Santa Cruz – Monterey – Merced Managed Medical Care Commission

Meeting Agenda

Wednesday, May 25, 2022

3:00 p.m. – 5:00 p.m.

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

Alliance offices have opened for Board meetings in each county. Masks are required in all Alliance facilities and must be worn throughout the duration of the meeting regardless of vaccination status.

1. Members of the public wishing to observe the meeting remotely via online livestreaming 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: 842 565 139#

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Tuesday, May 24, 2022 to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to five minutes.
    b. In person, during the meeting, when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to five minutes.

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

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

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

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

3. Comments and announcements by Commission members.

A. Board members may provide comments and announcements.

4. Comments and announcements by Chief Executive Officer.

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

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

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

- Reference materials: Executive Summary from the CEO; and LHPC – Highlights from Governor's May revise for 2022-23.

Pages 5-01 to 5-29

6. Accept Alliance Dashboard for Q1 2022.

- Reference materials: Alliance Dashboard – Q1 2022.

Pages 6-01 to 6-02

7. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the third month ending March 31, 2022.

- Reference materials: Financial Statements as above.

Pages 7-01 to 7-09

Appointments: (8A. – 8B.)

8A. Approve appointment of Commissioner Shebreh Kalantari-Johnson to the Finance Committee.

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

Page 8A-01

8B. Approve appointments of Ms. Yaneth Venegas Virgen and Ms. Melissa Raya to the Member Services Advisory Group.

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

Page 8B-01

Minutes: (9A. – 9D.)

9A. Approve Commission meeting minutes of April 27, 2022.

- Reference materials: Minutes as above.

Pages 9A-01 to 9A-06

9B. **Accept Compliance Committee meeting minutes of March 16, 2022.**
- Reference materials: Minutes as above.

Pages 9B-01 to 9B-04

9C. **Accept Continuous Quality Improvement Committee meeting minutes of January 27, 2022.**
- Reference materials: Minutes as above.

Pages 9C-01 to 9C-07

9D. **Accept Whole Child Model Family Advisory Committee meeting minutes of January 10, 2022.**
- Reference materials: Minutes as above.

Pages 9D-01 to 9D-05

Reports: (10A. – 10E.)

10A. **Accept decisions from the December 8, 2021 and March 9, 2022 meetings of the Peer Review and Credentialing Committee.**
- Staff reports and recommendations on above topic.

Pages 10A-01 to 10A-02

10B. **Accept Quality and Performance Improvement Program Report for Q4 2021.**
- Reference materials: Staff report and recommendation on above topic.

Pages 10B-01 to 10B-05

10C. **Accept Quality and Performance Improvement Program (QPIP) Annual Report for 2021.**
- Reference materials: Staff report and recommendation on above topic; and 2021 QPIP Work Plan.

Pages 10C-01 to 10C-29

10D. **Approve revisions to Alliance Policy 401-1101 – Quality and Performance Improvement Program and revisions to Alliance Policy 401-1201 – Continuous Quality Improvement Committee.**
- Reference materials: Staff report and recommendation on above topic; Policy 401-1101 – Quality and Performance Improvement Program; Attachment A: Central California Alliance for Health QPIP Committee Structure; Attachment B: QPIP Organizational Chart; and Policy 401-1201 – Continuous Quality Improvement Committee.

Pages 10D-01 to 10D-39

10E. **Accept Utilization Management Work Plan Report for Q4 2021 and Utilization Management Work Plan Template for 2022.**
- Reference materials: Staff report and recommendation on above topic; and 2022 Utilization Management Work Plan Template.

Pages 10E-01 to 10E-21

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

11. **Consider accepting audited financial statements and management letters for Alliance's fiscal year ending December 31, 2021 from Moss Adams LLP, independent auditors. (3:15 – 3:45 p.m.)**

A. Moss Adams staff will present, and Board will consider accepting audited financial statements and findings of independent auditors for FY 2021.
- Reference materials: Audited Financial Statements: FY 2021.

Pages 11-01 to 11-56

12. **Consider approving proposed changes to Alliance's Care-Based Incentives (CBI) for 2023. (3:45 – 4:05 p.m.)**

A. Dr. Dianna Diallo, Medical Director, will review and Board will consider approving proposed changes to Alliance CBI for 2023.

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

Pages 12-01 to 12-02

13. **Discuss Alliance Security. (4:05 – 4:25 p.m.)**

A. Mr. Cecil Newton, Chief Information Officer and Information Security Officer, will review and Board will discuss Alliance security.

Adjourn to Closed Session

14. **Closed session pursuant to Government Code Section 54957(b)(1) regarding Public Employment (three Executive roles). (4:25 – 4:40 p.m.)**

A. Closed session agenda item.

15. **Closed session pursuant to Government Code Section 54956.9(d)(2) – Conference with Legal Counsel – Potential litigation (One Case). (4:40 – 4:55 p.m.)**

A. Closed session agenda item.

Return to Open Session

16. **Open session regarding Public Employment. (4:55 – 5:00 p.m.)**

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

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

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

Information Items: (18A. – 18E.)

A. Alliance in the News Page 18A-01
B. Alliance Fact Sheet – April 2022 Page 18B-01
C. Letters of Support Page 18C-01
D. Member Appeals and Grievance Report – Q1 2022 Page 18D-01
E. Membership Enrollment Report Page 18E-01

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, May 25, 2022; 1:30 – 2:45 p.m.

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

- Physicians Advisory Group
  Thursday, June 2, 2022; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee
  Thursday, June 16, 2022; 12:00 – 1:00 p.m. [*teleconference*]

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

The above meetings will be held in person and remotely via livestream unless otherwise noticed.

The next regular meeting of the Commission, after this May 25, 2022 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced Managed Medical Care Commission
  Wednesday, June 22, 2022, 3:00 – 5:00 p.m.
  Locations: Videoconference from Alliance offices in Scotts Valley, Salinas and Merced

Locations for the meeting:

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

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

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

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

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: May 25, 2022

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

FROM: Stephanie Sonnenshine, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

Service Area Expansion: San Benito and Mariposa Counties. On May 4, 2022 the Department of Health Care Services (DHCS) held a meeting with staff from San Benito and Mariposa counties, Alliance staff and DHCS staff to officially kick off the Alliance service area expansion/County Medi-Cal managed care plan model change. DHCS provided a timeline for key milestones culminating in a January 1, 2024 implementation. Additionally, Alliance staff have initiated this project internally and are developing an 18-month implementation timeline. Critical dependencies and restrictions include final approval of the plan's operational readiness by DHCS, development of a provider network that meets network adequacy standards, and review of proposed capitation revenue for adequacy. The addition of these two counties to the Alliance service area will result in the implementation of all aspects of the Alliance's Medi-Cal benefit responsibility in these two counties and the addition of approximately 25,000 new members.

State Budget 2022-23: May Revise. Governor Newsom released the May Revision to his January budget proposal on May 13, 2022. Budget assumptions include a $49.2B budget surplus and a $55B increase in revenue from the January proposal. The Medi-Cal total budget is $135.5B, $2.9B higher than the January proposal, and the 2022-23 projected Medi-Cal caseload is 14.46M. A summary of the May Revise provided by Local Health Plans of California (LHPC) is included as an attachment to this report. Staff will continue its review of budget details and monitor the legislature's deliberations and will provide a report on the final budget to the Board once enacted.

Unwinding of the Public Health Emergency (PHE). On May 17, 2022, the Department of Health Care Services (DHCS) released the Medi-Cal COVID-19 Public Health Emergency (PHE) Operational Unwinding Plan. The two primary purposes of this document are to: 1) describe DHCS' approach to unwinding or making permanent temporary flexibilities implemented across the Medi-Cal program during the PHE; and 2) describe DHCS' approach to resuming normal Medi-Cal eligibility operations following the end of the PHE. The PHE is currently set to expire on July 15, 2022. However, Health and Human Services agency (HHS) has previously committed to providing at least a 60-day notice prior to the official end date. As HHS has not yet provided such notice, DHCS expects the PHE to be extended for at least one additional period.

Alternative Health Care Service Plan (AHCSP). On May 4, 2022, an informational hearing was held by the joint Senate health and budget subcommittees to hear from stakeholders about the Administration's proposed statewide AHCSP direct contract. LHPC testified regarding the concerns of local plans, including those unique concerns of County Organized Health Systems. Senators asked questions and engaged both those in support and in opposition to the proposal.

Staff continue to encourage stakeholders to contact their legislative representatives to express any concerns regarding the impacts of this proposal locally.

Subsequent to the hearing, the May Revise included additional detail on the AHCSP proposal indicating the following proposed changes to the trailer bill language:

- Clarification that former foster youth are included in the enrollment provisions related to foster youth.
- Addition of language confirming that default enrollment is part of the growth in Medi-Cal enrollment.
- Specifying that Kaiser cannot deny or disenroll any individual that meets the specified enrollment or default criteria.
- Specifying that Kaiser is subject to all the same standards and requirements, except those related to beneficiary enrollment, as required for other Medi-Cal managed care plans, including the requirements pursuant to CalAIM.
- Requirement for DHCS and Kaiser enter into a Memorandum of Understanding (MOU) describing the requirements that are different than those imposed on other Medi-Cal managed care plans. The MOU shall include, but not be limited to, the commitment of Kaiser to increase its enrollment of new Medi-Cal members over the course of the contract term and requirements related to Kaiser's collaboration with safety net providers, including Federally Qualified Health Centers.
- Requirement that DHCS post this MOU and publish a report describing the implementation of the requirements imposed by the MOU.
- Provision that Kaiser shall implement the California Children Services Whole Child Model in applicable counties.
- Ensuring Kaiser maintain Knox-Keene licensure from the DMHC.

Community Involvement. On May 11, 2022 I attended and provided remarks at the MidPen Housing Groundbreaking for 1500 Capitola Road Housing. I attended the virtual Department of Health Care Services Stakeholder Advisory Committee and Behavioral Health Stakeholder Advisory Committee meeting and the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting on May 12, 2022. I attended the LHPC Board meeting and Strategic Retreat on May 16, 2022 and the Health Leadership Council meeting on May 18, 2022 in Merced. On May 19, 2022 I attended the grand opening of the Coastal Kids Home Care, Rodgers Center for Children's Health in Salinas and the virtual HIPSCC Executive Committee meeting.

Health Services

The Health Services (HS) division is in the process of updating its organizational configuration following a division assessment by the HS Director team wherein alignment with CalAIM, the Alliance Strategic Plan and the new DHCS Comprehensive Quality Strategy were considered. Changes planned as a result of the assessment include the addition of a Chief Health Officer who will work with Dr. Maurice Herbelin, Chief Medical Officer, (who joined the Alliance on May 13, 2022) and will oversee division operations. A Behavioral Health Director position is in the process of being added to oversee a new Behavioral Health Department which is currently managed within the Community Care Coordination (CCC) Department. Adult Care Management and Pediatric Care Management programs are transitioning from the Utilization Management/Complex Care Management Department to CCC to facilitate continuity with the Enhanced Case Management (ECM) and Community Support (CS) program team. With the

transition of outpatient Medi-Cal pharmacy administration to Magellan as a result of the Medi-Cal Rx/pharmacy carve-out, the Pharmacy and Utilization Management (UM) Departments will merge as the UM Department and the UM Director will oversee both UM and Pharmacy. These changes will position the HS Division well to improve efficiency while taking on additional CalAIM programs, to expand behavioral health efforts as directed in the Alliance Strategic Plan, and for preparation of the upcoming National Committee for Quality Assurance accreditation requirement.

The Health Services Division's current priorities and efforts include continuing the booster incentive program for the COVID-19 Vaccine Incentive Program, the Behavioral Health Director recruitment and finalizing the data collection for the Medi-Cal Accountability Set quality metrics for 2021. Work continues in preparation for the July 1, 2022 launch of the ECM/CS program in Merced County as well as increasing ECM/CS member and provider engagement in Santa Cruz and Monterey Counties.

COVID-19 Report

Reported COVID-19 activity is currently highest statewide in the Bay Area including Santa Cruz (SC) County. Case rates in SC County may be due to higher rates of reporting because of a county requirement of lab testing in school aged children vs. unreported home testing which is acceptable in some jurisdictions.

COVID Disease Activity (May 9, 2022)

County	Cases per 100K (7-day average)	14-Day Average of Hospitalized Patients	Rate of Positive Tests (7-day rate)	Confirmed Deaths (total)
Merced	5.6	5.1	5.1%	818
Monterey	9.6	77..9	4.8%	733
Santa Cruz	33.7	3.5	3.3%	263
California	17.1	1,075.2	4.1%	89,957

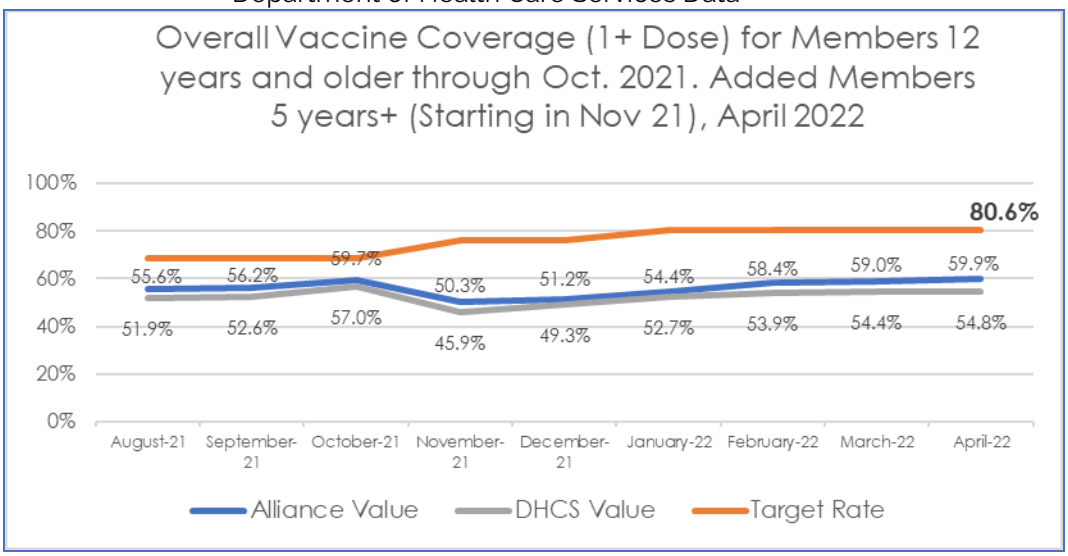
Source: https://covid19.ca.gov/state-dashboard/#location-california

There are slight increases in all measures over the last few weeks, indicating the increasing circulation of the omicron subvariants known as BA.2 and BA2.12.1 which make up the largest proportion of cases in the United States. (Sourced: CDC's Data tracker). (https://covid.cdc.gov/covid-data-tracker/#variant-proportions).

Current COVID-19 Vaccination Status and DHCS COVID-19 Vaccination Incentive Plan (VIP) Initial Results. Medi-Cal plans have seen vaccination rates grow anywhere from two to 12 percentage points between August and April. Alliance rates have increased by 10 percentage points.

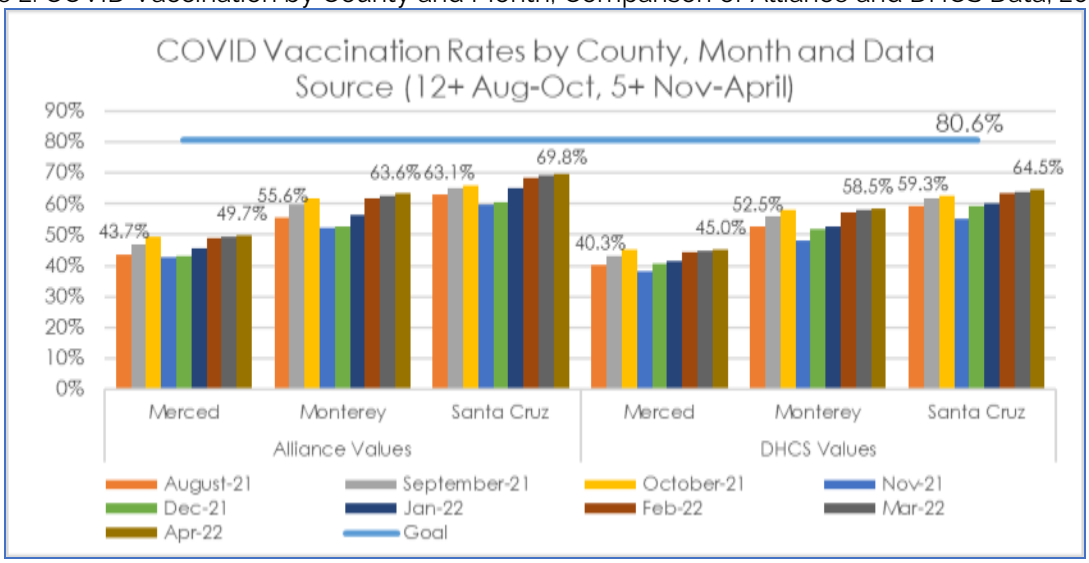
The COVID-19 Vaccine Incentive Plan that the Alliance participated in, to promote at least one dose, began September 1, 2021 and ended on February 28, 2022. The VIP included a comprehensive media plan, provider, pharmacy, and member incentives. Overall, there has been incremental increases in COVID-19 vaccination through this effort. We continue to monitor overall rates of members initiating vaccination series for those five years and older. DHCS reported the Alliance overall rate at 59.9% on April 22, 2022 (Figure 1).

Figure 1. Overall COVID Vaccine Rates for Alliance Members Ages 5 Years and Older, Alliance and Department of Health Care Services Data



Throughout this program we also tracked county progress (Figure 2). DHCS shows that each county made about a 5% increase in vaccination rates. The monthly data trends follow the Alliance data, but our data showing rates like that of DHCS, some lower but also with some by 5% over what DHCS data displays. The overall goal for the plan was for 80.6% of members five years of age and older to have received at least one dose of vaccine by March 6, 2022. Some reasons for the differences in rates include the integration of multiple data sources from the registries, DHCS encounters, pharmacy claims, and provider submitted data.

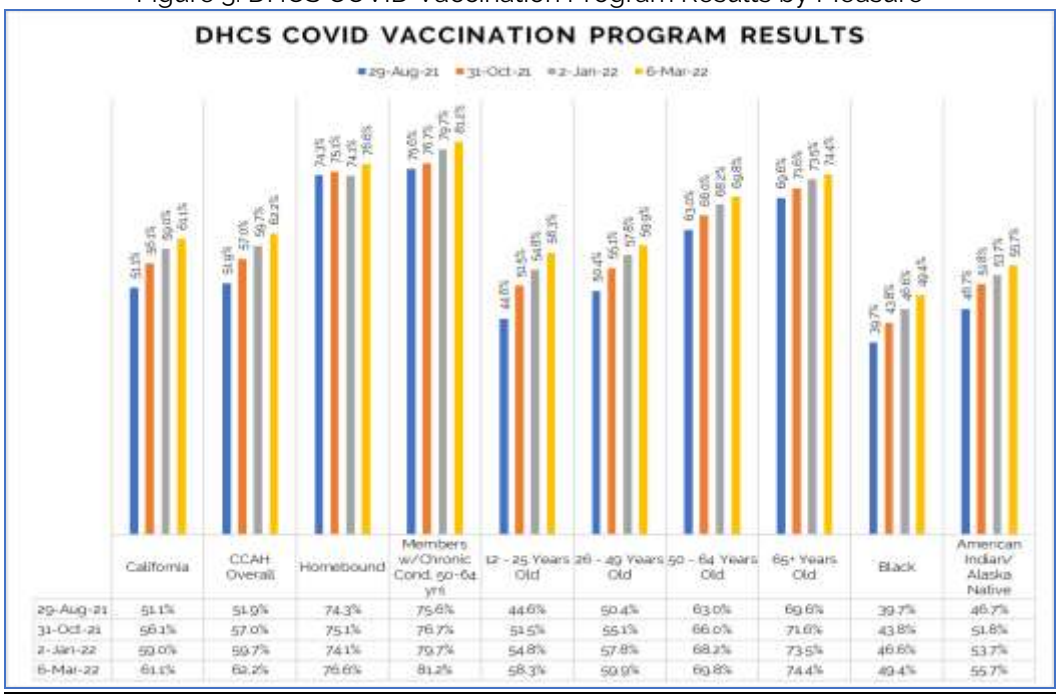
Figure 2. COVID Vaccination by County and Month, Comparison of Alliance and DHCS Data, 2020-21



The Alliance Vaccine Incentive Program was successful and as a result, the Alliance has received payment of $1,606,947.50 for the first measurement period, from September 1 to October 31, 2021. Payment for partial gap closure was received for the following measures: overall plan improvement, members 12-25 years of age, members 26-49 years of age, members 65-64 years of age, members 65 years and older, and Black and American

Indian/Alaskan Native members. The next ascertainment and potential payments are expected for July or August from DHCS.

Figure 3. DHCS COVID Vaccination Program Results by Measure



	California	CCAH Overall	Homebound	Members w/Chronic Cond. 50-64 yrs	12 - 25 Years Old	26 - 49 Years Old	50 - 64 Years Old	65+ Years Old	Black	American Indian/ Alaska Native
29-Aug-21	51.1%	51.9%	74.3%	75.6%	44.6%	50.4%	63.0%	69.6%	39.7%	46.7%
31-Oct-21	56.1%	57.0%	75.1%	76.7%	51.5%	55.1%	66.0%	71.6%	43.8%	51.8%
2-Jan-22	59.0%	59.7%	74.1%	79.7%	54.8%	57.8%	68.2%	73.5%	46.6%	53.7%
6-Mar-22	61.1%	62.2%	76.6%	81.2%	58.3%	59.9%	69.8%	74.4%	49.4%	55.7%

Provider Incentives. The COVID-19 vaccine incentive included two components, a fee-for-service (i.e., data submission and CalVax) and programmatic incentive ($25 per linked member of achieving at least 70% or $45 if achieving 85% of the provider's total linked members during the measurement periods). The second period of the incentive (January - February 2022) is in the process of data analysis and validation. Provider payments are expected in June.

Provider Incentive Results from January 1 - February 28, 2022. For the second reporting period, January 1 to February 28, 2022 the Provider Incentive Program paid out $145,730.00. We had 128 active providers participating in the program.

- For the first incentive, CalVax enrollment after August 31, 2021: There was one recipient ($10k each) for a total of $10,000.
- For the second incentive, FFS payments: 27 sites received payment (3,487 members), $87,175 total.
- For the third incentive, programmatic payments: We paid out $48,555 and vaccination rates for clinic sites ranged from 41-89%. Thirty-seven clinics achieved a rate of 70-84% and two clinics achieved 85% or higher.

Program Name	Payment Amount
Santa Cruz Medi-Cal Managed Care Program	$47,568.33
Monterey Medi-Cal Managed Care Program	$59,728.33
Merced Medi-Cal Managed Care Program	$38,433.33
	$145,729.99

Member Incentives. The Alliance launched the $50 gift card member mailing incentive to complement the gift card distribution in the field by the Your Health Matters team at local pop-up clinics. The Alliance mailed out approximately 70,000 member incentives for vaccinations administered September 2021 to February 2022.

Member Incentive for COVID-19 Booster Vaccination. On March 1, 2022, the Alliance implemented a member incentive for receiving their first or second booster dose. Our Alliance data (tri-county) shows that as of March 1, 2022 it was 37.6% for fully vaccinated members with booster doses on file. (Note: Initial March baseline rate was updated to reflect corrected and updated data in May). Using the California Department of Public Health data, we identified that the overall county (Merced, Monterey and Santa Cruz combined) rate of fully vaccinated persons with booster doses was 49.6% on March 1, 2022. The target rate identified for the Alliance Booster Program is to achieve 45% by May 31, 2022. Current booster dose data is displayed below in Figure 4. Overall, the plan is making progress to the target of 45% and is working to close the gap with the overall population.

Figure 4. Overall COVID-19 Vaccine Rates for Alliance Members Ages 5 Years and Older by County

COVID-19 Vaccination Rates for Eligible Alliance Members as of 5/11/2022				
	% Alliance members with at least one dose	% Alliance members fully vaccinated	% Alliance members partially vaccinated	% Alliance members with >1 Booster dose (12+)
Merced	**50.0%**	**43.2%**	**6.8%**	**32.70%**
Monterey	**64.1%**	**58.6%**	**5.5%**	**42.11%**
Santa Cruz	**70.0%**	**65.0%**	**5.0%**	**51.49%**
CCAH	**60.2%**	**54.4%**	**5.9%**	**41.66%**
Alliance vaccination data is collected from numerous sources including CAIR, claims, DHCS, RIDE, and SCHIO.				

Quality Improvement and Population Health

Department of Health Care Services Encounter Data Validation Audit. The Alliance completed the DHCS Encounter Data Validation (EDV) audit for 2021/2022 on May 11, 2022. The EDV audit is a medical record procurement process administered by DHCS' contracted External Quality Review Organization, Health Services Advisory Group (HSAG), Inc. to evaluate encounter data completeness and accuracy by comparing the encounter data to information documented in the medical records for sampled physician services rendered. The Alliance was able to retrieve and upload 97.6% of the records, and a final report from HSAG will be forthcoming.

Blood Lead Screening. DHCS issued an All-Plan Letter (20-016) that outlines the federal law requirements and reflects the implementation of Assembly Bill 2276 (Chapter 216, Statutes of 2020) adding blood lead related requirements to state law. Plans are required to report out quarterly, starting in 2022, child members under the age of six years (i.e., 72 months) who have no record of receiving a blood lead screening test as required by Title 17 CCR Section 37100. Below are the results from the first report, reflecting children meeting the continuous eligibility requirements who were unscreened as of December 31, 2021 by county.

County	# children not tested by age 1 (6-18 months of age)	# children not tested by age 2 (19-30 months of age)	# children not tested by age 6 (31-72 months of age)
Merced	1,406	1,691	1,284
Monterey	1,048	1,599	1,490
Santa Cruz	339	496	418

To increase lead screenings, the Alliance promoted the "exploratory" Care Based Incentive measure with providers. Primary care provider's screening rates are reported to them quarterly on their provider profile compared to benchmarks and their peer's performance. Monthly quality reports are also available to providers for proactive outreach to Alliance members. Providers have been challenged by the recall of blood lead test kits which allowed a quick capillary sample to be collected and measured in the office. These test kits had a recall that was initiated in mid-2021 and supplies have just become more available.

Indigenous Interpreting Vendor. The Alliance was notified that the indigenous interpreting vendor (Indigenous Interpreting+, a Natividad Foundation program) could no longer provide interpreting services as of May 1, 2022. The indigenous community is one of the most impacted and a large part of the workforce in one of our service areas (primarily residing in Monterey County). Overcoming language barriers is essential to ensure safety and that all members receive quality and equitable health care. The Indigenous Interpreting+ vendor served the community and was committed to bridging the language gap in our service areas for seven years. This specialized service is highly valued, ensuring effective communication with our indigenous-speaking members. As an interim plan, for indigenous languages starting May 1, 2022, providers/staff were informed to utilize Pacific Interpreters (vendor) telephonic services. The Alliance is in the process of finalizing a contract with a new vendor that would offer a broader array of indigenous language for both telephone and in-person services to ensure language assistance services. The Alliance has taken active steps to ensure this service is not interrupted and is addressing any language access issues that may arise.

Utilization Management/Complex Case Management

Inpatient/Emergency Department Utilization. Inpatient utilization has continued to trend downward through March, likely reflecting the decreased impact of COVID-19 following the winter Omicron surge. In April and early May, the Alliance's concurrent review team has noted that inpatient activity has increased throughout the Alliance region indicating that members are returning to care. As of mid-May, no discernable impact of increased Omicron BA.2 cases on inpatient utilization has been seen, although several long-term care and nursing facilities have noted outbreaks.

Emergency department (ED) volumes continue to trend downward through March, likely reflecting the combination of improved COVID-19 conditions following the Omicron surge and the waning of normal winter seasonal utilization. No discernable impact of increased Omicron BA.2 cases on ED utilization has been noted.

Prior Authorization. Overall, prior authorization volumes decreased in April 2022. While the reason for the decrease is not completely clear at this time, it likely reflects changes put in place to reduce provider authorization requirements by the Authorization Redesign Project.

Pharmacy

Medi-Cal Rx Update:

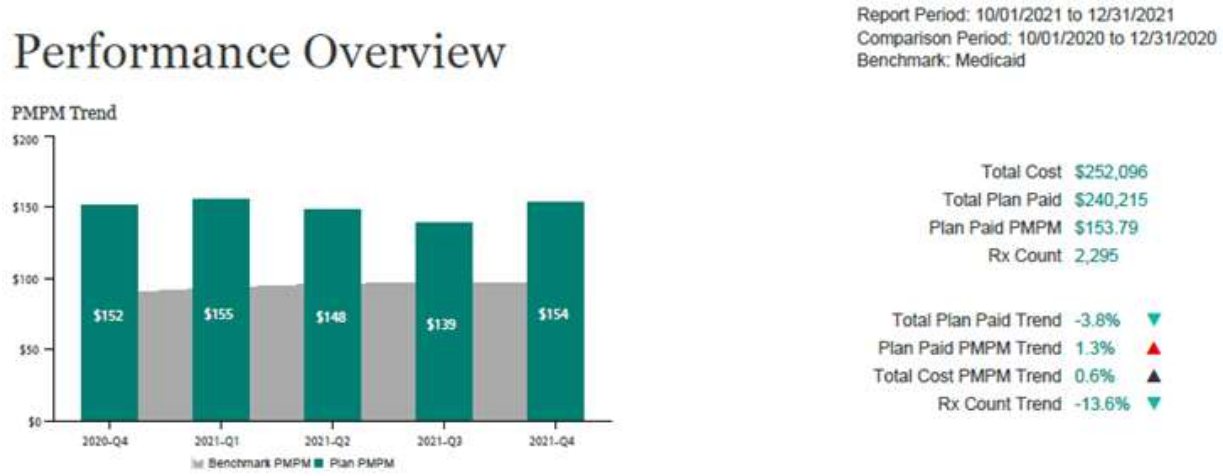
180-Day Transition Policy. The transition period will not end on July 1, 2022 as planned. DHCS is evaluating the appropriate timeline for ending the transition period and will give stakeholders 90 days' notice before it is retired.

Claim Edits and Prior Authorization Requirements. Since February 2022, Medi-Cal Rx has stabilized the call center and prior authorization operations due to the temporary removal of claims edits and the prior authorization requirement. The claim edits originally proposed to be reinstated by May 1, 2022, will not occur until such time as the education and outreach efforts have been completed by Magellan Medicaid Administration.

Special Population Clinician Liaison Team. Medi-Cal Rx has created a Special Populations Clinical Liaison Team within the Customer Service Center that has been trained to serve the specific needs of populations enrolled in California Children's Services, the Genetically Handicapped Persons Program, and those who have specialty behavioral health conditions. This team is comprised of pharmacy technicians and pharmacists.

Starting May 9, 2022, the Special Populations Clinical Liaison Team will be available Monday through Friday, 8:00 a.m. to 8:00 p.m., excluding holidays, and will serve beneficiaries, providers, and county users who are able to authenticate and discuss Protected Health Information for the given beneficiary.

Q1 2022 (IHSS) Pharmacy Trends.



The Alliance has delegated the prior authorization review and formulary management to MedImpact starting January 1, 2022. Plan paid PMPM ($132) for Q1 2022 post delegation is lower as compared to Q4 2021 ($154). The decrease is primarily due to the low utilization seen in Q1 2022. The Alliance will continue to monitor the PMPM trends in addition to other aspects of delegate oversight of MedImpact.

Community Care Coordination

Enhanced Case Management and Community Support Services. The Alliance has successfully onboarded additional ECM/CS providers in Santa Cruz and Monterey counties this month. These additional contracted providers expanded our contracted network by 50%. Our internal teams continue to meet with ECM/CS providers to discuss and operationalize program activities and to support the implementation of the care coordination software platform, as well as closed loop referral systems. Our consultant, Health Management Associates, or HMA, continue efforts of providing practice coaching to ECM/CS providers, as well as recently launching their first learning session for Monterey and Santa Cruz County providers. Work has also progressed in the Incentive Payment Program (IPP), and most organizations have completed, or are at near completion, of the IPP milestone development and have identified funding opportunities to expand their infrastructure.

Efforts continue to identify potential ECM/CS providers for Merced County. An additional provider engagement session was held this month during a Merced County Behavioral Health Mental Health Services Act Ongoing Planning Council Meeting. A few new community-based organizations reached out after that meeting to express interest in learning more about becoming an ECM/CS contracted provider. Those providers have received a tool to delineate their existing/planned infrastructure to provide the ECM benefit and CS services, and to identify their infrastructure needs that could be addressed with the Incentive Payment Program funding.

The Alliance is also working more closely with each county's Continuum of Care as part of the Board approved state-initiated Housing and Homelessness Incentive Program, or HHIP. The Alliance will be able to earn incentive funds for making investments and progress in addressing homelessness and keeping people housed, working in collaboration with existing county Continuum of Care (CoC) efforts. Staff are meeting with county's CoC groups, as well as county behavioral health, county social services, and local housing departments to submit a

homelessness plan to DHCS at the end of June. The homelessness plan will align with the work planned by the CoC in their Housing Assistance Program round III application.

Behavioral Health. Recruiting efforts are well underway for identifying the Alliance's new Behavioral Health (BH) Director. First round interviews have been completed, and second round interviews are scheduled. This position supports the expansion of BH initiatives within CalAIM, as well as the increased emphasis of BH within the Alliance Strategic Plan goal of Improved Behavioral Health Services and Systems to be Person-Centered and Equitable, within the Priority Area Person-Centered Delivery System Transformation.

The Alliance continues to collaborate with County BH partners, Beacon, and treating BH facilities to modify existing coordination of services and benefits to align with newer state guidance to improve member care. Internal efforts are underway to modify processes and systems to align with the changes and to develop new relationships with treating BH providers to support timely and coordinated access to needed BH services, especially for members in need of eating disorder support and treatment.

Employee Services and Communications

Alliance Workforce. As of May 9, 2022, the Alliance has 522.55 budgeted positions of which our active workforce number is 499.4 (active FTE and temporary workers). There are 24 positions in active recruitment, and 42 positions are vacant. The organization continues to review and monitor all position requests to ensure we are meeting FTE targets. Human Resources continues to partner with Budget & Reporting to ensure alignment in FTE goals.

With Alliance offices reopening, Human Resources is assessing and updating all onboarding processes to align with our hybrid work environment. Talent Acquisition and Training & Development have finalized the new Integration Plan and will be piloting this work beginning this month. Our goal is to create an enriched employee experience, which begins with the onboarding of new staff. The next phase of the Onboarding Reboot is expected to go live in June 2022.

In response to feedback from the 2021 Employee Engagement Survey results, Human Resources is commencing work on a competency and career development/pathway system designed to focus on position competency and career navigation and growth. Work has commenced on this project.

Communications. In April, we launched a new paid media campaign to promote the COVID-19 booster incentive. The campaign slogan is "Stay one step ahead of COVID-19". The bi-lingual paid media campaign will run through May 31, 2022. Paid media components include digital ads, streaming Pandora radio ads in all three counties, billboard posters in all three counties, and interior bus ads in every bus (154 buses total) in both Monterey and Santa Cruz counties (Merced does not offer bus advertising options). Also included are a website landing page, member-facing flyers in English and Spanish, as well as messaging to providers. Since the launch, the landing pages are #4 and #5 in terms of most visited pages on our website (English and Spanish, respectively). Referrals to the state's MyTurn site will be tracked via a tracking code embedded in QR codes in transit ads, and we will report on these next month.

The Executive Summary of the Strategic Plan is currently in development. This one-page, two-sided document will provide a succinct overview of our Strategic Priorities and Goals and will

be available in digital format and printed in hard copy to be distributed to a variety of external stakeholders and partners. Staff expect to have these ready for distribution in late May.

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

Facilities and Administrative Services. 1098 38th Avenue: The demolition of the existing structure has been completed and a future meeting with MidPen Housing is scheduled.

As of May 2, 2022, all Alliance offices are now fully reopened.

Operations

Member Calls. The Member Services Call Center continues to evaluate the increase in call talk time, leading to members waiting more than usual to speak with an Alliance representative. While the Call Center has brought on an additional four staff in the last month, these staff are still in training. In addition to bringing on additional staff, Call Center leadership has identified additional opportunities to increase Alliance representative availability, including additional training in customer service, engagement and de-escalation tactics.

COVID-19 Public Health Emergency. The United States Department of Health & Human Services, along with the Centers for Medicare & Medicaid Services (CMS) has signaled the potential end of the Public Health Emergency (PHE) put in place in response to COVID-19. With the unwinding of the PHE, the federal requirement to maintain continuous Medicaid enrollment for enrollees will also end, requiring California counties to resume the full Medi-Cal redetermination process for all beneficiaries. Due to the potential of millions of Medi-Cal beneficiaries losing Medi-Cal eligibility, DHCS has implemented a communications campaign to reach as many beneficiaries as possible and has directed the Alliance to participate in this campaign. In response, the Alliance has implemented a workplan to reach members and coordinate with community and county partners. CMS has committed to providing states at least 60-days' notice prior to the PHE ending. Once the end of the PHE is confirmed, the Alliance will implement additional activities, including a member text and call campaign, and implementing member information sharing between the Alliance and county partners.

Older Adult Expansion. On May 1, 2022, DHCS extended full scope Medi-Cal to all California residents who are 50 years of age or older regardless of immigration status. Medi-Cal beneficiaries that were enrolled in restricted scope Medi-Cal who had previously not met immigration requirements transitioned to full scope Medi-Cal and enrolled with the Alliance effective May 1, 2022. DHCS had identified 5,290 Medi-Cal beneficiaries to transition to the Alliance under this expansion. As of May 6, 2022, 4,930 new members enrolled, and the remaining were escalated to DHCS to ensure enrollment in the Alliance. To support the expansion, the Alliance developed community flyers, internal communications, social media content, editorial articles, and website updates. We also partnered with providers to ensure continuity of care for this population. With this enrollment, we experienced a significant increase in our monthly enrollment of Seniors and Persons with Disabilities members. To support, the CCC department is taking an "all hands-on deck" approach to conduct outreach to these members and ensure timely completion of required health information forms.

Claims. Claims inventory is beginning to flatten out with the last four weeks having an average increase in week over week inventory of 2.64%. However, the last two weeks of inventory have yielded a week over week delta of minus 0.1% which is very exciting. This is due to increased overtime and an increase in our Claims Per Hour production. In addition, we have onboarded temporary claims technicians to assist with managing the claims volume.

Provider Services. On an annual basis, the Network Development Steering Committee (NDSC) adopts an Access Plan which sets the focus and strategy for provider network development efforts. The Access Plan is developed based on internal and external inputs, including member feedback, utilization trends, market share, and regulatory requirements. Provider Services develops and executes the annual Access Plan. The 2022 Access Plan focuses on four main areas:

1) Expansion of ECM and CS capacity in Santa Cruz and Monterey, and development of capacity in Merced;
2) Development of a CHW and Doula network in support of benefit expansions planned for July 2022 and January 2023, respectively;
3) Fulfillment of regulatory access requirements for select specialties in Southern Monterey County; and
4) Expansion of NEMT services to support member need.

These focus areas reflect current opportunities and are responsive to meeting member needs. Updates will be provided to the NDSC throughout the year, and a formal evaluation of progress against established goals will be completed at year-end.

The Provider Services Department continues to work closely with Health Services staff to prepare for ECM and CS services in Merced County. Initial contracts have been sent to those entities who expressed interest and readiness in participating, and additional organizations will be onboarded in the coming weeks and months. In Santa Cruz and Monterey, ECM capacity has expanded to include two new clinic systems, and additional organizations are preparing to contract for CS services, further expanding the availability of housing supports throughout these two counties.

Regional Operations Santa Cruz/Monterey/Merced. The Alliance Community Engagement Coordinators along with the Your Health Matters volunteers continue to engage in weekly outreach events in our tri-county region. Focus educational topics have included updates on Medi-Cal expansion and information about redetermination.

The Alliance recently attended the UC Merced Bobcat Day, a special day for first year students, transfer students, and their families. This year, UC Merced received more than 6,200 RSVPs, the most in the history of the event, for the first Bobcat Day to be held in person since the beginning of the pandemic. Many UC Merced students are enrolled in Medi-Cal and a significant number of the students are from outside the Alliance service region and often find it difficult to transfer to Medi-Cal and find a local provider. It is crucial for students with Medi-Cal to understand the process and requirements, especially for those that will not be covered for primary care in their new residing county. The Your Health Matters team provided students and their families information and answered questions about Alliance benefits, health coverage requirements, and transferring Medi-Cal to Merced County.

Our Alliance volunteers spoke with many students and families including a parent who was worried about their child who would be away from home for the first time. The volunteers

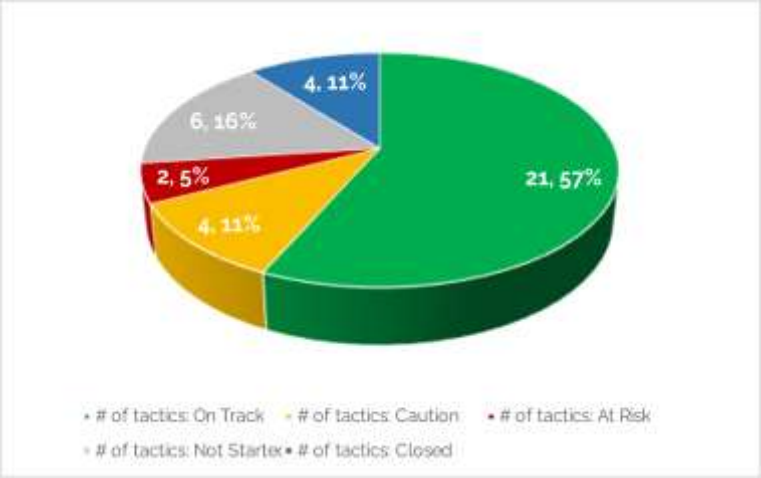
helped her by explaining the Alliance is the local Medi-Cal Managed Care plan and the automatic enrollment process, providing example providers near the campus, and sharing about transportation benefits. The parent was happy and relieved to hear about the wonderful benefits provided by the Alliance.

Q1 2022 Organizational Dashboard Results. The Q1 2022 Alliance Dashboard is comprised of 134 metrics monitoring 64 health plan core, support and managerial processes. These 64-health plan processes are rolled-up to 13 top-level (Level 1) processes for Board monitoring using a composite methodology.

The Q1 2022 Alliance Dashboard indicates healthy performance with a composite organizational result of 97.5%. Results for 10 of 13 Level 1 processes met or exceeded 95% of target. Exceptions to the 95% standard and other notable performance are as follows:

Level 1 Process	Q1 Results	Qtr over Qtr Change	Key Drivers
Engage and Support Members	93.0%	-1.0 percentage point	The Level 2 process Help Members Navigate (80.2%) continued to be impacted by staff shortages leading to a reduction in service levels for incoming member calls. In addition, timely distribution of new member welcome materials also did not meet targets due to paper supply issue and has since been mitigated.
Manage Alliance Finances	94.8%	-0.8 percentage points	Below target performance is the result of the performance of the investment portfolio. The US Bond yields in Q1 2022 increased by 139%, which magnifies unrealized losses. Bonds are kept until their maturity date; therefore, these losses are not materialized unless sold early.
Manage Organizational Communications and Branding	94.3%	-2.7 percentage points	Below target performance is the result of community engagement on social media. Social media reach grew over 50% in January and February due to the vaccine campaign. This quick growth in audience without additional budget made engagement more challenging.
Optimize the Alliance Workforce	96.7%	+3.3 percentage points	A significant improvement in early turnover rate (down to 8.9% from 20.5% the previous quarter) is contributing to overall positive performance of this process. This metric is calculated using a 12-month rolling average to smooth data and reduce volatility of results, high rates in Q121 were driving a high percentage result and have now dropped off from the calculation.

Operating Plan Portfolio Performance. Twenty-one of the 37 tactics on the Operating Plan are active and on track to be completed on schedule. Two projects are at risk for being completed on time, and both are related to system upgrades for existing applications.



Attachments.

1. LHPC – Highlights from Governor's May revise for 2022-23

To: Board of Directors & Plan Staff

From: Jennifer Lopez, Director of Health Plan Financing

Subject: Highlights from Governor's May Revision for 2022-23

Date: May 14, 2022

This memo includes highlights from Governor Newsom's proposed May Revision for 2022-23, specifically health and human services proposals of relevance to local plans. See the Governor's Budget Summary and the DHCS Budget Highlights for additional details (references and page numbers are provided throughout the memo). LHPC will continue to review and analyze Budget proposals impacting local plans and provide additional information as it becomes available. Please contact Jennifer Lopez at JLopez@lhpc.org with any questions.

State Budget Overview

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

- *Total Revised Budget*: $300.7 billion ($227.4 billion General Fund) in 2022-23 (Summary Chart, p. 14).
- *Total Revised Budget Surplus:* $49.2 billion is the projected surplus
  - 94 percent of the discretionary surplus was allocated towards one-time spending.
  - The budget is projected to be structurally balanced through 2025-26.
- *Total Revised Budget Reserves:* $37.1 billion in budgetary reserves, the reserves include:
  - $23.3 billion in the Rainy Day Fund
  - $900 million in the Safety Net Reserve
  - $9.5 billion in the Public School System Stabilization Account, and
  - $3.4 billion in the state's operating reserve

The state's General Fund revenue is projected to be $55 billion greater than the January estimates and the Rainy Day fund reflects $4 billion in supplemental deposits over a multi-year period above what is constitutionally required. The State Appropriations Limit (Gann Limit) is no longer projected to be above the constitutional limit for 2020-21 and 2021-22 fiscal years, the January Budget assumed the limited would be exceeded. The budget does caution the limit may be exceeded in future years and highlights the importance of focusing on one-time spending.

Given the current inflation levels, the May Revision reflects an added inflation adjustment beginning in 2023-24 fiscal year to reflect the anticipated higher costs of state services. As required by Proposition 2, additional payments for state's retirement liabilities have been revised to $3.4 billion in 2022-23 and $7.6 billion over the next three years.

Inflation Relief Package

In an effort to provide direct relief to California's for rising costs, the May Revision proposes an $18.1 billion relief package which would provide:

- $11.5 billion in Tax Refunds to Help with Inflation –$400 payments would be distributed to every eligible registered vehicle owner, with a cap of two checks per individual.
- $2.7 billion in Emergency Rental Assistance – State funds would be used for qualifying low-income tenants who requested assistance before March 31.
- $1.4 billion for Payment of Past-Due Utility Bills –The May Revision includes $1.2 billion for past-due electricity bills and $200 million for past due water and wastewater bills. This funding is in addition to the $1 billion provided in the 2021 Budget Act.
- $933 million for Payments to Hospital and Nursing Facility Staff – Up to $1,500 retention payments would be issued to all hospital and skilled nursing facility workers.
- $750 million for Free Public Transit – Incentive grants to provide 3-months of free public transit.
- $304 million for Health Care Premium Assistance– Premium subsides would be provided through Covered California for the middle-class.
- $439 million to Pause the Diesel Sale Tax –Proposed 12-month moratorium on diesel sales tax.
- $157 million to Extend Child Care Fee Waivers for Low-Income Families-The proposed fee waivers are for the period of July 2022 to June 2023 for state subsidized pre-school and child care.

With inflation levels projected to exceed 7 percent in 2021-22, an accelerated minimum wage increase of $15.50 per hour would go into effect January 1, 2023. Noting the increase would be required irrespective of employer size.

Other Notable Investments included in the May Revision

- $8 billion over a five-year period to increase state's energy reliability and provide consumer relief.
- An additional $1.6 billion for drought response efforts.
- An additional $233 million for wildfire and forest protection in 2022-23, this is in addition to the $1.8 billion investment included in the January Budget.
- An additional $700 million for Homelessness
    - $500 million for the development of crisis response/interim housing (i.e., tiny homes)
    - $150 million for Homekey expansion
    - $65 million for Community Assistance, Recovery, and Empowerment (CARE) court, which is a new court process aimed at assisting individuals with untreated schizophrenia or other psychotic disorders.

Reference: Budget Summary, pp. 2-5, 7, 9.

Significant Medi-Cal Budget Items

Overall Medi-Cal Budget

- *2022-23 May Revision includes* $135.5 billion ($36.6 billion General Fund) which is:
  - $2.9 billion ($1.7 billion General Fund) higher than the 2022-23 proposed January estimates.
  - $13.6 billion ($11.5 billion General Fund) higher than the revised 2021-22 projections of $121.9 billion ($25.1 billion General Fund)
  - The May Revision assumes caseload increased 6.6 percent from 2020-21 to 2021-22 and will increase by 0.6 percent from 2021-22 to 2022-23.
- *Total projected enrollment*: The 2022-23 projected caseload is 14.46 million.

References: Budget Summary p. 75; DHCS Highlights pp. 14, 16-17.

Unwinding the Public Health Emergency

To aid in the future expected unwinding of the current Public Health Emergency (PHE) an Unwinding Operational Plan will be developed. This plan will outline the continuation, modification, or conclusion of over 100 programmatic flexibilities. The May Revision includes $176.5 million to permanently extend the following flexibilities:

- Separate payments to Federally qualitied Health Centers for COVID-19 vaccinations
- Presumptive eligibility for older adults and individuals with disabilities
- Maintain Medicare reimbursement rates for oxygen and respiratory durable medical equipment
- Continuation of the 10 percent rate increase for Intermediate Care Facilities for Developmentally Disabled (ICF-DD)

The current federal PHE declaration is through July 15, 2022, and the federal government will provide states at least 60-days notices prior to ending this declaration. Eligibility redeterminations are required to resume the month following the end of the PHE and states must initiate and complete all needed redeterminations over a 14-month period. To support continuity of coverage the May Revision includes:

- $146 million over a two-year period to support additional county workload costs
- $60 million to continue Health Enrollment Navigators Project over a 4-year period
- $25 million for Media and Outreach Campaign targeted at the collecting updated member contact information

References: Budget Summary pp. 75-76; DHCS Highlights pp. 4, 9.

Hospital and Nursing Facility Worker Retention Payments

The May Revision includes $933 million for retention payments to 600,000 hospital and nursing facility workers. The state has committed providing a one-time baseline payment to every worker and will increase the payment up to $1,500 if the employer fully matches the additional amount. These payments are geared towards retaining these essential workers.

References: Budget Summary p. 77; DHCS Highlights p. 5.

Skilled Nursing Facility Payment Reform
The Skilled Nursing Facility (SNF) payment reform is expected to be implemented January 1, 2023. The goal of this payment reform is to incent better value, quality, and workforce. The May Revision includes $280 million for new Workforce and Quality Incentive Program for payments to facilities that meet quality benchmarks or for facilities who have demonstrated substantial improvement.

With the Long-Term Care carve-in into managed care it is unclear how the SNF payment reform will be implemented in managed care and whether additional directed payment or incentives programs will be implemented as a result of these payment reforms.

Reference: Budget Summary p. 77.

Equity and Practice Transformation Payments Update
The May Revision includes $700 million for Equity and Practice Transformation Payments (EPTP) available over 5-years, this is an increase of $300 million from the proposed January budget. The EPTP are expected to be implemented January 1, 2023, and will advance equity; address gaps in preventive, maternity, and behavioral health care measures; reduce COVID-19 driven disparities; support upstream interventions to address social drivers of health and improve early childhood outcomes. These payments include:

- $25 million for a statewide learning collaborative
- $25 million to support practice-level activities
- $650 million to support actual equity and transformation payments:
    - $200 million will be used to prepare practice for value-based care, implementing practice infrastructure such as electronic health record systems, improved data collection and exchange, and implementation of care management systems.

It is anticipated that some if not all of these payments will flow through managed care though key details on implementation have not been shared.

References: Budget Summary, p. 78; DHCS Highlights, p. 6.

Medi-Cal Eligibility Expansion
The May Revision continues to assume a January 1, 2024 coverage date for the Medi-Cal coverage expansion of young and old adults (age 26 to 49) regardless of immigration status. The May Revision includes $834 million ($625 million General Fund) in FY 2023-24 and ongoing costs of $2.6 billion ($2.1 billion General Fund).

Reference: DHCS Highlights, pp. 12-13.

CalAIM Update
The May Revision includes $3.1 billion ($1.2 billion General Fund), notable updates are as follows:

- Delayed long-term care carve-in for ICF-DD and Subacute Care facilities, implementation was shifted from January 2023 to July 2023. Note the remainder of long-term care benefits and facility types will continue the transition into managed care in January 2023.
- The Department has identified additional mandatory managed care enrollees who remain in the fee-for-service delivery system who should have already transitioned into manage care. The Department is working on noticing managed care plans and members, the transition of these members will occur in January 2023.
- Justice Package estimated costs of inmate pre-release has been updated to included expanded pharmacy services. The Department is proposing to cover medications consistent with the full scope of covered outpatient drugs under Medi-Cal State Plan as part of the 90-day pre-release services.
- The Department is seeking trailer bill language to:
    - Align the federal approvals received for CalAIM
    - Authorize DHCS to seek federal approval for an 1115 Serious Mental Illness/Serious Emotional Disturbance Waiver
    - Delay the transition of ICF-DDs and Subacute Care Facilities

Reference: DHCS Highlights pp. 9-10.

Home and Community-Based Services Spending Plan Update
The HCBS spending plan includes 27 program initiatives across several departments in which CMS provided approval in January 2022. Due to program claiming and expenditure updates resulting in a deficiency of $175 million the Community Base Residential Continuum Pilots for Vulnerable, Aging and Disabled population will no longer be implemented.

Reference: DHCS Highlights, pp. 11-12.

Community Health Workers
The May Revision continues to provide $350 million in General Fund to recruit, train, and certify 25,000 new community health workers by 2025, with specialty certifications in areas that include climate health, homelessness, and dementia.

Reference: Budget Summary, p 5.

Doula Benefit Update
The new Medi-Cal benefit is anticipated to implement in January 2023. Based on stakeholder discussion and further policy development, DHCS plans to increase the estimated average cost per labor rate from $450 to $1,094.

Reference: DHCS Highlights, p. 8.

Proposition 56 Update
The May Revision continues to allocate General Fund for the continuation of the many Proposition 56 programs. Inclusive of 2022-23 ongoing payments and necessary backfill due to due inadequate revenue levels, $444 million in General Fund in 2022-23 is proposed.

Reference: DHCS Highlights, p 12.

Elimination of Certain AB 97 Provider Rate Reductions Update
The May Revision continues to propose the elimination of AB 97 provider rate reductions for the following eight provider types.

- Nurses of all types
- Alternative birthing centers
- Audiologists and hearing aid dispensers
- Respiratory care providers
- Durable medical equipment providers
- Chronic dialysis clinics
- Non-emergency medical transportation providers
- Emergency medical air transportation providers

The trailer bill language included in the May Revision added the following eliminations:

- Doula services
- Community health worker services
- Continuous glucose monitoring system or continuous glucose monitoring system supplies and accessories
- Health care services delivered via remote patient monitoring
- Asthma prevention services
- Dyadic services
- Medication Therapy Management

Reference: DHCS Highlights, p. 8.

Continuous Glucose Monitoring (CGM) Reimbursement Methodology Update
Through the May Revision, DHCS is proposing trailer bill language to amend the definition of medical supplies under the pharmacy benefit to be inclusive of diabetic products, effective July 1, 2022. This change would allow DHCS to implement t a revised reimbursement methodology for CGMs.

Reference: DHCS Highlights, p. 8.

Other Health Proposals

Children's Behavioral Health
The May Revision includes an additional $290 million to address the urgent youth mental health crisis. Funding is focused on preventing youth suicide and supporting the wellness and resilience of children, youth, and parents.

- $85 million over two years for Children and Youth Behavioral Health Initiative (CYBHI) grants to schools, cities, counties, tribes, and/or community-based organizations for wellbeing and mindfulness programs as well as parent support and training.
- $75 million for digital supports for remote and metaverse based mental health assessment and intervention.
- $50 million for school and community-based crisis response pilots following a youth suicide or suicide attempt and to pilot new approaches for triggering screening and resource connections.
- $40 million for community-based youth suicide prevention and outreach
- $25 million for career development for high school students interested in mental health careers
- $15 million for the development and distribution of a video series to educate parents on tools for supporting the behavioral health of their children.

Reference: Budget Summary, pp. 71-72.

Reproductive Health
The May Revision includes an additional $57 million to maintain and improve availability of safe and accessible reproductive health care services. Specifically:

- $40 million one-time funding available over a six-year period for reproductive health care provider grants to offset the cost of providing care to individuals without abortion care services.
- $15 million for grants to community-based reproductive health, rights, and justice organizations to conduct medically accurate and culturally competent outreach and education on sexual health and reproductive health issues.
- An additional $2 million for a comprehensive reproductive rights website and funding for the research of unmet reproductive health care needs.

Reference: Budget Summary, pp. 68-69.

Reducing the Cost of Insulin
The May Revision includes $100 million for CalRX Biosimilar Insulin Initiative to implement partnerships of increase generic manufacturing under Chapter 207, Statutes of 2020 (SB 852) to acknowledge the high cost of insulin and the Administration's commitment to ensuring the availability of insulin to all Californians. The cost of CalRX Biosimilar Insulin is expected to be well below the current market price of over $300 per vial.

Reference: Budget Summary, p. 70.

Health and Human Services Data Exchange Framework (DxF)
The May Revision includes $50 million in grants for technical assistance to small or under-resourced providers, mainly small physician practices, rural hospitals, and community-based organizations new to health information exchange. The DxF efforts are being lead California Health and Human Services Agency and is a single data sharing agreement and common set of policies and procedures that will govern the exchange of health and human services information among health care and social services entities.

Reference: Budget Summary, p. 70.

Opioid Response
The May Revision includes an additional $41.8 million in opioid settlement funds for substance use disorder workforce training, naloxone distribution, and a public awareness campaign geared toward youth education on fentanyl risk.

Reference: Budget Summary, p. 73.

The SMARTER Plan and the Next Phase of COVID-19
The May Revision focuses on the California SMARTER plan which focuses on shots, masks, awareness, readiness, testing, education, and Rx. Oversaw by the Department of Public Health this plan will help prepare the state to use differed strategies and new innovation to protect the state as we navigate through the next phase of COVID-19. The May Revision includes:

- $100 million for medical surge staffing to support facilities needing additional staffing during surges of COVID. Effective April 2022, facilities are required to reimburse the rates for deployed staff.
- $40 million in resources for vaccine staff to prepare for release of vaccines for children under 5-years of age and boosters.
- $530 million for addition antigen tests to support school testing including laboratory costs, and the continuation of rapid testing sites.
- $93 million for expanded programming prioritization of children under 5 and boosters for individuals over 50 or those that are high risk.

Reference: Budget Summary, pp. 86-88.

Support of Aging and Community Living
The May Revision includes additional funding to continue the implementation of the Master Plan for Aging, notable investments are:

- $3.5 million for Long-Term Care Ombudsman Outreach Campaign to raise awareness of the resources available to residents and families in skilled nursing, assisted living, and other residential facilities.
- $10 million Community Living Fund that will assist non-Medi-Cal eligible older adults and persons with disabilities, including older adults, in transitioning from nursing homes to independent living.

Reference: Budget Summary, pp. 73-74.

Appendix

Major Health and Human Services Program Caseloads

	2021-22 Revised	2022-23 Estimate	Change
Medi-Cal	14,374,000	14,463,500	89,500
California Children's Services (CCS) [1/]	9,206	12,812	3,606
CalWORKs	306,053	368,633	62,580
CalFresh	2,594,435	2,669,900	75,465
SSI/SSP (support for aged, blind, and disabled)	1,141,109	1,121,398	-19,711
Child Welfare Services [2/]	97,462	95,410	-2,052
Foster Care	51,936	51,612	-324
Adoption Assistance	85,939	85,885	-54
In-Home Supportive Services	583,516	600,627	17,111
State Hospitals [3/]	7,526	8,289	763
Regional Centers	371,388	400,485	29,097
DDS State-Operated Residential and Community Facilities [4/]	322	322	0
Vocational Rehabilitation	110,557	124,810	14,253

[1/] Represents unduplicated quarterly caseload in the CCS Program. Does not include Medi-Cal CCS beneficiaries.
[2/] Represents Emergency Response, Family Maintenance, Family Reunification, and Permanent Placement service areas on a monthly basis. Due to transfers between each service area, cases may be reflected in more than one service area.
[3/] Represents the year-end population at State Hospitals, county Jail-Based Competency Treatment programs, and Kern Admission, Evaluation and Stabilization center.
[4/] Represents the year-end population. Previously listed as "Developmental Centers."

Reference: Budget Summary, p. 68.

Alliance Dashboard

Quarter 1, 2022

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

93.0% Of Target

SUBPROCESSES
- 99.0 Help Members Engage
- 80.2 Help Members Navigate
- 99.8 Member Experience

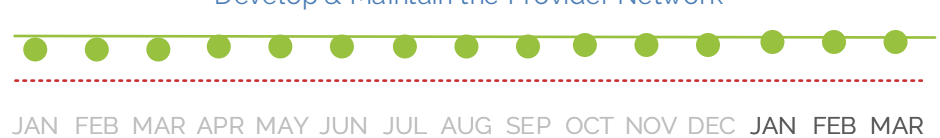
Manage & Improve Care

99.1% Of Target

SUBPROCESSES
- 98.2 Manage Care Use
- 100 Improve Care

Develop & Maintain the Provider Network

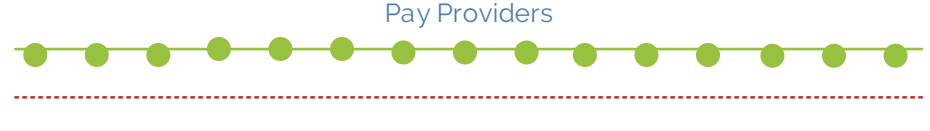
99.1% Of Target



SUBPROCESSES
- 98.4 Develop the Network
- 99.8 Maintain the Network

Pay Providers

99.2% Of Target

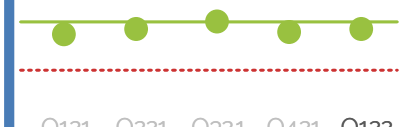


SUBPROCESSES
- 98.3 Fee-for-Service Payments
- 100 Value-Based Payments

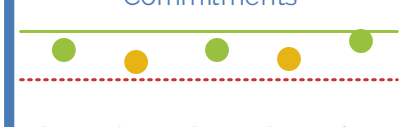
Managerial Processes

Guide the organization

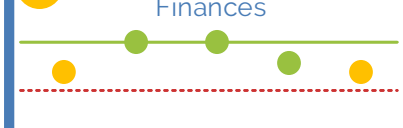
98.8 Enhance Operational Effectiveness



97.2 Manage Compliance Commitments



94.8 Manage Finances

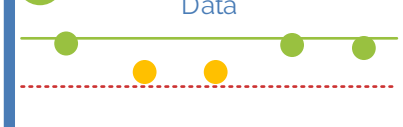


99.6 Manage Governmental & Community Relations

Support Processes *Enable organizational operations*

96.7 Optimize Alliance Workforce

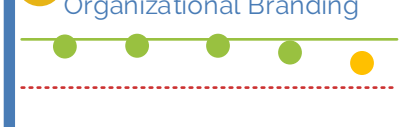
97.8 Manage Data



97.5 Manage Technology

99.8 Provide Administrative Services

94.3 Communications & Organizational Branding



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Alliance Dashboard – Board Metrics

Quarter 1, 2022

No.	Metric	Period	Target	Performance
1	Calls to Member Services answered within 30 seconds	Q122	80.0%	33.3%
2	New Member Welcome Call Completion Rate	Q421	30.0%	28.0%
3	Timely Resolution of Member Complaints	Q122	100.0%	99.0%
4	Members' Favorable Rating of Health Plan (CAHPS) (Medi-Cal)	2020	Child: 86.0% | Adult: 73.0%	Child: 88.8% | Adult: 79.8%
5	Members' Favorable Rating of Health Care (CAHPS) (Medi-Cal)	2020	Child: 84.5% | Adult: 70.5%	Child: 87.1% | Adult: 79.1%
6	Routine PCP Facility Site Reviews Completed Timely	Q122	100.0%	100.0%
7	Facility Sites Reviewed in Good Health	Q122	100.0%	100.0%
8	In Area PCP Market Share (all counties)	Q122	80.0%	86.0%
9	In Area Specialist Market Share (all counties)	Q122	80.0%	86.0%
10	Contracted PCP Open % (all counties)	Q122		63.6%
11	Overall Provider Satisfaction Rate	2021	88.0%	89.0%
12	Inpatient Bed Days/ 1,000 members/Year (Medi-Cal)	Q421	282.0	280.0
13	Admissions/1,000 Members/Year (Medi-Cal)	Q421	63.0	57.0
14	Total 30 Day All-Cause Readmissions %	Q421	11.0%	11.0%
15	Ambulatory Care Sensitive Admissions (Medi-Cal)	Q421	8.0%	7.8%
16	Average Length of Stay (Medi-Cal)	Q421	4.5	5.0
17	Emergency Department visits/1,000 members/year (all LOBs)	Q421	513.0	429.0
18	Avoidable Emergency Department visits (all LOBs)	Q421	18.0%	16.6%
19	Behavioral Health Utilization Rate by County (All Ages)	Q421	3.6%	SC: 13.6% | Mont: 7.3% | Merced: 6.6%
20	Routine Medical/Surgical Prior Authorizations Adjudicated Timely	Q122	100.0%	99.4%
21	Medical/Surgical authorization denial rate	Q122		0.6%
22	Clean Claims Processed and Paid Within 30 Calendar Days	Q122	90.0%	90.3%
23	Employee Turnover Rate	Q221-Q122	10.0%	7.8%
24	Total Staffed Workforce	Q122	90.0%	94.1%
25	Board Designated Reserves Percentage	Q122	100.0%	125.0%
26	Net Income Percentage	Q122	1.0%	7.2%
27	Medical Loss Ratio	Q122	92.0%	84.4%
28	Administrative Loss Ratio	Q122	6.0%	5.2%

DATE: May 25, 2022

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Third Month Ending March 31, 2022

For the month ending March 31, 2022, the Alliance reported an Operating Income of $15.0M. The Year-to-Date (YTD) Operating Income is at $39.1M, with a Medical Loss Ratio (MLR) of 84.4% and an Administrative Loss Ratio (ALR) of 5.2%.

For March 2022 YTD, an operating income of $23.5M was expected based on the 2022 budget. The actual operating income is favorable to budget by $15.6M or 66.3%, driven primarily by $10.8M in favorable revenue rate variances and $2.3M from medical expense rate variances. Increased enrollment as compared to budget drove offsetting revenue and medical expense variances of $8.9M and ($8.1M), respectively. Such increased enrollment is driven by the extension of the Public Health Emergency (PHE) into 2022; the 2022 budget assumed the PHE would end, and enrollment would decrease effective January 1, 2022, while the PHE is currently anticipated to end in mid-July 2022 with decreased enrollment to follow.

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

	Mar-22 MTD (In $000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*392,688*	*377,272*	*15,416*	*4.1%*
Revenue	127,138	117,504	9,634	8.2%
Medical Expenses	105,204	110,570	5,366	4.9%
Administrative Expenses	6,950	7,413	463	6.2%
Operating Income/(Loss)	14,984	(479)	15,463	100.0%
Net Income/(Loss)	8,761	(1,715)	10,476	100.0%
MLR %	*82.7%*	*94.1%*	*11.4%*	
ALR %	*5.5%*	*6.3%*	*0.8%*	
Operating Income %	*11.8%*	*-0.4%*	*12.2%*	
Net Income %	*6.9%*	*-1.5%*	*8.4%*	

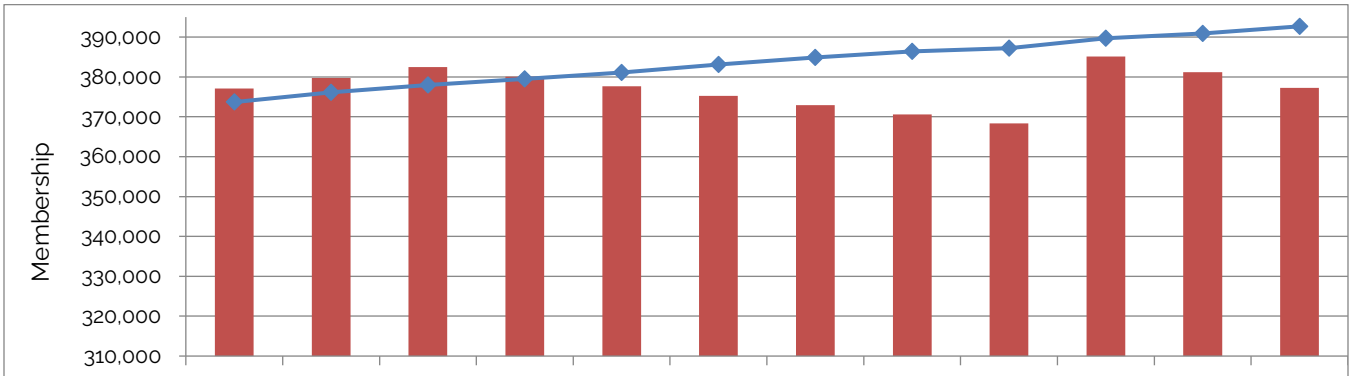
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

	Mar-22 YTD (In $000s)			
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*1,173,221*	*1,143,538*	*29,683*	*2.6%*
Revenue	376,020	356,206	19,814	5.6%
Medical Expenses	317,388	311,663	(5,725)	-1.8%
Administrative Expenses	19,565	21,054	1,489	7.1%
Operating Income/(Loss)	39,067	23,489	15,578	66.3%
Net Income/(Loss)	27,253	19,780	7,473	37.8%
PMPM				
Revenue	320.50	311.49	9.01	2.9%
Medical Expenses	270.53	272.54	2.02	0.7%
Administrative Expenses	16.68	18.41	1.74	9.4%
Operating Income/(Loss)	33.30	20.54	12.76	62.1%
MLR %	84.4%	*87.5%*	*3.1%*	
ALR %	*5.2%*	*5.9%*	*0.7%*	
Operating Income %	*10.4%*	*6.6%*	*3.8%*	
Net Income %	*7.2%*	*5.6%*	*1.7%*	

Per Member Per Month. Capitation revenue and medical expenses are variables based on enrollment fluctuations; therefore, the PMPM view offers more clarity than the total dollar amount. Conversely, administrative expenses do not directly correspond with enrollment and are consequently viewed in terms of total dollar amount. At a PMPM level, YTD revenue is $320.50, which is favorable to budget by $9.01 or 2.9%. Medical cost PMPM is $270.53, which is favorable by $2.02 or 0.7%. The resulting operating income is $33.30 PMPM, which is favorable by $12.76 as compared to budget.

Membership. March 2022 Member Months are favorable to budget by 4.1%. Please note that the 2022 budget assumed the Public Health Emergency (PHE) would end in January 2022 and redetermination would resume. Therefore, it was expected that enrollment would decrease gradually to the pre-pandemic level by December 2022. The State anticipates the PHE will expire no sooner than July 2022. This will result in favorable membership and member months for the first half of the year, with the percentage variance anticipated to increase monthly.

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



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Budget	377,057	379,753	382,481	380,048	377,645	375,273	372,929	370,611	368,326	385,108	381,158	377,272
Actual	373,691	376,094	377,967	379,537	381,066	383,089	384,876	386,374	387,235	389,667	390,866	392,688
Variance	(3,366)	(3,659)	(4,514)	(511)	3,421	7,816	11,947	15,763	18,909	4,559	9,708	15,416
Variance %	-0.9%	-1.0%	-1.2%	-0.1%	0.9%	2.1%	3.2%	4.3%	5.1%	1.2%	2.5%	4.1%

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

March 2022 capitation revenue of $126.8M is favorable to budget by $9.6M or 8.2%. Favorability to budget is attributed to increased enrollment revenue of $4.8M, prior period rate adjustments and retroactive WCM enrollment of $3.2M, MCO Tax revenue of $1.3M, and other miscellaneous rate adjustments of $0.3M.

March 2022 YTD revenue of $375.1M is favorable to budget by $19.7M or 5.5%, of which $8.9M is attributed to enrollment and $10.8M to rate variance. This includes funding for various programs not yet finalized when preparing the 2022 budget, including rapid genome sequencing and the expansion of Medi-Cal benefits to undocumented Californians aged 50 and older.

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

County	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Santa Cruz	84,515	80,437	4,078	1,913	2,165
Monterey	160,984	151,545	9,439	3,604	5,835
Merced	129,617	123,421	6,196	3,386	2,810
Total	**375,116**	**355,403**	**19,713**	**8,903**	**10,810**

Note: Excludes Mar-22 YTD In-Home Supportive Services (IHSS) premiums revenue of $0.9M.

Medical Expenses. March 2022 Medical Expenses of $105.2M are $5.4M or 4.9% favorable to budget. March 2022 YTD Medical Expenses of $317.4M are unfavorable to budget by $5.7M or 1.8%, with an MLR of 84.4%. Of this $5.7M unfavorability, $8.1M is due to enrollment and is partially offset by $2.4M attributed to PMPM cost variance.

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

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services (Hospital)	127,009	119,123	(7,886)	(3,092)	(4,794)
Inpatient Services (LTC)	42,100	36,627	(5,473)	(951)	(4,522)
Physician Services	61,805	65,300	3,496	(1,695)	5,191
Outpatient Facility	35,620	40,359	4,740	(1,048)	5,787
Pharmacy	(955)	201	1,156	(5)	1,161
Other Medical	51,810	50,053	(1,758)	(1,299)	(459)
Total	**317,388**	**311,663**	**(5,725)**	**(8,090)**	**2,365**

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

At a PMPM level, YTD Medical Expenses are $270.53, which is favorable by $2.02 or 0.7% as compared to budget. Please note that rate (PMPM) is the unit cost for a service multiplied by the utilization for the service.

Throughout the second half of 2021, Trended Authorization per 1,000 was indicating that utilization was rebounding from the most extreme suppressed levels observed in 2020 but not yet reaching 2019 levels. This trend has continued into 2022, possibly driven by loosened COVID-19 restrictions, resumption of outpatient surgeries and procedures, delivery of backlogged services, and members' increased confidence in seeking care outside of emergency care that may result in an inpatient stay. The 2022 budget assumed utilization would return to the 2019 level during Q1 2022 and increase 5% over 2019 by year-end.

Actual overall 2022 utilization has not achieved the 2019 level through March. Authorizations indicate that Inpatient (Hospital) utilization continued to be suppressed below the 2019 level through early 2022, which represents approximately 40% of medical expenses. However, $2M in retroactive claims payments from 2019 and 2020 and $8.9M in Incurred but Not Reported increases due to recent October and November 2021 payments have driven Inpatient Services costs higher than budget both on a PMPM and dollar basis.

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

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

Category	Actual	Budget	Variance	Variance %
Inpatient Services (Hospital)	108.26	104.17	(4.09)	-3.9%
Inpatient Services (LTC)	35.88	32.03	(3.85)	-12.0%
Physician Services	52.68	57.10	4.42	7.7%
Outpatient Facility	30.36	35.29	4.93	14.0%
Pharmacy	(0.81)	0.18	0.99	100.0%
Other Medical	44.16	43.77	(0.39)	-0.9%
Total	**270.53**	**272.54**	**2.02**	**0.7%**

Administrative Expenses. March 2022 YTD Administrative Expenses are favorable to budget by $1.5M or 7.1% with a 5.2% ALR. Salaries, Wages, & Benefits are favorable by $0.9M or 6.4% due to Benefits running lower than budget and vacant positions savings. Non-Salary Administrative Expenses are favorable by $0.5M or 8.6% due to the timing of the actual spend versus the budgeted timing.

Non-Operating Revenue/Expenses. March 2022 YTD Total Non-Operating Revenue is unfavorable to budget by $10.7M, primarily driven by unrealized gains/loss on investments. This is offset by a favorable March 2022 YTD Non-Operating Expense of $2.6M, resulting in an unfavorable net loss of $8.1M.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $27.3M, with an MLR of 84.4%, and an ALR of 5.2%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Third Month Ending March 31, 2022
(In $000s)

Assets	
Cash	$235,896
Restricted Cash	300
Short Term Investments	556,304
Receivables	164,590
Prepaid Expenses	4,644
Other Current Assets	17,724
Total Current Assets	**$979,457**
Building, Land, Furniture & Equipment	
Capital Assets	$83,315
Accumulated Depreciation	(42,090)
CIP	278
Total Non-Current Assets	**41,503**
Total Assets	**$1,020,960**
Liabilities	
Accounts Payable	$47,232
IBNR/Claims Payable	344,336
Accrued Expenses	1
Estimated Risk Share Payable	12,500
Other Current Liabilities	6,845
Due to State	0
Total Current Liabilities	**$410,914**
Fund Balance	
Fund Balance - Prior	$582,793
Retained Earnings - CY	27,253
Total Fund Balance	**610,046**
Total Liabilities & Fund Balance	**$1,020,960**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2022
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*392,688*	*377,272*	*15,416*	*4.1%*	*1,173,221*	*1,143,538*	*29,683*	*2.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$126,806	$117,237	$9,569	8.2%	$375,116	$355,403	$19,713	5.5%
Premiums Commercial	332	268	65	24.1%	905	803	102	12.6%
Total Operating Revenue	**$127,138**	**$117,504**	**$9,634**	**8.2%**	**$376,020**	**$356,206**	**$19,814**	**5.6%**
Medical Expenses								
Inpatient Services (Hospital)	$40,418	$41,869	$1,452	3.5%	$127,009	$119,123	($7,886)	-6.6%
Inpatient Services (LTC)	14,327	13,221	(1,107)	-8.4%	42,100	36,627	(5,473)	-14.9%
Physician Services	20,962	23,514	2,553	10.9%	61,805	65,300	3,496	5.4%
Outpatient Facility	11,664	14,850	3,186	21.5%	35,620	40,359	4,740	11.7%
Pharmacy	427	81	(346)	-100.0%	(955)	201	1,156	100.0%
Other Medical	17,406	17,034	(371)	-2.2%	51,810	50,053	(1,758)	-3.5%
Total Medical Expenses	**$105,204**	**$110,570**	**$5,366**	**4.9%**	**$317,388**	**$311,663**	**($5,725)**	**-1.8%**
Gross Margin	**$21,934**	**$6,934**	**$15,000**	**100.0%**	**$58,632**	**$44,543**	**$14,089**	**31.6%**
Administrative Expenses								
Salaries	$4,851	$5,278	$426	8.1%	$13,787	$14,731	$944	6.4%
Professional Fees	170	175	5	2.9%	420	548	128	23.4%
Purchased Services	808	720	(88)	-12.2%	2,057	2,050	(7)	-0.3%
Supplies & Other	730	853	124	14.5%	2,177	2,562	385	15.0%
Occupancy	111	101	(10)	-9.5%	283	308	25	8.0%
Depreciation/Amortization	281	285	5	1.6%	841	855	14	1.6%
Total Administrative Expenses	**$6,950**	**$7,413**	**$463**	**6.2%**	**$19,565**	**$21,054**	**$1,489**	**7.1%**
Operating Income	**$14,984**	**($479)**	**$15,463**	**100.0%**	**$39,067**	**$23,489**	**$15,578**	**66.3%**
Non-Op Income/(Expense)								
Interest	$472	$316	$156	49.2%	$1,323	$947	$377	39.8%
Gain/(Loss) on Investments	(6,211)	(239)	(5,973)	-100.0%	(11,891)	(715)	(11,176)	-100.0%
Other Revenues	155	83	71	85.7%	384	250	134	53.6%
Grants	(638)	(1,397)	759	54.3%	(1,631)	(4,190)	2,559	61.1%
Total Non-Op Income/(Expense)	**($6,223)**	**($1,236)**	**($4,987)**	**-100.0%**	**($11,814)**	**($3,709)**	**($8,106)**	**-100.0%**
Net Income/(Loss)	**$8,761**	**($1,715)**	**$10,476**	**100.0%**	**$27,253**	**$19,780**	**$7,473**	**37.8%**
MLR	*82.7%*	*94.1%*			*84.4%*	*87.5%*		
ALR	*5.5%*	*6.3%*			*5.2%*	*5.9%*		
Operating Income	*11.8%*	*-0.4%*			*10.4%*	*6.6%*		
Net Income %	*6.9%*	*-1.5%*			*7.2%*	*5.6%*		

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2022
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*392,688*	*377,272*	*15,416*	*4.1%*	*1,173,221*	*1,143,538*	*29,683*	*2.6%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$322.92	$310.75	$12.17	3.9%	$319.73	$310.79	$8.94	2.9%
Premiums Commercial	0.85	0.71	0.14	19.3%	0.77	0.70	0.07	9.8%
Total Operating Revenue	**$323.76**	**$311.46**	**$12.31**	**4.0%**	**$320.50**	**$311.49**	**$9.01**	**2.9%**
Medical Expenses								
Inpatient Services (Hospital)	$102.93	$110.98	$8.05	7.3%	$108.26	$104.17	($4.09)	-3.9%
Inpatient Services (LTC)	36.49	35.04	(1.44)	-4.1%	35.88	32.03	(3.85)	-12.0%
Physician Services	53.38	62.33	8.95	14.4%	52.68	57.10	4.42	7.7%
Outpatient Facility	29.70	39.36	9.66	24.5%	30.36	35.29	4.93	14.0%
Pharmacy	1.09	0.21	(0.87)	-100.0%	(0.81)	0.18	0.99	100.0%
Other Medical	44.32	45.15	0.83	1.8%	44.16	43.77	(0.39)	-0.9%
Total Medical Expenses	**$267.91**	**$293.08**	**$25.17**	**8.6%**	**$270.53**	**$272.54**	**$2.02**	**0.7%**
Gross Margin	**$55.86**	**$18.38**	**$37.48**	**100.0%**	**$49.98**	**$38.95**	**$11.02**	**28.3%**
Administrative Expenses								
Salaries	$12.35	$13.99	$1.63	11.7%	$11.75	$12.88	$1.13	8.8%
Professional Fees	0.43	0.46	0.03	6.7%	0.36	0.48	0.12	25.3%
Purchased Services	2.06	1.91	(0.15)	-7.7%	1.75	1.79	0.04	2.2%
Supplies & Other	1.86	2.26	0.40	17.8%	1.86	2.24	0.39	17.2%
Occupancy	0.28	0.27	(0.01)	-5.2%	0.24	0.27	0.03	10.4%
Depreciation/Amortization	0.71	0.76	0.04	5.5%	0.72	0.75	0.03	4.1%
Total Administrative Expenses	**$17.70**	**$19.65**	**$1.95**	**9.9%**	**$16.68**	**$18.41**	**$1.74**	**9.4%**
Operating Income	**$38.16**	**($1.27)**	**$39.43**	**100.0%**	**$33.30**	**$20.54**	**$12.76**	**62.1%**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Third Month Ending March 31, 2022
(In $000s)

	MTD	YTD
Net Income	$8,761	$27,253
Items not requiring the use of cash: Depreciation	281	841
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Receivables	(1,580)	80,959
Prepaid Expenses	404	(2,446)
Current Assets	(884)	(1,619)
Net Changes to Assets	**($2,059)**	**$76,894**
Changes to Payables:		
Accounts Payable	15,065	(9,708)
Accrued Expenses	-	-
Other Current Liabilities	(1,562)	(470)
Incurred But Not Reported Claims/Claims Payable	100,912	19,586
Estimated Risk Share Payable	833	2,500
Due to State	-	-
Net Changes to Payables	**$115,248**	**$11,908**
Net Cash Provided by (Used in) Operating Activities	**$122,231**	**$116,896**
Change in Investments	5,800	(18,420)
Other Equipment Acquisitions	(4)	(108)
Net Cash Provided by (Used in) Investing Activities	**$5,796**	**($18,528)**
Net Increase (Decrease) in Cash & Cash Equivalents	**$128,026**	**$98,368**
Cash & Cash Equivalents at Beginning of Period	**$107,870**	**$137,528**
Cash & Cash Equivalents at March 31, 2022	**$235,896**	**$235,896**

DATE: May 25, 2022

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Finance Committee: Commissioner Appointment

Recommendation. Staff recommend the Board approve the appointment of Commissioner Shebreh Kalantari-Johnson to the Finance Committee.

Background. Pursuant to Article 5.1 of the Commission's Bylaws, the Commission may create standing and ad hoc committees and appoint members to those committees. Only Commissioners may serve on the committees and all committees must be comprised of less than a quorum of voting Commissioners.

Discussion. Commissioner Kalantari-Johnson has indicated her interest in serving on the Finance Committee and Board appointment is required.

Finance Committee members include:

1. Commissioner Jimenez
2. Commissioner Radner
3. Commissioner Molesky
4. Commissioner Weber

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

Attachments. N/A

DATE: May 25, 2022

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

FROM: Ronita Margain, Regional Operations Director

SUBJECT: Member Services Advisory Group: Member Appointments

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

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

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

Name	Affiliation	County
Yaneth Venegas Virgen	Monterey County Department of Social Services	Monterey
Melissa Raya	Natividad Hospital	Monterey

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

SANTA CRUZ – MONTEREY – MERCED
MANAGED MEDICAL CARE COMMISSION

Meeting Minutes

Wednesday, April 27, 2022
10:45 a.m. – 3:00 p.m.

Los Banos Community Center Grand Room
645 7th Street
Los Banos, CA 93635

Commissioners Present:

Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Dorothy Bizzini	Public Representative
Ms. Leslie Conner	Provider Representative
Dr. Larry deGhetaldi	Provider Representative
Ms. Julie Edgcomb	Public Representative
Dr. Charles Harris	Hospital Representative
Ms. Dori Rose Inda	Hospital Representative
Ms. Elsa Jimenez	County Health Director
Ms. Shebreh Kalantari-Johnson	Public Representative
Mr. Michael Molesky	Public Representative
Ms. Mónica Morales	County Health Services Agency Director
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. Joerg Schuller	Hospital Representative
Mr. Tony Weber	Provider Representative

Commissioners Absent:

Dr. Maximiliano Cuevas	Provider Representative
Supervisor Zach Friend	County Board of Supervisors
Ms. Rebecca Nanyonjo	Director of Public Health
Ms. Elsa Quezada	Public Representative
Dr. James Rabago	Provider Representative
Dr. Allen Radner	Provider Representative
Mr. Rob Smith	Public Representative

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Staff Present:

Ms. Stephanie Sonnenshine	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Dr. Dale Bishop	Chief Medical Officer
Mr. Scott Fortner	Chief Administrative Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
Ms. Danita Carlson	Government Relations Director
Ms. Lilia Chagolla	Regional Operations Director
Ms. Ronita Margain	Regional Operations Director
Ms. Kathleen McCarthy	Strategic Development Director
Mr. Luis Somoza	Member Services Director
Ms. Michelle Stott, RN	Quality Improvement & Population Health Director
Ms. Jordan Turetsky	Provider Services Director
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Conner.

Commission Chairperson Conner called the meeting to order at 10:55 a.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

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.

4. 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 meeting. Mr. Cecil Newton, the new Alliance Chief Information Officer and Dr. Maurice Herbelin, who will join the Alliance as Chief Medical Officer on May 13, 2022 were introduced to the Board.

Staff were thanked for the planning and presentations for today's meeting which will be used to inform agenda preparation for the September Board retreat.

An Alternate Health Care Service Plan, AB 2724 update was presented to the Board.

Consent Agenda Items: (5. – 8D.): 11:02 a.m.

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

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

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, deGhetaldi, Edgcomb, Harris, Inda, Jimenez, Kalantari-Johnson, Molesky, Morales, Pedrozo, Schuller and Weber.

Noes: None.

Absent: Commissioners Cuevas, Friend, Nanyonjo, Quezada, Radner, Rabago and Smith.

Abstain: None.

Regular Agenda Item: (9. - 15.): 11:02 a.m.

9. Annual Election of Officers of the Commission. (11:02 – 11:04 a.m.)

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

Ms. Sonnenshine, CEO, explained that historically, the Chairperson and Vice Chairperson have served three, one-year terms and have rotated across counties. She noted that there is value in supporting Chairperson development by following a more typical practice of having the Vice Chairperson succeed the Chairperson, allowing for representation across different counties. Chair Conner indicated interest in serving a one-year term only.

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

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

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ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Bizzini, Conner, deGhetaldi, Edgcomb, Harris, Inda, Jimenez, Kalantari-Johnson, Molesky, Morales, Pedrozo, Schuller and Weber.

Noes: None.

Absent: Commissioners Cuevas, Friend, Nanyonjo, Quezada, Radner, Rabago and Smith.

Abstain: None.

Vice Chair Jimenez assumed the role of Chairperson for the remainder of the meeting.

10. Discuss key issues in Medi-Cal Financing. (11:04 – 11:43 a.m.)

Ms. Lisa Ba, Chief Financial Officer and Ms. Jennifer Lopez, Director of Health Plan Financing, Local Health Plans of California, discussed financial sustainability in the Medi-Cal managed care environment. Discussion topics and key issues in Medi-Cal financing included future rate impacts (regional rates and cost efficiencies, CalAIM shared savings, office of affordability and application of Medical Loss Ratio (MLR)), outyear base revenue uncertainty, available supplemental payments (hospital payments) and the financial outlook. CalAIM shared savings implementation is set to begin no sooner than January 1, 2024, sharing savings incurred through the delivery of Community Supports. State law requires a MLR remittance for Medi-Cal plans with less than an 85% beginning in 2024. Federal government approval of the CalAIM 1915b Waiver requires a MLR remittance for Medi-Cal plans and delegated entities with less than an 85% MLR beginning in 2025.

Ms. Ba provided a hospital supplemental payments summary, and shared data specific to the Alliance.

Commissioners further discussed Medi-Cal loss, surviving the current rate structure, physician recruitment, the totality of health care (holistically), and the 2024 elections and leveraging the press on Alliance services.

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

11. Discuss Member Engagement Transformation. (11:43 a.m. – 12:20 p.m.)

Ms. Van Wong, Chief Operating Officer (COO); Mr. Luis Somoza, Member Services Director; and Ms. Lilia Chagolla, Regional Operations Director, discussed the drivers for transforming member engagement; reviewed the current Alliance member engagement activities; shared the Alliance's approach for consistently incorporating member voice to inform on our programs, policies and practices; and discussed opportunities and challenges to support culturally sensitive and linguistically appropriate member engagement.

Key takeaways from the presentation and discussion included commitment to incorporate member voice to inform programs, practices and policies; targeting engagement by leveraging the right communication channel; and establishing a five-year roadmap with people, process and technology. Commissioners encouraged staff to engage and interact with the public, strengthen and engage member relationships, and challenged staff to look to the organization to lessen the responsibility on the member for requested services.

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

[Commissioner Pedrozo departed at this time: 12:20 p.m.]

12. Discuss Evolution of the Medi-Cal Managed Care Plan Network. (12:42 – 1:00 p.m.)

Ms. Wong, COO and Ms. Jordan Turetsky, Provider Services Director, presented on promoting awareness of the Medi-Cal managed care plan network; reviewed indicators of success and the Alliance's performance relative to network adequacy; shared the Alliance's approach to ensure a network that evolves under CalAIM; and discussed implications for the future as a result of CalAIM, market forces and other challenges.

The introduction of non-traditional services into managed care involves the introduction of new provider types. CalAIM adds Enhanced Care Management (ECM) and Community Supports and further expands benefits to include Community Health Workers and Doulas. These services addressing the social determinants of health are now becoming part of the health care continuum.

Focus for the next two years include: new services (ECM, CS, CHWs, Doulas); service area expansion into Mariposa and San Benito Counties; exceeding regulatory requirements; relying on member voice to inform cultural competency opportunities throughout the network; and ensuring that Alliance members have a choice in accessing care.

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

13. Discuss Equity and Quality in the Medi-Cal Managed Care Environment. (1:00 – 1:38 p.m.)

Dr. Dale Bishop, Chief Medical Officer (CMO) and Ms. Michelle Stott, Quality Improvement and Population Health Director, discussed drivers for transforming member engagement; reviewed the current Alliance member engagement activities; shared the Alliance's approach for consistently incorporating member voice to inform on Alliance programs, policies and practices; and discussed opportunities and challenges to support culturally sensitive and linguistically appropriate member engagement.

The vision of the Department of Health Care Services (DHCS) is to be achieved through partnerships with members, providers, communities, CBOs, schools, public health agencies, counties and health care systems as developed through the CalAIM program, utilizing a population health approach and setting quality goals through the DHCS quality strategy. The goals are to engage members as owners of their own care, keeping families and communities healthy via prevention, providing early interventions for rising risk and patient centered chronic disease management, and providing whole person care for high-risk populations addressing drivers of health.

The key concepts for population health include focusing on "upstream" health and wellness/prevention rather than illness, understanding needs and solutions through community outreach, addressing equity/health disparities/health in vulnerable groups, addressing the social/multiple determinants of health, and embracing inter-sectoral action and partnership.

The key takeaways from the discussion included a shared strategic alignment for equity and quality; performance is in line with peers; population health includes multiple actions to achieve results; primary care physician relationship and trust is critical to engage members in care; and QIS to evolve into a multi-dimensional program that incorporates population health, quality, and health equity frameworks.

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

[Commissioner Weber departed at this time: 1:38 p.m.]

14. Consider approving proposed changes to Alliance's Care Based-Incentives (CBI) for 2023.

This item was carried over to the May 25, 2022 meeting due to insufficient non-conflicted members in attendance eligible to vote on this item.

[Commissioner Kalantari-Johnson departed at this time: 1:43 p.m.]

15. Discuss evolution of the Medi-Cal Capacity Grant Program (MCGP): Framework for Goal Setting. (1:49 – 3:05 p.m.)

Ms. Kathleen McCarthy, Strategic Development Director, discussed the three new MCGP focus areas approved by the Board: 1) Access to Care (ensure members have access to high-quality, culturally competent care when, where and how they need it; 2) Healthy Beginnings (positively impact the health and well-being of our youngest members by ensuring families have the resources and support to thrive; and 3) Healthy Communities (ensure all members have access to what is needed to live their healthiest lives). The purpose of this discussion was to solicit ideas to support the development of goals against which new programs can be developed.

[Commissioner Molesky departed at this time: 2:01 p.m.]

Commissioners broke into one of the three focus area groups to discuss the following questions and reported back on 1) what impact would we like to have, 2) how will we know the grants have made a difference, and 3) to what should we direct our resources. Commissioners discussed the key themes that emerged from the group discussions.

[Commissioner Harris departed at this time: 2.29 p.m.]

Staff intend to return to the Board with proposed goals and a new Theory of Change, develop new funding opportunities that align with grantmaking strategy, develop policy related to the allocation of the MCGP budget, and explore opportunities for more equitable grantmaking and inclusion of member voice to inform investments.

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

The Commission adjourned its regular meeting of April 27, 2022 at 3:05 p.m. to the regular meeting of May 25, 2022 at 3:00 p.m. via videoconference from Alliance offices in Scotts Valley, Salinas, and Merced unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, March 16, 2022
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Bob Trinh	Technology Services Director
Bonnie Liang	Controller
Bryan Smith	Claims Director
Cecil Newton	Chief Information Officer
Dale Bishop	Chief Medical Officer
Danita Carlson	Government Relations Director
Frank Song	Analytics Director
Gordon Arakawa	Medical Director
Jenifer Mandella	Compliance Officer (Chair)
Jennifer Mockus	Community Care Coordination Director
Jordan Turetsky	Provider Services Director
Joy Cubbin	Accounting Director
Kathleen McCarthy	Strategic Development Director
Kay Lor	Provider Payment Director
Lilia Chagolla	Regional Operations Director, Monterey County
Linda Gorman	Communications Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Luis Somoza	Member Services Director
Mary Brusuelas	UM and Complex Case Management 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:

Committee Members Excused:

Kate Knutson	Compliance Manager

Dianna Diallo	Medical Director

Ad-Hoc Attendees:

Aaron McMurray	Information Security Analyst
Kat Reddell	Compliance Specialist II
Paige Harris	Regulatory Reporting Supervisor
Rebecca Seligman	Compliance Supervisor
Sara Halward	Compliance Specialist II

1. Call to Order by Chairperson Mandella.

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

2. Review and Approval of January 19, 2022 Minutes.

COMMITTEE ACTION: Committee reviewed and approved minutes of January 19, 2022 meeting.

3. Consent Agenda.

1. **Policy Hub Approvals**
2. **Regulatory and All Plan Letter Updates**
3. **Revised Code of Conduct**

Mandella, Compliance Officer pulled the revised Code of Conduct from the consent agenda and briefly described revisions, which included updates to the Alliance values, revisions to protected classes in the non-discrimination section, and revisions to the contact information for the Alliance confidential hotline.

COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. Regular Agenda

1. Program Integrity Quarterly Report

Seligman, Compliance Supervisor, presented the Q4 2021 Program Integrity Activity Report and reviewed select Matters Under Investigation (MUIs). Seligman reported that 22 concerns were referred to Program Integrity in Q4 2021, 15 of which resulted in the opening of a MUI. There were 51 active MUIs in Q4 2021.

Seligman reviewed referral trends for the period noting that of the 15 referrals which resulted in a MUI: 11 were provider specific, 3 were member specific, and 1 was a State Request.

Seligman reviewed performance of the Program Integrity metrics from the Q4 Alliance Dashboard noting that the efficiency metric did not meet threshold target as a result of late

referrals to Compliance staff. In each instance, Compliance staff reiterated the expectation and importance of timely reporting of suspected incidents.

Seligman reviewed 3 exemplar cases, highlighting investigative measures taken and next steps for completion of MUI investigation.

Seligman reviewed Q422 Program Integrity Financial Reporting noting the total requested recoupment was $12, 142.07 and completed recoupment was $14, 291.21.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2021 Program Integrity Report.

2. Internal Audit & Monitoring Quarterly Report

Halward, Compliance Specialist II, presented the Q4 2021 Internal Audit and Monitoring (Internal A&M) Activity Report noting that 2 internal reviews were conducted, both of which received a failing score. Halward noted that the decrease in audits conducted in the previous quarter was a result in the change in methodology for reporting audits conducted, and that only audits closed during the reporting quarter are reflected in the reporting. There were a total of 7 reviews finished, but pending Compliance management review or department response.

Halward reviewed one exemplar internal audit focused on ensuring requirements for NMT are being met pursuant to APL 17-010. The audit received a failed score and recommendations were made to ensure attestations are current and complete and tracked in HSP and a process is developed to provide accurate mileage and mileage data reimbursement rates.

Halward reviewed outcomes of the monitoring of 32 Alliance Dashboard metrics related to regulatory requirements, noting that all metrics met their established thresholds in Q4 2021.

Halward reviewed the 2022 DHCS Medical Audit preliminary findings reporting that potential findings were identified in the following areas:

- NEMT
- Grievance
- HIPAA
- Provider Training

COMMITTEE ACTION: Committee reviewed and approved the Q4 2021 Internal Audit & Monitoring Report.

3. HIPAA Program: Privacy and Security Quarterly Report

Mandella and McMurray, Information Security Analyst, presented the Q4 2021 HIPAA Program Report. Mandella reported that revisions to Compliance Instructor Led Training

(ILT) are in progress and Privacy & Security Training Gap Analysis was completed in Q421 as well as preparation for the 2022 DHCS Medical Audit.

Mandella reviewed HIPAA disclosure notifications received in Q4 2021, noting that of the 22 referrals received, 8 were determined to be incidents, 1 was determined to be a breach. Incorrect selection/entry remained the top root cause of HIPAA disclosures.

Mandella reviewed HIPAA related metrics included on the Alliance Dashboard for Q4 21 reporting that quality metrics met the target performance while efficiency metrics did not meet the target performance. Mandella requested feedback from Committee members on how to increase timely reporting of suspected HIPAA events. Committee members suggested conducting additional training for all staff, including all staff training and reminders about HIPAA compliance as staff return to the office in April.

McMurray reported security remediation efforts in Q421 resulted in correction of the majority of critical and high-risk findings from the most recent Security Assessment. McMurray advised the committee that Technology Services staff will be repositioning the Security Assessment away from project-based to ongoing operational work in 2022.

Newton, Chief Information Officer, also provided an overview of Security priorities in 2022 and beyond, which include the implementation of a SEIM and security standard framework.

COMMITTEE ACTION: Committee reviewed and approved the Q4 2021 HIPAA Program Quarterly Report.

The meeting adjourned at 10:00 a.m.

Respectfully submitted,

Robin Sihler
Compliance Administrative and Data Reporting Assistant

Continuous Quality Improvement Committee (CQIC)

Meeting Minutes
Thursday, January 27, 2022
12:00 – 1:30 p.m.

Virtual Meeting / Web Conference

Committee Members Present

Dr. Amy McEntee	Physician Representative
Dr. Caroline Kennedy	Physician Representative
Dr. Casey KirkHart	Physician Representative
Dr. Eric Sanford	Physician Representative
Dr. Madhu Raghavan	Physician Representative
Dr. Minoo Sarkarati	Physician Representative
Dr. Priti Golechha	Physician Representative
Dr. Stephanie Graziani	Physician Representative
Ms. Susan Harris	Provider Representative

Committee Members Absent:

Dr. Oguchi Nkwocha	Physician Representative
Ms. Rohini Mehta	Hospital Representative

Staff Present:

Dr. Dale Bishop	Chair and Chief Medical Officer
Dr. Dianna Diallo	Medical Director
Dr. Gordon Arakawa	Medical Director
Mr. Amit Karkhanis	Quality and Performance Improvement Mgr.
Mr. Luis Somoza	Member Services Director
Ms. DeAnna Leamon	Quality Improvement Nurse Supervisor
Ms. Deborah Pineda	Quality and Health Programs Manager
Ms. Hilary Gillette-Walch	Clinical Decision Quality Manager
Ms. Jacqueline Van Voerkens	Administrative Specialist
Ms. Jennifer Mockus	Community Care Coordination Director
Ms. Jordan Turetsky	Provider Services Director
Ms. Lilia Chagolla	Regional Operations Director, Monterrey
Ms. Linda Gorman	Communications 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, Merced
Ms. Viki Doolittle	UM/Complex Case Management Manager
Ms. Erika Ceja Salas	Regional Office Coordinator

1. Call to Order by Michelle Stott, RN, Quality Improvement and Population Health Director

Michelle Stott, RN, called the meeting to order at 12:05 PM, and welcomed all members present. Quorum established.

The following announcements were provided to the committee:

- Medi-Cal RX: The Alliance is assisting with present "grandfathering" issues, and noted Magellan and Med-Impact are experiencing a claims lag.
- DHCS will conduct an Audit at the Alliance February 15 through March 1, 2022

2. Consent Agenda

Dr. Dale Bishop introduced the consent agenda.

October 28, 2021 CQIC Meeting Minutes

Dr. Dale Bishop presented the October 28, 2021 CQIC Minutes. There were no edits requested at this time. All action items complete.

Committee Decision: Minutes were approved as written

Subcommittee/Workgroup Meeting Minutes

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

Workplans:

- Q3 2021 Utilization Management Work Plan
- Q3 2021 Utilization Management Work Plan Executive Summary
- Q3 2021 Quality and Performance Improvement Program (QPIP) Work plan
- Q3 2021 QPIP Workplan Executive Summary

Policies:

Require CQIC Approval		
Policy Number	**Title**	**Significant Changes**
401-1502	Adult Preventive Care	• Updated Reference to QI Department • Inserted updated SABIRT requirements • Added reference to cognitive assessment, SB 48
401-1505	Childhood Preventive Care	• Defined SHA • Updated Reference to QI Department • Updated formatting

		• Updated reference to QIPH, defined SHA, completed formatting, Inserted BHT language (Amendment 42) and inserted updated SABIRT references
401-1506	Immunization Services	• Added COVID Vaccine section to policy in response to the revised APL 20-22. • Updated II C to provide direction to Non-VFC participant providers about vaccine billing. • 12/27/21: Added Amendment 43 language regarding documentation of immunizations in the medical record, refusal, and reporting to the registry
401-1508	Facility Site Review Process	• Policy changed to reflect APL 20-006 implementation as of January 2022 • Language added regarding amendment 42 implementation
401-1509	Timely Access to Care	• Policy updated to reflect QIPH monitoring of the utilization of and/or outcomes resulting from the provision of Community Supports, including activities, reports, and analyses to understand the impact of delivery services through available data sources (i.e. claims, enrollment files, surveys, etc.) and as required by the Department of Healthcare Services.
401-1510	Medical Record Review and Requirements	• Inserted SABIRT language, added reference to cognitive assessments (SB 48)
401-1521	Physical Accessibility Review	• Language added regarding amendment 42 implementation
401-3104	Disease Management Program	• Policy updated in response to Medi-Cal Rx ("removed notations of "pharmacy" in the Program structure, and definition of "High Risk Members".)
401-3105	Diabetes Prevention and Self-Management Education Benefit	• Policy updated indicating starting 01/01/2022, the Department of Health Care Services (DHCS) will manage an administer pharmacy benefits and services under "Medi-Cal RX". • Updated references section
401-3109	Comprehensive Tobacco Cessation Services	• Policy updated in response to Medi-Cal Rx ("updated policy to indicate Medi-Cal RX formulary will managed FDA approved tobacco cessation medications".)
401-4101	Cultural and Linguistic Services Program	12/27/21: DHCS Medi-Cal Contract based on Amendment 43 revisions: • Protection of members regardless of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation or identification with any other persons or groups defined in Penal Code 422.56, except as needed to provide equal access to LEP Members or Members with disabilities, or as medically indicated. • Written member information materials will also be provided in alternative formats (Braille, large print font no smaller than **20-point,** accessible electronic formats
401-4103	Interpreter Services	• APL 21-004 Standards for determining threshold languages, nondiscrimination requirements, and language assistance services
Informational		
Policy Number	**Title**	**Significant Changes**

401-1305	Provider Preventable Conditions	• No significant changes were made to the policy or attachment B • Revised workflow attachment A
401-1514	In Office Telephone Triage	• Annual review, no changes
401-1519	Infection Control Practices	• Minor changes
401-1607	HEDIS	• Reference updated to include amendment 42 implementation
401-3101	Health Education and Promotion Program	• ECM program Language added

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

Committee Decision: Consent Agenda was approved as written.

3. Emerging Issues

a. The number of COVID related hospitalizations are dropping.
b. Shortages in COVID testing.
c. Federal program to provide N-95 masks in pharmacies
d. Distribution of COVID test kits:
   i. Medi-Cal RX will manage for Medi-Cal beneficiaries
   ii. Pharmacies and providers are receiving notification, and the member newsletter will provide this information.
   iii. MedImpact will manage for the IHSS beneficiaries
e. Medi-Cal credentialing for behavioral health providers

4. CQIC Roles and Responsibilities

Primary duties and accountability to the Alliance Board of CQIC was shared with the Committee. CQIC Roles and Responsibilities were attached to the meeting packet. CQIC is designated monitor, evaluate, and take effective actions for the Quality Improvement System (QIS), report on a scheduled basis, oversees the activities of the Pharmacy and Therapeutics (P&T) Committee, Utilization Management Workgroup (UMWG), Continuous Quality Improvement Workgroup (CQIW), Interdisciplinary CQIW and Care Based Incentive Workgroup (CBIW), and partners with the Compliance Committee to meet delegate oversight requirements.

CQIC members review and approve the Quality Improvement and Utilization Management Work Plans (QIWP and UMWP) quarterly and annually; provide leadership and oversight in the implementation of quality improvement principles and activities, participate in the development and/or adoption of specific utilization management criteria and benefit parameters, provide direction to and monitor all CQIC subcommittees / workgroups actions, QIS policies, and practice guidelines. CQIC is responsible to stimulate with the highest degree of

commitment to quality health care and to the goal of continuous improvement, to review and advise on QPIP related Corrective Action plans (CAP), individual provider issues and may refer to the PRCC and/or Program Integrity Unit depending on the nature of the issue. CQIC members also review the standards of care guidelines, as described in Policy 401-1501 – Standards of Care.

5. Covid-19 Vaccine Incentive Program

DHCS Metrics for the COVID Vaccine Incentive Program was shared with the Committee. DHCS, Alliance, and targeted percentages were presented. Measures are improving slowly. Member Mailing Incentive go live date was December 23, 2021. Members will be able to redeem their incentive gift card in three different ways (by phone, online, and by mail). The Alliance received positive feedback from members. Talking points on the COVID-19 "mail to home" incentive has been shared with internal staff.

Group discussed member incentive delivery. The Alliance is exploring all options of providing the incentive quickly and participate in Community point of service events and provide incentive to participating members. At the DHCS CMO meeting, it was announced in regards Vaccine Incentive Program, the Alliance has presently reached 30% of it's goal, indicating impressive progress.

The Member incentive is provided without limitation of the setting providing the vaccination. A provider incentive is also available. The Alliance is dependent on receiving the information (reports) from providers.

A Multilingual Vendor Call Center is being utilized for members to call regarding any questions, concerns or to confirm their address. The vendor has the list of eligible members.

Point of Service (POS) (Alliance approved selected Community Based Organizations and Provider sites) updates and key highlights were shared.

Updates:

- 26 POS events were engaged (from 10/21/2021-12/16/2021)
- 463 Alliance members (5 and older) received incentives
- Ordered more target gift cards (pending delivery)

Key highlights:

- Alliance members who were incentivized were pediatrics and adults getting their 1st or 2nd vaccine
- Members are informing other Alliance members about the inventive
- The younger members were excited about the gift card incentive
- Majority of members are children getting their 1st vaccine, many adults are getting their booster vaccine

Suggestion: Provide data on amount of vaccines and incentives received.

6. Utilization Management Criteria

a. **Enhanced Care Management (ECM) / ILOS Authorization Process**
ECM will be a Medi-Cal benefit beginning January 1, 2022 in Santa Cruz and Monterey Counties, and July 1st in Merced County. ECM is high-touch, face-to-face work in the community with frequent member contact, available to Medi/Medi's. The ECM benefit will provide intensive whole-person care management and coordination to help address the clinical and non-clinical needs of Medi-Cal MCP's highest risk members. ECM is person-centered, goal-oriented and culturally relevant. Services are arranged through county or community-based providers that serve the populations of focus.

Community Supports (CS) builds upon the work of the Whole Person Care Pilots to better address health related social needs of Medi-Cal members. Implementation statewide began 1/1/2022. CS are medically appropriate, cost-effective alternative services or settings that are provided "in lieu of" / substitute for more costly services or settings such as hospital or skilled nursing facility admissions, discharge delays, or ED use. CS is optional for Medi-Cal managed care members to receive. MCPs can add additional Community Supports every six months, discontinue once per year with DHCS approval.

Community Supports Services include:

i. Housing Transition Navigation
ii. Tenancy & Sustaining Services
iii. Housing Deposits
iv. Sobering Center (Monterey Co.)
v. Medically Tailored Meals

ECM Populations of focus timeline and Community Supports per county with the implementation effective date was presented. Recuperative Care and Short-Term Post Hospitalization Housing is scheduled to be implemented July 1, 2022.

A provider engagement session will be scheduled to recruit providers for the ECM program.

Providers can make referrals via:
Community Support Referral form here: https://thealliance.health/wp-content/uploads/PROV_Community-Supports-Provider-Referral_Form_Fillable.pdf

Enhanced Care Management form here: https://thealliance.health/wp-content/uploads/PROV_Enhanced-Care-Management-Provider-Referral-Form_fillable.pdf

Link to ECM article in the Provider Newsletter:
https://thealliance.health/provider-newsletter-issue-27/#Article_01

b. **Authorization Redesign:**

i. Authorization Redesign Update
UM team has activated rapid review processing mode to maintain turnaround times and prevent delays in care.

This UM high efficiency mode includes the following:
1) Minimal history checks
2) Diagnostics approved under rapid review
3) ARs to specialty centers approved for a year
4) Medical supplies and basic DME approved under rapid review
5) Palliative, acupuncture, chiropractic care, PT under rapid review
    a) CCS potential/eligible cases = regular review
    b) OOA requests = regular review
    c) Surgeries, Complex DME = regular review

7. Notice of Action (APL 21-011)
APL 21-011 requires MCHP's to provide fully translated notice of actions to members. The purpose of the APL is to increase member awareness of their rights. A fully translated notice is required to be provided to the member. The Alliance will utilize a vendor for this translation process.

8. Future Topics

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

Topics postponed to the April meeting:
- Auto-Authorization Approval Update
- Under/Over Utilization (Quality Improvement Study)
- Grievances and Discrimination (APL 21-004)
- Magellan Transition and Patient Safety (Medi-Cal RX)
- Readmission Incentive Dashboard

10. Action Items:
- Navneet Sachdeva will connect with Dr. Sanford regarding Proton Pump Inhibitors (action complete)

Next Meeting: Thursday, April 28, 2022 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

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, January 10, 2022

1:30p.m. – 3:00p.m.

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

Chairperson: Janna Espinoza, Chair and CCS WCM Family Member

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

WCMFAC Committee Present: Elsa Quezada, CCAH Board Member; Kim Pierce, Monterey County – Local Consumer Advocate; 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; Viki Gomez, Merced County – CCS WCM Family Member; Deadra Cline, CCS WCM Family Member; Manuel López Mejia, Monterey County – CCS WCM Family Member; Christine Betts, Monterey County – Local Consumer Advocate

CCAH Staff Present: Dianna Diallo, MD, Medical Director; Gabina Villanueva, Members Services Supervisor; Jennifer Mockus; Community Care Coordination Director (RN); Joulie Thao; Temp Care Coordinator I; Kelsey Riggs, RN, Complex Case Management Supervisor; Linda Gorman, Communications Director; Tammy Brass, Utilization Management and Complex Case Management Manager – Authorizations (RN); Van Wong, Chief Operating Officer

Guest: Anna Ruvalcaba, Merced County Department of Public Health – CCS; Fanta Nelson, Merced County Department of Public Health – CCS; Susan Paradise, Manager, Family Health Programs at County of Santa Cruz

Agenda Topic	Minutes	Action Items
Meeting Administration Lilia Chagolla	• Lilia Chagolla, Regional Operations Director (ROD) welcomed the group.	
Call to Order Janna Espinoza	• Janna, Committee Chair called the meeting to order.	
Roll Call Maria Marquez	• Committee introductions and roll call was taken.	
Oral Communications Janna Espinoza	• Janna Espinoza, Committee Chair opened the floor for any members of the public to address the Committee on items not listed on the agenda. • Janna Espinoza, Committee Chair welcomed staff to reach out to her or Lilia Chagolla, Regional Operations Director for the Alliance to include agenda topics for the following meeting. • Janna Espinoza, Committee Chair opened the floor for members/staff in attendance to make comments.	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, January 10, 2022

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	• Lilia Chagolla, ROD, provided an update for Merced County-CCS attendees. Shared that Blanca Sahagún is no longer with Merced County CCS and welcomed Anna Rubalcava, CCS Supervisor as the new regular attendee for Merced County.	
Consent Agenda Items: Accept WCMFAC Meeting Minutes from Previous Meeting Janna Espinoza	• Janna Espinoza, Committee Chair opened the floor for approval of the meeting minutes of the previous meeting on November 8, 2021. Motion to approve the consent agenda by Elsa Quezada, seconded by Kim Pierce.	
	• Janna Espinoza, Committee Chair reported on the Family Voices Health Summit. The Health Summit is an annual convening of families, youth, advocates, state and local agencies and legislators and staff. Encouraged WCMFAC committee members to participate. All presentations are available on the Family Voices website. Spanish translation available. Visit https://whova.com/web/vsfvo_202111/ to access the recorded sessions. Key takeaways and topics: • Peer grouping to communicate the needs of the special health care complex. Attendees get a peek into what other people are dealing with on a regular basis. • Behavioral Health and children and youth special health care needs: Challenges and opportunities. • Telehealth and Access to Care for children and youth with special care needs. • Partnering with your regional center coordinator to meet your child's needs. • What's new on the horizon for Medi-Cal? What does it mean for children and youth with special	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, January 10, 2022

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	health care needs? Briefly mentioned on the newly cover doula and midwife services. • Assembly Bill 988, which is also called Miles Hall Lifeline Act. AB 988 creates a new easy-to-remember three-digit phone line, 988, as the new 911 for suicidal and immediate mental health crises. With 988, callers will be connected with around-the-clock intervention, including mobile crisis teams staffed by trained mental health professionals and trained peers instead of law enforcement. • Durable Medical Equipment for children and youth with special health care needs.	
WCMFAC Roadmap - **Review 2021 Roadmap** - **2022 Roadmap Recommendations** Lilia Chagolla	• Lilia Chagolla reviewed the 2021 roadmap. Expanded on the 2021 quarterly tactics and accomplishments and solicited feedback from committee members on any of the work completed. • Reviewed and proposed the 2022 Roadmap. Shared the proposed quarterly tactics. Expanded on each of the quarterly tactics.	
Community Partner Feedback | COVID-19 Impact on Members	• Open forum for Committee members to share COVID-19 impact. • Janna Espinoza, Committee Chair opened the floor for members/staff in attendance to share COVID-19 impact on members and added that anyone can shared feedback at any time if something comes up in the interim even if it is outside this meeting. • E. Quezada, queried about the pandemic response the Alliance and other community organizations are providing. L. Chagolla shared the Alliance has started to adjust the approach due to the new surge and will be sharing more as information becomes available. • K. Pierce shared that they have a directive that came from the Department of Developmental Services that said if parents wanted in-person services, that they must honor it with the necessary precautions. Shared	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, January 10, 2022

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	they do not have enough therapists that will do in-person but have been able to accommodate shifting staff as needed. They are providing COVID testing every other week fore children who are a client of San Andreas. Clients need to contact their service coordinator at the Regional Center, and they will coordinate the testing. • Susan P. shared that Santa Cruz County MTU has revised their protocols as well. Very similar to Monterey County where they are offering in-person and virtual services for families as needed or requested from the families. They have secured some antigen tests for children who are not able to mask. • S. Skotzke recognized the school districts for providing students COVID home tests. • T. Brass shared on the Alliance fluctuations in authorizations, which shows the pattern of Alliance members due to the spike when the Omicron increased. Added that the Alliance is indirect communication with CCS families routinely and working to connect via telehealth and/or on-site visits. • L. Chagolla reported on the Alliance member COVID-19 immunization rates by county. • J. Espinoza shared that the COVID Newsletter that she received from the Alliance has been a great resource and commended on the infographic page that helps differentiate the difference between having a sinus infection, allergies, or a cold vs. COVID. • Going forward this agenda topic will be split into three sections as follows. - Community Feedback - Organizational Updates - Alliance Updates	M. Marquez to update the agenda trCOVID-19 Impact Feedback.
CCS Advisory Group Representative Report Susan Skotzke	• S. Skotzke asked if anyone is having any problems with the new Medi-Cal RX and asked that those that come across any issues they connect with the	

Whole Child Model Family Advisory Committee Meeting

Meeting Minutes

Monday, January 10, 2022

1:30p.m. – 3:00p.m.

Agenda Topic	Minutes	Action Items
	Department of Health Care Services (DHCS). Briefly shared on the Cal-Aim enhancing changes and asked that the Alliance shared any issues that arise. Elaborated on the roadblocks some CCS families face due to existing policies. L. Chagolla appreciate the feedback and asked that the issues continue to be reported for the committee and Alliance staff collaborate for solutions.	
Future Agenda Items Lilia Chagolla	• The following items will be added as future agenda items in addition to the standing agenda topics; RoadMap – Janna Espinoza, WCMFAC Chair • Review the Roadmap – Lilia Chagolla, Regional Operations Director • Revisit the number of appeals submitted for Genetic testing. Sara Sanders, Grievance and Quality Manager • Community Partner Feedback | COVID-19 Impact on Members. Add CCS members COVID vaccination rates.	
Review Action Items Maria Marquez	• Maria Marquez reviewed the action items.	
Adjourn (end) Meeting Janna Espinoza	The meeting adjourned at 2:55p.m.	
Minutes Submission	The meeting minutes are respectfully submitted by Maria Marquez, Administrative Specialist	

Next Meeting: Monday, March 14, 2022 at 1:30p.m.

DATE: May 25, 2022

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Peer Review and Credentialing Committee Report of December 8, 2021

Recommendation. Staff recommend the Board accept the decisions from the December 8, 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)
  - 24 Non-Physician Medical Practitioners
  - 14 Allied Providers
  - 3 Organizations

- Recredentialed Providers:
  - 117 Physician Providers (MD, DO, DPM)
  - 19 Non-Physician Medical Practitioners
  - 5 Allied Providers
  - 11 Organizations

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

Attachments. N/A

DATE: May 25, 2022

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

FROM: Dr. Dale Bishop, Chief Medical Officer

SUBJECT: Peer Review and Credentialing Committee Report of March 9, 2022

Recommendation. Staff recommend the Board accept the decisions from the March 9, 2022 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:
  - 29 Physician Providers (MD, DO, DPM)
  - 16 Non-Physician Medical Practitioners
  - 5 Allied Providers
  - 4 Organizations

- Recredentialed Providers:
  - 91 Physician Providers (MD, DO, DPM)
  - 27 Non-Physician Medical Practitioners
  - 18 Allied Providers
  - 17 Organizations

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

Attachments. N/A

DATE: May 25, 2022

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

FROM: Michelle N. Stott, Quality Improvement and Population Health Director

SUBJECT: Quality and Performance Improvement Program Report for Q4 2021

Recommendation. Staff recommend the Board accept the Quality and Performance Improvement Program (QPIP) Report for Q4 2021.

Summary. This informational report provides pertinent highlights, trends, and activities from the Q4 2021 QPIP Work Plan.

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 Work Plan, with review and input from CQIW-I.

The 2021 QPIP Work Plan 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)	**In progress**
D. Healthier Living Program	**Goal met**
II. Operational Performance	
A. Facility Site Review (FSR) Management	**Goal partially met**
B. Grievance and PQI Management	**Goals met**
C. Cultural and Linguistic Services	**Goals met**
D. Population Health	**In progress**

Project Outcomes

DHCS Performance Improvement Projects. 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 two 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 slightly to 17.52% from 18.79% in the previous quarter and was still below the baseline. The CIS rate for CFHC increased by more than two percentage points from 15.38% in the previous quarter to 17.42%.

2) Child and Adolescent Well Care Visits: The Alliance has partnered with Golden Valley Health Center (GVHC) 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 slightly this quarter to 33.18% from 33.57% in the previous quarter.

Limited provider engagement due to conflicting priorities with the COVID-19 vaccine, staffing challenges due to COVID-19 variants and member hesitancy to resume preventative care continue to be challenges in improving the CIS rate as well as the child and adolescent well care visits.

Breast Cancer Screening Plan-Do-Study-Act. 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 Breast Cancer Screening (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. The PDSA Cycle 1 intervention resulted in improving the screening compliance rate at Gettysburg Medical Clinic from 26.89% to 39.50%, exceeding the 10% improvement goal. The PDSA Cycle 2 intervention resulted in improving the screening compliance rate at Apex Medical Group from 60.92% to 77.82%, exceeding the 15% improvement goal.

DHCS provided an update on quality improvement activities and submission requirements for 2021 - 2022. In response to these requirements, the Alliance decided to continue with the BCS PDSA and completed the PDSA Cycle 3 intervention, which resulted in a further improvement of 13% in the screening compliance rate at Gettysburg Medical Clinic, exceeding the 10% improvement goal. During this quarter, the Alliance continued to work on PDSA Cycle 4 with Dignity Health Medical Foundation to improve their BCS compliance rate by 10%. The PDSA and "spread" of this initiative to other sites have demonstrated noteworthy best practices that can be shared broadly with other providers.

COVID-19 Quality Improvement Plan. In response to the DHCS submission requirements for 2021 - 2022, the Alliance made the initial submission for the COVID-19 Quality Improvement Plan (COVID QIP). During this quarter, the Alliance continued to work on the following three strategies:

1. Member incentive for completing the second dose of the flu vaccine in children between the ages of seven months to two years to improve the CIS Combination 10 rate.
2. Reminder letters prior to the child's 11th, 12^{th,} 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.

The second and final submission that includes a six-month progress update on the above strategies is due to DHCS in the first quarter of next year.

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.

Facility Site Review. 80% completed timely, 100% CAPs submitted, 80% CAPs completed. 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. Four sites or 80% (N=5) completed a full site review within three years of the last FSR. There were no Critical Element (CE) Corrective Action Plan (CAPs) issued. The clinics issued a CAP 100% (N=4) were able to submit a CAP plan within 45 calendar days to the Alliance. Four out of five practices (80%) with a CAP (FSR) were able to complete all planned actions within 90 calendar days. The team has continued to complete site reviews and, in some cases, also medical record review virtually. The team continues to work with a California health plan collaborative to create a webinar to orient and educate providers on the updated All Plan Letter 20-006. There continues to be challenges to complete the site review requirements at provider clinics due to the COVID-19 surge, and includes being short staffed, resource shortages, or operational challenges. As needed, the Alliance is providing temporary suspension for in-person site reviews and postponement or extensions on CAP due dates during the pandemic based on PCP requests and criticality of the requirement for completion.

Potential Quality Issues. The PQI team reviewed 100% of the 84-member grievances in Q4 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 90 calendar days of receipt and the team was successful for 97% of PQIs (N=103). All member grievances (N=84) opened as PQIs in Q4 were closed within Grievance department's timeframe of 25 days or less. During Q4, the team held an MD peer to peer interrater reliability study that resulted in 91% agreement of reviewed cases. Also, during Q4 the Medical Director Review of member complaints resolved by the RNs resulted in 100% approval, indicating that cases are being appropriately routed to Medical Directors for oversight. Challenges facing the program included staffing shortages due to resignations.

Health Education Disease Management. The Alliance's Quality and Health Programs (QHP) support members with chronic health conditions and other health promotion services who benefit from interventions that include virtual workshops and telephonic education. A total of 1,670 outreach calls were conducted in Q4 2021. In addition, in response to the COVID-19 pandemic, the QHP team has modified program processes to ensure members continue to be supported in different formats.

In Q4 2021, the QHP launched its first Healthier Living Program (HLP) virtual workshop with members. Members meet weekly for six weeks. Each session was two and a half hours. What members are saying about the HLP workshops:

- *"Everything was so helpful, and I appreciated all the support the group offered and advice. I liked making action plans each week and trying different techniques to manage my health."*

- *"Hearing other people's experiences or what they have done helps me. Learned about healthy eating and reading food labels, learning about setting goals and sticking to them. I loved the brainstorming and hearing people participating. Feeling of involvement."*
- *"It was very educational and taught me a lot using tools. It has helped me a lot in managing my symptoms. It has shown me that it is never too late to live a healthy lifestyle."*

Cultural and Linguistic Services. The volume of work for Cultural and Linguistic (C&L) Services continues to increase over time significantly. We've been able to meet our required timelines by shifting a few tasks to the Heath Educators. This was done to assist with the increased demand for interpreting/translation services and additional work related to health equity (training, development of staff/provider tools, education, etc.). This approach ensured we supported the completion of these requests.

- Telephonic Interpreter Services Utilization. In Q4 2021, the utilization of telephonic interpreting services decreased among providers, Alliance staff, and contracted Alliance vendors. A total of 6,499 telephonic interpreting services calls were reported across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). This is a 20% decrease when compared to Q4 2020 (8,149). This decrease can be due to a shift in how members accessed care in Q4 2021. Resuming care efforts were also underway, and we noticed a spike increase in face-to-face interpreting services.

- Face-to-Face Interpreter Services Utilization. As for face-to-face interpreting services, we had a total of 483 provider requests that were coordinated in Q4 2021 across the Alliance's service areas. This is a 69% increase when compared to Q4 2020 (285). This significant increase could be due to the multiple efforts taken to ensure Alliance members and providers are supported during the COVID-19 pandemic and when members are resuming care in-person, which aligns with the decrease in the use of telephonic interpreting services.

- Translation Services Utilization. In Q4 2021, the utilization of translation services increased by 54% (203) compared to Q4 2020 (132). Member communications have significantly increased due to COVID-19 related information, benefit changes, website maintenance, Enhanced Care Management (ECM), Medi-Cal Rx, Grievance, and NOA's. The C&L team supports coordination, readability, and suitability reviews to ensure materials are culturally and linguistically appropriate for members.

    - Project: In Q4 2021, the C&L/UMCCM teams have implemented DHCS APL 21-011 temporary process. Specifically, to fully translate NOAs/NARs, including the clinical rationale for the Alliance's decision that must be included in the NOA/NAR. While DHCS has made it clear that immediate translation of the entire NOA/NAR is required by federal and state law, DHCS acknowledges that some health plans may not have sufficient technological or contractual processes in place to ensure immediate translation of the clinical rationale. In the meantime, health plans are allowed to implement a temporary process, and full translation of the entire NOA/NAR is expected to comply with full translation within six months of this APL's issuance date (March 2022).

Population Health Management Program (PHMP). As reported in Q3, both the PHMP and ECM will require resources to segment and stratify the Alliance's membership to ensure that all Alliance members are appropriately matched with supports and services. The Alliance is waiting for the final guidance for the program description which will provide focus on additional areas needing support and development as we continue to build out this program. Upcoming areas will include drafting evaluation methods for the program and continuing to engage both internal and external stakeholders in this program.

Conclusion. The QPIP Work Plan does not have any critical areas of concern that require further intervention or follow-up. There is continued progress toward goals for the initiatives and operational metrics (despite staff shortages), including addressing any barriers to achieve outcomes. The pandemic continues to impact provider staffing and active engagement; however, there are efforts in participation and the team is providing support as needed.

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

Attachments. N/A

DATE: May 25, 2022

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

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

SUBJECT: Quality and Performance Improvement Program Annual Report for 2021

Recommendation. Staff recommend the Board accept the Quality and Performance Improvement Program (QPIP) Annual Report for 2021.

Summary. This informational report provides the 2021 activities for the Alliance's QPIP and an evaluation of the Quality Improvement (QI) Work Plan. A written description of activities is reflected in the QI Work Plan, as evidenced by goals and objectives reviewed quarterly and evaluated on an annual basis. These activities are approved by the Continuous Quality Improvement Committee (CQIC), and ultimately, the Alliance Board.

Background. The Alliance is contractually required by the Department of Healthcare Services (DHCS) to maintain a QPIP to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. Each year, the Alliance's QPIP focuses on areas with actionable challenges and significant outcomes that relate to a large proportion of members. The intent is to evaluate the activities related to quality and develop future interventions for improvements in care delivery and the health status of members. The 2021 QPIP Work Plan outcomes and evaluation are also described in the accompanying detailed report.

Discussion.

General 2021 QPIP Activities

Population Health

The QIPH is preparing for the roll out of another component of the California Advancing and Innovating Medi-Cal (CalAIM) program, development and implementation of a Population Health Management Program (PHMP) for all members. The Program's requirements are being finalized by DHCS, and the Alliance is expected meet the National Committee for Quality Assurance (NCQA) Population Health Accreditation Standards starting in 2023. The QIPH has laid the groundwork for PHMP by developing the strategy for on-going work that will extend in 2022 and 2023, including promotion among internal stakeholders. The annual Population Needs Assessment was submitted in July and action plans are underway. QIPH is currently working on outlining the systems that allow ongoing seamless risk scoring of all members and segmentation into appropriate service programs. Additionally, staff will review how to best interface with ECM operations and support other units and departments in identifying optimal roles to support our members. Challenges will also include how to work with the member, PCP and other local support services to connect members with a menu of services to support them in moving towards optimal health.

2021 QPIP Work Plan Outcomes and Evaluation

DHCS Performance Improvement Projects (PIPs)

Immunizations. The Alliance continued to focus on increasing the HEDIS Childhood Immunization Status (CIS) rates in Merced County. For 2021, the goal was to increase the CIS rates by at least five percentage points from 19.71% to 24.71% for children two years of age. The Alliance 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 to 17.52% in comparison to the baseline of 19.71%. The CIS rate for CFHC increased to 17.42% in comparison to the baseline of 12.22%.

Adolescent Well Care Visits. The Alliance partnered with Golden Valley Health Center (GVHC) 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% by December 2022. The child and adolescent well care visit rate increased slightly to 33.18% in comparison to baseline of 32.65%.

Limited provider engagement due to conflicting priorities with the COVID-19 vaccine, staffing challenges due to COVID-19 variants, and member hesitancy to resume preventative care continued to be challenges in improving the CIS rate as well as the child and adolescent well care visits. Given the importance of preventive care services and to minimize further gaps in pediatric care from the pandemic, the Alliance continues to collaborate with CFHC and GVHC on the PIPs to achieve the goal by December 2022.

Breast Cancer Screening Plan-Do-Study-Act. DHCS required all health plans to conduct a Plan-Do-Study-Act (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 Breast Cancer Screening (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. The PDSA Cycle 1 intervention resulted in improving the screening compliance rate at Gettysburg Medical Clinic from 26.89% to 39.50%, exceeding the 10% improvement goal. The PDSA Cycle 2 intervention resulted in improving the screening compliance rate at Apex Medical Group from 60.92% to 77.82%, exceeding the 15% improvement goal.

DHCS provided an update on quality improvement activities and submission requirements for 2021 - 2022. In response to these requirements, the Alliance decided to continue with the BCS PDSA and completed the PDSA Cycle 3 intervention, which resulted in a further improvement of 13% in the screening compliance rate at Gettysburg Medical Clinic, exceeding the 10% improvement goal. The PDSA and "spread" of this initiative to other sites have demonstrated noteworthy best practices that can be shared broadly with other providers. This included member rosters and a step-by-step process to outreach to members for visits, including coordination with the radiologist.

COVID-19 Quality Improvement Plan (QIP). In response to the DHCS submission requirements for 2021 - 2022, the Alliance made the initial submission for the COVID-19

Quality Improvement Plan. During this quarter, the Alliance continued to work on the following three strategies:

1. Member incentive for completing the second dose of the flu vaccine in children between the ages of seven months to two 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 Black Indigenous People of Color (BIPOC)/low-rate populations to improve PPC – postpartum/maternal mental health

The second and final submission that includes a six-month progress update on the above strategies is due to DHCS in Q1 2022.

Operational Performance. The QPIP includes surveillance to maintain and improve the clinical safety of services to members through Facility Site Review (FSR) and Potential Quality Issues (PQI) 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. During the pandemic, the team continued with site and medical record review using remote methods. The FSR team set out to achieve all operational goals at 100% compliance for 2021. Forty sites or 82% (N=49) completed a full site review within three years of the last FSR. When Critical Element (CE) Corrective Action Plan (CAPs) were issued at a review, only six out of seven sites (86%) had the CAP resolved within 10 business days. CEs require near immediate resolution, including items like infection control practices. The clinics issued a CAP, 93% (N=30) were able to submit a CAP plan within forty-five calendar days to the Alliance. Challenges in meeting these goals were driven by concerns reported from the providers; limited staff due to COVID-19, oxygen shortages, only able to conduct small staff training to avoid large groups in the interest of reducing risk for COVID-19 transmission, personal health concerns, and other urgent personal matters causing the CE CAP or CAP to exceed the due dates. Although DHCS flexibility to extend site reviews was an option, staff worked diligently to support providers in communicating FSR requirements and completing reviews virtually. The flexibility to continue use of the 2012 FSR and MRR tools was extended into 2022. Even with this delay in implementation, the team continues to work towards having providers aware and prepared for the new tool anticipated by mid-2022. Despite these challenges, an educational video was developed to prepare providers for improved performance on FSR scores in collaboration with Health Improvement Partnership.

For Grievance and PQI Management, the team reviewed 100% of the 386 member grievances and accepted additional reports of patient safety concerns from across the Alliance. All member grievances opened as PQIs in 2021 were closed within Grievance's timeframes (25 days or less), N=368. This reflects a process change that the team made in the first quarter of 2021. The quarterly MD inter-rater reliability (IRR) test of member complaints resolved by QI RNs resulted in 99% approval, indicating that cases are being appropriately routed to MD for oversight.

Examples of PQIs include a member who falls while inpatient, failure to follow through on lab results, inappropriate opioid prescribing that result in injury to the member. Of the PQI cases, 99% (N=545) completed investigation within 90 calendar days of receipt. These 545 PQIs include the 368 mentioned in the prior paragraph. An MD peer-to-peer IRR of PQIs resulted in 98% agreement, indicating Medical Directors are resolving cases with consistent methodology. Challenges facing the program included staffing shortages due to leaves of absence, onboarding new staff and ongoing program development. As the program evolves, changes include reporting to the Medical Board of California, collaboration with Special Investigative Unit and Provider Services for substantial cases, weekly RN case-study groups and updating the CAP policy. These changes have increased overall transparency to the Peer Review and Credentialing Committee and allowed additional follow-up for high-risk providers.

HEDIS/ Managed Care Accountability Set (MCAS) and Care-Based Incentive Programs.
HEDIS/MCAS RY2021 (Measurement Year 2020). The Alliance successfully passed its virtual audit with the audit firm, Health Services Advisory Group and the medical record review.

There was a total of four high performance level measures and 11 measures that were below the minimum performance level for both reporting regions (Santa Cruz-Monterey and Merced). The pandemic impacted any strides in preventive care, such as Controlling Blood Pressure, a measure that tracks members with hypertension and their most recent blood pressure results, and Diabetes HbA1c – Poor Control >9 where we look to decrease the number of members with diabetes with elevated or missing HbA1c values. The network struggled with pediatric measure performance like Well-Child Visits in the First Fifteen Months of Life, and in Merced with the Childhood Immunization measure, Combination 10. Finally, Breast Cancer and Chlamydia screening for women dropped below the MPL for both regions.

Due to the Pandemic, DHCS did not sanction plans for measures falling below MPL but did require COVID-19 Quality Improvement Projects (QIPs) to be completed that included both COVID-19 information and addressing measures needing improvement as described above.

HEDIS 2021 (Measurement Year 2020) Results by Region: Santa Cruz-Monterey and Merced

	Measure Acronym	*Held to MPL?	Performance Measure	SCMON	MERCED	NCQA Benchmarks 50th Percentile	75th Percentile	90th Percentile
Hybrid Measures	CBP	¥	Controlling High Blood Pressure	54.01%	53.28%	61.80	67.64	72.75
	CCS	¥	Cervical Cancer Screening	65.55%	63.66%	61.31	67.40	72.68
	CDC-H9 *(inverse)*	¥	HbA1c- Poor >9 *(inverse)*	37.24%	43.80%	37.47	32.85	27.98
	CIS-10	¥	Childhood Immunizations - Combo 10	53.66%	21.65%	37.47	44.77	52.07
	IMA-2	¥	Immunizations for Adolescents - Combo 2	59.49%	38.34%	36.86	43.06	50.85
	PPC-PRE	¥	Timeliness of Prenatal	93.15%	91.67%	89.05	92.94	95.86
	PPC-PST	¥	Postpartum Follow Up	84.93%	81.61%	76.40	80.89	84.18
	WCC - BMI	¥	Weight Assessment and Counseling - BMI	87.10%	88.56%	80.50	87.23	90.77
	WCC - N	¥	Counseling for Nutrition	82.48%	72.02%	71.55	80.05	85.16
	WCC - PA	¥	Counseling for Physical Activity	79.81%	70.56%	66.79	76.28	81.02
Administrative Measures	ADD-C&M	¥	Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	56.06%	52.00%	54.73	61.54	67.98
	ADD-Init	¥	Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase*Not held to MPL	48.41%	47.21%	42.95	48.05	55.33
	AMB-ED	N	Emergency Department Visits/1000MM	32.10%	35.32%	58.14	66.48	78.02
	AMM-Acute	¥	Antidepressant Medication Management - Effective Acute Phase Treatment	61.86%	58.10%	53.57	58.93	64.29
	AMM-Cont	¥	Antidepressant Medication Management - Effective Continuation Phase Treatment	43.71%	38.98%	38.18	43.10	49.37
	AMR	¥	Asthma Medication Ratio	75.32%	73.15%	62.43	68.13	73.38
	APM-B	¥	Blood Glucose Testing	100.00%	25.00%	54.42	61.03	69.66
	APM-BC	¥	Blood Glucose and Cholesterol Testing	0.00%	0.00%	35.43	44.30	56.34
	APM-C	¥	Cholesterol Testing	0.00%	0.00%	37.08	45.59	58.40
	BCS	¥	Breast Cancer Screening	56.58%	54.15%	58.82	64.06	69.22
	CHL	¥	Chlamydia Screening in Women	57.04%	52.04%	58.44	66.26	71.42
	PCR	N	Plan All Cause Readmissions	17.57%	14.22%	No B/Mark	No B/Mark	No B/Mark
	SSD	¥	Diabetes Screening for Schizophrenia or Bipolar Disorder Using Antipshychotic Meds	100.00%	100.00%	82.09	84.78	87.91
	W30-2+	¥	Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits	83.18%	62.39%	No B/Mark	No B/Mark	No B/Mark
	W30-6+	¥	Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	44.21%	34.76%	No B/Mark	No B/Mark	No B/Mark
	WCV	¥	Child and Adolescent Well-Care Visits	50.14%	37.76%	No B/Mark	No B/Mark	No B/Mark

Beneath 50th Percentile	4	7
50th - 74th Percentile	4	8
75th - 89th Percentile	6	3
Exceeded 90th Percentile	4	0
Reported but with no sanctions due to small denominator	4	4

*DHCS confirmed on 5/6/2021 that Plans are not held to MPL. MPLs noted for historical purposes.

The 2021 CBI evaluation is anticipated in April of 2022 following the completion of the 4th quarter build. In response to the decreased performance in the Well-Child Visits in the First Fifteen Months, the measure was added to the CBI Program along with a member incentive added to the program. The plan is actively reviewing the program's 2021 performance and planning for 2023 measures.

Member Experience - Consumer Assessment of Healthcare Providers and Systems (CAHPS). DHCS recognized the Alliance with a Consumer Satisfaction – Children for medium plans in 2021 based on their fielding of the CAHPS survey. Outstanding service can be attributed to organizational-wide efforts for children, including member and provider outreach, practice site reports and member experience toolkits, pediatric care management, and community engagement. The Alliance conducted a separate annual CAHPS survey between April 20, 2021 to July 1, 2021. The response rate for the adult survey slightly increased from 18.0% to 18.6% and the child survey decreased from 19.2% to 18.6%. For the adult survey, five composites showed improvement as compared to five composites last year. For the child survey, six composites showed improvement as compared to four composites last year. For the adult survey, the Alliance performed above the state 90th percentile for the two access measures: 1) *Getting Care Quickly, and 2) Getting Needed Care.* For both the child and adult surveys, routine and urgent care appointments were taking longer compared to last year.

Quality and Health Programs (QHP)

Health Education Disease Management. The Alliance's QHP supports members with chronic health conditions and other health promotion services who benefit from interventions that include virtual workshops and telephonic education. The QHP offers a variety of health education and disease management programs. Over 13,000 outreach calls were conducted in CY 2021. Programs include:

- Healthier Living Program
- Healthy Breathing for Life
- Healthy Moms and Health Babies
- Healthy Weight for Life
- Live Better with Diabetes
- Tobacco Cessation Support
- Wellness that Works

The QHP team also engaged with members in the following five Member Outreach Campaigns efforts with a total of 3,753 members:

1. COVID-19 vaccine for high-risk 65 and older members (N=394)
2. COVID-19 vaccine for high-risk 16-64 members (N=254)
3. COVID-19 vaccine for moderate risk 16-64 old members (N=1,103) residing in Merced County
4. Common spirit (N=1,103)
5. COVID-19 point-of-service event outreach (N=299)
6. Population Needs Assessment member outreach survey (N=600)

In addition, in response to the COVID-19 pandemic, the QHP team has modified a few program processes to ensure members continue to be supported in different formats (i.e., telephonic and virtual interventions).

In Q4 2021, the QHP launched its first Healthier Living Program (HLP) virtual workshop with members. The Alliance's HLP is an evidence-based self-management program originally developed at Stanford University. It is designed to help Alliance members diagnosed with chronic conditions gain self-confidence in their ability to control their symptoms and

understand how their health problems affect their lives. The program focuses on problems that are common for individuals suffering from chronic conditions, such as pain management, nutrition, exercise, stress reduction, emotions and communicating with doctors.

Traditionally, the HLP workshops were held in-person at community locations for Alliance members in our tri-county servicing areas. Due to COVID-19, the Alliance modified this program to be offered over the phone and now virtually. The telephonic HLP workshops are led by trained Alliance Health Education staff and the workshops consist of six one-hour sessions and virtual workshops consist of six 2.5-hour sessions.

During the HLP workshops, Alliance members create weekly action plans that include goal setting around managing their chronic condition(s) and healthier living. Each week, the Alliance Health Educators work with members to review the weekly action plans and discuss successes and challenges. The HLP allows members to also receive support and share ideas with other members who are experiencing similar life challenges living with a chronic condition.

In CY, QHP staff conducted a total of nine HLP workshops. The majority of participating Alliance members (65%) self-reported improvements in the ability to manage their chronic conditions after the workshops.

What members are saying about the new HLP telephonic workshops:

- *"During this pandemic time these calls were great."*
- *"Everything was so helpful and I appreciated all the support the group offered and advice. I liked making action plans each week and trying different techniques to manage my health."*
- *"These telephonic classes would be great for people who cannot leave their homes for whatever reason."*
- *"Hearing other people's experiences or what they have done helps me. Learned about healthy eating and reading food labels. Learning about setting goals and sticking to it. Loved the brainstorm and hearing people participating. Feeling of involvement."*
- *"It could give [people] a sense of belonging and know they are not alone to deal with their condition."*
- *"It was also nice to hear others and how they deal with their illness, I felt less overwhelmed."*
- *"With this workshop I learned to use my words and feeling when I was depressed."*
- *"It has helped me a lot in managing my symptoms. It has shown me that it is never too late to live a healthy lifestyle."*

Cultural and Linguistic Services (C&L). The Alliance is committed to delivering culturally and linguistically appropriate health care services to our diverse membership. The Cultural and Linguistic Services Program aims to ensure that all plan members have equal access to quality healthcare, and covered services are provided in a culturally and linguistically appropriate manner. There is collaboration with other departments across the organization to identify and address health disparities and contribute to the broader commitment by focusing on barriers related to language, health literacy, communications, ethnicity, and cultural beliefs.

The volume of work for C&L services continues to increase over time significantly. Required timelines were met by shifting a few tasks to the Heath Educators to assist with the increased demand for interpreting/translation services and additional work related to health equity (training, development of staff/provider tools, education, etc.). Completed metrics are noted below:

1. Telephonic Interpreter Services Utilization. The overall utilization of telephonic interpreting services has significantly increased among providers, Alliance staff, and contracted Alliance vendors. A total of 30,065 telephonic interpreting services calls were reported for CY 2021 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). This is a 4.3% increase when compared to the previous year (2021; 28,825).

2. Face-to-Face Utilization. As for face-to-face interpreting services, we had a total of 1,414 provider requests that were coordinated in CY 2021 across the Alliance's service areas. This is a 25.4% increase when compared to the previous year (2020; 1,127). This could be due to the multiple efforts taken to ensure Alliance members and providers are supported during COVID-19 pandemic and members are resuming care in-person.

3. Translation Services Utilization. In CY 2021 (718) utilization of translation service increased by 51.2% compared to the previous CY 2020 (475). Member communications have significantly increased due to COVID-19 related information, benefit changes, website maintenance, ECM, Medi-Cal Rx, Grievance, and NOA's. The C&L team provided support in coordination and quality control (QC) reviews and met delivery dates.
    - C&L/UMCCM teams have implemented DHCS APL 21-011 temporary process. Specifically, to fully translate NOAs/NARs, including the clinical rationale for the Alliance's decision that must be included in the NOA/NAR. While DHCS has made it clear that immediate translation of the entire NOA/NAR is required by federal and state law, DHCS acknowledges that some health plans may not have sufficient technological or contractual processes in place to ensure immediate translation of the clinical rationale. In the meantime, health plans are allowed to implement a temporary process, and full translation of the entire NOA/NAR is expected to come into compliance with full translation within six months of the issuance date of this APL (March-2022).

4. Readability and Suitability Services Utilization. To overcome language and cultural barriers, it's important for the Alliance to understand, create, and use culturally and linguistically appropriate materials. This included creating content at a 6th grade reading level, ensuring cultural considerations, translations, and acknowledging the different methods people might receive information. The C&L team conducts readability and suitability for all member facing content created, including redesign and content posted on the Alliance website, member flyers, and talking points when making outreach calls to members. This work supports the Alliance's health equity efforts to ensure improvements in health practices that address health literacy, engaged in disparities reduction efforts, and facilitates the interconnections between

member culture and language to improve health outcomes for culturally diverse Alliance members.

5. Department of Health Care Services Population Needs Assessment Report. This report provides an overview of the Alliance Population Needs Assessment (PNA), a DHCS contractual requirement, which identifies Medi-Cal member health status and behaviors, health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues. The 2021 PNA survey background, processes, and findings are summarized each year, and a report is submitted to DHCS. The 2021 PNA report has been completed by the Alliance Quality Improvement and Population Health team and has been approved by DHCS. The PNA report is available on the provider's website. Multiple internal and external data sources are used, including claims/encounter data, HEDIS, DHCS health disparities, and state and county-level data. Findings from the PNA highlight areas of success and areas of opportunities for improvement in the health plan. Based on the results outlined in the Alliance 2021 PNA report, the Alliance has developed targeted strategies for health education, cultural and linguistic, and quality improvement programs and services. In addition, the PNA action plan helps inform the Alliance Operating Plan to reduce health disparities, address member needs and improve health outcomes for Alliance members.

Conclusion. The QPIP continued to maintain on-going activities despite the impacts due to COVID-19 and other emerging issues. Although not all the QPIP goals and objectives were met, there were activities to engage providers and members with noted accomplishments as described above. Preventive care is a continued focus area and intensive work will be required to achieve pre-pandemic levels. There will be a need to promote the re-establishment of PCP-patient relationships to build trust, empowerment, and self-efficacy for health promotion and care with a focus on early prevention. In addition, member feedback, engagement, and stories will allow us to co-design the health care system to achieve the CalAIM goals. Overall, the QPIP remained stable with a continued focus to improve the quality of care, services, and experience of Alliance members.

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

Attachments.
1. 2021 QPIP Work Plan

I. Projects and Initiatives

A. Immunizations
B. Child and Adolescent Well Care Visits
C. PDSA, Breast Cancer Screening & COVID QIP
D. Healthier Living Program

II. Operational Performance

A. FSR Management
B. Grievance and PQI Management
C. Cultural and Linguistic Services
D. Population Health

INITIAL WORK PLAN AND EVALUATION APPROVAL:

Submitted and approved by CQIW-I — Date: 3/25/2021
Submitted and approved by CQIC — Date: 4/29/2021
Submitted and approved by Board — Date: 5/26/2021

Dale Bishop, MD, Chief Medical Officer — Date: 5/26/2021

Maya Heinert, MD, Medical Director — Date: 5/26/2021

Michelle Stott, RN, MSN, Quality Improvement Director — Date: 5/26/2021

FINAL EVALUATION APPROVAL:

Submitted and approved by CQIW-I — Date: 3/31/2022
Submitted and approved by CQIC — Date: 4/28/2022
Submitted and approved by Board — Date: 5/25/2022

Dale Bishop, MD, Chief Medical Officer — Date: 5/25/2022

Date:

Michelle Stott, RN, MSN, Quality Improvement Director — Date: 5/25/2022

A. Immunizations

Project Description and Goals:

Purpose: To improve health outcomes for pediatric members by ensuring all appropriate immunizations are given per current Centers for Disease Control and Prevention (CDC) schedule and Advisory Committee of Immunization Practices (ACIP) guidelines. To increase the Childhood Immunization Status (CIS) Combination (Combo) 10 rate of immunization for children above the minimum performance level (MPL) in Merced county.

Priority: Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP) implemented at Castle Family Health Center.

Goals for 2021:

- In the context of COVID-19 pandemic, QI will collaborate with internal and external stakeholders to increase CIS Combo 10 rate of immunization for children from 19.71% (HEDIS 2020) to 24.71% [stretch: 34.79% (Exceed the NCQA 50th percentile)] in Merced County in 2021. Combo 10 is defined as the percentage of children 2 years of age who had four diphtheria, tetanus and a cellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three *Hemophilus influenza* type B (HiB); three hepatitis B (HepB), one varicella (VZV); four pneumococcal conjugate (PCV) doses; 2 doses of hepatitis A (HepA); 2-3 rotavirus (RV) and 2 influenza doses (Flu) by their second birthday; and
- By December 31, 2022, Castle Family Health Center's will increase their percentage of children compliant with the HEDIS measure Childhood Immunization Status (Combination 10) among the three targeted sites from a baseline of 12.22% to 19.51%.

Activities (Secondary Drivers):

- Educate PCPs on EBP recommendations in the context of COVID-19 pandemic to improve Immunizations rates;
- Analysis of flu vaccination rates, where are children receiving no flu vaccine versus one flu vaccine dose. [parent is accepting of flu vaccine but did not get fully vaccinated]
- Model excellent provider communication strategies specific to immunizations;
- Refine and test interventions to increase rate for childhood immunizations including a tracking system;
- Through Practice Coaching, empower clinic staff to recall children behind on immunizations and create systems for COVID-19 vaccinations;
- Leverage required DHCS calls and written correspondence in addition to Alliance outreach to promote vaccinations directly to members;
- Increase routine local data submission and routine clinic use of the immunization registries;
- Emphasize health equity and increase outreach to member groups with lower rates of coverage (resuming care) with an emphasis on provider and community engagement.

2021 Evaluation

Review Period	Goal	Results	Key Accomplishments this Period	Issues	Next Steps
1st Quarter	1) In 2021 increase Merced County CIS rate from 19.71% to 24.71%. 2) By Dec 2022, increase CFHC CIS rate from 12.22% to 19.51%.	1) 18.96% (3/31/2021); decreased from baseline; however, increased from 17.85% in Q4 2020 to 18.96% in Q1 2021. 2) 12.84% (3/31/2021); increased slightly from 12.5% in Q4 2020.	1-1) A Proposal for a new member incentive to focus on CIS Flu 2nd Dose was introduced & approved by QI Leadership and CBIWG. Internal Application for New Member Incentive was submitted to Health Programs for review & approval. (currently pending review) 1-2) Completed 2 trainings in February (1 external & 1 internal) a. Importance of Immunizations(CIS population) at Parents as Teachers meeting b. Immunization Basics for Health Programs 1-3) Collaborated with CDPH and co-hosted IZ Training Webinar on COVID-19 Vaccine/County Updates/VFC Updates on March 17th; 113 participants attended 1-4) Co-Authored Member Newsletter Article on " Back-To -School IZ's" for June article. 2-1) In March, data exchange issue was corrected and vaccination data now uploads automatically reducing the number of error notifications	1-1) Providers are still dealing with COVID-19, COVID-19 Vaccine rollouts, reduced staffing. 1-2) Hesitancy from parent/guardians to resume care in office. 2-1) Getting data from OSIS, Castle's System Admin vendor. Luckily, we have received data from RIDE, that should suffice. 2-2) Lack of engagement with the CFHC team due to other clinic priorities which prompted a technical assistance call with HSAG/DHCS. They were understanding and provided us with flexible deadlines and options to pursue further engagement with the clinic was not possible.	1-1) Continue promotion of IZ Member Incentives. 1-2) IZ promotion on Facebook during National Infant Immunization Week (end of April) 1-3) Once Flu second dose MI is approved from DHCS being implementation of communication plan. 1-4) Virtual IZ Training on Back-to-School IZ's and Vaccine Hesitancy on 6/10/21. 2-1) Decided to use the data exchange correction as our first intervention, and will need to HSAG/DHCS approval.

2nd Quarter	1) In 2021 increase Merced County CIS rate from 19.71% to 24.71% 2) By Dec 2022, increase CFHC CIS rate from 12.22% to 19.51%.	1) 18.04% (6/30/2021); lower than baseline. 2) 12.61% (6/30/21); increase of 0.4 percentage points from baseline.	1-1) Application for a new member incentive to focus on CIS Flu 2nd Dose was submitted to DHCS for review & approval. 1-2) Collaborated with CDPH and co-hosted IZ Training Webinar on Back to School IZ & Vaccine Hesitancy on June 10th; 78 participants attended 1-3) Co-Authored article on " Back-To -School IZ's" for June bulletin of the Beat. 2-1) Module 3 (Intervention 1) approval received from HSAG/DHCS. 2-2) Module 4 (PDSA 1 Cycle 1) completed. 2-3) Working with data analytics team to create control charts to monitor data feed from SJCPHS immunization registry, piloting with 0-2 year old's.. 2-4) Starting the planning phase for next PDSA intervention.	1-1) Providers are still challenged with COVID-19 vaccine efforts and reduced staffing. 1-2) Hesitancy from parent/guardians to resume care in office. Provider and staff inadequacy in addressing vaccine hesitancy with patients. 2-1) Limited engagement from the CFHC team due to other clinic priorities.	1-1) Continue promotion of IZ Member Incentives. 1-2) IZ promotion on Facebook during National Immunization Month (August) 1-3) Once Flu second dose member incentive is approved from DHCS, begin implementation of communication plan. 1-4) Back to School IZ Banner in Merced on G St from 7/11-7/19 and in front of CCAH entrance the whole month of July. 1-5) Virtual IZ Training on Flu Season & Co-administration of IZ's on 9/2/21. 2-1) Schedule next meeting (in person) to discuss second intervention ideas.
3rd Quarter	1) In 2021 increase Merced County CIS rate from 19.71% to 24.71% 2) By Dec 2022, increase CFHC CIS rate from 12.22% to 19.51%.	1) 18.79% (9/30/21);slight increase from 6/30/21 but less than baseline. 2) 15.38% (9/30/21); increase of 3.14 percentage points from baseline	1-1) New member incentive, CIS Flu 2nd Dose, was launched 9/1! Promotional materials completed by end of Q3 for use in Q4 and beyond. 1-2) Collaborated with CDPH and co-hosted IZ Training Webinar on Flu Season & shot, coadministration w/ Covid-19 vaccine on Thursday, Sept 2nd; 68 participants attended 1-3) Co-Authored article on " Flu" for September Provider bulletin. 2-1) In-person meeting 7/15/21, CFHC focused on 0-2yo preventive care catch-up; holding Saturday clinic and seeing about 40 pts/day; new call center opening 9/2021; implementing more pt engagement tools i.e. texting 2-2) Member incentive info shared. Provided patient educational materials (posters and flyers) for exam rooms and front office. 2-3) Team identified importance of educating provider and staff first re: flu vaccine, expressed interest in holding staff training with Alliance and CDPH support. 2-4) Alliance CMO met with the COO at CFHC to disucss project, low vaccination rates, and to work on re-engaging their team in the project 2-5) 9/28/21 cJOC meeting, COO at CFHC committed support for CIS PIP and requested to schedule a meeting to discuss next steps.	1-1) Providers remain challenged with COVID-19 vaccine efforts and loss of staffing due to the pandemic and heightened by vaccine mandates. 1-2) Hesitancy from parent/guardians to resume care in office continues to be a factor. Provider and staff inadequacy in addressing vaccine hesitancy and co-administration with patients. 2-1) Limited engagement from the CFHC team	1-1) Continue promotion of IZ Member Incentives. 1-2) Planning in Q4 for 2022 IZ Trainings 1-3) Communication plan for CIS 2nd Flu Dose incentive finalized in Sept. Promotion included with Flu season campaign. 2-1) Working to schedule next meeting with project and sponsor team to discuss second intervention ideas.
4th Quarter	1) In 2021 increase Merced County CIS rate from 19.71% to 24.71% 2) By Dec 2022, increase CFHC CIS rate from 12.22% to 19.51%.	1) 17.52% (12/31/21) slight decrease from Q3 and less than baseline. 2) 17.42% (12/31/21); increase of 5.2 percentage points from baseline	1-1) Promotion of our new Flu 2nd Dose member incentive via FB post, and Provider e-blast. 1- 2) Completed 1 external training on Immunizations & iz member incentives for Community Health Workers. 1-3) First set of raffle winners were selected for Flu Second Dose member incentive for month of Sept & Oct. 1-4) Scheduled 2022 Meeting dates with Steve Vantine @ CDPH for Feb, April, and Sept. 2-1) Completed control chart project (started Qtr 2) to monitor data feed from SJCPHS immunization registry to easily identify unfavorable trends.	1-1) Providers remain challenged with staffing shortages and Omicron surge 1-2) Hesitancy from parent/guardians to resume care in office continues to be a factor. Provider and staff inadequacy in addressing vaccine hesitancy and co-administration with patients. 2-1) Multiple attempts to schedule a meeting with CFHC were unsuccessful 2-2) limited engagement from the CFHC team	1-1) Continue promotion of Flu Second Dose member Incentive through Q1 2022. 1-2) Promotion of first IZ training scheduled on 4/27/22 1-3) Brainstorm other possible CIS initiatives for 2022. 2-1) Considering alternative options, including changing project to a health plan intervention in order to complete the required DHCS PIP. (Alt option: Alliance presence at immunization clinic to give member covid-19 incentive giftcards - promote covid and other immunizations)

Year End	1) In 2021 increase Merced County CIS rate from 19.71% to 24.71% 2) By Dec 2022, increase CFHC CIS rate from 12.22% to 19.51%.	1) 17.52% (12/31/21) decrease of 2.19 percentage points from baseline. 2) 17.42% (12/31/21); increase of 5.2 percentage points from baseline	1-1) Created, launched and promoted new Flu 2nd Dose member incentive for our CIS (7-24 month old) population. Three raffles completed by year-end 2021. 1-2) Recognized opportunity for provider, member and staff education; utilized fax blasts, member and provider bulletins, and Communications Team for broad promotion. 1-3) Collaborated with CDPH and co-hosted 3 IZ Training Webinars in March, June and September 2021. 2-1) In response to DHCS submission requirements for 2021-2022: CIS PIP Modules 3 and 4 were completed for Intervention 1 (repair data feed between clinic and SJCPHS registry). 2-2) Completed control chart project (started Qtr 2) to monitor data feed from SJCPHS immunization registry to easily identify unfavorable trends 2-4) Utilized cJOC meetings and c-level leadership to engage with CFHC; limited result and lack of engagement from CFHC remained through 2021.	1-1) Provider offices staffing and their bandwidth has been continually challenged throughout 2021 due to Covid-19 1-2) Parent hesitation to bring children in for care amidst a pandemic. 2-1) Almost no engagement from the CFHC team; can be attributed to many factors i.e., Covid pandemic, inability to meet in-person, differing priorities, limited staff, and staff burnout.	1-1) Continue promotion of 2nd Flu Dose incentive through 2021-2022 Flu Season (May 2022). Perform analysis and make proposal to continue incentive into 2022-2023 Flu Season. 1-2) Continue to offer trainings to providers, members and Alliance staff as needs arise/are identified. 1-3) Continue work with CDPH and host 2 Immunization Training Webinars in 2022. 2-1) Considering alternative options, including changing project to a health plan intervention in order to complete the required DHCS PIP. Perhaps utilize direct member incentives and focus on Covid-19 boosters. 2-2) Pending leadership approval, support member and provider immunization incentives throughout 2022

B. Child and Adolescent Well Care Visits

Project Description and Goals:

Purpose: Using Associates in Process Improvement (API) Model for Improvement, effectively increase and enhance child and adolescent well-care visits in Merced County by testing changes on a small-scale using Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning and evaluation.

Strategic priority: Statewide Department of Healthcare Services (DHCS) Performance Improvement Project (PIP).

Goal/SMART Aim:

By December 31, 2022, CCAH aims to increase the percentage of child and adolescent members 3-17 years of age, linked to Golden Valley Health Center - Los Banos clinic, who receive at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the intervention period, from 32.65% to 48.56% (rate of peer benchmark [Taylor Farms Family Health and Wellness Center - Gonzales, CA] in Monterey/reference county).

Activities:

In collaboration with partnering clinical site (Golden Valley Health Center), complete the following DHCS/HSAG deliverables:

- Build internal and external PIP Teams and establish SMART Aim.
- Complete a process map, analyze failure modes and effects, identify interventions, and develop a key driver diagram.
- Plan intervention(s), effectiveness measure(s) and data collection process(es), test intervention(s), measure, monitor and analyze results, and evaluate intervention effectiveness (PDSA).
- Interpret overall results, assess successes, challenges and lessons learned, and evaluate potential for sustainability and spread."

2021 Evaluation

Review Period	Goal	Results	Key Accomplishments this Period	Issues	Next Steps
1st Quarter	1) By Dec 2022, increase GVHC Los Banos WCV ages 3-17 rate from 32.65% to 48.56%	1) Rate for Q1: 29.7% (PIP was not initiated yet, DHCS approved PIP in April 2021)	1-1) Built an internal & external (GVHC) PIP Team 1-2) Selected a clinic site to work with and established our SMART Aim 1-3) Completed all Module 1 deliverables 1-4) Submitted to DHCS/HSAG by due date of 3/26/21 for review/approval	1) GVHC has had other priorities due to COVID-19 Vaccine rollout and preparation to switch EHR system from NextGen to Epic; limited availability to meet.	1) Once Module 1 is approved, begin to track monthly rate and work on Module 2 deliverables/requirements.
2nd Quarter	1) By Dec 2022, increase GVHC Los Banos WCV ages 3-17 rate from 32.65% to 48.56%	1) Q2 rate: 30.62%	1-1) DHCS Approved Module 1 in April. 1-2) DHCS gave us a due date of 6/4/21 to complete Module 2. However, due to conflicting priorities with GVHC, DHCS granted an extension until Sept 3, 2021 to submit Module 2 deliverables. 1-3) Have been meeting weekly with GVHC to complete deliverables	1) GVHC has had other clinic priorities including working on glitches of new EHR system, Epic and at times have limited availability to meet and work on this project.	1) Complete Module 2 deliverables by Sept 3rd deadline.
3rd Quarter	1) By Dec 2022, increase GVHC Los Banos WCV ages 3-17 rate from 32.65% to 48.56%	1) Q3 rate: 33.57%	1-1) Completed Process Map & FMEA deliverables for Module 2. 1-2) Submitted Module 2 on 9/2/21	1-1) GVHC was meeting on a weekly basis thru first week of August, they have other priorities and limited availability to meet.	1-1) After Module 2 approval, need to select an intervention for Module 3.
4th Quarter	1) By Dec 2022, increase GVHC Los Banos WCV ages 3-17 rate from 32.65% to 48.56%	1) Q4 rate not available; December preliminary rate was: 33.18% (Does not include 30 day claim lag)	1-1) Module 2 was approved by DHCS in October 1-2) Module 3 due date was assigned for November 17th.	1-1) Unable to meet with GVHC due to scheduling conflicts and staff changes. 1-2) Had to request extension for Module 3 submission date; approved new due date 2/18/22.	1-1) Next meeting scheduled for 1/7/22; new staff from GVHC will be joining the PIP team. 1-2) Select an intervention and submit Module 3 deliverables on or before 2/18/22.
Year End	1) By Dec 2022, increase GVHC Los Banos WCV ages 3-17 rate from 32.65% to 48.56%	1) Preliminary year end rate is 33.18% (this does not include 30 day lag). Slight increase of 0.53 percentage points from baseline.	1) We were able to complete Module 1 & 2 in 2021.	1) Due to GVHC having other priorities such as dealing with COVID-19 surges, New EHR system, staff shortages/and changes, limited the availability to meet regularly.	1-1) PIP Team will meet again in January to discuss intervention ideas for Module 3 and collect information needed to submit deliverables by due date of 2/18/21 1-2) Goal for 2022 is to test several interventions to help increase WCV and hit our target rate by 12/31/22

C. PDSA: Breast Cancer Screening and COVID QIP
Project Description and Goals:

Purpose: To complete: (1) two DHCS imposed PDSA cycles for a single underperforming MCAS measure in Merced county by 6/02/2021, and (2) three interventions/strategies aimed at increasing the provision of preventive services, behavioral health services, and/or chronic disease care, for members amidst COVID-19.

Strategic priorities: By 12/31/2020, complete first cycle PDSA intervention of one provider site, Gettysburg Medical Clinic. By 6/02/2021, perform second PDSA cycle intervention based on outcomes of first cycle results. Satisfy DHCS's requirements of submitting a brief COVID-19 Quality Improvement Plan (COVID-19 QIP).

Goals:

- PDSA - Increase breast cancer screening rate by 5% of targeted provider site, Gettysburg. QIP - By 3/1/2021, submit a 6-month progress update to DHCS on the COVID-19 strategies implemented.

Activities:

- PDSA - Standing order provided to Gettysburg Medical Clinic, establishing the clinical protocol for staging and completing screening events for Alliance members. Roster provided to Gettysburg of 56 eligible members to be screened. Gettysburg to perform chart review for eligibility based on most recent PCP visit and details captured in tracking spreadsheet. Referrals to be sent to El Portal Imaging Center, an Alliance partnered service provider, and bi-monthly meetings to be held with EL Portal to capture, track, and assess metrics on rate of screening completion of members confirmed for screening.
- COVID QIP: Resuming preventive care during COVID-19 pandemic: Pull various MCAS measure data to analyze intervention impact. Aggregate information and submit to DHCS.

2021 Evaluation

Review Period	Goal	Results	Key Accomplishments this Period	Issues	Next Steps
1st Quarter	1) By 3/1/2021, submit a 6-month progress update to DHCS on the strategies implemented to satisfy the COVID-19 QIP. 2) By 2/2/2021, complete PDSA cycle 1 intervention to improve the breast cancer screening rate by 10% at Gettysburg Medical Clinic and submit to DHCS for approval. 3) By 6/2/21 complete PDSA cycle 2 intervention to improve the breast cancer screening rate by 15% at Apex Medical Group	1) Goal met 2) Goal met - The breast cancer screening compliance rate improved from 26.89% to 39.50% at Gettysburg Medical Clinic, exceeding the 10% goal. 3) N/A	1) Results of the COVID-19 QIP interventions were summarized and submitted to DHCS. 2) Completed PDSA cycle 1 intervention with DHCS approval. 3) Provider selection for PDSA Cycle 2 intervention completed. Intervention kicked off.	1) DHCS responded with a few question on 3/8/21. Response to questions were provided on 3/10/21. Responses were accepted by DHCS on 3/10/21. 2) No issues. 3) No issues.	1) Goal met, there is no additional submissions requested at this time. 2) No further action required. 3) Complete intervention activities for PDSA cycle 2 and submit results to DHCS by 6/2/2021.
2nd Quarter	1) By 3/1/2021, submit a 6-month progress update to DHCS on the strategies implemented to satisfy the COVID-19 QIP. 2) By 2/2/2021, complete PDSA cycle 1 intervention to improve the breast cancer screening rate by 10% at Gettysburg Medical Clinic and submit to DHCS for approval. 3) By 6/2/21 complete PDSA cycle 2 intervention to improve the breast cancer screening rate by 15% at Apex Medical Group and submit to DHCS for approval 4) By 8/31/21, complete PDSA cycle 3 intervention to improve breast cancer screening rate by	1) Goal met 2) Goal met - The breast cancer screening compliance rate improved from 26.89% to 39.50% at Gettysburg Medical Clinic, exceeding the 10% goal. 3) Goal met - The breast cancer screening compliance rate improved from 60.92% to 77.82% at Apex Medical Group, exceeding the 15% goal. 4) Goal is on target to meet expections.	1) Completed PDSA cycle 2 intervention with DHCS approval 2) PDSA cycle 3 is in beginning stages of project.	No Issues	Continue to monitor providers with low compliance rates for breast cancer screening and disseminate best practices for improvement

3rd Quarter	1) By 3/1/2021, submit a 6-month progress update to DHCS on the strategies implemented to satisfy the COVID-19 QIP. 2) By 2/2/2021, complete PDSA cycle 1 intervention to improve the breast cancer screening rate by 10% at Gettysburg Medical Clinic and submit to DHCS for approval. 3) By 6/2/21 complete PDSA cycle 2 intervention to improve the breast cancer screening rate by 15% at Apex Medical Group and submit to DHCS for approval 4) By 8/31/21, complete PDSA cycle 3 intervention to improve	1) Goal met 2) Goal met - The breast cancer screening compliance rate improved from 26.89% to 39.50% at Gettysburg Medical Clinic, exceeding the 10% goal. 3) Goal met - The breast cancer screening compliance rate improved from 60.92% to 77.82% at Apex Medical Group, exceeding the 15% goal. 4) Goal met - the breast cancer screening compliance rate improved by 13% thus exceeding the 10% goal of improvement.	In response to new DHCS submission requirements for 2021-2022: 1) Completed initial submission for the COVID QIP to DHCS. 2) Completed PDSA cycle 3 intervention with DHCS approval and achieved a further improvement of 13% in the screening compliance rate at Gettysburg Medical Clinic, exceeding the 10% improvement goal..	No Issues	1) Implement identified strategies for the COVID QIP. 2) Select clinic site for PDSA Cycle 4 intervention 3) Begin intervention activities for PDSA Cycle 4
4th Quarter	1) By 3/1/2021, submit a 6-month progress update to DHCS on the strategies implemented to satisfy the COVID-19 QIP. 2) By 2/2/2021, complete PDSA cycle 1 intervention to improve the breast cancer screening rate by 10% at Gettysburg Medical Clinic and submit to DHCS for approval. 3) By 6/2/21 complete PDSA cycle 2 intervention to improve the breast cancer screening rate by 15% at Apex Medical Group and submit to DHCS for approval 4) By 8/31/21, complete PDSA cycle 3 intervention to improve breast cancer screening rate by	1) Goal met 2) Goal met - The breast cancer screening compliance rate improved from 26.89% to 39.50% at Gettysburg Medical Clinic, exceeding the 10% goal. 3) Goal met - The breast cancer screening compliance rate improved from 60.92% to 77.82% at Apex Medical Group, exceeding the 15% goal. 4) Goal met - the breast cancer screening compliance rate improved by 13% thus exceeding the 10% goal of improvement.	In response to new DHCS submission requirements for 2021-2022: PDSA cycle 4 is in progress with DignityHealth Medical Foundation in Merced with an improvement goal of 10%	No Issues	1) Complete PDSA cycle 4 and submit documention to DHCS for approval. 2) Select clinic site for PDSA Cycle 5 intervention. 3) Begin intervention activities for PDSA Cycle 5.
Year End	1) By 3/1/2021, submit a 6-month progress update to DHCS on the strategies implemented to satisfy the COVID-19 QIP. 2) By 2/2/2021, complete PDSA cycle 1 intervention to improve the breast cancer screening rate by 10% at Gettysburg Medical Clinic and submit to DHCS for approval. 3) By 6/2/21 complete PDSA cycle 2 intervention to improve the breast cancer screening rate by 15% at Apex Medical Group and submit to DHCS for approval 4) By 8/31/21, complete PDSA cycle 3 intervention to improve breast cancer screening rate by 10% at Gettysburg Medical Clinic and submit to DHCS for approval.	1) Goal met 2) Goal met - The breast cancer screening compliance rate improved from 26.89% to 39.50% at Gettysburg Medical Clinic, exceeding the 10% goal. 3) Goal met - The breast cancer screening compliance rate improved from 60.92% to 77.82% at Apex Medical Group, exceeding the 15% goal. 4) Goal met - the breast cancer screening compliance rate improved by 13% thus exceeding the 10% goal of improvement.	1) Completed initial submission for the COVID QIP to DHCS. 2) PDSA cycle 1 completed with Gettysburg Medical Clinic. 3) PDSA cycle 2 completed with Apex Medical Group. 4) PDSA cycle 3 completed with Gettysburg Medical Clinic. 5) PDSA cycle 4 in progress with Dignity Health Medical Foundation.	No Issues	1) Complete PDSA cycle 4 with Dignity Health Medical Foundation and submit documention to DHCS for approval. By 01/31/2022. 2) Select clinic site for PDSA Cycle 5 intervention. 3) Begin intervention activities for PDSA Cycle 5.

D. Healthier Living Program

Project Description and Goals:

Purpose: To increase member self-efficacy in performing self-management behaviors by having member participate in the Alliance Healthier Living Program. (Chronic Disease Self-Management Program)

Strategic priorities: By 12/31/2021 at least 50% of participants will have scored "Good/Very Good/Excellent" for their "Overall Health" and "Quality of Life."

Goals:

- To increase member reporting favorable "Overall Health" and "Quality of Life"

-The % of members who participate in the Healthier Living Program and who report "Good/Very Good/Excellent" for their ability to manage their chronic health condition after the workshop.

-Members' self-reported pre and post surveys.

- To increase referrals to HLP
- To expand the quality improvement system in the community by having greater presence and promoting Alliance quality initiatives related to wellness and health promotion.

Activities:

- Increase program participation to the Healthier Living Program workshop by prompting the member incentive and by offering different format options. (telephonic and virtual)
- Promote member incentives
- Align, engage, and track participation of QI/PH staff in Health Care Collaboratives (HCC) and actively promote Alliance quality initiatives in the community.

2021 Evaluation

Review Period	Goal	Results	Key Accomplishments this Period	Issues	Next Steps
1st Quarter	50%	75%	1) Members reported benefiting the most from the weekly action planning, building communication skills, and gaining motivation to work on managing their condition. 2) Members reported via group feedback discussion that they felt connected, supported, and understood by their facilitators (Alliance Health Educators). 3) Member Voice: -*"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"*	1) Occasionally the Go-To-Meetings (GTM) would have connection issues. This intervention is currently held via conference call only and there were occasional issues for members calling into the GTM phone number. 2) Members reported they would like longer workshop sessions to work in more detail with key topics. 3.) Participating members also shared the idea of exploring zoom options to allow them to see each other.	1) The Chronic Disease Management Health Educators will conduct a member needs assessment to explore member feedback and readiness in offering the workshops virtually such as zoom. 2) Helpdesk tickets are submitted for GTM and phone system when issues occur. As a workaround, the QHP Health Educators who are not conducting the workshops are available to work with members on troubleshooting any call-in challenges.
2nd Quarter	50%	67%	1) One members during this quarter expressed an interest in video or in-person option. 2) Other members also expressed the need for more time to discuss weekly action plans. 3) Another requested different times of day options. 4) Member Voice: *- I did enjoy the education and learning how to manage my health and how to advocate for myself.* *-Time went by fast during the workshop. They should be longer so we can talk more and hear everyone's weekly*	1.) Members expressed video or in-person is a preferred method for the delivery of these workshops.	1.) Preparing for virtual HLP workshops to take place in Q3-2021

3rd Quarter	50%	60%	1) Health Educators completed their training practice and will launch virtual sessions in Q4-2021 2) Members have expressed gratitude for workshops and have felt supportive during this time of the pandemic 3) Member Voice: *-I think the information that helped me was learning to be organized and also learning how to set goals towards moving forward in my life. The book provides a lot of information that is laid out nicely and helps to understand my disease. It was also nice to hear others and how they deal with their illness, I felt less overwhelmed.* *-I learned that being mindful of my everyday activities will help me be able to make healthier choices. I also liked the section on how to prepare for a doctor's appointment. I found the communication section helpful as well.* *- With this workshop, I learned to use my words and feeling when I was depressed. My action plans were the best part of the workshop.*	1) Occasionally the Allaince phone systems would have connection issues. This intervention is currently held via conference call and there were occasional issues for members calling into the phone number.	1.) Preparing for virtual HLP workshops to take place in Q4-2021
4th Quarter	50%	56%	1) Launch 1st virtual HLP workshops that took place in Q4-2022 2) In Q4-2021, we added a vitural approach to our HLP program. 3) We focused on continuing the program telephonically and as we transition to a virtual platform. 4) Member Voice: *-Everything was so helpful and I appreciated all the support the group offered and advice. I liked making action plans each week and trying different techniques to manage my health.* *-With this workshop I learned to use my words and feeling when I was depressed.* *-It was also nice to hear others and how they deal with their illness, I felt less overwhelmed.* *-It was also nice to hear others and how they deal with their illness, I felt less overwhelmed*	1) Occasionally the Allaince MS system would have connection issues.	1.) Preparing for virtual HLP workshops to take place in 2022.

Year End	50%	65%	1) Members have expressed gratitude for workshops and have felt supportive during this time of the pandemic 2) Total of 9 workshops during CY 2021, of which 8 were telephonic and 1 virtual. As for language, 6 were done in English and 3 were done in Spanish. We had a total of 24 members who completed all 6 weekly sessions. 3) HLP participants top 5 chronic condition(s) self-identified -Type 2 diabetes -Anxiety or other emotional/mental health condition -High blood pressure -Arthritis or other rheumatic disease -Depression -Other chronic condition (anything not listed in the survey) 4) Alliance members provide feedback regarding HLP via pre and post program surveys. Health Educators complete surveys over the phone with members prior to starting and after the program ends. Health Educators collect group feedback during the last session of each series.	1) Address some of the system issues that occurred in CY 2021	1.) Increase promotion of the HLP programs with providers. Due to COVID-19, many providers are currently impacted. Providers are focused on testing and vaccination due to COVID-19. 2) Preparing for telephonic, in-person, and virtual HLP workshops to take place in CY 2022 (offer more formats to offer program)

II. Operational Performance

A. Facility Site Review (FSR) Management

Project Description and Goals:

- 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date.
- 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days
- 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. (MMCD Policy Letter 14-004 pages 8-9).
- 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by the FSR team. (MMCD Policy Letter 14-004 pages 8-9).

Activities:

- Promote FSR video
- Monitor and comply with DHCS FSR/MRR flexibilities or requirements as communicated during the pandemic.

2021 Evaluation

Review Period	Goal	Results	Key Accomplishments this Period	Issues	Next Steps
1st Quarter	1) 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days 3) 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar	1) 100% (5 of 5) of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) 100% (1 of 1) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days 3) 60% (3 of 5) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 80% (4 of 5) of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as	1) Outreach templates to help providers feel prepared for upcoming reviews were updated, which encouraged agreement to timely scheduling; 2) Extensions of the 45 and 90 day requirements were provided according to APL 20-011; 3) Continue to participate in the California health plan collaborative to create a webinar to educate providers on the updated All Plan Letter 20-006; and 4) Work with other departments within Quality Improvement and Population Health to identify PCP sites which might need targeted intervention and additional resources such as Practice Coaching or CBI Forensics.	1) Staff shortages in response to COVID, such as turnover and absence for childcare, delayed the provider's implementation of CAPs	1) Continue to monitor All Plan Letter 20-011 and other All Plan Letter correspondence to ensure compliance with state requirements; 2) Continue to work with the California health plan collaborative to create a webinar to educate providers on the updated All Plan Letter 20-006; and 3) Work with Alliance's communications to release the HIP educational resource to prepare providers to receive higher FSR scores and reduce the chance of a CAP.

2nd Quarter	1) 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days 3) 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar	1) 100% (19 of 19) of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) 100% (2 of 2) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days 3) 100% (9 of 9) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 89% (8 of 9) of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as	1) All providers agreed to conduct timely remote reviews; and 2) The 45 and 90 day requirements were met; 3) Continue to participate in the California health plan collaborative to create a webinar to educate providers on the updated All Plan Letter 20-006; and 4) Continue to work with other departments within Quality Improvement and Population Health to identify PCP sites which might need targeted intervention and additional resources such as Practice Coaching or CBI Forensics; and 5) Release of the HIP educational resource to prepare providers to receive higher FSR scores and reduce the chance of a CAP.	1) PCP office with many providers and support staff conduct many small trainings to address CAPs in order to prevent large staff gathering in compliance with reducing risk of COVID transmission. This created an extended timeline for CAP implementation of a site who had a large CAP due to a failed Medical Record Review.	1) Continue to monitor All Plan Letter 20-011 and other All Plan Letter correspondence to ensure compliance with state requirements; and 2) Continue to work with the California health plan collaborative to create a webinar to educate providers on the updated All Plan Letter 20-006.
3rd Quarter	1) 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days 3) 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar	1) 60% (12 of 20) of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) 0% (0 of 1) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. 3) 100% (12 of 12) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 92% (12 of 13) of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as	1) Providers have demonstrated that they are able to submit their plan of action within 45 days; and 2) The DHCS has issued an implementation date for APL 20-006, which is set to go into effect January 2022. This gives the site review team clear goals for submitting updated policies for approval and ensuring the updated templates and tools are ready to implement.	1) With the temporary suspension of contractual requirements for in-person site reviews, per All Plan Letter 20-011, the Facility Site Review team has taken into consideration our PCP's requests to postpone reviews and extensions on CAP due dates during this difficult time when provider offices are short staffed, undergoing personal health challenges, experiencing environmental concerns within their offices, facing resource shortages such as oxygen, and converting to new EMRs.	1) Create a plan to ensure the smooth transition from Policy Letter 14-004 to All Plan Letter 20-006; 2) Collaborate with Provider Services to ensure that all providers are updated on the new USPSTF requirements that will be implemented in the FSR and MRR tool in January; 3) Collaborate with IT and other departments who access the FSR tracker to ensure that the transition to data reporting through the the Managed Care Quality and Monitoring Division (MCQMD) Site Review Portal (MSRP) is successful; and 4) Collaborate with Practice Coaching and Provider Services to prepare for an influx in Corrective Action Plans (CAPs) due to the new FSR requirements.

4th Quarter	1) 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days 3) 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 100% of practices with a CAP arising from FSR	1) 80% (4 of 5) of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) N/A, No Critical Elements Corrective Action Plans (CE CAPs) were issued this quarter. 3) 100% (4 of 4) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 80% (4 of 5) of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as	1) Update Tools and Resources to prepare for the implementation of the All Plan Letter 20-006; 2) Provide DHCS with feedback on the new FSR Guidelines and Standards; 3) Conduct five past due site reviews, some of which were previously declined by the PCP but reconsidered when offered alternative virtual options; and 4) Continue to collaborate in the creation of a PCP facing FSR educational video produced by an MCP collaborative and endorsed by DHCS.	1) After preparation, the APL 20-006 has been postponed and virtual reviews have been extended by DHCS. Scheduled sites have been notified; 2) PCP sites continue to experience issues with reduced staffing and additional focus on pandemic related care; and 3) The Project Specialist that was offering FSR support is no longer available to support the team.	1) Assist in onboarding the new team member and evaluate for continued training needs; 2) Continue to collaborate in the creation of a PCP facing FSR educational video produced by an MCP collaborative and endoresed by DHCS; 3) Continue to work with the California health plan collaborative to create a webinar to educate providers on the updated All Plan Letter 20-006; and 4) Create job aids, provider resources, and databases to maximize primary care providers' operations, assist with timely CAP closures, and ensure timely access.
Year End	1) 100% of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) 100% of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days 3) 100% of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 100% of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by	1) 82% (40 of 49) of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date 2) 86% (6 of 7) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days 3) 93% (28 of 30) of practices with a Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. 4) 88% (28 of 32) of practices with a CAP arising from FSR complete all planned actions within 90 calendar days as evidenced by verification by	1) Update Tools and Resources to prepare for the implementation of the All Plan Letter 20-006 and updated FSR Standards and Guidelines; 2) Provide DHCS with feedback on the new FSR Guidelines and Standards; 3) Continue to make progress on past due site reviews by offering alternative virtual options; 4) Continue to collaborate in the creation of a PCP facing FSR educational video produced by an MCP collaborative and endorsed by DHCS. 5) Participation in the California health plan collaborative to create a webinar to educate providers on the updated All Plan Letter 20-006; 6) Work with other departments within Quality Improvement and Population Health to identify PCP sites which might need targeted intervention and additional resources such as Practice Coaching or CBI Forensics; and 7) Extensions of the 45 and 90 day requirements were provided according to APL 20-011.	1) PCP offices with many providers and support staff conduct many small trainings to address CAPs in order to prevent large staff gathering in compliance with reducing risk of COVID transmission. This created an extended timeline for CAP implementation. 2) With the temporary suspension of contractual requirements for in-person site reviews, per All Plan Letter 20-011, the Facility Site Review team has taken into consideration our PCP's requests to postpone reviews and extensions on CAP due dates during this difficult time when provider offices are short staffed, undergoing personal health challenges, experiencing environmental concerns within their offices, facing resource shortages such as oxygen, and converting to new EMRs; and 3) After preparation, the APL 20-006 has been postponed and virtual reviews have been extended by DHCS. Scheduled sites have been notified.	1) Assist in onboarding the new team member and evaluate for continued training needs; 2) Continue to collaborate in the creation of a PCP facing FSR educational video produced by an MCP collaborative and endorsed by DHCS; 3) Continue to work with the California health plan collaborative to create a webinar to educate providers on the updated All Plan Letter 20-006 including new Standards and Guidelines; 4) Create job aids, provider resources, and databases to maximize primary care providers' operations, assist with timely CAP closures, and ensure timely access; 5) Continue to monitor All Plan Letter 20-011 and other All Plan Letter correspondence to ensure compliance with state requirements; 6) Collaborate with Provider Services to ensure that all providers are updated on the new USPSTF requirements that will be implemented in the FSR and MRR tool pending the DHCS release; 7) Collaborate with IT and other departments who access the FSR tracker to ensure that the transition to data reporting through the the Managed Care Quality and Monitoring Division (MCQMD) Site Review Portal (MSRP) is successful; and

B. Grievance and PQI Management

Project Description and Goals:

- 100% of Potential Quality Issues (PQI) completed within 90 calendar days of receipt.
- Quality Improvement (QI) nurse to route 100% of grievances related to medical quality of care issues to the Medical Director. Conduct an inter-rater reliability audit on a quarterly basis.

Activities:

- Facilitate continuous quality improvement practices for grievances and PQI trends through cross-collaborative discussion and actions for improvement.
- Enhance Quality CAP process (i.e. high-risk provider issues/trends, involved departments, escalation)

2021 Evaluation

Review Period	Goal	Results	Key Accomplishments this Period	Issues	Next Steps
1st Quarter	1.) 100% 2.) 100%	Data as of 4/12/2021 1.) 135/137 (99%) of PQIs were completed within 90 calendar days; and 2.) 87/87 (100%) of member grievances received by QI related to potential medical quality of care issues shall be referred to the Medical Director	1.) The quarterly MD IRR of member complaints resolved by RNs resulted in 100% approval, indicating that cases are being appropriately routed to MD for oversight; and 2.) MD peer to peer IRR of member complaints resulted in 100% agreement, indicating Medical Directors are resolving cases with consistent methodology; and 3.) Established a virtual and in-person PQI closure workflow and meeting cadence that increases efficiency; and 4.) Successfully onboarded two additional Medical Directors to the member grievance and PQI process; and 5.) All member Grievances opened as PQIs in Q1-21 were closed within Grievance's timeframes (25 days or less). N=60.	1.) Team continues to work with reduced staffing due to LOA/pandemic.	1.) Continue to collaborate with Member Services regarding PQI/Member Grievance TAT and MD/QI resolution language; and 2.) Begin planning for and initiating an MD peer-to-peer IRR of PQIs to ensure cases are rated consistently between multiple MDs; and 3.) Further develop PPC and Hospital/SNF track & trend.
2nd Quarter	1.) 100% 2.) 100%	Data as of 7/13/2021 1.) 170/170 (100%) of PQIs were completed within 90 calendar days; and 2.) 118/118 (100%) of member grievances received by QI related to potential medical quality of care issues shall be referred to the Medical Director	1.) The quarterly MD IRR of member complaints resolved by RNs resulted in 100% approval, indicating that cases are being appropriately routed to MD for oversight; and 2.) MD peer to peer IRR of PQIs resulted in 100% agreement, indicating Medical Directors are resolving cases with consistent methodology; and 3.) All member grievances opened as PQIs in Q2-21 were closed within Grievance's timeframes (25 days or less). N=120.	1.) Team has 1 FTE on LOA and currently has (1) temp .5 FTE backfill and another temp .5 FTE starting mid-August.	1) Onboard temp RN to assist with processing cases; and 2) Continue to collaborate with Member Services and OpEx regarding PQI/Member Grievance TAT and MD/QI resolution language.
3rd Quarter	1.) 99% 2.) 100%	Data as of 10/27/2021 1.) 134/135 (99%) of PQIs were completed within 90 calendar days; and 2.) 97/97 (100%) of member grievances received by QI related to potential medical quality of care issues shall be referred to the Medical Director	1.) The quarterly MD IRR of member complaints resolved by RNs resulted in 97% approval, indicating that cases are being appropriately routed to MD for oversight; and 2.) MD peer to peer IRR of PQIs resulted in 100% agreement, indicating Medical Directors are resolving cases with consistent methodology; and 3.) All member grievances opened as PQIs in Q3-21 were closed within Grievance's timeframes (25 days or less). N=103.	1) Clinical team operating with 1 FTE and .5 temp FTE.	1) Onboarding .75 and (borrowed / internal staff) .5 FTE. Opening recruitment for .75 FTE currently posted.

4th Quarter	1.) 97% 2.) 100%	Data as of 1/27/2022 1.) 100/103 (97%) of PQIs were completed within 90 calendar days; and 2.) 84/84 (100%) of member grievances received by QI related to potential medical quality of care issues shall be referred to the Medical	1.) The quarterly MD IRR of member complaints resolved by RNs resulted in 100% approval, indicating that cases are being appropriately routed to MD for oversight; and 2.) MD peer to peer IRR of PQIs resulted in 91% agreement, indicating Medical Directors are resolving cases with consistent methodology; and 3.) All member grievances opened as PQIs in Q4-21 were closed within Grievance's timeframes (25 days or less). N=85.	1) Clinical team operating with 1.0 FTE and .5 temp FTE. 2) One case identified in the MD peer-to-peer IRR of PQIs for P level revision. Case brought back to MDs for discussion in track & trend meeting.	1) Onboarding .5 FTE (internal QI RN position moved .5 to PQI team). Open recruitment for .4 QI RN positions (1 senior QI RN FTE, .5 senior QI RN FTE and 2 QI RN FTEs)
Year End	1.) 99% 2.) 100%	Data as of 1/27/2022 1.) 539/545 (99%) of PQIs were completed within 90 calendar days; and 2.) 386/386 (100%) of member grievances received by QI related to potential medical quality of care issues shall be referred to the Medical	1.) The quarterly MD IRR of member complaints resolved by RNs resulted in 99% approval, indicating that cases are being appropriately routed to MD for oversight; and 2.) MD peer to peer IRR of PQIs resulted in 98% agreement, indicating Medical Directors are resolving cases with consistent methodology; and 3.) All member grievances opened as PQIs in 2021 were closed within Grievance's timeframes (25 days or less). N=368.	1) Staffing challenges throughout 2021.	1) Onboarding .5 FTE (internal QI RN position moved .5 to PQI team). Open recruitment for .4 QI RN positions (1 senior QI RN FTE, .5 senior QI RN FTE and 2 QI RN FTEs) and Project Specialist. 2) Continue collaboration with OpEx and internal stakeholders regarding the CAP Process; Continue collaboration with Member Grievance Department regarding process improvement opportunities. 3) Continue with MD peer to peer IRRs

C. Cultural and Linguistics Services

Project Description and Goals:

Project Goal: To measure the performance of the Alliance C & L Services program and to make improvements accordingly. Increase Provider Utilization of the Alliance Language Assistance Services program by 5%
-Measure Utilization per County

Project Description:

- Effective communication is critical for our members to ensuring understanding, empowering, and to provide high quality care. The Alliance Language Assistance Services program ensures that Alliance members receive high quality and appropriate language services by reducing health dipartites related to language/cultural barriers.
- Explore the effectiveness of cultural competency services provided by the Alliance in ensuring that member's receive high-quality, person-centered care, and identifying opportunities for improvement where necessary.

Monitoring effectiveness of the program:

Data Collection and Reports

- Monitor telephonic interpreting utilization
- Monitor face-to-face interpreting utilization
- Monitor translations and readability requests

Complaint Process

- Monitor member and provider complaints
- Monitor PQIs

Direct Communication and Feedback

- Development of a Health Literacy Tool kit for the organization
- Provider trainings

Activities:

- Develop Health Literacy Toolkit for the organization (PNA Education Campaign)
- [illegible]

2021 Evaluation

Review Period	Goal	Results	Key Accomplishments this Period	Issues	Next Steps
1st Quarter	**CY 2020 Baseline Goal** Telephonic Interpreter Services Utilization: Providers: 17,527; Staff: 11,298 [Total]: 28,825 Face-to-Face Interpreter Services Utilization: [ASL]: 272; [Non-ASL]: 855 [Total]: 1,127 Translation Services Utilization: [Standard]: 222; [Grievance]: 253 [Total]: 475 Readability Services Utilization: 36	**Q1-2021** Telephonic Interpreter Services Utilization: Providers: 6,366 Staff: 2.409 [Total]: 8,775 Face-to-Face Interpreter Services Utilization: [ASL]: 154 [Non-ASL]: 183 [Total]: 337 Translation Services Utilization: [Standard]: 54 [Grievance]: 78 [Total]: 132 Readability Services Utilization: 18	1.) Telephonic Interpreter Services Utilization: The overall utilization of telephonic interpreting services has significantly increased among providers, Alliance staff, and contracted Alliance vendors. A total of 8,775 telephonic interpreting services calls were reported for measuring Q1 2021 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). This is a 92% increase when compared to the previous Q1 2020 (4,581). 2.) Face-to-Face Utilization: As for face-to-face interpreting services, we had a total of 337 provider requests that were coordinated in Q1 2021 across the Alliance's service areas. This is a 28% decrease when compared to the previous Q1 2020 (471). This could be due to the multiple efforts taken to ensure Alliance members and providers are supported during a telehealth visit. This has emerged as a need due to COVID-19 as many of our provider's transition to telehealth visits that may include phone and video options and may no longer require to have a qualified interpreter to be present. 3.) Translation Services Utilization: The Q1-2021 (132) utilization of translation service increased by 27% when compared to the previous Q1-2020 (87). This was due to the website redesign and COVID-19 related information. The C&L team was able to provide support in coordination and	Face-to-Face Utilization: 1) We face challenges with same day appointments face-to-face interpreter service requests (Approximately, N=10 in Q1 2021) 2) We also face challenges with last minute cancellations. (N=34 in Q1 2021)	1) Implement audio interpreting services by Q3-2021 2) Continue with the development of the Alliance Health Literacy Tool kit for the organization 3) Collaborate with Provider Services in launching the upcoming Cultural Competency Provider Training by Q3-2021 4.) Collaborate with T&D to launch Provider Learning Modules on: C&L Services, Interpreting Services and working with SPD populations by Q4 2021

2nd Quarter	**CY 2020 Baseline Goal** Telephonic Interpreter Services Utilization: Providers: 17,527; Staff: 11,298 [Total]: 28,825 Face-to-Face Interpreter Services Utilization: [ASL]: 272; [Non-ASL]: 855 [Total]: 1,127 Translation Services Utilization: [Standard]: 222; [Grievance]: 253 [Total]: 475 Readability Services Utilization: 36	**Q2-2021** Telephonic Interpreter Services Utilization: Providers: 4,942 Staff: 2,939 [Total]: 7,881 Face-to-Face Interpreter Services Utilization: [ASL]: 86 [Non-ASL]: 209 [Total]: 295 Translation Services Utilization: [Standard]: 87 [Grievance]: 127 [Total]: 214 Readability Services Utilization: 15	1.) Telephonic Interpreter Services Utilization: The overall utilization of telephonic interpreting services decreased among providers, Alliance staff, and contracted Alliance vendors. A total of 7,881 telephonic interpreting services calls were reported for measuring Q2 2021 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). This is a 10% decrease when compared to the previous Q1 2021 (8,775). 2.) Face-to-Face Utilization: As for face-to-face interpreting services, we had a total of 295 provider requests that were coordinated in Q2 2021 across the Alliance's service areas. This is a 12% decrease when compared to the previous Q1 2021 (337). This could be due to the multiple efforts taken to ensure Alliance members and providers are supported during a telehealth visit. This has emerged as a need due to COVID-19 as many of our provider's transition to telehealth visits that may include phone and video options and may no longer require to have a qualified interpreter to be present. 3.) Translation Services Utilization: The Q2-2021 (214) utilization of translation service increased by 62% when compared to the previous Q1-2021 (132). This was due to the website updates and COVID-19 related information. The C&L team was able to provide support in coordination and	1) We also face challenges with last minute cancellations. (N=42 in Q2 2021)	1) Implement audio interpreting services by Q3-2021 2) Continue with the development of the Alliance Health Literacy Tool kit for the organization 3) Collaborate with Provider Services in launching the upcoming Cultural Competency Provider Training by Q3-2021 4.) Collaborate with T&D to launch Provider Learning Modules on: C&L Services, Interpreting Services and working with SPD populations by Q4 2021
3rd Quarter	**CY 2020 Baseline Goal** Telephonic Interpreter Services Utilization: Providers: 17,527; Staff: 11,298 [Total]: 28,825 Face-to-Face Interpreter Services Utilization: [ASL]: 272; [Non-ASL]: 855 [Total]: 1,127 Translation Services Utilization: [Standard]: 222; [Grievance]: 253 [Total]: 475 Readability Services Utilization: 36	**Q3-2021** Telephonic Interpreter Services Utilization: Providers: 3,944 Staff: 2,725 [Total]: 6,669 Face-to-Face Interpreter Services Utilization: [ASL]: 65 [Non-ASL]: 234 [Total]: 299 Translation Services Utilization: [Standard]: 55 [Grievance]: 104 [Total]: 159 Readability Services Utilization: 18	1.) Telephonic Interpreter Services Utilization: The overall utilization of telephonic interpreting services decreased among providers, Alliance staff, and contracted Alliance vendors. A total of 6,669 telephonic interpreting services calls were reported for measuring Q3 2021 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). This is a 24% decrease when compared to the previous Q1 2021 (8,775). 2.) Face-to-Face Utilization: As for face-to-face interpreting services, we had a total of 299 provider requests that were coordinated in Q3 2021 across the Alliance's service areas. This is a 11% decrease when compared to Q1 2021 (337). This could be due to the multiple efforts taken to ensure Alliance members and providers are supported during a telehealth visit. This has emerged as a need due to COVID-19 as many of our provider's transition to telehealth visits that may include phone and video options and may no longer require to have a qualified interpreter to be present. 3.) Translation Services Utilization: The Q3-2021 (159) utilization of translation service. This is an increased by 20.4% when compared to the Q1-2021 (132). This was due to website updates, COVID-19 related information, and upcoming member benefit information. The C&L team was able to provide support in coordination and quality control (QC)	No issues at this time	1) Implement audio interpreting services by Q1-2022 (we did a soft launch in Q3-2021 with a few providers to test this new service) 2) Continue with the development of the Alliance Health Literacy Tool kit for the organization 3) Collaborate with Provider Services in launching the upcoming Cultural Competency Provider Training by Q4-2021 4.) Collaborate with T&D to launch Provider Learning Modules on: C&L Services, Interpreting Services and working with SPD populations by Q1 2022

4th Quarter	**CY 2020 Baseline Goal** Telephonic Interpreter Services Utilization: Providers: 17,527; Staff: 11,298 [Total]: 28,825 Face-to-Face Interpreter Services Utilization: [ASL]: 272; [Non-ASL]: 855 [Total]: 1,127 Translation Services Utilization: [Standard]: 222; [Grievance]: 253 [Total]: 475 Readability Services Utilization: 36	**Q4-2021** Telephonic Interpreter Services Utilization: [Providers]: 3,797 [Staff]: 2,620 [Indigenous Lang]: 82 [Total]: 6,499 Face-to-Face Interpreter Services Utilization: [ASL]: 77 [Non-ASL]: 406 [Total]: 483 Translation Services Utilization: [Standard]: 105 [Grievance]: 98 [Total]: 203 Readability Services Utilization: 28	1.) Telephonic Interpreter Services Utilization: The overall utilization of telephonic interpreting services has significantly increased among providers, Alliance staff, and contracted Alliance vendors. 2.) Face-to-Face Utilization: As for face-to-face interpreting services, we had a total of 483 provider requests that were coordinated in Q4 2021 across the Alliance's service areas. This is a 69% increase when compared to the previous Q4 2020 (285). 3.) Translation Services Utilization: C&L/UMCCM teams have implemented DHCS APL 21-011 temporary process. Specifically, to fully translate NOAs/NARs, including the clinical rationale for the Alliance's decision that must be included in the NOA/NAR. While DHCS has made it clear that immediate translation of the entire NOA/NAR is required by federal and state law, DHCS acknowledges that some health plans may not have sufficient technological or contractual processes in place to ensure immediate translation of the clinical rationale. In the meantime, health plans are allowed to implement a temporary process, and full translation of the entire NOA/NAR is expected to come into compliance with full translation within six months of the issuance date of this APL (March-2022)	The volume of work for C&L services continues to increase over time significantly.	1) Continue with the development of the Alliance Health Literacy Tool kit for the organization 2.) Collaborate with T&D to launch Provider Learning Modules on: C&L Services, Interpreting Services and working with SPD populations by Q4 2021
Year End	**CY 2020 Baseline Goal** Telephonic Interpreter Services Utilization: Providers: 17,527; Staff: 11,298 [Total]: 28,825 Face-to-Face Interpreter Services Utilization: [ASL]: 272; [Non-ASL]: 855 [Total]: 1,127 Translation Services Utilization: [Standard]: 222; [Grievance]: 253 [Total]: 475 Readability Services Utilization: 36	**CY 2021** Telephonic Interpreter Services Utilization: [Providers]: 19,049 [Staff]: 10,693 [Indigenous Lang]: 323 [Total]: 30,065 **4.3% increase** Face-to-Face Interpreter Services Utilization: [ASL]: 382 [Non-ASL]: 1,032 [Total]: 1,414 **25.4% increase** Translation Services Utilization: [Standard]: 301 [Grievance]: 417 [Total]: 718 **51.2% increase** Readability Services Utilization: 79	1.) Telephonic Interpreter Services Utilization: The overall utilization of telephonic interpreting services has significantly increased among providers, Alliance staff, and contracted Alliance vendors. A total of 30,065 telephonic interpreting services calls were reported for CY 2021 across the Alliance's service areas (Merced, Monterey, and Santa Cruz counties). **This is a 4.3% increase when compared to the previous year (2021; 28,825).** 2.) Face-to-Face Utilization: As for face-to-face interpreting services, we had a total of 1,414 provider requests that were coordinated in CY 2021 across the Alliance's service areas. **This is a 25.4% increase when compared to the previous year (2020; 1,127).** This could be due to the multiple efforts taken to ensure Alliance members and providers are supported during COVID-19 pandemic and members are resuming care in-person. 3.) Translation Services Utilization: **In CY 2021 (718) utilization of translation service increased by 51.2% compared to the previous CY 2020 (475).** Member communications have significantly increased due to COVID-19 related information, benefit changes, website maintenance, ECM, Medi-Cal Rx, Grievance, and NOA's. The C&L team provided support in coordination and quality control (QC) reviews and met delivery dates.	The volume of work for C&L services continues to increase over time significantly. We've been able to meet our required timelines by shifting a few tasks to the Heath Educators. This was done to assist with the increased demand for interpreting/translation services and additional work related to health equity (training, development of staff/provider tools, education, etc.). This approach ensured we supported the completion of these requests. However, this is not sustainable. It has impacted resources in the Health Education and Disease Management team (i.e., the staff is limited on the number of member outreach efforts) and C&L projects (provider/staff training, the development of materials and tools)	1) Implement audio interpreting services by Q1-2022 2) Collaborate with Provider Services in launching the upcoming Cultural Competency Provider Training

D. Population Health

Project Description and Goals:

Purpose: Develop a population-based framework for the Alliance.

Project Goal:

- Based on the outcomes from the 2020 Population Health Gap Analysis, develop objectives and a strategy for population health to be implemented no sooner than 2022. Strategy will contemplate remediating any gaps identified in analysis, including those in people, process or systems. By the end of 2021, will have developed and implemented an enterprise-wide framework.

Project Description:

- Develop a PHM program based upon the NCQA gap analysis and the literature. Definitions of terms supporting the Population Health Initiative are finalized. List of critical elements to close gap-people, process and systems (leverage activities from Enhanced Care Management (ECM) efforts.
- Complete 2021 Population Health Needs Assessment. (June 2021)
- Shared definitions of terms supporting the Population Health Initiative are finalized. (Socialize)
- Complete at least one cycle of the S.P.I.A.A. cycle will be complete and have its evaluation documented.
- Program scope has been finalized and any necessary supporting policy documents are drafted and sent out to internal stakeholders for review. Completion of gap closure analysis and listed prioritization disseminated to internal stakeholders.
- Stakeholder engagement has occurred, discussion regarding shared measurement of health outcomes and equity have begun. Final population health strategy including gap closure sequencing plan presented to internal stakeholders.

2021 Evaluation

Review Period	Goal	Results	Key Accomplishments this Period	Issues	Next Steps
1st Quarter	Develop objectives and a strategy for population health to be implemented no sooner than 2021.	Project charter document in development. Population Needs Assessment (PNA) document planned completion by June 30, 2021.	Initiated project plan and Charter with PMO project Manager. Drafting of the Population Health Management Program (PHMP) Description is in progress. Population Needs Assessment (PNA) is on target to be completed by deadline.	PNA is in draft; planning to use health priorities identified by PNA in the PHMP plan to drive initial goal setting and patient segmentation and stratification. Socialize the draft Population Health Framework with other leadership.	Complete the project charter document. Continue to iterate on the Population Health Framework model. Complete the PNA and submit to DHCS.
2nd Quarter	Develop objectives and a strategy for population health to be implemented no sooner than 2021.	PNA complete and submitted on August 2, 2021. Population Health Management Strategy and goals were completed.	New Measure of Performance adopted: Establish a fully socialized and adopted Population Health Strategy and Objectives. Goals written for the Program description, Data management, Model of Care, and External partners.	Enhanced Care Management (ECM) Program role out is competing for resources with Population Health.	Distribute the PH Strategy slide deck to internal subject matter experts for review and feedback.
3rd Quarter	Develop objectives and a strategy for population health to be implemented no sooner than 2021.	Multiple findings from the PNA are informing the Plan's strategic and operating plans. Specifically a comprehensive review of ongoing inequities documented around pediatric care.	Feedback on the PH Strategy slide deck has been completed. Analysis of data is in progress at this time.	The PHMP and the Enhanced Care Management (ECM) will require resources to segment and stratify the Alliance's membership to ensure that all Alliance members are appropriately matched with supports and services. With the approval of the next Strategic Plan, ensuring that there is alignment between these two important bodies of work.	The next steps are to review and make revisions to objectives, measures, activities based on feedback or recent changes and using this information to finalize strategy.
4th Quarter	Develop objectives and a strategy for population health to be implemented no sooner than 2021.	Findings from the PNA are included in the 2022 Operating plan. In particular, health disparities in children, improved culturally appropriate care and emphasis on equitable behavioral health services.	Completed a successful root cause analysis led by QIPH staff that included Beacon leadership, Care Coordination, Care Management and the Behavioral Health Management. All teams engaged in the work came away with learning and started to work on improved communication pathways.	Issues remain for members needing timely and accessable behavioral health services as previously described in the Population Needs Assessment. The root cause work has initiated work to improve on member pathways to needed services.	The 2022 Alliance Operating Plan brings into focus many areas where quality improvement work can begin to address barriers to timely and quality care. Senior leadership found items from the 2021 PNA document that are now Breakthrough Objectives in the plan. QIPH is reviewieng objectives, needed resources and potential tactics.

Year End	Develop objectives and a strategy for population health to be implemented no sooner than 2021.	The 2022 Alliance Operating Plan, identifies Strategic Goal 1: Eliminate health disparities and achieve optimal health outcomes for children and youth	QIPH has laid a lot of ground work for the development of the Population Health Management Program during 2021. Staff are ready to receive the program requirement and directions from DHCS in order to have the program up and running by the end of 2022.	QIPH has laid a lot of ground work for the development of the Population Health Management Program during 2021. Staff are ready to receive the program requirement and directions from DHCS in order to have the program up and running by the end of 2022.	Continue to describe and promote the Population Health Management Program. Will be working on systems that allow a seamless risk scoring of members and segmentation of them into appropriate service programs. Will review how to best interface with ECM operations and support other units and departments in identifying optimal roles to support our members. Challenges will also include how to work with the member, PCP and others to connect members with a menu of services to support them in moving towards optimal health.

DATE: May 25, 2022

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 and Alliance Policy 401-1201 – Continuous Quality Improvement Committee

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Recommendation. Staff recommend the Board approve revisions to Alliance Policies 401-1101 – Quality and Performance Improvement Program and 401-1201 – Continuous Quality Improvement Committee (CQIC).

Background. The Quality and Performance Improvement Program (QPIP) is an organizational-wide, cross-divisional, and comprehensive program encompassing quality of care, patient safety, quality of service and member experience. 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.

The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Board) delegates oversight and performance responsibility of the QPIP to the CQIC, excluding credentialing/recredentialing[i] activities, which are directed by the Peer Review and Credentialing Committee.

Discussion. Alliance Policy 401-1101 – Quality and Performance Program was revised to align its content with the Quality Improvement System program description. This included adding the vision, values, and scope for the QPIP and revising the existing goals and objectives. Also, changes included adding description for the Enhanced Care Management and Long-Term Care Services programs and including some newly instituted committees. Finally, we implemented some changes to the staff titles to develop a career growth ladder for staff within the department and these have been included as revisions to the policy.

Alliance Policy 401-1201 – Continuous Quality Improvement Committee underwent its annual review, with minor revisions to the description of the meeting structure and the Care Based Incentive Workgroup membership.

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: Central California Alliance for Health QPIP Committee Structure
3. Attachment B: QPIP Organizational Chart
4. Alliance Policy 401-1201 – Continuous Quality Improvement Committee

[i] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12

	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:**
Approved by: Continuous Quality Improvement Committee (CQIC)	

Purpose
To describe Central California Alliance for Health's (the Alliance) the Quality and Performance Improvement Program (QPIP) also referred to as the Quality Improvement System (QIS), is an organizational-wide, cross-divisional and comprehensive program encompassing quality of care, patient safety, quality of service and member experience[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.

Vision: *"Quality for All"*
The QPIP is guided by the Alliance's vision of *Healthy People, Health Communities*, our mission of *accessible, quality health care guided by local innovation*, and Alliance values of *Improvement, Integrity, Collaboration and Equity .*

QPIP Values
The QPIP provides a comprehensive structure that meets the following requirements:
Continuous Quality Improvement (CQI)
1. Develop and maintain structures and processes that support CQI methodologies by demonstrating organizational commitment to the delivery of quality health care services through jointly developed goals and objectives across Divisions, approved by the Alliance Board, and periodically evaluated and updated[66].

Equitable and Person-Centered
1. Ensure all medically necessary covered services are: available and accessible to all members in any setting, regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56[3], and provided in a culturally and linguistically appropriate manner[4].
2. Provide tailored, consistent, and whole-person care across all member-facing team that meet the needs and experience of our members.

Safe, Accessible, and Effective Quality of Care and Services
1. Ensure integration with all departments within the Alliance, current community health priorities, standards, and public health goals;
2. Continuously review, evaluate, and improve access to and availability of services, including obtaining appointments within established standards[67];

3. Ensure consistent patient safety processes through proactive surveillance, investigation, and appropriate actions to address quality issues related to care, service, or satisfaction; and
4. Ensure effectiveness of the quality of care and services delivered across the continuum of care by addressing preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, behavioral and ancillary care services, including complex health needs, emerging risk, and multiple chronic conditions for improved health outcomes[68]

Scope

1. Quality and safety of clinical care services including, but not limited to: preventive care, chronic disease, perinatal care, family planning services, behavioral health services and reduction in health disparities.
2. Quality of non-clinical services including, but not limited to: availability, accessibility, grievance process, coordination and continuity of care, and information standards.
3. Standards for patient safety including, but not limited to: facility site reviews, credentialing of practitioners, and quality of care/peer review.
4. Standards in member experience including, but not limited to: satisfaction surveys and assessments, monitoring of member complaints, phone queue monitoring, access measurement and member grievance timeliness.

Goals and Objectives

The goal and objective of the QPIP is to objectively and systematically monitor and evaluate, pursue opportunities to improve, and resolve identified problems[5] related to the:

1. Quality and safety of healthcare and services provided by the Alliance's provider network:
   - 1.a. Incorporate provider and other appropriate professional involvement in the QPIP through review of findings, study outcomes, and on-going feedback for program activities[69]
   - 1.b. Conduct facility site reviews/medical record reviews at provider sites and reviewing quality issues or trends referred for further investigation and follow-up actions
   - 1.c. Develop and maintain a high-quality provider network through credentialing, re-credentialing, and peer review processes[27]
   - 1.d. Maintain an ongoing oversight process by incorporating performance metrics of QPIP-related functions performed by practitioners, providers, and delegated or independently contracted/sub-contracted delegates[70]
   - 1.e. Ensure that care and resources are available, appropriate, accessible, and timely for all members according to standards of care and evidence-based practices
   - 1.f. Monitor and act upon over/underutilization of services[71]

2. Quality of services provided by the Alliance to its members, providers, the community, and internal staff:
   - 2.a. Align quality improvement activities with activities that promote the continuous development of a provider network that meets member needs, such as the annual Access Plan
   - 2.b. Implement innovative practices, such as telephonic or virtual means, to ensure that members obtain care which is timely and meets their needs
   - 2.c. Utilize data-driven approaches and effective analysis, implementation, and evaluation towards improved clinical outcomes, services, and experiences
   - 2.d. Ensure care is provided regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and linguistically appropriate manner[4]
   - 2.e. Identify population-based strategies to address healthcare disparities in order to develop appropriate interventions and tools including cultural and linguistic (C&L) competency, communication, and education[72]
   - 2.f. Provide access to services and communication in alternate formats to ensure non-discrimination of members as defined in Section 1557 of the Patient Protection and Affordable Care Act[73]
   - 2.g. Education regarding accessing the health care system and support on obtaining care and services when needed
   - 2.h. Concerns resolved quickly and effectively including the right to voice complaints or concerns without fear of discrimination
   - 2.i. Engagement in the discussion about services, regardless of cost or benefit coverage
   - 2.j. Confidence that they can reach the Alliance quickly and be satisfied with the information received.

3. Members' experience of care and service provided by the Alliance and its contracted providers:
   - 3.a. Monitor member satisfaction with quality of care and services received from network providers, practitioners and delegates and acting upon identified opportunities
   - 3.b. Obtain information on member's values, needs, preferences, and health-related goals through feedback mechanisms and touch points, such as surveys, focus groups, member outreach, care management, and other means
   - 3.c. Establish population health programs to empower and encourage members to actively participate in and take responsibility for their own health through the provision of health education, evidence-based tools, and shared goals for optimal health[74]
   - 3.d. Create a trusted health care system to assure feelings of safety, self-efficacy, and effective communication with all their care partners
   - 3.e. Develop and implement activities for members that are Seniors and Persons with Disabilities or persons with chronic conditions, designed to assure the provision of case

management, coordination and continuity of care services for availability, accessibility, clinical services, and care management[50]

3.f. Integrate with current community health priorities, standards, and public health goals

3.g. Implement activities to monitor and act upon continuity and coordination of care improvements between medical and behavioral health specialties and within the medical care system[75]

Definitions

1. California Children's Services (CCS) Program[6] (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 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[7]: Specific identifiable activities or undertakings of the Alliance that address program deficiencies or problems.
4. Enhance Care Management (ECM): ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person centered.
5. External Accountability Set (EAS)[8]: Performance Measures: The EAS performance measures consist of a set of Healthcare Effectiveness Data Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). The EAS performance measures may also include other standardized performance measures and/or DHCS developed performance measures selected by DHCS for evaluation of health plan performance.
6. Healthcare Effectiveness Data and Information Set (HEDIS)[9]: The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.
7. High Performance Level (HPL): DHCS establishes an HPL for each required HEDIS performance measure and publicly acknowledges Managed Care Plans (MCPs) that meet or exceed the HPLs. DHCS's HPL for each required measure is the 90th percentile of the national Medicaid results.
8. Managed Care Accountability Set (MCAS): A set of measures based on the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets, and NCQA are selected by DHCS for evaluation of health plan performance.
9. 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.

10. National Committee for Quality Assurance (NCQA)[10]: A non-profit organization that committed to evaluating and publicly reporting on the quality of managed care plans.
11. Performance Improvement Projects (PIPs)[11]: Studies selected by the Alliance, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes[12].
12. 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[13].

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[14].

   1.a. Alliance Board[15]: 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[16];
      1.a.2. Appointment of an accountable entity or entities to provide oversight of the QPIP[17];
      1.a.3. Routine review of written progress reports from the CQIC[18];
      1.a.4. Directing the operational QPIP to be modified on an ongoing basis and tracking and following up on all review findings[19].
      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)[20]: The CQIC is the contractually required quality improvement committee with oversight and performance responsibility[21] of the QPIP – excluding credentialing and recredentialing[22] 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[23] 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.e.9. Network Development Steering Committee:
The Network Development Steering Committee's (NDSC) primary responsibility is to: 1. Monitor and evaluate member access to care through: · Comprehensive, coordinated, and regular review of access inputs, including but not limited to survey outcomes, regulatory compliance, and process-related information (e.g., grievances). 2. Support improved member access to care through oversight of the development and execution of an annual provider network Access Plan.

1.e.10. Member Support and Engagement Committee:
The Member Support and Engagement Committee (MSEC) is an interdepartmental collaborative intended to evaluate the Alliance processes that assist members in navigating the health care system. The Alliance's goal is to ensure members are supported and engaged, while being confident that they will receive appropriate care from providers and excellent service from the health plan. This committee facilitates the collaboration and integration of relevant service indicators as defined by the monitoring process, analysis, action, and measurement. Through monitoring of appropriate indicators, MSEC will identify areas of opportunity to improve

processes and implement interventions. The committee also works on member outreach to provide guidance to the Your Health Matters Outreach Program as appropriate to this committee's charter and any Quality Improvement Activities within the scope of this committee.

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

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

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

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

1.f.15. QI Program Advisor I (QIPA I): Under the direction of the QPH Manager, the QIPA I assists with monitoring data received from external partners. The QIPA I develops, writes, and produces reports to monitor compliance with contractual and regulatory

requirements. The QIPA I also supports the department with ad hoc reporting for internal and external stakeholders.

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

1.f.20. QIPH Administrative Specialist (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[24]. 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 System Work Plan (QISW): The QISW is developed and maintained by QIPH staff. The CMO, QIPH Director, and QIPH Managers review the QISW 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[25]. CQIC minutes are submitted to DHCS upon Alliance Board review and approval.

1.g.3. QIS Annual Report: The QIS Annual Report is submitted to the CQIC for its review, approval, and submission to the Alliance Board[26], and subsequent submission to DHCS. The QIS Annual Report includes an evaluation of areas of success and needed improvements. The evaluation includes but is not limited to: the QISW; aggregate data on utilization; results of the EAS measures; outcomes of PIPs; member satisfaction surveys; and collaborative initiatives as appropriate.

1.f.28. The QIS 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[27].

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[28]). These mechanisms include, but are not limited to:

2.b. External Quality Review[29]: 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 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[30]: 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[31]. 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[32]. The Alliance ensures that member medical records

are maintained by health care providers in accordance with contractual obligations[33]. The Alliance submits site review data to DHCS bi-annually[34].

2.d. Disease Surveillance[35]: 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[36]: The Alliance incorporates credentialing and recredentialing requirements into the QPIP as described in Alliance Policies 105-0004 – *Delegate Oversight*[37], 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[38].

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[39].

2.f. Timely Access Monitoring[40]: 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[41]: 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[42]: 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[43]: 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)[44]: 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[45]: 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 401-3104 – *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 QISW 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[46]: 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.

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

2.s. Long Term Care Services: The Alliance will implement quality monitoring, assurance, and improvement efforts for Long Term Care services at institutional settings once further guidance is received.

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[47]; and

3.a.1.c. CAHPS Survey results[48].

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[49]:

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[50]:

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[51]: The Alliance distributes information regarding QPIP 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 WCMCAC. Outcomes from these committees requiring modifications to the operational QPIP are incorporated by way of receipt of directives from the Alliance Board[52] 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)[53,54]: Under consultation and with guidance from the External Quality Review Organization (EQRO) and DHCS, the Alliance conducts a minimum of two (2) DHCS-approved PIPs. One PIP must be either an internal PIP or a small group collaborative. The second PIP must be a DHCS-facilitated state-wide collaborative.

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

- Measurement of performance using objective quality indicators;
- Implementation of 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[55]; and

3.c.3.b. Provider CAPs may be an intervention for certain PQIs, as deemed appropriate by the CMO or a Medical Director[56]. Refer to Alliance Policy 401-1306 - *Corrective Action Plan for Quality Issues*.

3.c.4. Improvement Plan[57]:
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 401-3104 – *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[58].

3.c.5.b Health Education and Promotion: Consistent with Alliance Policy 401-3101 – *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[59].

Health Programs services and information is shared with providers through the Provider Portal and special mailings for general performance reports[60], 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
200-9001 – Grievance Reporting, Quality Improvement and Audits
200-9004 – Staff Grievance Review Committee
280-0003 – Whole Child Model Family Advisory 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 – Reporting to the Medical Board of California and the National Practitioner Data Bank
300-4103 – Fair Hearing Process for Adverse Decisions
300-4110 – Organizational Providers Credentialing Guidelines
300-8030 – Monitoring Network Compliance with Accessibility Standards
400-1109 – Physicians Advisory Group Responsibilities and Functions
400-1112 – Whole Child Model Clinical Advisory Committee Responsibilities and 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 1300.67.2.2(d)(2)(C)
- California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.70
- California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.70(b)(c)
- Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 440, Subpart B, Section 440.262
- Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 438, Subpart E, Section 438.330
- Code of Federal Regulations, Title 42, 438.330(d) incorporated via [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
- DHCS communication dated 8/2016 related to Title 42, Code of Federal Regulations, Section 440.262;

Legislative:

Contractual:
- DHCS State Medi-Cal Contract
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 2
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3, 3.A, 3.B. 3.C, 3.D
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 5
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7, 7.D, 7.F, 7.H, 7.I,
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8, 8.B.
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9, 9.3.B, 9.A, 9.C, 9.D
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 10, 10.C, 10.D
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 11. 12., 12.C, 12.E, 13., 13.E
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 9, Provision 12.C
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 10, Provision 8
- DHCS State Medi-Cal Contract, Exhibit A, Attachment 23, Provision 2.A (Whole Child Model Amendment)
- DHCS State Medi-Cal Contract (Amendment 43), Exhibit A, Attachment 4, Provision 7F - 7G
- [MMC Final Rule] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1

[MMC Final Rule] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7.F
[MMC Final Rule] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8.B.
DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions

DHCS All Plan or Policy Letter:
MMCD PL 14-004
DHCS APL 15-023
DHCS APL 19-010
DHCS APL 19-017
DHCS APL 21-015

NCQA:
HEDIS Volume 2 Technical Specifications for Health Plans

Supersedes:

Other:
Alliance Provider Manual

Attachments:
Attachment A: Quality Improvement System Reporting Structure
Attachment B: Quality Improvement and Population Health Organizational Chart

Lines of Business This Policy Applies To
☒ Medi-Cal
☒ Alliance Care IHSS

LOB Effective Dates
(01/01/1996 – present)
(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

	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:**
Approved by: Continuous Quality Improvement Committee (CQIC)	

Reviewed Date	Revised Date	Changes Made By	Approved By
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
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

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Approved by: Continuous Quality Improvement Committee (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
4/28/2022	4/28/2022	Amit Karkhanis, Quality and Performance Improvement Manager	CQIC

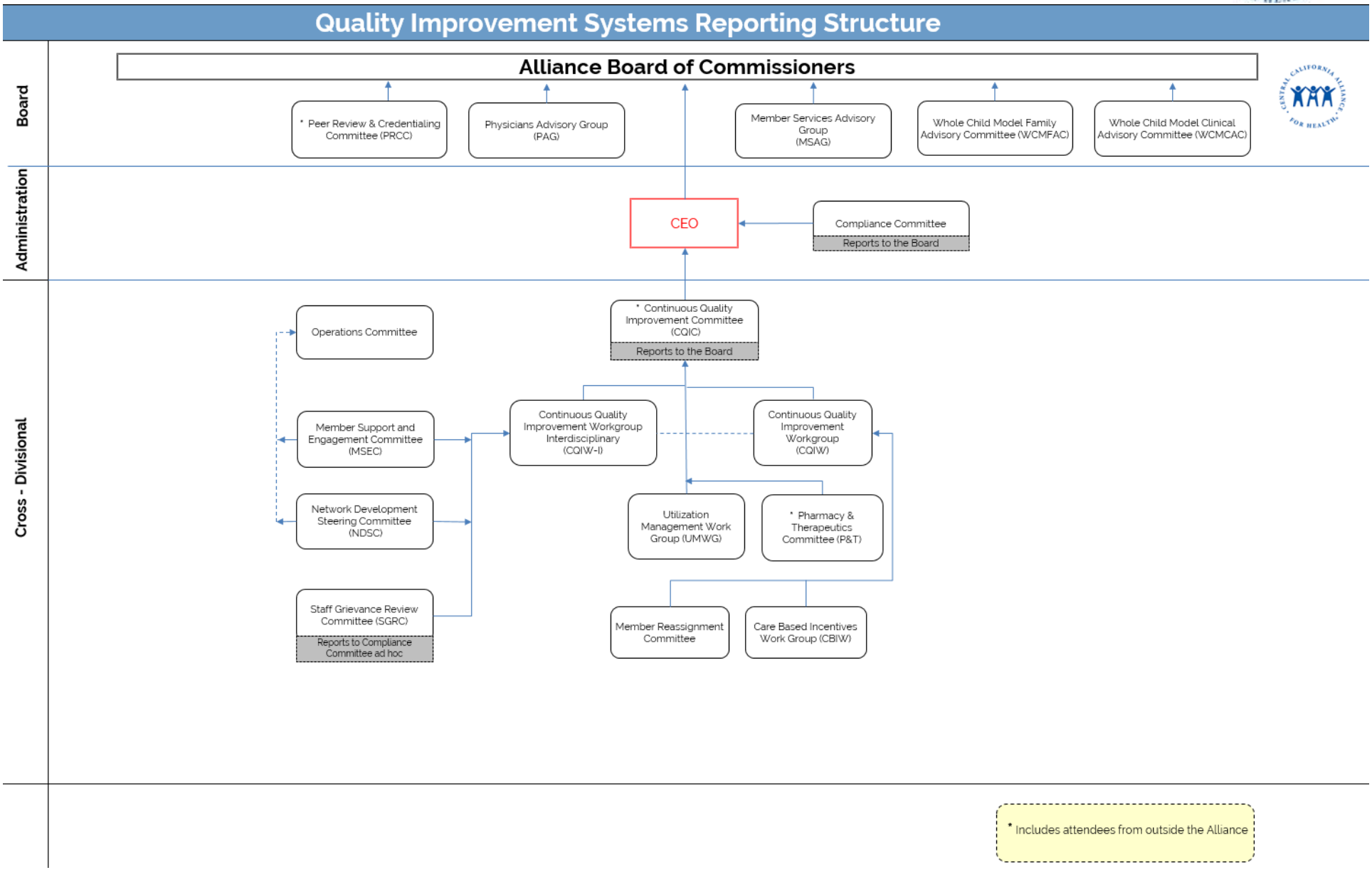
[1] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
[2] [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
[3] DHCS State Medi-Cal Contract (Amendment 43), Exhibit A, Attachment 4, Provision 7F - 7G
[4] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 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
[5] DHCS Medi-Cal Contract Exhibit A, Attachment 4
[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 State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[11] DHCS All Plan Letter 19-017
[12] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[13] DHCS All Plan Letter 19-017
[14] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 2; 28 CCR Section 1300.70(b)(C)
[15] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3
[16] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.A
[17] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.B
[18] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.C
[19] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.D
[20] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[21] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 2
[22] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12
[23] DHCS State Medi-Cal Contract, Exhibit A, Attachment 23, Provision 2.A (Whole Child Model Amendment)

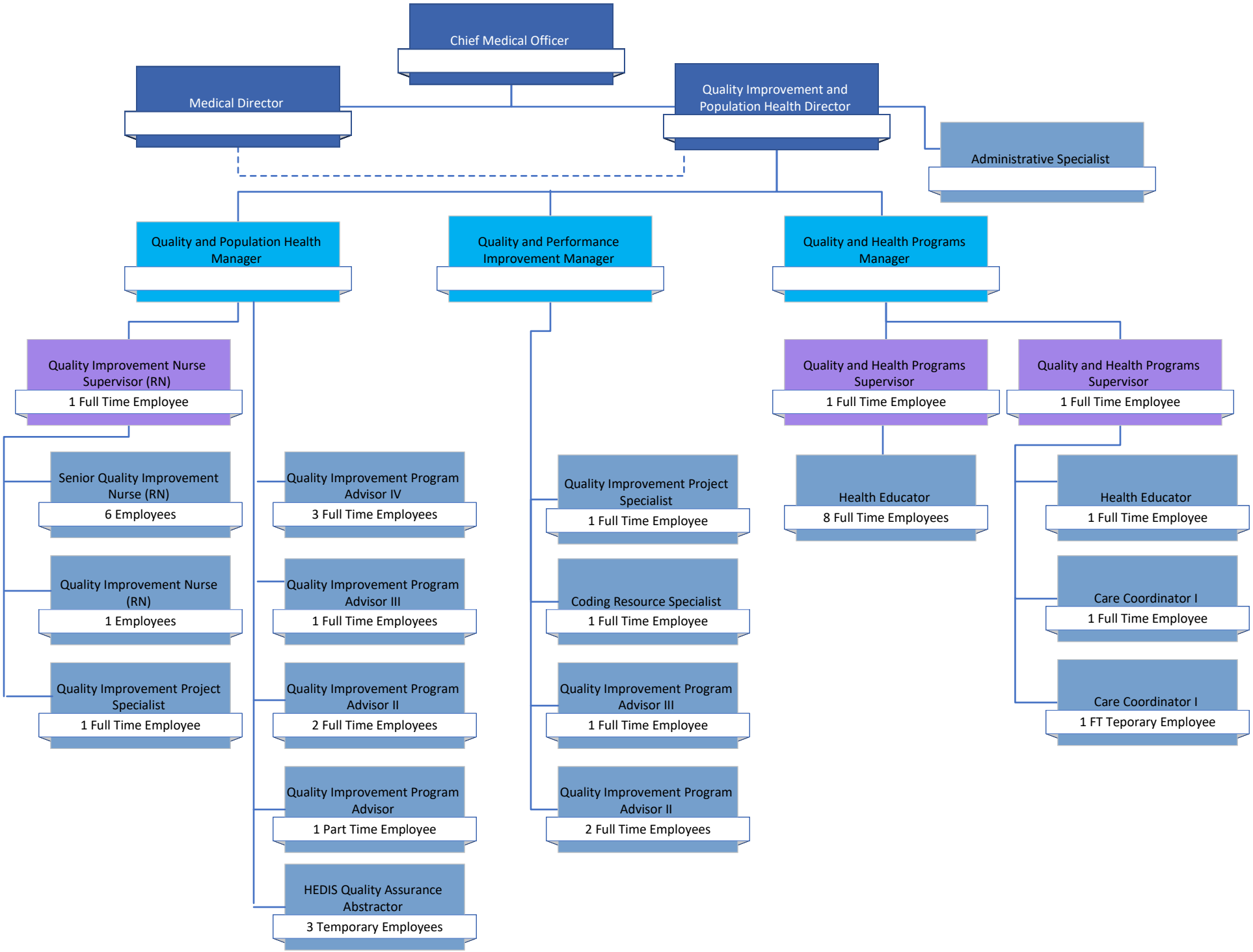
[24] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provisions 10.C and 12
[25] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.C
[26] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8
[27] [MMC Final Rule] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8.B.
[28] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7.H
[29] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9
[30] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 10
[31] MMCD PL 14-004; DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[32] DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[33] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 13
[34] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 13.E
[35] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 11
[36] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12
[37] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12.C
[38] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12.E
[39] 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
[40] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2
[41] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9.D; DHCS All Plan Letter 19-017
[42] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)
[43] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9.3.B
[44] DHCS State Medi-Cal Contract, Exhibit A, Attachment 9, Provision 12.C
[45] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7.I
[46] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6
[47] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9.A
[48] Policy 401-2001 – Member Surveys
[49] Policy 401-1502 – Adult Preventive Care
[50] Policy 401-1505 – Childhood Preventative Care
[51] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7.D
[52] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.D
[53] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 9.C; DHCS All Plan Letter 19-017
[54] 42 CFR 438.330(d) incorporated via [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
[55] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 10.D; MMCD PL 14-004
[56] Policy 401-1301 – Potential Quality Issue Review Process; Policy 401-1306 – Corrective Action Plan for Quality Issues
[57] DHCS All Plan Letter 19-017
[58] DHCS State Medi-Cal Contract, Exhibit A, Attachment 10, Provision 8
[59] DHCS State Medi-Cal Contract, Exhibit A, Attachment 10, Provision 8
[60] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 5
[66] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 7A
[67] DHCS Medi-Cal Contract Exhibit A, Attachment 4, Provision 7G
[68] DHCS Medi-Cal Contract Exhibit A, Attachment 4, Provision 7H, NCQA 2020 QI 3
[69] DHCS Medi-Cal Contract Exhibit A, Attachment 4, Provision 5 and 7D, NCQA 2020 QI 1, Element A, Factor 3
[70] DHCS Medi-Cal Contract Exhibit A, Attachment 4, Provision 6, NCQA 2020 QI 5
[71] DHCS Medi-Cal Contract Exhibit A, Attachment 4, Provision 9B

	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:**
Approved by: Continuous Quality Improvement Committee (CQIC)	

[72] NCQA 2020 QI 1, Element A, Factor 1 and 6
[73] Section 1157 Patient Protection and Affordable Care Act
[74] NCQA 2020 QI 1, Element A, Factor 1
[75] NCQA 2020 QI 3 and 4

Policy 401-1101: Quality and Performance Improvement Program (QPIP)
Attachment A: Central California Alliance for Health QPIP Committee Structure
Last Updated: January 13, 2022





Back to Agenda

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

Purpose

To define the role and responsibilities of Continuous Quality Improvement Committee (CQIC), Central California Alliance for Health's (the Alliance) contractually required quality improvement committee[1].

Policy

The Alliance maintains a Quality Improvement System (QIS)[2], internally referred to as the Quality and Performance Improvement Program (QPIP), as described in Alliance Policy 401-1101 – *Quality and Performance Improvement Program*. The Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board) delegates oversight and performance responsibility[3] of the QPIP to the CQIC, excluding credentialing/recredentialing[4] activities, which are directed by the Peer Review and Credentialing Committee.

Definitions[5]

1. Corrective Action: Specific identifiable activities or undertaking of the Alliance that address program deficiencies or problems.
2. Managed Care Accountability Set (MCAS) [Formerly referred to as External Accountability Set (EAS)]: A set of measures based on the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets selected by DHCS for evaluation of health plan performance.
3. Performance Improvement Projects (PIP)[6]: Studies selected by the Alliance, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes.

Procedures

The CQIC conducts oversight and manages performance of the QPIP as outlined below.

1. Structure
   The CQIC is designated by, and accountable to, the Alliance Board. The activities, findings, recommendations and actions of the CQIC are reported to the Alliance Board on a scheduled basis[7]. The CQIC oversees the activities of the Pharmacy and Therapeutics (P&T) Committee, Utilization Management Workgroup (UMWG), Continuous Quality Improvement Workgroup (CQIW) Interdisciplinary, and CQIW. The CQIC partners with the Compliance Committee to meet delegate oversight requirements[8].

2. Responsibilities
   Primary duties of the CQIC include the following:

2.a. Annually reviewing and approving the draft Quality Improvement and Utilization Management Work Plans (QIWP and UMWP);
2.b. Quarterly reviewing progress against active QIWP and UMWP goals;
2.c. Providing leadership and oversight in the implementation of quality improvement principles and activities in the daily operations of the Alliance;
2.d. Facilitating communication on the status and progress of Alliance QPIP activities to the Alliance Board on a scheduled basis;
2.e. Participating in the development and/or adoption of specific utilization management criteria[9] and benefit parameters;
2.f. Monitoring the activities of, and providing direction to, all CQIC subcommittees/ workgroups;
2.g. Stimulating the highest degree of commitment to quality health care and to the goal of continuous improvement;
2.h. Recommending and approving changes to select QPIP related Alliance policies, practice guidelines, and subcommittees' proposed action plans;
2.i. Overseeing the QPIP and UM Program policies (Alliance Policies 401-1101 and 404-1101 respectively), and the QIWP and UMWP for annual submission to the Alliance Board;
2.j. Reviewing, approving and submitting the Quality Improvement and Population Health (QIPH) Annual Report[10] to the Alliance Board;
2.k. Reviewing and advising on QPIP related Corrective Action plans (CAP), not including credentialing/recredentialing oversight related CAPs. Individual provider issues may be referred to the PRCC and/or Program Integrity Unit depending on the nature of the issue;
2.l. Reviewing standards of care guidelines, as described in Alliance Policy 401-1501 – *Standards of Care*; and
2.m. Partnering with the Compliance Committee to meet QPIP delegate oversight requirements[11].

3. Requirements
3.a. Frequency: The CQIC meets at least quarterly, but as frequently as necessary to demonstrate follow-up on all findings and required actions[12].

3.b. Chair: The CQIC is chaired by an Alliance Medical Director (or designee)[13].

3.c. Membership: Core membership consists of Alliance subcontractors and staff. Subcontractors representative of the composition of the Alliance contracted Provider Network, including but not limited to subcontractors who render services to Seniors and Persons with Disabilities (SPD) or persons with chronic conditions,

(e.g. diabetes, asthma and congestive heart failure) actively participate on the CQIC or medical subcommittee that reports to the CQIC[14]. Committee members must be in good standing with the Alliance (defined as not being under active investigation by the Special Investigations Unit nor having an open Corrective Action Plan for Quality Issues).

3.d. Core Alliance staff membership includes the Chief Medical Officer, Medical Director(s), QIPH Director, QIPH Managers, Quality and Health Programs (QHP) Manager, QIPH Nurse Supervisor, Pharmacy Director, Community Care Coordination Director (CCC), Utilization Management and Complex Case Management Director (UM/CCM) Director, UM/CCM Managers, Provider Services (PS) Director (or designee), Regional Operations Directors, Operational Excellence Director, and Member Services (MS) Director. Ad-hoc (non-core) membership varies as topics mandate.

3.e. Voting: Voting rights are afforded to all core CQIC members.

3.f. Quorum: A majority of core CQIC members constitutes a quorum[15].

3.g. Term: Alliance subcontractor CQIC members are appointed for a renewable one-year term. Membership forms are completed by each Alliance subcontractor member annually.

3.h. Attendance: CQIC members are required to attend a minimum of two of the four quarterly meetings in order to remain in good standing. Meetings are held in-person; members preferring to attend at an alternate Alliance office may do so by video-conference.

3.i. Minutes: CQIC minutes are reviewed by the Alliance Board on a routine basis[16]. CQIC minutes are submitted to DHCS[17] upon Alliance Board review and approval.

3.j. Reporting:

3.j.1. Quarterly: The activities, findings, recommendations, and actions of the CQIC relative to the QPIP are submitted to the Alliance Board in writing on a quarterly basis[18].

3.j.2. Annually: The QIPH Annual Report[19] is submitted to the CQIC for review, approval and submission to the Alliance Board, and subsequent submission to DHCS. The QIPH Annual Report includes:

3.j.2.a. A comprehensive assessment of the quality improvement activities undertaken and an evaluation of areas of success and needed improvements in services rendered within the quality improvement program, including but not limited to:
- The collection of aggregate data on utilization;
- The review of quality of services rendered;
- The results of the MCAS measures; and
- Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction surveys and collaborative initiatives.

3.j.2.b. Copies of all final reports of non-governmental accrediting (e.g. National Committee for Quality Assurance [NCQA]) if relevant, including any CAPs developed to address noted deficiencies, and an assessment of subcontractor performance of delegated quality improvement activities.

3.j.2.c. An assessment of subcontracting entities performance of delegated quality improvement activities.

3.k. Confidentiality[20]:

3.k.1. All members of the CQIC will agree to the terms of the Confidentiality Agreement;

3.k.2. The CQIC is a peer review committee whose activities, information and records are protected from disclosure under California Evidence Code Section 1157; and

3.k.3. All CQIC members must agree to respect and maintain the confidentiality of all CQIC discussions, deliberations, records and other information generated in connection with these activities and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of CQIC business.

3.l. Conflict of Interest[21]:

3.l.1. All members of the CQIC will agree to the terms of the Conflict of Interest Agreement;

3.l.2. All members of the CQIC who have a conflict of interest with respect to any matter being brought before the CQIC shall report the conflict of interest to the chairperson of the CQIC;

3.l.3. A CQIC member with a conflict of interest will refrain from casting a vote on any related issue and will abstain from any proceedings of the CQIC in which such issues are raised for consideration; and

3.l.4. A CQIC member is deemed to have a conflict of interest if there is any potential for personal, professional or financial gain in the item being presented, or any other involvement in the matter which may impair the member's objectivity in considering the matter.

4. Other Committees

4.a. P&T Committee: The P&T Committee operates under the authority of the CQIC as described in Alliance Policy 403-1104 – *Mission, Composition and Functions of the Pharmacy and Therapeutics Committee.*

4.b. UMWG: The UMWG operates under the authority of the CQIC as described in Alliance Policy 404-1101 – *Utilization Management Program.*

4.c. CQIW: The CQIW, under the direction and guidance of the CQIC, is responsible for ongoing QPIP operations and supporting work activities. The QIPH Director chairs the CQIW. Core membership includes: CMO, Medical Director(s), QIPH Director, QIPH Managers, QIPH Nurse Supervisor, UM/CCM Director, UM/CCM Managers, CCC Director, Pharmacy Director, and QHP Manager. Ad-hoc membership varies as topics mandate. The CQIW is responsible for activities, including but not limited to:

4.c.1. Ongoing review and approval of the QIWP, including refining interventions to address barriers and incorporate feedback from the CQIC, and the QIPH Annual Report[22];
4.c.2. Annual review and approval of various QIPH policies and related processes and functions;
4.c.3. Analysis of Managed Care Accountability Set (MCAS) [formerly referred to as External Accountability Set (EAS)] measures and the development of strategies to improve performance;
4.c.4. Development of QPIP related provider and member communications;
4.c.5. Development of disease management initiatives;
4.c.6. Ongoing oversight of delegated QIPH activities of subcontractors;

4.c.7. Oversight of language assistance and interpreter services as described in Alliance Policy 401-4101 – C*ultural and Linguistic Services Program*;
4.c.8. Review and analysis of provider and member survey results; and
4.c.9. Review and approval of QPIP-related standing reports, and state mandated PIPs.

4.d. Interdisciplinary CQIW: An interdisciplinary CQIW meeting is held quarterly to address high-priority and emerging quality issues requiring organization-wide and/or cross-departmental response, including, but not limited to, topics related to provider capacity and member access and satisfaction. Interdisciplinary CQIW membership includes: Chief Executive Officer (CEO), CMO, Chief Operating Officer, QIPH Director, QIPH Managers, QHP Manager, QIPH Nurse Supervisor, CCC Director, Pharmacy Director, UM/CCM Director, Medical Directors, MS Director (or designee), Grievance and Quality Manager, PS Director (or designee), Provider Quality and Network Development Manager, Claims Director, Analytics Director, Communications Director, Regional Operations Director(s), Strategic Development Director (or Grants Programs Manager), and Compliance Director (or designee).

4.e. Care Based Incentives Workgroup (CBIW): The CMO (or designee) chairs the CBIW. Core membership includes: QIPH Director, QIPH Program Advisors, QIPH Managers, QHP Manager, , QIPH Project Specialist, QIPH Coding Resource Specialist, Medical Directors, CCC Director (or designee), Pharmacy Director (or designee), PS Director (or designee), Contracts Manager, Analytics Director and Analytics Manager.

5. Delegate Oversight[23]
Oversight and performance responsibility of the Alliance's delegated QIPH functions, including UM/CCM, are maintained and monitored by the CQIC, in collaboration with the Compliance Committee, as described in Alliance Policy 105-0004 – *Delegate Oversight.*

References:
Alliance Policies:
105-0004 – Delegate Oversight
401-1101 – Quality and Performance Improvement Program
401-1501 – Standards of Care
401-4101 – Cultural and Linguistic Services Program
403-1104 – Mission, Composition and Functions of the Pharmacy & Therapeutics Committee
404-1101 – Utilization Management Program

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
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Approved by: Continuous Quality Improvement Committee (CQIC)	

Impacted Departments:
- Community Care Coordination
- Pharmacy
- Provider Services
- Utilization Management and Complex Case Management;

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

Legislative:

Contractual:
- DHCS State Medi-Cal Contract

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

NCQA:

Supersedes:

Other References:

Attachments:

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

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
12/01/1998	12/01/1998	Barbara Flynn, RN	Barbara Flynn, RN
01/01/2000	01/01/2000	Barbara Flynn, RN	Barbara Flynn, RN
02/01/2003	02/01/2003	Barbara Flynn, RN	Barbara Flynn, RN
02/01/2004	02/01/2004	Barbara Flynn, RN	Barbara Flynn, RN
01/01/2005	01/01/2005	Barbara Flynn, RN	Barbara Flynn, RN
03/01/2006	03/01/2006	Barbara Flynn, RN	Barbara Flynn, RN
01/01/2008	01/01/2008	Richard Helmer, MD	Richard Helmer, MD
11/01/2008	11/01/2008	Andres Aguirre	Andres Aguirre
03/01/2010	03/01/2010	Kaite McGrew	Richard Helmer, MD
01/23/2012	01/23/2012	David Altman, MD	David Altman, MD

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
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Approved by: Continuous Quality Improvement Committee (CQIC)	

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

[1] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4

	POLICIES AND PROCEDURES
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[2] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1
[3] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 2
[4] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 12
[5] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[6] DHCS All Plan Letter 19-017; and DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions "Quality Improvement Projects"
[7] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.C
[8] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6
[9] DHCS State Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.D
[10] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8
[11] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6
[12] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[13] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[14] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[15] Consistent with *Bylaws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission* (April, 2009)
[16] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 3.C
[17] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[18] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[19] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8
[20] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[21] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[22] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8
[23] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6

DATE: May 25, 2022

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

FROM: Gordon Arakawa, MD, PhD, Medical Director

SUBJECT: Utilization Management Work Plan Report for Q4 2021 and Utilization Management Work Plan Template for 2022

Recommendation. Staff recommend the Board accept the Utilization Management Work Plan (UMWP) Report for Q4 2021 and Utilization Management (UM) Work Plan Template for 2022.

Summary. This document provides an overall summary of the UMWP activities for Q4 2021 and end of year highlights and outcomes. Overall utilization of inpatient, emergency department (ED) visits, long-term care (LTC), and outpatient as indicated by authorization volume remained below 2019 levels in Q4 2021 due to the COVID-19 Omicron surge. Care coordination services and pilot programs continued, and progress was made in development of Enhanced Case Management.

Background. The UM Workgroup provides guidance and direction to the UM Program and operates under the authority of the Continuous Quality Improvement Committee. This quarterly summary continues to reflect 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.

Q4 2021 Workplan Outcomes and Evaluation

Project and Initiative Outcomes

Pediatric Case Management. The fourth quarter reflects continued increases in overall California Children's Services (CCS) referral activity, with a 6% increase in total eligible members as compared to the previous quarter. While Q4 also includes the early stages of CCS diagnostic referral activity, the impacts of increased COVID-19 activity are noted with decreased eligible member totals in Merced County. The reduced member volume is in part attributed to delays in review of Alliance CCS referrals related to pandemic activity and the impacts on county level staffing. Reduced member engagement in care due to COVID-19 activity was an additional factor in Q4 2021, though overall high and low risk capture rates remain consistent. Of note, Individual Care Plan totals continue to climb and are a positive reflection of member engagement with the Pediatric Complex Case Management (CCM) team and overall program growth.

The integration of the CCM and UM departments in 2020 have had a continued positive impact on the Whole Child Model Program, with early identification of potential CCS eligible members and referral of those members to the counties for determination. While Q4 also reflects the early work of diagnostic referrals, the collaboration with the Pediatric CCM and authorization teams is noted in the increased volumes over the year with an approximate 21% increase in total CCS eligible members across the counties in 2021. The increased activity in high and low risk identification is proportionate to total member volumes and in line with prior reporting periods. Of additional note is the increase in Individualized Care Plan activity, with the 59% increase a reflection of the overall growth of the program.

System Transformation Development / Community Care Coordination. Necessary operational requirements for Enhanced Case Management and Community Supports (ECM/CS) were met. Updates to Essette were made, and staff were identified for program implementation. Contracting is underway for the care coordination software platform and closed loop referral systems. Information for the Alliance website and provider manual was completed.

The Alliance has successfully transitioned the Whole Person Care pilot members into ECM, and are ramping up provider network, staff training, and implementation of the care coordination software platform/closed loop referral systems. Staff are anticipating and preparing for go-live implementation of ECM/CS in Merced County in July 2022.

Reducing Readmissions Initiative

Post Discharge Meal Delivery Program (PDMDP). Enrollment into the PDMDP in Q4 2021 shows a decrease of 33% over the previous quarter. Of the 74 members enrolled, there was a 2% decrease in the members completing the program as compared to Q3, with 68% of enrollees completing the 12-week program in Q4.

In Q4, 32% of the members enrolled in the PDMDP were disenrolled for a variety of reasons (member self-disenrolled, readmission). This reflects a disenrollment increase of 2% over the previous quarter.

In Q4, the readmission rate after PDMDP enrollment was 27%, slightly higher than rates seen in the two previous quarters. However, the Q4 readmission rate was well below the 34% readmission rate seen in Q1 2021, suggesting a positive impact of the program despite the COVID-19 Omicron surge at the end of the year.

Recuperative Care Program (RCP). In Q4, 36 members enrolled in RCP, which was similar to the number from Q3 (38). Enrollment in both the third and fourth quarters was much greater than what was seen in the first two quarters of 2021 (5 & 6, respectively).

Monterey County continues to have difficulties in expediting placements in their RCP program with only one admission in the final quarter of 2021. The CCAH RCP support team will continue to meet with Monterey County to identify areas of improvement

and to develop placement strategies to expediate the referral and acceptance process.

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

Authorization Turn Around Times (TAT). Total authorizations: 25,888, total noncompliant at 90 authorizations. The total TAT rate continued through Q4 near 100% goal and includes some Provider Change Request and Post Service data not manually filtered out, which if excluded would favorably impact the overall TAT rate. Increased pandemic activity during the final quarter of 2021 likely impacted overall authorization volumes (approximate 3% reduction in authorization activity).

Recommendation: Continue current practices with use of Essette authorization activity reports for twice daily TAT overview and assignments. Continue subject matter expert development and cross training of staff into various authorization assignment processes to further support TATs as authorization volumes increase.

Goal: 100%
Results: 99.7%

Prior Authorization Request Determination Metrics. Authorization volume in Q4 was approximately 37,508, slightly decreased compared to Q3. The overall Q4 denial rate was 1.3%, consistent with previous quarters. The appeal rate remained low at 10% of denials; the majority of denials were upheld on appeal (71%). The overall void rate was roughly stable at 15% in this quarter.

For the year, authorization volumes varied greatly (47,818 Q2, 37,508 Q4), likely reflecting fluctuations in member utilization due to the COVID-19 pandemic. Year-ending total authorizations were 153,671 (excludes Pharmacy, Concurrent Review, Referral Authorizations and Non-Emergent Medical Transportation). For the year, the overall denial rate was 1.4% and the overall void rate was 16%.

To assess the impact of authorization process redesign efforts, the authorization denial and void rates from 2021 were compared to those from 2019, prior to the initiation of the authorization process redesign project. In 2019, the overall denial rate was 2.1% and the void rate was 19%.

The decrease in authorization void rates (19% to 16%) is likely due to authorization process redesign efforts and increased provider use of the Provider Code Lookup (PCL) tool introduced in 2021.

While the authorization process redesign efforts should result in an increase in denial rates, the observed decrease in denial rates for 2021 are likely due to a combination of three factors leading to decreased denials: 1) auto-approved authorizations remain included in the total count of authorizations, 2) increased efforts to educate providers on submission of appropriate authorizations and the use of the PCL tool, and 3) “high

efficiency" authorization approval modes that were occasionally engaged during various stages of the COVID-19 pandemic in 2021.

Top 10 Prior Authorization Requests Resulting in Medical Necessity Denials. The overall denial rate for Q4 2021 remains at less than 2%. The majority of denials noted include consultation requests for out-of-network providers and large panel/whole exome sequencing genetic testing. Of note, genetic testing comprises seven of the 10 top denial categories, with multiple large panel/non-specific genetic requests submitted on a single authorization.

Utilization Performance Outcomes

Inpatient Utilization. Overall, our data for the Medi-Cal population has been steady throughout 2021 and below goal. This likely represents a balance between the impact of increased COVID-19 cases in Q2 (Delta) and Q4 (Omicron) and decreases in elective inpatient admissions due to the COVID-19 pandemic.

Goal: Bed-day per thousand/per year (PKPY) 282
Results: 275 PKPY

Ambulatory Care Sensitive Admission (ACSC). In the second and fourth quarters increased rates of ACSC were observed in both Monterey and Merced Counties, likely reflecting COVID-19-related surges (diagnosis of pneumonia is counted as ACSC). Lower percentage in Q4 for Santa Cruz could reflect decreased effect of COVID-19 due to increased immunization/booster rates relative to the other counties.

Goal: Dashboard target goal is 8.0 (threshold 8.9)
Results: 7.8

Readmissions. No real change in overall readmission rates was noted throughout 2021, with the rate remaining at approximately 11%.

Goal: Dashboard target 11%, (threshold is 12.2%.)
Results: 11%

Alternatives to Acute Inpatient Days – Skilled Nursing Facilities (SNF). Q4 2021 SNF and short-term rehabilitation (STR) bed days increased by 6% over the same quarter of the previous year. Of the 270 members admitted to SNF/STR in Q4, 20% of the members were readmitted to the hospital within 30 days. This is a 1% decrease over the same quarter in 2020.

Approval of SNF/STR bed days that resulted in the utilization of STR LOC 1 to cover the increased care associated with members in COVID-19 isolation was reinstituted in December 2021. Monitoring will continue for trends; anticipating the pandemic surges decreasing in Q1 2022 and anticipated increase in SNF/STR stays as the counties opened back up.

Long Term Care. New admissions to LTC increased slightly during Q4 compared to Q3 2021. This could be a result of the winter COVID-19 surge related to the Omicron variant associated with reduced disease severity that allowed LTC facilities to accept new admissions.

The number of new admissions to LTC in the final quarter of 2021 was increased by 40% as compared to the same quarter in 2020. This discrepancy is most certainly due to the unusually low number of new LTC admissions in Q4 2020 because LTC sites restricted new admissions as a result of the COVID-19 surge. LTC admissions remain below the pre-pandemic baseline.

.

Medi-Medi members comprise 84% of total members in LTC in Q4, roughly stable compared to the remainder of 2021.

Emergency Department Utilization Metric. A decrease in ED visits was identified in all three counties during Q4 2021, likely reflecting decreased ED utilization during the COVID-19 Omicron surge. ED visits averaged 418 per thousand per year in Q4 2021. Overall, for 2021, the ED visit rate was 407 per thousand per year. For comparison, in 2019 prior to the COVID-19 pandemic, the ED visit rate was 530 per thousand per year. This large decrease in ED utilization most likely reflects the impact of COVID-19.

Pharmacy Utilization. Per member/per month (PMPM) costs for retail increased by 2% compared to 2020 and met goal of remaining under 10% increase. In-Home Supportive Services (IHSS) utilization increased especially for branded drugs and high-cost specialty drugs.

Formulary management and prior authorization request reviews will be carved out to Medi-Cal Rx for Medi-Cal members and delegated to MedImpact for Alliance Care IHSS members starting in 2022. For Alliance Care IHSS LOB, changes in performance after MedImpact delegation will be monitored.

Out of Network Specialist Utilization Metric. There was an increase in out of network (OON) authorization approvals in Q4 compared to Q3. This increase, associated largely with CCS paneled provider activity, likely reflects members' resuming care despite continued pandemic activity.

Overall, for the year 2021, the volume of authorized approvals was 381, well below the 33,340 approvals seen in 2019, prior to the COVID-19 pandemic. Clearly, pandemic activity has impacted overall utilization; however, the Plan's proactive outreach for CCS paneling has continued with new OON outreach efforts initiated in Q4 2021, including a letter campaign for potential CCS paneled providers. Continued expansion of the CCS provider network into 2022 is anticipated, with orthopedics as an initial primary focus due to trauma and CCS referrals.

Under/Over Utilization Tracking and Reporting

1. Nerve Conduction Tests (95905-95913): Utilization decreased, slightly, from 322 in Q3, to 301 approved authorizations in Q4. The volume seems stable

over the course of the year and showing reduced volumes from last year (total 2020=1,758, total 2021=1,298).
2. EMG (95885-59887): Utilization for these codes decreased from 126 in Q3 to 105 in Q4. Total approved authorization for the 2021 reporting year was somewhat over the 2020 totals (2020=463, and 2021=516).
3. Neurology and Neuromuscular Procedures (95860-95782): Code reporting changed. Overall utilization for 2021 (51 approve authorizations), has decreased from 2020 (67) for these codes.

Overall, there has been no indication of over utilization; nerve conduction tests are stable and there has been some decrease seen for EMG codes.

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

Report drawn for the last 30 days of Q4 shows the top five average claims:

1. Therapeutic Behavioral Services (8,320)
2. Behavioral Health Day Treatment (3,348)
3. Medication List Documented in Medical Record (1,417)
4. Review of All Medication by a Prescribing Practitioner (1,416)
5. Oxygen Concentrator (1,317)

The current recommendation is to continue to monitor for trending behavioral health related services, medication review, and oxygen concentrator authorization requests.

Delegate Oversight Outcomes

Delegated Oversight Quarterly Report Summary. All reports were received on time for this reporting quarter and no recommendations were made.

Behavioral Health. The penetration rates lag by one quarter due to claims-based analysis. This information represents mild-moderate mental health services utilization rates for Q3 2021, roughly stable in comparison to the first and second quarters. Counties fall within or exceed the goal range with the exception of Merced County utilization for members aged 19+ which is under the goal range by 2.9%.

Staff recommendation is to bring penetration rates to the Beacon Joint Operations meeting. Ongoing collaboration with Beacon to expand network capacity within Merced and Monterey Counties continues.

Beacon UM File Audit. The UM file review for Q4 is still in progress and will be reported out next quarter.

2022 Utilization Management Workplan Template – Summary of Changes (by section)

Projects and Initiatives. No changes

Operational Performance. No changes

Utilization Performance.

- Inpatient Utilization: Updates made to meet or exceed State admissions averages and bed-day goals.
- Emergency Utilization: Updated State averages and goals.
- Pharmacy:
    - PMPM: Removed Pharmacy claims as they are now administered by Magellan.
    - Medical Necessity Pharmacy denied. Will only reflect physician administered drugs (PADs).
    - Top 10 Pharmacy drugs that result in medical necessity denial – changed to top five PADs.
    - Narcotic Utilization Program removed. Medi-Cal has transitioned to Magellan and IHSS line-of-business delegated to MedImpact.
    - Prescription Emergency Access removed per confirmation with Compliance as Medi-Cal Pharmacy claims are not the responsibility of the Alliance.
- Under/Over Utilization Tracking and Reporting: Added language to description for Auto Authorization/No Tar Required (NTR) monitoring.
- Emerging Under/Over Utilization: Added field for Auto Authorization/NTR reporting.

Utilization Management Delegated Oversight.

- Added sections to report out on the MedImpact UM File Audit and MedImpact Medical Necessity Pharmacy Denials Per Quarter.

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

Attachments.

1. 2022 Utilization Management Work Plan Template

Summary of Changes for 2022 UM Work Plan Template

Projects and Initiatives

A. Pediatric Case Management: No changes
B. System Transformation Development / Community Care Coordination: Objectives updated for 2022
C. Reducing Readmissions Initiative: No Changes

Operational Performance

A. Routine Prior Authorization Turn Around Time: No changes
B. Prior Authorization Request Determination Metrics: No changes
C. Top 10 Prior Authorization Medical Necessity Denials: No changes
D. Inter-Rater Reliability - Nurses/MDs/Rx: No changes

Utilization Performance

A. Inpatient Utilization: Updated Admins(K/Y) reported in 2021, State Admit Averages, and Bed-Day Goals
B. Ambulatory Care Sensitive Admissions (ACSA): No changes
C. Readmissions: No changes
D. Alternatives to Acute Inpatient Days: No changes
E. Long-term Care: No changes
F. Emergency Department Utilization: Updated State averages from DHCS Medi-Cal Dashboard released 1/24/22 (for data through 3/2021), and 2022 Goals.
G. Pharmacy Utilization:
    1. PMPM – removed. Pharmacy claims shifted to Magellan.
    2. Medical Necessity Pharmacy Denied – will only reflect PADs
    3. Top 10 Pharmacy drugs that result in medical necessity denial. – changed to top 5 PADs
    4. Narcotic Utilization program – removed – Medi-Cal moved to Magellan. IHSS moved to MedImpact.
    5. Prescription Emergency Access – Removed after confirmation with Compliance. Not pertinent as Medi-Cal Pharmacy claims not our responsibility.
H. Out-of-Network Specialist Utilization Metric: No changes
I. Under / Over Utilization Tracking and Reporting: Added language to description for Auto Auth/NTR monitoring
J. Emerging Under / Over Utilization Analysis: Added field for Auto Auth/NTR reporting

UM Delegate Oversight

A. UM Delegate Oversight Quarterly Report Summary: No changes
B. Medi-Cal Mental Health Utilization Rates: No changes
C. Beacon UM File Audit: No changes
D. Added MedImpact UM File Audit
Added MedImpact Medical Necessity Pharmacy Denial Per Quarter.

Central California Alliance for Health
2022 Utilization Management Work Plan and Evaluation

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

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

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

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

INITIAL WORK PLAN AND EVALUATION APPROVAL:

Submitted and approved by UMWG — Date: 3/15/2022

Submitted and approved by CQIC — Date: 4/28/2022

Submitted and approved by Board — Date:

Gordon Arakawa, MD, Medical Director — Date: 4/29/2022

Dale Bishop, MD, Chief Medical Officer — Date: 4/29/2022

N/A
TBD - UM/Complex Case Management Director — Date:

FINAL EVALUATION APPROVAL:

Submitted and approved by UMWG — Date:

Submitted and approved by CQIC — Date:

Submitted and approved by Board — Date:

Gordon Arakawa, MD, Medical Director — Date:

Dale Bishop, MD, Chief Medical Officer — Date:

UM/Complex Case Management Director — Date:

I. Projects and Initiatives

A. Pediatric Case Management

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

2022 Evaluation								
Time Period	Total # of Eligible members by County	# Newly Eligible by County	# Aged Out by County	# Approved NICU/PICU by County	# High Risk Members	# Low Risk Members	# ICPs	Comments/Recommendations
1st Quarter								
2nd Quarter								
3rd Quarter								
4th Quarter								
Year End								

B. System Transformation Development / Community Care Coordination

Prepare for Execution of Enhanced Case Management (ECM) and In-Lieu of Services (ILOS) in Merced County in Q3, and expand ECM and CS to meet the 3 new DHCS populations of focus in Jan. 2023.

2022 Evaluation			
Time Period	Objective	Status	Comments/Recommendations
1st Quarter	Implement ECM and CS in Santa Cruz and Monterey Counties. Support the development of contracted providers understanding of ECM core services.		
2nd Quarter	Align with PS dept. to provide Merced County Provider Engagement Sessions, and review provider engagement questionnaires, and provide recommendations regarding onboarding new providers.		
3rd Quarter	Implement ECM and CS in Merced County. Support the development of contracted providers understanding of ECM core services.		
4th Quarter	Align with PS dept. to provide contracted and noncontracted potential ECM and CS providers with information about the 3 populations of focus to be added in 2023. Support the expansion of the ECM/CS network to assist these new populations of focus in 2023.		
Year End			

C. Reducing Readmissions Initiative

To support reducing hospital readmissions, UM/CCM will track and evaluate the impact of the Post Discharge Meal Delivery Program (PDMDP) and the Recuperative Care Pilot (RCP) as it relates to reductions in readmissions for members participating in these services.

2022 Evaluation								
Time Period	PDMDP # Enrolled	PDMDP # Completed in 12 Weeks	PDMDP # Not Competed in 12 Weeks	PDMDP # Readmits During 12 Week Period	RCP # Enrolled	RCP # Enrolled	RCP Length of Stay	Comments/Recommendations
1st Quarter								
2nd Quarter								
3rd Quarter								
4th Quarter								
Year End								

II. Operational Performance

A. Routine Prior Authorization Turn Around Time

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

2022 Evaluation				
Time Period	**Goal**	**Results**	**Assessment & Interventions**	**Recommendation for Future**
1st Quarter	**100%**			
2nd Quarter	**100%**			
3rd Quarter	**100%**			
4th Quarter	**100%**			

B. Prior Authorization Request Determination Metrics

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

2022 Evaluation							
Time Period	**#PA Volume**	**# Voided Auths**	**# Medical Necessity Denials**	**# Appeals**	**#Appeals Upheld**	**# Overturned**	**Assessment & Interventions**
1st Quarter							
2nd Quarter							
3rd Quarter							
4th Quarter							
YTD/Year End							

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

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

2022 Evaluation		
Time Period	**List Denials**	**Assessment & Interventions**
1st Quarter		
2nd Quarter		
3rd Quarter		
4th Quarter		

D. Inter-rater Reliability Review – Nurses

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

2022 Evaluation				
Time Period	**Goal**	**Results**	**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**		Annual measure - Q4 Results	Annual measure - Q4 Results

F. Inter-rater Reliability Review – Physicians

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

2022 Evaluation				
Time Period	**Goal**	**Results**	**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**		Annual measure - Q4 Results	Annual measure - Q4 Results

G. Inter-rater Reliability Review – Pharmacists

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

2022 Evaluation				
Time Period	**Goal**	**Results**	**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**		Annual measure - Q4 Results	Annual measure - Q4 Results

III. Utilization Performance

A. Inpatient Utilization

The goals per line of business and by Medi-Cal aid category groupings were developed using Alliance historical performance, and DHCS state benchmarks. Of note; the state benchmarks reflect admissions per thousand per year (K/Y), while the Alliance uses bed-days per K/Y. The bed-days per K/Y goal was established by utilizing the historic average length of stay as a multiplier. The Alliance Bed Ambulatory Care Sensitive Admissions (ACSA) and 30-day Readmissions tracked per line of business and region.

IHSS							Goal						
Time Period	2021 Admit/K/Y Reported	2022 Admit/K/Y	Admit/K/Y State Average	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance		ACSA %	Readmits %	Assessment	Interventions
1st Quarter	54		N/A				200						
2nd Quarter	64		N/A				200						
3rd Quarter	32		N/A				200						
4th Quarter	63		N/A				200						
YTD/Year End	53		N/A				200						

Medi-Cal Child and Family Aid Codes							Goal						
Time Period	2021 Admit/K/Y Reported	2022 Admit/K/Y	Admit/K/Y State Average 03/21	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	31		82				160						
2nd Quarter	36		82				160						
3rd Quarter	36		82				160						
4th Quarter	37		82				160						
YTD/Year End	35		82				160						

Medi-Cal Seniors and Persons with Disabilities Aid Codes							Goal						
Time Period	2021 Admit/K/Y Reported	2022 Admit/K/Y	Admit/K/Y State Average 03/21	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	233		433				1300						
2nd Quarter	328		433				1300						
3rd Quarter	227		433				1300						
4th Quarter	224		433				1300						
YTD/Year End	234		433				1300						

New Medicaid Expansion Members (i.e. former LIHP, as well as new M aid code and 7U/7W aid code members)							Goal						
Time Period	2021 Admit/K/Y Reported	2022 Admit/K/Y	Admit/K/Y State Average 03/21	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	72		122				375						
2nd Quarter	75		122				375						
3rd Quarter	74		122				375						
4th Quarter	75		122				375						
YTD/Year End	73		122				375						

A. Inpatient Utilization (Continued)

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

							Goal					
Time Period	2021 Admit/K/Y Reported	2022 Admit/K/Y	Admit/K/Y State Average 12/2019	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	52		53				292					
2nd Quarter	57		53				292					
3rd Quarter	55		53				292					
4th Quarter	57		53				292					
YTD/Year End	55		53				292					

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

Ambulatory Care Sensitive Admissions (ACSA) per region.

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

C. Readmissions (%)

*30-day Readmissions per region

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

D. Alternatives to Acute Inpatient Days - Skilled Nursing Facility

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

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

E. Long-term Care

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

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

F. Emergency Department

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

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

Medi-Cal Child and Family				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 03/21	% CCS Visits	Assessment	Interventions
1st Quarter				400		317			
2nd Quarter				400		317			
3rd Quarter				400		317			
4th Quarter				400		317			
YTD/Year End				400		317			

F. Emergency Department (Continued)

Medi-Cal Seniors and Persons with Disabilities				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 03/21	% CCS Visits	Assessment	Interventions
1st Quarter				900		917			
2nd Quarter				900		917			
3rd Quarter				900		917			
4th Quarter				900		917			
YTD/Year End				900		917			

Medicaid Expansion (i.e. former LIHP, as well as new M aid code and 7U/W aid code members)				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 03/21	% CCS Visits	Assessment	Interventions
1st Quarter				500		502			
2nd Quarter				500		502			
3rd Quarter				500		502			
4th Quarter				500		502			
YTD/Year End				500		502			

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

G. Pharmacy

Medical Necessity Pharmacy Denials Per Quarter

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

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

Top 5 Physician Administered Drugs that Result in Medical Necessity Denial

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

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

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

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

Time Period	Total Auths	Approvals	Denials	Voided / Canceled	Top 5 Specialty Types by County	Assessment & Interventions
1st Quarter					Merced: Monterey: Santa Cruz:	
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End	0	0	0	0		

I. Under / Over Utilization Tracking and Reporting

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

2022 Evaluation				
Time Period	Monitored Category	Over or Under	Assessment	Interventions
1st Quarter	1.EMG 2. Auth Redesign Codes (As identified) 3. IHA 4. Breast Cancer Screening 5. Colon Cancer Screening 6. Lead Screening 7. ACE Screening 8. Mental Health Visits 9. ED Utilization	1.Over 2. Over 3. Under 4. Under 5. Under 6. Under 7. Under 8. Under 9. Over		
2nd Quarter				
3rd Quarter				
4th Quarter				

J. Emerging Under / Over Utilization Analysis

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

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

IV. UM Delegate Oversight

A. UM Delegate Oversight Quarterly Report (Analysis Summary)

Time Period	Delegate	Report Due Date	Reports Received	Reports Required	Follow-up Plan
Q4-20: Reported - Q1-21	Beacon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q1-21: Reported - Q2-21	Beacon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q2-21: Reported - Q3-21	Beacon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q3-21: Reported - Q4-21	Beacon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	

B. Medi-Cal Mental Health Utilization Rates

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

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

C. Beacon UM File Audit

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

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

D. MedImpact UM File Audit

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

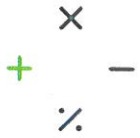
Time Period	% Compliance	Summary of Non-Compliance	Follow-up Actions
1st Quarter			
2nd Quarter			
3rd Quarter			
4th Quarter			

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

MedImpact Medical Necessity Pharmacy Denials Per Quarter

Monitoring of Pharmacy prior authorization volume and appeals.

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



Communication with
the Commissioners

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

December 31, 2021

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Communication with the Commissioners

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

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health (the "Alliance") as of and for the year ended December 31, 2021 and have issued our report thereon dated April 28, 2022. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America

As stated in our engagement letter dated October 2, 2017 and amendment dated February 25, 2020, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). As part of an audit conducted in accordance with U.S. GAAS, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health's internal control over financial reporting. Accordingly, we considered Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The required supplementary information and supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated October 2, 2017, as amended February 25, 2020.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health are described in Note 2 to the financial statements. No new accounting policies were adopted and there were no changes in the application of existing policies during 2021. We noted no transactions entered into by the Alliance during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the financial statements were:

- Management's estimate of the liability for incurred but unreported claims expense is based on historical claims experience and known activity subsequent to year end. We evaluated the key factors and assumptions used to develop the incurred but unreported claims expense in determining that they are reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the capitation receivable and revenue for eligible program beneficiaries is based upon a historical experience methodology using contracted rates and member counts. We evaluated the key factors and assumptions used to develop the capitation receivable in determining that they are reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the fair market values of 401a plan investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We found management's process to be reasonable.

Financial Statement Disclosures

The disclosures in the financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were medical claims liability and capitation revenue.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the Alliance's financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the Alliance's financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with U.S. GAAS. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected and uncorrected misstatements, whose effects, as determined by management were material, both individually or in the aggregate, to the financial statements taken as a whole

Management Representations

We have requested certain representations from management that are included in the management representation letter dated April 28, 2022.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the Alliance's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Commissioners and management of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health, and is not intended to be, and should not be, used by anyone other than these specified parties.

Moss Adams LLP

San Francisco, California
April 28, 2022

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April 28, 2022

Moss Adams LLP
101 2nd Street, Suite 900
San Francisco, California, 94105

We are providing this letter in connection with your audits of the financial statements of Central California Alliance for Health (the "Alliance"), which comprise the statements of net position, statements of revenues, expenses, and changes in net position, and cash flows as of December 31, 2021 and 2020 and for the years then ended, and the related notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP). Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial matters less than $2,570,000 collectively are not considered to be exceptions that require disclosure for the purpose of the following representations. This amount is not necessarily indicative of amounts that would require adjustment to or disclosure in the financial statements.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of April 28, 2022.

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated October 2, 2017, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.

2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

3. We acknowledge our responsibility for the design, implementation, and maintenance of internal controls to prevent and detect fraud.

4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

5. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.

6. All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.

7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.

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Information Provided

8. We have provided you with:

   a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation, and other matters;

   b. Minutes of the meetings of stockholders, directors, and committees of directors, or summaries of actions of recent meetings for which minutes have not yet been prepared;

   c. Additional information that you have requested from us for the purpose of the audit;

   d. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

9. All transactions have been properly recorded in the accounting records and are reflected in the financial statements.

10. We have retained copies of all information we provided to you during the engagement and have been provided copies of all necessary financial and non-financial schedules, memos, data, and other information related to all services performed by you, such that in our opinion our records are complete, including our records supporting our financial statements and all related accounting policies and positions. Furthermore, you do not act as the sole host of any financial or non-financial information system for us, nor do you provide any electronic security or back-up services for our data or records.

11. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

12. We have no knowledge of any fraud or suspected fraud that affects the entity and involves—

    a. Management,

    b. Employees who have significant roles in internal control, or

    c. Others when the fraud could have a material effect on the financial statements.

13. We have no knowledge of any allegations of fraud or suspected fraud affecting the entity's financial statements communicated by employees, former employees, analysts, regulators, or others.

14. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

15. We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the financial statements.

16. We have disclosed to you the identity of all the entity's related parties and all the related party relationships and transactions of which we are aware.

17. There are no—

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a. Violations or possible violations of laws or regulations, such as those related to the Medicare antifraud and abuse statutes, including but not limited to the Anti-Kickback Act, Limitations on Certain Physician Referrals (commonly referred to as the "Stark law"), and the False Claims Act, in any jurisdiction whose effects should be considered for disclosure in the financial statements or as basis for recording a loss contingency other than those disclosed or accrued in the financial statements.

b. Possible illegal acts brought to the attention of management.

c. Unasserted claims or assessments that our lawyer has advised us are probable of assertion and must be disclosed in accordance with GASB 62 section 1500, *Reporting Liabilities*, paragraph .114 and section C50, *Claims and Judgments*, paragraph .115.

d. Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB 62 section 1500 paragraph .114 and section C50 paragraph .115.

18. The Alliance has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral, except as disclosed to you and reported in the financial statements.

19. The Alliance has complied with all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance.

20. The Alliance has been in compliance with the requirements of licensure under the Knox-Keene Health Care Service Plan act of 1975.

21. Capitation revenue as disclosed in Note 2 of the financial statements is fairly stated in accordance with GAAP.

22. We have complied with all restrictions on resources and all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance.

23. We have disclosed to you any change in the Alliance's internal control over financial reporting that occurred during the Alliance's most recent fiscal year that has materially affected, or is reasonably likely to materially affect, the Alliance's internal control over financial reporting.

24. We have responded fully and truthfully to all inquiries made to us by you during your audits.

25. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the financial statements or on the disclosure in the notes to the financial statements.

26. We have made available to Moss Adams all known reviews, surveys and inquiries from Federal, State and local regulatory authorities completed or ongoing. We confirm that we are not aware of any non-compliance with laws and regulations.

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27. No violations or possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements. This is including, but not limited to, the anti-kickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law), and the False Claims Act.

28. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning the investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.

29. We have appropriately reconciled our books and records (e.g., general ledger accounts) underlying the financial statements to their related supporting information (e.g. sub ledger or third-party data). All related reconciling items considered to be material were identified and included on the reconciliations and were appropriately adjusted in the financial statements. There were no material un-reconciled differences or material general ledger suspense account items that should have been adjusted or reclassified to another account balance. There were no material general ledger suspense account items written off to a statement of net position account, which should have been written off to an income statement account and vice versa.

30. Medical claims liability, including amounts for incurred but not reported claims and estimated recoveries for salvage and subrogation have been determined using appropriate estimated ultimate costs of settling the claims (including the effects of inflation and other societal and economic factors), considering past experience adjusted for current trends and any other factors that would modify past experience. The estimated liability is to the best of our knowledge and belief, an accurate estimate of our incurred but unreported health claims liability as of December 31, 2021 and 2020. The data used in projecting the ultimate unpaid claims and claims adjustment expense is complete and accurate, and is reconciled to the underlying accounting records.

31. Management has no knowledge of a large pool of impending claims outstanding at December 31, 2021 and 2020 that would materially affect the estimate for liability for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims.

32. All reinsurance transactions entered into by the Alliance are final and there are no side agreements with reinsurers, or other terms in effect, which allow for the modification of term under existing reinsurance arrangements. Furthermore, the Alliance's reinsurance arrangements meet the risk transfer provisions or are accounted for as deposits.

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33. Pay for performance, provider incentive, withhold, capitation and other arrangements with providers wherein the Alliance is obligated to provide for a settlement of accounts with providers have been calculated in accordance with the existing arrangements and are included in the statement of net positions at net realizable value, giving consideration to all amounts due under arrangements. We believe provider incentives payable is fairly stated as of December 31, 2021 and 2020, respectively.

34. Board designated reserves have been approved by the Alliance's Board and is complete and accurate.

35. The Alliance has accepted the following responsibilities related to the non-attest services provided related to the drafting the financial statements and related footnotes as of December 31, 2021 and 2020:

    a. Make all management decisions and perform all management functions.

    b. Designate an individual with suitable skill, knowledge, and / or experience to oversee the non-attest services.

    c. Evaluate the adequacy and results of the non-attest services performed.

    d. Accept responsibility for the results of the non-attest services performed.

    e. Establish and maintain internal controls including monitoring ongoing activities.

36. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by third-party organizations or other regulatory agencies.

37. We have the intent and ability to commit the necessary resources to become compliant with the laws and regulations contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") by the required compliance deadlines. We have no information that indicated that a significant vendor may be unable to sell to the Alliance; a significant customer may be unable to purchase from the Alliance; or a significant service provider may be unable to provide services to the Alliance, in each case because of their respective inability to comply with HIPAA.

38. We have reviewed all recently released accounting pronouncements and have evaluated those that may have an effect on the Alliance in the current and subsequent periods and disclosed as appropriate in the financial statements.

39. We are not aware of any reason that Moss Adams LLP would not be considered to be independent for purposes of the Alliance's audit.

40. To our knowledge, there are no instances where any officer or employee of the Alliance has an interest in a company with which the Alliance does business that would be considered a "conflict of interest." Such an interest would be contrary to the Alliance's policy.

41. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the financial statements of the Alliance are properly disclosed.

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42. We have performed an analysis of expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under our contracts. We have determined that expected costs do not exceed anticipated revenues. Based on our analysis, we believe no premium deficiency reserves are necessary at December 31, 2021 and 2020, respectively.

43. We acknowledge our responsibility for presenting the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position, in accordance with accounting principles generally accepted in the United States of America and we believe the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position are measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.

44. To the best of our knowledge and belief, no events have occurred subsequent to the balance sheet date and through the date of this letter that would require adjustment to or disclosure in the aforementioned financial statements.

DocuSigned by:
Lisa Ba
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Lisa Ba, CFO

DocuSigned by:
Joy Cubbin
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Joy Cubbin, Accounting & Administrative Contracts Director

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Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
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Signing Complete	Security Checked	4/28/2022 10:22:20 AM
Completed	Security Checked	4/28/2022 10:46:15 AM

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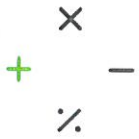

Report of Independent Auditors and
Financial Statements with Supplementary Information

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

December 31, 2021 and 2020

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Management's Discussion and Analysis

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Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Management's Discussion and Analysis
Years Ended December 31, 2021, 2020, and 2019

The intent of the management's discussion and analysis of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health (the Alliance) is to provide readers with an overview of the Alliance's financial activities for the fiscal years ended December 31, 2021, 2020, and 2019. Readers should review this summation in conjunction with the Alliance's financial statements and accompanying notes to the financial statements to enhance their understanding of the Alliance's financial performance.

Key Operating Indicators – Proprietary Fund

The table below compares key operating indicators for the Alliance for the fiscal years 2021, 2020, and 2019:

Key operating indicators	Fiscal years ended December 31 2021	2020	2019	2021-2020 Change	2020-2019 Change
Members (at end of fiscal period):					
Medi-Cal program	386,535	364,613	333,603	21,922	31,010
IHSS program	517	540	586	(23)	(46)
Average member months:					
Medi-Cal program	377,585	349,674	339,406	27,911	10,268
IHSS program	514	568	619	(54)	(51)
Total revenues (in millions)	$ 1,732.7	$ 1,474.6	$ 1,303.4	$ 258.1	$ 171.2
Capitation revenue	$ 1,733.1	$ 1,467.6	$ 1,285.5	$ 265.5	$ 182.1
Investment and other income	$ (0.4)	$ 7.0	$ 17.9	$ (7.4)	$ (10.9)
Operating expenses (in millions):					
Medical expenses (in millions)	$ 1,360.9	$ 1,222.0	$ 1,214.1	$ 138.9	$ 7.9
Administrative expenses (in millions)	$ 243.6	$ 224.5	$ 145.2	$ 19.1	$ 79.3
Increase (decrease) in net assets (in millions):	$ 118.2	$ 13.8	$ (69.0)	$ 104.4	$ 82.8
Total revenues per member per month	$ 381.9	$ 350.9	$ 319.4	$ 31.0	$ 31.4
Operating expenses per member per month:					
Medical expenses per member per month	$ 299.9	$ 290.8	$ 297.6	$ 9.2	$ (6.8)
Administrative expenses per member per month	$ 53.7	$ 53.4	$ 35.6	$ 0.3	$ 17.8
Increase (decrease) in net assets per member per month	$ 26.1	$ 3.3	$ (16.9)	$ 22.8	$ 20.2
Medical loss ratio	78.5 %	83.3 %	94.4 %	(4.80) %	(11.10) %
Administrative expense ratio	14.1 %	15.2 %	11.1 %	(1.10) %	4.10 %
Administrative expense ratio (excluding premium tax)	4.9 %	5.6 %	6.2 %	(0.70) %	(0.60) %

Overview of the Financial Statements

This annual report consists of the basic financial statements of the business-type activities and the aggregate remaining fund information of the Alliance, and the related notes to those statements, which reflect the Alliance's financial position and results of its operations for the fiscal years ended December 31, 2021 and 2020. The basic financial statements of the Alliance, including the statements of net position, statements of revenues, expenses, and changes in net position; statements of cash flows, represent the combined accounts and transactions of the two programs – Medi-Cal and Alliance Care IHSS program – operated by the Alliance.

- The statements of net position include all of the Alliance's assets and liabilities, using the accrual basis of accounting, as well as an indication about which assets are utilized to fund obligations to providers and which are restricted or designated as a matter of the Alliance's board of directors' policy.

- The statements of revenues, expenses, and changes in net position present the results of operating and nonoperating activities during the respective fiscal years and the resulting decrease or increase in net position.

- The statements of cash flows report the net cash provided by operating activities, as well as other sources and uses of cash from investing and capital and noncapital related financing activities.
- The statements of fiduciary net position include all of the Alliance's assets and liabilities for the 401(a) Money Purchase Plan and Trust, using the accrual basis of accounting.
- The statements of changes in fiduciary net position, present the results of activities during the respective fiscal years and the resulting decrease or increase in fiduciary net position.

The following discussion and analysis addresses the Alliance's overall program activities. The Medi-Cal program accounted for approximately 99.8% of the Alliance's annual revenues during fiscal years 2021, 2020, and 2019.

Financial Highlights Fiscal Year 2021

- Total assets at year-end were $981.8 million and exceeded liabilities by $582.8 million.
- Net position increased by $118.2 million or 25.4% during fiscal year 2021.

Financial Highlights Fiscal Year 2020

- Total assets at year-end were $833.4 million and exceeded liabilities by $464.6 million.
- Net position decreased by $13.8 million or 3.1% during fiscal year 2020.

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

Financial position	As of December 31			2021-2020 Change		2020-2019 Change	
	2021	2020	2019	Amount	Percentage	Amount	Percentage
Assets:							
Current assets	$ 545,465	$ 451,649	$ 317,781	$ 93,816	20.8 %	$ 133,868	42.1 %
Capital assets, net	42,236	49,929	54,263	(7,693)	(15.4)	(4,334)	(8.0)
Board-designated investments and restricted deposit	394,098	331,862	305,645	62,236	18.8	26,217	8.6
Total assets	$ 981,799	$ 833,440	$ 677,689	$ 148,359	17.8 %	$ 155,751	23.0 %
Liabilities:							
Current liabilities	$ 399,006	$ 368,850	$ 226,914	30,156	8.2 %	$ 141,936	62.6 %
Total liabilities	399,006	368,850	226,914	30,156	8.2	141,936	62.6 %
Net position:							
Invested in capital assets	42,236	49,929	54,263	(7,693)	(15.4) %	(4,334)	(8.0) %
Restricted	300	300	300	-	-	-	-
Unrestricted	540,257	414,361	396,212	125,896	30.4	18,149	4.6
Total net position	582,793	464,590	450,775	118,203	25.4 %	13,815	3.1 %
Total liabilities and net position	$ 981,799	$ 833,440	$ 677,689	$ 148,359	17.8 %	$ 155,751	23.0 %

Capital Assets Fiscal Year 2021

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

Capital Assets Fiscal Year 2020

Capital assets, net decreased from $54.3 million to $49.9 million, or by $4.4 million, in 2020 compared to the previous year. This decrease is the net result of $2.2 million in capital additions and $6.5 million in depreciation expense. Capital additions included $1.8 million in construction in process, which was subsequently transferred and reflected in building additions and in furniture and equipment.

Liquidity Fiscal Year 2021

At December 31, 2021, the Alliance maintained a working capital ratio, including board-designated investments, of 2.35. The increase of $125.9 million in working capital in 2021 compared to the prior year is primarily due to the change in net position.

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

Liquidity Fiscal Year 2020

At December 31, **2020**, the Alliance maintained a working capital ratio, including board-designated investments, of 2.12. The increase of $18.1 million in working capital in **2020** compared to the prior year is primarily due to the change in net position.

During **2020**, board-designated investments increased by $26.2 million from the prior year. The increase is due to improved revenues in 2020.

Results of Operations

The Alliance's fiscal year 2021 operations resulted in a $118.2 million increase in net position compared to a $13.8 million increase in net position in fiscal year 2020. The Alliance's fiscal year 2019 operations resulted in a $69.0 million decrease in net position.

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

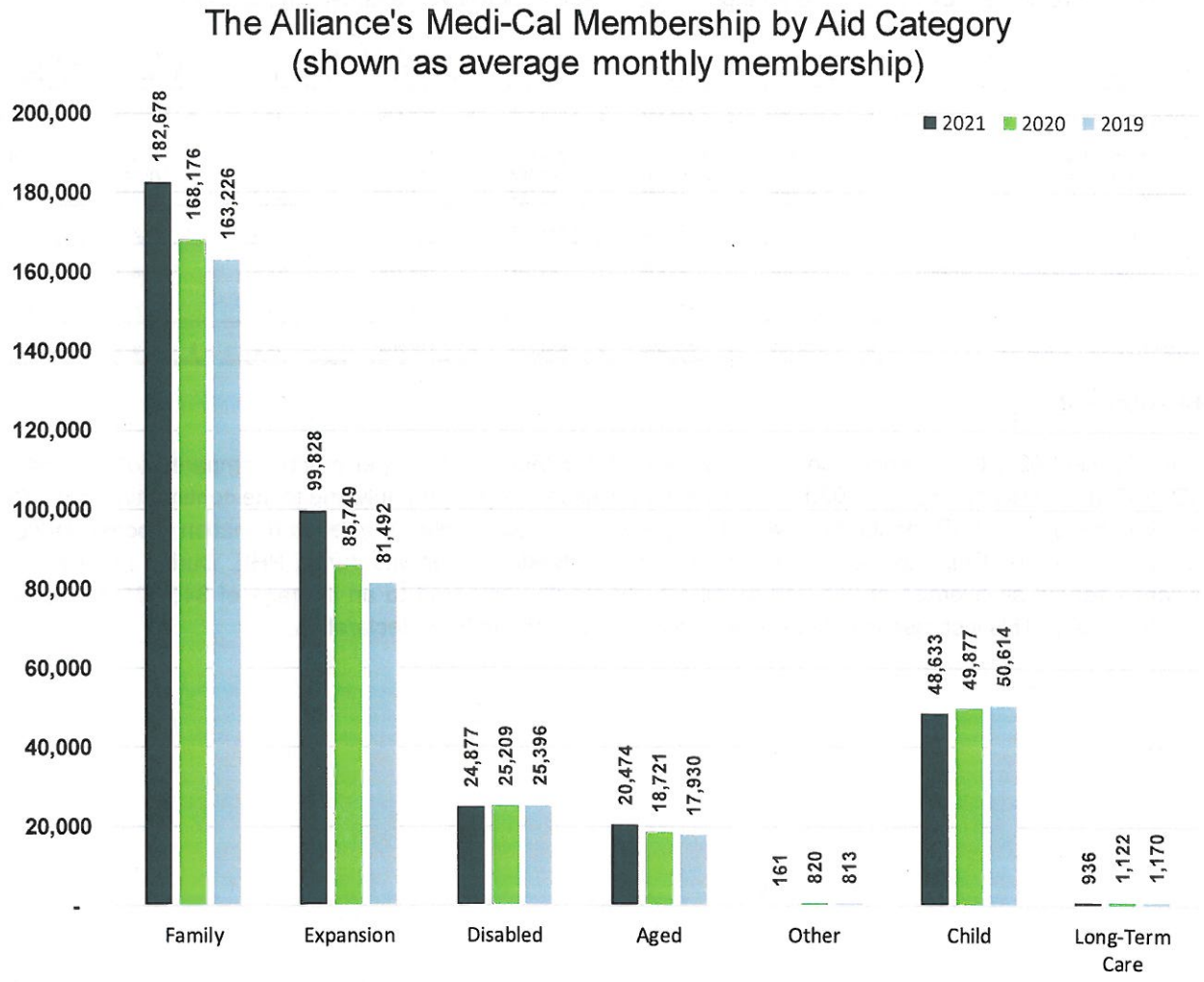
Condensed revenues, expenses, and changes in net position for the years ended (in thousands):

Results of operations	2021	2020	2019	2021-2020 Change Amount	2021-2020 Change Percentage	2020-2019 Change Amount	2020-2019 Change Percentage
Revenues	$ 1,732,733	$ 1,474,585	$ 1,303,376	$ 258,148	17.5 %	$ 171,209	13.1 %
Expenses:							
Total medical expenses	1,360,894	1,222,017	1,214,097	138,877	11.4	7,920	0.7
Total administrative expenses	243,570	224,508	145,163	19,062	8.5	79,345	54.7
Grants	10,066	14,245	13,162	(4,179)	(29.3)	1,083	8.2
Total expenses	1,614,530	1,460,770	1,372,422	153,760	10.5	88,348	6.4
Increase (decrease) in net position	118,203	13,815	(69,046)	104,388	755.6	82,861	(120.0)
Total net position, beginning of year	464,590	450,775	519,821	13,815	3.1	(69,046)	(13.3)
Total net position, end of year	$ 582,793	$ 464,590	$ 450,775	$ 118,203	25.4 %	$ 13,815	3.1 %

Enrollment

During fiscal 2021, the Alliance served an average of 378,099 members per month compared to an average of 350,242 members per month in 2020. This increase in membership is primarily due to the continuation of the Public Health Emergency (PHE) declaration, which temporarily freezes the eligibility redetermination process. Under the Governor's orders, Counties cannot reduce or terminate Medi-Cal benefits during PHE. During fiscal 2020, the Alliance served an average of 350,242 members per month compared to an average of 340,025 members per month in 2019. This increase in membership is primarily due to the PHE declaration.

The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2021, 2020, and 2019:



Operating Revenues Fiscal Year 2021

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

Operating Revenues Fiscal Year 2020

Revenues in 2020 increased over 2019 mostly due to increased Medi-Cal capitation rates from the Department of Health Care Services (DHCS). Membership also increased in 2020 over 2019.

Medical Expenses Fiscal Year 2021

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

- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $38.6 million in 2021 compared to $35.0 million in 2020. The increased cost is attributable to a small increase in membership.
- Hospital inpatient and long-term care expenses increased by $21.0 million, or 3.8%, in 2021. The increased cost of care is due to increased membership.
- Expenses related to physicians, outpatient facilities, and allied health providers increased by $86.3 million, or 21.3%, in 2021. Most of the increase is due to increased rates paid to providers. Increased membership also contributed to the increase in expenses.
- Other medical increased by $7.1 million or 28.7% in 2021 primarily due to increased allocation of salaries to medical as well as expenses related to COVID vaccination member incentive expenses.
- Prescription drugs expenses increased by $13.2 million or 6.3% during 2021. The increase was due to prescription volume.
- Alliance Care IHSS program expenses decreased by $400 thousand. The decrease was due to a decrease in membership.
- Net reinsurance expense increased by $8.0 million compared to 2020 due to a decrease in recoveries as well as an increase in premiums.

Medical Expenses Fiscal Year 2020

Overall, medical expenses increased by 0.7% in 2020, totaling $1,222.0 million compared to $1,214.1 million in 2019. The Alliance's medical expenses, as a percentage of capitation revenues, was 83.3% in fiscal year 2020, compared to 94.4% in 2019. The Alliance's average medical costs per member per month decreased by 2.3% in 2020. Medical expenses include the following:

- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $35.0 million in 2020 compared to $33.9 million in 2019. The increased cost is attributable to a small increase in membership.

- Hospital inpatient and long-term care expenses increased by $18.3 million, or 3.4% in 2020. The increased cost of care is due to increased membership.

- Expenses related to physicians, outpatient facilities, and allied health providers decreased by $18.6 million, or 4.4%, in 2020. The primary reason for the decrease is decreased utilization due to the COVID 19 pandemic.

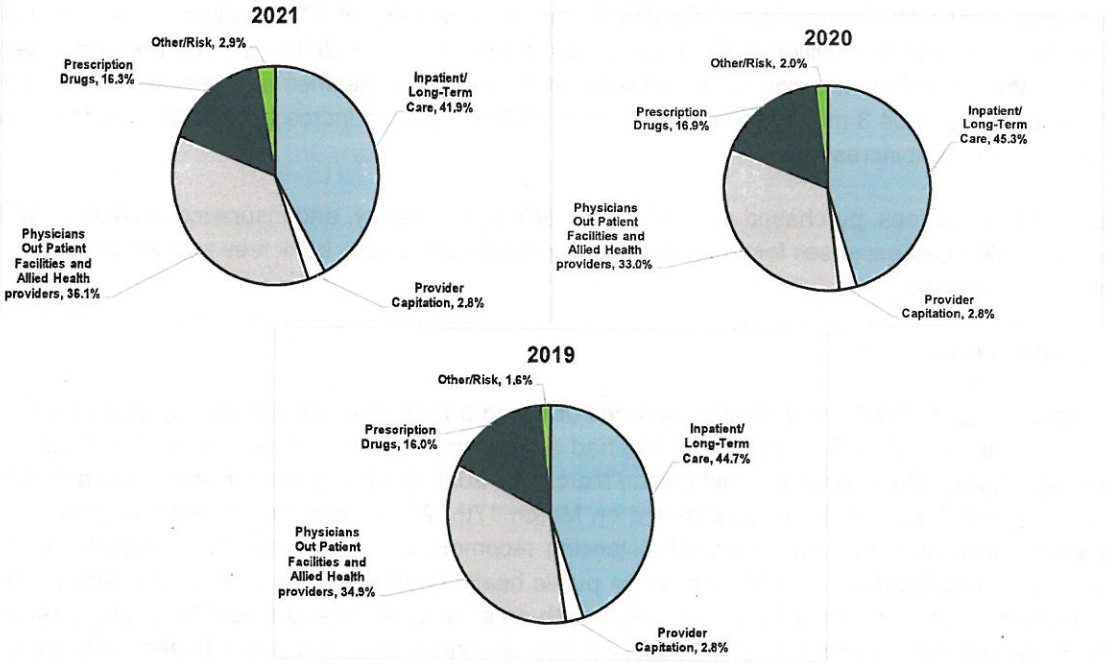
- Other medical decreased by $1.6 million or 6% in 2020 primarily due to decreased provider incentives in 2020.

- Prescription drugs expenses increased by $12.8 million or 6.5% during 2020. The increase was due to increased prescription drug pricing.

- Alliance Care IHSS program expenses increased by $274 thousand. The increase was due to favorable utilization.

- Net reinsurance recoveries decreased by $7.4 million compared to 2019 due to a large decrease in recoveries.

Below is a side-by-side comparison of medical expenses by major category and their respective percentages of the overall medical expenses in fiscal years 2021, 2020, and 2019:



Administrative Expenses Fiscal Year 2021

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

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

Administrative Expenses Fiscal Year 2020

Total administrative expenses were $224.5 million in 2020 compared to $145.2 million in 2019, for a net increase of $79.3 million or 54.7%. This increase is primarily due to an increase of $77.2 million in premium taxes in 2020. Premium taxes were $141.3 million in 2020, compared to $64.1 million in 2019. In 2019, premium taxes were only effective for the first six months compared to twelve months in 2020. Salaries and benefits expenses were $55.6 million, an increase of $4.3 million compared to 2019. Salary expense increased in 2020 due to increased head count and annual merit increases.

Overall, professional fees, purchased services and supplies, occupancy, and insurance decreased $2.3 million or 9.7% in 2020. Reduced expenses for temporary employee services, travel, bank fees and penalties were the largest drivers of the decrease.

Economic Factors

On January 31, 2020, Health and Human Services declared a Public Health Emergency as a result of confirmed COVID-19 cases. The COVID-19 pandemic has had a major impact on California's economy. Governor Newsom proclaimed a State of Emergency in California on March 4th, 2020 due to the serious and ongoing threat of COVID-19. A subsequent Executive Order was issued on March 17th, 2020, citing the widespread economic impact to nearly every business sector due to social distancing recommendations. Under these orders, Counties cannot reduce or terminate Medi-Cal benefits during the public health emergency. As a result, the Alliance experienced moderate membership growth. When the public health emergency ends and Medi-Cal eligibility redetermination resumes, membership is expected to decrease. As stay at home orders and public health guidance continued to encourage people to limit activities, the Alliance experienced significant utilization decrease throughout. As restrictions are loosened and vaccine becomes more widely available, it is expected that medical services will return to normal and back to the pre-pandemic level.

Effective in 2022, the State assumes the pharmacy coverage for all Medi-Cal members. As a result, the associated revenue and expenses for the Alliance will decrease.

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

FINANCIAL HIGHLIGHTS – FIDUCIARY FUND

The table below is a summarized comparison of the assets, liabilities and fiduciary net position of Central California Alliance for Health 401a Qualified Retirement Plan as of December 31, and the changes in fiduciary net position for the years ended December 31 (in thousands):

	2021	2020	2019
TOTAL ASSETS	$ 52,893	$ 43,156	$ 36,117
TOTAL LIABILITIES	-	-	-
TOTAL FIDUCIARY NET POSITION	$ 52,893	$ 43,156	$ 36,117
TOTAL ADDITIONS	$ 11,206	$ 8,649	$ 9,953
TOTAL DEDUCTIONS	1,469	1,610	1,788
INCREASE IN FIDUCIARY NET POSITION	9,737	7,039	8,165
FIDUCIARY NET POSITION - BEGINNING OF YEAR	43,156	36,117	27,952
FIDUCIARY NET POSITION - END OF YEAR	$ 52,893	$ 43,156	$ 36,117

Total fiduciary fund net position as of December 31, 2021, increased by $9.7 million from December 31, 2020 due to an increase in fair value of investments and contributions. Total fiduciary fund net position as of December 31, 2020, increased by $7.0 million from December 31, 2019 due to an increase in fair value of investments and contributions.

MOSSADAMS

Report of Independent Auditors

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

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health, as of and for the years ended December 31, 2021 and 2020, and the related notes to the financial statements, which collectively comprise Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health's financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements present fairly, in all material respects, the respective financial position of the business-type activities and aggregate remaining fund information of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health as of December 31, 2021 and 2020, and the respective changes in net position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 10 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audits were conducted for the purpose of forming an opinion on the financial statements that comprise the Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a Central California Alliance for Health's basic financial statements. The supplementary schedules of revenues and expenses by program and changes in net position for the years ended December 2021 and 2020, on pages 36 and 37 are presented for purposes of additional analysis and are not a required part of the basic financial statements.

The supplementary schedules of revenues and expenses by program and changes in net position is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the supplementary schedules of revenues and expenses by program and changes in net position for the years ended December 31, 2021 and 2020, are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Moss Adams LLP

San Francisco, California
April 28, 2022

Financial Statements

Back to Agenda

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Net Position
December 31, 2021 and 2020
(in thousands)

	2021	2020
Assets		
Current assets		
Cash and cash equivalents	$ 2,313	$ 11,172
Short-term investments	279,301	170,421
Capitation receivable from the Department of Health Care Services (DHCS)	242,183	244,359
Prepaid expenses and other assets	21,668	25,697
Total current assets	545,465	451,649
Capital assets, net		
Nondepreciable	7,778	10,044
Depreciable, net of accumulated depreciation	34,458	39,885
Capital assets, net	42,236	49,929
Board-designated investments	393,798	331,562
Restricted deposits	300	300
Total assets	$ 981,799	$ 833,440
Liabilities and Net Position		
Current liabilities		
Medical claims liability	$ 238,365	$ 200,716
Directed payments payable	98,686	110,100
Provider incentives payable	10,000	10,010
Accounts payable	3,032	3,121
Accrued liabilities	48,923	44,903
Total current liabilities	399,006	368,850
Net position		
Invested in capital assets	42,236	49,929
Restricted	300	300
Unrestricted	540,257	414,361
Total net position	582,793	464,590
Total liabilities and net position	$ 981,799	$ 833,440

See accompanying notes.

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

Statements of Revenues, Expenses, and Changes in Net Position

Years Ended December 31, 2021 and 2020

(in thousands)

	2021	2020
Operating revenues		
Capitation revenue	$ 1,733,131	$ 1,467,559
Operating expenses		
Medical expenses		
Medi-Cal		
Provider capitation	38,600	34,999
Claim payments to providers	1,060,662	953,263
Prescription drugs	221,921	208,701
Other medical	31,701	24,627
Alliance Care: In Home Supportive Services (IHSS) program	2,552	2,952
Reinsurance and other, net of (recoveries) expense	5,458	(2,525)
Total medical expenses	1,360,894	1,222,017
Administrative expenses		
Premium tax expense	157,938	141,313
Salaries, wages, and employee benefits	51,007	55,636
Supplies, occupancy, insurance, and other	16,083	9,230
Professional fees	9,806	8,689
Depreciation and amortization	5,759	6,499
Purchased services	2,977	3,141
Total administrative expenses	243,570	224,508
Total operating expenses	1,604,464	1,446,525
Operating income	128,667	21,034
Investment (loss) income, including net realized and unrealized gains and losses	(1,782)	5,909
Other income	1,384	1,117
Grants	(10,066)	(14,245)
Increase in net position	118,203	13,815
Net position, beginning of year	464,590	450,775
Net position, end of year	$ 582,793	$ 464,590

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Cash Flows
Years Ended December 31, 2021 and 2020
(in thousands)

	2021	2020
Cash flows from operating activities:		
Capitation and other revenue	$ 2,141,313	$ 1,813,119
Payments to providers	(1,721,600)	(1,530,507)
Payments to vendors	(188,916)	(145,664)
Payments to employees	(51,208)	(53,336)
Net cash provided by operating activities	179,589	83,612
Cash flows from capital and related financing activities:		
Purchases of capital assets	(5,497)	(2,165)
Net cash used in capital and related financing activities	(5,497)	(2,165)
Cash flows from noncapital financing activities:		
Grants	(10,066)	(14,245)
Net cash used in noncapital financing activities	(10,066)	(14,245)
Cash flows from investing activities:		
Purchases of investments	(377,033)	(304,226)
Sales of investments	205,918	234,444
Cash received from investment income	(1,770)	6,625
Net cash used in investing activities	(172,885)	(63,157)
Net change in cash and cash equivalents	(8,859)	4,045
Cash and cash equivalents, beginning of year	11,172	7,127
Cash and cash equivalents, end of year	$ 2,313	$ 11,172
Reconciliation of increase in net position to net cash provided by operating activities:		
Increase in net position	$ 118,203	$ 13,815
Adjustments to reconcile decrease in net position to net cash provided by operating activities:		
Depreciation and amortization	5,759	6,499
Investment income	1,782	(5,909)
Loss on disposal of capital assets	7,431	-
Grants	10,066	14,245
Changes in assets and liabilities:		
Capitation receivable from the DHCS	2,176	(72,637)
Prepaid expenses and other assets	4,017	(14,338)
Medical claims liability	37,649	15,783
Directed payments payable	(11,414)	110,100
Provider incentives payable	(10)	(154)
Medical loss ratio liability	-	(23,950)
Accounts payable	(89)	338
Accrued liabilities	4,019	39,820
Net cash provided by operating activities	$ 179,589	$ 83,612

See accompanying notes.

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

Statements of Fiduciary Net Position

December 31, 2021 and 2020

(in thousands)

	2021	2020
ASSETS		
Investments, at fair value		
Stable value/cash management	$ 5,861	$ 6,542
Bond	2,444	1,809
Guaranteed lifetime income	310	346
Balanced/asset allocation	31,422	24,096
U.S. stock	8,517	6,590
International/global stock	1,626	1,455
Specialty	1,567	1,319
Total investments, at fair value	51,747	42,157
Receivables		
Notes receivable from participants	1,146	999
Total receivables	1,146	999
NET POSITION AVAILABLE FOR BENEFITS	$ 52,893	$ 43,156

See accompanying notes.

Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2021 and 2020
(in thousands)

	2021	2020
Additions to net position attributed to Investment income		
Net appreciation in fair value of investments	$ 6,010	$ 4,347
Total investment income	6,010	4,347
Interest income on notes receivable from participants	46	47
Contributions		
Employer and employee contributions	4,646	4,252
Rollover contributions	504	3
Total contributions	5,150	4,255
Total additions	11,206	8,649
Deductions from net position attributed to		
Benefits paid to participants	1,504	1,493
Miscellaneous (credits) debits	(35)	117
Total deductions	1,469	1,610
Increase in net position	9,737	7,039
Net position available for benefits		
Beginning of year	43,156	36,117
End of year	$ 52,893	$ 43,156

See accompanying notes.

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NOTE 1 – ORGANIZATION

The Santa Cruz-Monterey-Merced Managed Medical Care Commission d.b.a. Central California Alliance for Health (the Alliance) is a Regional County Organized Health System serving Medi-Cal eligible persons in Santa Cruz, Monterey, and Merced Counties, California (the Counties). The Alliance is a local public agency separate and distinct from the respective county governments. The Alliance began serving enrollees in Santa Cruz County, expanded the Alliance's services into Monterey County, and expanded again into Merced County.

The Alliance has contracted with the California Department of Health Care Services (DHCS) to provide healthcare benefits to eligible County residents. In turn, the Alliance has contracted with various healthcare providers to provide or arrange hospital and medical services for its members. The Alliance's contract with DHCS extends through December 31, 2022.

The Alliance, in partnership with Monterey County In Home Supportive Services (IHSS) Public Authority, operates the Alliance Care IHSS program. Alliance Care IHSS provides comprehensive healthcare to IHSS caregivers in Monterey County.

The Medi-Cal program accounted for approximately 99.8% of the Alliance's revenues for the years ended December 31, 2021 and 2020.

The Alliance sponsors a 401(a) Money Purchase Plan and Trust (the Plan), which is a defined-contribution plan covering all of its employees. The Alliance also sponsors a voluntary 457 deferred compensation plan. See Note 7.

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of presentation – The Alliance is a locally governed and operated public health plan governed by the 21-member Santa Cruz-Monterey-Merced-Managed Medical Care Commission Board. The Alliance has no component units and is not reported as a component unit of any governmental entity.

Accounting standards – The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB). The activities of the Alliance are reported using the economic resources measurement focus and the accrual basis of accounting. Under this method, revenues are recorded when earned and expenses are recorded when the related liability is incurred. As permitted by GASB Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, the Alliance has elected to apply all Financial Accounting Standards Board Statements and Interpretations, Accounting Principles Board Opinions, and Accounting Research Bulletins issued after November 30, 1989, which have been codified under Accounting Standards Codification (ASC), except for those that conflict with or contradict GASB pronouncements.

Statements of net position – Net position is required to be classified for accounting and reporting purposes in the following categories:

Invested in capital assets – This component of net position consists of capital assets including capital assets, net of accumulated depreciation and amortization and reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of external constraints placed on net position by law. It also pertains to constraints imposed by constitutional provisions or enabling legislation.

Unrestricted – This component of net position consists of net position that do not meet the definition of "restricted" or "invested in capital assets." A portion of the unrestricted net position is board-designated.

Use of estimates – The preparation of financial statements in accordance with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements. Significant items subject to estimates include claims incurred but not reported, which is reported in medical claims liability.

Cash and cash equivalents – The Alliance considers all highly liquid instruments purchased with an original maturity of three months or less to be cash equivalents.

Investments – The Alliance adopted GASB Statement No. 72, *Fair Value Measurement and Application* (GASB Statement No. 72), effective January 1, 2016. GASB Statement No. 72 requires the Alliance to use valuation techniques which are appropriate under the circumstances and are consistent with the market approach, the cost approach or the income approach. GASB Statement No. 72 establishes a hierarchy of inputs used to measure fair value consisting of three levels. Level 1 inputs are quoted prices in active markets for identical assets or liabilities. Level 2 inputs are inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. Level 3 inputs are unobservable inputs.

The Alliance adheres to the disclosure requirements of GASB Statement No. 40, *Deposits and Investment Risk Disclosures – An Amendment of GASB Statement No. 3 Deposits with Financial Institutions, Investments (including Repurchase Agreements and Reverse Repurchase Agreements)*.

Investments are stated at fair value in accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools.* The fair value of investments is estimated based on quoted market prices for these or similar investments.

Capital assets – Capital assets are stated at cost. Significant additions, replacements, major repairs, and renovations to infrastructure and buildings and furniture, software, and equipment are capitalized if the cost exceeds $10,000 and a useful life of at least three years. The expenses of normal maintenance, repairs, and minor replacements are charged to operations when incurred.

Depreciation is calculated on a straight-line basis over the estimated lives of the assets, which are summarized as follows:

Building	39 years
Building equipment	5 to 15 years
Furniture and equipment	3 to 5 years
Software	3 to 5 years

The Alliance evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Board-designated investments – The Board designated the establishment of certain reserve funds for contingencies. The desired balance for this fund is three times the average of monthly premium capitation revenue. As of December 31, 2021 and 2020, the Alliance had accumulated board-designated investments of $393.8 million and $331.6 million, respectively.

Medical claims liability – The Alliance establishes a medical claims liability based on estimates of the ultimate cost of claims in process and provision for claims incurred but not yet reported, which is determined based on historical claims payment experience and other statistics. Such reserves are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known; such adjustments are included in operations. Although considerable variability is inherent in such estimates, management believes that the medical claims liability is adequate and fairly stated; however, this liability is based on estimates and the ultimate liability may differ from the amount provided.

Provider incentives – Under the terms of its provider agreements, the Alliance has agreed to incentive arrangements in the Medi-Cal line of business. All Primary Care Providers (PCP) incentive budgets are paid through the Care Based Incentives (CBI) program. For 2021, the Board allocated $10.0 million to the PCP Medi-Cal Program CBI incentive budget. For 2020, the Board allocated $10.0 million to the PCP Medi-Cal Program CBI incentive budget. During the years ended December 31, 2021 and 2020, respectively, $10.0 million and $10.0 million were paid out. Accrued annual incentive program as of December 31, 2021 and 2020 is $10.0 million, as included in provider incentives payable in the statements of net position.

Medical loss ratio – For months of service beginning January 1, 2014, the DHCS requires the Alliance to expend at least 85% of net capitation payments received for adult expansion members on allowable medical expenses. If the minimum 85% medical loss ratio threshold is not met, the Alliance is required to return the difference between the actual medical loss ratio and 85% to DHCS. The Alliance records a liability for the amount estimated to be returned to DHCS based upon the direct claims incurred, estimated indirect allowable medical expenses, and estimated incurred but not yet reported claims for adult expansion members at reporting periods, which is recorded in medical loss ratio liability in the statements of net position. In 2021, the Alliance made payments to the State of $20.7 million related to the July 1, 2016 – June 30, 2017 period. Based on final determination letters received from the State in 2021, as of December 31, 2021 and 2020, the Alliance is owed approximately $9.1 million by the State, relating to reporting period July 1, 2017 – June 30, 2018, as included in prepaid expenses and other assets in the statements of net position. There are no estimated liabilities for DHCS between the minimum threshold and the actual allowed medical expenses for the reporting period July 1, 2018 to December 31, 2021.

Premium deficiencies – The Alliance performs periodic analyses of its expected future medical expenses and maintenance expenses to determine whether such expenses will exceed anticipated future revenues under its contracts. Should expected expenses exceed anticipated revenues, a premium deficiency reserve is recorded. No premium deficiency reserve was needed at December 31, 2021 or 2020.

Statements of revenues, expenses, and changes in net position – For purposes of display, transactions deemed by management to be ongoing, major, or central to the serving of their members in Santa Cruz, Monterey, and Merced Counties are reported as operating revenues and expenses. Peripheral or incidental transactions are reported as nonoperating revenues and expenses. These peripheral activities include investment income, changes in unrealized gains and losses on investments, and grant expenditures.

Revenue recognition – Revenue is recognized in the month in which the members are entitled to healthcare services. Capitation revenue is received from DHCS each month following the month of service based on estimated enrollment and capitation rates as provided for in the DHCS contract. Eligibility of beneficiaries are determined by the Counties of Merced, Monterey, and Santa Cruz and validated by the State. The State provides the Alliance the validated monthly eligibility file in support of capitation revenue for the month. Further, the Alliance receives monthly reconciliations reflecting retrospective enrollment amounts from DHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to DHCS for these retrospective adjustments. These estimates are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known; such adjustments are included in operations.

Eligibility for the Alliance Care IHSS program is determined by Monterey County In Home Supportive Services Public Agency. A list of covered members is provided to the Alliance each month by the County of Monterey. Premiums are paid by the County to the Alliance in the month coverage is provided. Retroactive additions or deletions are not allowed under the agreement.

Premium tax – Effective July 1, 2013 until June 30, 2016, Senate Bill 78 added Revenue and Taxation Code Article 5 to impose a 3.9375% sales tax on sellers of Medi-Cal health care services subject to DHCS providing capitation payments that make the Alliance actuarially sound. In 2016, California's Senate Bill X2.2 enacted a new Managed Care Organization tax, effective for a taxing period of July 1, 2016 through June 30, 2019. The approved tax structure is based upon enrollment between specified tiers that are assessed different tax rates. On April 3, 2020, the Centers for Medicare & Medicaid Services (CMS) approved a waiver for the broad-based and uniformity requirements related to the State of California's Managed Care Organization (MCO) tax, effectively renewing the program effective January 1, 2020. Total premium tax liability recorded in accrued liabilities as of December 31, 2021 and 2020 was $41.6 million and $37.4 million, respectively. The premium tax expense totaled $157.9 million and $141.3 million for the years ended December 31, 2021 and 2020, respectively.

Grants – In December 2014, the Alliance Board approved $116.7 million in grant funding. An additional $106.3 million was approved in October 2016. The purpose of the grant program is to further the Alliance's mission by increasing member access to quality health-care through strategic planning, program development, and responsive Medi-Cal capacity investments. In 2016, the grant program became fully operational. Grant expenditures are classified as nonoperating. For the years ended December 31, 2021 and 2020, a total of $10.1 million and $14.2 million, respectively, had been expended by the Alliance under this program.

Risk management – The Alliance is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illness; natural disasters; and employee health, dental, and accident benefits. The Alliance carries commercial insurance for claims arising from such matters, and no settled claims have ever exceeded the Alliance's commercial coverage.

Medical reinsurance (stop-loss insurance) – The Alliance has entered into a reinsurance (stop-loss) agreement with a third party to limit its losses. Under the terms of the agreement, the third party will reimburse the Alliance certain proportions of claims in excess of specified deductibles ($350,000 for 2021 and $250,000 for 2020) for all lines of business for inpatient claims, which include hospital, sub-acute, skilled nursing, long term care, and durable medical equipment, implants, orthopedics and prosthesis, limited to $1,000,000 in aggregate over all contract years per member. Stop-loss insurance premiums of $10.3 million and $7.6 million are included in reinsurance and other expense in 2021 and 2020, respectively. In 2021 and 2020, there is a total of $4.8 million and $10.1 million, respectively, in recoveries.

Professional liability insurance –The Alliance maintains insurance coverage for professional liability and errors and omissions insurance. The policy is an occurrence-based policy and designed to provide comprehensive professional liability insurance and errors and omissions insurance for Alliance employees. There have been no reductions in coverage or any claims that have exceeded coverage in any of the past three years.

Income taxes – The Alliance operates as a government unit under the purview of Internal Revenue Code Section 501(a) whose income is excluded from taxation under Internal Revenue Code Section 115 and corresponding provisions of the California Revenue and Taxation Code. As such, the Alliance is not subject to federal or state taxes on income.

New accounting pronouncements – In June 2017, the GASB issued Statement No. 87, *Leases* (GASB 87), which is effective for financial statements for periods beginning after December 15, 2019. GASB 87 increases the usefulness of financial statements by requiring recognition of certain lease assets and liabilities for leases that previously were classified as operating leases and recognized as inflows of resources or outflows of resources based on the payment provisions of the contract. GASB 87 also establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. In May 2020, the GASB issued Statement No. 95, *Postponement of the Effective Dates of Certain Authoritative Guidance* ("GASB No. 95"), which extended the effective date for GASB 87. The Alliance is reviewing the impact of the adoption of GASB 87 for the fiscal year ending 2022.

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

NOTE 3 – CASH AND CASH EQUIVALENTS, SHORT-TERM INVESTMENTS, AND BOARD-DESIGNATED INVESTMENTS

Cash and cash equivalents and investments as of December 31, 2021 and 2020, consist of the following (in thousands):

	2021	2020
Cash and cash equivalents	$ 2,313	$ 11,172
Short-term investments	279,301	170,421
Restricted deposits	300	300
Board-designated investments, at fair value	393,798	331,562
Total cash, cash equivalents, and investments	$ 675,712	$ 513,455

Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure, the Alliance may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code (the Code) requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the State law. At year-end, deposits were collateralized with securities held by the pledging financial institution's trust department or agent in the Alliance's name.

	2021		2020	
	Carrying Amount	Bank Balance	Carrying Amount	Bank Balance
Insured	$ 450	$ 450	$ 450	$ 450
Collateralized	2,163	4,623	11,022	14,767
Total cash and restricted deposits (in thousands)	$ 2,613	$ 5,073	$ 11,472	$ 15,217

Investments – The Alliance invests in obligations of U.S. government agencies, corporate notes, and instrumentalities. The Alliance's investment policy allows only high-quality investments as permitted by the Code and subject to the limitations of the Alliance's Annual Investment Policy (investment policy).

The Alliance also invests in the State of California Local Agency Investment Fund (LAIF). The Local Investment Advisory Board provides oversight for LAIF. The Board consists of five members as designated by statute. The chairman is the state treasurer or his designated representative.

Two members qualified by training and experience in the field of investment or finance, and the state treasurer appoints two members who are treasurers, finance or fiscal officers, or business managers employed by any county, city, or local district or municipal corporation of this state. The term of each appointment is two years or at the pleasure of the appointing authority. The recorded value of the Alliance's investments in LAIF is equal to the Alliance's share of the estimated fair value of the underlying assets.

In 2016, the Alliance invested in the Investment Trust of California (CalTrust) as one of its discretionary advisory partners. Blackrock Financial Management, a registered investment advisor, provides oversight for CalTrust pursuant to Joint Exercise of Powers Agreement. The Board of Trustees consists of ten Trustees, at least seventy-five percent are members of the governing body, officers, or personnel of the Members which are appointed by the initial Members and the Board. The Trustees and Officers currently serve without compensation but are reimbursed for reasonable expenses in connection with their duties. The Board is responsible for setting overall policies and procedures and for the retention and monitoring of all agents acting on behalf of CalTrust. The recorded value of the Alliance's investments in CalTrust is equal to the Alliance's share of the estimated fair value of the underlying assets.

LAIF and CalTrust are external investment pools. Per GASB 72, fair value hierarchy disclosure is not required for these external pooled investments.

Government money market funds are required to invest at least 99.5% of their total assets in (i) cash; (ii) securities issued or guaranteed by the United States or certain U.S. government agencies or instrumentalities; and/or (iii) repurchase agreements that are collateralized fully. The Fund is exempt from requirements that permit money market funds to impose a liquidity fee and/or temporary redemption gates. Shares are not restricted as to when they may be redeemed.

The following is a summary of the fair value hierarchy of the Alliance's short-term investments and board-designated investments, as of December 31 (in thousands):

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

	2020				
Investment type	Total	Investment Exempt from Fair Value	Level 1	Level 2	Level 3
Corporate bonds	$ 47,886	$ -	$ 47,886	$ -	$ -
State & local agency bonds	5,396	-	5,396	-	-
U.S. agency bonds	19,938	-	19,938	-	-
U.S. treasury notes	18,145	-	18,145	-	-
Money market funds	193,698	193,698	-	-	-
	285,063	$ 193,698	$ 91,365	$ -	$ -
External Investment Pool					
LAIF	63,819				
CalTrust	153,101				
	$ 501,983				

Interest rate risk – In accordance with its investment policy, the Alliance manages its exposure to declines in fair value from increasing interest rates by matching maturity dates to the extent possible with the Alliance's expected cash flow draws. The policy of the Alliance limits maturities to five years. As of December 31, 2021, the Alliance's short-term and board designated investments have the following related maturity schedule (in thousands):

Investment type	Fair value	Less Than 1 Years	1-5 Years
Corporate bonds	$ 74,322	$ -	$ 74,322
State and local agency bonds	6,158	-	6,158
U.S. agency bonds	15,311	-	15,311
Money market funds	166,756	166,756	-
CalTrust	336,457	336,457	-
LAIF	74,095	74,095	-
	$ 673,099	$ 577,308	$ 95,791

As of December 31, 2020, the Alliance's short-term and board designated investments have the related maturity schedule (in thousands):

Investment type	Fair value	Less Than 1 Years	1-5 Years
Corporate bonds	$ 47,886	$ -	$ 47,886
State and local agency bonds	5,396	-	5,396
U.S. agency bonds	19,938	-	19,938
U.S. treasury notes	18,145	-	18,145
Money market funds	193,698	193,698	-
CalTrust	153,101	153,101	-
LAIF	63,819	63,819	-
	$ 501,983	$ 410,618	$ 91,365

Credit risk – The Alliance's investment policy is intended to conform to the Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments and by diversifying the investment portfolio in accordance with the investment policy. The investment policy sets minimum acceptable credit ratings for investments from two nationally recognized rating services: Standard and Poor's Corporation (S&P) and Moody's Investor Service (Moody's). For an issuer of short-term debt, the rating must be no less than A-1 (S&P) or P-1 (Moody's), while an issuer of long-term debt shall be rated no less than an A (S&P or Moody's).

As of December 31, 2021, the following are the credit ratings of short-term and board designated investments (in thousands):

Investment Type	Fair Value	Unrated	Rating as of Year-End AAA	AA+	AA	AA-	A+	A	A-	BBB+
Money market fund	$ 166,756	$ 166,756	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	74,322	-	5,106	8,155	5,105	8,574	18,409	23,863	2,049	3,061
F.N.MA	11,809	-	-	11,809	-	-	-	-	-	-
Federal Home Loan Mortgage	3,502	-	-	3,502	-	-	-	-	-	-
State and local bonds	6,158	-	-	2,011	4,147	-	-	-	-	-
LAIF	74,095	74,095	-	-	-	-	-	-	-	-
CalTrust	336,457	336,457	-	-	-	-	-	-	-	-
Total	$ 673,099	$ 577,308	$ 5,106	$ 25,477	$ 9,252	$ 8,574	$ 18,409	$ 23,863	$ 2,049	$ 3,061

As of December 31, 2020, the following are the credit ratings of short-term and board designated investments (in thousands):

Investment Type	Fair Value	Unrated	Rating as of Year-End AAA	AA+	AA	AA-	A+	A	A-
Money market fund	$ 193,698	$ 193,698	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	47,884	-	13,778	7,708	7,581	1,082	2,104	12,551	3,080
F.N.MA	16,358	-	-	16,358	-	-	-	-	-
Federal Home Loan Mortgage	3,581	-	-	3,581	-	-	-	-	-
State and local bonds	5,396	-	-	-	3,509	1,887	-	-	-
United States Treasury Notes	18,146	18,146	-	-	-	-	-	-	-
LAIF	63,819	63,819	-	-	-	-	-	-	-
CalTrust	153,101	153,101	-	-	-	-	-	-	-
Total	$ 501,983	$ 428,764	$ 13,778	$ 27,647	$ 11,090	$ 2,969	$ 2,104	$ 12,551	$ 3,080

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of a government's investment in a single issuer. The Alliance's investment policy limits to no more than 5% of the total market value investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises; no more than 20% may be invested in one money market fund. The investment policy places a diversification limit of 5% for all issuers other than anyone U.S. government agency, for which the policy allows 100%, and only one repurchase agreement counterparty, for which the policy allows 25% to 50% depending on the maturity. Medium Term Maturity Corporate Securities are limited to 30% and State and Local Obligations are limited to 25%. The dollar limit of investments in LAIF is $75.0 million.

Investment	Issuer	Percentage of Portfolio 2021	2020
Money market funds		24.8 %	38.6 %
U.S. government securities	Federal Home Loan Mortgage	0.5	0.7
	United States Treasury Notes	-	3.6
F.N.M.A.	Federal National Mortgage Association	1.8	3.3
Corporate bonds	Various	11.0	9.5
State and local bonds	Various	0.9	1.1
LAIF	State of California	11.0	12.7
CalTrust	CalTrust JPA	50.0	30.5
		100 %	100 %

NOTE 4 – CAPITAL ASSETS

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

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

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

Capital assets activity in 2020 consists of the following (in thousands):

	December 31, 2019	Increases	Decreases/ Transfers	December 31, 2020
Capital assets not being depreciated:				
Land	$ 7,564	$ -	$ -	$ 7,564
Construction in process	3,584	1,794	(2,897)	2,481
Total capital assets not being depreciated	11,148	1,794	(2,897)	10,045
Capital assets being depreciated:				
Buildings and building equipment	44,594	-	583	45,177
Furniture and equipment	11,973	371	2,128	14,472
Software	16,657	-	-	16,657
	73,224	371	2,711	76,306
Less accumulated depreciation for:				
Buildings and building equipment	9,563	1,516	-	11,079
Furniture, equipment, and software	20,546	4,983	(186)	25,343
	30,109	6,499	(186)	36,422
Total capital assets being depreciated, net	43,115	(6,128)	2,897	39,884
Total capital assets, net	$ 54,263	$ (4,334)	$ -	$ 49,929

NOTE 5 – MEDICAL CLAIMS LIABILITY

The following is a reconciliation of the medical claims liability, including loss adjustment expenses for the years ended December 31, 2021 and 2020 (in thousands):

	2021	2020
Beginning balance	$ 200,716	$ 184,933
Incurred:		
Current year	1,364,589	1,219,345
Prior years	(16,771)	(18,033)
Total	1,347,818	1,201,312
Paid:		
Current year	1,138,285	1,032,870
Prior years	171,884	152,659
Total	1,310,169	1,185,529
Ending balance	$ 238,365	$ 200,716

Amounts incurred related to prior years represent changes from previously estimated liabilities. Liabilities at any year-end are continuously reviewed and reestimated as information regarding actual claims payments and expected payment trends become known. Negative amounts reported for incurred related to prior years result from claims being adjudicated and paid for amounts less than originally estimated.

Medical expenses in the statements of revenues, expenses, and changes in net position also include capitation payments to providers, reinsurance premiums, and other direct payments to providers, which do not flow through the medical claims liability.

NOTE 6 – RESTRICTED NET ASSETS AND TANGIBLE NET EQUITY

As a limited license plan under Knox-Keene Health Care Service Plan Act of 1975 (the Act), the Alliance is required to maintain a minimum level of tangible net equity, as determined by the State of California. The required tangible net equity level was approximately $60.4 million and $55.5 million at December 31, 2021 and 2020, respectively. The Act also requires the Alliance to maintain $300,000 restricted deposits, which is displayed as a restricted deposit in the accompanying statements of net position. As of December 31, 2021 and 2020, total net position was $582.8 million and $464.6 million, respectively, which exceeded the minimum tangible net equity level for both years.

NOTE 7 – CENTRAL CALIFORNIA ALLIANCE FOR HEALTH 401(A) QUALIFIED RETIREMENT PLAN

The Alliance sponsors a 401(a) Money Purchase Plan and Trust (the Plan), which is a defined-contribution plan covering all its employees. Under the terms of the plan agreement after one year of service, the Alliance will contribute 10% of salaries and wages on behalf of each participant for the plan year. The Alliance has the authority to amend the Plan's provisions.

The Alliance also sponsors a deferred compensation plan created in accordance with Internal Revenue Service Code Section 457. This is an elective defined contribution plan in which employees with work schedules of at least 30 hours per week may participate. The Alliance does not make any contributions to this plan.

The Alliance incurred $5.2 million and $4.4 million of retirement plan expense during 2021 and 2020, respectively, included in salaries, wages, and employee benefits in the statements of revenues, expenses, and changes in net position.

Summary of Significant Accounting Policies

Basis of accounting – The Plan fiduciary financial statements are prepared using the accrual basis of accounting. The Plan's contributions are recognized in the period in which contributions are made. Benefits are recognized when due and payable in accordance with the terms of the Plan.

Investments – The Plan's investments are reported at fair value, including certain investments held in collective investment trusts. Investments held in each trust are maintained on a unit basis. The units represent a proportional ownership interest in each of the funds in which a participant is invested (net asset value or NAV). The NAV of a unit is determined by adding the market value of each respective fund's investments, plus receivables and other assets, and then deducting liabilities. The balance, called net assets, is divided by the number of units outstanding. The value of a unit at any given time will depend on the investment performance of the particular fund's portfolio of investments. All earnings (interest, dividends, realized gains, unrealized gains), losses (realized and unrealized), and expenses are recorded and reflected in changes in the NAV. The NAV is calculated daily.

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

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

Description	2020	Level 1	Level 2	Level 3
Investments by fair value level	$ -	$ -	$ -	$ -
	-	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
Collective investment trusts - at NAV	42,157			
Total investments	$ 42,157			

Plan description – Participant data for the Plan, as of the measurement date for the year indicated, is as follows:

- All full-time, part-time, and per-diem employees of the Organization are eligible to participate in the Plan. Employees are eligible to receive employer contributions upon completion of one year of service, defined as working 12 months for a minimum of 1,000 hours.
- Participants will receive an employer contribution of 10% of compensation. Employees who wish to make elective contributions may do so through the agency's 457 plan.
- Participants are fully vested in employer contributions.

Employer contribution – The Alliance makes contributions based on the established funding practice.

Notes receivable from participants – Participants may borrow from their accounts a minimum of $1,000 up to a maximum equal to the lesser of $50,000 or 50% of their vested account balance. The maximum loan term is five years unless the loan term qualifies as a home loan, in which case the term of the loan is not to exceed thirty years.

Loans are secured by the balance of the participant's account and bear fixed, reasonable rates of interest, as determined by the custodians. Principal and interest are paid directly by the participant to the custodians through monthly ACH transactions. As of December 31, 2021 and 2020, the rates of interest on outstanding loans with ICMA-RC was 3.75%, respectively, with maturities extending up to five years. The interest rate is locked in for the term of the loan and established at the onset of the loan. The loan totals as of December 31, 2021 and 2020 were $1,146,231 and $999,070, respectively.

Rate of return – The Plan is a defined contribution plan with investment returns varying per participant based on investment elections. On a cumulative basis for the years ended December 31, 2021 and 2020, the cumulative rate of return for the 401(a) plan was 13.5% and 11.3%, respectively.

NOTE 8 – RISKS AND UNCERTAINTIES

The Alliance primarily serves Medi-Cal eligible persons. Laws and regulations governing the Medi-Cal program are complex and subject to interpretation. The Alliance believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medi-Cal programs.

NOTE 9 – CONTINGENCIES

The Alliance is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on the Alliance's financial position or results of operations.

NOTE 10 – HEALTH CARE REFORM

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates or benefits. The ultimate outcome of these proposals, including the potential effects of or changes to health care reform that will be enacted cannot presently be determined.

NOTE 11 – SUBSEQUENT EVENTS

The Alliance held investments at December 31, 2021, that may experience a significant decline in market value in 2022 as a result of market reaction to the coronavirus outbreak, inflation and potential actions of the Federal Reserve. The Alliance will continue to monitor the financial markets closely, but how these significant factors may impact market values is uncertain. At this time, management believes any potential decline in fair value for these securities is temporary. The Alliance has evaluated subsequent events through April 28, 2022, which is the date the financial statements were available to be issued.

Supplementary Information

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

Schedule of Revenues and Expenses by Program and Changes in Net Position

Year Ended December 31, 2021

(in thousands)

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

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Santa Cruz-Monterey-Merced
Managed Medical Care Commission
(d.b.a. Central California Alliance for Health)
Schedule of Revenue and Expenses by Program and Changes in Net Position
Year Ended December 31, 2020
(in thousands)

	Medi-Cal					
	Santa Cruz County	Monterey County	Merced County	IHSS Program	Administrative	Total
Operating revenues						
Capitation revenue	$ 326,597	$ 635,405	$ 502,330	$ 3,227	$ -	$ 1,467,559
Operating expenses						
Medical expenses						
Medi-Cal						
Provider capitation	4,789	15,660	14,550	-	-	34,999
Claim payments to providers	207,693	412,953	332,617	-	-	953,263
Prescription drugs	51,936	89,582	67,183	-	-	208,701
Other medical	4,612	10,978	9,037	-	-	24,627
Alliance Care: IHSS program	-	-	-	2,952	-	2,952
Reinsurance and other, net of (recoveries) expense	(1,823)	43	(745)	-	-	(2,525)
Total medical expenses	267,207	529,216	422,642	2,952	-	1,222,017
Administrative expenses						
Premium tax expense	-	-	-	-	141,313	141,313
Salaries, wages, and employee benefits	-	-	-	-	55,636	55,636
Supplies, occupancy, insurance, and other	-	-	-	-	9,230	9,230
Professional fees	-	-	-	-	8,689	8,689
Depreciation and amortization	-	-	-	-	6,499	6,499
Purchased services	-	-	-	-	3,141	3,141
Total administrative expenses	-	-	-	-	224,508	224,508
Total operating expenses	267,207	529,216	422,642	2,952	224,508	1,446,525
Operating income (loss)	59,390	106,189	79,688	275	(224,508)	21,034
Investment income, including net realized and unrealized gains and losses	-	-	-	-	5,909	5,909
Other income	-	-	-	-	1,117	1,117
Grants	-	-	-	-	(14,245)	(14,245)
Increase (decrease) in net position	$ 59,390	$ 106,189	$ 79,688	$ 275	$ (231,727)	13,815
Net position, beginning of year						450,775
Net position, end of year						$ 464,590

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MOSSADAMS

DATE: May 25, 2022

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

FROM: Dr. Dianna Diallo, Medical Director

SUBJECT: Care-Based Incentive 2023

Recommendation. Staff recommend the Board approve the 2023 Care-Based Incentive (CBI) proposal as described in detail below.

Summary. This report provides an overview of the CBI program and makes a recommendation for structural program changes to CBI 2023.

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

Historically CBI has aligned with many DHCS mandated reported measures, but other state policies have also impacted measure selection including the California State Auditor's reports, DHCS All Plan Letters (APL), California Governor directives, and directives during the Public Health Emergency. Measures selection for CBI has also taken into consideration those preventive service measure gaps and focus on health equity under the DHCS Quality Strategy to select new measures or modifications to support the Medi-Cal population.

Discussion.

Proposed changes to 2023 programmatic measures are:

- Add Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents
- Add Health Plan Health Disparity
- Retire Unhealthy Alcohol Use in Adolescents and Adults
- Retire Asthma Medication Ratio

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

- Add $200 FFS measure for provider completion of the ACEs training and attestation

Proposed changes to 2023 exploratory measures are:

- Add Colorectal Cancer Screening
- Retire 90-Day Referral Completion
- Retire Tuberculosis (TB) Risk Assessment

For 2023 programmatic Care Coordination - Hospital Access measures, staff recommend no change.

The proposed 2023 programmatic Care Coordination - Access measures will add the ACEs Screening in Children and Adolescents measure, transitioning from an exploratory to a programmatic status. Recommended for retirement is the Unhealthy Alcohol Use in Adolescents and Adults measure, which has made limited impact in improving overall screening rates and is not a required reporting measure by the health plan. In retiring the Unhealthy Alcohol Use in Adolescents and Adults measure, those points can be distributed to help improve low ACEs screening rates within the Alliance population.

In terms of 2023 programmatic Quality of Care measures, the following are recommended to remain unchanged: Body Mass Index Assessment: Children and Adolescent; Breast Cancer Screening; Cervical Cancer Screening, Child and Adolescent Well-Care Visit, Diabetic HbA1c Poor Control (>9%); Immunizations: Adolescents; Immunizations: Children (Combo 10); Screening for Depression and Follow-up Plan; and Well-Child Visit in the First 15 Months. Asthma Medication Ratio is recommended for retirement following general high performance over the past couple of years, as well as the removal from being held to the minimum performance level by DHCS starting in reporting year 2022.

For 2023, it's recommended that the health plan health disparity measure change from an exploratory measure to a programmatic measure that will set aside approximately 5% of the overall CBI payment which will be distributed if we achieve the health plan challenge to close each of the racial/ethnical gaps for the designated measure. Currently the health plan health disparity measure reviews overall Alliance rates among the Child and Adolescent Well-Care Visit to determine whether different ethnic groups had or did not have equitable access to primary care, relative to our largest member population. The recommended change is to instead focus on closing gaps to the 50th and 75th percentile, that would distribute money to all CBI groups if a 50% closure can be achieved for race/ethnic groups currently below the 50th percentile and a 50% closure to the 75th percentile for race/ethnic groups currently above the 50th percentile. Each race/ethnicity that reaches the gap closure goal will distribute 1% of set aside 5% payment.

FFS Measures are recommended to add an additional $200 measure for completion of the certified ACEs Aware Core Training and attestation. This measure intended to provide compensation for the time spent in completing the DHCS required training and attestation needed in order to begin screening and billing the health plan for ACEs. The payment will be $200 per clinician, and the Alliance will pay for each CBI group that the clinician practices under. This payment would be retroactive for all rendering providers who have already completed their training and attestation with the state and received through confirmation to the Alliance.

Recommended additions to exploratory measures include Colorectal Cancer Screening. Recommendations for retirement are the 90-day Referral Completion, and TB Risk Assessment.

Fiscal Impact. There is no fiscal impact associated with this agenda item. CBI has been budgeted and the design of the program will not have a negative fiscal impact.

Attachments. N/A

Information Items: (18A. – 18E.)

A. Alliance in the News Page 18A-01
B. Alliance Fact Sheet – April 2022 Page 18B-01
C. Letters of Support Page 18C-01
D. Member Appeals and Grievance Report – Q1 2022 Page 18D-01
E. Membership Enrollment Report Page 18E-01

May 2022 Board Report

May Board Report- Alliance in the News

Total Online + Print Audience
418,084

Total Online + Print Publicity
USD $4,252

Total Number of Clips 12

A proposed no-bid Medi-Cal contract for Kaiser could signal the end of a public health system.

1

Date Collected Apr 28, 2022 3:55 AM EDT
Category Local
Source Monterey County Weekly
Author Pam Marino

Est. Audience 4,113
Est. Publicity Value USD $1
Market Seaside, CA
Language English

... create a health care safety net for low-income residents who receive the state's version of Medicaid, known as Medi-Cal, through publicly-governed nonprofit entities called the County Organized Health System. In Monterey County, 1 out of every 3 residents is a Medi-Cal member of the COHS nonprofit **Central California Alliance for Health**.

The future of that system is now in doubt, according to critics of a state plan to award a no-bid contract in 2024 to Kaiser Permanente to care for Medi-Cal patients in 32 counties without organized systems. They say the five-year contract could be disruptive and potentially harmful to the COHS ...

County agencies, leaders celebrate Village of Hope opening

2

Date Collected Apr 27, 2022 6:47 PM EDT
Category Local
Source MercedCountyTimes.com
Author Jonathan Whitaker

Est. Audience 103
Est. Publicity Value USD $1
Market Merced, CA
Language English

Leaders and nonprofit representatives cut the ceremonial red ribbon to introduce the new Village of Hope campus.

County Supervisors Josh Pedrozo, Daron McDaniel and Lloyd Pareira join with Mark Mayo, the chairman of the Mission board (at center), and Mission CEO Bruch Metcalf, second from right.

Merced Mayor Matthew Serratto recognizes Bruch Metcalf.

Mission CEO Bruce Metcalf shakes the hand of one of the builders on the project.

Cori Lucero of the Central Valley Opportunity Fund with Rescue Mission CEO Bruce Metcalf.

Rich Moreland, interim president of Merced Medical Center ...

Battle lines are drawn over California's no-bid deal with Kaiser Permanente

3

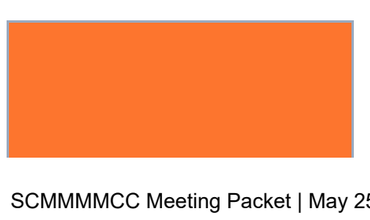
Date Collected Apr 18, 2022 12:06 PM EDT
Category Local
Source Fresno Bee
Author Bernard J. Wolfson

Market Fresno, CA
Language English

... with the counties, their safety-net health facilities, and private-sector medical providers. In the 40 years since they were established in California, they have been the only state-contracted Medi-Cal plan in their counties.

"It's the end of the model," said Stephanie Sonnenshine, CEO of the **Central California Alliance for Health**, a county organized health system for Santa Cruz, Monterey, and Merced counties. "It's a significant policy change that hasn't been vetted as a policy change."

KHN correspondent Rachel Bluth contributed to this story.



Battle lines are drawn over California's no-bid deal with Kaiser Permanente

4

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Date Collected Apr 18, 2022 11:59 AM EDT
Category Local
Source San Luis Obispo.com
Author Bernard J. Wolfson

Est. Audience 70,647
Est. Publicity Value USD $77
Market San Luis Obispo, CA
Language English

... with the counties, their safety-net health facilities, and private-sector medical providers. In the 40 years since they were established in California, they have been the only state-contracted Medi-Cal plan in their counties.

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Battle lines are drawn over California's no-bid deal with Kaiser Permanente

5

Date Collected Apr 18, 2022 11:58 AM EDT
Category Local
Source Sacramento Bee
Author Bernard J. Wolfson

Market Sacramento, CA
Language English

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Battle lines are drawn over California's no-bid deal with Kaiser Permanente

6

Date Collected Apr 18, 2022 11:56 AM EDT
Category Local
Source Modesto Bee
Author Bernard J. Wolfson

Market Modesto, CA
Language English

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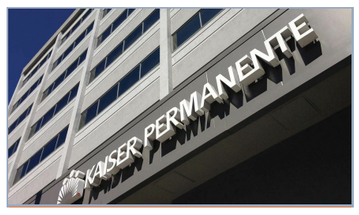
KHN correspondent Rachel Bluth contributed to this story.



Battle lines are drawn over California deal with Kaiser Permanente

7

Date Collected Apr 18, 2022 11:27 AM EDT
Category Trade
Source Modern Healthcare
Author Bernard J. Wolfson

Est. Audience 56,560
Est. Publicity Value USD $106
Market United States
Language English

... with the counties, their safety-net health facilities, and private-sector medical providers. In the 40 years since they were established in California, they have been the only state-contracted Medi-Cal plan in their counties.

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Battle Lines Are Drawn Over California Deal with KP

8

Date Collected Apr 18, 2022 8:46 AM EDT
Category Trade
Source Health Leaders

Est. Audience 39,078
Est. Publicity Value USD $224
Market United States
Language English

... with the counties, their safety-net health facilities, and private-sector medical providers. In the 40 years since they were established in California, they have been the only state-contracted Medi-Cal plan in their counties.

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Online News

Battle Lines Are Drawn Over California Deal With Kaiser Permanente

9

Date Collected Apr 18, 2022 5:44 AM EDT
Category Organization
Source Kaiser Health News
Author Bernard J. Wolfson:

Est. Audience 77,127
Est. Publicity Value USD $448
Market United States
Language English

... with the counties, their safety-net health facilities, and private-sector medical providers. In the 40 years since they were established in California, they have been the only state-contracted Medi-Cal plan in their counties.

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Online News

Battle Lines Are Drawn Over California Deal With Kaiser Permanente

10

Date Collected Apr 18, 2022 5:22 AM EDT
Category Organization
Source California Healthline
Author Bernard J. Wolfson:

Est. Audience 8,227
Est. Publicity Value USD $49
Market United States
Language English

... with the counties, their safety-net health facilities, and private-sector medical providers. In the 40 years since they were established in California, they have been the only state-contracted Medi-Cal plan in their counties.

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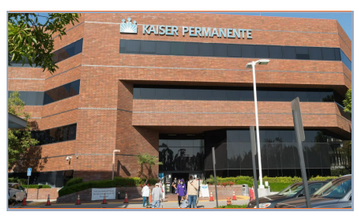
KHN correspondent Rachel Bluth contributed to this report.

Bernard J. Wolfson: bwolfson@kff.org, @bjwolfson



Battle Lines Are Drawn Over California Deal With Kaiser Permanente

11

Date Collected Apr 18, 2022 5:58 PM EDT
Category Local
Source LAist

Est. Audience 71,985
Est. Publicity Value USD $81
Market Carson, CA
Language English

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KHN correspondent Rachel Bluth contributed to this report.

What questions do you have about Southern California?

Ask a Question

Battle lines are drawn over California's no-bid deal with Kaiser Permanente

12

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Date Collected Apr 18, 2022 4:24 PM EDT
Category Local
Source Sacramento Bee
Author Bernard J. Wolfson; The Sacramento Bee

Est. Audience 90,244
Est. Publicity Value USD $3,265
Market Sacramento, CA
Language English

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Alliance Fact Sheet

April 2022

ABOUT THE ALLIANCE

The Alliance is an award-winning regional non-profit health plan, established in 1996, with **over 26 years** of successful operation. Using the State's County Organized Health System (COHS) model, we currently serve **392,494 members** in Merced, Monterey and Santa Cruz counties. We work in partnership with our contracted providers to promote prevention, early detection and effective treatment, and improve access to quality health care for those we serve. This results in the delivery of innovative community-based health care services, better medical outcomes and cost savings. The Alliance is governed with local representation from each county on our Board of Commissioners.

Quick Facts[2]

1996
Year Established

497
Number of Employees

$376.0M
YTD Revenue

5.2%
Spent on Administration

Service Area:
Merced, Monterey and Santa Cruz counties.

Membership by Program

Total Membership: **392,494**[3]

391,905	589
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

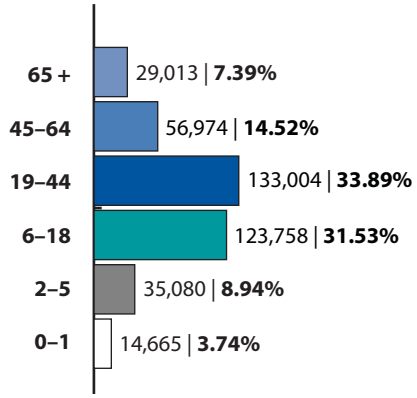
Our members represent 40 percent[1] of the population in Merced, Monterey and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income mothers and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled, and low-income, childless adults ages 19–64.

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

PROVIDER PARTNERSHIPS

The Alliance partners with more than 10,800 providers to form our provider network, with 86 percent of primary care physicians and 87 percent of specialists within our service area contracted to provide services to our members. The Alliance also partners with more than **2,950** providers to deliver behavioral health and vision services.

Membership by Age Group



EXECUTIVE LEADERSHIP

Stephanie Sonnenshine
Chief Executive Officer

Lisa Ba
Chief Financial Officer

Dale Bishop, MD
Chief Medical Officer

Scott Fortner
Chief Administrative Officer

Cecil Newton
Chief Information Officer

Van Wong
Chief Operating Officer

GOVERNING BOARD

The Alliance's 21-member governing board, the Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan. 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
- **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
- **Supervisor Zach Friend,** County of Santa Cruz
- **Charles Harris,** MD, Interim Chief Executive Officer, Natividad Medical Center
- **Dori Rose Inda,** Chief Executive Officer, Salud Para La Gente
- **Elsa Jimenez,** Director of Health, Monterey County Health Department - Alliance Board Chairperson
- **Shebreh Kalantari-Johnson,** Public Representative
- **Michael Molesky,** Public Representative
- **Monica Morales,** Health Services Agency Director, County of Santa Cruz Health Services Agency
- **Rebecca Nanyonjo,** Director of Public Health, Merced County, Department of Public Health
- **Supervisor Josh Pedrozo,** County of Merced – Alliance Board Vice Chairperson
- **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:

DHCS 2021

- Consumer Satisfaction Award for going above and beyond in children's care for medium-sized health plans in 2021

2019

- Outstanding Performance for Medium-sized Plan

2018

- Most Improved Runner Up for Santa Cruz and Monterey Counties
- Innovation Award for Academic Detailing

Customer Service Honors:

- DHCS 2011 Gold Quality Award for Outstanding Service and Support

Employer Workplace Distinctions:

- American Heart Association 2016 Workplace Health Achievement Gold Level Award as a "Fit and Friendly Workplace"
- Second Harvest Food Bank, Santa Cruz County – CEO Cup 2018, 2017; Titanium Award 2015, 2014, 2013
- United Way of Santa Cruz County 2018, 2013 Corporate Campaign Gold Award
- 2020 Certified California Green Business - Program Participant since 2008
- 2020 Blue Zones Project Approved Worksite
- Recognized by the Santa Cruz County Breastfeeding Coalition and Community Bridges WIC for being a model for employee lactation accommodation, 2021

[1]County population data source: U.S. Census Bureau 2021 population estimate (as of Jul. 1, 2021). Membership percentage by county: Merced (50 percent); Monterey (40 percent); Santa Cruz (28 percent).
[2]Fact sheet data as of April 1, 2022., [3]Fact sheet data as of April 1, 2022.

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

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

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

April 28, 2022

Assemblymember Alex Lee
Capitol Office
P.O. Box 942849
Sacramento, CA 94249-0025

RE: AB 1944 – SUPPORT

Dear Assemblymember Lee,

As Chief Executive Officer of the Central California Alliance for Health (the Alliance), which is the regional, non-profit Medi-Cal managed care health plan serving over 390,000 residents of Santa Cruz, Monterey, and Merced counties, I am writing to express the Alliance's support for AB 1944.

AB 1944 modernizes teleconferencing procedures for public meetings while maintaining the core principles of the Brown Act. Under AB 1944, a legislative body would be required to post on public agendas an updated list of those members while protecting the physical address of their remote-access location, if that location is not a public place. Likewise, the bill affirms that all open and public meetings be video streamed for public access.

In light of COVID-19, teleconferencing under the Brown Act has allowed for increased safety as well as broader access to meetings for members of the public who may have been unable to travel to in-person conferences. AB 1944 allows for remote participation in public meetings to the benefit of the legislative bodies while accommodating public access to local agency meetings.

For these reasons, the Alliance is pleased to support AB 1944, which assists facilitation and access for teleconferenced public meetings.

Sincerely,

Stephanie Sonnenshine
Chief Executive Officer

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

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

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

May 12, 2022

Ms. Leslie Conner
Chief Executive Officer
Santa Cruz Community Health Centers
125 Water Street
Santa Cruz, CA 95060

RE: Letter of Support – Santa Cruz Community Health Center

Dear Ms. Conner:

This letter is to confirm Central California Alliance for Health's (the Alliance)'s support for Santa Cruz Community Health Centers (SCCHC)'s proposed change in scope to add SCCHC-Live Oak Health Center, a new primary care clinic site located at 1500 Capitola Road, Santa Cruz, to the health center's scope of project. The Alliance is a regional, publicly operated Medi-Cal managed care plan established in 1996 to improve access to healthcare for lower income residents. The Alliance has approximately 78,000 Medi-Cal members in Santa Cruz County or about one out of every four residents.

The addition of SCCHC's proposed new site will improve access to care for our members and other low income residents, and advance our work to connect patients with a provider of quality, timely primary care services. Therefore, the Alliance has invested $2,650,000 over five years in construction of the new SCCHC-Live Oak Health Center. This new site is an important step towards achieving and maintaining positive health outcomes and improving the wellbeing of the most vulnerable Santa Cruz County residents and, on behalf of the Alliance, I am pleased to offer our support.

Sincerely,

Stephanie Shonnenshine
Chief Executive Officer

Member Appeals and Grievance Report
Q1, 2022

Q1 2022 Appeals and Grievances: 496

Appeals: 11% [77% in favor of Plan; 23% in favor of Member]
Exempt: 4%
Grievances: 78%
Other: 7% [Inquiries, Duplicates, Withdrawn]

Category Figures
Transportation: 32%
Quality of Care: 19%
Billing: 10%
Provider/Staff Attitude: 5%
Provider Availability: 4%
Authorization: 2%
Other: 28%

Analysis and Trends
- A high percentage of grievances involved transportation issues for late, missed rides and quality of service issues.
- No other significant trends noted for grievances in Q1 2022.

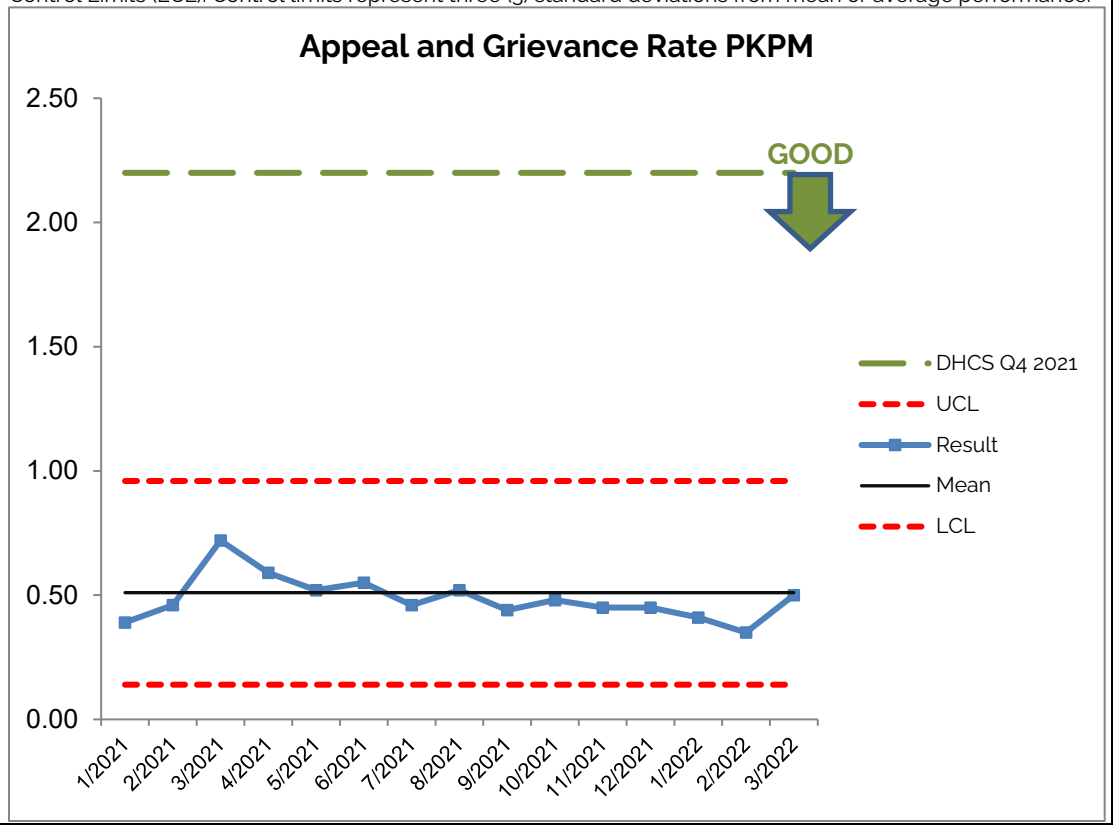
Highest Grievances Filed by County
1. Merced: 40%
2. Monterey: 35%
3. Santa Cruz: 25%

Behavioral Health Beacon Grievances:
- Member Grievances: 20

IHSS Summary:
- Member Grievances: 2

☒ **In Control**
☐ **Not in Control**

A lower rate demonstrates a good or positive result when compared to Upper Control Limits (UCL) and Lower Control Limits (LCL). Control limits represent three (3) standard deviations from mean or average performance.



	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
2021 Enrollment	**367,138**	**369,438**	**371,533**	373,656	376,321	377,793	379,441	380,928	383,057	384,843	386,026	387,091
A&G Issues	**145**	**170**	**269**	222	195	206	173	197	167	184	172	173
Rate PKPM*	**0.39**	**0.46**	**0.72**	0.59	0.52	0.55	0.46	0.52	0.44	0.48	0.45	0.44
2022 Enrollment	**389,700**	**390,812**	**392,592**									
A&G Issues	**161**	**137**	**198**									
Rate PKPM*	**0.41**	**0.35**	**0.51**									

*Grievances Per 1,000 Member Month

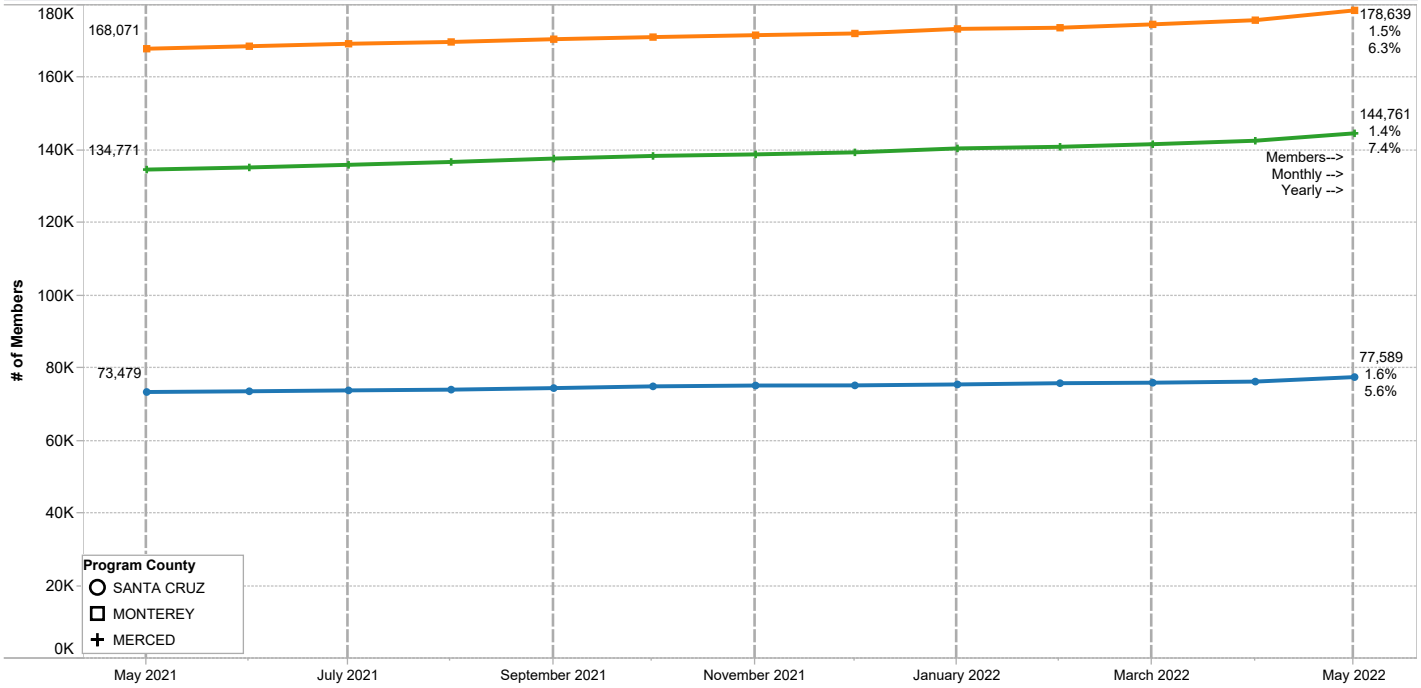
Back to Agenda

Enrollment Report

Year: *2017 & 2018* **County:** *All* **Program:** *IHSS & Medi-Cal*
Aid Cat Roll Up: *All* **Data Refresh Date:** *5/5/2022*

StaticDate
5/1/2021 12:00:00 AM to 5/31/2022 11:59:59 PM

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



Program..	ProgramCo..	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022
Medi-Cal	SANTA CRUZ	73,479	73,679	73,921	74,129	74,554	75,036	75,264	75,304	75,563	75,905	76,045	76,349	77,589
	MONTEREY	167,566	168,257	168,939	169,425	170,180	170,763	171,292	171,757	173,027	173,344	174,194	175,312	177,990
	MERCED	134,771	135,356	136,083	136,865	137,807	138,531	138,955	139,513	140,599	141,052	141,764	142,716	144,761
IHSS	MONTEREY	505	501	498	509	516	513	515	517	511	511	589	624	649
Total Members		**376,321**	**377,793**	**379,441**	**380,928**	**383,057**	**384,843**	**386,026**	**387,091**	**389,700**	**390,812**	**392,592**	**395,001**	**400,989**