinator training, and related organizational process adjustments by October to be in compliance with DHCS requirements.

Provider Services. The Alliance was informed on August 16, 2021 that we received a full pass with no deficiencies for our 2021-2022 Annual Network Certification filing. Receipt of a full pass with no deficiencies is a testament to the work of the Alliance in our pursuit to develop a provider network that meets the needs of our members. Work to begin the 2022-2023 Annual Network Certification filing will begin in the Fall.

The annual Provider Satisfaction Survey (PSS) completed in August, while the annual Provider Appointment and Availability Survey (PAAS) launched on August 30. Results of the PSS are expected before year-end and will help to inform needed areas of provider support in 2022. The PAAS is a required survey intended to assess access to urgent and routine appointments within timeliness standards. Alliance staff spend 6-8 weeks sending emails and placing calls to contracted providers to collect appointment data, the results of which are then analyzed to produce rates of compliance which are submitted to state regulators.

Supporting our providers continued to be a primary focus in August and will be in September, including phone calls and virtual visits to share information and resources specific to COVID-19, and to ensure local and regional coordination with Local Health Departments.

Regional Operations. Regional Operations continues to work towards building collaboration with community partners. In August, we released the third edition of *The Beat*, the Alliance's community newsletter which included information on how Community Based Organizations can support their clients in becoming vaccinated, obtaining well child visits and understanding the Alliance's recuperative care pilot. Staff were on-site in Merced at a large drive-through community event and a large virtual event, and supported two additional events by providing outreach materials.

Staff have continued efforts within the Your Health Matters (YHM) Outreach Program. Outreach calls were made to members who were identified as being homebound. The calls were made to inform members of their eligibility for the COVID-19 vaccine to be given at home if they are unable to leave their home. We have successfully provided information on where to call and how to schedule an appointment as well as how to stay safe. Since the beginning of the call campaign there have been over 15,000 calls made and over 9,000 members reached. The YHM team also resumed in-person outreach through five community events in August. The key messages were focused on COVID- 19 vaccine access, vaccine importance, and safety precautions.

Partnership with the local public health department has been a focus throughout the pandemic and will continue to support improving vaccination rates in our service area.

Q2 2021 Operational Dashboard Results:

Organizational Performance Update: Q2 2021 Alliance Dashboard. The Q2 2021 *Alliance Dashboard* is comprised of 151 metrics monitoring 13 top-level health plan core, support and managerial processes. The Q2 2021 *Alliance Dashboard* indicates healthy performance, with 10 of 13 top-level processes meeting or exceeding 95% of target. Exceptions to the 95% standard and other notable performance are as follows:

- *Engage and Support Members:* Q2 2021 performance met the threshold expected performance (95.9%), and declined 1.0 percentage point over Q1 2021. Decline in performance is the result of reduced performance in the *Help Members Navigate* process (88.2%), primarily due to Carenet staffing issues and Alliance staff leaves and position vacancies. This downward trend is most prominent in April and May 2021, with a rise in performance in June 2021.

- *Manage and Improve Care:* Q2 2021 performance met the threshold for expected performance (96.1%) and declined 3.1 percentage points over Q1 2021. Decline in performance is the result of reduced performance in the *Improve Care* process (93.7%) which declined 6.3 percentage points over Q1 2021, secondary to a modest increase in moderate-severe potential quality issues; the veracity of that increase is being assessed through inter-rater reliability testing on Medical Director potential quality issue reviews.

- *Manage Alliance Compliance Commitments:* Q2 2021 performance (91.7%) declined 3.7 percentage points over Q1 2021. Decline is the result of cases reported to the plan via Beacon Health Options quarterly fraud, waste and abuse reporting, rather than on occurrence.

- *Manage Alliance Finances:* Q2 2021 performance (100.0%) increased 6.4 percentage points over Q1 2021. Rise in performance is the result of increased performance in the *Manage Alliance Revenue* process (100.0%), driven by improvements in board designated reserves (100% of target) and investment portfolio performance (100% of target).

The Q2 2021 Alliance Dashboard follows this report.

Attachments.

1. 2021-22 State Budget Summary

2021-22 State Budget Summary

Program	Funding Amount	Description	Implementation Date	Source
Cal AIM				
Enhanced Case Management (ECM)	$187.5M ($93.7M GF)	Implementation of an enhanced care management benefit in Medi-Cal managed care, to be implemented in phases beginning January 1, 2022.	January 1, 2022	WIC Section 14184.205
ECM and In Lieu of Services (ILOS) Incentives	$300M ($150M GF)	Incentives for Medi-Cal managed care plans to expand infrastructure and capacity in support of ECM and ILOS. The May Revision included language authorizing additional incentives through MCPs for this purpose if the non-federal share is provided via IGT by eligible local entities.	January 1, 2022	WIC 14184.207
ILOS Rate Add-on	$47.9M ($24M GF)	Additional rate component for continuation of ILOS-like services in WPC counties and existing plan services.	January 1, 2022	TBD
Population Health Management (PHM)	$315M ($41.5M GF) *through 2024*	DHCS to implement the Population Health Management Program under the Medi-Cal managed care delivery system to improve health outcomes, care coordination, and efficiency through application of standardized health management requirements. Each Medi-Cal managed care plan shall develop and maintain a beneficiary-centered population health management program, which is a model of care and plan of action designed to address member health needs at all points along the continuum of care Each Medi-Cal managed care plan in the population health management program shall, at a minimum, do the following: (1) Prioritize preventive and wellness services. (2) Identify and assess beneficiary member risks and needs on an ongoing basis. (3) Manage beneficiary member safety and outcomes during care transitions, across all applicable delivery systems and settings, through effective care coordination. (4) Identify and mitigate social determinants of health and reduce health disparities or inequities.	January 1, 2023	WIC Section 14184.204
Transitioning Populations	$401.6M ($174.7M GF) Budget neutral cost shift from FFS to managed care	Mandatory managed care enrollment for specific populations.	January 1, 2022 (largely N/A to the Alliance.)	WIC Section 14184.200
Providing Access and Transforming Health (PATH) Program	$200M ($100M GF)	Funding to support justice-involved initiatives within CalAIM, including capacity building, coordination, and planning for implementation of pre-release care and re-entry coordination.	January 1, 2023	WIC Section 14184.700

D-SNP	N/A	DHCS may require each Medi-Cal managed care plan to operate, or continue to operate, a D-SNP	January 1, 2026	WIC Section 14132.277 & WIC Section 14184.208
NCQA	N/A	DHCS may require each Medi-Cal managed care plan and each health plan subcontractor of a Medi-Cal managed care plan to be accredited by the National Committee for Quality Assurance, or an alternative. DHCS shall not use findings from the accreditation to deem a Medi-Cal managed care plan's compliance with applicable state and federal Medicaid requirements, except in the area of credentialing	January 1, 2026	WIC Section 14184.203
Major Organ Transplants	N/A	Donor and recipient transplant surgeries are a capitated benefit under all Medi-Cal managed care plans. From January 1, 2022 to December 31, 2024, plans shall reimburse a provider furnishing organ or bone marrow transplant surgeries to a Medi- Cal beneficiary enrolled in that plan, and each provider of organ or bone marrow transplant surgeries shall accept the payment amount the provider of organ or bone marrow transplant surgeries would be paid for those services in the Medi-Cal fee-for-service delivery system	January 1, 2022	WIC Section 14184.201(c)(1)
Medi-Cal Eligibility				
Medi-Cal Expansion	$67M ($48M GF) in 2021-22 increasing to $1.5B TF by 2024-25	Expands full-scope Medi-Cal to adults ages 50 and over regardless of immigration status.	No sooner than May 1, 2022	WIC Section 14007.8
Elimination of Medi-Cal Asset Test	$394M ($197GF) in 2022-23	Eliminates the Medi-Cal assets test, so that seniors, and individuals with disabilities, with assets of more than $2,000 do not lose or are not denied Medi-Cal coverage	No sooner than July 1, 2022	WIC Section 14005.62
Postpartum Eligibility	$90.5M ($45.3M GF) in 2021-22 $362.2M ($181.M GF) annually from 2022-23 to 2027-28	Expands eligibility from 60 days to 12 months for postpartum individuals.	Effective April 1, 2022 (in effect for up to 5 years)	WIC Section 15840

2021-22 State Budget Summary

Children and Youth Behavioral Health Initiative				
	$4.4B over 5 years	14 discrete programs or services funded with the following to be implemented in Medi-Cal managed care1414		
Student Behavioral Health Incentive	$400M over 3 years	Incentive payments paid through Medi-Cal managed care plans to build infrastructure, partnerships, and capacity, statewide for school behavioral health services	January 1, 2022	Chapter 2. Children and Youth Behavioral Health Initiative Act WIC Section 5961
Dyadic Care	$800M	In this integrated behavioral care model, pediatric mental health professionals are available to address developmental and behavioral health concerns as soon as they are identified, bypassing the many obstacles families face when referred to offsite behavioral health services. Furthermore, in this model, health care for the child is delivered in the context of the caregiver and family (i.e. "dyadic health care services") so that families are screened for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability	No sooner than July 1, 2022	WIC Section 14132.755
School partnership infrastructure and capacity grants	$550M ($100M in 2021-22 and $450M in 2022-23)	Build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services from schools, providers in schools, school-affiliated community-based organizations, or school-based health centers, in collaboration with managed care plans. Of the $500M, $400M is allocated to K-12, and $150M to higher education.		Chapter 1. Behavioral Health Continuum Infrastructure Program WIC Section 5960
Statewide school based behavioral health fee schedule*	N/A	Requires DHCS to develop a statewide fee schedule for outpatient MH or SUD treatment provided to a student at a school site. Commencing January 1, 2024, requires plans and counties to reimburse schools for medically necessary mental health or SUD treatment provided at a school site.	January 1, 2024	WIC Section 5961(a)(4)
Evidence-based behavioral health program grants*	$429M	Support statewide scale and spread of evidence-based interventions proven to improve outcomes for children and youth with or at high risk for mental health conditions, with a focus on programs serving disproportionately impacted communities or communities of color, such as on early psychosis, youth drop-in wellness centers, intensive outpatient programs for youth, and prevention and early intervention services for youth. These interventions and practices will be developed by a workgroup composed of subject matter experts convened by DHCS.	January 1, 2022	WIC Section 5961.5
**Multiple entities, including plans, are eligible to apply for and receive grant funding*				

2021-22 State Budget Summary

Benefits and Allowable Provider Types				
Doula Services	$403K ($152K GF) in 2021-22 $4.4M ($1.7M GF) annually thereafter	Adds doula services as a Medi-Cal covered benefit	Effective January 1, 2022	TBD
Community Health Workers	$16.3M ($6.2M GF) increasing to $201M ($76M GF) by 2026-27	Adds community health workers as a Medi-Cal allowable provider type	Effective January 1, 2022	TBD
Optional Benefits	$47M ($15.6M GF)	Permanently eliminates the suspension of optional benefits, including: • Audiology and speech therapy • Incontinence creams and washes • Optician and optical lab services • Podiatric services	N/A	WIC Section 14131.10
Continuous Glucose Monitors	$10.9 M ($3.8 M GF)	Adds continuous glucose monitors as a Medi-Cal covered benefit for beneficiaries with Type 1 diabetes.	Effective January 1, 2022	TBD
Over the Counter Medications	$21M ($7.8M GF) est savings	Reinstates adult over the counter cough/cold and acetaminophen as Medi-Cal covered drugs.	Effective July 1, 2021	WIC Section 14132
Whole Genome Sequencing	$3M GF annually	Adds whole genome sequencing as a Medi-Cal benefit for infants one year of age or younger receiving inpatient hospital services in an intensive care unit	Effective no sooner than January 1, 2022	WIC Section 14132
Other Health and related Budget Items				
Telehealth	Budget Neutral	Extends all telehealth PHE flexibilities through December 31, 2022. Requires DHCS to convene a stakeholder workgroup on billing and UM policies to inform the 2022-23 State Budget. Specifies stakeholders for this workgroup, including MediCal managed care plans. Adds remote patient monitoring as a Medi-Cal covered modality for services deemed appropriate.	N/A	WIC Section 14124.12
Data Exchange	$2.5M for expenditure through June 30, 2023	Establishes the California Health and Human Services Data Exchange Framework. • Requires creation, via a stakeholder advisory group process through CHHSA, of a single data exchange "framework" by July 1, 2022. • Does not address the infrastructure or mechanism by which data exchange would occur and instead focuses on the data that must be exchanged by different entities or systems by January 1, 2024. • Requires that Agency convene an Advisory Group by December 1, 2021 to develop the framework.	N/A	HSC Section 130290

2021-22 State Budget Summary

Proposition 56	$759.9M GF (est savings) Total Prop 56 funding $3.2B ($275.3M GF, $717.8M Prop 56 fund, $2.2B FF)	Permanent elimination of the Proposition 56 suspensions that would otherwise have been effective on July 1, 2021 for most Proposition 56 supplemental payments.	N/A	AB 133 Section 419 repeals Section 69 of Chapter 12 of Statutes of 2020
Public Hospital Grants	$300M GF	Requires DHCS to make grants to designated public hospitals to support increased health care expenditures as a result of COVID-19. This was a CAPH proposal adopted by the Legislature and Administration	TBD	TBD
DMHC Quality and Equity Standards	$952K in 2021-22 increasing to $5.4M in 2028-29	DMHC to establish quality measures and equity benchmark standards, including enforcement actions for non-compliance. Requires coordination and collaboration with DHCS for Medi-Cal managed care plans	Jan 2022: DMHC convene Health Equity & Quality Committee September 2022: DMHC establish set of measures & benchmarks for MY 2023 2024-25: DMHC may take enforcement action 2025: DMHC to publish Health Equity &Quality Compliance Report for MY 2023	HSC Sections 1399.870, and 1399.871

2021-22 State Budget Summary

California Home and Community Based Services Spending Plan Submitted to CMS 7/12/21 – Pending Approval				
Housing and Homelessness Incentive Program	$1.3B	Medi-Cal managed care plans would be able to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed. There would be a requirement that 85% of the funds go to beneficiaries, providers, local homeless Continuum of Care, and/or counties. Funds would be allocated by Point in Time counts of homeless individuals and other housing related metrics determined by DHCS	TBD	HCBS Spending Plan
Community Based Residential Continuum Pilots	$298M	The Community Based Residential Continuum Pilots, funded through Medi-Cal managed care plans, would provide medical and supportive services in the home, independent living settings including permanent supportive housing, and community care settings (home, ARFs, RCFEs, affordable housing) in order to avoid unnecessary healthcare costs, including emergency services and future long-term care placement in a nursing home. This program would ensure individuals are able to live in the least restrictive setting possible by ensuring access to home-based health and other personal care services for vulnerable populations, including seniors and people with disabilities	TBD	HCBS Spending Plan

Alliance Dashboard – *Quarter 2 2021*

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

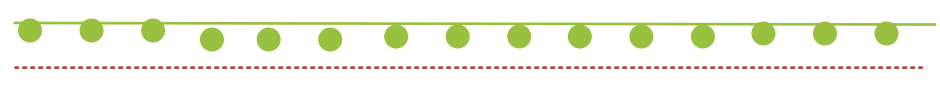
Engage & Support Members
95.9% Of Target

SUBPROCESSES
- 100 Help Members Engage
- 88.2 Help Members Navigate
- 99.5 Member Experience

Manage & Improve Care
96.1% Of Target

SUBPROCESSES
- 98.4 Manage Care Use
- 93.7 Improve Care

Develop & Maintain the Provider Network
98.4% Of Target



SUBPROCESSES
- 98.5 Develop the Network
- 98.3 Maintain the Network

Pay Providers
99.5% Of Target

SUBPROCESSES
- 99.0 Fee-for-Service Payments
- 100 Value-Based Payments

Managerial Processes
Guide the organization

98.0 Enhance Operational Effectiveness

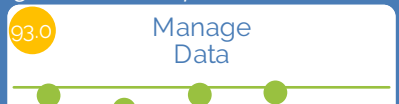

91.7 Manage Compliance Commitments


100 Manage Finances


98.9 Manage Governmental & Community Relations


Support Processes *Enable organizational operations*

94.6 Acquire & Retain Employees


93.0 Manage Data


100 Manage Technology


100 Provide Administrative Services


98.9 Communications & Organizational Branding


Back to Agenda

Alliance Dashboard

Board Metrics

No.	Metric	Period	Target	Performance
1	% of days achieving member call answer time service level target	Q221	80.0%	54.7%
2	New Member Welcome Call Completion Rate	Q121	30.0%	26.9%
3	Timely Resolution of Member Complaints	Q221	100.0%	99.2%
4	Members' Favorable Rating of Health Plan (CAHPS) (Medi-Cal)	2019	Child: 86.0% | Adult: 73.0%	Child: 86.5% | Adult: 75.6%
5	Members' Favorable Rating of Health Care (CAHPS) (Medi-Cal)	2019	Child: 84.5% | Adult: 70.5%	Child: 82.0% | Adult: 69.7%
6	% of Routine PCP Facility Site Reviews Completed Timely	Q221	100.0%	100.0%
7	% of Facility Sites Reviewed in Good Health	Q221	100.0%	100.0%
8	In Area PCP Market Share (all counties)	Q221	80.0%	85.8%
9	In Area Specialist Market Share (all counties)	Q221	80.0%	84.1%
10	Contracted PCP Open % (all counties)	Q221		58.0%
11	Overall Provider Satisfaction Rate	2020	88.0%	84.0%
12	Inpatient Bed Days/ 1,000 members/Year (Medi-Cal)	Q121	282.0	264.0
13	Admissions/1,000 Members/Year (Medi-Cal)	Q121	63.0	53.0
14	Total 30 Day All-Cause Readmissions %	Q121	11.0%	12.0%
15	Ambulatory Care Sensitive Admissions (Medi-Cal)	Q121	8.0%	6.1%
16	Average Length of Stay (Medi-Cal)	Q121	4.5	5.0
17	Emergency Department visits/1,000 members/year (all LOBs)	Q121	513.0	310.0
18	Avoidable Emergency Department visits (all LOBs)	Q121	18.0%	8.8%
19	Behavioral Health Utilization Rate by County (All Ages)	Q121	3.6%	SC: 9.1% | Mont: 4.1% | Merced: 4.1%
20	Routine Medical/Surgical Prior Authorizations Adjudicated Timely	Q221	100.0%	99.0%
21	Medical/Surgical authorization denial rate	Q221		1.0%
22	Pharmacy Cost/Member/Month - Retail, Outpatient & Specialty	Q221	$46.59	$50.51
23	Generic Prescription %	Q221	88.0%	89.7%
24	Clean Claims Processed and Paid Within 30 Calendar Days	Q221	90.0%	94.7%
25	Employee Turnover Rate	Q320-Q221	10.0%	6.4%
26	Total Staffed Workforce	Q221	90.0%	94.4%
27	Board Designated Reserves Percentage	Q221	100.0%	104.4%
28	Net Income Percentage	Q221	1.0%	10.2%
29	Medical Loss Ratio	Q221	92.0%	84.1%
30	Administrative Loss Ratio	Q221	6.0%	5.3%

Back to Agenda

DATE: September 22, 2021

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Seventh Month Ending July 31, 2021

For the month ending July 31, 2021, the Alliance reported a Medical Loss Ratio (MLR) of 79.4%, an Administrative Loss Ratio (ALR) of 4.7%, and an Operating Income Ratio of 15.9%. The Year-to-Date (YTD) MLR is 85.2%, ALR is 5.3%, and the Operating Income is 9.5%.

The 2021 budget assumed services to rebound starting Q4 2020 and Q1 2021 to return to the 2019 level. However, the assumption was not realized and utilization continued to be suppressed through March 2021. Utilization from physician services, outpatient services and pharmacy picked up in Q2 2021 and has slightly trended down in July. As a result, YTD medical expenses are favorable to budget by $60.4M or 7.2%.

Jul-21 MTD (In $000s)

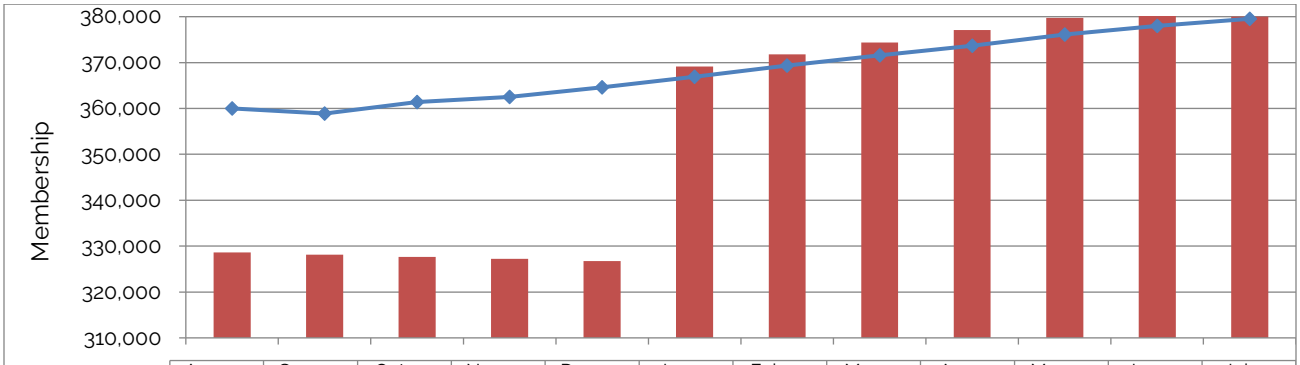
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*379,537*	*380,048*	*(511)*	*-0.1%*
Revenue	138,031	125,920	12,111	9.6%
Medical Expenses	109,580	122,071	12,491	10.2%
Administrative Expenses	6,529	7,452	923	12.4%
Operating Income/(Loss)	21,922	(3,603)	25,525	100.0%
Net Income/(Loss)	21,157	(4,313)	25,470	100.0%
MLR %	*79.4%*	*96.9%*	*17.6%*	
ALR %	*4.7%*	*5.9%*	*1.2%*	
Operating Income %	*15.9%*	*-2.9%*	*18.7%*	
Net Income %	*15.3%*	*-3.4%*	*18.8%*	

Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
	Jul-21 YTD (In $000s)			
Membership	*2,615,166*	*2,634,627*	*(19,461)*	*-0.7%*
Revenue	908,222	873,571	34,651	4.0%
Medical Expenses	773,960	834,409	60,448	7.2%
Administrative Expenses	48,025	49,961	1,936	3.9%
Operating Income/(Loss)	86,237	(10,799)	97,036	100.0%
Net Income/(Loss)	81,943	(15,520)	97,463	100.0%
PMPM				
Revenue	347.29	331.57	15.72	4.7%
Medical Expenses	295.95	316.71	20.76	6.6%
Administrative Expenses	18.36	18.96	0.60	3.2%
Operating Income/(Loss)	32.98	(4.10)	37.07	100.0%
MLR %	85.2%	*95.5%*	*10.3%*	
ALR %	*5.3%*	*5.7%*	*0.4%*	
Operating Income %	*9.5%*	*-1.2%*	*10.7%*	
Net Income %	*9.0%*	*-1.8%*	*10.8%*	

Per Member Per Month. Capitation revenue and medical expenses are variable based on enrollment fluctuations; therefore, the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not directly correspond with enrollment and are therefore viewed in terms of total dollar amount. At a PMPM level, YTD revenue is $347.29, which is favorable to budget by $15.72 or 4.7%. Medical cost PMPM is $295.95, which is favorable by $20.76 or 6.6% and administrative cost PMPM is $18.36, which is favorable by $0.60 or 3.2%. The resulting operating income is $32.98 PMPM.

Membership. July 2021 Member Months are unfavorable to budget by 0.1%. Please note that the budget assumes the Public Health Emergency (PHE) will end in June 2021.
In the Governor's May Revision, the PHE is assumed to end in December 2021. This will result in favorable membership and member months for the year.

Membership. Actual vs. Budget (based on actual enrollment trend for Jul-21 rolling 12 months)



	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Budget	328,615	328,140	327,668	327,197	326,727	369,146	371,753	374,390	377,057	379,753	382,481	380,048
Actual	359,992	358,888	361,422	362,525	364,602	366,938	369,355	371,584	373,691	376,094	377,967	379,537
Variance	31,377	30,748	33,754	35,328	37,875	(2,208)	(2,398)	(2,806)	(3,366)	(3,659)	(4,514)	(511)
Variance %	9.5%	9.4%	10.3%	10.8%	11.6%	-0.6%	-0.6%	-0.7%	-0.9%	-1.0%	-1.2%	-0.1%

Revenue. The budgeted revenue was based on the 2021 rate package as of October 2020. Revised rates received July 13, 2021 included Pharmacy, COVID and LTC add-ons for the entire CY 2021. This resulted in stronger and more favorable revenue.

July 2021 capitation revenue of $137.8M is favorable to budget by $12.1M or 9.7%. Of this $12.1M favorability, $6.8M is attributed to revised rates received on July 13, 2021 for the period of January 2021 to July 2021, and $0.6M for prior year Hyde adjustments. July 2021 YTD revenue of $906.4M is favorable to budget by $34.9M or 4.0%, of which $3.1M is attributed to enrollment and $31.8M to rate variance.

Jul-21 YTD Capitation Revenue Summary (In $000s)

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	202,402	195,810	6,593	1,587	5,006
Monterey	394,889	379,303	15,586	527	15,059
Merced	309,089	296,373	12,716	956	11,760
Total	**906,380**	**871,485**	**34,895**	**3,070**	**31,825**

Note: Excludes Jul-21 YTD In-Home Supportive Services (IHSS) premiums revenue of $1.8M.

Medical Expenses. July 2021 Medical Expenses of $109.6M are favorable to budget by $12.5M or 10.2%. July 2021 YTD Medical Expenses are $774.0M, which is favorable to budget by $60.4M or 7.2%, with an MLR of 85.2%. Of this $60.4M favorability, $6.2M is attributed to enrollment and $54.3M to PMPM cost variance.

Jul-21 YTD Medical Expense Summary ($ In 000's)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	253,049	254,887	1,838	1,883	(44)
Inpatient Services (LTC)	80,547	112,326	31,779	830	30,949
Physician Services	134,680	137,081	2,401	1,013	1,388
Outpatient Facility	58,085	48,330	(9,755)	357	(10,112)
Pharmacy	121,445	124,753	3,307	922	2,386
Other Medical	126,155	157,032	30,877	1,160	29,718
Total	**773,960**	**834,409**	**60,448**	**6,163**	**54,285**

Note: Surgical Clinics cost was reclassified to Outpatient Facility and budget is in the Other Medical category.

At a PMPM level, YTD Medical Expenses are $295.95, which is favorable by $20.76 or 6.6% as compared to budget. Please note that rate (PMPM) is the unit cost for a service, and when multiplied by the utilization for the service, equals the medical cost. The suppressed utilization contributed to the favorable rate variance.

YTD authorization trends indicate outpatient services are rising, whereas inpatient services are right at budget. As the pandemic is turning a corner, we believe members are now aggressively seeking services within the outpatient setting that may have been postponed to post-pandemic times. This would explain the unfavorable variance in outpatient services against budget.

Jul-21 YTD Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	96.76	96.75	(0.02)	0.0%
Inpatient Services (LTC)	30.80	42.63	11.83	27.8%
Physician Services	51.50	52.03	0.53	1.0%
Outpatient Facility	22.21	18.34	(3.87)	-21.1%
Pharmacy	46.44	47.35	0.91	1.9%
Other Medical	48.24	59.60	11.36	19.1%
Total	**295.95**	**316.71**	**20.76**	**6.6%**

Administrative Expenses. July 2021 YTD Administrative Expenses are favorable to budget by $1.9M with a 5.3% ALR.

Non-Operating Revenue/Expenses. July 2021 YTD Total Non-Operating Revenue is unfavorable to budget by $3.0M, primarily driven by lower interest income and unrealized gain/loss on investments. This is offset by a favorable July 2021 YTD Non-Operating Expense of $3.4M, for a net impact of $0.4M.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $81.9M, with a MLR of 85.2%, and an ALR of 5.3%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Seventh Month Ending July 31, 2021
(In $000s)

Assets	
Cash	$73,766
Restricted Cash	300
Short Term Investments	490,123
Receivables	173,067
Prepaid Expenses	3,312
Other Current Assets	17,652
Total Current Assets	**$758,219**
Building, Land, Furniture & Equipment	
Capital Assets	$83,662
Accumulated Depreciation	(39,584)
CIP	3,437
Total Non-Current Assets	**47,515**
Total Assets	**$805,734**
Liabilities	
Accounts Payable	$16,193
IBNR/Claims Payable	229,464
Accrued Expenses	1
Estimated Risk Share Payable	5,856
Other Current Liabilities	7,688
Due to State	0
Total Current Liabilities	**$259,201**
Fund Balance	
Fund Balance - Prior	$464,590
Retained Earnings - CY	81,943
Total Fund Balance	**546,533**
Total Liabilities & Fund Balance	**$805,734**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Seventh Month Ending July 31, 2021
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*379,537*	*380,048*	*(511)*	*-0.1%*	*2,615,166*	*2,634,627*	*(19,461)*	*-0.7%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$137,751	$125,609	$12,141	9.7%	$906,380	$871,485	$34,895	4.0%
Premiums Commercial	281	311	(30)	-9.7%	1,843	2,086	(243)	-11.7%
Total Operating Revenue	**$138,031**	**$125,920**	**$12,111**	**9.6%**	**$908,222**	**$873,571**	**$34,651**	**4.0%**
Medical Expenses								
Inpatient Services (Hospital)	$39,455	$36,775	($2,680)	-7.3%	$253,049	$254,887	$1,838	0.7%
Inpatient Services (LTC)	9,740	17,286	7,547	43.7%	80,547	112,326	31,779	28.3%
Physician Services	19,494	20,210	716	3.5%	134,680	137,081	2,401	1.8%
Outpatient Facility	7,854	7,030	(824)	-11.7%	58,085	48,330	(9,755)	-20.2%
Pharmacy	15,527	17,343	1,816	10.5%	121,445	124,753	3,307	2.7%
Other Medical	17,511	23,427	5,916	25.3%	126,155	157,032	30,877	19.7%
Total Medical Expenses	**$109,580**	**$122,071**	**$12,491**	**10.2%**	**$773,960**	**$834,409**	**$60,448**	**7.2%**
Gross Margin	**$28,451**	**$3,849**	**$24,602**	**100.0%**	**$134,262**	**$39,162**	**$95,100**	**100.0%**
Administrative Expenses								
Salaries	$4,341	$4,775	$435	9.1%	$32,534	$32,615	$81	0.2%
Professional Fees	209	175	(34)	-19.6%	967	1,176	209	17.8%
Purchased Services	807	849	42	4.9%	5,946	5,920	(26)	-0.4%
Supplies & Other	552	901	350	38.8%	4,223	5,191	968	18.6%
Occupancy	68	108	40	37.4%	490	762	272	35.7%
Depreciation/Amortization	553	644	91	14.1%	3,866	4,298	432	10.0%
Total Administrative Expenses	**$6,529**	**$7,452**	**$923**	**12.4%**	**$48,025**	**$49,961**	**$1,936**	**3.9%**
Operating Income	**$21,922**	**($3,603)**	**$25,525**	**100.0%**	**$86,237**	**($10,799)**	**$97,036**	**100.0%**
Non-Op Income/(Expense)								
Interest	$316	$565	($249)	-44.1%	$2,074	$4,028	($1,954)	-48.5%
Gain/(Loss) on Investments	142	(23)	164	100.0%	(1,359)	(162)	(1,197)	-100.0%
Other Revenues	107	82	24	29.7%	806	665	141	21.3%
Grants	(1,330)	(1,335)	5	0.4%	(5,815)	(9,252)	3,437	37.2%
Total Non-Op Income/(Expense)	**($765)**	**($710)**	**($55)**	**-7.7%**	**($4,294)**	**($4,721)**	**$427**	**9.0%**
Net Income/(Loss)	**$21,157**	**($4,313)**	**$25,470**	**100.0%**	**$81,943**	**($15,520)**	**$97,463**	**100.0%**
MLR	*79.4%*	*96.9%*			*85.2%*	*95.5%*		
ALR	*4.7%*	*5.9%*			*5.3%*	*5.7%*		
Operating Income	*15.9%*	*-2.9%*			*9.5%*	*-1.2%*		
Net Income %	*15.3%*	*-3.4%*			*9.0%*	*-1.8%*		

Back to Agenda

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Seventh Month Ending July 31, 2021
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*379,537*	*380,048*	*(511)*	*-0.1%*	*2,615,166*	*2,634,627*	*(19,461)*	*-0.7%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$362.94	$330.51	$32.43	9.8%	$346.59	$330.78	$15.80	4.8%
Premiums Commercial	0.74	0.82	(0.08)	-9.5%	0.70	0.79	(0.09)	-11.0%
Total Operating Revenue	**$363.68**	**$331.33**	**$32.36**	**9.8%**	**$347.29**	**$331.57**	**$15.72**	**4.7%**
Medical Expenses								
Inpatient Services (Hospital)	$103.96	$96.76	($7.19)	-7.4%	$96.76	$96.75	($0.02)	0.0%
Inpatient Services (LTC)	25.66	45.48	19.82	43.6%	30.80	42.63	11.83	27.8%
Physician Services	51.36	53.18	1.82	3.4%	51.50	52.03	0.53	1.0%
Outpatient Facility	20.69	18.50	(2.20)	-11.9%	22.21	18.34	(3.87)	-21.1%
Pharmacy	40.91	45.63	4.72	10.4%	46.44	47.35	0.91	1.9%
Other Medical	46.14	61.64	15.50	25.2%	48.24	59.60	11.36	19.1%
Total Medical Expenses	**$288.72**	**$321.20**	**$32.48**	**10.1%**	**$295.95**	**$316.71**	**$20.76**	**6.6%**
Gross Margin	**$74.96**	**$10.13**	**$64.84**	**100.0%**	**$51.34**	**$14.86**	**$36.48**	**100.0%**
Administrative Expenses								
Salaries	$11.44	$12.57	$1.13	9.0%	$12.44	$12.38	($0.06)	-0.5%
Professional Fees	0.55	0.46	(0.09)	-19.7%	0.37	0.45	0.08	17.2%
Purchased Services	2.13	2.23	0.11	4.8%	2.27	2.25	(0.03)	-1.2%
Supplies & Other	1.45	2.37	0.92	38.7%	1.61	1.97	0.36	18.0%
Occupancy	0.18	0.28	0.11	37.3%	0.19	0.29	0.10	35.3%
Depreciation/Amortization	1.46	1.69	0.24	13.9%	1.48	1.63	0.15	9.4%
Total Administrative Expenses	**$17.20**	**$19.61**	**$2.40**	**12.3%**	**$18.36**	**$18.96**	**$0.60**	**3.2%**
Operating Income	**$57.76**	**($9.48)**	**$67.24**	**100.0%**	**$32.98**	**($4.10)**	**$37.07**	**100.0%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Seventh Month Ending July 31, 2021
(In $000s)

	MTD	YTD
Net Income	$21,157	$81,943
Items not requiring the use of cash: Depreciation	553	3,338
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	(6,067)	74,663
Prepaid Expenses	135	(490)
Current Assets	1,304	1,853
Net Changes to Assets	**($4,628)**	**$76,025**
Changes to Payables:		
Accounts Payable	(24,909)	(24,367)
Accrued Expenses	-	-
Other Current Liabilities	125	225
Incurred But Not Reported Claims/Claims Payable	(10,227)	(81,352)
Estimated Risk Share Payable	842	(4,154)
Due to State	-	-
Net Changes to Payables	**($34,169)**	**($109,649)**
Net Cash Provided by (Used in) Operating Activities	**($17,086)**	**$51,657**
Change in Investments	(50,626)	(134,012)
Other Equipment Acquisitions	(551)	(924)
Net Cash Provided by (Used in) Investing Activities	**($51,177)**	**($134,937)**
Net Increase (Decrease) in Cash & Cash Equivalents	**($68,264)**	**($83,279)**
Cash & Cash Equivalents at Beginning of Period	**$142,030**	**$157,045**
Cash & Cash Equivalents at July 31, 2021	**$73,766**	**$73,766**

DATE: September 22, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Whole Child Model Clinical Advisory Committee: Member Appointment

---

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

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

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

Name	Affiliation	County
Dr. Salvador Sandoval	Physician	Merced

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

Attachments. N/A

SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, June 23, 2021
9:30 a.m. – 4:00 p.m.
Central California Alliance for Health
1700 Green Hills Road, Scotts Valley, CA 95066

Commissioners Present:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Supervisor Ryan Coonerty	County Board of Supervisors
Dr. Larry deGhetaldi	Provider Representative
Ms. Julie Edgcomb	Public Representative
Ms. Dori Rose Inda	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative (by teleconference)
Ms. Rebecca Nanyonjo	Director of Public Health
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Dr. Joerg Schuller	Hospital Representative (by teleconference)
Mr. Rob Smith	Public Representative
Mr. Tony Weber	Provider Representative

Commissioners Absent:

Dr. Maximiliano Cuevas	Provider Representative
Ms. Mimi Hall	County Health Services Agency Director
Ms. Elsa Quezada	Public Representative

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Dr. Dale Bishop	Chief Medical Officer
Ms. Marina Owen	Chief Operating Officer
Ms. Van Wong	Chief Information Officer
Ms. Kathleen McCarthy	Strategic Development Director
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Conner.

Commission Chairperson Conner called the meeting to order at 9:37 a.m.

There were no supplements or deletions to the agenda.

Roll call was taken and a quorum was present.

2. Oral Communications.

Chair Conner 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 Conner opened the floor for Commissioners to make comments.

No comments or announcements from Commissioners at this time.

Consent Agenda Items: (4. – 7D.): 3:09 p.m.

Chair Conner opened the floor for approval of the Consent Agenda 4-7D.

MOTION: Commissioner Askew moved to approve Consent Agenda items 4-7D, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, Coonerty, deGhetaldi, Edgcomb, Inda, Jimenez, Kalantari-Johnson, Pedrozo, Rabago, Radner, Smith and Weber.

Noes: None.

Absent: Commissioners Cuevas, Hall, Molesky, Nanyonjo, Quezada and Schuller.

Abstain: None.

Chair Conner advised the Board that item 7E presented potential conflicts of interest. Board members who perceived that they were at risk for a conflict of interest were advised to abstain from discussion and voting.

Chair Conner opened the floor for approval of Consent Agenda item 7E to approve recommendation on fee-for-service Care-Based Incentive 2022 measure.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Coonerty, Edgcomb, Kalantari-Johnson, Pedrozo and Smith.

Noes: None.

Absent: Commissioners Cuevas, Hall, Molesky, Nanyonjo, Quezada and Schuller.

Abstain: Conner, deGhetaldi, Inda, Jimenez, Rabago, Radner and Weber.

8. Comments and announcements by Chief Executive Officer.

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

Ms. Sonnenshine, CEO, welcomed Commissioners to the retreat. Efforts have concluded under the last strategic plan and the pandemic has put a spotlight on health and income disparities and racial injustice. She indicated that this is a great time to consider what is most important for the Alliance to focus on over the next five years to move our members and communities closer to health. Today's retreat is meant to engage and affirmatively indicate support and to voice any different ideas or concerns where they may exist.

Ms. Sonnenshine introduced Ms. Wendy Todd and Ms. Selma Abinader who assisted with retreat facilitation. Their biographies were included in the June 23, 2021 retreat agenda packet.

Retreat Agenda Item: (9. - 16.): 9:47 a.m.

9. Introductions. (9:47 – 10:07 a.m.)

Ms. Sonnenshine introduced Ms. Wendy Todd, Wendy Todd Consulting, who reviewed the retreat agenda and provided an overview of the day. The retreat began with a land acknowledgement and introductions. Alliance values (equity, integrity, improvement and collaboration) were posted around the room and Commissioners and Executive staff moved to the value that resonated most with them. Each group reported out on why they chose that value.

[Commissioner Molesky arrived by teleconference at this time: 9:53 a.m.]

10. Board Discussion: Context Setting. (10:07 – 10:43 a.m.)

Ms. Kathleen McCarthy, Strategic Development Director and Ms. Todd set the context of where the Alliance is headed and provided an overview of the SWOT (strengths, weaknesses, opportunities, and threats) analysis.

[Commissioner Schuller arrived by teleconference at this time: 10:11 a.m.]

Ms. Todd reviewed the SWOT analysis including strengths, weakness/opportunities to improve, external opportunities, and external threats.

[Commissioner Nanyonjo arrived at this time: 10:25 a.m.]

Ms. McCarthy presented the draft Strategic Plan and goals to orient the Board for the afternoon conversation and reviewed the areas the Alliance should focus on in order to achieve its mission.

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

11. Board Discussion: Embedding Operations in the Strategic Plan. (10:53 – 11:15 a.m.)

Ms. Sonnenshine and Ms. Lisa Ba, Chief Financial Officer, reviewed operational themes identified in the SWOT as perceived threats or weaknesses. These areas include organizational alignment, technology and analytics, Alliance workforce and financial environment, performance and strategy. Ms. Sonnenshine noted that alignment, technology and analytics and workforce are consistent with the 2018 themes resulting in "building blocks" in the 2018-2020 plan. Ms. Sonnenshine identified these areas as ever objectives, areas where strength enables performance and weakness constrains performance. Prioritizing action in these areas alone won't advance the Alliance's vision, and the Alliance's strategy execution and business process management accounts for and prioritizes work in these areas as a routine matter of business. Ms. Ba addressed the fourth identified area of operational focus, financial performance and strategy, and noted the staff and board emphasis in this area over the past three years. Ms. Ba reviewed core financial concepts regarding financial performance that will inform future strategy execution and business process management. Medical Cost takeaways: 1) Plan and providers have a shared responsibility in the availability and quality of services to drive appropriate utilization; 2) Plan and providers should have a shared focus in unit cost containment to ensure program sustainability; and 3) Medical Cost is a key factor to revenue development. Reserves takeaways: 1) reserves protect against unexpected events, losses of revenue, and large unbudgeted expenses; 2) reserves are not intended to fund ongoing or escalating medical costs or new benefits not supported by revenue; and 3) reserves beyond regulatory and board requirements can strategically be used for Medi-Cal purposes to expand capacity, increase efficiency and address social determinants of health. The focus for financial strategy for 2022 and beyond includes executing the Cost Containment Plan, value-based payment and aligned incentives, maintaining operational efficiency and investing in administrative capacity, optimizing the use of technology for financial analysis, and leveraging strategic use of reserves to advance the newly articulated vision.

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

12. Board Discussion: Health Equity. (11:15 – 11:48 a.m.)

Dr. Palav Babaria, Chief Quality Officer and Deputy Director of Quality and Population Health Management, California Department of Health Care Services, presented remotely on health equity at the State level. Ms. Selma Abinader facilitated Board discussion.

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

13. Board Discussion: Diversity Equity and Inclusion. (12:21 – 12:34 p.m.)

Mr. Scott Fortner, Chief Administrative Officer provided an update on the Diversity, Equity and Inclusion (DEI) initiative. The Alliance has contracted with DEI initiative consultants Dr. Carley Corrado and Ms. Lisa Dennen-Young of Enliven Leadership to lead this effort. A steering

committee has been established and meetings are underway. A staff survey is currently in development and a four-hour all-staff DEI training is scheduled for July 22, 2021. Town Hall events and listening tours will be scheduled in the near future.

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

[Commissioner Rabago departed at this time: 12:44 p.m.]

14. Strategic Priorities: Small Group Discussions. (12:52 – 2:00 p.m.)

Commissioners and Executive staff broke into small groups (world café) to discuss the strategic priorities and goals. There were six groups that engaged in discussions on Accessible Behavioral Health, Health Equity, and Medi-Cal Delivery System Transformation.

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

15. Strategic Priorities: Large Group Debrief. (2:10 – 3:32 p.m.)

Commissioners and Executive staff reconvened to discuss the themes that emerged from the small group discussions. Key takeaways from the small group discussions included:

- Support of health equity, system transformation and behavioral health as they align with the Alliance's vision, mission and values.
- Feedback was provided about how the organization should approach health equity and how it is defined.
- Commissioners emphasized a need to focus on kids and known disparities, a need for and reliance on data (evaluating, assessing and accessing data), and partnerships.
- Commissioners expressed excitement around the idea of health equity and acknowledged that this is new territory for the health plan. They recognized too, that health equity is going to be a long-term priority.
- Commissioners acknowledged the need to bring providers along on this journey toward health equity.
- Commissioners expressed excitement around System Transformation with an emphasis on partnerships. There was excitement as well as some apprehension around System Transformation.
- Commissioners discussed thinking and acting regionally as opposed to focusing on their own county.
- Commissioners expressed financial concerns, and raised challenges related to silos and the politics that are present in the work we do.
- Commissioners expressed interest in not letting go of, or losing sight of, the work we do today as we transform the system.
- There was interest and engagement around having a priority or goals related to Behavioral Health.
- Discussion focused on moving upstream on prevention and measuring clinical outcomes.
- Commissioners determined that Behavioral Health should have specific goals that fall under Health Equity and System Transformation instead of being its own priority.

16. Closing Activity and Wrap up: Reflections on the Day. (3:32 – 3:42 p.m.)

Ms. Todd led Commissioners and Executive staff in a closing exercise asking them to each provide a headline for a newspaper article articulating what success would look like for the organization five years from now.

[Commissioner Molesky departed at this time: 3:37 p.m.]

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

The Commission adjourned its meeting of June 23, 2021 at 3:42 p.m. to September 22, 2021 at 3:00 p.m. via teleconference unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, June 16, 2021
8:30 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Bob Trinh	Technology Services Director
Bryan Smith	Claims Director
Chris Morris	Operational Excellence Director
Danita Carlson	Government Relations Director
Frank Song	Analytics Director
Gordon Arakawa	Medical Director
Jay Sen	Budgeting and Reporting Director
Jenifer Mandella	Compliance Officer (Chair)
Jennifer Mockus	Community Care Coordination Director
Jordan Turetsky	Provider Services Director
Joy Cubbin	Accounting Director
Kay Lor	Provider Payment Director
Lilia Chagolla	Regional Operations Director, Monterey County
Linda Gorman	Communications Director
Lisa Ba	Chief Financial Officer
Lisa Hauck	Human Resources Director
Luis Somoza	Compliance Manager
Marina Owen	Chief Operating Officer
Mary Brusuelas	UM and Complex Case Management Director
Maya Heinert	Medical Director
Michelle Stott	Quality Improvement and Population Health Director
Navneet Sachdeva	Pharmacy Director
Rick Dabir	Application Services Director
Ronita Margain	Regional Operations Director, Merced County
Ryan Inlow	Facilities & Administrative Services Director
Scott Fortner	Chief Administrative Officer
Stephanie Sonnenshine	Chief Executive officer
Van Wong	Chief Information Officer

Committee Members Absent:

Back to Agenda

Dianna Diallo	Medical Director

Committee Members Excused:

Dale Bishop	Chief Medical officer
Kathleen McCarthy	Strategic Development Director

Ad-Hoc Attendees:

Kate Knutson	Compliance Supervisor
Sara Halward	Compliance Specialist

1. Call to Order by Chairperson Mandella.

Chairperson Jenifer Mandella called the meeting to order at 8:32 a.m.

2. Review and Approval of May 19, 2021 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of May 19, 2021 meeting.

3. Consent Agenda.

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

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. Program Integrity Quarterly Report

Knutson, Compliance Supervisor, presented the Q1 2021 Program Integrity Activity Report and reviewed select Matters Under Investigation (MUIs). Knutson reported that 25 concerns were referred to Program Integrity in Q1 2021, 18 of which resulted in the opening of an MUI. There were 67 active MUIs in Q1 2021.

Knutson reviewed referral trends for the period noting that of the 18 referrals which resulted in an MUI: 10 were provider specific related to potential false billing, potential lack of medical necessity for services and general billing irregularities; 5 were member referrals related to potential eligibility fraud and medical identity theft; 2 were requests from DHCS for provider or member data; and 1 was waste related.

Knutson reviewed performance of the Program Integrity metrics from the Q1 Alliance Dashboard, noting that performance was above threshold for the quality metric. The efficiency metric was below the performance threshold due to lack of timely reporting to Program Integrity.

Knutson reviewed 2 exemplar cases, highlighting investigative measures taken and next steps for completion of MUI investigation.

COMMITTEE ACTION: Committee reviewed and approved the Q1 2021 Program Integrity Report.

2. Internal Audit & Monitoring Quarterly Report

Halward, Compliance Specialist II, presented the Q1 2021 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 3 reviews were conducted, 2 of which received a passing score.

Halward reviewed one exemplar internal audit focused on ensuring that Pharmacy authorizations are voided for the appropriate reasons. The audit received a failed score and resulted in required modification of Pharmacy policies and procedures and recommended management review findings and process modifications with responsible staff.

Halward reviewed outcomes of the monitoring of 42 Alliance Dashboard metrics related to regulatory requirements, noting that 40 metrics met their established thresholds and 2 did not meet their established thresholds in Q1 2021. Staff have requested department response for the metrics that did not meet threshold.

Halward reported that the Alliance received preliminary findings report from DMHC in regards to the 2020 Medical Survey. The report included 15 findings related to Grievances and Appeals, Utilization Management, Access to Emergency Services and Payment and Prescription Drug Coverage. A response was submitted to DMHC on May 28, 2021.

Mandella advised that DMHC plans to begin focused investigations on compliance with Mental Health Parity laws and advised that the Alliance proactively prepare for such a review.

COMMITTEE ACTION: Committee reviewed and approved the Q1 2021 Internal Audit & Monitoring Report.

3. Beacon Pre-Delegation Evaluation

Somoza, Compliance Manager and Mockus, Community Care Coordination Director, presented pre-delegation evaluation and outcomes for Beacon Health Options of California (BHOC).

Mockus reported that Utilization Management (UM), Member Services and Compliance staff reviewed requested documentation from BHOC and found BHOC processes met Alliance requirements. Staff recommend approval of delegation of the UM and Member Appeals functions to BHOC.

COMMITTEE ACTION: Committee reviewed and approved the delegation of Utilization Management, including Member Appeals to Beacon Health Options of California.

The meeting adjourned at 9:52 a.m.

Respectfully submitted,

Robin Sihler
Administrative Assistant - Compliance

CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

Meeting Minutes
Thursday, April 29, 2021
12:00 – 1:30 p.m.

Virtual Meeting / Web Conference

Committee Members Present

Dr. Amy McEntee	Provider Representative
Dr. Caroline Kennedy	Provider Representative
Dr. Casey KirkHart	Provider Representative
Dr. Eric Sanford	Provider Representative
Dr. Eugene Santillano	Provider Representative
Dr. Madhu Raghavan	Provider Representative
Dr. Oguchi Nkwocha	Provider Representative
Dr. Stephanie Graziani	Provider Representative
Ms. Susan Harris	Hospital Representative

Guests Present:

Ms. Katilyn Mcintire	Hospital Representative

Committee Members Absent:

Ms. Allyse Gilles	Hospital Representative
Ms. Rohini Mehta	Hospital Representative

Staff Present:

Dr. Dale Bishop	Chair and Chief Medical Officer
Mr. Amit Karkhanis	Quality and Performance Improvement Mgr.
Mr. Chris Morris	Operational Excellence Director
Ms. DeAnna Leamon	Quality Improvement Nurse Supervisor
Ms. Deborah Pineda	Quality and Health Programs Manager
Dr. Dianna Diallo	Medical Director
Ms. Hilary Gillette-Walch	Quality and Population Health Manager
Dr. Gordon Arakawa	Medical Director
Ms. Jacqueline Van Voerkens	Administrative Specialist
Ms. Jennifer Mockus	Community Care Coordination Director
Ms. Lilia Chagolla	Regional Operations Director
Ms. Mary Brusuelas	UM/Complex Case Management Director
Ms. Michelle Stott	QI/ Population Health Director
Ms. Navneet Sachdeva	Pharmacy Director
Ms. Ronita Margain	Regional Operations Director

1. Call to Order by Dr. Dale Bishop, Chief Medical Officer

Dr. Dale Bishop called the meeting to order at 12:05 PM, welcomed all members present and established the quorum.

Jennifer Mockus, CCC Director, announced in January of 2022 Enhanced Care Management (ECM) will be available to Medi-Cal recipients of specifics target populations. The Alliance is working in collaboration with Department of Health Care Services (DHCS) on this new benefit.

Committee member inquired if the Alliance is aware of a solution for members with medical issues who experience incarceration, and are discontinued of their Medi-Cal insurance. This population will be included in the new ECM benefit. This is one of seven populations ECM will focus on.

Consent Agenda
Dr. Dale Bishop introduced the consent agenda.

January 28, 2021 CQIC Meeting Minutes

Dr. Dale Bishop presented the January 28, 2021 CQIC Minutes. No edits requested at this time. One action item is pending.

Committee Decision: Dr. Sanford, motioned, Dr. Kennedy, 2nd. Minutes were approved as written.

Subcommittee/Workgroup Meeting Minutes

- Continuous Quality Improvement Workgroup – Interdisciplinary (CQIW - I) Minutes (Q4 2020)
- Continuous Quality Improvement Workgroup (CQIW) Minutes (Q4 2020)
- Pharmacy and Therapeutic (P&T) Committee – Formulary Q4 2020 & Q1 2021)
- Utilization Management Workgroup (UMWG) Minutes (Q1 2021)

Workplans:

- Q4 2020 Utilization Management Work Plan
- Q4 2020 Quality Improvement Work Plan
- 2020 Quarter 4: Quality Improvement (QI) Workplan. Executive Summary
- 2021 Utilization Management Work Plan
- 2021 Quality Improvement and Population Health Work plan
- 2020 Quality and Performance Improvement Program (QPIP) Annual Report

Committee discussed potential negative outcomes of reduced admissions. Committee also discussed utilization of a dashboard, which would include public

health data to monitor such consequences such as death/stroke/heart attacks, as well as readmission and hospitalization rates.

Policies Requiring CQIC Approval:

Policy Number	Title	Significant Changes
401-1101	Quality and Performance Improvement Program	• Annual Review of Policy. • Updated department name and job titles as appropriate. • Included staff from Health Programs • Emphasized on the integration and cross collaboration with all departments within the Alliance
401-1306	Corrective Action Plan for Quality Issues	• Updated policy to align with APL 20-006 Site Reviews: Facility Site Review and Medical Record Review

Delegate Oversight Report (BEACON): Q4-2020 delegate oversite summary included in consent agenda meeting packet.

QIPH Reports

- Care-Based Incentive 2020 Program Outcomes Executive Summary
- Proposed Changes for Care-Based Incentives 2022 Executive Summary

Vaccine Hesitancy Best Practices for BIPOC: Tips and resources to address COVID-19 vaccine hesitancy and build confidence around COVID-19 vaccines in our local communities was provided, requested at the January 2021 CQIC. Tip sheet provides nurturing and empowering suggestions, as well as encouragement to focus on qualitative and quantitative perspectives.

Committee discussed hesitancy, availability of the vaccine, encouragement to utilize vaccine's in stock, and mass vaccination clinics, mobile onsite vaccine clinics, and second dose difficulties.

CQIC Charter: Annual review. Changes include notation of remote attendance of future meetings, and update of Committee Membership.

Committee Decision: Consent Agenda was approved as written.

2. Enhancing Quality Improvement System

The Alliance implemented a new Organizational Tactic of enhancing the Quality Improvement System (QIS). Quality Improvement is working with additional Alliance Departments to align Health Services work-planning with organizational priorities and planning approach. There are four phases within the project, each phase is assigned per quarter, and includes:

Phase 1: Co-defining the vision and scope to align with organizational priorities and planning approaches
Phase 2: Identify and prioritize improvements towards that vision
Phase 3: Integrate and coordinate work planning within Health Services and Operations Divisions.
Phase 4: Integrate planning activities and document into QI and UM workplans

The draft Vision is complete. The second goal is to share the vision and invite others to participate in making that vision shared through individual Director Meetings by the end of May 2021.

3. Auto Authorization Process

The Medical Necessity Criteria decision hierarchy was reviewed. Whole Child CCS member medical necessity criteria is guided by diagnoses and CCS All Plan Letters (APL's). It was noted that there are currently no contractual/regulatory requirements that specify what health plans must subject to authorization. There are a few contractual/regulatory requirements about what cannot be subject to authorization (e.g. emergency or sensitive services), outside of these the health plan has discretion as to what is subject to authorization. Contractual/regulatory requirements define what must be complied with in authorization procedures (e.g. medical necessity, timeframes, noticing, appeals & grievances, etc.)

The Alliance is in the process of aligning authorization requirements with peer benchmarks, by eliminating at least 90% of authorization requirements currently in excess of peer cohort authorization requirements. The goal is to improve process value to customers through a reduction in the percent of total pre and post service authorizations that are voided because they do not require authorization. An auto auth feature has been added to the Provider Portal, tested, and the outcome indicated no increase in fraud or waste.

Criteria for auto authorizations was presented to the committee. Considerations for change in criteria was around patient safety, services which were approved 98% of the time, comparison of authorizations requiring approval from other plans, and cost of item requested in the authorizations. A report to monitor the activity of the auto authorizations was created.

4. Utilization Management Criteria: Recuperative Care Pilot

The Board approved a 2-year Recuperative Care pilot which launched in March 2021. The pilot provides funding of temporary housing solutions for Medi-Cal members who are homeless and recovering from an acute illness or injury.
The pilot assists with the transition from hospital to a recuperative care, monitoring of medications, and work with social workers to assist finding permanent housing.
The goals of the pilot are to improve health outcomes, reduce hospital admissions and ED utilization, and reduce the cost of care.

Eligibility criteria was reviewed. Recuperative care facilities may have their own unique eligibility criteria. Alliance UM nurses will review for eligibility and authorize the recuperative care services. Initial length of stays are up to 30 days. There can be up to two 15-day extensions with Alliance approval. UM MSW/RN will attend weekly IDT meetings with RCP staff to assist with DC planning.

The Alliance is presently working with one RC center in Santa Cruz county. One member has participated, and successfully received permanent housing. The Alliance has received 3 more referrals. Pilot evaluation criteria was reviewed.

5. COVID-19 Vaccination Results

COVID-19 vaccination data was presented to the committee. Count and percent of members vaccinated with at least one dose of COVID-19 vaccine by age group and county, December 2020- March 2021 (As of April 27,2021) was reviewed. The Alliance's largest age group is 18 – 64 (50% of membership). Of this age group 11 – 20 % are partially vaccinated, dependent on the county.

Race of members fully vaccinated by year to date by race and county as of April 12, 2021 was reviewed. The highest rate of members vaccinated are of the Hispanic community, throughout all three counties.

Members 16-64 years of age and respective COVID-19 health risks was examined. Members with a chronic cardiovascular condition have the highest risk score.

Data was reviewed of members aged 16-64 years with one or more health risk conditions for COVID-19 infection. The high to moderate risk group (~2.5k members), are monitored by the "Your Health Matters" team. The high-risk group (~254 members) are monitored by the Alliance's Health Programs team.

Committee discussed data collection of domestic violence, curious if an increase has been noted during the COVID pandemic. Unfortunately, the Alliance does not receive this data. An increase in Beacon Behavioral Health utilization was noted, and that members are actively reaching out for this service.

6. Discussion

Committee member inquired if the Alliance has an update regarding Magellan and its pharmacy formulary.

The Alliance is expecting an update from DHCS around mid-May or early June. The Alliance is continuing to prepare for the transition, and ensure a smooth transition.

7. Future Topics

Committee discussed the Healthy Weight for Life redesigned program, which has transitioned to a virtual workshop. Committee discussed implementing Medical Nutrition Therapy in the program.

Future Topic: MNT criteria and Weight Reduction Drugs Formulary/PA Criteria Update - Pharmacy

Committee members are encouraged to submit items for discussion, at any time, to Michelle Stott or Mary Brusuelas.

Next Meeting: Thursday, July 29, 2021 12:00 p.m. – 1:30 p.m.

The meeting adjourned at 1:30 p.m.

Minutes respectfully submitted by,

Jacqueline Van Voerkens
Administrative Specialist

Meeting Minutes

Thursday, May 13, 2021

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

Members Present:	
John Beleutz	Health Projects Center
Humberto Carrillo	Consumer
Michael Molesky	Commissioner
Margaret O'Shea	Consumer
Ericka Peterson	Merced County Head Start
Elsa Quezada	Commissioner
Alene Smith	Consumer

Members Absent:	
Celeste Armijo	Monterey Department Social Services
Rebekah Capron	Merced HSA
Lupe Chavez	Consumer
Leo Demushkane	Consumer
Enid Donato	Natividad Medical Center
Doris Drost	Consumer
Ashley Lynne Gregory	Consumer
Alexandra Heidelbach	Consumer
Linda Jenkins	Consumer
Shebreh Kalantari-Johnson	Commissioner
Tamara McKee	HICAP – Alliance on Aging
Debby Perez	Consumer
Vivian Pittman	Consumer
Myisha Reed	First 5 Merced County
Rex Resa	Consumer
Martha Rubbo	Consumer
Candi Walker	Consumer
Sylvia Wilson	Monterey County – CalHeers

Staff Present:

Hilary Gillette-Walch, RN	Quality and Population Health Manager
Yomayra Gomez	Member Services Project Specialist
Rebecca Huth	Digital Communications Supervisor
Kathleen McCarthy	Strategic Development Director
Maura Middleton	Administrative Assistant
Ronita Margain	Regional Operations Director
Deborah Pineda	Quality and Health Programs Manager
Gina Rhoads	Program Development Manager
Megan Sims	Member Services Operations Manager
Kayla Zoliniak	Administrative Specialist

1. Call to Order by Chairperson Beleutz.

Chair Beleutz called the meeting to order at 10:02 a.m.

No changes to the agenda were made.

Self-introductions were made.

2. Oral Communications.

Chair Beleutz opened the floor for any members of the public to address the Committee on items listed in the agenda.

No members of the public addressed the committee.

3. Comments and announcements by Member Services Advisory Group members.

Chair Beleutz opened the floor for Advisory Group members and Plan Staff to make comments.

M. O'Shea reported hearing concerns from the community regarding difficulty with provider appointment availability.

H. Gillette-Walch stated the Alliance will be conducting outreach to members who are home-bound to determine interest in receiving the COVID-19 vaccine and if applicable, arranging the appointment.

M. Sims stated the recruitment for Member Services Director is in progress. Member Services is available to assist members with questions or issues.

Consent Agenda Items:

4. Chair Beleutz opened the floor for approval of the Consent Agenda.

Action: All consent items approved.

Regular Agenda Items:

5. Strategic Planning for 2022+

Kathleen McCarthy, Strategic Development Director, provided an update on the strategic planning process, shared the themes identified to date, and solicited input to inform the Alliance's future priorities. K. McCarthy addressed the Advisory Group's inquiries about technology, analytics, and staff capacity. Advisory Group members provided the following feedback:

- Viewing CalAIM as an opportunity in addition to a threat in SWOT analysis
- Include social determinants of health and community partners as part of the health equity conversations
- Support staff retention

6. Website Use and Navigation

Rebecca Huth, Digital Communications Supervisor, asked focused questions in regards to website use and navigation and gave a demonstration of the new website. Advisory Group members provided the following feedback:

- Website use varies by relationship to the Alliance
  - Responses included researching questions posed by community members, viewing meeting agendas and minutes, finding a doctor, and submitting feedback
- Website access varies by person
  - Responses ranged from an individual accessing the website on the computer, tablet, and phone to an individual not accessing the website and relying on the Member Services line and face-to-face visits
- Members may have limited or no access to website with the closure of public computer access points due to COVID-19
- Consider language and readability level
- Consider publishing announcement of new website in local newspapers
- Solicit feedback from Whole Child Model Family Advisory Committee

Adjourn:

Chair Beleutz adjourned the meeting of May 13, 2021 at 10:59 a.m. to August 12, 2021 at 10 a.m. via teleconference unless otherwise noticed.

Respectfully submitted,
Kayla Zoliniak
Administrative Specialist

Physicians Advisory Group

Meeting Minutes

Thursday, June 3, 2021
12:00 - 1:30 p.m.

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

Group Members Present:	
Dr. Anjani Thakur	Provider Representative
Dr. Misty Navarro	Provider Representative
Dr. Scott Prysi	Provider Representative
Dr. Caroline Kennedy	Provider Representative
Dr. Barry Norris	Provider Representative
Dr. Jennifer Hastings	Provider Representative
Dr. Amy McEntee	Provider Representative
Dr. Casey Kirkhart	Provider Representative
Dr. Devon Francis	Provider Representative
Dr. James Rabago	Board Representative

Group Members Absent:	
Dr. Chuyen Trieu	Provider Representative
Dr. Shirley Dickinson	Provider Representative
Dr. Patrick Clyne	Provider Representative
Dr. Michael Yen	Provider Representative

Staff Present:	
Dr. Dale Bishop	Chief Medical Officer
Dr. Gordon Arakawa	Medical Director
Dr. Maya Heinert	Medical Director
Dr. Dianna Diallo	Medical Director
Ms. Jennifer Mockus	Community Care Coordination Director
Ms. Jordan Turetsky	Provider Services Director
Ms. Michelle Stott	QI & Population Health Director
Ms. Lila Chagolla	Regional Operations Director
Mr. Jim Lyons	Provider Relations Manager
Ms. Ronita Margain	Regional Operations Director
Ms. Kathleen McCarthy	Strategic Development Director
Ms. Gina Rhoads	Program Development Manager
Ms. Deborah Pineda	Quality & Health Programs Manager
Ms. Mary Brusuelas	Utilization Management/CCM Director
Ms. Jacqueline Van Voerkens	Administrative Specialist
Ms. Tracy Neves	Clerk of the Advisory Group

Public Representatives Present:

Ms. Becky Shaw	Public Representative
Mr. Michael Molesky	Board Representative

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

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

   No supplements or deletions were made to the agenda.

2. Oral Communications.

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

   No members of the public addressed the Group.

Consent Agenda

3. The group reviewed the March 4, 2021 Physicians Advisory Group (PAG) minutes.

   Minutes approved as written.

4. Old Business - Updates
   A. Care Based Incentives (CBI) 2022
      Dr. Diallo presented the Summary of Board Approved CBI Changes for 2022;
      - Programmatic Measures:
        - Add: Breast Cancer Screening and Controlling High Blood Pressure
        - Change: Antidepressant Medication Management → Depression Screening and Follow-up Plan
        - Change: Reallocate Plan All-Cause Readmission points → Post Discharge Care
        - Redistribute Ambulatory Care Sensitive Conditions & Preventable Emergency Visits points → Quality of Care Measures
        - Retire: Maternity Care: Prenatal and Maternity Care: Postpartum
      - Fee-For-Service Measures:
        - Change: Additional training in Behavioral Health Integration
        - Remove: Incentive for X wavier.
      - Exploratory Measures:
        - Add: ACE Screening in Children and Adolescents and Health Disparity Measure.

Provider inquired how the depression screening is tracked. It was noted there is no coding for this visit, the provider will note screening, diagnosis, and schedule a follow-up appointment within 2-4 weeks. Screening can be done by a primary care provider (PCP), social worker or Beacon. Data is being captured through claims data.

Provider noted she would like to see continued engagement with providers in obtaining the X-Wavier (for prescribing buprenorphine). Dr Bishop stated that providers are eligible for 6 more months in 2021 for the $1000 incentive. Group noted lots of work is being done in Santa Cruz, Watsonville, and Salinas with providers obtaining the wavier. Provider noted some providers obtain the wavier but do not use it, and suggested providing incentives for prescriptions. Also noted follow-up care for emergency departments (EDs) would be very helpful.

B. Pharmacy Carve-Out Update
Dr. Bishop noted as previously reported, the Department of Health Care Services (DHCS) has delayed the planned Go-Live date for Medi-Cal Rx. Currently there is no set date for implementation. DHCS is reviewing conflict of interest concerns brought about by Centene Corporation's (Centene's) announced plan to acquire Magellan Health, Inc., the parent company of Magellan Medicaid Administration, Inc. (MMA), the contracted vendor for the Medi-Cal Rx. Centene operates – through subsidiaries – managed care plans and pharmacies that participate in Medi-Cal. Dr Bishop noted currently there is no implementation date in 2021 and possibly beyond.

5. **New Business**

A. Pandemic Care Taskforce Update
Dr. Heinert shared vaccination distribution data for Alliance members in all 3 counties. Provider Outreach continues with a 3rd party administrator through My Turn, Vaccine Finder, and Lyft Vaccine Access. Provider support continues in promotion of provider testing for identification of infection and potential for COVID variants. An Alliance video regarding vaccine hesitancy that was promoted on social media and was also shared with the Group.

The Alliance conducted telephonic outreach to high-risk members in geographic areas with most need, homebound members and soon outreach will be conducted to high-risk pediatric members. Outreach was centered around safe behaviors and vaccine navigation, and valuable member information was obtained during the calls. Several teams within the Alliance worked collaboratively on the member outreach.

The Resuming Care Task Force in June 2020 began outreach to members and providers in the safe resumption of care. Outreach efforts emphasized heavily on immunization during the summer and fall seasons. Efforts expanded to the safe resumption of office visits by autumn 2020.

Adolescent Immunization data from all 3 counties was shared with the Group. From Q4 2019 to Q1 2021, immunization data remained the same and a bit below the plan goal. Child Immunizations in all 3 counties saw a sharp decrease beginning in Q1 2020 due to the pandemic and low rates continued through 2020. Well Child Visits for ages 3-6 yrs. also decreased in 2020 and continued to decline. Well Adolescent Visits also declined in 2020. Well Child Visits for the first 15 months beginning in Q1 2020 increased, and public education continues.

Provider noted due to social distancing protocols, there is a limited number of providers working at their clinic. Provider also noted that well visits are not able to be done telephonically but hopes to begin in-office visits soon. Also noted was the need for additional pediatricians and whether the Alliance is recruiting providers. Dr. Bishop noted the Grant Program was available for providers, and Kathleen McCarthy noted funds only remain for Merced County. Michelle Stott noted the Alliance is currently conducting a DHCS required Pediatric Campaign for ages 7-21 yrs. with outreach to members that have not received services within the last 6 months. In addition, efforts are underway to send letters to members ages 11-13 yrs. in promotion of adolescent visits and immunizations.

B. Strategic Planning

Kathleen McCarthy shared an overview of the Strategic Planning Process with the Group; the planning process began in February with the Board. Strategic Plan. Input encompassed many individuals and groups including Physician and Member Advisory Committees. The Alliance's SWOT snapshot was shared with the Group. The SWOT is a tool that identifies strengths, weaknesses, opportunities and threats. Information was obtained from stakeholders to form the SWOT and key themes were identified.

In 2020, the Alliance revised our vision and values and reaffirmed our mission statement. When identifying strategic goals for 2022 and beyond, the Alliance is focusing on our vision and mission.

After reviewing the SWOT with our internal Strategic Planning Committee, two areas were identified as strategic priorities and goals areas emerged. This information will be shared at the upcoming Board Retreat.
Strategic Priorities:

1. Health Equity
    - The Alliance has the internal capability (knowledge, skills, resources) to successfully address health inequities in all 3 counties.
    - More members, particularly in Monterey and Merced counties are able to access behavioral health services.
    - More members who are people of color/or have a primary language that is not English receive culturally competent healthcare.
    - More children and youth experience optimal health outcomes.

2. Medi-Cal Delivery Transformation
    - New services available to address the social determinants of health in lieu of traditional medical services.
    - More members receive a streamlined, coordinated, whole-person approach to care.

Kathleen asked the Group for their input and whether they support this plan over the next 3-5 years. Provider asked how the process is used to create new roles, budgets, etc. It was noted that these are high-level goals and possibly a 5-year plan. The Alliance has a strategic execution process and within the process annual objectives and tactics are created.

Provider noted that social determinants of health is a very important topic as well as equity. Provider also noted, behavioral health is important and glad it is included. Provider suggested prenatal equity in pediatrics and adding pregnant mothers. Group noted the strategic priorities align with their current work. Provider inquired about the Alliance's growth strategy and whether more members or a broader base is being considered as they have capacity and would like more patients. It was noted, this is not included in the planning although there are considerations of geographic expansion and other possible expansions within CalAIM. Kathleen thanked the Group for their feedback.

C. COVID-19 Member Incentive: Analysis of Vaccine Hesitancy
Deborah Pineda gave a presentation regarding vaccine hesitancy. The Alliance conducted multiple member outreach campaigns to high-risk members. The outreach is crucial in engaging member dialogue and assists the Alliance to understand and serve this population. The Alliance partnered with internal

departments, providers and local health departments, and outreach is continuous. Deborah shared data from a subset of members that included members 65 yrs. and older at high-risk, 16-64 yrs. high-risk, and 16-64 yrs. moderate risk. Members were provided resources and access such as transportation. There was a subset of 21% of members that were unsure of refused the vaccine so efforts were made to outreach to those members. Key results were shared from the outreach with the Group. Of those members that were unvaccinated, some key themes were no reason. fear and/or mistrust, needing to speak with PCP/specialist, complex health conditions, and family beliefs. Other factors that were shared with the Group were member insights and contributing factors to vaccine hesitancy. The majority of members were vaccinated but a key finding for those that were unvaccinated was to wait and learn more. Communication and trust were common themes that emerged when engaging with members.

Some health plans are offering vaccine incentives, mailings, and health fairs. The Alliance is exploring incentives for members. Providers suggested having incentives to promote healthy behaviors such as exercising and healthy eating would be very beneficial for members.

Disparities in geographic areas and among languages was also identified. Internal talking points were created for engagement with members and Deborah offered to share those with providers. Work is ongoing and the Alliance is continually exploring ways to engage with members.

6. **Open Discussion**

Chairperson Bishop opened the floor for the Group to have an open discussion. There was no additional discussion.

The meeting adjourned at 1:30 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Group

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

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, June 17, 2021
12:00 p.m. - 1:00 p.m.

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

Committee Members Present:

Cal Gordon, MD	Provider Representative
Jennie Jet, MD	Provider Representative

Committee Members Absent:

Patrick Clyne, MD	Provider Representative
Salem Magarian, MD	Provider Representative
John Mark, MD	Provider Representative

Staff Present:

Dianna Diallo, MD	Medical Director
Jennifer Mockus, RN	Community Care Coordination Director
Jordan Turetsky	Provider Services Director
Lilia Chagolla	Regional Operations Director, Monterey
Ronita Margain	Regional Operations Director, Merced
Mary Brusuelas, RN	UM & Complex Case Management Director
Michelle Stott, RN	QI & Population Health Director
Sarah Sanders	Grievance and Quality Manager
Jessie Newton, RN	Complex Case Management Supervisor
Kelsey Riggs, RN	Complex Case Management Supervisor
Julie Norton, LMFT	Behavioral Health Program Manager
Jacqueline Van Voerkens	Administrative Specialist
Tracy Neves	Clerk of the Committee

Hospital Representatives Present:

Salvador Sandoval, MD	Provider Representative
Mike Barrett	Aveanna Healthcare
Kaitlyn Krentz	Aveanna Healthcare

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

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

No members of the public addressed the Committee.

3. Consent Agenda Items.

A. Approval of WCMCAC Minutes
Minutes from the March 18, 2021 meeting were reviewed.

B. Grievance Update
Sarah Sanders reviewed the Grievance presentation with the Committee.

M/S/A Consent agenda items approved.

4. New Business.

A. Whole Child Updates: Advances in Closing Corrective Action Plans (CAPs), Age-Out Process, California Children's Services (CCS) Eligibility/Referrals
Dr. Diallo noted Alliance teams have been meeting with all 3 counties monthly to discuss process improvements, targeted physician paneling, increasing referrals, coordination of care and any issues that arise.

Kelsey Riggs, RN noted in March 2020, there were 5 areas of opportunity identified in Alliance programs and since then the CAPs were completed and condensed into 3 areas. Areas include age-out risk stratification and CCS referrals and the Alliance continues to monitor and develop process improvements.

The Alliance is required to initiate an Initial Care Plan (ICP) for all high-risk members within 90 days of enrollment. Improvements have been made in this area and are ongoing. In 2019, there were approximately 70 ICPs completed and currently ICPs are about 1,500 for high-risk members. In Q1 2021, there was 100% compliance for ICPs. Work continues on the care plan which includes standardized tools for monitoring and consistency.

The age-out process was developed to help members that are aging out of CCS at 21 years of age and recently this was expanded to age 17; this change will double outreach from about 25 to 50 members per month. A standardized tool was developed to help assess these unique needs, and additional outreach has been added to this process.

Jessie Newton, RN noted that CCS referrals continue to increase even during the pandemic. Monthly and quarterly CCS referral data was presented to the Committee. The increase has resulted from a team effort with the counties, and various teams within Health Services and collaboration continues.

Provider noted the aging-out process is much smoother now, and all the teams are more confident with the process in assisting clients make the transition, good job!

B. Non-Emergency Medical Transportation (NEMT)/All Plan Letter (APL)/Memorandum of Understanding (MOU)
Mary Brusuelas, RN noted there has been a revision to the APL California Children's Services Whole Child Model Program. APL letters are received for the WCM and the Alliance adjusts policies and practices based on the direction. The Alliance follows the recent APL that was updated, and it supersedes the previous letter. The Alliance received direction through the APL regarding screenings and referrals:

- MCPs must provide screening, diagnostic, and treatment services in accordance with APL 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21, or any superseding APL, to identify potential CCS-eligible members.
- MCPs must also refer potential CCS-eligible members to the County CCS program for a CCS eligibility determination if the members:

The Alliance is meeting with the 3 counties monthly and is in the process of working on the changes and responsibilities in the MOUs. The MOUs are reviewed every 2 years, and outline the plan and counties' responsibilities.

The red-line draft APL was shared with the Committee. Once the APL is received by the Alliance, the draft requirements are reviewed and the Alliance has the opportunity to provide feedback to the state. APL letters are published and are available online. CCS letters and APLs are also reviewed at Tri-County Meetings. The Alliance will keep the Committee updated on any further changes.

Regarding NEMT, the Alliance met with the transportation provider regarding transporting members. There are many transportation grievances and this is true for most plans. Members were missing specialist visits due to transportation issues. When appointments are missed, it can affect the entire day. Call-to-Car calls was sending non-scheduled visits out to Lyft drivers and they were not always willing to travel far distances for extended periods of time. The Alliance is working on finding vendors that will work with families with specials needs and help to expand other services.

C. COVID/Children's' Behavioral Health
Julie Norton, LMFT began the presentation by asking the Committee reflective questions. What if any are 2 impacts of COVID-19 for you or your kids and families you serve (physical, emotional, financial, social)? Data was shared with the Committee regarding the effects of COVID. Changes noted include significant sleep disturbances, weight changes, increased obesity in children, lower mood, increase in irritability major financial changes, sense of isolation and disconnection, and social anxiety. Information from the kid's study for California households was shared with the Committee, it was noted that households with children experienced nervousness and stress and households with special needs children experienced more of these symptoms.

Mental Health problems increased for both parents and children during 2020.

- Those who experienced hardships had worse psychological well-being.
- Providers and pediatricians should screen for mental health problems among the children in their practices, with particular attention to children whose families are vulnerable to economic as well as disease aspects of the crisis.
- Beginning in April 2020, children's mental health related emergency department (ED) visits among all pediatric ED visits increased and remained elevated through October.
- Compared with 2019, the proportion of mental health related visits for children 5–11 years increased approximately 24%. and 12–17 years increased 31%.

Warning signs from the National Alliance on Mental Illness:

- Excessive worrying or fear, feeling excessively sad or low.
- Confused thinking or problems concentrating.
- Extreme mood changes.
- Prolonged or strong feelings of irritability or anger.
- Avoiding friends and social activities.
- Difficulties understanding or relating to other people.
- Changes in sleeping habits or feeling tired and low energy.
- Changes in eating habits.
- Thinking about suicide.
- Multiple physical ailments without obvious causes.

Information regarding access to mental health services through Beacon was shared with the Committee. Members can **call 855-765-9700**, 24 hours a day, 7 days a week, and a Beacon staff person will help. Beacon's website is **www.beaconhealthoptions.com.** For Substance Abuse Services, contact the county's Behavioral Health department:
• Santa Cruz: 800-952-2335
• Monterey: 888-258-6029
• Merced: 888-334-0163

Providers can fill-out a screening form from the Alliance's website to determine the level of care needed: **https://www.ccah-alliance.org/medical_MH_benefits.html**

Resources and references were shared with the Committee:
• https://www.cdc.gov/childrenindisasters/helping-children-cope.html
• https://zerotothrive.org/helping-children-with-big-feelings-during-covid-19/
• https://www.kidsdata.org/blog/?p=9530
• https://psychiatry.ucsf.edu/copingresources/families#a

5. Open Discussion.

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

Dr. Diallo noted that the WCMCAC is seeking Committee members, please pass along the information to providers and specialists.

The meeting adjourned at 12:30 p.m.

Respectfully submitted,

Ms. Tracy Neves
Clerk of the Advisory Committee

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

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, July 12, 2021

1:30p.m. – 3:00p.m.

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

Chairperson: Elsa Quezada, Vice-Chair and Monterey County Board Member

CCAH Support Staff Present: Lilia Chagolla, Regional Operations Director**;** Maria Marquez, Administrative Specialist

WCMFAC Committee Present: Deadra Cline, CCS WCM Family Member; Irma Espinoza, Merced County – CCS WMC Family Member; Manuel López Mejia, Monterey County – CCS WCM Family Member; Susan Skotzke, Santa Cruz – CCS WCM Family Member

WCMFAC Committee Absent: Ashley Gregory, Santa Cruz County – CCS WCM Family Member; Cindy Guzman, Merced County – CCS WCM Family Member; Cristal Vera, Merced County – CCS WCM Family Member; Cynthia Rico, Merced County – CCS WCM Family Member; Frances Wong, Monterey County – CCS WCM Family Member; Kim Pierce, Monterey County – Local Consumer Advocate; Lori Butterworth, Santa Cruz County – Local Consumer Advocate

CCAH Staff Present: Dianna Diallo, Medical Director; Gabina Villanueva, Members Services Supervisor; Jennifer Mockus, RN, Community Care Coordination Director; Jessie Newton, Complex Case Management Supervisor – Pediatric; Linda Gorman, Communications Director; Ronita Margain, Regional Operations – Merced County

Guest: Christine Betts, Monterey County – Local Consumer Advocate; Jose, Special Kids Connect

Agenda Topic	Minutes	Action Items
Meeting Administration Lilia Chagolla	• Lilia Chagolla, Regional Operations Director (ROD) welcomed the group.	
Call to Order Elsa Quezada	• Elsa Quezada, Committee Vice-Chair called the meeting to order at 1:04p.m.	
Roll Call Maria Marquez / Lilia Chagolla	• Committee introductions and roll call was taken.	
Oral Communications Elsa Quezada	• Elsa Quezada, Committee Vice-Chair opened the floor for any members of the public to address the Committee on items not listed on the agenda. No members of the public addressed the Committee. • Elsa Quezada, Committee Vice-Chair opened the floor for members/staff in attendance to make comments.	
Consent Agenda Items: Accept WCMFAC Meeting Minutes from Previous Meeting	• Elsa Quezada, Committee Vice-Chair opened the floor for approval of the meeting minutes of the previous meeting on May 10, 2021.	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, July 12, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
Elsa Quezada	Motion to approve the consent agenda as presented. Seconded and passed unanimously.	
Regular Agenda Item **CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS)** Jennifer Mockus, Central California Alliance for Health	• Jennifer Mockus presented on the CalAIM Enhanced Care Management (ECM) and In Lie of Services (ILOS). • What is Enhanced Care Management (ECM) - ECM will be a Medi-Cal benefit beginning January 1, 2022 -High-touch, face-to-face work in the community with frequent member contact -Extends beyond standard case management, care coordination and disease management activities -Person-centered, goal-oriented, and culturally relevant -Services are arranged through community-based providers -Integrated with other care coordination processes. ECM assumes primary responsibility for all primary, acute, behavioral, developmental, oral, and long-term services and supports, regardless of setting • Further outlined the goals, eligibility, and population focus. • In Lieu of Services (ILOS) overview. Listed the 14 ILOS services and planning. • Presented on the Whole Person Care Pilot (WPC) that began in 2017 throughout the state. • Shared implementation timeline for ECM and ILOS for counties with Whole Person Pilots (Santa Cruz and Monterey) -January 1, 2022 - Alliance launches ECM benefit for 2022 populations of focus that align with the populations currently served by the WPC Pilots -Alliance automatically transitions Members currently served by WPC or in the process of enrolling in WPC into ECM and reassess within 6 months	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, July 12, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	-Alliance may begin offering ILOS as prescribed by WPC pilots -January 1, 2023 – Alliance expands ECM for three of the remaining populations of focus -July 1, 2023 – Alliance expands ECM to all populations of focus, including Children and Youth • Shared implementation timeline for counties without Whole Person Care Pilots (Merced) -January 1, 2022 – Alliance may begin offering ILOS in alignment with their service area -July 1, 2022 – Alliance begin implementation of ECM -January 1, 2023 – Alliance expands ECM to three other populations of focus -July 1, 2023 – Alliance expands ECM to all populations of focus, including Children and Youth • Elsa Quezada, Committee Vice-Chair requested the percentage of Alliance members that will be receiving the services and the breakdown by county. • Elsa Quezada, Committee Vice-Chair share her disappointment on having the Children component implemented a year later. Suggested for the Committee Members to start gathering questions and watch how phase I evolves. Suggested being part of in sharing feedback. • Elsa Quezada, Committee Vice-Chair asked that this topic comes back to this meeting and provide further information on the children component. Jennifer Mockus added that she and Susan Skotzke attend the WCM Stakeholder meetings where this topic may be further discussed, and additional information may be given. They can bring additional information as it becomes available.	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, July 12, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
WCMFAC Brochure Development – Updated Draft Lilia Chagolla	• Lilia Chagolla, ROD presented an updated draft of the WCMFAC flyer. • Solicited feedback and edits to the WCMFAC flyer. Committee members provided feedback and edits to the flyer. • Solicited members to identify 1-3 organizations to share the flyer digital via email. • Next steps are to update the flyer and provide a final version to the Committee Members via email with links to the flyers. Flyers are to be shared with Community Based Organizations and well as WCM parents of newly diagnosed children. • Manuel López Mejia, Committee Member requested printed copies of the flyer as he does not have access to technology and or resources to print the flyer. • Committee Members to share feedback on the distribution of the flyer at the next WCMFAC meeting scheduled for September 2021.	Lilia Chagolla to update the flyer with the suggested edits. Final version to be delivered to Committee members via email and provide an email template for distribution. Maria Marquez to connect with Manuel López Mejia to discuss printed flyers and best way to distribute.
Community Partner Feedback | COVID-19 Impact on Members	• Open forum for Committee members to share COVID-19 impact. • Susan Skotzke, Committee Member voice her personal struggles and voiced her desired for system improvements in having a portal access that can provide patient history and patient needs. This will be extremely helpful to have and be able to access the information when needed.	
CCS Advisory Group Representative Report Susan Skotzke	• No updates shared as the CCS Advisory Group meeting is scheduled for July 14, 2021. • Lilia Chagolla ROD communicated on the interest of FAC members attending any of the meetings as a WCMFAC representative and asked committee member to share any agenda topics or concerns they would like address at the CCS Advisory Group meetings.	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, July 12, 2021

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
Other Business	• Linda Gorman, Communications Director for Central California Alliance for Health briefly shared on the new Alliance website rebuilt. • New URL is www.thealliance.health. Previous URL will automatically redirect to new URL. • Website enhancements for easier navigation, search tool, member and provider sections improved, new community section. • Handout of member section of the website to be included to the WCMFAC Meeting packet. • Some Committee Members voiced that they had not received their WCMFAC meeting packets in a timely manner, others did not receive the packet. It was suggested that the packets be mailed sooner to ensure timely delivery. • Irma Espinoza, Committee Member shared a change of address.	M. Marquez to ensure meeting packets are mailed out sooner. M. Marquez to connect with Committee Member Irma Espinoza to update change of address on file.
Future Agenda Items Lilia Chagolla	• New Alliance Website – Linda Gorman • Continue the conversation on Portal Discussion – Lilia Chagolla • WCMFAC Flyer outcomes – Committee Members Feedback • Alliance Grievance team – The Alliance designee	
Review Action Items Maria Marquez	• Maria Marquez reviewed the action items.	
Adjourn (end) Meeting Elsa Quezada	The meeting adjourned at 3:04p.m.	
Minutes Submission	The meeting minutes are respectfully submitted by Maria Marquez, Administrative Specialist	

Next Meeting: November 8, 2021 at 1:30p.m.

DATE: September 22, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Alliance Donations and Sponsorship of Events and Organizations Policy

---

Recommendation. Staff recommend the Board approve an Alliance Donations and Sponsorship of Events and Organizations Policy.

Background. The Alliance Donations and Sponsorship of Event and Organizations Policy provides guidelines to promote and implement opportunities for donations to non-profit 501c3 community organizations and sponsorship of such organizations' events within the Alliance's service area.

Discussion. The intent of the policy is to provide guidelines and criteria for staff and the community in order that the Alliance may donate to non-profit 501c3 organizations and/or sponsor their events which further a Medi-Cal purpose, the Alliance's strategic priorities, align with the Alliance's mission, vision, and values, and comply with the Alliance's Code of Conduct. Staff recognize the importance of sponsorship opportunities for the Alliance as a leader in the community and as a partner in the work that impacts our members in our service areas. The attached policy further defines the purpose and procedures.

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

Attachments.

1. Alliance Donations and Sponsorship of Events and Organizations Policy

	POLICIES AND PROCEDURES
Policy #:	**Lead Department:**
Title: Alliance Donations and Sponsorship of Events and Organizations	
Original Date:	**Policy Hub Approval Date:**
Approved by:	

Purpose: To describe the Alliance's policy and procedure for financial donations to non-profit 501c3 community organizations and sponsorship of such organizations' events within the Alliance's service area.

Policy: It is the policy of the Central California Alliance for Health (the Alliance) to be responsible stewards of public funds. The Alliance, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons or entities. Donations to a non-profit 501c3 organization or sponsorship of such organization's event must serve a direct and substantial public purpose and make appropriate use of public funds and Alliance staff time.

As such, the Alliance may donate to non-profit 501c3 organizations and/or sponsor their events which further a Medi-Cal purpose, the Alliance's strategic priorities, align with the Alliance's mission, vision, and values, and comply with the Alliance's Code of Conduct. Sponsorships and donations may only be awarded to the extent funds budgeted for such donations/sponsorships are available, and there is no guarantee of Alliance sponsorships or donations.

Alliance funds will not be used responsive to specific employee personal volunteer interests, including specific employee family and friend volunteer or associated non-profit organizations or their events (i.e. children's school fundraisers, etc.).

Definitions:

1. Donation: Financial contributions by the Alliance to support a non-profit 501c3 organization that serves a public purpose that is aligned with the Alliance's vision, mission, values and strategic priorities. Donations support the organization, and are not restricted to a specific purpose nor are they subject to specific terms and conditions beyond the general requirement that they used by a 501c3 for a public purpose, aligned with the Alliance's V/M/V. Donations may also include time provided by Alliance staff during business hours.

2. Sponsorship: Financial contributions by the Alliance, to a non-profit 501c3 organization for an event hosted by the organization which serves a public purpose, and that is aligned with the Alliance's vision, mission, values and strategic priorities. Sponsorship can also include contribution of goods or tangible items in support of an

event and may also include time provided by Alliance staff to support the event during Alliance business hours.

Procedures:

1. Budget. Annually, the CEO will propose a budget to be included in the annual Alliance administrative budget proposal acted on by the Alliance's board. The budget will be adequate to provide sponsorships and/or donations aligned with this policy in each of the counties in which the Alliance operates.

2. Requests. An organization requesting donation or sponsorship shall submit a request and any applicable supporting documents utilizing the mandatory Alliance request form, detailing how the requested funds are intended to be used, outlining the scope and purpose of the organizational donation or event sponsorship, and agreeing to the Alliance's requirements around benefits and recognition for any event sponsorship.

3. Action on Requests.
   - **a.** For documentation purposes, the Executive Assistant/Clerk of Board will track all requests, with data including but not limited to: organization, date of event, type of request, staffing information, amount of request, and ultimate disposition of the request. The EA/COB will forward all requests to the Regional Operations Directors for review and recommendation.
   - **b.** Requests for donation/sponsorship shall be reviewed by the ROD for the county in which the organization operates for confirmation of alignment with this policy, verification of adequate budget for the requested sponsorship/donation, and recommendation for action to the Alliance's CEO. The ROD will consult with Finance to determine whether funding the donation or sponsorship would constitute a medical expense attributable to the Alliance medical budget or whether it is an administrative expense, attributable to the donation/sponsorship budget in the administrative budget.
   - **c.** If the request is aligned with criteria and there is adequate budget available, the ROD will submit requests for recommended approval to the CEO. The CEO has the authority to approve or deny all requests.
   - **d.** The CEO will notify the ROD, the Executive Assistant and Finance of any approval. Finance will prepare the check for the approved sponsorship/donation. The Executive Assistant will prepare a letter indicating approval of the request and enclosing the sponsorship/donation.

e. The CEO will notify the ROD and the Executive Assistant of any denial. The Executive Assistant will prepare a letter for the organization notifying the organization of the denial.

4. Benefits and recognition. Event sponsorship may be promoted by the Alliance in communications channels as deemed appropriate, including the web site, social media, press releases, print and electronic newsletters and other collateral. The non-profit will assume the responsibility of securing signed photo releases from any individuals included in photos or other visual material provided to the Alliance by the non-profit. As a benefit of sponsorship, the non-profit agrees to promote the sponsorship on the non-profit's and/or event promotional material, including website, press releases, public event recognition, social media, newsletters and other collateral. The non-profit agrees to include the Alliance's name and approved logo in such promotional materials as deemed appropriate and agreed upon via the sponsorship terms and with advance approval from the Alliance's Communications Department.

   In the event the organization is identifying the Alliance as a donator to the organization, the organization will also only utilize the Alliance's approved logo and with advance approval from the Alliance's Communications Department.

5. Reporting. On an annual basis, the Alliance will report all donation and sponsorship activities to the Board of Commissioners to assure compliance and consistency with the criteria set forth in this policy.

References:
Alliance Policies: 101-1038
Impacted Departments: Administration, Regional Operations, Communications, Finance
Regulatory:
Legislative:
Contractual:
MMCD Policy Letter:
NCQA:
Supersedes:
Other References:
Attachments:

	**POLICIES AND PROCEDURES**
Policy #:	**Lead Department:**
Title: Alliance Donations and Sponsorship of Events and Organizations	
Original Date:	**Policy Hub Approval Date:**
Approved by:	

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

DATE: September 22, 2021

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

FROM: Michelle Stott, RN, Quality Improvement and Population Health Director

SUBJECT: Alliance Policy 401-1101 – Quality and Performance Improvement Program

---

Recommendation. Staff recommend the Board approve revisions to Alliance Policy 401-1101 – Quality and Performance Improvement Program (QPIP).

Background. The QPIP exists to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 438.330. Additionally, QPIP oversight entities may electively incorporate best practice standards (e.g., National Committee for Quality Assurance standards) into the QPIP as they deem appropriate.

The QPIP is in alignment with the Alliance's Mission of accessible, quality health care guided by local innovation.

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

1. Ensure all medically necessary covered services are: available and accessible to all members in any setting, regardless of cultural and ethnic background, race, color, national origin, creed, ancestry, religion, language, age, sex, sexual orientation, gender identity, marital status, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56; and provided in a culturally and linguistically appropriate manner;
2. Ensure integration with all departments within the Alliance, current community health priorities, standards, and public health goals;
3. Ensure patient safety;
4. Identify and act upon opportunities to address potential quality issues (PQIs) and review trends;
5. Identify and act upon overuse, misuse and underuse of services;
6. Ensure appropriate care for members with complex health needs;
7. Ensure that the cultural and linguistic needs of the diverse population of Alliance members are met; and
8. Ensure appropriate care for members with behavioral health needs.

The QPIP goals are achieved by:

1. Maintaining accountability of care systems;
2. Maintaining continuous quality monitoring utilizing specific quality and performance improvement methods; and
3. Analyzing data, incorporating provider feedback and developing interventions.

Discussion. Emphasized on the integration and cross collaboration with all departments within the Alliance, Policy 401-1101 – Quality and Performance Program, underwent its annual review, and was revised to ensure accuracy. Content revisions include update of the department name and edits of, as well as the addition of, job titles as appropriate. The Department Organizational Chart was also updated for accuracy.

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

Attachments.

1. Alliance Policy 401-1101 – Quality and Performance Improvement Program
2. Attachment A – QPIP Committee Structure
3. Attachment B – Quality Improvement Department Organization Chart

	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality and Performance Improvement Program	
Original Date: 02/01/1996	**Policy Hub Approval Date:** 06/21/2021
Approved by: Continuous Quality Improvement Committee (CQIC)	

Purpose
To describe Central California Alliance for Health's (the Alliance) Quality Improvement System (QIS), internally referred to as the Quality and Performance Improvement Program (QPIP). The QPIP serves to monitor, evaluate, and take effective action to address needed improvements in quality of care and services delivered by the Alliance through Providers rendering services on its behalf[1].

Policy
The QPIP exists to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services (DHCS) requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 438.330[2]. Additionally, QPIP oversight entities may electively incorporate best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) into the QPIP as they deem appropriate.

The QPIP is in alignment with the Alliance's Mission of accessible, quality health care guided by local innovation.

The QPIP provides a comprehensive structure that meets the following requirements:
1. Ensure all medically necessary covered services are: available and accessible to all members in any setting, regardless of cultural and ethnic background, race, color, national origin, creed, ancestry, religion, language, age, sex, sexual orientation, gender identity, marital status, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56; and provided in a culturally and linguistically appropriate manner[3];
2. Ensure integration with all departments within the Alliance, current community health priorities, standards, and public health goals;
3. Ensure patient safety;
4. Identify and act upon opportunities to address potential quality issues (PQIs) and review trends;
5. Identify and act upon overuse, misuse and underuse of services[4];
6. Ensure appropriate care for members with complex health needs;
7. Ensure that the cultural and linguistic needs of the diverse population of Alliance members are met; and
8. Ensure appropriate care for members with behavioral health needs.

The QPIP goals are achieved by:
1. Maintaining accountability of care systems;
2. Maintaining continuous quality monitoring utilizing specific quality and performance improvement methods; and

3. Analyzing data, incorporating provider feedback and developing interventions.

Definitions

1. California Children's Services (CCS) Program[5] (as part of the Whole Child Model Program): CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years of age can get the health care and services they need for CCS-eligible conditions. CCS also provides medical therapy services that are delivered at public schools through their Medical Therapy Unit (MTU).
2. Consumer Assessment of Healthcare Providers and Systems (CAHPS): Standardized surveys of patients' experiences with ambulatory and facility-level care. Managed by the Agency for Healthcare Research and Quality (AHRQ), the CAHPS' surveys health plan members to measure their experiences with a variety of areas, including access to care and satisfaction with the health plan.
3. Corrective Action[6]: Specific identifiable activities or undertakings of the Alliance that address program deficiencies or problems.
4. Managed Care Accountability Set (MCAS) [formerly referred to as External Accountability Set (EAS)][7]: 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.
5. Healthcare Effectiveness Data and Information Set (HEDIS)[8]: The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.
6. High Performance Level (HPL): DHCS establishes an HPL for each required HEDIS performance measure and publicly acknowledges MCPs that meet or exceed the HPLs. DHCS's HPL for each required measure is the 90th percentile of the national Medicaid results.
7. Minimum Performance Level (MPL): Medi-Cal managed care health plans must meet or exceed the DHCS established MPL for each required HEDIS performance measure. If MPL is not met, then an Improvement Plan must be completed. DHCS's MPL for each required measure is the 50th percentile of the national Medicaid results.
8. National Committee for Quality Assurance (NCQA)[9]: A non-profit organization that committed to evaluating and publicly reporting on the quality of managed care plans.
9. Performance Improvement Projects (PIPs)[10]: Studies selected by the Alliance, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes[11].
10. Plan, Do, Study, Act (PDSA): A cyclical, four-step management method used for continuous improvement and monitoring of processes. The methodology is a rapid-cycle/continuous quality improvement process designed to perform small tests of change, which allows more flexibility to make adjustments throughout the improvement process[12].

Procedures

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

1. Maintain Accountability of Care Systems
   Accountability for the QPIP development and performance review includes the Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board), the Continuous Quality Improvement Committee (CQIC), the Peer Review and Credentialing Committee (PRCC), the Compliance Committee, the Chief Medical Officer (CMO), and Alliance network physicians[13].

   1.a. Alliance Board[14]: The Alliance Board promotes, supports, and has ultimate accountability and authority for a comprehensive and integrated QPIP. Alliance Board responsibilities include:
      1.a.1. Annual review and approval of the QPIP and applicable QPIP reports[15];
      1.a.2. Appointment of an accountable entity or entities to provide oversight of the QPIP[16];
      1.a.3. Routine review of written progress reports from the CQIC[17];
      1.a.4. Directing the operational QPIP to be modified on an ongoing basis, and tracking and following up on all review findings[18].
      1.a.5. The Alliance Board has delegated direct supervision, coordination, and oversight of the QPIP to the Chief Executive Officer (CEO) and Alliance Quality Improvement and Population Health (QIPH) Department under the supervision of the Chief Medical Officer (CMO). The CMO regularly provides QPIP operational reports to the Alliance Board.

   1.b. Continuous Quality Improvement Committee (CQIC)[19]: The CQIC is the contractually required quality improvement committee with oversight and performance responsibility[20] of the QPIP – excluding credentialing and recredentialing[21] activities, which are directed by the PRCC – as described by Alliance Policy 401-1201 – *Continuous Quality Improvement Committee.*

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

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

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

1.e.1. Continuous Quality Improvement Workgroup (CQIW): The CQIW (core and interdisciplinary), under the direction and guidance of the CQIC, is responsible for ongoing QPIP operations and supporting work activities, as described in Alliance Policy 401-1201 – *Continuous Quality Improvement Committee*.

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

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

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

1.e.5. Pharmacy and Therapeutics Committee (P&T): The P&T Committee operates under the authority of the CQIC and participates in the QPIP as described in

Alliance Policy 403-1104 – *Mission, Composition and Functions of the Pharmacy & Therapeutics Committee*.

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

1.e.7. Whole Child Model Clinical Advisory Committee (WCMCAC): The WCMCAC operates under the authority of the Alliance Board and serves to advise on clinical issues relating to CCS conditions including treatment authorization guidelines[22] as described in Alliance Policy 400-1112 – *Whole Child Model Clinical Advisory Committee Responsibilities and Functions.*

1.e.8. Whole Child Model Family Advisory Committee (WCMFAC): The WCMFAC operates under the authority of the Alliance Board and serves as a venue to discuss perspective on issues relating to diagnosis and treatment of CCS conditions as well as to review and offer advice about policies, programs and initiatives relating to care of members in the WCM program as described in Alliance Policy 200-1007 – *Whole Child Model Family Advisory Committee.*

1.f. Program Staff

Alliance staff participating in the QPIP are described below. Specific qualifications and training for each role are available in the respective position description for each role.

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

1.f.2. Chief Medical Officer (CMO): The CMO is responsible for assuring the availability and quality of health care services for Alliance members. Responsibilities include leadership and direction of UM, Quality Management and CM programs, including medical management policies and effective operation of the Health Services (HS) Division. The CMO uses the health plan's systems and data to analyze HS Division issues and policies, and is responsible for communicating findings and

recommendations within the health plan, to the governing board, to physician committees and other providers, and to other stakeholders. This position is an advocate and liaison for the provider network and participates in strategic planning for new programs, lines of business, and special projects at the health plan. The CMO is also responsible for direction and supervision of the Medical Directors.

1.f.3. Medical Directors: The Medical Directors provide clinical leadership within one or more of the HS functional areas including but not limited to: UM/CCM, QIPH, Pharmacy, and CCC. The Medical Directors are responsible for day-to-day guidance and direction of QPIP activities.

1.f.4. Quality Improvement and Population Health (QIPH) Director: Under the direction of the CMO, the QIPH Director is responsible for strategic direction and management of the Alliance QPIP. The QIPH Director manages the Alliance's preparations and response to regulatory and internal medical audits, and manages implementation of selected NCQA standards. The QIPH Director is also responsible for community outreach and education regarding QIPH activities.

1.f.5. Quality and Performance Improvement Manager (QPIM): Under the direction of the QIPH Director, and in collaboration with the Medical Directors, the QPIM: manages and leads quality and performance improvement initiatives; supports development, management and implementation of practice coaching program activities in the community clinics to improve clinical outcomes; accountable for collaborating with staff in the implementation of the QPIP, and assists in coordinating member experience surveys, such as the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

1.f.6. Quality and Population Health Manager (QPHM): Under the direction of the QIPH Director, and in collaboration with the Medical Directors, the QPHM provides technical leadership and expertise in clinical data for one or more of the following areas in implementation of the QPIP: data management and retrieval, reporting standards and complex analysis, state policy and procedure implementation, Potential Quality Issue investigative process, Facility Site Review audit process, and systems configuration and research for Alliance HS Division leadership. The QPHM also: provides statistical modeling methodologies in the development of health plan, provider, and member analysis; coordinates HEDIS reporting activities; and prepares and

participates in audits conducted by regulatory agencies regarding all quality issues.

1.f.7. Quality and Health Programs Manager (QHPM): Under the direction of the QIPH Director and in collaboration with the Medical Directors, the QHPM maintains administrative oversight and is responsible for all aspects of planning and managing the Alliance Health Education and Disease Management programs and Cultural and Linguistic services. As well as the Member Incentive and Health Education Materials approval process for the Alliance. The QHPM also coordinates the Health Education and Cultural and Linguistic Population Needs Assessments reporting activities and participates in audits conducted by regulatory agencies.

1.f.8. Quality and Health Programs Supervisor(s) (QHPS): Under the direction of the QHPM, the QHPS coordinates and implements the Alliance Health Education and Disease Management programs and Cultural and Linguistic services (oversees interpretation and translation services and vendors) and processes. The QHPS also leads preparing health and disease management program promotional materials, including newsletter articles, and member/provider communications. The QHPS also supervises the Health Educators and Care Coordinator.

1.f.9. Health Educator(s): Under the direction of the QHPM and QHPS, the Health Educators primary responsibility is to provide outreach to members participating in health education and disease management programs and implement specific programs as assigned. Health education and disease management programs are provided by the Health Educators directly by telephonic and/or workshops. They co-facilitate health education and disease management member programs, such as trainings, workshops, and community presentations.

1.f.10. Care Coordinator I: Under the direction of the QHPS, the Care Coordinator I assists with coordination of Language Assistance services via the Alliance's internal care tracking system, and other duties as needed.

1.f.11. Quality Improvement Nurse (RN) Supervisor: Under the direction of the QPHM, the QI Nurse Supervisor coordinates and implements QIPH programs and processes, including Facility Site Review (FSR), Medical Record Review (MRR), Physical Accessibility Review (PAR), and Potential Quality Issues. The

QI RN Supervisor also supervises, mentors, develops, coordinates and conducts training for QIPH staff.

1.f.12. Lead QI Program Advisor (Lead QIPA): Under the direction of the QPHM, the Lead QIPA leads the planning, implementation and management of select QIPH programs, including but not limited to Care Based Incentive (CBI), HEDIS, and Performance Improvement. The Lead QIPA provides orientation, training and mentorship to subordinate QIPH staff and acts as the subject matter expert in support of QPIP objectives.

1.f.13. Senior QI Program Advisor (Senior QIPA): Under the direction of the QPIM, Senior QIPAs lead the planning, implementation and management of select QIPH programs, including but not limited to Care Based Incentive (CBI), HEDIS, and Performance Improvement; and provide training and expertise in support of QPIP objectives.

1.f.14. QI Program Analyst: Under the direction of the QPHM, or QPIM, the QI Program Analyst supports QIPH Department leadership with program administration; conducts studies and analyzes data to evaluate the Alliance's performance; and analyzes, develops and implements improvement activities to increase performance against national, state and/or regional benchmarks and definitions.

1.f.15. QI Data Specialist QIDS): Under the direction of the QPH Manager, the QIDS assists with monitoring data received from external partners. The QIDS develops, writes and produces reports to monitor compliance with contractual and regulatory requirements. The QIDS also supports the department with ad hoc reporting for internal and external stakeholders.

1.f.16. QI Nurse: Under the direction of the QI RN Supervisor, QPHM or the QPIM, the QI Nurse develops, manages and measures a comprehensive preventive health care strategy in collaboration with internal stakeholders and network providers to promote best evidence-based practices and improve member health outcomes. The QI Nurse participates in local, regional and state audits and improvement initiatives.

1.f.17. Senior QI Nurse: Under the direction of the QI RN Supervisor, QPHM or the QPIM, the Senior QI Nurse develops, manages and measures a comprehensive preventive health care strategy in collaboration with internal stakeholders and network providers to promote best evidence-based

practices and improve member health outcomes. The Senior QI Nurse participates in local, regional and state audits and improvement initiatives. In addition, the Senior QI Nurse trains and mentors other QIPH department nurses.

1.f.18. Coding Resource Specialist: Under the direction of the QPIM, the Coding Resource Specialist acts as the clinical coding expert across all departments for the Alliance and utilizes advanced knowledge of professional coding to review and recommend changes to systems, policies, and/or procedures to guarantee current and appropriate coding guidelines are maintained.

1.f.19. QI Project Specialist: Under the direction of either the QPIM or QI Nurse Supervisor, the QI Project Specialist acts as a key program assistant by coordinating efforts for QIPH programs such as CBI, C&L, FSR, Health Programs, PQI and HEDIS. The QI Project Specialist supports in the planning of departmental projects and communication activities.

1.f.20. QIPH Administrative Assistant (QIPH Admin): Under the direction of the QIPH Director, the QIPH Admin performs multiple administrative functions in support of the QPIP and QIPH department; and performs administrative staff support to QPIP committees as needed.

1.f.21. Compliance Officer: Under the direction of the CEO, the Compliance Officer is responsible for overseeing and coordinating Compliance Committee activities, including serving as Chair of the Compliance Committee and providing oversight of delegate oversight activities in accordance with Alliance policy 105-0004 – *Delegate Oversight*.

1.f.22. Utilization Management Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of Utilization Management Program staff.

1.f.23. Community Care Coordination (CCC) Staff: See Alliance policy 404-1101 – *Utilization Management Program* for a comprehensive listing of CCC Program staff.

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

1.f.25. Grievance Staff: Alliance Grievance staff is responsible for routing grievances to QIPH for research and analysis, routing, and resolution of clinically related member or provider complaints.

1.f.26. Credentialing Staff: Alliance Credentialing staff is responsible for ensuring the accuracy and completion of provider credentialing files prior to PRCC review. Credentialing staff oversee the completion of credentialing application information in accordance with Alliance Policies 300-4020 – *Peer Review and Credentialing Committee – Authority, Roles and Responsibilities* and 300-4040 – *Professional Provider Credentialing Guidelines*. The Credentialing staff monitors timeliness of review for re-credentialing[23]. The Credentialing staff also ensure the ongoing monitoring of provider credentials and issues in accordance with Alliance Policy 300-4090 – *Ongoing Monitoring of Provider Credentials and Issues*.

1.f.27. Other staff: The Alliance encourages active involvement of all Alliance staff in the design and implementation of the QPIP.

1.g. QPIP Alliance Board Reports

1.g.1. Quality Improvement Work Plan and Evaluation (QIWP): The QIWP is developed and maintained by QIPH staff. The CMO, QIPH Director, and QIPH Managers review the QIWP and obtain approval from CQIW and the CQIC prior to sending it to the Alliance Board for final approval.

1.g.2. Committee Minutes: CQIC and Compliance Committee minutes, and PRCC credentialing/re-credentialing related reports, are reviewed by the Alliance Board on a routine basis[24]. CQIC minutes are submitted to DHCS upon Alliance Board review and approval.

1.g.3. QIPH Annual Report: The QIPH Annual Report is submitted to the CQIC for its review, approval and submission to the Alliance Board[25], and subsequent submission to DHCS. The QIPH Annual Report includes an evaluation of areas of success and needed improvements. The evaluation includes, but is not limited to: the QIWP; aggregate data on utilization; results of the EAS measures; outcomes of PIPs; member satisfaction surveys; and collaborative initiatives as appropriate.

1.f.28. The QIPH Annual Report also includes copies of all independent private accrediting agencies (e.g. NCQA) if relevant, including accreditation status,

survey type, and level, as applicable; accreditation agency results, including recommended actions or improvements, corrective actions plans, summaries of findings; and expiration date of accreditation[26].

2. Maintain Continuous Quality Monitoring Utilizing Specific Quality and Performance Improvement Methods

2.a. The QPIP uses a variety of mechanisms to identify potential quality of service issues, ensure patient safety, and ensure compliance with standards of care across the care continuum (i.e., preventative health services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, and ancillary care services[27]). These mechanisms include, but are not limited to:

2.b. External Quality Review[28]: The Alliance incorporates external quality review requirements into the QPIP as described in Alliance Policy 401-1607 – *Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight*. The Alliance is contractually required to annually undergo an external quality review using MCAS (formerly referred to as EAS) performance measures. MCAS performance measures consist of a set of CMS Adult and Child measures developed by NCQA, other standardized performance measures, and/or DHCS developed performance measures.

2.c. Site Review[29]: The Alliance incorporates site review requirements into the QPIP as described in Alliance Policies 401-1508 – *Facility Site Review Process*, 401-1510 – *Medical Record Review and Requirements* and 401-1521 – *Physical Accessibility Review*. The Alliance conducts a Facility Site Review (FSR) for new primary care providers (PCPs) before initial credentialing and a minimum of every three (3) years thereafter as a requirement for participation in the California State Medi-Cal Managed Care Program. Physical Accessibility Reviews (PARs) are conducted during the initial FSR for new primary care provider sites, and at a minimum of every three (3) years upon re-credentialing[30]. Specialists and Ancillary sites that serve a high-volume of SPD members (providers whose monthly average of encounters for SPD members are above the monthly average of encounters) receive a PAR at a minimum of every three (3) years[31]. The Alliance ensures that member medical records are maintained by health care providers in accordance with contractual obligations[32]. The Alliance submits site review data to DHCS bi-annually[33].

2.d. Disease Surveillance[34]: The Alliance incorporates disease surveillance requirements into the QPIP as described in Alliance Policy 401-1519 – *Infection Control Practices*.

The Alliance requires providers report diseases or conditions that must be reported to public health authorities to applicable local, state and federal agencies as required by state law.

2.e. Credentialing and Recredentialing[35]: The Alliance incorporates credentialing and recredentialing requirements into the QPIP as described in Alliance Policies 105-0004 – *Delegate Oversight*[36], 300-4020 – *Peer Review and Credentialing Committee - Authority, Roles and Responsibilities*, 300-4030 – *Credentialing Criteria and Identified Issues*, 300-4040 – *Professional Provider Credentialing Guidelines*, 300-4090 – *Ongoing Monitoring of Provider Credentials and Issues*, 300-4110 – *Organizational Providers Credentialing Guidelines*, and 401-1523 – *Non-Physician Medical Practitioner: Scope of Practice and Supervision*.

2.e.1. The Alliance delegates oversight of credentialing, re-credentialing, recertification, and physician reappointment activities to the PRCC. The Alliance credentialing standards, as approved by PRCC, are aligned with applicable DHCS and Department of Managed Health Care (DMHC) credentialing and certification requirements[37].

2.e.2. The Alliance maintains a system of reporting serious quality deficiencies that result in suspension or termination of a practitioner to the appropriate authorities. Disciplinary actions include: reducing, suspending or terminating a practitioner's privileges. The Alliance maintains an appeal process[38].

2.f. Timely Access Monitoring[39]: The Alliance incorporates timely access monitoring requirements into the QPIP as described in Alliance Policies 401-1509 – *Timely Access to Care* and 300-8030 – *Monitoring Network Compliance with Accessibility Standards*. The Alliance ensures the provision of covered services in a timely manner consistent with the DMHC Timely Access requirements. The Alliance continuously reviews, evaluates and seeks to improve access to and availability of services. This includes ensuring that members are able to obtain appointments from contracted providers according to established access standards.

2.g. Member Satisfaction Monitoring[40]: The Alliance incorporates member satisfaction monitoring requirements into the QPIP as described in Alliance Policies 401-2001 – *Member Surveys*, 200-9001 – *Grievance Reporting, Quality Improvement and Audits*, and 200-9004 – *Staff Grievance Review Committee*. Member satisfaction survey results are reviewed and monitored for variations. Grievance data is reviewed and analyzed regularly to identify trends as part of the Alliance's efforts to improve and optimize the delivery and management of health care services. Grievance staff

refers individual cases for clinical review to QIPH staff as appropriate and the SGRC reports trends in quality issues to the Compliance Committee.

2.h. Provider Satisfaction Monitoring[41]: The Alliance incorporates provider satisfaction monitoring requirements into the QPIP as described in Alliance Policy 300-3092 – *Annual Provider Satisfaction Survey*. The Alliance conducts annual surveys of contracted physicians to determine provider satisfaction with the Alliance's performance and to identify any provider concerns with compliance with various regulatory standards.

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

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

2.k. Under/Over-Utilization Monitoring[42]: The Alliance incorporates under/over-utilization monitoring requirements into the QPIP as described in Alliance Policies 404-1101 – *Utilization Management Program* and 404-1108 – *Monitoring of Over/Under Utilization of Services*. The UM Program serves to ensure appropriate, high quality, cost-effective utilization of health care resources and that these resources are available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on evidence-based criteria, and expert clinical opinion when needed.

2.l. Population Needs Assessment (PNA)[43]: The PNA evaluates the health education and cultural and linguistic needs of members and the findings are used to guide the development and implementation of cultural and linguistic health education interventions. The Alliance prepares a PNA annually.[50]

2.m. Seniors and Persons with Disabilities (SPD) Activities[44]: The Alliance incorporates SPD activity requirements into the QPIP as described in Alliance Policies 404-1114 – *Continuity of Care*, 405-1112 – *Care Management of Seniors and Persons with Disabilities for Medi-Cal*, and 405-2210 – *Disease Management Program*. The Alliance conducts studies for SPDs or persons with chronic conditions that are designed to assure the provision of case management, coordination and continuity of care services, including ensuring availability, access to care, and clinical services.

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

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

2.p. Behavioral Health Services Monitoring: The Alliance incorporates behavioral health services monitoring requirements into the QPIP as described in Alliance Policy 405-1305 – *Behavioral Health Services for Medi-Cal*. Oversight and monitoring of any delegated portions of mental health services are outlined in Policy 105-0004 – *Delegate Oversight*.

2.q. Quality Improvement Delegate Oversight Activities[45]: The Alliance incorporates QIPH delegate oversight activities into the QPIP as described in Alliance Policies105-0004 – *Delegate Oversight* and 401-1201 – *Continuous Quality Improvement Committee*. The Alliance may delegate QIPH functions to subcontracting entities, as outlined in Alliance Policy 105-0004 – *Delegate Oversight*. These delegated functions are set forth in the Alliance's contracts with subcontracting entities and include specific performance and reporting standards that must be met.

3. Analyze Data, Incorporate Provider Feedback and Develop Interventions

Using the methods outlined above, QIPH analyzes data using current evidence-based standards as benchmarks. Significant quality, service, or utilization issues are analyzed for barriers, trends, or root causes. This process incorporates provider review and feedback into performance improvement activities and may include a multidisciplinary

team, quantitative and qualitative analysis, and development of interventions that are implemented and/or planned for continuous monitoring.

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

3.a.1. CMS Child and Adult Core Set Standards
- 3.a.1.a. MCAS HPLs and MPLs;
- 3.a.1.b. Under-utilization of DHCS identified performance measures as part of the MCAS which will be measured as part of the HEDIS compliance audit[46]; and
- 3.a.1.c. CAHPS Survey results[47].

3.a.2. Preventive Care Guidelines: The preventive care guidelines address periodic health and behavioral risk screening and preventive services for asymptomatic adults and children. Individuals identified as being at high risk for a given condition may require more frequent or additional screening tests specific to the condition. These guidelines establish the minimum standard of preventive care.

3.a.2.a. Adult preventive care guidelines include[48]:
- a. The United States Preventive Services Task Force (USPSTF) guidelines;
- b. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (CDC ACIP); and
- c. The State of California DHCS Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004.

3.a.2.b. Pediatric preventive care guidelines include[49]:
- a. The provision of the Early and Periodic Screening, Diagnostic, and Treatment Services for members under the age of 21 years old in accordance with the American Academy of Pediatrics (AAP) Bright Future guidelines (All Plan Letter 19-010);
- b. CDC ACIP;
- c. Child Health and Disability Prevention Program (CHDP); and
- d. The DHCS MMCD Policy Letter 14-004.

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

3.a.4. MCG (formerly Milliman Care Guidelines): MCG is utilized as outlined in Alliance Policy 404-1112 – *Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests*.

3.b. Incorporate Provider Feedback[50]: The Alliance distributes information regarding QIPH programs, activities, and reports and actively elicits provider feedback through the following:

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

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

3.b.3. Publication of Board Reports;

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

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

3.b.6. Medical Director and Provider Services' onsite and network communication;

Coordination and facilitation of external committee meetings, including Safety Net Clinic Coalition, and hospital and clinic Joint Operation Committees (JOC); and

3.b.7. Coordination and facilitation of Alliance physician committees, including CQIC, PAG, PRCC, and WCCAC. Outcomes from these committees requiring

modifications to the operational QPIP are incorporated by way of receipt of directives from the Alliance Board[51] and/or by receipt of reports from the CMO.

Develop Interventions

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

Performance Improvement Project (PIP)[52,53]: Under consultation and with guidance from the EQRO and DHCS, the Alliance conducts a minimum of two (2) DHCS-approved PIPs. One PIP must be either an internal PIP or a small group collaborative. The second PIP must be a DHCS-facilitated state-wide collaborative.

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

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

The Alliance will ensure appropriate staff resources are available to complete PIP submissions in a timely manner and in compliance with DHCS due dates.

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

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

that do not correct cited deficiencies are to be terminated from the network[54]; and

3.c.3.b. Provider CAPs may be an intervention for certain PQIs, as deemed appropriate by the CMO or a Medical Director[55]. Refer to Alliance Policy 401-1306 - *Corrective Action Plan for Quality Issues.*

3.c.4. Improvement Plan[56]:
The Alliance must submit a PDSA Cycle Worksheet to DHCS for each MCAS measure with a rate that does not meet the MPL or is given an audit result of "Not Reportable" (NR). DHCS will notify MCPs of the due date. Submission includes: analysis of barriers, targeted interventions, relevant data to support analysis, targeted interventions, and a rapid cycle /continuous quality improvement process to guide PDSA outcomes. The Alliance will conduct at least a quarterly evaluation of ongoing rapid-cycle quality improvement efforts to determine whether progress is being made.

3.c.5. Quality and Health Programs:

3.c.5.a Disease Management: Consistent with Alliance Policy 405-2110 – *Disease Management Program*, the Alliance maintains comprehensive health and disease management programs designed to improve current health status and health outcomes, and avoid future complications from chronic disease for Alliance members[57].

3.c.5.b Health Education and Promotion: Consistent with Alliance Policy 405-2101 – *Health Education and Promotion Program*, the Alliance offers important health education and promotion programs for its members. These programs are intended to assist members to improve their health, properly manage illness, and avoid preventable conditions. These programs have been implemented in all Alliance service areas, and are routinely reviewed for access, quality, and outcomes and reported as part of the QPIP[58].

Health Programs services and information is shared with providers through the Provider Portal and special mailings for general performance reports[59], which may include:

a. Listings of members who need specific services;
b. Listings of members who need intervention based on pharmacy indicators; and

c. Alliance-sponsored training directed at improving performance.

3.c.5.c. CBI: The CBI Program provides incentive payments to providers and members for a variety of activities and serves as a mechanism to identify specific areas of a provider's care that are below the standard of care and may be amenable to improvement through various interventions. Details of the CBI Program are updated annually and available in the Alliance Provider Manual and on the Alliance website. Refer to Alliance Policy 401-1705 - *Care-Based Incentive Program*

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

References:

Alliance Policies:

105-0004 – Delegate Oversight
105-3002 – Program Integrity: Special Investigations Unit Operations
200-1007 – Whole Child Model Family Advisory Committee
200-9001 – Grievance Reporting, Quality Improvement and Audits
200-9004 – Staff Grievance Review Committee
300-3092 – Annual Provider Satisfaction Survey
300-4020 – Peer Review and Credentialing Committee – Authority, Roles and Responsibilities
300-4030 – Credentialing Criteria and Identified Issues
300-4040 – Professional Provider Credentialing Guidelines
300-4090 – Ongoing Monitoring of Provider Credentials and Issues
300-4102 – Fair Hearing Process for Adverse Decisions
300-4103 – Reporting to the Medical Board of California and the National Practitioner Data Bank
300-4110 – Organizational Providers Credentialing Guidelines
300-8030 – Monitoring Network Compliance with Accessibility Standards
400-1109 – Physicians Advisory Group Responsibilities and Functions
400-1112 – Whole Child Model Clinical Advisory Committee Responsibilities and Functions
401-1201 – Continuous Quality Improvement Committee
401-1301 – Potential Quality Issue Review Process
401-1306 – Corrective Action Plan for Quality Issues

401-1501 – Standards of Care
401-1502 – Adult Preventive Care
401-1505 – Childhood Preventive Care
401-1508 – Facility Site Review Process
401-1509 – Timely Access to Care
401-1510 – Medical Record Review and Requirements
401-1519 – Infection Control Practices
401-1521 – Physical Accessibility Review
401-1523 – Non-Physician Medical Practitioner: Scope of Practice and Supervision
401-1607 – Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight
401-1705 – Care-Based Incentive Program
401-2001 – Member Surveys
401-3101 – Health Education and Promotion Program
401-3104 – Disease Management Program
401-4101 - Cultural and Linguistic Services Program
403-1104 – Mission, Composition and Functions of the Pharmacy and Therapeutics Committee
404-1101 – Utilization Management Program
404-1108 – Monitoring of Over/Under Utilization of Services
404-1112 – Medical Necessity- The Definition and Application of Medical Necessity Provision to Authorization Requests
404-1114 – Continuity of Care
405-1112 – Care Management of Seniors and Persons with Disabilities for Medi-Cal
405-1305 – Behavioral Health Services

Impacted Departments:

Community Care Coordination
Compliance
Provider Services
Utilization Management /Complex Case Management

Regulatory:

California Evidence Code Section 1157
California Code of Regulations Title 28 Chapter 2, Article 7, Section 1300.67.2.2
California Code of Regulations Title 28, Chapter 2, Article 7, Section 1300.70
Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 440, Subpart B, Section 440.262
Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 438, Subpart E, Section 438.330

Legislative:

Contractual:

	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality and Performance Improvement Program	
Original Date: 02/01/1996	**Policy Hub Approval Date:** 06/21/2021
Approved by: Continuous Quality Improvement Committee (CQIC)	

DHCS State Medi-Cal Contract
DHCS All Plan or Policy Letter:
PL 14-004
APL 15-023
APL 19-010
NCQA:
HEDIS Volume 2 Technical Specifications for Health Plans
Supersedes:
Other:
Alliance Provider Manual
Attachments:
Attachment A: Central California Alliance for Health Committee Structure
Attachment B: Quality Improvement Organizational Chart

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
02/01/2000	02/01/2000	Barbara Flynn, RN	Barbara Flynn, RN
02/01/2003	02/01/2003	Barbara Flynn, RN	Barbara Palla, MD
02/01/2004	02/01/2004	Barbara Flynn, RN	Barbara Palla, MD
03/01/2005	03/01/2005	Barbara Flynn, RN	Barbara Palla, MD
04/01/2006	04/01/2006	Barbara Flynn, RN	Barbara Palla, MD
04/01/2007	04/01/2007	Barbara Flynn, RN	Barbara Palla, MD
01/01/2008	01/01/2008	Richard Helmer, MD	CQIC
10/01/2008	10/01/2008	Andres Aguirre	Richard Helmer, MD
11/01/2008	11/01/2008	Andres Aguirre	Richard Helmer, MD
01/01/2010	01/01/2010	Barbara Flynn, RN	CQIC
07/01/2010	07/01/2010	Barbara Flynn, RN	CQIC
11/14/2011	11/14/2011	David Altman, MD	CQIC
09/21/2012	09/21/2012	David Altman, MD	David Altman, MD, AMDQI
02/08/2013	02/08/2013	Herschel Leland, Sr. Compliance Specialist	David Altman, MD, AMDQI
08/15/2013	08/15/2013	Peg Behan, RRT, QI Manager	CQIW

	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality and Performance Improvement Program	
Original Date: 02/01/1996	**Policy Hub Approval Date:** 06/21/2021
Approved by: Continuous Quality Improvement Committee (CQIC)	

Reviewed Date	Revised Date	Changes Made By	Approved By
09/16/2014	09/16/2014	Kelly Salazar, RN, QI Nurse	CQIW
01/22/2015	01/22/2015	Peg Behan, RRT, QI Manager	CQIW
01/20/2016	01/20/2016	Julio Porro, MD, Medical Director for QI	CQIW
03/21/2017	03/21/2017	Chris Morris, Accreditation Manager	CQIW
08/15/2016	08/15/2016	Sitara Cavanagh, Accreditation Specialist	CQIW
01/26/2017	01/26/2017	Sitara Cavanagh, Accreditation Specialist	CQIC
05/17/2017	05/17/2017	Chris Morris, Quality & Performance Improvement Manager	CQIW
06/07/2017	06/07/2017	Chris Morris, Quality & Performance Improvement Manager	CQIC
01/2/2018	01/2/2018	Chris Morris, Quality & Performance Improvement Manager	CQIW
01/19/2018	01/19/2018	Chris Morris, Quality & Performance Improvement Manager	CQIC
01/16/2019	01/16/2019	Amit Karkhanis, Quality and Performance Improvement Manager	CQIW
01/24/2019	01/24/2019	Amit Karkhanis, Quality and 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
09/18/2019	09/18/2019	Michelle Stott, RN, Quality Improvement Director	CQIW
10/24/2019	10/24/2019	Michelle Stott, RN, Quality Improvement Director	CQIC

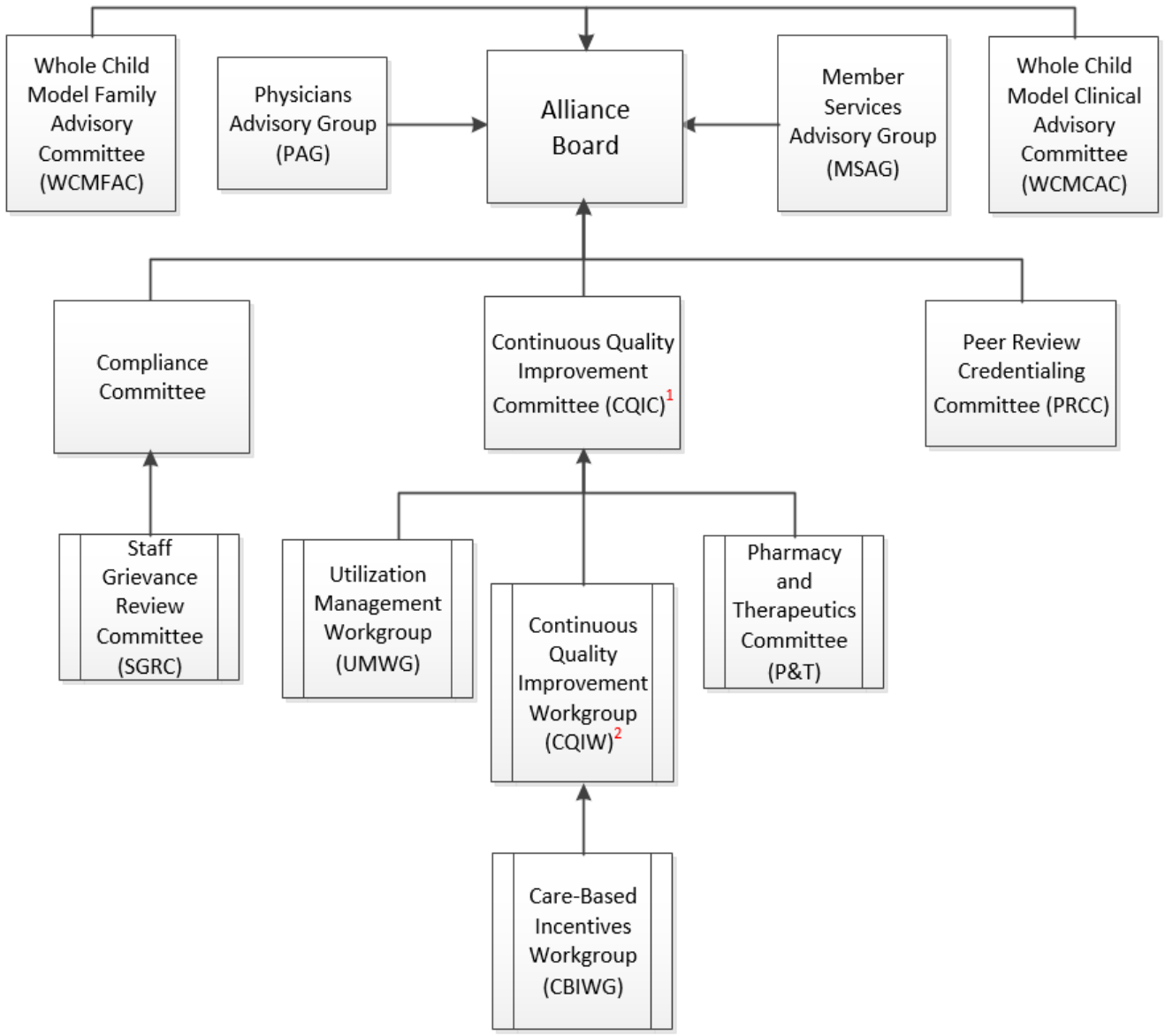
Reviewed Date	Revised Date	Changes Made By	Approved By
01/15/2020	01/15/2020	Oscar Sanchez, Quality Improvement Administrative Assistant	CQIW
01/23/2020	01/23/2020	Michelle Stott, RN, Quality Improvement Director	CQIC
02/14/2020	02/14/2020	Amit Karkhanis, Quality and Performance Improvement Manager	Michelle Stott, RN, Quality Improvement Director
03/25/2021	03/25/2021	Amit Karkhanis, Quality and Performance Improvement Manager	CQIW-I
04/29/2021	04/29/2021	Amit Karkhanis, Quality and Performance Improvement Manager	CQIC

[1] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
[2] [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
[3] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7.F; DHCS communication dated 8/2016 related to Title 42, Code of Federal Regulations, Section 440.262; [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7.F
[4] 42 CFR 438.330(b)(3) incorporated via [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
[5] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[6] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[7] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[8] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[9] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[10] DHCS All Plan Letter 19-017
[11] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[12] DHCS All Plan Letter 19-017
[13] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 2; 28 CCR Section 1300.70(b)(C)
[14] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3
[15] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.A
[16] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.B
[17] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.C
[18] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.D

[19] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[20] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 2
[21] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12
[22] DHCS State Medi-Cal Contract, Exhibit A, Attachment 23, Provision 2.A (Whole Child Model Amendment)
[23] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provisions 10.C and 12
[24] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.C
[25] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8
[26] [MMC Final Rule] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8.B.
[27] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7.H
[28] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9
[29] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 10
[30] MMCD PL 14-004; DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[31] DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[32] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 13
[33] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 13.E
[34] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 11
[35] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12
[36] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12.C
[37] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12.E
[38] Policy 300-4103 – Fair Hearing Process for Adverse Decisions; Policy 300-4102 – Reporting to the Medical Board of California and the National Practitioner Data Bank; 401-1306 – Corrective Action Plan for Quality Issues; 300-4090 – Ongoing Monitoring of Provider Credentials and Issues
[39] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2
[40] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9.D; DHCS All Plan Letter 19-017
[41] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)
[42] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9.3.B
[43] DHCS State Medi-Cal Contract, Exhibit A, Attachment 9, Provision 12.C
[44] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7.I
[45] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6
[46] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9.A
[47] Policy 401-2001 – Member Surveys
[48] Policy 401-1502 – Adult Preventive Care
[49] Policy 401-1505 – Childhood Preventative Care
[50] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7.D
[51] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.D
[52] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9.C; DHCS All Plan Letter 19-017
[53] 42 CFR 438.330(d) incorporated via [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
[54] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 10.D; MMCD PL 14-004

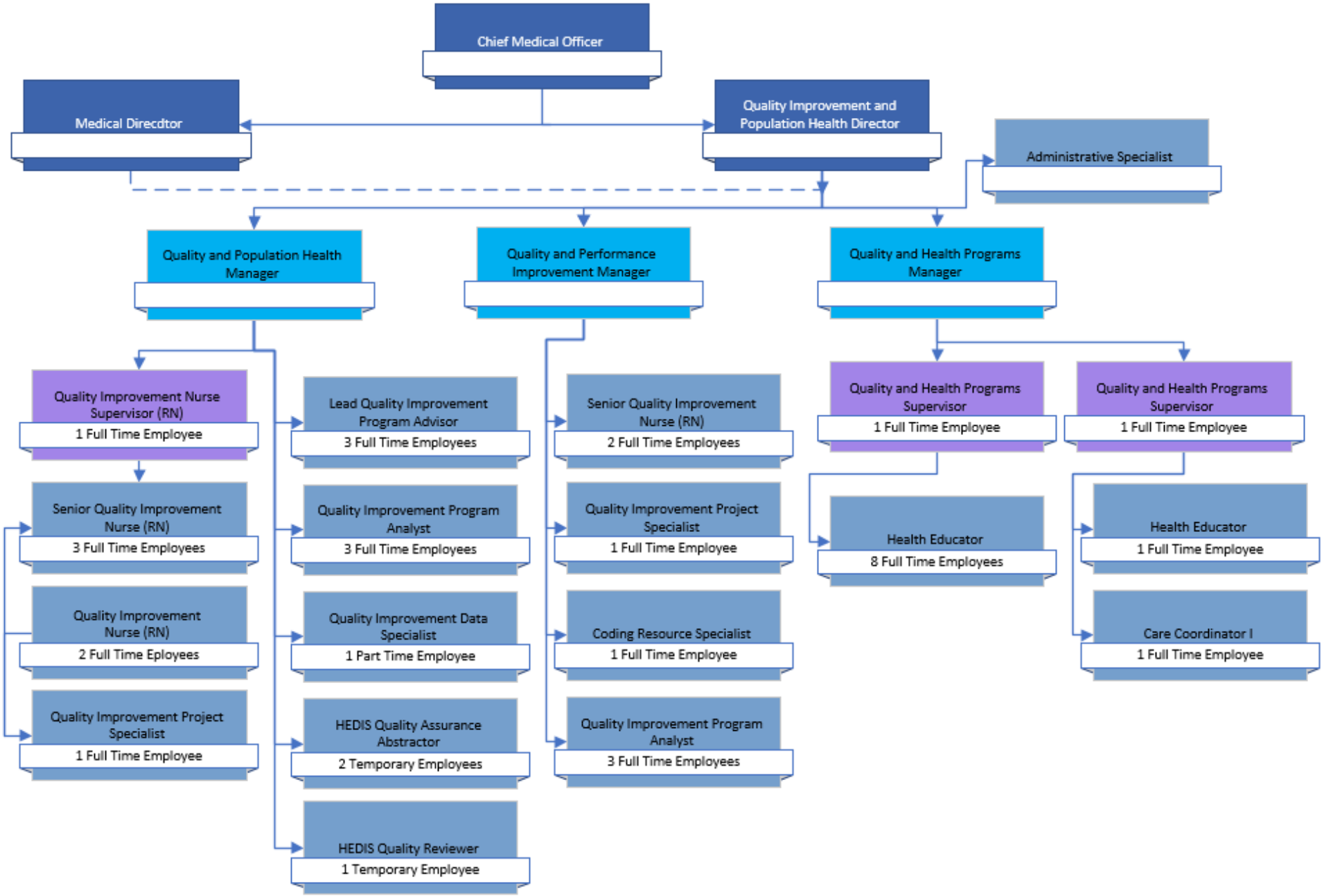
[55] Policy 401-1301 – Potential Quality Issue Review Process; Policy 401-1306 – Corrective Action Plan for Quality Issues
[56] DHCS All Plan Letter 19-017
[57] DHCS State Medi-Cal Contract, Exhibit A, Attachment 10, Provision 8
[58] DHCS State Medi-Cal Contract, Exhibit A, Attachment 10, Provision 8
[59] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 5

Policy 401-1101: Quality and Performance Improvement Program (QPIP)
Attachment A: Central California Alliance for Health QPIP Committee Structure
Last Updated: April 16, 2021



[1] Functions as the Alliance's DHCS contractually required "Quality Improvement Committee."
[2] Refers to both Continuous Quality Improvement Workgroup (CQIW) or Interdisciplinary Continuous Quality Improvement Workgroup (CQIW-i)

Policy 401-1101: Quality and Performance Improvement Program (QPIP)
Attachment B: Quality Improvement Department Organization Chart
Last Updated: April 16, 2021



Back to Agenda

DATE: September 22, 2021

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

FROM: Danita Carlson, Government Relations Director

SUBJECT: Conflict-of-Interest Code: Biennial Review

Recommendation. Staff recommend the Board approve the attached Conflict-of-Interest Code of the Santa Cruz-Monterey-Merced Managed Medical Care Commission.

Background. As a multi-county governmental agency, the Santa Cruz-Monterey-Merced Managed Medical Care Commission is required to have an approved Conflict-of-Interest Code on file with the Fair Political Practices Commission (FPPC). In addition, multi-county agencies must review their Conflict-of-Interest Code biennially to ensure that the code is up to date with a current list of designated staff positions and appropriate disclosure categories. The Board most recently approved its Conflict-of-Interest Code on February 27, 2019.

Discussion. Staff reviewed the Board's current Conflict-of-Interest Code, in accordance with the FPPC requirements for biennial review and determined that the changes were necessary to update the list of designated positions required to file the annual Statement of Economic Interests – Form 700. Staff worked with the FPPC to ensure that updates and revisions met regulatory requirements.

Pursuant to FPPC regulations, the Alliance opened a 45-day public comment period on May 28, 2021. The Notice of Intention to Adopt or Amend a Conflict-of-Interest Code was disseminated to all employees and Code filers and was posted on the Alliance's website as required. The comment period closed on July 15, 2021 without comment. The FPPC approved the Conflict-of-Interest Code, at the close of the comment period.

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

Attachments.

1. Conflict-of-Interest Code of the Santa Cruz-Monterey-Merced Managed Medical Care Commission

CONFLICT-OF–INTEREST CODE OF THE

SANTA CRUZ – MONTEREY– MERCED MANAGED MEDICAL CARE COMMISSION

dba CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

The Political Reform Act (Government Code Section 81000, et seq.) requires state and local government agencies to adopt and promulgate conflict-of-interest codes. The Fair Political Practices Commission has adopted a regulation (2 Cal. Code of Regs. Sec. 18730) which contains the terms of a standard conflict-of-interest code, which can be incorporated by reference in an agency's code. After public notice and hearing, the standard code may be amended by the Fair Political Practices Commission to conform to amendments in the Political Reform Act. Therefore, the terms of 2 California Code of Regulations Section 18730 and any amendments to it duly adopted by the Fair Political Practices Commission are hereby incorporated by reference. This regulation and the attached Appendices, designating positions and establishing disclosure categories, shall constitute the conflict-of-interest code of the **Santa Cruz-Monterey-Merced Managed Medical Care Commission dba Central California Alliance for Health ("Central California Alliance for Health").**

Individuals holding designated positions shall file their statements of economic interests with the **Central California Alliance for Health**, which will make the statements available for public inspection and reproduction. (Gov. Code Sec. 81008.) All statements will be retained by the **Central California Alliance for Health**.

CONFLICT-OF-INTEREST CODE, APPENDIX
EXHIBIT "A"

Designated Positions	Disclosure Category
Accounting and Administrative Contracts Director	2, 3
Accounting Manager	2
Administrative Services Manager	2
Advanced Analytics Manager	2
Application Manager	2
Application Development Manager	2,3
Application Services Director	2,3
Behavioral Health Program Manager	2
Budgeting and Reporting Director	2
Business Resiliency Program Manager	2,3
Care Coordination Manager	2
Chief Administrative Officer	1, 2, 3, 4
Chief Information Officer	2, 3
Chief Medical Officer	2, 3, 4
Chief Operating Officer	1, 2, 3, 4
Claims Director	2, 3
Claims Manager - Operations	2
Claims Manager - Provider Support	2
Claims Quality Manager	2
Clinical Pharmacy Manager	2
Communications Director	2, 3
Community Care Coordinator Director	2, 3
Compliance Manager	2
Compliance Officer	2, 3, 4
Contracts Manager	2
Credentialing and Provider Data Configuration Manager	2
Data Analytics Services Director	2. 3
EDI Manager	2

Enterprise Data Warehouse (EDW) Manager	2
Facilities & Administrative Services Director	2, 3
Facilities Manager	2
Finance Manager	2
Financial Analytics Manager	2, 3
Government Relations Manager	2
Government Relations Director	2, 4
Grant Program Manager	2
Grievance and Quality Manager	2, 4
Health Analytics Manager	2
Human Resources Director	2, 3
Human Resources Manager	2
IT Manager	3
Media & Content Manager	2
Medical Director	2, 3
Member Services Call Center Manager	2
Member Services Operations Manager	2
Member Services Director	2, 3
Operational Excellence Director	2,3
Payroll Manager	2
Pharmacy Director	2, 3
Process Excellence Manager	2
Program Development Manager	2
Project Management Office Portfolio Manager	2Provider
Payment Director	2, 3
Provider Quality & Network Development Manager	2
Provider Relations Manager	2
Provider Services Contracts Manager	2
Provider Services Director	2, 3, 4
Purchasing Manager	2, 3
Quality & Health Programs Manager	2
Quality & Population Health Manager	2,3

Quality & Performance Improvement Manager	2, 3
Quality Improvement & Population Health Director	2, 3
Regional Operations Director	2, 3
Service Desk Manager	2
Strategic Development Director	2,3
Talent Acquisition Manager	2
Technology Services Director	2, 3
Training and Development Manager	2
Utilization Management & Complex Case Management Director	2, 3
Utilization Management & Complex Case Management Manager - Authorizations	2
Utilization Management & Complex Case Management Manager – Concurrent Review	2
Consultant/New Position	*

Consultants and new positions shall be included in the list of designated employees and shall disclose pursuant to the broadest disclosure category in the code subject to the following limitation:

> The Chief Executive Officer may determine in writing that a particular consultant or new position, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to comply fully with the disclosure requirements described in this section. Such determination shall include a description of the consultant's or new position's duties and, based upon that description, a statement of the extent of disclosure requirements. The (executive director's or executive officer's) determination is a public record and shall be retained for public inspection in the same manner and location as this conflict of interest code.

The following positions are not covered by the code because the positions manage public investments. Individuals holding such positions must file under Government Code Section 87200 and are listed for informational purposes only. Section 87200 requires disclosure of all investments and business positions in business entities, all sources income, including gifts, loans and travel payments, and real property.

Governing Board Members
Chief Executive Officer
Chief Financial Officer

An individual holding one of the above listed positions may contact the Fair Political Practices Commission for assistance or written advice regarding their filing obligations if

they believe their position has been categorized incorrectly. The Fair Political Practices Commission makes the final determination whether a position is covered by Section 87200.

CONFLICT-OF-INTEREST CODE, APPENDIX
EXHIBIT "B"

DISCLOSURE CATEGORIES

CATEGORY 1: Interests in Real Property. All interests in real property located within the jurisdiction of the Central California Alliance for Health.

CATEGORY 2: Sources of Income. Investments and Business Positions Held by Designated Position. All investments, business positions in any business entity or trust, and sources of income (including gifts, loans, and travel payments) from sources that are of the type to provide services, supplies, equipment, or other property to be utilized by Central California Alliance for Health. The type of sources include, but are not limited to: health care providers, hospitals, pharmacies, laboratories, medical care treatment facilities, insurance companies, ambulance companies, and any person that provides consulting services of the type to be negotiated or to be utilized by the Central California Alliance for Health.

CATEGORY 3: Interests in Information Technology Companies: Investments, business positions and sources of income, (including gifts, loans and travel payments) from sources of the type that manufacture, distribute, supply, or install computer hardware or software of the type to be utilized by the Central California Alliance for Health, as well as entities providing computer consultant services.

CATEGORY 4: Claims Category: Investments and business positions in business entities, and income, including receipt of loans, gifts, and travel payments, from sources, that filed a legal claim or demand, or have a legal claim or demand pending, against the Central California Alliance for Health during the previous two years.

This is the last page of the conflict of interest code for the **Central California Alliance for Health**.

CERTIFICATION OF FPPC APPROVAL

Pursuant to Government Code Section 87303, the conflict of interest code for the **Central California Alliance for Health** was approved on 8/13/ 2021. This code will become effective on 9/12/ 2021.

John M. Feser, Jr.
Senior Commission Counsel
Fair Political Practices Commission

DATE: September 22, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Alliance Formulary Changes for Q3 2021

Recommendation. Staff recommend the Board approve the decision from the August 5, 2021 Pharmacy and Therapeutics (P&T) Committee on Alliance formulary changes for Q3 2021 listed below.

Background. The Alliance formulary is developed and maintained by the P&T Committee. The P&T Committee reports to the Continuous Quality Improvement Committee (CQIC). The CQIC is designated by, and accountable to, the Santa Cruz-Monterey-Merced Managed Medical Care Commission (Board). The activities, findings, recommendations and actions of the CQIC are reported to the Board on a scheduled basis.

Discussion. The P&T Committee accepted the following changes recommended by Alliance Pharmacists based on safety, efficacy, cost, scientific evidence and standards of practice.

Drug	Action
Narcan nasal spray	Added to formulary for IHSS members
Kloxxado nasal spray	Added to formulary for IHSS members
Naloxone cartridge	Added to formulary for IHSS members
Naloxone syringe	Added to formulary for IHSS members
Fintepla oral solution	New prior authorization criteria
Xcopri tablet	New prior authorization criteria
Saxenda	Modified Prior Authorization Criteria
Wegovy	New Prior Authorization Criteria
Qsymia	Modified Prior Authorization Criteria
Contrave ER	Modified Prior Authorization Criteria
Trelegy Ellipta	Modified Prior Authorization Criteria
Breztri Aerosphere	New Prior Authorization Criteria
Lokelma	New Prior Authorization Criteria

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

Attachments. N/A

DATE: September 22, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Peer Review and Credentialing Committee Report of June 9, 2021

Recommendation. Staff recommend the Board accept the decisions from the June 9, 2021 meeting of the Peer Review and Credentialing Committee (PRCC).

Background. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Board) is accountable for all provider credentialing activities. The Board has delegated to the PRCC the authority to oversee the credentialing program for the Central California Alliance for Health (the Alliance).

Discussion. The PRCC is currently a seven-member committee comprised of Alliance-contracted physicians who make recommendations to approve, defer, or deny network participation for new and existing providers based on established credentialing criteria. The committee meets quarterly. The PRCC also conducts peer review of network providers and offers advice and expertise when making credentialing decisions. Provider credential verification and review ensures that network providers possess the legal authority, relevant training and experience, and professional qualifications necessary to provide a level of care consistent with professionally recognized standards. The Alliance credentialing standards are aligned with applicable credentialing and certification requirements of the State of California, the Department of Health Care Services, the Department of Managed Health Care and, as appropriate, the National Committee for Quality Assurance.

- New Providers:
  - 44 Physician Providers (MD, DO, DPM)
  - 24 Non-Physician Medical Practitioners
  - 8 Allied Providers
  - 3 Organizations

- Recredentialed Providers:
  - 49 Physician Providers (MD, DO, DPM)
  - 17 Non-Physician Medical Practitioners
  - 4 Allied Providers
  - 13 Organizations

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

Attachments. N/A

DATE: September 22, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Peer Review and Credentialing Committee Report of September 9, 2021

Recommendation. Staff recommend the Board accept the decisions from the September 9, 2021 meeting of the Peer Review and Credentialing Committee (PRCC).

Background. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Board) is accountable for all provider credentialing activities. The Board has delegated to the PRCC the authority to oversee the credentialing program for the Central California Alliance for Health (the Alliance).

Discussion. The PRCC is currently a seven-member committee comprised of Alliance-contracted physicians who make recommendations to approve, defer, or deny network participation for new and existing providers based on established credentialing criteria. The committee meets quarterly. The PRCC also conducts peer review of network providers and offers advice and expertise when making credentialing decisions. Provider credential verification and review ensures that network providers possess the legal authority, relevant training and experience, and professional qualifications necessary to provide a level of care consistent with professionally recognized standards. The Alliance credentialing standards are aligned with applicable credentialing and certification requirements of the State of California, the Department of Health Care Services, the Department of Managed Health Care and, as appropriate, the National Committee for Quality Assurance.

- New Providers:
  - 34 Physician Providers (MD, DO, DPM)
  - 11 Non-Physician Medical Practitioners
  - 8 Allied Providers
  - 3 Organizations

- Recredentialed Providers:
  - 69 Physician Providers (MD, DO, DPM)
  - 15 Non-Physician Medical Practitioners
  - 7 Allied Providers
  - 14 Organizations

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

Attachments. N/A

DATE: September 22, 2021

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

FROM: Kathleen McCarthy, Strategic Development Director

SUBJECT: Recuperative Care Pilot Funding and Criteria Adjustments

---

Recommendation. Staff recommend the Board approve changes to the Recuperative Care Pilot timeline and budget allocations for each county to allow for adjustments of the per diem rate from $140 to $181 and inclusion of dual eligible members in the eligibility criteria.

Summary. This report provides background information on the Recuperative Care Pilot and recommendations for adjustments to the timeline, budget allocations and eligibility criteria in order to ensure the sustainability of the pilot for both participating organizations and the Alliance.

Background. On December 2, 2020, the Alliance Board approved $5,857,020 of unallocated Medi-Cal Capacity Grant Program (MCGP) funds to establish a two-year Recuperative Care Pilot to operate from March 2021 to February 2023. The Recuperative Care Pilot provides funding for short-term housing with medical and social support services for Alliance Medi-Cal members who are experiencing homelessness and recovering from an acute illness or injury. The Recuperative Care Pilot also funds bridge housing, which extends a stay in the recuperative care facility, or a separately approved bridge housing facility, after a member no longer meets the medical criteria for recuperative care and while awaiting a permanent housing placement.

Under the Recuperative Care Pilot, the Alliance contracted with three organizations to provide recuperative care and bridge housing services. These organizations all operate recuperative care facilities in the Alliance service area (one organization per respective county). On March 3, 2021, the Alliance launched the Recuperative Care Pilot with Housing Matters' Santa Cruz Recuperative Care Center in Santa Cruz County. After meeting their pre-contract implementation requirements, the Recuperative Care Pilot launched on August 3, 2021, in Merced County with Mission Merced Incorporated's (formerly Merced County Rescue Mission) Hope Medical Respite Care, and on August 16, 2021, in Monterey County with Community Homeless Solution's Central Coast Respite Center.

The original two-year Recuperative Care Pilot budget allocation for recuperative care services was based on projected Medi-Cal utilization (90 percent) of the recuperative care beds available in each county at a per diem rate of $140 per day, for an average of 30 bed days per stay. For recuperative care services, MCGP grant payments are made in monthly installments, based on member utilization, after receipt of each required invoice from participating organizations. Bridge Housing payments are made quarterly. Due to their later pilot start dates, Merced and Monterey counties' grants were prorated for the second year of recuperative care and bridge housing.

The Recuperative Care Pilot was designed in part to prepare the Alliance for CalAIM's In Lieu of Services (ILOS) proposal that will allow Medi-Cal managed care plans to offer medically appropriate and cost-effective alternatives to covered services, such as recuperative care, starting in 2022.

Discussion. The Recuperative Care Pilot was originally proposed as a two-year grant-funded pilot to end in February 2023; however, the Department of Health Care Services (DHCS) is strongly encouraging managed care plans to begin offering ILOS starting in 2022. By transitioning from a grant-funded pilot to ILOS, the Alliance will be able to fund these services through the medical budget and the cost and utilization will be factored into the medical portion of the Alliance's rates. The Alliance will also be eligible for performance incentives available to managed care plans to invest in ILOS infrastructure, information technology and data exchange and workforce capacity. The Alliance has indicated to DHCS the interest to transition both recuperative care and bridge housing services from the grant-funded Recuperative Care Pilot to CalAIM ILOS (Recuperative Care and Short-term Post-Hospitalization Housing, respectively) in July 2022 for Recuperative Care and January 2023 for Short-term Post-Hospitalization Housing. Staff will work with all three participating organizations to prepare for the transition. While the grant-funded pilot will technically end when the services are transitioned to ILOS, staff will conduct a thorough evaluation of the impact of these services on member health and any reductions in cost of care at the end of two years, as originally planned.

Furthermore, prompted by feedback from participating organizations, the Alliance conducted a mid-pilot funding analysis and found that the current funding structure for recuperative care services may not be financially sustainable for participating organizations. One key reason is the slow ramp up and low utilization numbers in the first months of the pilot. In order to address this issue, staff recommends an increase to the recuperative care per diem rate from $140 to $181, in alignment with the lower bound of the proposed CalAIM Recuperative Care ILOS rate range ($181-$226) developed by DHCS.

The Alliance also heard from participating organizations a desire to include in the pilot Alliance Medi-Cal members who are dually eligible for both Medicare and Medi-Cal (also known as "Medi-Medis"). Medi-Medis were not included in the original pilot eligibility criteria, yet Medi-Medis will be eligible for ILOS under CalAIM. Staff, therefore, recommend an adjustment to pilot eligibility criteria to include Medi-Medis, which will also contribute to a more financially sustainable funding structure for participating organizations by potentially increasing enrollment.

Fiscal Impact. The original total Recuperative Care Pilot budget (see Table 1 below), as previously approved by the Alliance Board, was set not to exceed $5,857,020, with specific county allocations not to exceed $3,301,380 for Merced County, $1,001,880 for Monterey County and $1,553,760 for Santa Cruz County. The proposed adjusted total Recuperative Care Pilot budget (see Table 2 below), would not exceed $3,446,764, with specific county allocations not to exceed $1,877,752 for Merced County, $539,186 for Monterey County and $1,029,826 for Santa Cruz County. The difference between the original and adjusted budget is a decrease of $2,071,236, including $1,310,827 for Merced County, $349,893 for Monterey County and $410,517 for Santa Cruz County.

When recuperative care and bridge housing transition from grant-funded pilot to ILOS, the Alliance will fund these services through the Alliance's medical budget instead of MCGP budget, and any remaining Recuperative Care Pilot funding will be returned to the MCGP unallocated budget for each county.

Table 1. Original Board-Approved Budget

County	Number of Beds Available	Maximum Amount for Recuperative Care Over Two Years ($140 per diem rate)	Fixed Amount for Bridge Housing Over Two Years ($450,000 lump sum)	Total Maximum Amount for Recuperative Care & Bridge Housing Combined Over Two Years
Merced County	30-32	$2,851,380	$450,000	$3,301,380
Monterey County	6	$551,880	$450,000	$1,001,880
Santa Cruz County	12	$1,103,760	$450,000	$1,553,760
Total	**48-50**	**$4,507,020**	**$1,350,000**	**$5,857,020**

Table 2. Updated Prorated Budget Based on Funding Structure Adjustments for Transition to ILOS for Recuperative Care in July 2022 and Bridge Housing in January 2023

County	Number of Beds Available	Maximum Amount for Recuperative Care Over Prorated Pilot Term ($181 per diem rate)	Fixed Amount for Bridge Housing Over Prorated Pilot Term ($450,000 *prorated* lump sum)	Total Maximum Amount for Recuperative Care & Bridge Housing Combined Over Prorated Pilot Term
Merced County	30-32	$1,652,766	$337,787	$1,990,554
Monterey County	6	$314,200	$337,787	$651,987
Santa Cruz County	12	$730,255	$412,988	$1,143,243
Total	**48-50**	**$2,697,222**	**$1,088,562**	**$3,785,784**

Attachments. N/A

DATE: September 22, 2021

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

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

SUBJECT: Quality and Performance Improvement Program Workplan Report – Q1 2021

Recommendation: Staff recommend the Board accept the Q1 2021 Quality and Performance Improvement Program (QPIP) Workplan report.

Summary. This report provides pertinent highlights, trends, and activities from the Q1 2021 QPIP Workplan.

Background. The Alliance is contractually required to maintain a 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 (Board) is accountable for all QPIP activities. The Board has delegated to the Continuous Quality Improvement Committee (CQIC), the authority to oversee the performance outcomes of the QPIP. This is monitored through quarterly and annual review of the QPIP Workplan, with review and input from CQIW-I.

The 2021 QPIP Workplan was developed to align with the Alliance Strategic Plan of Member Wellness, Access to Care, and Promotion of Value. This is accomplished through the following initiatives:

I. Projects and Initiatives	**Status**
A. Department of Healthcare Services (DHCS) Performance Improvement Project (PIP): Immunizations	**In progress**
B. DHCS PIP: Child and Adolescent Well Care Visits	**In progress**
C. DHCS Plan-Do-Study-Act (PDSA): Breast Cancer Screening, COVID Quality Improvement Project (QIP)	**Goals met**
D. Healthier Living Program	**Goal met**
II. Operational Performance	**-**
A. Facility Site Review (FSR) Management	**Goal partially met**
B. Grievance and Potential Quality Issues (PQI) Management	**Goal partially met**
C. Cultural and Linguistic Services	**Goals met**
D. Population Health	**In progress**

Discussion.

QPIP Workplan Outcomes

DHCS Performance Improvement Projects (PIPs). 1) Immunizations: The Alliance continues to focus on increasing the HEDIS Childhood Immunization Status (CIS) rates in Merced County. For 2021, the goal is to increase the CIS rates by at least five percentage points from 19.71% to 24.71% for children 2-years of age. The Alliance has partnered with Castle Family Health Center (CFHC) on a PIP to increase their CIS rates from 12.22% to 19.51% by December 2022. The CIS rate in Merced county decreased from the baseline of 19.71%; however, increased by more than a percentage point from 17.85% in the last quarter of 2020 to 18.96% at the end of the first quarter in 2021. The CIS rate for CFHC increased slightly from 12.5% in the last quarter of 2020 to 12.84% at the end of the first quarter in 2021.

2) Child and Adolescent Well Care Visits: The Alliance has partnered with Golden Valley Health Center at their Los Banos clinic on a PIP to increase the number of child and adolescent members 3-17 years of age who receive at least one adolescent well care visit with a PCP or OB/GYN practitioner from 32.65% to 48.56%. The child and adolescent well care visit rate decreased to 29.7% in the first quarter of the year. The PIP was not approved by DHCS until April of this year and active engagement was not fully established during Q1. Once Module 1 is approved, we will begin to track monthly rates and work on Module 2 deliverables/requirements.

Breast Cancer Screening (BCS) PDSA. DHCS required all health plans to conduct a PDSA rapid cycle project on a single performance measure that focuses on preventive care, chronic disease management or behavioral health MCAS measure impacted by COVID-19. The Alliance decided to focus on increasing the BCS rate as the measure needing most improvement and set the global aim to be above the NCQA Medicaid 50th percentile benchmark in Merced county. Data revealed that the screening compliance rates at Gettysburg Medical Clinic were lower than the other providers and the Alliance partnered with them and El Portal Imaging Center to improve their BCS rate by 10%. The eligible and non-compliant members were identified and as an intervention, a screening mammogram order was developed, and referrals were placed with El Portal by Gettysburg for these members. The El Portal staff completed up to three call attempts to these members requesting them to schedule their BCS. The compliance rate for these members was measured at 39.50% post-intervention in comparison to the 26.79% rate pre-intervention, exceeding the 10% improvement goal. The PDSA Cycle 1 intervention was successfully submitted to DHCS by the February due date and the Alliance started working on the PDSA Cycle 2 intervention activities in March.

COVID-19 Quality Improvement Plan (QIP). In response to the COVID-19 pandemic, DHCS required all health plans to submit a brief COVID-19 QIP, aimed at interventions or strategies to increase the provision of preventive, behavioral health and/or chronic disease care services for members amidst the COVID-19 pandemic. The Alliance decided to focus on the member outreach efforts that were implemented in response to the COVID-19 pandemic for this QIP. For the initial submission, which was due in October 2020, the Alliance included a description of the interventions which consisted of live phone calls, automated phone calls and letters to members in each of the three counties. The Alliance successfully submitted a

six-month progress update to DHCS which was due in March 2021, which included analyzing the impact of these interventions on the various MCAS measures. The QIP was unable to establish any relationship between the interventions and their impact on any of the MCAS measures.

Healthier Living Program. To increase member self-efficacy in performing self-management behaviors, members participate in the Alliance Healthier Living Program (Chronic Disease Self-Management Program). By December 31, 2021, the goal is for at least 50% of participants to score "Good/Very Good/Excellent" for their "Overall Health" and "Quality of Life." In Q1, 75% of the participants scored "Good/Very Good/Excellent" for their "Overall Health" and "Quality of Life". The members reported benefiting the most from the weekly action planning, building communication skills, and gaining motivation to work on managing their condition. In addition, members reported via group feedback discussion that they felt connected, supported, and understood by their facilitators (Alliance Health Educators). Member Voice and benefits expressed included:

- "Managing my stress and anxiety and getting through the day. The workshop helped me feel motivated."
- "To follow through with weekly Action Planning. Motivating me to continue healthy habits week by week."

Operational Performance. The QPIP includes surveillance to maintain and improve the clinical safety of services to members. Two key clinical safety operational functions: FSR and PQI programs, are reported below.

Clinical Safety: Facility Site Review and Potential Quality Issues. The FSR team monitors all primary care providers within the network to ensure that facilities are safe and accessible, care is evidence-based, prevention-focused and safe for our members. The FSR team set out to achieve all operational goals at 100% compliance for 2021. Five sites or 100% (N=5) completed a full site review within 3 years of the last FSR. When Critical Element (CE) Corrective Action Plan (CAPs) were issued at a review, only 1 out of 1 site (100%) had the CAP resolved within 10 business days. Critical Elements require near immediate resolution, including items like infection control practices. The clinics issued a CAP 60% (N=3) were able to submit a CAP plan within forty-five calendar days to the Alliance. Challenges in meeting these goals were driven by staff turnover and absence for childcare related to COVID-19 delayed provider's implementation of CAPs. The team continues to work with California Health Plan Collaborative to create a webinar to educate providers on the updated All Plan Letter 20-006.

For PQI, the team reviewed 100% of the 87-member grievances in Q1 2021 and accepted additional reports of patient safety concerns from across the Alliance. Examples include a member who falls while inpatient, failure to follow through on lab results, inappropriate opioid prescribing that result in injury to the member. The aim is to complete investigation of cases within ninety calendar days of receipt and the team was successful for 99% of PQIs (N=137). Challenges facing the program included staffing shortages due to leaves of absence, onboarding new staff, and ongoing program development specific to our Corrective Action Plan procedures. The team established a virtual and in-person PQI closure workflow and meeting cadence that effectively routes cases between clinical staff. Successfully onboarded two additional Medical Directors to the member grievance and PQI process.

Cultural and Linguistic Services (C&L). The goal is to increase Provider Utilization of the Alliance Language Assistance Services program by 5%. Current utilization numbers are detailed in the QPIP workplan. There continues to be increase in telephonic interpretation services from providers and staff. There continues to be a slow increase in face-to-face interpretation services for both ASL and Non-ASL. For translation services, there was an increase in utilization due to the website redesign. The C&L team was able to provide support in coordination and quality control (QC) reviews and met delivery dates. For readability services, there was an increase in utilization due to the website redesign. The C&L team was able to provide support in reviewing content and providing feedback.

Population Health Management. The Alliance 2021 Operating Plan includes the tactic of *Develop a Population Health Strategy* with the goal of developing objectives and a strategy for population health based on the 2020 Population Health NCQA gap analysis. Strategy will contemplate remediating any gaps identified through the gap analysis, including those in people, process or systems. QIPH leadership will meet with internal and external stakeholders to introduce the concepts of population health, including CalAIM requirements, and initiate the project tactic. Staff are working to complete a partial draft Population Health Management Program description, addressing the first five sections from the DHCS' CalAIM "*Population Health Management Template Discussion Guide*". Discussions have been initiated with ITS division to explore additional avenues for data collection to support the need to perform population segmentation and stratification using a wide range of clinical information, including electronic health record data feeds. The Population Needs Assessment document is on track to be completed by June 30, 2021.

Conclusion. The QPIP Workplan met the goals for two of the initiatives (PDSA Breast Cancer Screening and COVID QIP) in Q1, and continue to have progress towards the goals for the remaining initiatives and operational metrics. The pandemic continues to impact provider staffing and active engagement; however, there are efforts in participation. The QPIP Workplan does not have any critical areas of concern that require further intervention or follow-up.

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

Attachments. N/A

DATE: September 22, 2021

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

FROM: Mary Brusuelas, RN, UM, Complex Case Management Director

SUBJECT: Utilization Management Workplan Report – Q1 2021

Recommendation. Staff recommend the Board accept the Q1 2021 Utilization Management (UM) Workplan report.

Summary. This report provides an overall summary of the UM Workplan activities and Q1 2021 highlights and outcomes.

Background. The UM Workgroup (UMWG) provides guidance and direction to the UM Program and operates under the authority of the Continuous Quality Improvement Committee. This initial quarterly summary reflects the outcomes of the changes to the UMWP established for 2021. In addition, projects and initiatives carried forward from 2020 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.

Q1-2021 Workplan Outcomes and Evaluation

Project and Initiative outcomes:

Pediatric Case Management. The ongoing optimization of the Whole Child Model, California Children Services (CCS) program reflected a continued increase in the total number of CCS eligible members with Q1 at 7,228. This represents an increase of 11% over the prior quarter total of 6,529. All three counties saw higher numbers of newly eligible members in February 2021, likely in response to county return to usual activities and enhanced review of CCS referrals for eligibility determinations. Reporting efforts put into place to capture potential referrals have been successful. These efforts include, but are not limited to, Emergency Department visit review for potential CCS eligible conditions, and auto authorization consultations. Remaining report development as part of the Corrective Action Plan from 2020 included the age out process with outreach beginning at age 17 to being in the second quarter of this year. This effort will align with the intent of allowing greater transition time for members aging out into the adult medical delivery system.

System Transformation Development/Community Care Coordination. The Enhanced Case Management/In Lieu of Services project was launched. Core members of the project team have been identified and are meeting on a regular cadence. In addition to the project team, subgroups have been developed to focus on specific aspects of the operational development of future structure for this

program. Measures of performance have been developed and system teams are working to ensure anticipated reporting requirements will be in place by January 1, 2022. The Department of Health Care Services (DHCS) draft guidelines are being utilized to establish preparedness for the final DHCS deliverables. Policies and procedures are in development.

Reducing Readmissions Initiative:

Post Discharge Meal Delivery Program (PDMDP). The number of members identified as eligible for the program continue to increase from previous quarters. Enrollment into the PDMDP for the first quarter of 2021 showed a 28% increase over the first quarter of 2020. Of the 83 members enrolled, 53% completed the 12-week program, 47% disenrolled due to a variety of reasons. 33% of those enrolled were readmitted during the 12-week enrollment period. Case Management RNs, MSWs, and an Alliance Registered Dietician, continue to telephonically follow the members through the course of the program.

Recuperative Care Program. During the first quarter, the first active Recuperative Care Program was the Recuperative Care Center (RCC) in Santa Cruz County. Of the four members enrolled, stays ranged from 1-55 days. Three members were transitioned to alternative housing from the RCC as part of the bridge to long-term housing solutions. Weekly team meetings with Alliance staff and the RCC program staff continue for program development and interdisciplinary team member discussion.

Both Monterey and Merced County programs are preparing for the implementation of those respective programs over the next two quarters. Collaborative meetings between Alliance staff and those entities continue in preparation for the rollout of each program. Merced County is expected to be prepared to receive eligible members in the second quarter of this year followed by Monterey County in the third quarter.

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

Authorization Turn-Around Times. First quarter results were slightly below goal as anticipated decreases in authorizations were not as effective as predicted, and resumption of care impacted authorization volumes. Work continues on the Authorization Redesign project, including implementation of PCL tool for providers to decrease overall volumes and unnecessary voids negatively impacting routine authorization volume turn-around times.

Goal: 100%
Goal: not met at 98.5%

Prior Authorization Request Determination Metrics. Authorization volumes increased in Q4 2020 as members resumed seeking care post COVID-19 surges. Retrospective review of that quarter reflected a significant amount of authorizations not processed

until the first quarter of 2021. This was a result of post-service requests as well as those finalized after the quarter ended.

Medical Necessity denials remain low with the overall denial rate at 1%. These denials were overturned in favor of the member in 26% of the cases.

Conservative estimates indicate an 8% increase in Q1 2021 authorization volumes over the previous quarter. Voids remain high with a total of 16% of all authorization volumes processed in the first quarter attributed to void activity. Ongoing work with the Authorization Redesign Project will focus on eliminating the volume of authorizations that are not required due to auto approval status, and further support decreasing unnecessary work through portal updates and provider education.

Top 10 Prior Authorization Requests Resulting in Medical Necessity Denials. Trending increases continued with newer high-volume categories in consultation requests (as noted in the previous quarter). Some of this is reflective of Out of Area/ Non-Contracted provider requests as members resuming care are being redirected to in network providers where indicated, and as capacity continues to improve in area. Genetics authorization requests remain as a higher volume denial category, along with immunotherapy. The first quarter saw an increase in denials related to surgical requests for procedures determined to be cosmetic in nature. This is being addressed by increased Medical Director discussions on a peer to peer level.

Utilization Performance Outcomes:

Inpatient Utilization. The overall Medi-Cal line-of-business average length of stay increased from the same quarter last year, though remains stable to the overall 2020 average. Interventions continue to include: PDMDP, and post discharge calls from the CCM teams. In addition to these interventions, regular meetings with Case Management staff from key hospitals and the UM/CCM team have been established to assist with discharge planning and shared goals towards decreasing re-admissions.

COVID-19 positive hospitalized members with co-morbidities continued to account for longer lengths of stay in the first quarter, as the pandemic population declined from previous quarters. A slight increase in COVID-19 hospitalizations will be monitored closely in the second quarter for potential surge activity related to the Delta variant.

Goal: Bedday PKPY 282.
Goal met at 264.

Ambulatory Care Sensitive Admission. While there were increases in some facilities, the overall percentages remain relatively consistent over last year's averages. Any increases trending in a quarter are addressed with respective hospital leadership teams at the regular Joint Operating Committee meetings.

Goal: Dashboard goal is 8.0 Goal
Goal met at 6.1

Readmissions. First quarter 30-day readmission rates are below goal and relatively consistent with Q1 2020. The second quarter will be monitored daily for any increased COVID positive readmissions as well as ongoing outcomes of projected decreases related to the Case Management interventions.

Goal: Dashboard target 11%, threshold is 12.2%.
Goal met**:** Below threshold at 12% but 1% above dashboard target.

Alternatives to Acute Inpatient Days – Skilled Nursing Facilities (SNF). First quarter 2021 SNF/Short Term Rehab (STR) bed days have increased by 25% over the previous quarter. When compared to Q1 2020, the first quarter of 2021 reflects a 14% increase in admissions for a total of 250 members admitted to SNF/STR. Of those 250 members, 15.5% were readmitted to the hospital within 30 days. This is the first quarter this readmission metric is reported. UM will continue to monitor for trends as the pandemic surges decrease. The uptick in SNF/STR bed days may partially be a result of the utilization of level of care authorized to allow for the increased care associated with member type. This enhanced benefit is utilized for both members requiring isolation due to COVID-19 exposure, and those who tested positive for the virus. Readmissions from SNF/LTC may be assessed for facility of care patterns and potential quality of care concerns. Further analysis may also indicate inappropriate discharge level from inpatient facilities

Long Term Care. The number of new admissions to long term care (LTC) for the first quarter of this year increased by 19% as compared to the last quarter of the previous year. This increase is associated with a decrease in the spread of COVID-19 in the community facilities. New admissions to LTC facilities remained 31% lower than those seen in pre-pandemic Q1 2020.

Medi-Medi members comprised 85% of total members in LTC. UM will continue to monitor LTC metrics for trends and changes as the unknown path of the pandemic continues to influence utilization.

Emergency Department Utilization Metric. The Q1 2021 target in the dashboard is 513 Emergency Department visits P/K/PY and total visits that quarter equaled 310. This is consistent with the previous quarter and remains well below the first quarter of 2020.

Reduction in visits may continue to be due to the COVID-19 pandemic, as well as the availability of telehealth visits. There has been an increase in the utilization of the Nurse Advice Line that has previously been stable for the previous year. This will continue to be monitored for trending in future quarters.

Pharmacy Utilization. Per member per month (PMPM) for retail increased by 4.9% compared to the previous quarter, and there was a 1.6% decrease compared to Q1 2020 in utilization of acute medications. For IHSS, there was a 4.4% increase in PMPM from the previous quarter, due to a new utilizer for high cost oncology drug. This will continue to be monitored until transition to Medi-Cal Rx. There is a plan to delegate IHSS LOB to MedImpact for formulary and prior authorization management. In the upcoming quarters, there may be an increase in utilization from members resuming their care as counties reopen.

Out of Network Specialist Utilization Metric. As reported from the prior quarter, out of network (OON) requests generally were approved during the COVID-19 pandemic to decrease member/provider obstacles to care. OON activity is decreasing as the COVID-19 pandemic subsides and local in-network provider availability increases. There is an ongoing partnership with Provider Services to further develop network expansion related to CCS specialties that require OON referrals. Continued internal referral and partnership with CM remains in place for denials of OON requests requiring redirection in network.

Under/Over Utilization Tracking and Reporting. The existing over utilization monitoring has continued with those areas focused on the specific codes and procedures that may lead to potential fraud, waste and abuse. Through the use of advanced analytics, methodology and adaptations are being developed to benchmark providers' utilization patterns against national standards.

While there were decreases in utilization for this first quarter in the areas of Nerve Conduction tests and Neurology/Neuromuscular Procedures, it is not known whether this trend will continue with the pandemic patterns that decreased overall utilization. No new areas of concern were added to the UMWP in the first quarter.

Emerging Under/Over Utilization Analysis. Reports for this new measure are still in development and Q1 will be updated upon receipt of the data. The expectation is that this will be finalized for formal reporting by the end of the third quarter, to include some retrospective data. All codes and services for which new auto approval guidelines are in place will be monitored for utilization changes via benchmark standards.

Delegate Oversight Outcomes:

Delegated Oversight Quarterly Report Summary. No recommendations were made for this reporting period for UM/CCM oversight. All reports were submitted timely.

Behavioral Health. First quarter penetration rates, by county, met goals but remain lower in Merced County vs. Monterey and Santa Cruz Counties.

The quarterly file audits were performed with no recommendations for improvement

Goals Met: 100%

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

Attachments. N/A

DATE: September 22, 2021

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Provider and Member Vaccine Incentive Program

Recommendation. Staff recommend the Board authorize staff to implement and execute provider and member vaccine incentive programs in compliance with applicable federal and state requirements and guidelines established by the Department of Health Care Services (DHCS) and as outlined in the Alliance's Vaccine Response Plan (VRP) approved by DHCS.

Summary. In late August, DHCS announced the development of a Vaccine Incentive Plan program for Medi-Cal managed care plans (MCPs). This program provides a pool of up to $250 million to MCPs based on their performance in ensuring higher vaccination rates for their members. The maximum allocation available to each health plan will be based on plans' enrolled members as a proportion of the overall Medi-Cal population. In addition, DHCS is providing $100M for direct member incentives to members who receive at least one dose of the COVID-19 vaccine during the program period which runs from September 21, 2021 through February 28, 2022.

Background. To participate in the Vaccine Incentive Program, MCPs were required to submit a VRP to DHCS no later than September 1, 2021. To that end, staff developed a VRP for submission that included the Alliance's strategies for building vaccine confidence, combating misinformation, addressing barriers to vaccine access, and for addressing data and operational challenges. The Alliance VRP included its commitment to develop provider and member incentive plans which staff are developing.

Based on current membership, the Alliance estimates that we may earn up to $7M under the Vaccine Incentive Program. The first program milestone was submission of the VRP no later than September 1, 2021. Once this plan is approved, each health plan will receive 20% of its available incentive funding, which could total $1.5M that can be used to ramp up vaccine and outreach efforts. Subsequent funding will be based on achievement of benchmarks linked to improvement in vaccine rates for each plan's Medi-Cal members.

Discussion. The Alliance proposes to offer a minimum of two incentive opportunities for providers. The first will be an incentive for providers to enroll in CalVax to be eligible to administer COVID-19 vaccines. The goal of this incentive will be to increase the number of access points for members to receive vaccines from trusted sources, recognizing that a member's provider is typically the most trusted source of information on vaccinations. The second will be a payment to Primary Care Providers for increasing vaccination rates for their linked members, and potentially a per-encounter payment made to specialists and pharmacies upon vaccination of an eligible Alliance member. The goal of this incentive will be to increase the number of members who are vaccinated, and the Alliance will support this effort through the provision of member hot lists to providers which detail those members eligible for, but who have not yet received, a vaccine.

In addition, the Alliance will administer a direct member incentive through which all members who receive at least one vaccine dose between September 1, 2021 and February 28, 2022 will be

eligible to receive a $50 gift card. The Alliance will implement a point of service incentive in geographic areas with the greatest need and lowest vaccination rates through providers and CBOs serving those geographic areas and hard to reach populations. Eligible Alliance members will receive their gift card either at the point of services from their providers' or CBOs' vaccine sites that are participating in the VRP, or through the mail from the Alliance for vaccines received from any other provider. With this approach, the Alliance will ensure that the incentive is equally available to all eligible members such that they will receive a gift card regardless of vaccine provider or site. Furthermore, the Alliance will ensure that there is no duplication (i.e., each eligible member receives only one gift card).

Fiscal Impact. Costs associated with the incentive program will be covered through incentive revenue made available by DHCS or through earned net income for CY 2021.

Attachments. N/A

DATE: September 22, 2021

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: 2022-2026 Strategic Plan

Recommendation. Staff recommend the Board approve the Strategic Priorities and Goals for the Alliance for 2022 through 2026.

Background. In February 2021, the Alliance's board began a strategic planning process aimed at identifying focused and bold priorities that would advance the organization's vision of Healthy people. Healthy communities. Staff engaged Wendy Todd Consulting to support facilitation of the process. This report summarizes the planning process and context, and presents the strategic priorities and goals for the Board's approval.

Planning Process and Current Context. The Alliance developed the organization's next strategic plan in the midst of significant changes in the health care, social and political landscape at the county, state and federal levels. A wide variety of stakeholders contributed to the development of the plan, which included a review of the organization's internal data, as well as publicly available community data. Stakeholders who provided input include:

- Community residents who are members of the Alliance;
- Community partners;
- Alliance Board of Commissioners and advisory committees; and
- Alliance staff.

The Alliance used the information gathered to determine the organization's internal strengths and weaknesses and external threats and opportunities. The Alliance's Board, advisory groups and internal Strategic Planning Committee then engaged in a facilitated process to identify the strategic priorities towards which the Alliance must act over the next five years to advance member and community health.

Key points of context across the federal, state and regional landscapes include:

- ***New Federal Administration***

  The election of Joe Biden as the 46th President of the United States brought several changes to federal health care policy and the Medicaid program. The Biden administration committed to protecting and strengthening Medicaid and the Affordable Care Act (ACA). The administration directed federal agencies to reexamine actions taken by the previous administration that reduced coverage or undermined Medicaid and/or the ACA and proposed plans that would bring more people into the program.

- ***COVID-19 Pandemic***

  The COVID-19 pandemic significantly impacted, and continues to impact, household finances, jobs, health care, housing, transportation, caregiving and well-being. While the pandemic impacts every person around the world, not everyone is impacted in the same way. For example, COVID-19 has disproportionately impacted Latino, Black and Native American communities with high rates of cases, hospitalizations and deaths, while residents in rural communities face distinct challenges accessing health care. The pandemic highlighted and exacerbated weaknesses in the health care system and the unconscionable health disparities that exist in our region. In addition to the broader impacts of the pandemic, Alliance operations and health care delivery changed dramatically during the pandemic. Alliance Medi-Cal enrollment increased due to protections against beneficiary disenrollment during the public health emergency. Many people delayed or avoided medical care during the pandemic because of concerns about COVID-19. This had implications both on member health and on provider viability. During this same time period, utilization of telehealth services increased dramatically due to the enhanced telehealth allowances by the Department of Health Care Services (DHCS) as a result of the public health emergency. It's clear that the pandemic will have the long-term implications for the health care system and the members the Alliance serves.

- ***Medi-Cal Delivery System, Program and Payment Reform***

  California Advancing and Innovating Medi-Cal (CalAIM), is a multi-year initiative led by DHCS to improve the health outcomes and quality of life of Medi-Cal enrollees. CalAIM includes broad delivery system, program and payment reforms across the Medi-Cal program. Included in CalAIM are new services designed to better integrate the physical, behavioral and social needs of Medi-Cal members with complex conditions. CalAIM also simplifies the rate-setting process and allows for regional managed care plans to have more capacity to implement outcomes-based and value-based payment structures. It is anticipated that CalAIM and other state-mandated programs will shift more responsibilities to Medi-Cal managed care plans, which will further demand health plan resources and attention.

- ***Data Sharing and Health Information Exchange***

  Achieving the goals of CalAIM will require information exchange among health plans; physical, behavioral, community-based and social service providers; and county agencies. The CMS Interoperability and Patient Access final rule that took effect in 2021 also requires increased member electronic access to their health care information and will ultimately improve electronic exchange of health information among payers, providers and members. This will continue to be an important focus for the Plan.

- ***Behavioral Health Access, Integration and Coordination***

  Expanding access, integration and coordination of behavioral health services, including mental health and substance use, will remain a high priority among Medi-Cal delivery system stakeholders. The State plans to address critical gaps across the behavioral health continuum and to enhance access to behavioral health services to improve the mental well-being of children and adolescents.

- ***Integrity and Improvement in Core Operations***

  The Alliance recognizes that the integrity of its core operations is foundational to the organization's ability to advance its vision and strategic priorities. The Alliance remains committed to its members' access to quality health care, guided by local innovation. The Alliance will maintain effective operations and meet all regulatory program requirements while advancing its strategic goals.

  During the execution of the strategic plan, the Alliance has identified a few key areas of operational focus that will guide the scope and pace of its strategic efforts.

  - First, the Alliance will maintain focus on strong financial performance, ensuring that strategic activities contribute to a financially sustainable delivery system.
  - Second, the Alliance recognizes the imperative to continue to attract and retain a skilled, mission-driven workforce capable of meeting the Alliance's business objectives. The Alliance will provide an environment that supports staff performance and wellbeing, and embraces diversity, inclusion and belonging for every employee.
  - Finally, the Alliance will continue efforts to advance its data sharing and technology capabilities to realize operational efficiencies, both internally and externally.

The Alliance will account for core operational requirements and any needed improvements through its annual strategy execution process. This process identifies opportunities to maintain or improve operations (ongoing objectives) and to stretch in new ways to advance the strategic plan (breakthrough objectives), and manages the scope and pace of the Alliance's efforts across all objectives to ensure achievability.

Strategic Priorities and Goals 2022-2026

Throughout this five-year period, the Alliance will pursue two Strategic Priorities: Health Equity and Person-Centered Delivery System Transformation. The Alliance will align internal resources and leverage external opportunities to make measurable progress in these areas. The long-term goals within these two priorities are presented below. Staff will identify measurable outcomes and develop strategies and tactics to achieve those outcomes. Staff's execution of this plan will account for any and all actions to maintain the Alliance's fiscal health and as noted above, to maintain excellence in core operations.

Health Equity

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and health care (RWJF).

To fully address health inequities, the health care system will need to shift practices and policies that have traditionally benefitted some groups of people and left others out. The Alliance will seek to understand root causes of health disparities, particularly those experienced by members who identify as Black, Indigenous and people of color (BIPOC).

The Alliance will take an inclusive approach to ensure equity in Alliance policies, processes and results, embracing diversity, inclusion and belonging in its workforce, and partnering

with providers and engaging with members to inform and guide its actions. This includes creating opportunities for member inclusion in the Plan's decision-making processes to improve organizational policies to yield health equity.

Goal 1: Eliminate health disparities and achieve optimal health outcomes for children and youth.

Almost half of the Alliance's members are children and youth. Action to ensure the health and wellness of this population is a key step towards health equity for the communities the Alliance serves. The Alliance will partner to identify and act to eliminate barriers to children's preventive and clinical care and will consider upstream strategies to improve children and youth's long-term health and wellness.

The Alliance recognizes not all children and youth experience the same opportunities to reach their full health potential. The Alliance will emphasize early action to close disparities in utilization and/or outcomes for those members most impacted by racial inequity, while working towards an overarching goal of increased delivery of screenings, preventive services and clinical care, so all children and youth achieve optimal health.

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

The Alliance is committed to ensuring that members receive health care services that are high quality, culturally competent and guided by cultural humility. Alliance members speak more than 29 different languages and represent a wide variety of cultures from all over the world. Individuals have better experiences and outcomes when health care is provided with a person-centered approach, when the provider understands and respects the individual's culture and beliefs and when information is provided in the individual's preferred and/or primary language.

The Alliance is committed to strengthening the cultural competency of the provider network and Alliance workforce and will work to expand the provider network to include more providers who are bicultural/bilingual. The Alliance will operate with cultural humility and will amplify member voice and lived experience to understand community needs and assets. The Alliance will also partner with members, providers and community-based organizations to better understand and meet member's needs.

Person-Centered Delivery System Transformation

Throughout the planning process, the Alliance identified the need to center on the people it serves rather than centering on the health care services it delivers. Such a shift requires a transformation to honor the dignity and self-determination of members and to focus on their health as the intended result, rather than the delivery of health care services alone. This is an evolution towards a system that yields member health through shared decision making and action, rather than a system that simply delivers health care services.

The state's CalAIM initiative holds promise to reform programs and payments to improve the quality of life and health outcomes for Medi-Cal members. The Alliance's five-year goals are in alignment with the goals of CalAIM and will provide focus to the plan's transformative actions to meet member needs with members' improved health and well-being as the Alliance's long-term goal.

Goal 1: Improve behavioral health services and systems to be person-centered and equitable.

The Alliance will seek to improve the quality and member use of behavioral health services through improved coordination, integration and expanded capacity of the behavioral health delivery system. Currently, people with Medi-Cal receive behavioral health services through a complicated, siloed system which requires the member seek services through different systems depending on severity of mental health or behavioral health diagnosis. The system is not designed to address the member's expressed need for support or to emphasize prevention. Nor does it harness the power of empathy to combat the stigma which prevents healing and recovery. The Alliance seeks to address key impacts of this design: poorly managed mental health and disparities in utilization across race, age and geographic populations.

The Alliance will engage members and partners to identify and co-create solutions to address barriers to behavioral health services, with an emphasis on providing a culturally sensitive, individualized approach based on a member's expressed need for support. The Alliance will also work to improve coordination across systems and increase integration of behavioral health services in clinical and non-clinical settings.

Goal 2: Improve the system of care for members with complex medical and social needs.

Many Medi-Cal members rely on multiple siloed systems to address complex medical and social needs, often without coordination or collaboration across overlapping systems. Social and environmental factors, including a lack of housing, nutritious food or transportation, also have a profound impact on health. There are gaps in delivery system capacity to address those factors because such services are not Medi-Cal benefits or because they fall within shared responsibilities between siloed programs in the delivery system.

To support members with complex medical and social needs to achieve better health outcomes, the Alliance will rely on a population health-based approach and will increase data sharing with providers and community-based organizations to more effectively collaborate and coordinate patient care. The Alliance will also partner with providers and community-based organizations to improve the capacity for community-based care coordination (where members live, work, learn and play). In order to avoid long-term poor health and to improve member health outcomes, the Alliance will partner with community stakeholders to identify and address gaps in services that could support member health and will seek to integrate supportive services that address health-related social needs into the health care delivery system.

Next Steps. Staff are committed to advancing the Strategic Priorities and Goals outlined in this plan. Staff will finalize the five-year measures of performance for each of the identified goals and will share those with the Alliance board in a following meeting. Activities to advance the goals will be incorporated into the Alliance's annual operating plan development, including the identification of annual breakthrough objectives, and responsive tactics. Environmental factors will influence the pace of the work, the strategies to advance the work and the scope of change achieved. The health care and political landscape will undoubtedly shift over the next five years. The long-term public health and economic impacts of the COVID-19 pandemic remain uncertain. Change is a constant in health care

and the Alliance anticipates the need to monitor the impact of future changes and to adjust the execution of this plan accordingly.

On a periodic basis, the Alliance will assess the results of this plan and any significant changes to the environment, and may make necessary adjustments. Staff will report progress and any significant changes through updates to the Board and on its website.

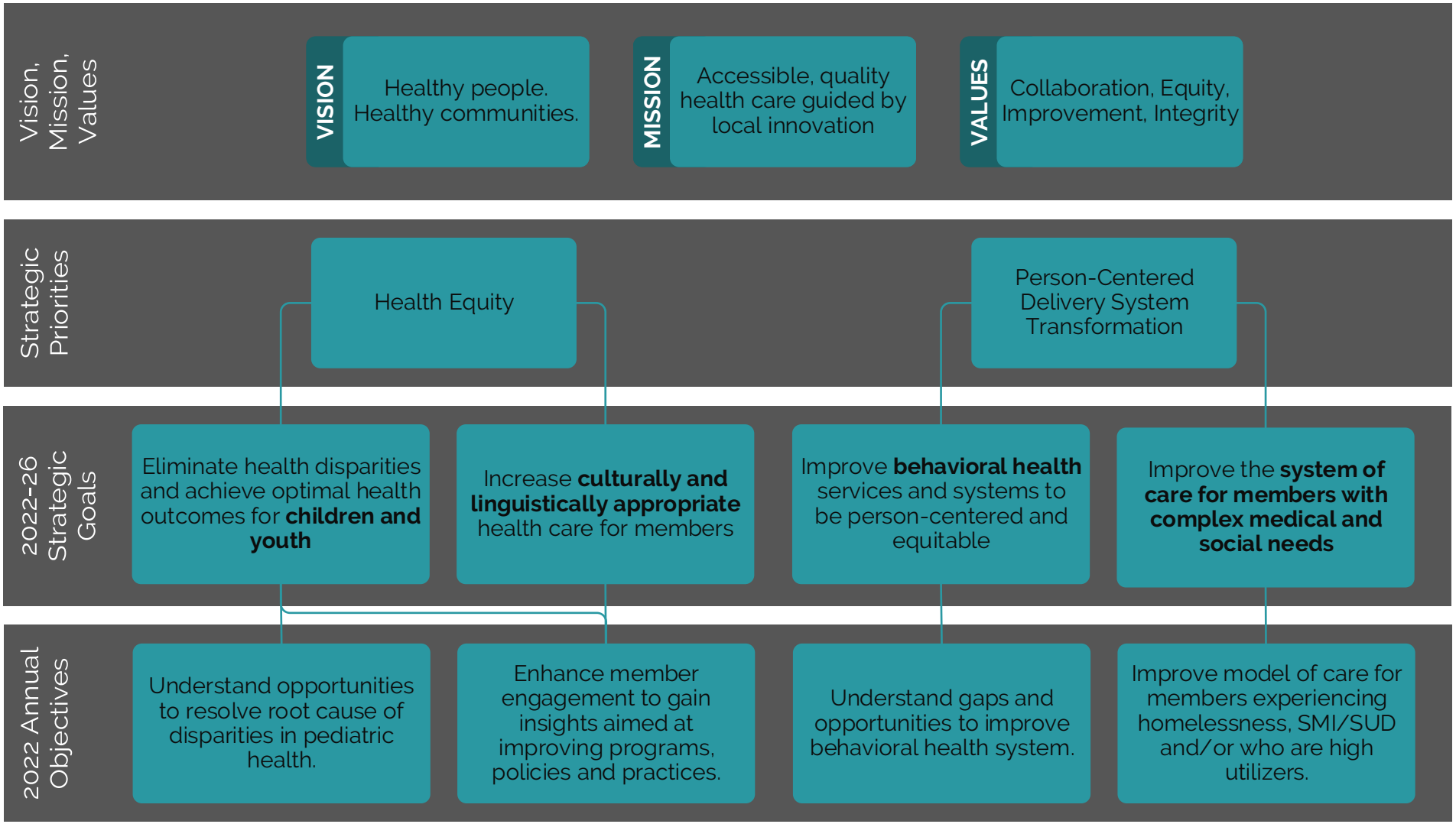
Fiscal Impact. There is no immediate fiscal impact associated with this agenda item.

Attachments.

1. Draft 2022-2026 Strategic Plan Framework

Draft 2022-2026 Strategic Plan Framework

September 2021



Information Items: (14A. – 14G.)

DATE: September 22, 2021

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

FROM: Scott Fortner, Chief Administrative Officer

SUBJECT: Alliance in the News

California's Medi-Cal Expansion is Good News

Alliance in the News
Monterey County Weekly
August 2, 2021

Assembly Bill 133 brings good news for the long-term health of all Monterey County residents.

Good afternoon. Pam Marino here, reflecting today on how the long-term health of all Monterey County residents is about to improve thanks to thousands who will soon get better access to health care insurance and services.

That's because last week Gov. Gavin Newsom signed Assembly Bill 133 into law, which among a significant list of other ambitious goals, will expand Medi-Cal coverage to low-income Californians age 50 and up regardless of immigration status. Statewide that's approximately 235,000 residents who will now be eligible for health care.

There are at least several thousand older adults in the county who for the first time will be able to sign up for Medi-Cal and access care through the Central California Alliance for Health. (That's the Medi-Cal provider in Monterey, Santa Cruz and Merced counties.)

Not only will they have access to preventative care—an important need in a county with high rates of diabetes and heart disease—they'll also be able to receive long-term care and in-home supportive services.

Monterey County's representative to the Alliance, Board of Supervisors Chair Wendy Root Askew, says the nonprofit is ready to accept those new people who qualify into the fold and that's a good thing for the county.

"We do know that Monterey County has one of highest rates of uninsured residents and with the pandemic it's become clear to everyone that our health relies on the health of those around us," Root Askew says. "The benefit of expanding health access is it's not only benefiting those who are gaining access, it's helping all of us."

In that vein, on July 1, the county expanded its Esperanza Care program for low-income adults aged 26 and up from 3,500 residents to 4,500, using a $500,000 increase approved by the board in the 2021-22 budget. The health care program now totals $2.5 million annually providing direct medical services to those who qualify. It's part of the county's ongoing commitment to provide health care to those who need it regardless of their ability to pay, Root Askew says.

Under AB 133 it's not just older adults who benefit—undocumented families will see an expansion of the Medi-Cal postpartum care period from 60 days to 12 months without requiring a mental health diagnosis.

The bill also creates a prevention-focused behavioral health system in which all Californians age 25 and younger may be supported and screened for emerging and existing behavioral health needs and creates a portal to connect young people to telehealth visits.

Finally, as part of Newsom's "California Comeback Plan" and a $12 billion package to address homelessness, AB 133 also creates more opportunities to provide services and housing to those without homes who also struggle with serious behavioral health issues. That includes $2.2 billion in competitive grants for local governments to purchase real estate and build or rehabilitate housing or invest in mobile services.

It's a bit of good news in the midst of the ongoing health crisis that is the Covid-19 pandemic that more of our neighbors will be able to improve their overall health, and in turn improve the health of all of us.

-Pam Marino, staff writer, pam@mcweekly.com

New project will end chronic homelessness for 120 vulnerable community members

Alliance in the News
Lookout Santa Cruz
August 2, 2021

By recognizing that every single person is worthy of housing and that housing is a powerful foundation from which to build health — physically, spiritually, mentally and emotionally — a new residential project is poised to offer the stability and resources to some of the most vulnerable unhoused members of the community through permanent supportive housing.

Housing Matters plans to build 120 units of permanent supportive housing for people experiencing chronic homelessness in Santa Cruz County. The organization, a leader in creating pathways out of homelessness and into permanent housing, is halfway through its summer-long "Building With Purpose" campaign to raise awareness, support and funds for the project.

"We are building the largest permanent supportive housing project ever undertaken in the county of Santa Cruz," said Phil Kramer, executive director of Housing Matters. "The solution to homelessness is housing."

"By adding a permanent supportive housing building to Housing Matters' campus, we are creating 120 units of affordable housing for people experiencing chronic homelessness in Santa Cruz County."

— Phil Kramer, executive director of Housing Matters.

Called the Harvey West Studios, the 5-story residential complex will be located on the Housing Matters campus at 115 Coral Street. The project has already received full approval by the Santa Cruz Planning Commission and building plans will be submitted for approval later this year. Construction will begin next year and the building will be ready for occupancy in 2023.

The project is supported by generous philanthropists, a bank loan, and public and private grants, including a $2.5 million gift from Central California Alliance for Health.

"If people are really interested in improving the health of the community overall, one important way to do that would be to invest in solutions to homelessness," said Stephanie Sonnenshine, CEO of Central California Alliance for Health. "If people are housed they are more likely to be healthy. If people are healthy, we can focus on prevention as opposed to really expensive acute care."

In about 300 sq. ft., each of the 120 apartments at Harvey West Studios will provide individuals modest accommodations. High-quality modular construction will incorporate passive design with low environmental impact, ensuring lower cost and time to build without compromising quality. The restorative environment will incorporate gathering areas, landscaped spaces, and a rooftop deck to foster intentional community and staff interaction.

Santa Cruz County's lack of housing with onsite support perpetuates chronic homelessness in the community. Incorporating essential services onsite will ensure people experiencing chronic homelessness have the support they need to have a stable and comfortable place to call home.

"So often when we think of homelessness in Santa Cruz County, we only see the problems. If we want to look, instead, at solutions, there is hope on the horizon."

— Susan True, CEO of Santa Cruz County Community Foundation.

In the last two years, more than 550 people have found a pathway to permanent housing with support through Housing Matters.

"A lot of people talk about the need for affordable housing in our community and Housing Matters is doing something about it," said Cecilia Espinola, Board President of Housing Matters.

Learn more about Building With Purpose.

A Covid legacy worth embracing: access to telehealth

Alliance in the News
Santa Cruz Sentinel
June 9, 2021

While the pandemic has devastated people and economies globally, it has also required the world to adapt in unexpected ways. Telehealth, for one, has revolutionized health care, offering access to anyone with a phone and serving as a great equalizer for low-income people and people of color.

Nowhere has this been more evident than in local community health centers: Salud Para la Gente, Santa Cruz Community Health, and the County's health clinics, which – after approximately 50 years in operation – now collectively serve 50,000 low-income people, regardless of their ability to pay.

When COVID-19 hit, instead of closing our doors and laying off staff, the clinics quickly pivoted to virtual and telephonic care. Not only did the clinics offer access to COVID-19

testing, treatment, and vaccines, but they also saw patients with chronic, urgent and behavioral health needs.

The continuity of care enabled by telehealth was a literal lifeline to our most vulnerable communities, where computers and internet access are luxuries that many cannot afford.

The pandemic underscored appalling disparities in Santa Cruz, accentuating the North-South County divide. Per Santa Cruz County public health data, 58% of all COVID-19 cases occurred in South Santa Cruz County, even though it is home to just 29% of all residents. Likewise, 54% of Santa Cruz's Latino population tested positive for COVID-19, yet they comprise only 34% of all county residents.

Throughout the county, where substance use and mental health needs have reached epidemic proportions, patients used their phones to access appointments with clinical social workers and evidence-based behavioral therapies. The phone was a bridge to those who were at high risk of isolation yet lacked transportation, childcare or the ability to take time off work. Local clinics saw access increase by as much as 50% over prior years, ensuring Medi-Cal patients the same humanely easy access that their privately insured counterparts already enjoy.

The Newsom administration's telehealth proposal is greatly concerning because of its discriminatory effect on Medi-Cal covered patients. The proposal would exclude most community health center patients from receiving care via telehealth and telephone because the governor's proposed 35% cut to reimbursement is simply not sustainable.

It is for these reasons that health care leaders, from community health centers across the state, to the Central California Alliance for Health and the Health Improvement Partnership of Santa Cruz County (which represents a coalition of public and private providers, including hospitals and the local Medical Society) urge the legislature to reject the Governor's anemic telehealth proposal and replace it with AB 32 (Aguiar-Curry), as amended in the Assembly Health Committee. AB 32 would allow all Medi-Cal providers to continue providing telehealth and telephonic care that meet all clinical elements of a visit beyond the declared public health emergency.

It is imperative that Gov. Gavin Newsom take action to preserve telehealth access for communities of color facing poverty, homelessness, or critical medical and behavioral health conditions. If the governor is committed to equity as a driving policy principle, if we have learned anything about disparities across racial and economic lines during the 2020 pandemic, and if we want to ensure the health of our community for all people, then telehealth as it has been utilized during the pandemic must be preserved.

Elisa Orona is Executive Director of the Health Improvement Partnership of Santa Cruz County.

Housing and Health Coming to Live Oak

Alliance in the News
TPG Online
June 7, 2021

In my 25 years here in Santa Cruz County, I've seen lots of housing developments. I've new medical buildings get built. And I've seen dentists invest in new offices.

This is the first time I've seen a development combining affordable housing, health care and dental care, all at one location.

It's a first for Santa Cruz County, perhaps for the state and nation, and no small venture, estimated at $58 million to $68 million.

You'll see construction underway at 1500 Capitola Road in Live Oak, five minutes from the Capitola Mall.

What makes this possible is a very unusual partnership of three nonprofits where the leaders were willing to step out of their silos, resulting in synergy, doing more for people who didn't have dentists, or doctors or affordable housing in their neighborhood.

A year from now, in summer 2022, they will have a 20,000-square-foot primary care center, serving pregnant moms, children, and people who are homeless and a dental clinic with 11 chairs. Next year, construction will start on 57 affordable rental units, projected to house 157 people.

Let's name names.

MidPen Housing, based in Foster City with an office in Watsonville, owns and manages 13 affordable housing communities in Santa Cruz County, providing tailored on-site services to families, seniors, and people with special needs. Its share of the project is $30 million to $40 million.

Santa Cruz Community Health since 1980 has focused on underserved Santa Cruz County residents with special attention to families. Its share is $19.5 million.

Dientes, founded in 1992, sees adults and children who don't have dental insurance and provides affordable care at three clinics. Its share is $8.3 million.

Great Need

The need is stark:

15 percent of local children are considered homeless.

15,000 people do not have a doctor.

Seniors on Medicare have no dental coverage, and 78 percent of adults with the state's MediCal insurance do not have a dentist.

No surprise that nearly 200 people showed up for a ceremonial groundbreaking May 22 where heavy equipment parked by the contractor, Bogard Construction of Santa Cruz, was silent for the day as local talent Anthony Arya performed on his guitar.

The 3.6-acre site, like others in the county being redeveloped, is next to property with a problematic former use allowing soil and groundwater to be contaminated with cancer-causing chemicals.

A 569-page report on the site found tetachloroethene, a likely carcinogen, a dry cleaning solvent known as PCE — likely used by the Fairway Dry Cleaner, which operated from 1966 to 1984, creating an underground plume. The operators are no longer available to provide information on chemical use or waste management practices.

Sampling of soil vapor found PCE exceeded the residential environmental screening level in 22 of 34 vapor samples, with the highest 15,600 micrograms per cubic meter, and TCE exceeded it in 21 of 29 samples.

Other chemicals of concern were attributed to a gas station which had underground storage tanks and also is out of business.

Contamination issues are a major reason for-profit developers haven't redeveloped the former Skypark airport site and the Watkins-Johnson (later Aviza) plant property.

In the case of 1500 Capitola Road, a dearth of available properties led the nonprofits to focus on a solution, with state regulators approving a remediation system.

Fundraising

The biggest contribution, $6,075,000 promised over five years, comes from Central California Alliance for Health, a not-for-profit health plan serving 320,000 members in Santa Cruz, Monterey and Merced counties.

Dientes will get $2.9 million, Santa Cruz Community Health $2.65 million, and MidPen $625,000.

"Prevention and early intervention in dental care are often overlooked and are core to the vision of Dientes," said Dientes CEO Laura Marcus. "The project would never have gotten off the ground without the Alliance and many others in our community who are stepping up to make this dream a reality."

Santa Cruz Community Health CEO Leslie Conner said, "We are deeply grateful."

She said Santa Cruz Community Health has been aligned with the Alliance since it launched some 25 years ago, with the two nonprofits sharing missions "to improve access to quality care for those who need it most."

MidPen Housing Chief Real Estate Development Officer Jan Lindenthal called the Alliance an "exceptional" partner, adding, "Thanks to their support, residents of Santa Cruz County will have the access to health care and affordable housing they need to live happy and healthy lives and achieve their dreams for the future."

Alliance's CEO Stephanie Sonnenshine explains, "Access to treatment, regular preventative care, and stable housing is key to achieving and maintaining positive health outcomes."

Community Foundation Santa Cruz County is investing $2.2 million.

The California Health Facilities Financing Authority is providing $1.5 million each to Santa Cruz Community Health and Dientes.

"It takes a village," said Drew Gagner, chief philanthropy officer of the Dominican Hospital Foundation.

"Very inspiring," added Dr. Bill Maclean, physician in charge for Kaiser Permanente Santa Cruz County.

Local philanthropists Bud Colligan and Bob and Sharon Bailey spoke to show their support.

"We're still raising money," said Carol Fuller, who at 75 decided to invest $500,000 out of an inheritance in this project to match other gifts. "This project spoke to me — social justice, dental care."

After Fuller spoke, a woman approached her, check in hand.

•••

To learn more or make a donation, visit: 1500CapitolaRoad.org

---

Good Work: Money Where our Mouths Are
Alliance in the News
goodtimes.sc
May 19, 2021

Central California Alliance for Health has invested a total of $6 million with Santa Cruz Community Health, Dientes Community Dental Care and MidPen Housing. The investment will contribute to the costs of a new medical clinic, dental clinic, affordable housing and a family-friendly public plaza in Live Oak. The Alliance's contribution will help make affordable housing and health services more accessible to families and senior citizens in the community.

Alliance in the News: Integrated State-of-the-Art Health and Housing Coming to Live Oak
Alliance in the News
Patch.com
May 6, 2021

Integrated State-of-the-Art Health and Housing Coming to Live Oak

Central California Alliance for Health invests $6M in first mixed-use development of its kind in Santa Cruz County

Santa Cruz Community Health (SCCH), Dientes Community Dental Care, and MidPen Housing collectively received a $6,075,000 investment from the Central California Alliance for Health (the Alliance) to support the construction of a 20,000-square-foot medical clinic, an 11-chair dental clinic, 57 units of affordable housing, and a family-friendly public plaza in the heart of Live Oak. The new health and housing campus will provide healthcare for up to 10,000 patients, along with affordable supportive housing for 157 people.

This major commitment from the Alliance, the largest collective contribution to the project to date, demonstrates the Alliance's ongoing commitment to increasing access to health services and housing for children, families, and seniors, regardless of income. The grants provide $2,650,000 to SCCH, $2,900,000 to Dientes, and $625,000 to MidPen over five years for the construction of the new campus.

The Need for Care is Great

In a community where up to 26 percent of Live Oak School District students are homeless, thousands of adults do not have a doctor, and 78 percent of adults on Medi-Cal do not have a dentist, this vibrant 3.6-acre health and housing complex in Live Oak will address the goals of increasing access to healthcare and growing affordable housing.

"Prevention and early intervention in dental care are often overlooked and are core to the vision of Dientes," said Dientes CEO Laura Marcus. "The project would never have gotten off the ground without the Alliance and many others in our community who are stepping up to make this dream a reality."

SCCH CEO Leslie Conner continues, "Santa Cruz Community Health has been strongly aligned with the Alliance since it first launched some 25 years ago. Their investment today

points to our overlapping missions to improve access to quality care for those who need it most. We are deeply grateful for their partnership."

The investment from the Alliance is in line with their overall vision of healthy people, healthy communities. The Alliance's CEO Stephanie Sonnenshine explains, "Access to treatment, regular preventative care, and stable housing is key to achieving and maintaining positive health outcomes, so this community-based healthcare and housing solution at 1500 Capitola Road will be an important step towards improving the well-being of our most vulnerable Santa Cruz residents."

Capital Campaign is Ongoing

The 1500 Capitola Road campus integrates the strengths and services of its three owners:

• SCCH has been serving the medical and mental health needs of underserved Santa Cruz County residents since 1980, with a special focus on families.

• Dientes has a nearly 30-year track record of providing affordable, high-quality and comprehensive dental care through three existing clinics and a 30+ location outreach program.

• MidPen Housing owns and manages 13 affordable housing communities throughout Santa Cruz County, serving families, senior, and special needs populations and providing on-site resident services tailored to the unique needs of each population.

MidPen Housing Chief Real Estate Development Officer Jan Lindenthal comments, "The Alliance has been an exceptional partner in helping MidPen achieve our mission of expanding affordable housing opportunities in Santa Cruz County. Thanks to their support residents of Santa Cruz County will have the access to health care and affordable housing they need to live happy and healthy lives and achieve their dreams for the future."

The construction of the campus will be in two phases. Dientes and Santa Cruz Community Health will break ground on their clinics this month and open in 2022. MidPen will break ground on the housing component in 2022 and open in 2023.

To learn more about the project or make a donation, visit: http://1500CapitolaRoad.org

---

Housing Matters to bulid facility for unhoused in Santa Cruz

Alliance in the News
Santa Cruz Sentinel
May 6, 2021

SANTA CRUZ – Housing Matters secured more than $4 million in funding to build permanent supportive housing on its campus in on Coral Street.

The project is funded by two programs from the Central California Alliance for Health. The first $2.5 million will come from the Alliance's Capital Implementation grant, which will fund the construction of the five-story building. The remaining $1.5 million will be funded by its Recuperative Care Pilot program, which funds programs that recuperate homeless individual who are recovering from illness or injury.

"The link between housing and health is undeniable," Alliance CEO Stephanie Sonnenshine said in a statement. "Supportive housing helps individuals with complex health needs

achieve and maintain positive health outcomes. The Alliance's partnership with Housing Matters on this important local initiative aligns with our vision of 'health people, health communities.'"

The project will feature 120 studio apartments at around 200 square feet per unit, which will span four floors of the edifice. Each unit will include an Americans with Disabilities Act accessible bathroom, kitchen appliances and an intercom system for residents to contact staff in times of need.

California unemployment claims climb, $300 extra benefits expiration looms

The first floor will house an expanded medical clinic. The clinic will provide 12 beds for recuperative care and on-site medical care. The idea of combining an on-site medical facility with four floors of recuperative living allows those afflicted with homelessness to have shelter and medical care while they regain stability.

"This housing project is designed specifically for those individuals who will benefit most from having on-site supportive services," said Housing Matters Executive Director Phil Kramer. "It will help end homelessness for some of our most medically vulnerable, unsheltered community members."

Housing Matters' on-site medical facility will be unique to other medical facilities due to the relationship its staff has formed with the county's homeless population. Those experiencing homelessness are generally more receptive to recuperative treatment if a layer of trust is built first, Kramer said.

The housing project and adjoining medical facility will also serve as a harm reduction site. While substance use is strictly prohibited on the Housing Matters campus, the staff recognizes a lot of its clients may be the victims of addiction and are prepared to treat the illness, Kramer said. In fact, Housing Matters medical staff is trained to treat people in a trauma-informed way.

Construction on the facility is expected to begin early next year. Housing Matters already has approval for the project and is finalizing the building plans. Building permits are expected to be granted by the end of 2021.

Housing Matters expects to start housing those in need after completion of the project by the end of 2023. The tight turnaround is made possible by modular construction. The facility will be built using prefabricated units that are called modules, which are built offsite then installed at the building location.

While the project will cost $4 million in grant funding, Kramer noted it is still cheaper than the alternative, which is having homeless individuals file in an out of public services, whether it be for medical or punitive reasons.

Kramer alluded to a man known as "Million Dollar Murray" in Reno, Nevada. Each year, he cost the city around $100,000 as he cycled in and out of government-funded systems, he said. Eventually the city realized it would be cheaper to house Murray rather than allow the cycle to continue.

"It's a better use of the public purse and attention," Kramer said. "People who don't have the benefit of long-term housing find themselves in the very expensive revolving door of acute public services. It's actually less expensive to get someone housed."

Alliance Fact Sheet
July 2021

ABOUT THE ALLIANCE

The Alliance is an award-winning regional non-profit health plan, established in 1996, with **over 25 years** of successful operation. Using the State's County Organized Health System (COHS) model, we currently serve **377,554 members** in Santa Cruz, Monterey and Merced 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

497
Number of Employees

$770.2M
YTD Revenue

5.4%
% Spent on Administration

Service Area:
Santa Cruz, Monterey and Merced counties

Membership by Program

Total Membership: **377,554**[3]

377,053	501
Medi-Cal	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

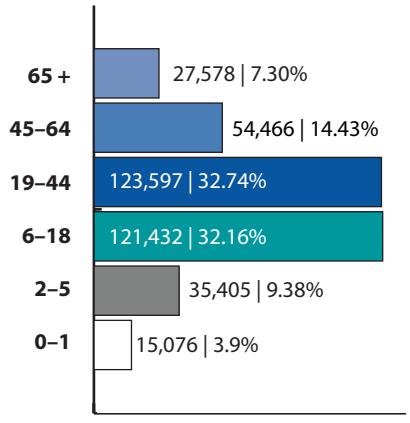
Our members represent 39 percent[1] of the population in Santa Cruz, Monterey and Merced counties. We serve seniors, persons and children with disabilities, low-income mothers and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled, and low-income, childless adults ages 19–64.

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

PROVIDER PARTNERSHIPS

The Alliance partners with more than 11,743 providers to form our provider network, with 85.83 percent of primary care physicians and 84.10 percent of specialists within our service area contracted to provide services to our members.

Membership by Age Group



HEALTHY PEOPLE. HEALTHY COMMUNITIES.

EXECUTIVE LEADERSHIP

Stephanie Sonnenshine
Chief Executive Officer

Lisa Ba
Chief Financial Officer

Dale Bishop, MD
Chief Medical Officer

Scott Fortner
Chief Administrative Officer

Marina Owen
Chief Operating Officer

Van Wong
Chief Information 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. In alphabetical order, current Board members are:

- **Supervisor Wendy Root Askew,** County of Monterey
- **Dorothy Bizzini,** Public Representative
- **Leslie Conner,** Executive Director, Santa Cruz Community Health Centers – Alliance Board Chairperson
- **Supervisor Ryan Coonerty,** County of Santa Cruz
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas
- **Larry deGhetaldi, MD,** President, Santa Cruz Division, Palo Alto Medical Foundation (Sutter Health)
- **Julie Edgcomb,** Public Representative
- **Mimi Hall,** Director, Santa Cruz County Health Services Agency
- **Charles Harris,** MD, Interim Chief Executive Officer, Natividad Medical Center
- **Dori Rose Inda, CEO,** Salud Para La Gente
- **Elsa Jimenez,** Director of Health, Monterey County Health Department - Alliance Board Vice Chairperson
- **Shebreh Kalantari-Johnson,** Public Representative
- **Michael Molesky,** Public Representative
- **Rebecca Nanyonjo,** Director of Public Health, Merced County, Department of Public Health
- **Supervisor Josh Pedrozo,** County of Merced
- **Elsa Quezada,** Public Representative
- **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
- **Tony Weber,** Chief Executive Officer, Golden Valley Health Centers

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:

2019

- Outstanding Performance for Medium-sized Plan

2018

- Most Improved Runner Up for Santa Cruz/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.

---

[1]County population data source: U.S. Census Bureau 2019 population estimate (as of Jul. 1, 2019).

Membership percentage by county: Santa Cruz (28 percent); Monterey (39 percent); Merced (49 percent).

[2]Fact sheet data as of July 1, 2021.

[3]Fact sheet data as of July 1, 2021.

Member Appeals and Grievance Report
Q2, 2021

Q2 2021 Appeals and Grievances: 623

Appeals: 15% [67% in favor of Plan; 33% in favor of Member]
Exempt Grievances: 5%
Grievances: 79%
Other: 1% [Inquiries, Duplicates, Withdrawn]

Category Figures
Referrals: 1%
Access Issues: 7%
Benefits and Coverage 1%
Quality of Care Issues: 13%
Other: 74%
- Transportation: 55% of "Other" Category
- Provider Billing Issues: 11% of "Other" Category
- Medication Issues: 6% of "Other" Category
- Communication Issues: 3% of "Other" Category

Analysis and Trends
- A high percentage of "Other" grievances involved transportation issues for late, missed rides to appointments and quality of service issues
- Grievances stabilized as members resumed receiving care in the community
- Access grievances declined to a stabilized rate upon successful agreement with a contracted provider.
- No other significant trends noted for grievances in Q2 2021.

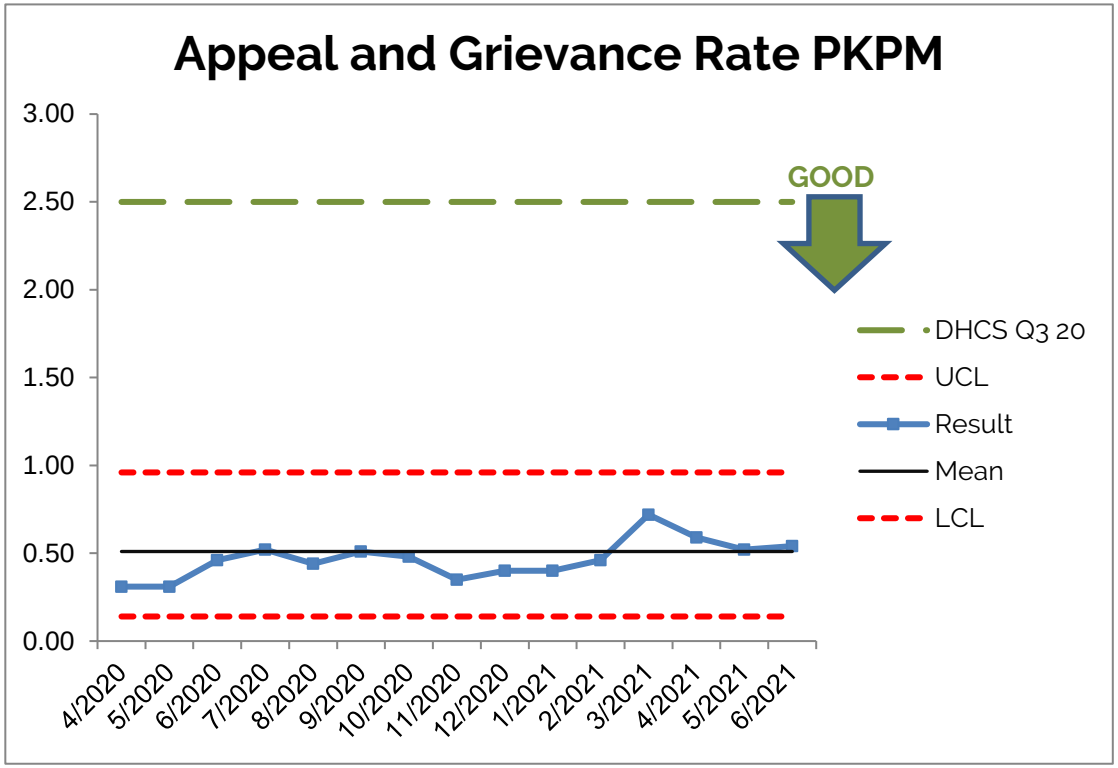
Highest Grievances Filed by County
1. Merced: 40%
2. Monterey: 37%
3. Santa Cruz: 23%

Behavioral Health Beacon Grievances:
- Member Grievances: 11

IHSS Summary:
- Member Grievances: 5

☒ **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) which represent three (3) standard deviations from mean or average performance.



	Jan	Feb	Mar	**Apr**	**May**	**Jun**	July	Aug	Sep	Oct	Nov	Dec
2020 Enrollment	334,394	337,611	337,444	341,861	346,268	350,131	352,983	355,570	358,607	360,426	362,625	365,250
A&G Issues	173	167	141	107	108	162	187	157	183	173	126	146
Rate PKPM*	0.52	0.49	0.42	0.31	0.31	0.46	0.53	0.44	0.51	0.48	0.35	0.40
2021 Enrollment	367,090	369,387	371,453	**373,561**	**376,203**	**377,671**						
A&G Issues	145	170	269	**222**	**195**	**206**						
Rate PKPM*	0.40	0.46	0.72	0.59	0.51	0.54						

*Grievances Per 1,000 Member Month

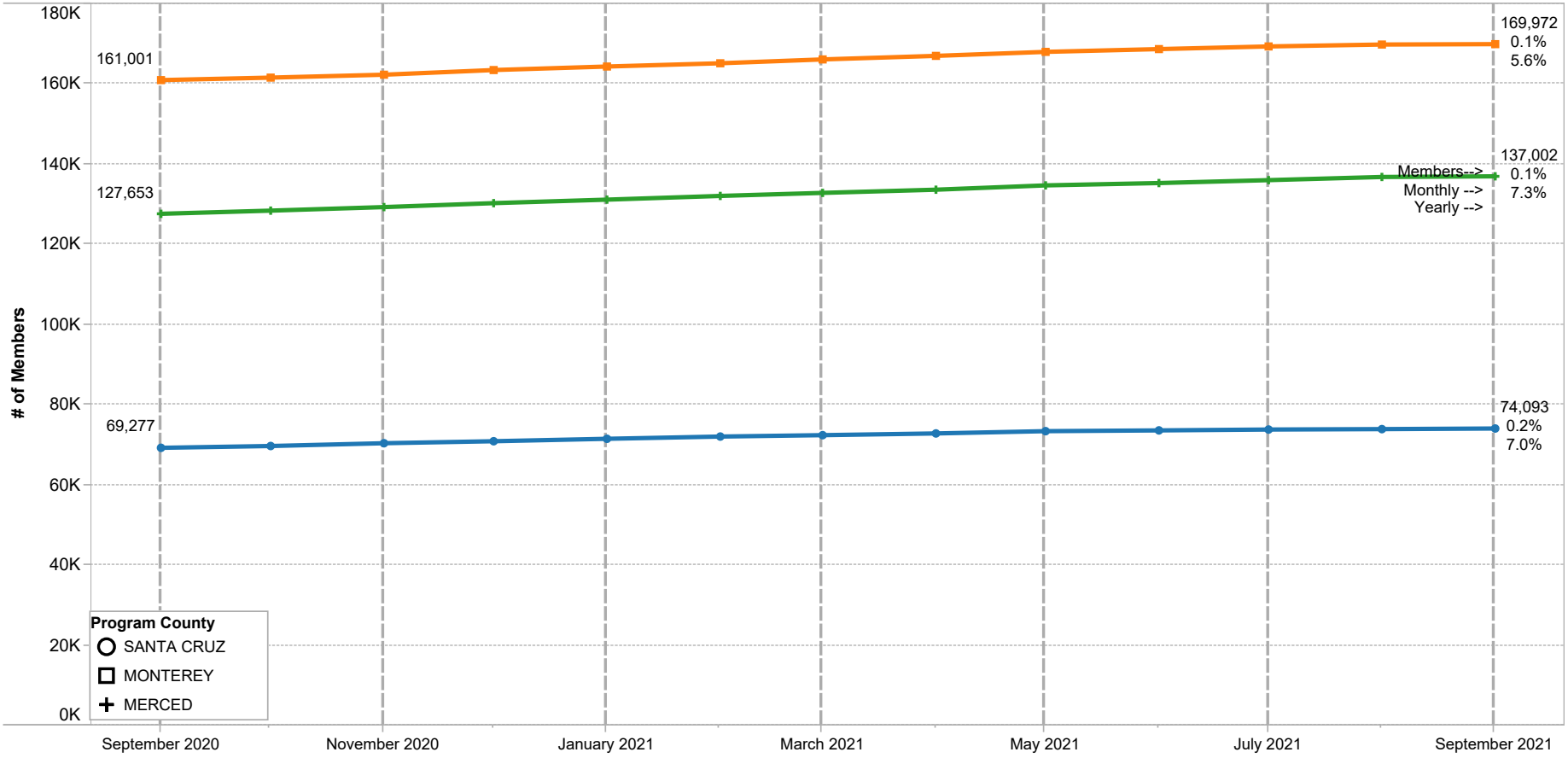
Back to Agenda

Enrollment Report

Year: *2017 & 2018* **County:** *All* **Program:** *IHSS & Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *9/3/2021*

StaticDate
9/1/2020 12:00:00 AM to 9/30/2021 11:59:59 PM

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



Program..	ProgramCo..	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Medi-Cal	SANTA CRUZ	69,277	69,728	70,423	70,920	71,529	72,087	72,434	72,864	73,432	73,622	73,838	73,942	74,093
	MONTEREY	160,441	161,068	161,802	162,971	163,852	164,673	165,645	166,535	167,539	168,236	168,901	169,366	169,457
	MERCED	127,653	128,440	129,326	130,310	131,184	132,112	132,869	133,665	134,739	135,323	136,046	136,839	137,002
IHSS	MONTEREY	560	554	546	540	537	529	516	512	505	501	498	509	515
Total Members		**357,931**	**359,790**	**362,097**	**364,741**	**367,102**	**369,401**	**371,464**	**373,576**	**376,215**	**377,682**	**379,283**	**380,656**	**381,067**