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

Meeting Agenda

Wednesday, May 22, 2024

3:00 p.m. – 5:00 p.m.

Location:

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

1. Members of the public wishing to observe the meeting remotely via online livestreaming may do so as follows. Note: Livestreaming for the public is listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
    Click here to join the meeting
    b. Or by telephone at:
    United States: +1 (323) 705-3950
    Phone Conference ID: 905 032 033#

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 21, 2024 to the Clerk of the Board at clerkoftheboard@ccah-alliance.org.
        i. Indicate in the subject line "Public Comment". Include your name, organization, agenda item number, and title of the item in the body of the e-mail along with your comments.
        ii. Comments will be read during the meeting and are limited to three minutes.
    b. In person, from an Alliance County office, during the meeting when that item is announced.
        i. State your name and organization prior to providing comment.
        ii. Comments are limited to three minutes.

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

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

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

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

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

3. Comments and announcements by Commission members.

A. Board members may provide comments and announcements.

4. Comments and announcements by Chief Executive Officer.

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

Consent Agenda Items: (5. – 9I.): 3:25 p.m.

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

- Reference materials: Executive Summary from the CEO; and Local Health Plans of California Memo: Governor's Budget May Revise 2024-25.

Pages 5-01 to 5-12

6. Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the third month ending March 31, 2024.

- Reference materials: Financial Statements as above.

Pages 6-01 to 6-09

Appointments: (7A. - 7B.)

7A. Approve appointments of Ralph Armstrong, DO and Ms. Anita Aguirre to the Finance Committee.

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

Page 7A-01

7B. Approve appointments of Ms. Debra Barcellos, Mr. John Alexander and Ms. Aluriel (Alu) Ceballos to the Member Services Advisory Group.

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

Page 7B-01

Minutes: (8A. – 8B.)

8A. Approve Commission meeting minutes of April 24, 2024.

- Reference materials: Minutes as above.

Pages 8A-01 to 8A-06

8B. Accept Quality Improvement Health Equity Committee meeting minutes of November 30, 2023.

- Reference materials: Minutes as above.

Pages 8B-01 to 8B-14

Reports: (9A. – 9I.)

9A. Approve revised 2024 Physicians Advisory Group meeting schedule.
- Reference materials: Staff report and recommendation on above topic.

Page 9A-01

9B. Approve revisions to Alliance Policy 401-1101 – Quality Improvement and Health Equity Transformation Program.
- Reference materials: Staff report and recommendation on above topic; and Alliance Policy 401-1101 – Quality Improvement and Health Equity Transformation Program.

Pages 9B-1 to 9B-30

9C. Approve revisions to Alliance Policy 401-1201 – Quality Improvement Health Equity Committee.
- Reference materials: Staff report and recommendation on above topic; and Alliance Policy 401-1201 – Quality Improvement Health Equity Committee.

Pages 9C-01 to 9C-10

9D. Accept Quality Improvement Health Equity Transformation Workplan for 2024.
- Reference materials: Staff report and recommendation on above topic; and Quality Improvement System Workplan for 2024.

Pages 9D-01 to 9D-16

9E. Accept Quality Improvement Health Equity Transformation Workplan for Q4 2023.
- Reference materials: Staff report and recommendation on above topic; and Q4 2023 QIHET Workplan.

Pages 9E-01 to 9E-26

9F. Accept Utilization Management Work Plan Report for Q4 2023.
- Reference materials: Staff report and recommendation on above topic; and Utilization Management Work Plan Q4 2023

Pages 9F-01 to 9F-30

9G. Accept Alliance Utilization Management: 2023 Annual Program Review.
- Reference materials: Staff report and recommendation on above topic; and Alliance Utilization Management: 2023 Annual Program Review.

Pages 9G-01 to 9G-05

9H. Accept Utilization Management Work Plan for 2024.
- Reference materials: Staff report and recommendation on above topic; and Utilization Management Work Plan for 2024.

Pages 9H-01 to 9H-17

9I. Approve Utilization Management Work Group Charter.
- Reference materials: Staff report and recommendation on above topic; and Utilization Management Work Group Charter.

Pages 9I-01 to 9I-04

Regular Agenda Items: (10. – 12.): 3:30 p.m.

10. Consider accepting audited financial statements and management letters for Alliance's fiscal year ending December 31, 2023 from Moss Adams LLP, independent auditors. (3:30 – 4:00 p.m.)

A. Moss Adams staff will present and Board will consider accepting audited financial statements and findings of independent auditors for FY 2023.

- Reference materials: Audited Financial Statements: FY 2023.

Pages 10-01 to 10-58

11. Consider approving proposed changes to Alliance's Care-Based Incentives (CBI) for 2025. (4:00 – 4:30 p.m.)

A. Dr. Dennis Hsieh, Chief Medical Officer, will review and Board will consider approving proposed changes to Alliance CBI for 2025.

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

Pages 11-01 to 11-02

12. Consider request for Letter of Support for Program of All-Inclusive Care for the Elderly (PACE). (4:30 – 5:00 p.m.)

A. Mr. Marwan Kanafani, Health Services Officer, will discuss and Board will consider request for letter of support from GoldenPACE Health to develop PACE to serve Santa Cruz, Monterey and San Benito counties.

- Reference materials: Staff report on above topic; Attachment A: Criteria for Assessment of PACE Letter of Support by Central California Alliance for Health; Attachment B: Letter of Support request received from GoldenPACE Health dated April 12, 2024; and Attachment C: Letters of Concern from Community Bridges/Elderday Adult Day Health Care and La Casa Adult Day Health Center, Inc.

Pages 12-01 to 12-40

Information Items: (13A. – 13C.)

A. Alliance in the News — Page 13A-01
B. Alliance Fact Sheet – April 2024 — Page 13B-01
C. Membership Enrollment Report — Page 13C-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, June 26, 2024; 1:30 – 2:45 p.m.
- Member Services Advisory Group
  Thursday, August 8, 2024; 10:00 – 11:30 a.m.
- Physicians Advisory Group
  Thursday, June 6, 2024; 12:00 – 1:30 p.m.
- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Thursday, June 20, 2024; 12:00 – 1:00 p.m.
- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, July 8, 2024; 1:30 – 3:00 p.m.

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

The next regular meeting of the Commission, after this May 22, 2024 meeting, unless otherwise noticed:

- Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
  Wednesday, June 26, 2024; 3:00 – 5:00 p.m.

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

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

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

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

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

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

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

The complete agenda packet is available for review on the Alliance website at https://thealliance.health/about-the-alliance/public-meetings/. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-5523. 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 22, 2024

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Executive Summary from the Chief Executive Officer

Executive

State Budget: May Revise FY 2024-2025. On Friday, May 10, 2024, Governor Newsom released his May Revision to the State's FY 2024-2025 budget. Unlike past years when the entire revised budget proposal is released, the Governor only presented a summary proposal which included significant adjustments to the budget to mitigate the anticipated multi-billion dollar budget shortfall.

Following include some of the key May Revision proposals impacting Medi-Cal:

Managed Care Organization (MCO) Tax: Reducing $6.7 billion over multiple years from the Medi-Cal provider rate increases planned for January 1, 2025, as well as Graduate Medical Education and Medi-Cal labor workforce. The May Revision proposes an amendment to the MCO Tax to include health plan Medicare revenue in the total revenue limit calculation, which increases the allowable size of the tax resulting in an additional net state benefit of $689.9 million in 2024-25, $950 million in 2025-26, and $1.3 billion in 2026-27. Overall, the May Revision includes an additional $9.7 billion in MCO Tax funds over multiple years to support the Medi-Cal program.

Equity and Practice Transformation Payments to Providers: Eliminating $280 million one-time over multiple years for grants to Medi-Cal providers for quality, health equity, and primary care infrastructure. The May Revision maintains $70 million General Fund included in the 2022 Budget Act.

In-Home Supportive Services for Undocumented Individuals: Reducing $94.7 million ongoing by eliminating the In-Home Supportive Services undocumented expansion coverage for all ages

Healthcare Workforce Reduction: Eliminating $300.9 million in 2023-24, $302.7 million in 2024-25, $216 million in 2025-26, $19 million in 2026-27, and $16 million in 2027-28 for various healthcare workforce initiatives including community health workers, nursing, social work, Song-Brown residencies, Health Professions Career Opportunity Program, and California Medicine Scholars Program. The May Revision also eliminates $189.4 million Mental Health Services Fund for programs proposed to be delayed to 2025-26 at Governor's Budget.

A summary provided by the Local Health Plans of California, which is based on an initial review of the May Revise, is included as an attachment to this Executive Summary.

Follow-up from April Board Meeting. Staff appreciated the opportunity for the robust discussion at our all in-person meeting last month. Discussion from that meeting will inform future Board

discussions including a discussion next month regarding the Alliance's community engagement efforts and a proposal for development of a new supplemental provider payment program.

Program of All-Inclusive Care for the Elderly (PACE). At your Board's May 22, 2024 meeting staff will provide a report of its assessment and evaluation of a request by a new entity, Golden PACE Health for a letter of support from your Board for GoldenPACE Health to develop and operate a PACE program to serve eligible individuals in Santa Cruz, Monterey and San Benito counties. The staff report, found in Agenda Item 12, provides background on this topic as well as the request received from representatives of GoldenPACE Health.

Community Involvement. On May 9, 2024, I attended the virtual Health Improvement Partnership of Santa Cruz County (HIPSCC) Council meeting and on May 16, 2024, I attended the virtual HIPSCC Executive Committee meeting. I plan to attend the Bienestar Plaza grand opening and ribbon cutting ceremony in Santa Cruz county on May 29, 2024,

Health Services

Health Services continues its busy month. The entire team continues to work on the Essette Replacement Project transition to ZeOmega Jiva. Quality Improvement is continuing to work on our Healthcare Effectiveness Data and Information Set submission which is due at the end of the month. Utilization Management is focused on the National Committee for Quality Assurance (NCQA) in addition to the Essette transition. Pharmacy continues with its drug utilization reviews and pharmacist led academic detailing. We welcomed Ms. Elizabeth Leary as the director of Care Management, and she is taking a deep dive into our care management program. Ms. Leary is focusing on complex case management, NCQA accreditation, and internal operations. Behavioral Health (BH) continues with the insourcing of BH from Carelon. Program Development successfully oversaw the first submission for all 15 of our Equity and Practice Transformation practices. The Medical Directors continue to work on a number of projects including partnering with information and technology services on improving our data infrastructure as well as transitions of care. More details are included below:

Quality Improvement and Population Health

Healthcare Effectiveness Data and Information Set/Managed Care Accountability Sets Report 2024. Medical records review has been completed and the Managed Care Accountability Sets audit team is finalizing submission to the auditors. Additional improvement over the MPL (Minimum Performance Level - Medicaid 50th percentile) has been found for several metrics in Merced following the medical record review.

Utilization Management (UM). Work continues in the transition from Essette to the ZeOmega Jiva care management system replacement platform. User acceptance testing has teams engaged across all modules within the platform (Provider Portal, UM, Case Management, Appeals and Grievances) and the teams continue to work through configuration updates in preparation for end to end testing and full scale internal and external training activities. Workflows for the Provider Portal, CCS/CM, UM, ECM, AG, and transportation (NEMT) are all nearing completion and sign off. Mission critical elements are under final development prior to go-live with tracking in place for post go-live system enhancements. To further prepare for the changes ahead, the Alliance has partnered with an external vendor for development and delivery of a robust training program that will support both Alliance staff and external providers in orientation to the new platform. The

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initially planned Jiva go-live date scheduled for March has been delayed to July 2024 as ZeOmega Jiva system optimizations are further developed and tested.

NCQA accreditation preparation continues in parallel with Essette replacement activity. NCQA sets standards and measures performance for healthcare organizations and providers, focusing on areas such as patient care, patient experience, and health plan operations. UM teams are optimizing annual UM Program Evaluation processes for successful completion of deliverables in advance of the October 2024 NCQA lookback period. UM criteria review processes have been increased to include routine external independent medical reviews, with external experts additionally assessing policies both at initial creation and upon annual review as part of NCQA readiness. Organizational NCQA impacts are under full assessment given the delays with the ZeOmega Jiva implementation.

BH UM integration processes are well underway in advance of the July 1, 2025 implementation date, with recruitment beginning this month for a BH UM Manager to oversee internal BH UM program development and authorization activity. Next steps will include further development of the Alliance's BH authorization framework development and recruitment for prior authorization staff to support utilization oversight of the plan's BH requests.

Inpatient and Emergency Department. Post Acute Care remained relatively unchanged when comparing quarter one year over year activity with total skilled nursing admissions and average length of stays consistent, despite increases in membership with the two new counties. The team's increased focus on transitions of care and external interdepartmental team (IDT) meetings are factors supporting improved metrics in this area and a continued focus in 2024 as the team works to support sustained reductions in avoidable emergency department utilization and inpatient readmissions. IDT processes will be expanded in 2024 to include Enhanced Care Management (ECM) providers as a measure to further support transitions of care and member/ECM provider connections and improved member outcomes.

Prior Authorization. The Prior Authorization team has increased team efficiencies, with authorization activity advanced to day three turnaround time (versus five) and approximately half of the total UM team additionally engaged in ZeOmega Jiva testing and training. The authorization intake team has ECM/Community Supports (CS) authorizations under optimization review, potentially leveraging Non-Emergency Transportation Authorization processes wherein increased direct member engagement has proven successful in connecting members to services across the plan's several counties. Potential overutilization with meal delivery/community supports is under review with additional CS policy updates recently completed and under DHCS review.

The plan's new expansion counties continue to see low but increasing submissions in authorization activity and remain an area of ongoing transitions of care and special populations of focus, with internal UM referral activity supporting increased uptake in ECM and complex case management support. Well-organized interdepartmental continuity of care processes are now fully embedded processes for the plan's new expansion members and the team continues to partner internally with the Alliance's Provider Services team for ongoing review of and focus on areas of potential network development.

Additional collaboration is underway to explore further provider enhancements for complex durable medical equipment (DME) providers including those for services such as wheelchair repairs and custom orthotics. Internal Alliance processes for UM to Case Management referrals for members with complex DME requests are reflecting success over the year, with decreased

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grievance activity and increases in member connection to requested complex DME services. Overall utilization activity reflects consistent trends with successful redirection for in network specialty referrals, decreased denial activity and improved member access to care.

Pharmacy

Prior authorization volume for physician-administered drugs increased back to January levels, and there is a 26% increase in volume from the same time last year. Compliance with turnaround time is at goal (98%). The Pharmacy team is adapting to multiple workflow changes to meet NCQA standards, and a significant amount of time continues to be spent on testing the new care management system.

Pharmaceutical Management. Osteoporosis Physician-Administered Drugs (PAD) Review: Pharmaceutical management procedures and clinical guidelines were reviewed for physician-administered osteoporosis medications including zoledronic acid (Reclast), denosumab (Prolia) and romosozumab (Evenity). Changes in prior authorization requirements and updates to prior authorization criteria were approved by the Pharmacy & Therapeutics (P&T) Committee.

Pharmacist-Led Academic Detailing (PLAD) Program. Diabetes PLAD: During April, the Alliance pharmacists began working with two clinics (a total of two providers) divided into two separate groups. Both providers completed two out of five meetings and are scheduled to complete the program by July 2024.

Diabetes Presentation. A one-hour diabetes pharmacotherapy review presentation was given to 15 medical resident physicians. To assess knowledge gain, they were asked to complete pre- and post-presentation tests. The average accuracy rate was 66% pre-presentation and 95% after the presentation. Additionally, residents completed a post-program survey in which the majority strongly agreed that the presentation was useful, enhanced their knowledge, and that they are likely to recommend the program to colleagues. Requests were made for additional presentations on other medications and disease states.

Care Management (CM)

Care Management has continued efforts to assist hard-to-place members with long hospital stays with placements in Residential Care Facilities for the Elderly. These members require close monitoring and collaboration between our CCM team and our UM department. This collaboration has been successful in reducing unnecessary hospitalizations and acute utilization for our high-risk members with complex conditions.

We continue with training and preparation for our Essette system replacement. We have been testing and reviewing of all workflows to ensure that we are able to meet our members' needs in a more streamlined approach as well as meeting NCQA standards.

In preparation for NCQA accreditation we are also strengthening our member outreach efforts to engage high-risk complex patients for the survey and are streamlining our workflows and processes.

Whole Child Model/Pediatric Complex Care Management. The Pediatric Complex Case Management (CCM) team continues work with the Essette system replacement, to ZeOmega Jiva. Work in the ZeOmega Jiva platform is in full swing across all teams. Optimization for both CCS and

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case management and other key health services functions is under design as the new platform is developed to best align with NCQA standards as well as other requirements. We are currently in the UAT (User Acceptance and Testing) phase. This is end-to-end system testing. This current phase includes full engagement of pediatric team members to explore and validate system functionality as well as test critical business workflows.

The Pediatrics CCM team is successfully managing the increased volume of pediatric cases for Mariposa and San Benito members and working closing with our County CCS partners. The Whole Child Model (WCM) expansion project work for San Benito and Mariposa counties continues to be a priority. WCM will be implemented in these two counties in January 2025. This project spans multiple departments and divisions and will build off the work that was initiated for the county expansion project. Collaborative meetings with both our new counties and DHCS continue. DHCS has provided multiple deliverable request to implement this expansion. Impacted departments include (but are not limited to) Pediatrics CCM, UM, and Provider Services. In our three existing WCM counties, staff continue to monitor and observe steady CCS referrals and enrollment rates.

Enhanced Care Management (ECM)/Community Supports (CS). Focus remains on increased enrollment in ECM services. There are ongoing engagement efforts to support awareness of the benefits through community contacts. The PATH Collaborative groups are working with the ECM team to focus on working relationships across multiple sectors for increased awareness and referral volume into the program. Provider network support remains a priority to encourage capacity expansion as well as quality provision of services for members. A cohort of new providers have been onboarded as of the beginning of Q2.

Behavioral Health

The BH department maintains a strong focus on oversight of the delegate Carelon. This includes daily engagement via email, weekly executive level meetings to discuss and mitigate issues, and distribution of multiple trackers to monitor provider and member issues. This month emphasis was placed on provider relations disputes which were escalated through the Alliance when providers were unable to get their needs met through Carelon channels. In addition, Carelon received a corrective action plan from the Alliance regarding the March discovery that a large number of members were awaiting connection to specialized services for Autism spectrum and developmental disorders but were not connected. The team has added a regular status update regarding this issue to the calendar to ensure oversight as Carelon remedies the issue and remediates risks for future occurrences.

As part of the BH Integration Planning (BHIP), workgroups and project teams continue to meet on frequent cadences to transition from planning to execution phase. Targeted efforts have included development of a value-based payment proposal which is designed to incentivize providers to address network and care gaps in our system, as well as the refinement of a prioritized recruitment strategy to leverage when building the provider network. Further, the clinical workgroups have partnered to outline a clinical strategy to guide the work and share organizationally to provide insight into the core principles of the projects.

The BH Learning Sessions concluded in April with the final module on the future state of BH at the Alliance. This included a broad overview of our insourcing efforts as well as the structure of the BHIP work. Having completed the session which began in 2023, the BH director will transition to offering monthly BH office hours. The sessions will be unstructured free periods for all staff to

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attend to ask questions, raise concerns, make comments and dialogue about all components of BH.

Program Development

CalAIM Incentive Payment Program (IPP). Alliance staff is awaiting a report from DHCS on the amount of IPP funds earned from Submission 4. The Alliance has the potential to earn $10.8M for the report submitted to DHCS on March 15, 2024 covering the measurement period of July 1, 2023 – December 31, 2023. This submission covered only Merced, Monterey, and Santa Cruz. The Alliance is eligible to participate in Submission 5 in both Mariposa and San Benito counties, pending completion of the Managed Care Plan transition requirements, including a Needs Assessment and Gap-Filling Plan, submitted to DHCS on May 15, 2024. The Alliance must submit its last IPP progress report (Submission 5) by Monday, September 2, 2024 for the measurement period of January 1, 2024 – June 30, 2024. The Alliance has the potential to earn $9.9M with Submission 5. Staff continue to execute LOAs for the newly contracted ECM/CS providers serving Populations of Focus (PoF) that went live January 2024 (Justice Involved and Birth Equity), as well as to encourage expansion of ECM/CS in all five service areas. To date, 51 IPP LOAs have been executed, for a total of $26.4M.

Housing and Homelessness Incentive Program (HHIP). In Q2 2024 staff will formally announce the Alliance's Housing Fund. The Housing Fund provides capital investments to build, renovate and/or furnish permanent housing units, recuperative care facilities, and short-term post-hospitalization housing units across the Alliance's service area. To seed the Housing Fund, staff will leverage dollars earned from DHCS through the Housing and Homelessness Incentive Program (HHIP), as well as a $10M Medi-Cal Capacity Grants Program (MCGP) allocation.

Alliance staff are coordinating with local homelessness Continuums of Care to identify potential projects and have committed Housing Fund dollars to one proposed project, thus far. The Alliance is partnering with Monterey County to address housing shortages through a $4.9 million investment in a King City housing project. The King City initiative assists individuals transitioning from encampments to interim housing at a local motel and within a year, to a permanent housing solution with comprehensive support services.

With the pending formal Housing Fund announcement, Alliance staff will post a request for Letters of Interest to solicit additional potential projects across the Alliance service area.

Student Behavioral Health Incentive Program (SBHIP). Partners are preparing to submit the third progress report, covering the time frame of January 1 - June 30, 2024. The reports will encompass SBHIP updates on each targeted intervention project (21 total, across seven districts in all five counties), and will come to Alliance staff by May 31, 2024 for June 30, 2024 submission to DHCS. The report is associated with 12.5% of allocation funding (~$1.5M) and will be the first time the Alliance serves as the MCP for report submission for San Benito and Mariposa.

Equity and Practice Transformation (EPT). The Alliance is supporting 15 providers (the 4th most projects out of all health plans in the state) in the EPT pass-through payment program. The Alliance received the Initial Provider Planning Incentive Payment in the amount of $836,645.96. Staff are determining how best to utilize the funds to further equity efforts. The first EPT deliverable was completion of a survey tool (phmCAT) and was due from practices on May 1, 2024;

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all 15 practices submitted 3+ PhmCATs and will be able to earn their first payment by October 2024. Required deliverables for future milestones have yet to be released.

Medical Directors

The Medical Directors continue with performing utilization management and complex case review. In addition, Dr Wang is providing clinical informatics support for multiple data initiatives including electronic data warehouse, ECM, transitions of care, and follow-up after emergency department for mental health. He is also heavily involved in facilizing the execution of the hospital quality incentive program and data sharing incentive program. Dr. Wang also provides broad support for various Alliance initiatives around data quality across the organization as well as broad clinical support for inpatient-related projects. Dr Heinert is working on case review and pattern identification for transitional care services. She is currently evaluating the Alliance's partnerships with Palliative Care providers. Dr Heinert continues to provide broad support for potential quality issues and grievances. Dr Heinert also advises the Health Services Employee Engagement Group which provides Health and Wellness presentations and activities for the Health Services division.

Employee Services and Communications

Human Resources

Alliance Workforce. As of April 22, 2024, the Alliance has 613.4 budgeted positions of which our active workforce number is 569.9 (active FTE and temporary workers covering LOAs and vacancies). Additionally, the Alliance has 41.5 budgeted temporary workers, of which 21.5 are filled. Overall, the Alliance is 91.0% staffed. Additionally, there are 46 regular and temporary positions in active recruitment. Human Resources partners with Finance to ensure alignment in this area and provides a bi-weekly workforce dashboard to all Directors and Chiefs for transparency regarding our workforce statistics.

Q1 2024 Goal Check-in. As part of the Alliance's performance management process, supervisors met with their teams for a Q1 2024 check-in on goal progression. This is an opportunity for staff and supervisors to dialogue on goal status updates, milestones, and progress of assigned goals. This body of work has concluded for Q1 2024.

Employee Engagement Survey. The Alliance encourages staff to participate in the Annual Employee Engagement Survey in order to gauge their level of engagement in both the work we do, and with the organization itself. The survey provides staff with the opportunity to share feedback so that the Alliance understands what is important to them, what we are getting right, and where there are opportunities for growth. This year, the survey is open from May 6 – May 17, 2024. Human Resources will review results, train department directors on how to access department-specific results and provide staff information sessions in June which covers overall organization results and comparisons to last year's survey outcomes.

Facilities and Administrative Services

Generator Installation. Facilities is working with an electrical contractor to install a permanent generator at the 1600 Green Hills Road building in Scotts Valley. The installation is expected to be completed by December 2024.

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Tenant Improvement Projects. There are several tenant improvement projects underway in the Salinas office location for tenants that will be leasing vacant space from the Alliance. Construction is expected to last well into 2024.

Communications

Behavioral Health In-House Project. Communications staff continue to work on communication plans to support the BH in-house project. The communications plan to support provider recruitment has been approved and tactics are currently in development. In addition, the broader communications plan for members, community partners and employees has been approved. Staff are prioritizing communications support for provider recruitment tactics and expect to wrap up this work in early summer.

Member Texting and Engagement Project. The member texting and engagement project is picking up steam. The texting policy and terms and conditions have been finalized and a texting short code has been obtained. The team is currently prioritizing data integration and campaign prioritization work. We are also seeking to obtain approval to revise the project scope to incorporate using the platform to deliver a digital member ID card. Next, we are revising initial campaign scripts for well checks, vaccines, flu vaccines and welcome texts. Once those scripts are finalized and translated, we will work to complete the texting application submission to DHCS. We have tentative plans to launch full-scale texting by early fall; however, this will largely depend on our internal capabilities to support this timeline and the external approval timelines from DHCS. If approvals from DHCS come sooner than expected, we can likely move the launch forward.

Co-Branded Media Campaign. Our first co-branded media campaign launched last month and runs through mid-June. The campaign targets Merced families with school-aged children, aiming to raise awareness of the importance of well-checks for school. Campaign partners include Merced County Office of Education (MCOE) and Mercy Health. Campaign tactics include a billboard (provided by MCOE), flyers, newsletter articles, website content, social media content, Spanish and English terrestrial radio, radio interviews with SMEs, YouTube and Snapchat ads. Next, staff will be working on a paid vaccine campaign targeting families with kids aged 13 and under, with a planned launch in early August, to coincide with National Immunization Month.

Operations

Alliance in the Community. The Alliance Community Engagement team has been out at many community events throughout our five-county region. Some notable events include:

- The Mariposa Butterfly Festival (Mariposa)
- Merced Lao New Year (Merced)
- Second Harvest Food Bank's CalFresh Forum (Santa Cruz)
- Alisal Integrated Health Center Resource Fair (Monterey)
- YMCA Healthy Kids Day (San Benito)

At these events we are reminding members and the community of Alliance services and benefits.

In May, the Alliance hosted a Public Information Officer Roundtable with partners from Merced County to collaborate on healthcare messaging. Staff were also able to attend UC Merced's Medical Education Building Groundbreaking Ceremony.

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County Expansion Stabilization. Members continue to seek assistance in the Mariposa and San Benito office locations. Staff have served members in person and on the phone. There were 25 walk-ins in Mariposa and 59 in San Benito County. Staff have strengthened relationships with local county staff and have partnered to serve members.

Dual Eligible Special Needs Plans (D-SNPs) Implementation. The Board approved the specialist and facilities payment approaches at the April meeting. Outreach to prospective D-SNP providers is due to begin by or before the end of this month. The goal is to have a compliant network ready to submit when the Alliance files our Notice of Intent to Apply submission to Centers for Medicare & Medicaid Services (CMS) in November of this year. Any gaps in our network should be addressed by the time the Alliance applies for our Medicare D-SNP contract with CMS by early February 2025. Additionally, the Alliance is in the process of finalizing request for proposals to acquire software around enrollment, risk adjustment and customer relationships management functionalities.

Network Development. The Provider Services team has been working on expanding PCP locations to those areas within time and distance standards but outside of county lines. The first group of 25 additional sites were credentialed and added effective May 1, 2024. This has been a large effort intended to expand members' options for PCP office locations and providers. Additionally, the Alliance continues to assess realized access and identify opportunities whereby we can address those either in the short or long term, including assessment of telehealth capacity and grant innovation funding.

Operations Impact. Claim receipt volumes were artificially suppressed for part of February and all of March because of the Change Healthcare cyber-attack. However, beginning in April through May, we have seen those receipt volumes bounce back and increase substantially. April's claim receipt volumes were up 48% compared to April 2023 and May receipt volumes are up 13% compared to May 2023. We have also seen a substantial increase in the number of paper claim submissions through our vendor. This is a result of those providers who utilized Change Healthcare as their electronic claim submission clearinghouse. We anticipate that our paper claim volumes will move back into their normal range as a result of Change Healthcare recently bringing their clearinghouse back online.

Attachment.

1. Local Health Plans of California Memo: Governor's Budget May Revise 2024-25

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To: Board of Directors & Plan Staff

From: Katie Andrew, Director of Government Affairs, Quality & Behavioral Health

Subject: Highlights from Governor's Budget May Revision for 2024-25

Date: May 10, 2024

This memo includes highlights from Governor Newsom's Budget May Revision for 2024-25, specifically health and human services proposals of relevance to local plans. See the Governor's Budget May Revision Summary. LHPC will update this memo once the administration releases both the DHCS Budget Highlights and the DHCS Medi-Cal Estimate, expected Tuesday, May 14, 2024. There may be additional cuts that are not reflected in the budget summary that will be revealed in the coming days. LHPC will continue to monitor any additional budget developments that will impact local plans and provide additional information as it becomes available. Please contact Katie Andrew (kandrew@lhpc.org) with any questions.

One important omission from the May Revision is how the administration plans to address the healthcare worker minimum wage passed into law through SB 525 (Durazo). During the May Revise press conference Governor Newsom indicated that negotiations are ongoing and more would be revealed over the course of the next few weeks of the budget process.

While we wait for additional detail, more information can be found in the Department of Finance Budget Solutions document.

State Budget Overview

The 2024-2025 May Revision looks beyond the current fiscal year and attempts to address anticipated budget shortfalls in FY 2024-2025 and FY 2025-2026 FY. The following highlights provide a snapshot of California's overall State Budget:

- ***Total May Revised Budget***: $288.1 billion total fund ($200.9 billion General Fund) in 2024-25 (Summary Chart, p. 23).
- ***Reduced Revenues and Budget Shortfall:*** In January, the Governor's proposed budget estimated a $37.9 billion budget deficit for FY 2024-2025. The administration and legislature addressed $17.3 billion of the estimated deficit through an early action budget package. However, revenues continued to come in below projections, increasing the deficit by an estimated $7 billion for a total of $27.6 billion; however, the May Revision includes budget solutions to address a total deficit of $28.4 billion, accounting for an additional $1.2 billion that was not fully addressed through the proposed January budget solutions. The budget solutions include spending cuts to government operations, reductions to programs, and pauses new investments. Below is a snapshot of the budget solutions in the May Revision to address the total budget deficit:

- *Reserves ($22.8 billion of reserves remaining)*
  - Withdrawal BSA Balance ($3.3 billion for FY 2024-2025; $8.9 billion FY 2025-2026)
  - Withdrawal from the Safety Net Reserve ($900 million)
- *Revenue/Borrowing*--$7.7 billion (additional $2 billion in May Revise)
  - **Additional Managed Care Organization (MCO) Tax (Medicare Revenue):** Increase the MCO Tax to achieve additional net state benefit of $689.9 million in 2024-25, $950 million in 2025-26, and $1.3 billion in 2026-27 by including health plan Medicare revenue in the total revenue limit calculation, which increases the allowable size of the tax.
- *Reductions and Fund Shifts*—$26.5 billion
  - $19.2 billion in reductions (additional $10.7 billion in May Revise)
    - **Children Youth Behavioral Health Initiative:** A reduction of one-time $72.3 million General Fund in 2023-24, $348.6 million General Fund in 2024-25, and $5 million General Fund in 2025-26.
  - $7.3 billion in fund shifts (additional $3.9 billion in May Revise)
- *Delays and Deferrals*—$7.7 billion
  - $5.6 billion in delays (additional $520 million in May Revise)
  - $2.1 billion in deferrals
- May Revision includes $8.4 billion withdrawal from the Public School System Stabilization Account.

Reference: Governor's Budget May Revision Summary, pp. 5-6

Significant Medi-Cal Budget Items

- **Managed Care Organization (MCO) Tax**—Reducing $6.7 billion over multiple years from the Medi-Cal provider rate increases planned for January 1, 2025, as well as Graduate Medical Education and Medi-Cal labor workforce. The May Revision proposes an amendment to the MCO Tax to include health plan Medicare revenue in the total revenue limit calculation, which increases the allowable size of the tax resulting in an additional net state benefit of $689.9 million in 2024-25, $950 million in 2025-26, and $1.3 billion in 2026-27. Overall, the May Revision includes an additional $9.7 billion in MCO Tax funds over multiple years to support the Medi-Cal program.
- **Equity and Practice Transformation Payments to Providers**—Eliminating $280 million one-time over multiple years for grants to Medi-Cal providers for quality, health equity, and primary care infrastructure. The May Revision maintains $70 million General Fund included in the 2022 Budget Act.
- **In-Home Supportive Services for Undocumented Individuals**—Reducing $94.7 million ongoing by eliminating the In-Home Supportive Services (IHSS) undocumented expansion coverage for all ages.
- **Children and Youth Behavioral Health Initiative**—Reducing $72.3 million one-time in 2023-24, $348.6 million in 2024-25, and $5 million in 2025-26 for school-linked health partnerships and capacity grants for higher education institutions, behavioral health services and supports platform, evidence-based and community-defined grants,

public education and change campaign, and youth suicide reporting and crisis response pilot.

- **Behavioral Health Continuum Infrastructure Program**—Eliminating $450.7 million one-time from the last round of the Behavioral Health Continuum Infrastructure Program, while maintaining $30 million one-time General Fund in 2024-25.
- **Behavioral Health Bridge Housing Program**—Reducing $132.5 million in 2024-25 and $207.5 million in 2025-26 for the Behavioral Health Bridge Housing Program, while maintaining $132.5 million General Fund in 2024-25 and $117.5 million ($90 million Mental Health Services Fund and $27.5 million General Fund) in 2025-26.
- **Foster Care Permanent Rate Structure**—Including statutory language that would make the proposed foster care rate structure subject to a trigger-on, based on the availability of General Fund in spring 2026.

Other Areas of Interest Impacted

- **Healthcare Workforce Reduction**—Eliminating $300.9 million in 2023-24, $302.7 million in 2024-25, $216 million in 2025-26, $19 million in 2026-27, and $16 million in 2027-28 for various healthcare workforce initiatives including community health workers, nursing, social work, Song-Brown residencies, Health Professions Career Opportunity Program, and California Medicine Scholars Program. The May Revision also eliminates $189.4 million Mental Health Services Fund for programs proposed to be delayed to 2025-26 at Governor's Budget.
- **Elimination of Public Health Funding**—Eliminating $52.5 million in 2023-24 and $300 million ongoing for state and local public health.
- **California Food Assistance Program Expansion**—Delaying for two years the California Food Assistance Program expansion automation to begin in 2026-27 with benefits beginning in 2027-28.
- **CalWORKs Home Visiting Program**—Reducing $47.1 million ongoing for the CalWORKs Home Visiting Program.
- **CalWORKs Mental Health and Substance Abuse Services**—Reducing $126.6 million ongoing for the CalWORKs Mental Health and Substance Abuse Services.

TBL Section

The following list outlines trailer bill language of interest to local plans. LHPC will be monitoring for additional trailer bill language in the coming weeks and will share more information as available:

- Managed Care Organization Provider Tax Amendment
- CYBHI Fee Schedule MCP Fee

DATE: May 22, 2024

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Third Month Ending March 31, 2024

For the month ending March 31, 2024, the Alliance reported an Operating Income of $25.9M. The Year-to-Date (YTD) Operating Income is $52.6M, with a Medical Loss Ratio (MLR) of 84.7% and an Administrative Loss Ratio (ALR) of 4.9%. The Net Income is $59.2M after accounting for Non-Operating Income/Expenses.

The budget expected a $27.1M Operating Income for YTD March. The actual result is favorable to budget by $25.5M or 94.0%, driven primarily by rate variance and membership favorability.

	Mar-24 MTD ($ In 000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*457,197*	*424,119*	*33,078*	*7.8%*
Revenue	$171,273	$143,770	$27,502	19.1%
Medical Expenses	137,138	126,098	(11,040)	-8.8%
Administrative Expenses	8,269	8,458	189	2.2%
Operating Income	25,866	9,214	16,652	100.0%
Net Income	$30,712	$10,695	$20,017	100.0%
MLR %	80.1%	87.7%	7.6%	
ALR %	4.8%	5.9%	1.1%	
Operating Income %	15.1%	6.4%	8.7%	
Net Income %	17.9%	7.4%	10.5%	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Mar-24 (In $000s)				
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*1,371,070*	*1,297,063*	*74,007*	*5.7%*
Revenue	$504,880	$439,568	$65,312	14.9%
Medical Expenses	427,469	386,761	(40,707)	-10.5%
Administrative Expenses	24,774	25,668	894	3.5%
Operating Income/(Loss)	52,637	27,139	25,499	94.0%
Net Income/(Loss)	$59,171	$31,771	$27,400	86.2%
PMPM				
Revenue	$368.24	$338.89	$29.34	8.7%
Medical Expenses	311.78	298.18	(13.60)	-4.6%
Administrative Expenses	18.07	19.79	1.72	8.7%
Operating Income/(Loss)	$38.39	$20.92	$17.47	83.5%
MLR %	84.7%	88.0%	3.3%	
ALR %	4.9%	5.8%	0.9%	
Operating Income %	10.4%	6.2%	4.2%	
Net Income %	11.7%	7.2%	4.5%	

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

At a PMPM level, YTD revenue is $368.24, which is favorable to budget by $29.34 or 8.7%. Medical cost PMPM is $311.78, which is unfavorable by $13.60 or 4.6%. Overall, this results in a favorable gross margin of $15.75 or 38.7% compared to the budget. The operating income PMPM is $38.39, which is favorable to the budget by $17.47 or 83.5%.

Membership. March 2024 membership is favorable to budget by 7.8%. The 2024 budget assumed a 17% decrease over the course of redetermination (July 2023 to June 2024) based on Mercer projections. Mercer later updated their projections to be less impactful than initially estimated and now only assumes an 11% decrease.

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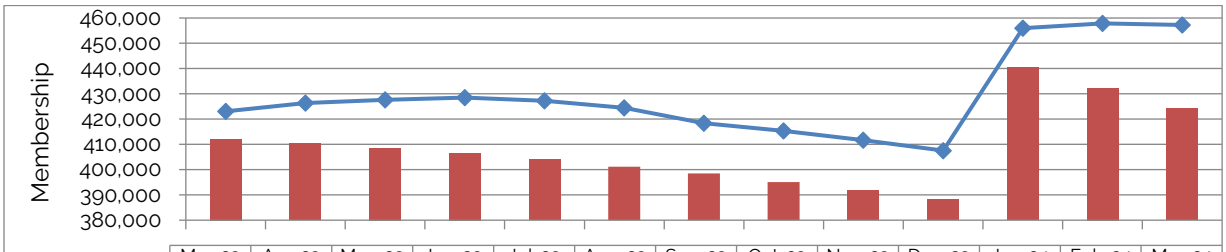
Membership. Actual vs. Budget (based on actual enrollment trend for Mar-24 rolling 13 months)



	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Budget	412,231	410,347	408,481	406,635	403,892	401,191	398,530	395,036	391,611	388,255	440,590	432,354	424,119
Actual	423,002	426,328	427,656	428,448	427,275	424,399	418,442	415,304	411,670	407,542	456,002	457,871	457,197
Variance	10,771	15,981	19,175	21,813	23,383	23,208	19,912	20,268	20,059	19,287	15,412	25,517	33,078
Variance %	2.6%	3.9%	4.7%	5.4%	5.8%	5.8%	5.0%	5.1%	5.1%	5.0%	3.5%	5.9%	7.8%

Revenue. The 2024 revenue budget was based on the Department of Health Care Services (DHCS) 2024 draft rate package (dated 10/13/2023), which reflected a 0.4% rate increase, not including the Targeted Rate Increase (TRI). Furthermore, the budget assumed breakeven performances for the San Benito Region. The CY 2024 Prospective rates from DHCS (dated 12/5/2023, including Maternity) represented a 2.1.% increase over CY 2023 Rates excluding TRI.

March 2024 operating revenue of $171.3M is favorable to budget by $27.5M or 19.1%. Of this amount, $11.1M is from boosted enrollment, and $16.4M is due to rate variance.

March 2024 YTD operating revenue of $504.9M is favorable to budget by $65.3M or 14.9%. Of this amount, $24.1M is from boosted enrollment, and $41.2M is due to rate variance.

Beginning January 2024, the new general ledger structure is reported by region and immigration status. Central California (CEC) includes the counties of Santa Cruz, Monterey, Merced, and Mariposa, and San Benito (SBN) includes San Benito. Immigration status is reported as UIS (Unsatisfactory Immigration Status) or SIS (Satisfactory Immigration Status).

Mar-24 YTD Capitation Revenue Summary (In $000s)

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	380,030	328,644	51,386	19,335	32,051
CEC UIS	101,429	94,069	7,360	2,916	4,444
SBN SIS	19,036	13,095	5,941	1,418	4,524
SBN UIS	3,187	2,728	460	241	219
Total*	**503,682**	**438,535**	**65,147**	**23,909**	**41,238**

*Excludes Mar-24 In-Home Supportive Services (IHSS) premiums revenue of $1.2M.

Medical Expenses. The 2024 budget assumed a 3.7% increase in utilization over the base data that spanned from 2018 through June 2023 and a 2.9% unit cost increase that included case mix and changes in fee schedules. 2024 incentives include a $15M Care-Based

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Incentive (CBI), $4M Data Sharing Incentives, $18M for the Hospital Quality Incentive Program (HQIP), and $10M for the Specialist Care Incentive (SCI).

March 2024 Medical Expenses of $137.1M are $11.0M or 8.8% unfavorable to budget. March 2024 YTD Medical Expenses of $427.5M are above budget by $40.7M or 10.5%. Of this amount, $22.0M is due to higher enrollment and $18.7M is due to rate variances. YTD, we are seeing increases in spending in the categories of Physician Services, Long Term Care (LTC), and Outpatient Facility.

Mar-24 YTD Medical Expense Summary ($ In 000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Services - Hospital	145,226	141,771	(3,455)	(8,067)	4,612
Inpatient Services - LTC	50,843	33,270	(17,573)	(1,888)	(15,686)
Physician Services	99,597	82,414	(17,183)	(4,706)	(12,477)
Outpatient Facility	60,992	48,101	(12,891)	(2,739)	(10,152)
Other Medical*	70,811	81,205	10,394	(4,644)	15,038
State Incentive Programs	-	-	-	-	-
TOTAL COST	**427,469**	**386,761**	**(40,707)**	**(22,044)**	**(18,663)**

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

At a PMPM level, YTD Medical Expenses are $311.78, unfavorable by $13.60 or 4.6% compared to the budget.

LTC's unfavorability is primarily driven by unit cost. The budget underestimated the baseline cost and did not consider the continuation of the 10% COVID-19 add-on for certain codes or the 3% annual fee schedule increase. We expect the unfavorable variance will continue.

Physician Services: The budget assumed utilization would increase by 2% compared to 2023. However, utilization has increased by 15%, mostly driven by the new UIS members.

Mar-24 YTD Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	105.92	109.30	3.38	3.1%
Inpatient Services - LTC	37.08	25.65	(11.43)	-44.6%
Physician Services	72.64	63.54	(9.10)	-14.3%
Outpatient Facility	44.48	37.08	(7.40)	-20.0%
Other Medical	51.65	62.61	10.96	17.5%
State Incentive Programs	-	-	-	0.0%
TOTAL MEDICAL COST	**311.78**	**298.18**	**(13.60)**	**-4.6%**

Administrative Expenses. March YTD Administrative Expenses are favorable to budget by $0.9M or 3.5% with a 4.9% ALR. Salaries are slightly favorable by $0.2M, driven by savings

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from vacant positions, benefits, and PTO. Non-Salary Administrative Expenses are favorable by $0.7M or 8.3% due to the timing of the actual spend versus budget.

Non-Operating Revenue/Expenses. March YTD Net Non-Operating income is $6.5M, which is favorable to the budget. Total Non-Operating Revenue is unfavorable to budget by $0.5M, attributed to a $3.4M unrealized investment loss offsetting $3.0M in interest income. Non-Operating Expenses are favorable by $2.4M due to lower grant expenses.

Summary of Results. Overall, the Alliance generated a YTD Net Income of $59.2M, with an MLR of 84.7% and an ALR of 4.9%.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Third Month Ending March 31, 2024
(In $000s)

Assets	
Cash	$621,971
Restricted Cash	300
Short Term Investments	790,636
Receivables	295,601
Prepaid Expenses	3,017
Other Current Assets	4,816
Total Current Assets	**$1,716,340**
Building, Land, Furniture & Equipment	
Capital Assets	$79,417
Accumulated Depreciation	(44,982)
CIP	1,967
Lease Receivable	3,084
Subscription Asset net Accum Depr	10,510
Total Non-Current Assets	**49,996**
Total Assets	**$1,766,337**
Liabilities	
Accounts Payable	$277,948
IBNR/Claims Payable	513,143
Provider Incentives Payable	52,381
Other Current Liabilities	9,264
Due to State	8,038
Total Current Liabilities	**$860,773**
Subscription Liabilities	8,687
Deferred Inflow of Resources	2,933
Total Long-Term Liabilities	**$11,620**
Fund Balance	
Fund Balance - Prior	$834,772
Retained Earnings - CY	59,171
Total Fund Balance	**893,943**
Total Liabilities & Fund Balance	**$1,766,337**
Additional Information	
Total Fund Balance	**$893,943**
Board Designated Reserves Target	437,851
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	164,472
Value Based Payments	46,100
Total Reserves	**705,123**
Total Operating Reserve	**$188,820**

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2024
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*457,197*	*424,119*	*33,078*	*7.8%*	*1,371,070*	*1,297,063*	*74,007*	*5.7%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$170,872	$143,426	$27,446	19.1%	$503,682	$438,535	$65,147	14.9%
State Incentive Programs	-	-	-	0.0%	-	-	$0	0.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	$0	0.0%
Premiums Commercial	400	344	56	16.3%	1,197	1,032	165	16.0%
Total Operating Revenue	**$171,273**	**$143,770**	**$27,502**	**19.1%**	**$504,880**	**$439,568**	**$65,312**	**14.9%**
Medical Expenses								
Inpatient Services (Hospital)	$51,551	$46,211	($5,340)	-11.6%	$145,226	$141,771	($3,455)	-2.4%
Inpatient Services (LTC)	16,489	10,844	(5,645)	-52.1%	50,843	33,270	(17,573)	-52.8%
Physician Services	32,972	26,864	(6,108)	-22.7%	99,597	82,414	(17,183)	-20.8%
Outpatient Facility	27,324	15,679	(11,645)	-74.3%	60,992	48,101	(12,891)	-26.8%
Other Medical**	8,802	26,499	17,698	66.8%	70,811	81,205	10,394	12.8%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Total Medical Expenses	**$137,138**	**$126,098**	**($11,040)**	**-8.8%**	**$427,469**	**$386,761**	**($40,707)**	**-10.5%**
Gross Margin	**$34,135**	**$17,672**	**$16,463**	**93.2%**	**$77,411**	**$52,807**	**$24,604**	**46.6%**
Administrative Expenses								
Salaries	$5,881	$5,705	($176)	-3.1%	$17,366	$17,593	$228	1.3%
Professional Fees	227	283	56	19.9%	559	864	305	35.3%
Purchased Services	988	998	11	1.1%	3,141	3,177	36	1.1%
Supplies & Other	781	1,058	277	26.2%	2,556	2,810	255	9.1%
Occupancy	134	127	(8)	-6.2%	379	396	17	4.3%
Depreciation/Amortization	258	287	29	10.3%	773	827	53	6.5%
Total Administrative Expenses	**$8,269**	**$8,458**	**$189**	**2.2%**	**$24,774**	**$25,668**	**$894**	**3.5%**
Operating Income	**$25,866**	**$9,214**	**$16,652**	**100.0%**	**$52,637**	**$27,139**	**$25,499**	**94.0%**
Non-Op Income/(Expense)								
Interest	$4,523	$2,683	$1,839	68.5%	$11,389	$8,390	$2,999	35.7%
Gain/(Loss) on Investments	1,105	100	1,005	100.0%	(3,226)	150	(3,376)	-100.0%
Bank & Investment Fees	(80)	(36)	(44)	-100.0%	(132)	(109)	(23)	-20.9%
Other Revenues	133	197	(64)	-32.5%	472	590	(118)	-20.0%
Grants	(835)	(1,463)	628	43.0%	(1,970)	(4,389)	2,419	55.1%
Total Non-Op Income/(Expense)	**4,846**	**1,481**	**3,365**	**100.0%**	**$6,533**	**$4,632**	**$1,901**	**41.0%**
Net Income/(Loss)	**$30,712**	**$10,695**	**$20,017**	**100.0%**	**$59,171**	**$31,771**	**$27,400**	**86.2%**
MLR	*80.1%*	*87.7%*			*84.7%*	*88.0%*		
ALR	*4.8%*	*5.9%*			*4.9%*	*5.8%*		
Operating Income	*15.1%*	*6.4%*			*10.4%*	*6.2%*		
Net Income %	*17.9%*	*7.4%*			*11.7%*	*7.2%*		

*Prior Year Revenue consist of revenue booked in the current calendar year for services rendered in prior years.

**Other Medical includes Pharmacy and IHSS.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Third Month Ending March 31, 2024
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*457,197*	*424,119*	*33,078*	*7.8%*	*1,371,070*	*1,297,063*	*74,007*	*5.7%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$373.74	$338.17	$35.56	10.5%	$367.36	$338.10	$29.27	8.7%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	0.88	0.81	0.06	7.9%	0.87	0.80	0.08	9.7%
Total Operating Revenue	**$374.61**	**$338.99**	**$35.63**	**10.5%**	**$368.24**	**$338.89**	**$29.34**	**8.7%**
Medical Expenses								
Inpatient Services (Hospital)	$112.75	$108.96	($3.80)	-3.5%	$105.92	$109.30	$3.38	3.1%
Inpatient Services (LTC)	36.07	25.57	(10.50)	-41.1%	37.08	25.65	(11.43)	-44.6%
Physician Services	72.12	63.34	(8.78)	-13.9%	72.64	63.54	(9.10)	-14.3%
Outpatient Facility	59.76	36.97	(22.79)	-61.7%	44.48	37.08	(7.40)	-20.0%
Other Medical**	19.25	62.48	43.23	69.2%	51.65	62.61	10.96	17.5%
State Incentive Programs	-	-	-	0.0%	-	-	-	0.0%
Total Medical Expenses	**$299.95**	**$297.32**	**($2.64)**	**-0.9%**	**$311.78**	**$298.18**	**($13.60)**	**-4.6%**
Gross Margin	**$74.66**	**$41.67**	**$32.99**	**79.2%**	**$56.46**	**$40.71**	**$15.75**	**38.7%**
Administrative Expenses								
Salaries	$12.86	$13.45	$0.59	4.4%	$12.67	$13.56	$0.90	6.6%
Professional Fees	0.50	0.67	0.17	25.7%	0.41	0.67	0.26	38.8%
Purchased Services	2.16	2.35	0.19	8.2%	2.29	2.45	0.16	6.5%
Supplies & Other	1.71	2.49	0.79	31.5%	1.86	2.17	0.30	14.0%
Occupancy	0.29	0.30	0.00	1.5%	0.28	0.31	0.03	9.4%
Depreciation/Amortization	0.56	0.68	0.11	16.8%	0.56	0.64	0.07	11.5%
Total Administrative Expenses	**$18.09**	**$19.94**	**$1.86**	**9.3%**	**$18.07**	**$19.79**	**$1.72**	**8.7%**
Operating Income	**$56.58**	**$21.73**	**$34.85**	**100.0%**	**$38.39**	**$20.92**	**$17.47**	**83.5%**

*Prior Year Revenue consist of revenue booked in the current calendar year for services rendered in prior years.

**Other Medical includes Pharmacy and IHSS.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Third Month Ending March 31, 2024
(In $000s)

	MTD	YTD
Net Income	$30,712	$59,171
Items not requiring the use of cash: Depreciation	258	773
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	340,974	195,987
Prepaid Expenses	71	(789)
Current Assets	993	790
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**342,038**	**195,988**
Changes to Payables:		
Accounts Payable	(83,586)	(127,928)
Other Current Liabilities	675	72
Incurred But Not Reported Claims/Claims Payable	3,584	224,770
Provider Incentives Payable	4,047	12,381
Due to State	(783)	(2,663)
Subscription Liabilities	0	0
Net Changes to Payables	**(76,063)**	**106,632**
Net Cash Provided by (Used in) Operating Activities	**296,945**	**362,565**
Change in Investments	(3,371)	55,196
Other Equipment Acquisitions	(441)	(873)
Net Cash Provided by (Used in) Investing Activities	**(3,813)**	**54,323**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**293,132**	**416,888**
Cash & Cash Equivalents at Beginning of Period	**328,838**	**205,083**
Cash & Cash Equivalents at March 31, 2024	**$621,971**	**$621,971**

Back to Agenda

DATE: May 22. 2024

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Finance Committee: Member Appointment

Recommendation. Staff recommend the Board approve the appointments of the individuals listed below to the Finance Committee.

Background. The Board established the Finance Committee as authorized in the Bylaws of the Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission.

Discussion. The following individuals have indicated interest in participating on the Finance Committee and are recommended.

Name	Affiliation	County
Ralph Armstrong, DO	Commissioner	San Benito
Anita Aguirre	Commissioner	Santa Cruz

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: May 22, 2024

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Member Services Advisory Group: Member Appointment

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

Background. The Board established MSAG pursuant to Welfare and Institutions Code §14094.17(b)(1) (SB 586 – Statutes 2015).

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

Name	Affiliation	County
Debra Barcellos	Consumer	Mariposa
John Alexander	Consumer	Mariposa
Aluriel (Alu) Ceballos	Consumer	Merced

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

Attachments. N/A

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

Meeting Minutes

Wednesday, April 24, 2024
10:00 a.m. – 2:30 p.m.

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

Commissioners Present:

Ms. Anita Aguirre	At Large Health Care Provider Representative
Dr. Ralph Armstrong	At Large Health Care Provider Representative
Supervisor Wendy Root Askew	County Board of Supervisors
Ms. Tracey Belton	County Health and Human Services Agency Director
Ms. Dorothy Bizzini	Public Representative
Dr. Maximiliano Cuevas	Health Care Provider Representative
Ms. Janna Espinoza	Public Representative
Dr. Donaldo Hernandez	Health Care Provider Representative
Ms. Elsa Jimenez	County Director of Health Services
Ms. Mónica Morales	County Health Services Agency Director
Ms. Rebecca Nanyonjo	County Public Health Director
Supervisor Josh Pedrozo	County Board of Supervisors
Dr. James Rabago	Health Care Provider Representative
Dr. Allen Radner	At Large Health Care Provider Representative

Commissioners Absent:

Ms. Leslie Abasta-Cummings	At Large Health Care Provider Representative
Supervisor Zach Friend	County Board of Supervisors
Mr. Michael Molesky	Public Representative

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Mr. Scott Fortner	Chief Administrative Officer
Dr. Omar Guzmán	Chief Health Equity Officer
Dr. Dennis Hsieh	Chief Medical Officer

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Ms. Jenifer Mandella	Chief Compliance Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
Mr. Scott Crawford	Medicare Program Executive Director
Ms. Jessie Dybdahl	Provider Services Director
Ms. Sherri Katz	Medicare Program Manager
Ms. Andrea Swan	Quality Improvement and Population Health Director
Ms. Kathy Stagnaro	Clerk of the Board

1. Call to Order by Chair Jimenez.

Commission Chairperson Jimenez called the meeting to order a 10:00 a.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

[Commissioners Hernandez and Morales arrived at this time: 10:02 a.m.]

Chair Jimenez welcomed Ms. Anita Aguirre, At Large Health Care Provider Representative, Santa Cruz County, to the Board.

2. Oral Communications.

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

No members of the public addressed the Commission.

3. Comments and announcements by Commission members.

Chair Jimenez opened the floor for Commissioners to make comments.

Chair Jimenez announced that the Alisal Integrated Health Center ribbon cutting ceremony and open house will be held on April 29, 2024 at 1:00 p.m. in Salinas.

4. Comments and announcements by Chief Executive Officer.

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

Mr. Schrader thanked Commissioners for traveling to Merced for today's Board Meeting. In addition he welcomed Ms. Anita Aguirre to the Board.

There is one remaining vacancy on the Commission and staff anticipate that the Mariposa County Board of Supervisors will make an appointment prior to the May 22, 2024 Board meeting.

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

Mr. Schrader met with Mr. Michael Zimmerman, CEO, John C. Fremont Hospital in Mariposa. Some of Mr. Zimmerman's priorities include the establishment of more on-call specialists, planning for a dialysis program, construction of a new John C. Fremont Hospital that meets state seismic standards, and hospital finances.

On April 15, 2024, Mr. Schrader attended the Local Health Plans of California Board meeting in Sacramento with the CEOs of the 17 local health plans. Included was a session with Ms. Michelle Baass, Department of Health Care Services (DHCS) Director, Ms. Sarah Brooks, Chief Deputy Director of Health Care Programs, and Mr. Tyler Sadwith, newly appointed Medicaid Director. They gave an overview on Proposition 1, the Behavioral Health Services Act, which was approved by voters in March. Plans asked that DHCS hold combined stakeholder meetings with plans and counties in 2024 as part of developing the three-year plan to implement Proposition 1 which will begin in 2026. The meeting also included a session with Mr. Jim Daboo, former top aide to Governor Newsom, who managed the Proposition 1 ballot measure. He is now managing the planned ballot measure for the Managed Care Organization tax which will be on the November ballot.

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

Monterey County announced that it was awarded two state grants of more than $11M to assist individuals in two major homeless encampments in the cities of Soledad and King City. Included in the press release, that in addition to the $11M, the County received $4.7M from the Alliance for the King City project which helps individuals transition from the encampment to interim housing at a local motel, within one year, to a permanent housing solution with comprehensive support services. Alliance funding came from dollars earned from DHCS as part of the Housing and Homeless Incentive Program.

Staff met with Alliance Board member, Dr. Maximiliano Cuevas, Clinica de Salud del Valle de Salinas, earlier this month to discuss AB 2860. The bill is co-authored by Assemblymember Esmeralda Soria and sponsored by the California Primary Care Association and several Federally Qualified Health Centers, including Clinica de Salud del Valle de Salinas. The bill would extend upon and make permanent a pilot program that brings in physicians from Mexico to practice medicine in California under a three-year non-renewable license. This program is intended to create access to culturally and linguistically competent doctors and to assist in addressing physician shortages. Staff brought this bill to the attention of LHPC, who along with the Alliance, will be taking a position of support.

Notable on the regular agenda was item 10, Alliance Provider Network Adequacy and Realized Access. This presentation highlighted some of the steps the Alliance is taking to help address access issues. Regular agenda item 11, Medicare Dual Eligible Special Needs Plan (D-SNP) Implementation Framework, discussed the future D-SNP program for Medi-Cal members who are also eligible for Medicare benefits. And lastly, regular agenda item 12, Quality and Health Equity in Merced and Mariposa counties which recognized the geographic health disparity in California.

At today's meeting staff will begin to lay the groundwork for a planned multi-year Alliance supplemental payment for certain provider types. The purpose of the proposed supplemental payment is to use operating surplus from CY 2023 which would otherwise add additional funding to the reserve to support providers with the intent of improving access, quality and health equity for members. In June, staff intend to seek Board approval to set aside all or part of the operating surplus from CY 2023 for the multi-year supplemental payments. In the Fall, staff will return to the Board to seek approval for the methodology and timing for the provider supplemental payments.

Consent Agenda Items: (5. – 9B.): 10:17 a.m.

Chair Jimenez opened the floor for approval of Consent Agenda items 5 through 9B.

MOTION: Vice Chair Pedrozo moved to approve Consent Agenda items 5 – 9B, seconded by Commissioner Bizzini.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Aguirre, Armstrong, Askew, Belton, Bizzini, Cuevas, Espinoza, Friend, Hernandez, Jimenez, Nanyonjo, Pedrozo, Rabago and Radner.

Noes: None.

Absent: Commissioners Abasta-Cummings, Friend and Molesky.

Abstain: None.

Regular Agenda Item: (10. - 14.): 10:18 a.m.

10. Discuss State of Alliance Network. (10:18 – 10:34 a.m.)

Ms. Van Wong, Chief Operating Officer and Ms. Jessie Dybdahl, Provider Services Director, discussed Alliance's access framework including the concept of realized access and updated metrics and Alliance performance relative to network adequacy and realized access were reviewed.

Commissioners discussed exploring Federal and State loan forgiveness programs and community partnerships.

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

11. Discuss Medicare Dual Eligible Special Needs Plan (D-SNP) Implementation Framework and consider approving Medicare D-SNP Specialty and Hospital Provider Payment Rates recommendation. (11:34 a.m. – 12:22 p.m.)

Ms. Van Wong, Chief Operating Officer, Mr. Scott Crawford, Medicare Program Executive Director and Ms. Sherri Katz, Medicare Program Manager discussed the Medicare D-SNP implementation framework.

The Board was reoriented to the DHCS CalAIM D-SNP requirements and the Alliance's D-SNP implantation framework and execution approach. The Alliance is implementing a Medicare Advantage D-SNP, for Medi-Cal members who are also eligible for Medicare benefits by January 2026. The Alliance continues to focus implementation efforts on operational integration of all the functional areas impacted by D-SNP.

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

Ms. Van Wong, Chief Operating Officer, presented staff's recommendation on the Medicare D-SNP Specialty and Hospital Provider Payment Rates.

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

In preparation of contracting with the provider network, staff brought the rates approval request to begin building the network in Q2 2024. Alliance payment policy and principles include maintaining a provider network that meets member needs, maintaining and improving the operational efficiency of Alliance staff and providers, and investing in continuous improvement of member care.

MOTION: Commissioner Bizzini moved to approve 100% of Medicare rates for specialty providers and align hospital providers to Medicare payment methodology as part of the Medicare Dual Eligible Special Needs Plan (D-SNP) expansion, effective January 1, 2026, seconded by Vice Chair Pedrozo.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Askew, Belton, Bizzini, Espinoza and Pedrozo.

Noes: None.

Absent: Commissioners Abasta-Cummings, Friend, Molesky and Morales.

Abstain: Commissioners Aguirre, Armstrong, Cuevas, Hernandez, Jimenez, Nanyonjo, Rabago and Radner.

[Vice Chair Pedrozo departed at this time: 12:22 p.m.]

12. Discuss Quality and Health Equity in Merced and Mariposa Counties. (1:06 – 1:42 p.m.)

Dr. Omar Guzman, Chief Health Equity Officer, Dr. Dennis Hsieh, Chief Medical Officer, and Ms. Andrea Swan, Quality Improvement and Population Health Director, discussed strategies and tactics actively being deployed in Merced and Mariposa counties to address the gap on the Managed Care Accountability Set. The three areas of focus included improving data collection and reporting, increasing provider support and collaboration, and meeting members where they are and regaining trust.

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

Adjourn to Closed Session

Chair Jimenez moved the commission into Closed Session at 1:54 p.m.

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

[Commissioner Radner departed at this time: 2:34 p.m.]

Return to Open Session

Chair Jimenez reconvened the meeting to Open Session at 2:35 p.m.

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

Chair Jimenez reported from Closed Session that the Board accepted the evaluation of the CEO and approved a merit increase for Mr. Michael Schrader. The vote passed with 13 ayes and 4 absent.

The Commission adjourned its regular meeting of April 24, 2024 at 2:37 p.m. to the regular meeting of May 22, 2024 at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa unless otherwise noticed.

Respectfully submitted,

Ms. Kathy Stagnaro
Clerk of the Board

Quality Improvement Health Equity Committee

Date: November 30, 2023

Time: 12pm – 1:20pm

Location: MS Team Meeting

MINUTES

Chair: Dennis Hsieh, MD, CMO			Minutes by: Jacqueline Van Voerkens
	Members Present:	Dr. Caroline Kennedy, Family Med., Dr. Eric Sanford, Family Med., Dr. Minoo Sarkarati, Pediatrician, Dr. Stephanie Graziani, Pediatrician, Ms. Stacey Kuzak, and Ms. Susan Harris.	
	Guest Present:	Oscar Sanchez, Quality Improvement Director, Santa Cruz Community Health, and Myisha Reed, Golden Valley Health Center.	
	Members Absent:	Dr. Casey Kirkhart, Dr. Eugene Santillano, Family Med., Dr. Madhu Raghavan, Pediatrician Dr. Oguchi Nkwocha, Family Med., and Ms. Cheri Collette.	
	Central California Alliance for Health staff:	Ms. Andrea Swan — QI/ Population Health Director Ms. Carissa Grepo — UM Manager – Prior Authorizations Mr. Cecil Newton — Chief Information Officer Ms. DeAnna Leamon — Clinical Safety Quality Manager Ms. Desirre Herrera — Quality and Health Programs Manager Dr. Dianna Diallo — Medical Director Ms. Georgia Gordon — Quality Improvement Program Advisor II Ms. Kristen Rohlf — Quality Improvement Manager Dr. Kristynn Sullivan, PhD — Program Development Director Ms. Linda Gorman — Communications Director Ms. Lilia Chagolla — Member Services Director Ms. Navneet Sachdeva — Pharmacy Director Ms. Ronita Margain — Community Engagement Dir., Merced Ms. Sarah Sanders — Grievance and Quality Manager Ms. Sarina King — Quality and Performance Improvement Manager Dr. Shaina Zurlin — Behavioral Health Director Ms. Stacie Simmons — Community Engagement Program Manager Ms. Tammy Brass — Utilization Management Director	

Quality Improvement Health Equity Committee

Date: November 30, 2023

Time: 12pm – 1:20pm

Location: MS Team Meeting

MINUTES

Item No.	Agenda Item		
I.	**Call to Order**	Dr. Dennis Hsieh called the meeting to order at 12:05 PM and welcomed the members. Dr. Hsieh opened the floor for announcements. Announcement: Dr. Sanford announced that the Santa Cruz Residency Program is interested in collaborating with the Alliance to learn how the Alliance's Health Systems are organized.	Andrea Swan will connect with Dr. Sanford regarding the Residency programs interest. Navneet Sachdeva will connect with Dr. Sanford and Dr. Kennedy. **Update: Navneet provided P&T information to Dr. Sanford on 11/30/23**
Items for Approval		**Discussion**	**Action/Recommendation**
II.	**Review & Approve Minutes**	**The Minutes from the September 28, 2023 QIHEC Meeting were reviewed.** Dr. Sanford indicated that the data on members admitted for overdoses and frequency was fascinating. Dr. Sanford also appreciated the data on the death rates after admission, with the attempt to prescribe Suboxone during admission. **Dr. Sanford motioned to approve the minutes from the QIHEC meeting.* **Dr. Kennedy 2nd the motion for approval.* **Committee approved September 28, 2023 QIHEC as presented.*	*The QIHEC approved the September 28, 2023 QIHEC meeting minutes.*
Action Item Follow Up			
III.		**All action items complete.**	
Items for Review/Approval		**Consent Agenda Items**	**Action/Recommendation**
IV.	**Review**	Subcommittee/Workgroup Meeting Minutes	
		• Pharmacy and Therapeutic (P&T) Committee Minutes	*Approved at P&T*
		• Quality Improvement Health Equity Workgroup (QIHEW) Minutes	*Approved at QIHEW*

MINUTES

		• Utilization Management Workgroup (UMWG) Minutes	*Approved at UMWG*
		Delegate Oversight Report: The VSP Q3 2023 and the Carelon Q3 2023 quarterly delegate oversite summary included in consent agenda meeting packet.	
	Approve	Workplans:	
		• Q3 2023 Utilization Management Work Plan Tammy Brass, UM Director, indicated that the Readmission Reduction and Transitional Care Work has been successful. The Concurrent Review team, Case management team, and ECM team externally engage the ECDM partners and facilitate placements in RCFE. UM is reviewing various avenues for inpatient discharge that have not previously been explored. These alternate facilities are showing some success. A significant reduction in bed days was notice due to the hard work this quarter. UM is focusing on the Jiva upgrade work, the platform replacement used for authorizations and case management. Authorization framework is updated quarterly, codes are reviewed to remove authorization requirements where applicable.	*Approved*
		• Q3 2023 Utilization Management Work Plan Executive Summary	*Approved*
		• Q3 2023 Quality Improvement Health Equity Transformation (QIHET) Program Work plan Andrea Swan, QIPH Director, noted that in the QIHET work plan, several different areas converge to make the work plan. Member experience and Quality of Care, involving outreach and engagement, with access and availability, some of the surveys are in progress and considering measuring to ensure adequate access for Members, whether it is timely or Geo. Provider Satisfaction goals around were met. The provider satisfaction survey is completed towards the end of the year, and the results in will be available in February. Quality of Clinical Care goals have been met and work continues on the Disease Management Program, CBP, and High Blood Pressure, There are a few projects in Children's Domain, in which those goals have been met.	*Approved*

MINUTES

		Follow up after ED metrics actually remain positive, and reporting and monitoring throughout the year will continue. Ms. Swan informed the Committee that next year, the QIHETP work plan will change slightly. It will continue to collate all of the same sections into really big and broad areas for NCQA, and additional quarterly metrics on facility site review, grievances, and PQI. Dr. Sanford inquired if Ms. Swan could elaborate on Health Care Collaboratives, what exactly is being measured, or quantified. Ms. Swan indicated that the healthcare collaborative has been adjusted. It is an opportunity to measure an outcome with Community Based Organizations (ex: WIC). Committee agreed it is an important topic but difficult to measure. Ms. Swan indicated that this metric will be removed from the 2024 QIHET Workplan due to the lack of measurable quantifiable goals. If a project is created in the future, say with WIC to increase enrollment, then this metric could be brought back.	
		• Q3 2023 QIHET Workplan Executive Summary	*Approved*
	Approve	2024 Quality Improvement Health Equity Committee (QIHEC) Schedule	*Approved*
Policies: Require QIHEC Approval			
Number/Title		**Significant Changes**	**Action/Recommendation**
401-1101 Quality Improvement & Health Equity Transformation Program		The Alliance Quality and Performance Improvement Program (QPIP) was modified to align with the 2024 Medi-Cal contract with the new name of Quality Improvement and Health Equity Transformation Program (QIHETP) Significant modifications were made to align with the DHCS Comprehensive Quality Strategy Guiding Principles and contractual requirements: • Encompassed core continuous quality improvement activities, population health management interventions, and health equity.	*Approved*

MINUTES

	• Included the oversight and accountability by the Alliance Board of the QIHETP by the Quality Improvement Health Equity Committee (QIHEC), with the Chief Executive Officer (CEO) and Alliance Quality Improvement and Population Health (QIPH) Department under the supervision of the Chief Medical Officer (CMO) in collaboration with the Chief Health Equity Officer (or designee). Modified CQIW name to Quality Improvement Health Equity Workgroup (QIHEW) A written summary of the QIHEC activities publicly available on the Alliance website at least on a quarterly basis -Specific requirements for the QIHE annual report): QIHE-Workplan, analyses of fully delegated subcontractor's and downstream fully delegated subcontractor's performance measure results and actions to address any deficiencies, actions taken to address the annual External Quality Review (EQR) technical report and evaluation reports, planned equity-focused interventions to address identified patterns of over- or under-utilization, description of member and/or family focused care such as Community Advisory Committee (CAC) findings, Population Health management activities and findings, and outcomes/findings from Performance Improvement Projects Ensures participation of network providers, fully delegated subcontractors, and downstream fully delegated subcontractors in the QIHETP and PNA by: • (added) On-going provider, fully delegated subcontractors, and downstream fully delegated subcontractors meetings or outreach, such as technical assistance, practice coaching, or other means to provide updates on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results • (Added) Communications Committee: On-going updates on the QIHETP are provided to the committee to support planning, promotion, and communication of QIHETP activities • (Added) Supporting Taskforces (i.e., Pediatric Equity Taskforce) • 401-1101 Attachment A QIHETP Reporting Structure modified	

Quality Improvement Health Equity Committee

Date: November 30, 2023

Time: 12pm – 1:20pm

Location: MS Team Meeting

MINUTES

401-1201 Quality Improvement Health Equity Committee	Updated policy to include call out of specific provider types required in committee structure. Committee members include Physicians specializing in: Obstetrics/Gynecology, Podiatry, Family Medicine, General Surgery, Psychiatry, Pediatrics, Internal Medicine, as well as Community Practitioners and Community Partners.	*Approved*
401-1301 Potential Quality Issues	Changes include impacted departments and contractual revisions.	*Approved*
401-1306 Corrective Action Plan for Quality Issues	Changes include impacted departments and contractual revisions.	*Approved*
401-1501 Standards of Care	Annual review of policy. Updated references section, including 2024 contractual references.	*Approved*
401-1502 Adult Preventive Care and attachment	Updated policy section regarding prior auth requirements. Updated references section, including 2024 contractual references	*Approved*
401-1505 Childhood Preventive Care	Updated: Policy language for EPSDT and case management, Procedures for Bright futures guidelines, and services, EPSDT, Dyadic Services, and to comply with APL 23-005 Review Tool criteria #1, #1.a, #2, #2.a, 2.b, Added: Contract references	*Approved*
401-1506 Immunization Services and Reimbursement	R.0094: added the following language: "The Alliance will reimburse local health departments for the administration fee for immunizations given to Members who are not already immunized as of the date of the immunization, in accordance with the terms set forth in DHCS APL 18-004 – Immunization Services. The local health department must provide immunization records when immunization services are billed to the Alliance. The Alliance is not obligated to reimburse Providers for immunizations under this provision unless the Provider enters into an agreement with the Alliance." APL 23-014: modified the following language: "The Alliance shall ensure that Member-specific immunization information is reported to an immunization registry(ies) as part of the Statewide Immunization Information	*Approved*

MINUTES

	System, the California Immunization Registry (CAIR). Reporting to the registry shall be made following the Member's Initial Health Assessment (IHA) and all other health care visits that result in an administered immunization. Reporting shall be in accordance with all applicable State and Federal laws. Information reported to immunization registries may be used as a supplemental data source for vaccine-related measures." R.0058: added the following language: "Provider Enrollment and Communication. The Alliance will promote and support enrollment of applicable Network Providers in the VFC program in order to improve access to immunizations and disseminate VFC program information to Network Providers via cadenced news articles and new provider orientation presentations." • Updated the policy to match the new policy template • 2024 Contractual References section updated	
401-1509 Timely Access to Care	Updated: • Preventive care definition • Procedures for Access-To-Care standards updates for non-urgent care appointments, access to out-of-network emergency services, provider extension of waiting time, protections to access services, and timely access to Indian Health services Added: Regulatory, DHCS All Plan Letter, and contract references	*Approved*
401-1510 Medical Record Review	• Corrected APL References within policy • Updated references section • Added verbiage under Basic medical record format: Notice of Privacy must be signed in record. • Added verbiage under Clinical Information: History of present illness or reason for visit is documented. • Major content added under Medical Records Documentation Standards • References section updated to reflect the 2024 contractual changes.	*Approved*
Policies: Informational		
Number/Title	**Significant Changes**	**Action/Recommendation**

MINUTES

401-1514 In Office Telephone Triage	Annual review of policy. Updated references section. Contractual reference not listed in the crosswalk. No contractual changes required.	*Approved at QIHEW*
401-1515 Nurse Midwife Guidelines	Annual review of policy. Updated references section, including 2024 contractual references	*Approved at QIHEW*
401-1519 Infection Control Practices	• R.0044 – added verbiage for Reporting of Communicable Disease that every health care provider, is to report to the state public health authority at California Department of Public Health (CDPH) • Updated references • References section updated: 2024 contract	*Approved at QIHEW*
401-1523 Non-Physician Medical Practitioner Guidelines	Annual review of policy. Updated impacted departments, references section, including 2024 contractual references.	*Approved at QIHEW*
401-1524 County FSR Collaboration	Annual review of policy. Updated header. Contractual reference not listed in the crosswalk. No contractual changes required.	*Approved at QIHEW*
401-1607 HEDIS	Updated: Purpose and Procedure to include reporting of audit findings by June 15m updated plan thresholds/targets, and description of measures reported. Added: Contract references, attachment B	*Approved at QIHEW*
401-1705 Care Based Incentive Program	Updated: Policy description, program structure, measure selection committee review, program support information for portal reports and resources. Added: 2024 Contract references	*Approved at QIHEW*

		Regular Agenda	Action/Recommendation
IV.	Health Information Exchange (HIE) Update	Cecil Newton and Kristynn Sullivan provided an overview of the Alliance Data management strategy. This included the background, DSI Leadership Team, DMS Drivers, Regulatory Requirements, Transitional Care Services & ADT Notifications, Data Sharing Incentive Program, Phased Go Live Dates/Rollout Strategy Payment Frequency & Performance Measures, and Implementation Timing/Project Timeline. The Data Management strategy is that of a Health Information Exchange (HIE) centric model where most of the healthcare data in and out of the Alliance is via the HIEs, which calls for a provider data sharing incentive program to increase provider willingness and capability to share data.	*No Action*

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		The regulatory requirements were shared with the committee. The CMS interoperability and Patient Access use, three have been completed. The Alliance is working on the Prior Auth rule, which will be in place as of January 1, 2026, and the Admit, Discharge, Transfer (ADT) notifications, which had a deadline of May 1, 2021, but is in process. Cal Aim requirements are in process. Requirements include AB 133, Data Exchanged Framework, and Information Blocking Policy. Dr. Kennedy noted that from a provider standpoint, this amount of admit, discharge and transfer data ruins their day. She believes the system needs to develop a way to build in and maybe compensate with Cal Aim. Dr. Kennedy requested a response from anyone available to help, add to her team who can look at those admissions, discharges, and transfers and coordinate them because currently this information is in Epic. This task automatically falls only onto the actual care team who needs to be seeing the patient. Cecil Newton noted that maybe the distinction between having data and having information, and acknowledged it as a relevant point that getting the data should be clarified as one item, but turning it into information that's actionable is a whole other entity and not every piece of data that means action is required, but it's imperative to have the information at the right time to determine if action is needed. Cecil Newton reviewed the incentive program, and the financial structure and how performance is evaluated Dr. Kennedy inquired about funding and how to ensure providers who might not easily have a system in place be able to participate in the funding. Mr. Newton informed the committee that the DSI Payment is created to incentivize providers. Dr. Sanford inquired about building data and codes. Are the requirements and preparation for push back from administration regarding HIPAA clarified. Mr. Newton	

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		clarified that information blocking rule trumps this because the request will come from the HIE. The request for the membership roster is validation.	
	PQI 2022 Annual Presentation	DeAnna Leamon provided the 2022 year end PQI report to the committee. The discussion included a review of PQI Definition and Severity Rating, 2022 PQI Stats, PQI Track & Trend Methodology, 2022 Track & Trend Outliers and Outcomes, and 2023 next steps. Dr. Sanford asked for an example of a PQI that is "fixable." Ms. Leamon responded that the majority of the incidents are regarding referrals, such as significant referral delays, which if it is becoming a trend with a provider, a CAP can be created. Next step the Alliance QIPH staff will partner with the Provider and provide guidance, process improvement by coming to the providers office, to help fix their referral system, or make recommendations. Recent struggles have been with access, so another focus is on telehealth visits, and also ensuring telehealth visits are capturing diagnoses accurately to prompt an in-person appointment. The purpose of a CAP is to "hold hands" with that provider and help them with process improvement to fix the issue that the Members are reporting. Dr. Hsieh asked for some examples of CAP their outcomes in 2022. • A PCP failed an FSR. Trends were reviewed, and PQI was considered and put in place. The quality of care, HEDIS measures, utilization of a new FSR tool that was released in 2022 to help understanding that, and link quality of care issues. In this case all three were linked to this PCP and currently still working with this PCP, with focus area of access to care. • A long-term acute care facility: A member was inpatient for an extended long time and, according to their records, had 37 PPC's, which is a provider preventable condition. That is also reportable to DHCS and noticed extensive	*No Action*

		cloning in these medical records, as it was 10,000 pages of medical records for one patient. The LTAC was informed that their PQI is outstanding in comparison with their peers. Collaboration with this provider continues. A request was sent (CAP) , for their response and how they going to fix this issue and they wanted to do a training. Evidence of those trainings was tracked and continuance to trend their PQI was monitored by the team, which did stop. • Transportation issue with an NEMT company where members were being hurt. Connected with company, and monitoring.	
	Utilization Management Criteria	Tammy Brass, RN provided an update on the Authorized Specialty Referrals, and Enhanced Case Management, changes to Prenatal testing for Cystic Fibrosis and Orthotics and prosthetics codes. Medi-Cal additional codes include Skin Substitutes, Proprietary Lab Analysis, and Radiology. Terminated codes reviewed included those for Covid Vaccines and Proprietary Lab Analysis. The Alliance is working diligently to remove the authorization requirements altogether for the specialty referrals. Authorization automations for ECM is in process to coincide with the platform updates so that this is a more seamless process for providers and to include the many changes are made especially with this ECM here. Dr. Sanford inquired if there is a system in place to notify the Alliance if a member is paying for a radiology procedure that previously would not have had to , which would clearly enhance patient care. Ms. Brass replied that frequently requests are received that are not an explicitly spelled out medical benefit, and each are review for medical necessity, and at times, depending on the medical necessity of previous service, are approved. If a member is paying out of pocket for services, please notify the Alliance. This is something the Alliance would want to review, even if it is not a Medi-Cal approved code.	*No Action*

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	Vaccine Awareness and Member Outreach Efforts	Linda Gorman began the presentation informing the committee about the Communications calendar which Communications collaborates on with various departments within the organization and incorporate vaccine and well check related messaging. These were covered typically in each month in 2023 across a variety of communications channels. Also utilized is the Alliance website, social media Flyers, and newsletter publications for providers and members. Bilingual paid media campaigns were implemented across print and digital channels and all three counties with a special focus in Merced on the last campaign, and a messaging in all of the earned communications channels, including the Member bulletins, website content and new blogs provider facing newsletters, social media posts and Flyers for member outreach events. The vaccine incentive campaign includes collaborating with the Cultural and Linguistics unit to launch a campaign around Health Start Rewards, some messaging in Facebook, both in English and Spanish. Lilia Chagolla announced that Member Services outreach effort included actively interacting with members who call in to the call center regarding services and promotion of immunizations. Members calling in are able to connect with a member services representative, which is able to flag the Alliance's system when somebody is calling regarding that specific need, such as a WellCare exam or immunizations. During that phone call the Member Services representative is also able to remind them to get their care exam or go back to their doctors for a visit. Susan Harris mentioned that the struggle mainly has to do with patient education. Parents used to be hesitant to agree to some vaccinations but is now more difficult to convince after the pandemic. Ms. Harris asked if there was any follow up on the success of the fliers, for instance. Linda Gorman informed the committee that there has been nearly a 200% increase in Web visits since the campaign started. Dr. Kennedy indicated that she is always very interested in outcome and although it might be difficult to measure outcome, but that's the type of data physicians follow in	

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		order to make metrics. The combo 10 rates continue to go down. Dr. Kennedy is in agreement with Ms. Harris on how the pandemic is still harming vaccine rates. Flu shot rates are declining because parents feel they are protecting their children. Dr. Sanford suggested outreach. Behavior change is the best opportunity. Expressing that the clinicians, and the Alliance, all care about the kids just as much as the parent and being a good parent means vaccinating your kids. Identify any particulars about, like who in Merced is refusing vaccines um, and what are their characteristics, and what are their concerns. Dr. Kennedy mentioned that in Carmel Valley the more highly educated are resisting the vaccines.	
	Emerging Issues	Dr. Hsieh informed the committee about the DHCS Quality Sanctions. Dr. Kennedy offered support to discuss the metrics. Falling below the metric will mean a sanction of a minimum of $25,000 per plan. If the plan does have any penalties, it is taken into consideration improvements are shown year over year, which may decrease that penalty. There is not a minimum dollar amount, but it will probably be significantly if the plan falls below the MPL. They will review all the members in the population who did not meet the MPL, and fine per member a certain amount ,as opposed to above the MPL even though the MPL may be 50%, meaning 50% did not get things, there is no effect. They will do a correction factor if the plan improves year over year and may decrease the penalty. If the plan is getting worse year over year, the penalty will increase and will implement a correction for the difficult areas from a social, economic standpoint.	*Andrea Swan will connect with Dr. Kennedy for her resources on succeeding in the MPL's to avoid the sanctions.* ***- Action Complete***
	Future Topics	No future topics suggested	

Quality Improvement Health Equity Committee

Date: November 30, 2023

Time: 12pm – 1:20pm

Location: MS Team Meeting

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Action Items			
Agenda Item	**What is the action item**	**Due date**	**Responsible staff**
Emerging Issues: DHCS Quality Sanctions	*Andrea Swan will connect with Dr. Kennedy for her resources on succeeding in the MPL's to avoid the sanctions.A**Action Complete***	**3/25/24**	**Andrea Swan**
Meeting adjourned at 1:30 pm.			
Next Meeting March 28, 2024			
Approved by QIPH Committee 4/25/24:	***Signature:*** *Andrea Swan, RN, Quality Improvement Population Health Director*		**Date:** *April 25, 2024*

DATE: May 22, 2024

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

FROM: Dennis Hsieh, MD, Chief Medical Officer

SUBJECT: Revised 2024 Physicians Advisory Group Meeting Schedule

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Recommendation. Staff recommend the Board approve a revised 2024 Physicians Advisory Group (PAG) meeting schedule to include rescheduling the June 6, 2024 meeting to May 30, 2024. In addition, staff recommend rescheduling the September 5, 2024 meeting to September 12, 2024.

Discussion. The primary responsibilities of the Physicians Advisory Group (PAG) are to advise and provide perspective to the Chief Medical Officer and staff regarding Alliance policies, programs, and initiatives. PAG meetings are held quarterly and are within the Ralph M. Brown Act.

If approved, the revised schedule for the remainder of 2024 would be as follows:

- May 30, 2024
- September 12, 2024
- December 5, 2024

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

Attachments. N/A

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE: May 22, 2024

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

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

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

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

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

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

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

Attachments.

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

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

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

Purpose

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

Policy

The QIHETP[3] exists to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services (DHCS) requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 438.330 and 438.340[4]. Additionally, QIHETP oversight entities may electively incorporate best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) into the QIHETP as they deem appropriate.

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

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

QIHETP Values

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

Continuous Quality Improvement (CQI)[5]

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

Equitable and Person-Centered

1. Ensure all medically necessary covered services are: available and accessible to all members in any setting, regardless of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender,

gender identity, or sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56[6], and provided in a culturally and linguistically appropriate manner[7].

2. Provide tailored, consistent, and whole-person care across all member-facing team that meet the needs and experience of our members.
3. Ensure delivery of health care services complies with all mental health parity requirements in 42 CFR section 438.900 for Alliance, Subcontractors, Downstream Subcontractors, Network Providers, and other entities.

Safe, Accessible, and Effective Quality of Care and Services

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

Population Health Management Interventions[8]

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

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

Comprehensive Quality Strategy Guiding Principles[9]

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

Scope

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

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

Goals and Objectives

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

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

2. Quality of services provided by the Alliance to its members, providers, the community, and internal staff:
   - 2.a. Align quality improvement activities with activities that promote the continuous development of a provider network that meets member needs, such as the annual Access Plan
   - 2.b. Implement innovative practices, such as telephonic or virtual means, to ensure that members obtain care which is timely and meets their needs

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

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

Definitions

1. California Children's Services (CCS) Program[18] (as part of the Whole Child Model Program): CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years of age can get the health care and services they need for CCS-eligible conditions. CCS also provides medical therapy services that are delivered at public schools through their Medical Therapy Unit (MTU).

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

process designed to perform small tests of change, which allows more flexibility to make adjustments throughout the improvement process[25].

Procedures

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

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

   1.a. Alliance Board[27]: The Alliance Board promotes, supports, and has ultimate accountability and authority for a comprehensive and integrated QIHETP. Alliance Board responsibilities include:
   - 1.a.1. Annual review and approval of the QIHETP and applicable QIHETP reports;
   - 1.a.2. Appointment of an accountable entity or entities to provide oversight of the QIHETP;
   - 1.a.3. Routine review of written progress reports from the QIHEC0;
   - 1.a.4. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and DHCS Comprehensive Quality Strategy;
   - 1.a.5. The Alliance Board has delegated direct supervision, coordination, and oversight of the QIHETP by the Quality Improvement Health Equity Committee (QIHEC), with the Chief Executive Officer (CEO) and Alliance Quality Improvement and Population Health (QIPH) Department under the supervision of the Chief Medical Officer (CMO) in collaboration with the Chief Health Equity Officer or designee. The CMO regularly provides QIHETP operational reports to the Alliance Board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.g.3. Chief Health Equity Officer (CHEO)[30] or designee: Provide leadership to ensure health equity is prioritized and health inequities are addressed within the QIHETP.

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

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

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

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

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

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

Assessments reporting activities and participates in audits conducted by regulatory agencies.

1.g.10. Quality and Health Programs Supervisor(s) (QHPS): Under the direction of the QHPM, the QHPS coordinates and implements the Alliance Health Education and Disease Management programs and Cultural and Linguistic services (oversees interpretation and translation services and vendors) and processes. The QHPS also leads preparing health and disease management program promotional materials, including newsletter articles, and member/provider communications. The QHPS also supervises the Health Educators and Care Coordinator.

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

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

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

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

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

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

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

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

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

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

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

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

1.g.23. Chief Compliance Officer: Under the direction of the CEO, the Chief Compliance Officer is responsible for overseeing and coordinating Compliance Program activities, including serving as Chair of the Compliance Committee and providing oversight of delegate oversight activities in accordance with Alliance policy 105-0004 – *Delegate Oversight*.

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

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

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

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

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

1.g.29. Other staff: The Alliance encourages active involvement of all Alliance staff in the design and implementation of the QIHETP.

1.g. QIHETP Alliance Board Reports

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

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

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

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

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

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

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

2.b. Site Review[37]: The Alliance incorporates site review requirements into the QIHETP as described in Alliance Policies 401-1508 – *Facility Site Review Process*, 401-1510 – *Medical Record Review and*

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

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

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

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

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

2.e. Timely Access Monitoring[47]: The Alliance incorporates timely access monitoring requirements into the QIHETP as described in Alliance Policies 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 and participation in the EQRO's network adequacy validation studies. The Alliance continuously reviews,

evaluates, and seeks to improve access to and availability of services. This includes ensuring that members are able to obtain appointments from contracted providers according to established access standards.

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

2.g. Provider Satisfaction Monitoring[49]: The Alliance incorporates provider satisfaction monitoring requirements into the QIHETP as described in Alliance Policy 300-3092 – *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.h. Claims Encounter Data Monitoring: The Alliance incorporates claims encounter data monitoring requirements into the QIHETP as described in Alliance Policy 105-3002 – *Program Integrity: Special Investigations Unit Operations*. Should claims review identify potential fraud, waste or abuse concerns appropriate referrals are made to the Alliance Special Investigations Unit (SIU). QIPH works with Compliance to address any PQIs, provider preventable conditions, or any other variations in practice. Appropriate actions are taken based upon these claim reviews and other fraud, waste, and abuse investigations.

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

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

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

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

2.l. Population Needs Assessment (PNA)[52]: The PNA evaluates the health education and cultural and linguistic needs of members, and the findings are used to guide the development and implementation of cultural and linguistic health education interventions. The Alliance prepares a PNA annually.[50]

2.m. Seniors and Persons with Disabilities (SPD) Activities[53]: The Alliance incorporates SPD activity requirements into the QIHETP as described in Alliance Policies 404-1114 – *Continuity of Care*, 405-1112 – *Care Management of Seniors and Persons with Disabilities for Medi-Cal*, and 401-3104 – *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. Focused Studies: The Alliance participates in the external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided[54].

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

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

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

2.r. Behavioral Health Services Monitoring: The Alliance incorporates behavioral health services monitoring requirements into the QIHETP as described in Alliance Policy 405-1305 – *Behavioral Health Services for Medi-Cal to ensure delivery of Medically Necessary non-specialty and specialty mental health services*. Oversight and monitoring of any delegated portions of mental health services are outlined in Policy 105-0004 – *Delegate Oversight*.

2.s. Quality Improvement Delegate Oversight Activities[56]: The Alliance incorporates QIPH delegate oversight activities into the QIHETP as described in Alliance Policies105-0004 – *Delegate Oversight*

and 401-1201 –*Quality Improvement Health Equity Committee*. The Alliance may delegate QIPH functions to subcontracting entities, as outlined in Alliance Policy 105-0004 – *Delegate Oversight*. These delegated functions are set forth in the Alliance's contracts with subcontracting entities and include specific performance and reporting standards that must be met.

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

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

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

3. Analyze and Evaluate Annual Data, Incorporate Provider Feedback and Develop Interventions
Using the methods outlined above, QIPH analyzes data using current evidence-based standards as benchmarks. As stated in the provider manual, providers, practitioners, and facilities must make performance data available to the Alliance to cooperate with and participate in quality improvement activities.Significant quality, service, or utilization issues are analyzed for barriers, trends, or root causes. This process incorporates provider review and feedback into performance improvement activities and may include a multidisciplinary team, quantitative and qualitative analysis, and development of interventions that are implemented and/or planned for continuous monitoring.

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

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

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

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

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

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

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

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

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

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

1. The provision of the Early and Periodic Screening, Diagnostic, and Treatment Services 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);
2. CDC ACIP;
3. Child Health and Disability Prevention Program (CHDP); and
4. The DHCS MMCD Policy Letter 14-004.

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

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

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

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

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

3.b.3. Publication of Board Reports;

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

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

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

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

3.b.8. On-going provider, fully delegated subcontractors, and downstream fully delegated subcontractors meetings or outreach, such as technical assistance, practice coaching, or other means to provide updates on activities, findings, and recommendations of the QIHEC's QIHETP and PNA results.

Develop Interventions

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

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

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

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

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

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

3.c.3.a Provider CAPs resulting from FSR and Medical Record Review (MRR) must be addressed and documented, consistent with Alliance Policy 401-1508 – *Facility Site Review Process*. PCP sites that do not correct cited deficiencies are to be terminated from the network[70]; and

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

3.c.4. Improvement Plan[72]:

The Alliance must submit a PDSA Cycle Worksheet to DHCS for each MCAS measure with a rate that does not meet the MPL or is given an audit result of "Not Reportable" (NR). 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 an evidence-based disease management programs that incorporate health education interventions, target members for engagement and seek to close care gaps for members participating in these programs[73].

3.c.5.b Health Education and Promotion: Consistent with Alliance Policy 401-3101 – *Health Education and 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 QIHETP[74].
Health Programs services and information is shared with providers through the Provider Portal and special mailings for general performance reports, which may include:

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

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

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

References:

Alliance Policies:

105-0004 – Delegate Oversight
105-3002 – Program Integrity: Special Investigations Unit Operations
200-9001 – Grievance Reporting, Quality Improvement and Audits
200-9004 – Staff Grievance Review Committee
280-0003 – Whole Child Model Family Advisory Committee
300-3092 – 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
408-1107 – Behavioral Health Services

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

Regulatory:
California Evidence Code Section 1157
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)
California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.70

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

Legislative:

Contractual (Previous Contract):

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

Contractual (2024 Contract):

2024 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2
2024 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1
2024 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.A-D
2024 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6.K
2024 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6.L

DHCS All Plan Letter:

MMCD PL 14-004 Site Reviews: Facility Site Review and Medical Record Review
DHCS APL 15-023 Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers
DHCS APL 19-010 Requirements for Coverage of Early and Periodic Screening, Diagnostic, And Treatment Services for Medi-Cal Members Under the Age Of 21
DHCS APL 19-017 Quality and Performance Improvement Adjustments Due to Covid-19
DHCS APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of The California Advancing and Innovating Medi-Cal Initiative

NCQA:

HEDIS Volume 2 Technical Specifications for Health Plans

Supersedes:

Other:

Alliance Provider Manual

Attachments:

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

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

Revision History:

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

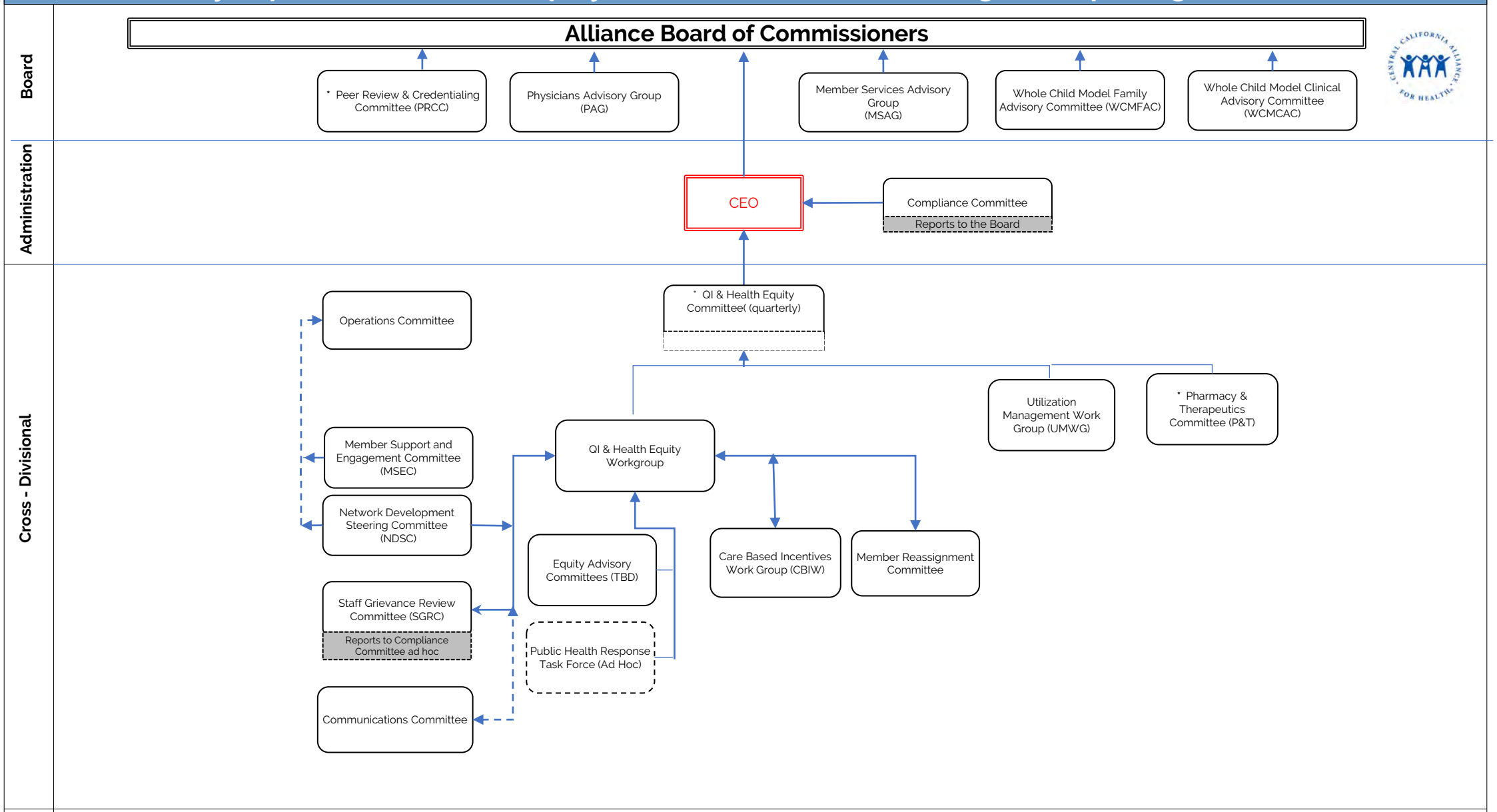
Reviewed Date	Revised Date	Changes Made By	Approved By
02/14/2020	02/14/2020	Amit Karkhanis, Quality and Performance Improvement Manager	Michelle Stott, RN, Quality Improvement Director
03/25/2021	03/25/2021	Amit Karkhanis, Quality and Performance Improvement Manager	CQIW-I
04/29/2021	04/29/2021	Amit Karkhanis, Quality and Performance Improvement Manager	CQIC
4/28/2022	4/28/2022	Amit Karkhanis, Quality and Performance Improvement Manager	CQIC
06/24/2022	06/24/2022	Michelle Stott, RN, Quality Improvement and Population Health Director	CQIC
2/2/2023	2/2/2023	Michelle Stott, RN, MSN, Quality Improvement and Population Health Director	QIHEW
11/14/2023	11/14/2023	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEW
01/26/2024	01/26/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
03/20/2024	03/20/2024	Sarina King, Quality and Performance Improvement Manager	QIHEW
04/25/2024	04/25/2024	Sarina King, Quality and Performance Improvement Manager	QIHEC

[1] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[2] DHCS State Medi-Cal Contract, Exhibit A, Attachment 34, Provision 2.2.6
[3] DHCS State Medi-Cal Contract, Exhibit A, Attachment 34, Provision 2.2
[4] DHCS Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2
[5] DHCS Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2B
[6] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[7] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[8] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.C.
[9] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[10] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6.
[11] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.A.
[12] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2

[13] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.12
[14] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6M
[15] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6F
[16] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6G
[17] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6P
[18] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[19] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[20] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[21] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[22] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[23] DHCS All Plan Letter 19-017
[24] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[25] DHCS All Plan Letter 19-017
[26] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.1
[27] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.2
[28] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3
[29] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[30] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 1.1.7
[31] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provisions 2.2.12
[32] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.12
[33] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3D
[34] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[35] [MMC Final Rule] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7.
[36] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[37] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision5.2.14
[38] MMCD PL 14-004; DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[39] DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[40] DHCS State Medi-Cal Contract, Exhibit A, Attachment , Provision 5.2.14
[41] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.14
[42] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.11
[43] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[44] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[45] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[46] Policy 300-4103 – Fair Hearing Process for Adverse Decisions; Policy 300-4102 – Reporting to the Medical Board of California and the National Practitioner Data Bank; 401-1306 – Corrective Action Plan for Quality Issues; 300-4090 – Ongoing Monitoring of Provider Credentials and Issues
[47] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2, DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.5
[48] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision2.2.9.C,; DHCS All Plan Letter 19-017
[49] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)
[50] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision2.2.9E
[51] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.3.3
[52] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.2
[53] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[54] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9F

[55] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9G
[56] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.5
[57] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.4.16A
[58] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.5.13C
[59] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9.A4
[60] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[61] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[62] Policy 401-2001 – Member Surveys
[63] Policy 401-1502 – Adult Preventive Care
[64] Policy 401-1505 – Childhood Preventative Care
[65] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.4
[66] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1
[67] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9; DHCS All Plan Letter 19-017
[68] 42 CFR 438.330(d), Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9B
[69] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9B5
[70] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.14; MMCD PL 14-004
[71] Policy 401-1301 – Potential Quality Issue Review Process; Policy 401-1306 – Corrective Action Plan for Quality Issues
[72] DHCS All Plan Letter 19-017
[73] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.10
[74] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.7

Quality Improvement Health Equity Transformation (QIHET) Program Reporting Structure



* Includes attendees from outside the Alliance

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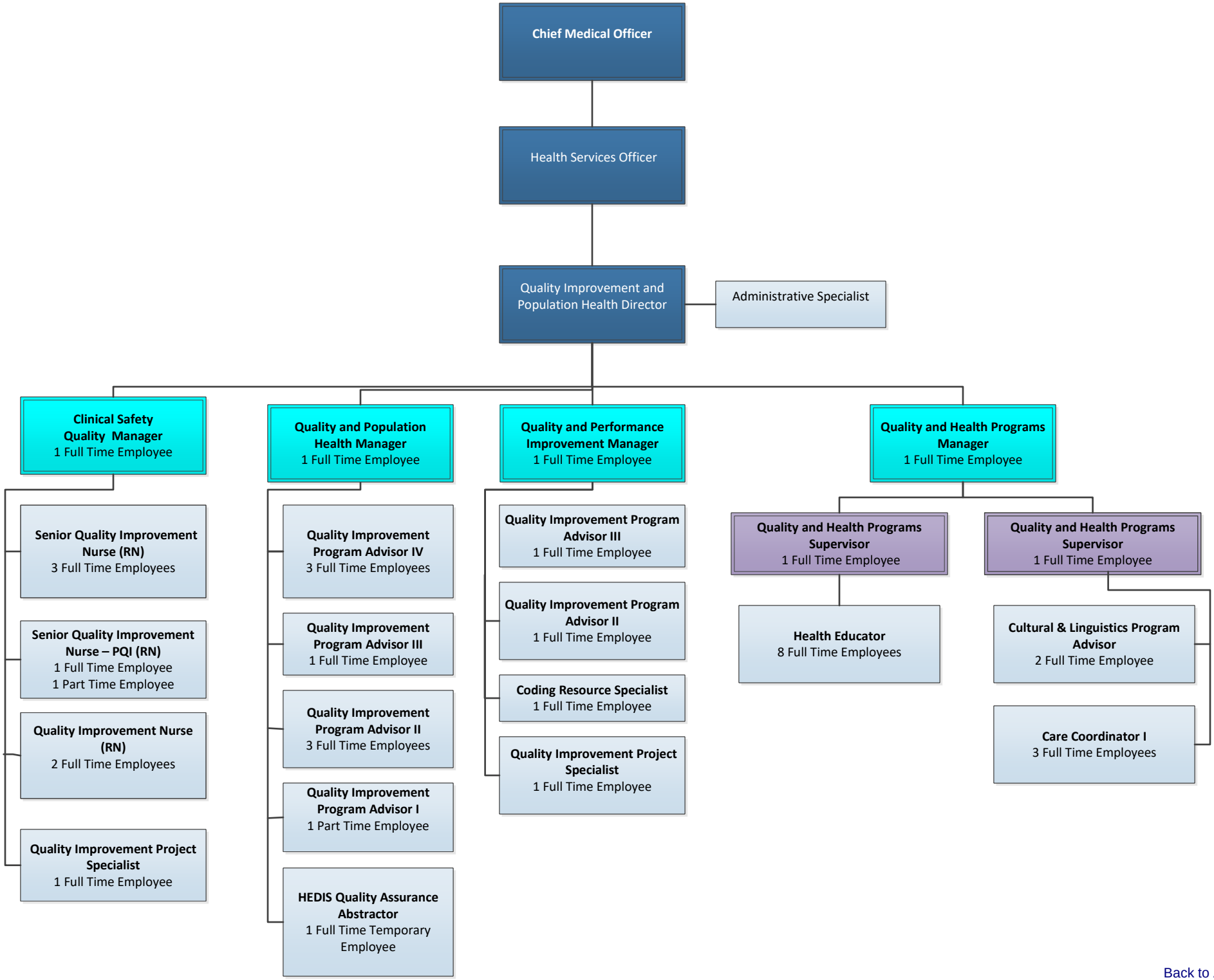
Updated Jan. 25, 2024



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DATE: May 22, 2024

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

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

SUBJECT: Policy Revision – 401-1201 – Quality Improvement Health Equity `Committee

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Recommendation. Staff recommend the Board approve revisions to Alliance Policy 401-1201 – Quality Improvement Health Equity Committee (QIHEC)

Background. This policy defines the roles and responsibilities of the Alliance's QIHEC, as contractually required by the 2024 Medi-Cal Contract.

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

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

Attachments.

1. Alliance Policy 401-1201 – Quality Improvement Health Equity Committee

[i] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

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

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

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

Definitions[4]
1. Corrective Action: Specific identifiable activities or undertaking of the Alliance that address program deficiencies or problems.
2. Managed Care Accountability Set (MCAS): A set of measures based on the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets selected by DHCS for evaluation of health plan performance.
3. Performance Improvement Projects (PIP)[5]: Studies selected by the Alliance, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes.

Procedures
The QIHEC conducts oversight and manages performance of the QIHETP as outlined below.

1. Structure
   The QIHEC is designated by, and accountable to, the Alliance Board, supervised by the Chief Medical Officer or designee, in collaboration with the Chief Health Equity Officer. The activities, findings, recommendations, and actions of the QIHEC are reported to the Alliance Board on a scheduled basis[6]. The QIHEC oversees the activities of the Pharmacy and Therapeutics (P&T) Committee, Utilization Management Workgroup (UMWG), Continuous Quality Improvement Workgroup (CQIW) Interdisciplinary, and CQIW. The QIHEC partners with the Compliance Committee to meet delegate oversight requirements[7].

2. Responsibilities
   Primary duties of the QIHEC[8] include the following:

2.a. Annually reviewing and approving the draft Quality Improvement and Health Equity and Utilization Management Work Plans (QIHEWP and UMWP);
2.b. Quarterly reviewing progress against active QIHEWP and UMWP goals;
2.c. A written summary of QIHEC activities, as well as QIHEC activities of its fully delegated subcontractors and downstream fully delegated subcontractors, findings, recommendations, and actions are prepared after each meeting
2.d. Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings of the activities of other committees such as the Community Advisory Committee (CAC)
2.e. Institute actions to address performance deficiencies, including policy recommendations;
2.f. Ensure appropriate follow-up of identified performance deficiencies;
2.g. Providing leadership and oversight in the implementation of quality improvement principles and activities in the daily operations of the Alliance;
2.h. Facilitating communication on the status and progress of Alliance QIHETP activities to the Alliance Board on a scheduled basis;
2.i. Participating in the development and/or adoption of specific utilization management criteria[9] and benefit parameters;
2.j. Monitoring the activities of, and providing direction to, all QIHEC subcommittees/ workgroups;
2.k. Stimulating the highest degree of commitment to quality health care and to the goal of continuous improvement;
2.l. Recommending and approving changes to select QIHETP related Alliance policies, practice guidelines, and subcommittees' proposed action plans;
2.m. Overseeing the QIHETP and UM Program policies (Alliance Policies 401-1101 and 404-1101 respectively), and the QIHEWP and UMWP for annual submission to the Alliance Board;
2.n. Reviewing, approving, and submitting the Quality Improvement and Health Equity (QIHE) Annual Report[10] to the Alliance Board;
2.o. Reviewing and advising on QIHETP related Corrective Action plans (CAP), not including credentialing/recredentialing oversight related CAPs. Individual provider issues may be referred to the PRCC and/or Program Integrity Unit depending on the nature of the issue;
2.p. Reviewing standards of care guidelines, as described in Alliance Policy 401-1501 – *Standards of Care*;
2.q. Oversight of language assistance and interpreter services as described in Alliance Policy 401-4101 – *Cultural and Linguistic Services Program*

2.r. Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and the DHCS Comprehensive Quality Strategy

2.s. For fully delegated subcontractors and downstream fully delegated subcontractors, ensure maintenance of a QIHEC and reporting to the Alliance on a quarterly basis, at a minimum; and

2.t. Partnering with the Compliance Committee to meet QIHETP delegate oversight requirements[11].

3. Requirements

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

3.b. Chair: The QIHEC is chaired by an Alliance Medical Director (or designee)[13] in collaboration with the Chief Health Equity Officer.

3.c. Membership: Core membership consists of Alliance network providers, including but not limited to hospitals, clinics, county partners, fully delegated subcontractors ensuring representation of all required specialties as outlined below and downstream subcontractors. They are representative composition of the provider network and provide health care services to members affected by health disparities, limited English proficiency (LEP), children with special health care needs (CSHCN), seniors and persons with disabilities (SPDs) and persons with chronic conditions[14]. Committee members must be in good standing with the Alliance. Good standing is defined as:

3.c.1. Having an unrestricted license to practice medicine or osteopathic medicine in the state of California; and,

3.c.2. Not having an open accusation or disciplinary action by any state licensing board; and,

3.c.3. Not having any ongoing or unresolved program integrity corrective action plans (CAPs).

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

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

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

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

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

3.i. Minutes: QIHEC minutes are reviewed by the Alliance Board on a routine basis[16]. QIHEC minutes are submitted to DHCS[17] upon Alliance Board review and approval and made publicly available on the Contractor's website at least on a quarterly basis.

3.j. Reporting:

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

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

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

3.j.2.b. A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully Delegated Subcontractor's performance measure results and actions to address any deficiencies;

3.j.2.c. An analysis of actions taken to address any recommendations in the annual External Quality Review (EQR) technical report and specific evaluation reports;

3.j.2.d. An analysis of the delivery of services and quality of care and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including

quality performance results, Encounter Data, Grievances and Appeals, Utilization Review, and the results of consumer satisfaction surveys;

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

3.j.2.f. A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Alliance utilizes the information from this engagement to inform policies and decision-making.

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

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

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

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

3.k. Confidentiality[20]:

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

3.k.2. Peer review committee whose activities, information and records are protected from disclosure under California Evidence Code Section 1157; and

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

3.l. Conflict of Interest[21]:

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

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

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

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

4. Other Committees

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

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

4.c. Quality Improvement Health Equity Workgroup (QIHE-W): The QIHE-W, under the direction and guidance of the QIHEC, is responsible for addressing high-priority and emerging quality and health equity trends requiring organization-wide and/or cross-departmental response, including, but not limited to, topics related to provider capacity, grievances, member access and satisfaction, and QIHET program activities. The QIPH Director or designee chairs the QIHE-W. Core membership includes: CEO, CMO, Medical Director(s), QIPH Director, QIPH Managers, QIPH Nurse Supervisor, UM/CCM Director, UM/CCM Managers, CCC Director, Pharmacy Director, QHP Manager, Medical Directors, MS Director, Grievance and Quality Manager, PS Director, Provider Quality and Network Development Manager, Claims Director, Analytics Director, Communications Director, Community Engagement Director(s), Strategic Development Director (or Grants Programs Manager), and Compliance Director or designees from the departments. Ad-hoc membership varies as topics mandate. The QIHE-W is responsible for activities, including but not limited to:

4.c.1. Ongoing review and approval of the QIHEWP, including refining interventions to address barriers and incorporate feedback from the QIHEC, and the QIHE Annual Report[22];
4.c.2. Annual review and approval of various QIPH policies and related processes and functions;
4.c.3. Analysis of HEDIS/Managed Care Accountability Set (MCAS) measures and the development of strategies to improve performance;
4.c.4. Development of QIHETP related provider and member communications;
4.c.5. Development of disease management initiatives;
4.c.6. Ongoing oversight of delegated QIHE activities of subcontractors;
4.c.7. Review of language assistance and interpreter services as described in Alliance Policy 401-4101 – *Cultural and Linguistic Services Program*
4.c.8. Review and analysis of provider and member survey results; and
4.c.9. Review and approval of QIHETP-related standing reports, and state mandated PIPs.

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

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

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

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

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

Legislative:

Contractual (Previous Contract):

Contractual (2024 Contract):
2024 Medi-Cal Contract A.3.2.2-A.3.2.2.1

DHCS All Plan Letter:
APL 19-017 – Quality and Performance Improvement Requirements

NCQA:

Supersedes:

Other References:

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
04/28/2022	04/28/2022	Amit Karkhanis, Quality & Performance Improvement Manager	CQIC
01/27/2023	01/27/2023	Michelle N. Stott, Quality Improvement & Population Health Director	QIHEW
03/30/2023	03/30/2023	Dale Bishop, MD, Chief Medical Officer	QIHEC
11/02/2023	11/02/2023	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEW

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

Reviewed Date	Revised Date	Changes Made By	Approved By
11/30/2024	11/30/2023	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEW
12/11/2023	12/11/2023	Jenifer Mandella, Chief Compliance Officer	Andrea Swan
03/11/2024	03/11/2024	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEW
04/25/2024	04/25/2024	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEC

[1] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[2] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1
[3] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12

[5] DHCS All Plan Letter 19-017; and DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[6] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.2
[7] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 3.1.4
[8] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[9] DHCS State Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.D
[10] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8
[11] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6
[12] DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 4
[13] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[14] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[15] Consistent with *Bylaws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission* (April, 2009)
[16] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[17] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[18] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3
[19] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[20] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[21] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3
[22] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[23] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.5

DATE: May 22, 2024

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

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

SUBJECT: Quality Improvement Health Equity Transformation Workplan for 2024

Recommendation. Staff recommend the Board accept the Quality Improvement Health Equity Transformation (QIHET) Workplan for 2024.

Background. This informational report provides a summary of the activities planned for the 2024 QIHET Workplan. The workplan includes contractual required Performance Improvement Projects, operational performance metrics, health programs and cultural and linguistic services, and development of the population health management program. Refer to the QIHET Workplan attachment for additional details.

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

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

Attachment.

1. 2024 QIHET Workplan

SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To develop a comprehensive evaluation of all Quality Improvement activities for 2024.	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements.	1/1/2024	Andrea Swan, Quality Improvement & Population Health Director	1st update-	1:	1.	☐ Yes ☐ No	
2.	2. Present for approval Quality Improvement workplan which contains all required sections for the evaluation.	3/31/2024 – 3/31/2024	Andrea Swan, Quality Improvement & Population Health Director	2nd update			☐ Yes ☐ No	
3.	3. Ensure all quarterly updates are reviewed and approved by QIHEC.	3/31/24,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director		2:	2:	☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

PROGRAM DESCRIPTION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Finalize 2024 Program Description for presentation to QIHEC	1. Ensure all required sections of the workplan meet DHCS, and NCQA requirements.	1/31/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director	1st update: 2nd update:	1:	1	☐ Yes ☐ No	
2. Presentation of the Program Description to both the QIHEW, and QIHEC for approval by 3/31/2024	2. Submission of Program Description to QIHEW staff	2/1/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director				☐ Yes ☐ No	
3. Develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS, and NCQA requirements.	3. Review all DHCS, and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2024-12/31/2024	Andrea Swan, Quality Improvement & Population Health Director		2:	2:	☐ Yes ☐ No	

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4.	4.						☐ Yes ☐ No	

ANNUAL WORKPLAN (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. To executes a QI program annual work plan that reflects ongoing activities throughout the year and addresses all required DHCS, and NCQA requirements	1. Create a workplan that captures yearly activities, time frame for each activity's completion, staff members responsible for each activity, monitoring of previously identified issues, and evaluation of QI program.	1/1/2024-2/15/2024	Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1: Qtr. 2 Qtr. 3: Qtr. 4:	1:	1:	☐ Yes ☐ No	
2. Ensure all workplan elements are properly documented and reflect appropriate follow up by each business owner.	2. Regular quarterly check-ins to review workplan entries, with regular feedback provided to business owners when applicable.	3/31/204,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director				☐ Yes ☐ No	
3. Review and approval of workplan quarterly by QIHEC	3. Review of all workplan entries prior to each committee to ensure appropriate documentation.	3/31/204,6/30/2024,9/30/2024,12/31/2024	Andrea Swan, Quality Improvement & Population Health Director		2:	2:	☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

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SECTION 2: QUALITY OF CLINICAL CARE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provider Partnership program established and launched	1. Sign up 4 providers by 3.31.24 2. Do onsite meetings and observations by 4.31.24 3. Develop and implement interventions for 1-2 MCAS measures at each site by 6.30.24 4. Monitor and adjust interventions and MCAS rates 9.30.24	1/1/24-3/31/24 3/31/24-4/31/24 4/1/24-6/30/24 7/1/24-9/30/24	Alex Sanchez, Quality Improvement Advisor	Launched program and contacted providers.			☐ Yes ☐ No	
2. Develop a comprehensive MCAS committee to capture, plan, and discuss quality improvement activities that will improve DHCS required MCAS measures, and NCQA HEDIS prioritized measures.	1. Create project charter and project tracker. 2. Establish regular monthly check in with committee to monitor activities. 3. Evaluation current intervention strategies against finalized audited measurement year (MY) MY2023 MCAS measure rates. 4. Request direction of interventions from.	1/1/2024-3/31/2024 3/1/2024-6/30/2024 6/17/23-8/31/2024 4/1/24-12/31/2024	Britta Vigurs, Quality Improvement Program Advisor				☐ Yes ☐ No	
3. Enhance data source capture and analyze gaps in data sources	1. Review the quality of the data sources for any new configuration issues for initial HEDIS build. Test solutions for implementation into the build. 2. Evaluate laboratory data capture enhancement through Quest historical files for consideration in contract. 3. Evaluate laboratory data for data sources in San Benito and	1/1/24-3/31/2024. 1/1/24-3/31/2024.	Magdalena Kowalska, Quality Improvement Program Advisor, Charley Aebersold, Quality Improvement Program Advisor, Jo Pirie, Quality Improvement Program Advisor, Britta Vigurs, Quality Improvement Program Advisor.				☐ Yes ☐ No	

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	Mariposa County that would benefit from additional sftp data transfer process for MCAS reporting in 2025. 4. Assess Provider Portal reports that enhance outreach with the addition of individual language needs for members linked to network providers. 5. Assess Provider Portal reports that enhance outreach with the addition of race/ethnicity for members linked to network providers. 6. Perform a gap analysis on data sources for the Eye Exam for Patients with Diabetes Review against previously submitted eye exam data. 7. Create business requirements to add high priority MCAS reported measures on monthly reports not currently represented.	1/1/24-3/31/2024. 1/1/24-3/1/2024. 1/1/24-3/31/2024. 3/1/2024-6/1/2024						
4. Create a new MCAS Dashboard that allows for enhanced health disparity analysis.	1. Develop business requirements for a new MCAS dashboard on Tableau that allows for quantitative analysis of reported MCAS and prioritized Alliance measures through trended graphs, geomapping, and individual member reports. Create filters that stratifies data based on race/ethnicity, language, gender, and county. 2. Add additional health disparity analysis to the 2023 PNA for Colorectal Cancer Screening, Controlling High Blood Pressure, Hemoglobin A1c Control for Patients with Diabetes, Prenatal and Postpartum Care. 3. Assess functionality of the MCAS dashboard in automating analysis for health disparities for Population Needs Assessment (PNA) review.	1/1/24-3/31/2024. 3/1/2024-5/30/2024. 5/1/24-8/31/2024.	Shannon Fletcher, Quality Improvement Program Advisor, Charley Aebersold, Quality Improvement Program Advisor, Kristen Rohlf, Quality and Population Health Manager				☐ Yes ☐ No	

CARE BASE INCENTIVE (CBI) (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Enhance Provider Portal reports to streamline access to reports and increase availability of functions and measures monthly.	1. Create business requirements for a roll-up function that allows multiple clinics sites to see a combined monthly rate for	1/1/2024-3/31/2024	Alex Sanchez, Quality Improvement Program Advisor, Magdalena Kowalska, Quality Improvement Program Advisor, Shannon Fletcher, Quality Improvement				☐ Yes ☐ No	

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	measures available monthly on the Provider Portal Quality Report. 2. Develop workflow to extract and generate the additional column that notes members meeting continuous enrollment specifications to applicable monthly Provider Portal Quality reports. 3. Create business requirements to add trending graphs to monthly quality reports. 4. Create business requirements to add a Gaps in Care report. 5. Create business requirements to generate email reminders for portal reports for providers.	1/1/2024-6/30/2024 6/30/2024-12/31/2024 4/1/2024-12/31/2024 4/1/2024-12/31/2024 1/31/2024-3/31/2024	Program Advisor, Annecy Majoros, Quality Improvement Program Advisor					
2. Increase access to introductory CBI program information for network providers.	1. Record a CBI 2024 introductory video. 2. Create survey for feedback on training content. 3. Published video on the Alliance Webinars and Training website. 4. Advertise video to network providers, with additional targeting for newly added Mariposa and San Benito County providers. 5. Create Data Submission Tool (DST) training video. 6. Create and record coding training material for MCAS/CBI.	4/1/2024-5/30/2024. 4/1/2024-5/30/2024. 6/1/2024-6/30/2024 7/1/2024-7/31/2024 6/1/2024-8/31/2024 6/1/24-8/31/24	Annecy Majoros, Quality Improvement Program Advisor, Juan Velarde, Quality Improvement Program Advisor, Britta Vigurs, Quality Improvement Program Advisor, Tera Mendoza, Coding Resource Specialist				☐ Yes ☐ No	
3.	6.						☐ Yes ☐ No	
4.	7.						☐ Yes ☐ No	

BASIC POPULATION HEALTH MANAGEMENT (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal department staff that interact with members to increase awareness of Health	1. The project team will reach out to internal departments that interact with members. Examples of teams: a. Health Education team b. Member Services team c. Care Coordination team	3/31/2024, 6/30/2024 9/30/2024, 12/31/2024	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager				☐ Yes ☐ No	

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Education services and health rewards available for members.	d. Community Engagement team 2. Schedule presentations 3. Deliver Health Education and Member Health Rewards services presentation. 4. Request input regarding presentation content and any member needs that they have encountered regarding Health Education services.							
2. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.	1. The project team will conduct outreach and education activities to inform members of services available to them via: a. Member outreach calls b. Member workshops c. Member mailings d. Member newsletter articles e. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager				☐ Yes ☐ No	
3. On a quarterly basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact.	1. The project team will conduct satisfaction surveys with members to evaluate: a. Information about the overall program b. Usefulness of the information shared c. Percentage of members indicating that the program helped them achieve health goals. 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager				☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

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SECTION 3: SAFETY OF CLINICAL CARE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date.	1. Address current staffing to support provider scheduling by onboarding three additional QI RNs to perform facility site reviews. 2. Review upcoming reviews one quarter prior. 3. Schedule reviews by sending the provider sites multiple review dates to choose from two months before the review due date. 4. Continue communication with the provider site until a review date is confirmed.	01/01/2024 – 03/29/2024	Joana Castaneda, Quality Project Specialist, Tisha Criswell Senior Quality Improvement Nurse, Nicole Lyles, Senior Quality Improvement Nurse				☐ Yes ☐ No	
2. 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.	1. Address current staffing to support CAP management by onboarding three additional QI RNs to perform facility site review. 2. Send email reminders to provider sites with CAP due dates. 3. Address non-responsive providers with direct phone calls and PRR involvement.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Tisha Criswell Senior Quality Improvement Nurse, Nicole Lyles, Senior Quality Improvement Nurse				☐ Yes ☐ No	
3.	3.						☐ Yes ☐ No	

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4.	4.						☐ Yes ☐ No	

POTENTIAL QUALITY ISSUES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 100% of member grievances received by QI related to the potential medical quality of care issues are completed within Member Grievance regulatory timeframes.	2. Create due dates in SharePoint for PQIs that provide enough time for investigation and translation needs (if applicable) and for the Grievance Coordinator to resolve the case. 3. If medical records are needed for the PQI investigation, request timely upon case assignment to QI RN. 4. Coordinate timely discussion if the case requires MD guidance or potential P2/P3 recommendation.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Eleni Papazisis, Quality Improvement Program Advisor, Naomi Kwabata, Senior Quality Improvement Nurse, Emily Kaufman, Senior Quality Improvement Nurse, Katie Lutz, Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, and Bethany Fung, Quality Improvement Nurse				☐ Yes ☐ No	
1. 80% of non-grievance related PQIs are completed within 90 calendar days.	2. Triage and prioritize incoming internal referrals for the following case types: a. Known provider to track and trend. b. Provider on a CAP or open Quality Study c. LTSS member 3. Consider revising the PQI policy to expand the due date to 120 days due to prioritizing regulatory cases and expansion into two additional counties.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Eleni Papazisis, Quality Improvement Program Advisor, Naomi Kwabata, Senior Quality Improvement Nurse, Emily Kaufman, Senior Quality Improvement Nurse, Katie Lutz, Quality Improvement Nurse, Sandy Clay Senior Quality Improvement Nurse, and Bethany Fung, Quality Improvement Nurse				☐ Yes ☐ No	
3:	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

GRIEVANCE & APPEALS REVIEW (SARAH SANDERS)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide grievance updates to interdisciplinary groups including SGRC and QIHEW.	a. Monitor and process concerns within regulatory timeframes. b. Provide internal communications on appeal and grievances trends and outcomes.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager				☐ Yes ☐ No	

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	c. Track and trend grievance data by demographics including language to analyze disparities. d. Identify actionable opportunities for improvement							
2. Support Members by resolving issues of dissatisfaction with the Alliance.	a. Ensure that where appropriate, corrective action is implemented and effective in improving identified problems. b. Track grievance and appeals for access/QOC trends, system issues, and identify actionable corrections needed.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager				☐ Yes ☐ No	
3. Quality Data: External Report requirements are met 100% of the time.	a. Monitor timely data and state submissions to ensure completeness. b. Evaluate and identify opportunities to improve the data accuracy of AG information.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager				☐ Yes ☐ No	
4. Ongoing monitoring of AG results to support that appropriate action is taken when occurrences of poor performance are identified. Identify and track allegations of discrimination.	a. Identify and, when appropriate, act on substantiated issues in a timely manner. Monitor and report findings bi-monthly. Complete audits for allegations of discrimination to monitor, prevent and identify any discriminatory practices.	01/01/2024 – 03/29/2024 3/31/204,6/30/2024 9/30/2024,12/31/2024	Sarah Sanders, Grievance and Quality Manager				☐ Yes ☐ No	

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SECTION 4: MEMBER EXPERIENCE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start& end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. CAHPS survey fielded timely, and results reported out to internal stakeholders within 8 weeks of receiving results	1. CAHPS workflows, processes, and timelines documented and reviewed in Q1 2024, and steps are taken to begin MY2023 surveys	2/8/24 – 3/31/24	Alex Sanchez, Quality Improvement Program Advisor		There was not a documented process or workflow for working with SPH to ensure CAHPS were administered timely.		☐ Yes ☐ No	
2. Increase organizational awareness of what CAHPS is and current what current rates are	2. Present MY 2022 CAHPS rates to targeted and appropriate stakeholders 1. Begin outreach to chiefs/admins to present CAHPS overview and high-level rates to organization at all-staff or division meetings	3/1/2024 – 10/31/24 Same timeline as above	Sarina King, Quality Performance Improvement Manager				☐ Yes ☐ No	

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SECTION 4: QUALITY OF SERVICE

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with DMHC Timely Access Survey Requirements	1. Ensure 90% of After-hours triage compliance in Timely Access Survey. (Provider Appointment Availability Survey [PAAS]). 2. Ensure 75% Urgent and routine appointment access compliance, as well as next available follow up appointment for non-physician mental health care, within required time frames. 3. PAAS work begins in the summer with vendor engagement and finalization of the project plan and contact lists. The survey is launched from August to November/December. Results are available in Q1 of the subsequent year.	7/1/2024-12/31/2024	Jessie Dybdahl, Provider Service Director				☐ Yes ☐ No	
2. Quarterly review of provider to member ratios for PCPs and High-volume/high-impact Specialties. To ensure all ratios meet regulatory requirements.	1. Ensure provider to member ratios are w/in compliance and mitigate if out of compliance on a quarterly basis. 2. Tableau report is monitored no less than quarterly to ensure provider to member ratios are met for each required provider type.	1/1/2024-3/31/2024	Jessie Dybdahl, Provider Service Director				☐ Yes ☐ No	

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3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with Time or Distance Standards set forth by DHCS	1. Ensure the network meets time or distance standards in compliance with DHCS requirements when a provider is available. 2. Monitor areas where no provider is available and ensure alternative access requests are in place on a quarterly basis. 3. Evaluate the non-contracted provider network to determine if recruitment might remedy access gaps. Launch recruitment efforts as applicable.	1/1/2024-3/31/2024 1/1/2024-3/31/2024	Jessie Dybdahl, Provider Service Director				☐ Yes ☐ No	
2.	2.						☐ Yes ☐ No	
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provider Satisfaction Survey	1. Monitor Provider Satisfaction annually. Ensure no less than 5% decrease in overall satisfaction with the plan from prior year. 2. The Provider Satisfaction Survey (PSS) is launched in the summer with vendor engagement in spring. Contact lists are sent for primary care, specialty care, and non-physician mental health care. The survey is launched from July to August. Results are available in quarter 4.	7/1/2024 - 12/31/2024	Jessie Dybdahl, Provider Service Director				☐ Yes ☐ No	
2.	2.						☐ Yes ☐ No	
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

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TELEPHONE ACCESS (GISELA TABOADA)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. 80% of calls to Member Services answered within 30 seconds.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. Improvement efforts slated for 2024: • The adoption of a Workforce Management Tool to assist with call forecasting and representative scheduling, ensuring we have appropriate levels of staff supporting the queues at any given time/day. • Call Audit Optimization: We are developing formal call audit guidelines and defined audit methodology to ensure staff is adhering to Alliance updates and processes. This will ensure representatives are provided with the appropriate resources and are getting through calls, timely. • Developing additional call circles (queues) to: o Optimize resource availability. o Improve speed to answer. o Reduce representative training time. o Increase member satisfaction. • Leverage technology to reduce wait times for members where their inquiries can be filled by the system. Example: Interactive voice response to check eligibility or change PCP. • Computer Telephone Integration: • Enhance HSP/Finesse by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time on phone for the MSR and will make each call more efficient.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Gisela Taboada, MS Call Center Manager				☐ Yes ☐ No	

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2. Call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	2. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. (Same as above)	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Gisela Taboada, MS Call Center Manager				☐ Yes ☐ No	
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. On a quarterly basis, provide C&L services presentations to Alliance internal department staff that interact with members to increase awareness of C&L services available for members.	1. The C&L team will reach out to internal departments that interact with members. Examples: a. QIPH new hire orientation b. Member Services team c. Care Coordination team d. Community Engagement team 2. Schedule C&L services presentation 3. Deliver C&L services presentation. 4. Request input regarding presentation content and any member needs that they have encountered regarding C&L services.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager				☐ Yes ☐ No	
2. On a quarterly basis, inform members of C&L Services available to them in 2024.	1. The C&L team will conduct outreach and education activities to inform members of services available to them via: a. Member newsletter articles b. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor				☐ Yes ☐ No	
3. On a quarterly basis, collect member feedback on their experience with language assistance services in a clinical setting.	1. The project team will conduct satisfaction surveys with members to evaluate: a. Individual ratings of access to language services. b. Overall rating of interpretation services. c. Access to language services at a health care encounter. d. Gather individual experiences with the services.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager				☐ Yes ☐ No	

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	2. Request input from members regarding program and services. 3. Incorporate member feedback into bi-annual planning of health education activities.							
3.	4.						☐ Yes ☐ No	

DELEGATION OVERSIGHT (ANDREA SWAN)

Goals/Objectives for Calendar Year 2024	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations.	1. Quarterly review of delegate reports to ensure compliance, and identification of any issues.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director				☐ Yes ☐ No	
2. Ensure oversight of all delegated activities by governing board.	2. Present quarterly updates of all reviewed activities with identification of any issues to the governing board for review, and feedback.	3/31/2024,6/30/2024 9/30/2024,12/31/2024	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director				☐ Yes ☐ No	
3.	3.						☐ Yes ☐ No	
4.	4.						☐ Yes ☐ No	

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DATE: May 22, 2024

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

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

SUBJECT: Quality Improvement Health Equity Transformation Workplan – Q4 2023

Recommendation. Staff recommend the Board accept the Q4 2023 Quality Improvement Health Equity Transformation (QIHET) Workplan report.

Summary. This report provides pertinent highlights, trends, and activities from the Q4 2023 QIHET Workplan.

Background. The Alliance is contractually required to maintain a Quality and Performance Improvement Program (QPIP) to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. The Santa Cruz – Monterey – Merced – San Benito - Mariposa Managed Medical Care Commission (the Board) is accountable for all QPIP activities. The Board has delegated to the Quality Improvement Health Equity Committee (QIHEC), the authority to oversee the performance outcomes of the QPIP. This is monitored through quarterly and annual review of the QIHET Workplan, with review and input from QIHEW.

The 2023 QIHET Workplan was developed to align with the Alliance Strategic Plan of Member Wellness, Access to Care, and Promotion of Value. This is accomplished through the following initiatives:

Section I: Member Experience	**Status**
A. Member Experience	
1. Health Care Collaboratives	**Goal Not Met**
2. Health Services Division Member Outreach & Engagement Campaigns	**Goal Met**
3. Member Support – Call Center	**Goal Met**
4. Cultural and Linguistics (C&L) Services & Population Needs Assessment Education	**Goal Met**
5. CAHPS: How Well Doctors Communicate	**Goal Not Met**
Section II: Quality of Service	
B. Access and Availability	
1. Annual Access Plan	**In Progress**
2. Provider Choice: In-Area Market Share	**In Progress**
3. CAHPS Survey: Access Measures	**Goal Not Met**
C. Provider Experience	
1. Provider Satisfaction	**Goal Met**
Section III: Quality of Clinical Care	
D. Utilization	

1. Under / Overutilization	**Goal Met**
2. Site of Care	**Goal Met**
3. Drug Utilization Review (DUR)	**Goal Met**
E. Adult Preventive Care Services	
1. Health Education and Disease Management	**Goal Met**
2. Controlling Blood Pressure	**Goal Partially Met**
3. Diabetes HbA1c >9% (poor control)	**Goal Met**
F. Performance Improvement Projects (State Mandated)	
1. Women's Health Domain SWOT	**Goal Met**
2. Children's Domain SWOT	**Goal Met**
3. Childhood Immunizations	**Goal Met**
4. Child and Adolescent Well Care Visits in Merced County	**Goal Met**
5. Well-Child Visits in the First 30 Months of Life; Well-Child Visits in the first 15 Months – Six or More Well Child Visits W 30 – 6 Measure	**Goal Met**
6. Follow-Up After Emergency Department Visits for Mental Illness – 30 Day Follow-Up; Total and Follow-Up after Emergency Department Visit for Substance Use; 30 day Follow-Up - Total	**Goal Met**
G. Behavioral Health	
1. Eating Disorders	**Goal Partially Met**
Section IV: Clinical Safety	
H. Clinical Safety	
1. Grievance and PQI Management	**Goal Partially Met**
2. Facility Site Review (FSR) Management	**Goal Partially Met**

Discussion.

2023 QIHET Workplan Outcomes and Evaluation

Member Experience

Health Care Collaboratives. The goal of the Health Care Collaboratives topic was to determine baseline performance by calculating the number of ideas acted upon by the organization (as defined by assessing feasibility of, starting or completing a project, taking direct action) against ideas brought back to the organizations by the Community Engagement Team from Health Care Collaborative meetings.

Metrics for 2023 were: Q1 2023 = 38%, Q2 2023 - Q4 2023 = 0%. Staff input to the status report forms were not consistent and may need leadership support. The metric has been canceled and will not be measured moving forward at this time.

Health Services Division Member Outreach and Engagement Campaigns. Member outreach is critical to inform, foster dialogue, and support at risk Alliance members. Member outreach will consist of calling members impacted by the emergent issues, impact on access to care, and member voice assessments. Mobilize an internal team to identify members, develop scripting and information of appropriate resources and health education, and conduct telephonic outreach to high-risk, vulnerable members.

Activities in 2023 include tracking and monitoring all ad hoc member outreach and engagement campaigns, and tracking each campaign's intervention, percentage of successful calls (information provided/LVM) vs. unsuccessful calls, and member counts.

Summary of outreach completed in 2023. In Q1 2023, 80% of members were successfully contacted during emergency outreach campaigns of Q1. This outreach consisted of reaching out to members in January and March regarding flood emergencies. In Q2 2023, 79% of members were successfully contacted during the Department of Health Care Services (DHCS) SWOT campaign for well-child visits in Merced County. There was no emergency, or ad-hoc member outreach campaigns conducted in Q3 or Q4.

In summary members were successfully reached and provided resources and information during the ad-hoc campaigns in 2023.

Member Support – Call Center. The purpose of reporting call center metrics is to inform stakeholders of Member Services Call Center performance. No issues were identified for 2023. There are no updates at this time, the call center met all performance metrics for Q4 2023.

Cultural and Linguistics (C&L) Services and Population Needs Assessment Education. The C&L 2023 goal was to measure the performance of the Alliance C&L Services program and to make improvements accordingly (measure utilization per County). Goals include increasing Provider Utilization of the Alliance Language Assistance Services program by 5% when compared to the previous year and increase the Alliance network provider's familiarity with the Alliance Language Assistance Services Program.

There were increases in utilization of the C&L interpreting services each quarter in 2023: In Q1 2023 there was a 97% increase of utilization compared to Q1 2022. In Q2 2023 there was a 48.40% increase of utilization compared to Q2 2022. In Q3 2023 there was a 55.50% increase of utilization compared to Q3 of 2022. In Q4 2023 there was a 11.33% increase of utilization compared to Q4 2022.

In summary the 5% goal was met and exceeded each quarter.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): How Well Doctors Communicate. How Well Doctors Communicate was below MPL for both Child and Adult in 2022 and the goal was to get to BoB SRS or increase from 93.1% for Child to 94.% and from 91.5% for Adult to 92.7%. Three articles were placed in the provider newsletter in 2023 including "Using Language Assistance for High Quality Care", "Health Literacy and Culturally Appropriate Care", and information on ASL interpreters and general contact information for our cultural and linguistics team. MY 2022 rates did not hit the goal rates with Child rates down from 93.1% to 91.7% and Adult rates flat at 91.6% from 91.5%.

Quality of Service

Access and Availability

Annual Access Plan. The Access Plan will articulate identified areas within the Alliance provider network where targeted activities can increase or enhance choice and/or access. In Q1-Q2, Access areas identified based on specific access criteria for compliance, operational impact, return on investment, strategic alignment and stakeholder value. In Q3, metrics based on grievances and potential delays in care were discussed.

In Q4, the committee further discussed recruitment prioritization and socialized Provider Satisfaction Survey data which offers additional insight on the providers perception of access to care for their members.

Provider Choice: In-Area Market Share. Ongoing recruitment to address gaps and improve market share. Goal to achieve 80% Market Share (PCP and Specialist) target with 75% lower threshold. Goal to maintain Market Share stability with a no more than 5% decrease annually.

In Q4, efforts were focused largely on the recruitment of providers in and around Mariposa and San Benito counties to support service area expansion. Q4 PCP market share increased by 0.19% when compared to Q1, to 87.30%, and specialist market share increased by 0.32% when compared to Q1, to 84.98%. Additionally, the turnaround for provider credentialing decreased to an average of 24.7 days in Q4 2023 (compared to 70 days in Q1 2023).

CAHPS Survey: Access Measures. The questions measured were Getting Care Quickly and Getting Needed Care. The goal for the Child rates was to go from 84.5% to 86.7% for Getting Care Quickly and 79.2% for Getting Needed Care. For Adult rates the goal was to move from 73.4% to 80.9% for Getting Care Quickly and to hold steady at 82.8% for Getting Needed Care. Care gap clinics were rolled out in 2023 to support access. 2022 rates for both measures for both populations fell below the National Committee for Quality Assurance (NCQA) Quality compass national benchmark and did not meet their goals.

Provider Experience

Provider Satisfaction. The survey was completed September 15, 2023. Target of 88% of surveyed providers who are satisfied with the Alliance (annual measure based on Satisfaction Survey); lower threshold is 79.2%.

Eighty-eight percent (88%) of surveyed providers in 2023 reported being satisfied with the Alliance.

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Quality of Clinical Care

Utilization

Under Overutilization. Under/over utilization is closely monitored, and Utilization Management investigates identified cases, develops interventions, and works closely with other departments such as Program Integrity, Quality Improvement and Provider Services. As authorization codes are waived as part of the Authorization Reduction Project, 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.

The most over utilized services (EMG, Authorization Redesign, IHA, Breast Cancer Screening, Colon Cancer Screening and ED Utilization) are consistent across all four quarters in 2023. In comparison, IHA, Breast Cancer Screening, Colon Cancer Screening were previously under-utilized in 2022. These preventative health measures are now being instituted more frequently by providers. The most under-utilized services (Lead Screening, ACE Screening, Mental Health Visits) continue to trend from 2022 and will continue to be monitored.

Q4 UMWP data reflects the following Claims activity, with percentages measured against Claims activity in prior quarter (Q3 2023). ACE at 14,090 claims, a 15.9% increase over prior quarter (n=12,162). Breast Cancer Screening at 6,823 claims, a 35.5% increase over prior quarter (n=5,035). Colorectal Cancer Screening at 6,426 claims, a 31.6% increase over prior quarter (n=4,882). EMG at 336 claims, a 31.2% increase over prior quarter (n=256). Initial Health Assessment at 76,464 claims, an 18.2% increase over prior quarter (n=64,692). Lead Screening in Children at 5,157 claims, an 8.2% increase over prior quarter (n=4,765). Depression screening remains unchanged from prior quarter and likely reflects incomplete capture of screening activity with new metric, consistently noting fewer than 50 claims/quarter.

Site of Care. Site of Care purpose is to improve access to drug infusions by transitioning to the home setting, which may lead to improvement in medication adherence and health outcomes.

Previously identified issues included an insufficient number of home infusion contracted pharmacies. Lack of response from prescribers, despite multiple outreaches to obtain the necessary information to transition to home infusion.

Based on 2023 results, we will decide on what operational changes we would like to implement for our Site of Care program in 2024.

Drug Utilization Review (DUR). The DUR 2023 goal was to perform retrospective drug utilization review to assure that drug utilization is appropriate, medically necessary, and not likely to result in adverse events. Based on DUR, provide active and ongoing outreach to educate providers on common drug therapy problems with the goals of improving prescribing and dispensing practices, increasing medication compliance, and improvement of over-all member health.

Eight drug utilization reviews were completed. Provider education was performed by using different methods, and members were referred to care management for outreach. Barriers included limitation in report generation that required manual analyses that were time-consuming and competing priorities for pharmacists.

For 2024, pharmacists will be working with Advanced Analytics to automate many of the analyses for better efficiency. DUR topics are being reassessed to meet regulatory and contractual requirements while addressing competing priorities.

Adult Preventive Care Services

Health Education and Disease Management. The Health Education and Disease Management 2023 goal was to increase member self-efficacy in performing self-management behaviors by having members participate in the Alliance Healthier Living Program (HLP). (Chronic Disease Self-Management Program)

Goals included by December 31, 2023, at least 50% of participants in the Healthier Living Program will have scored "Good/Very Good/Excellent" for their ability to manage their chronic health conditions after the workshop, and overall increasing improvements of the scores (i.e., poor to fair).

Summary of member survey results per quarter. In Q1 2023, 78% of members that completed the HLP reported improved scores in ability to manage their chronic health condition after the workshop. In Q2 2023, 83% of members that completed the HLP reported improved scores in ability to manage their chronic health condition after the workshop. In Q3 2023, 100% of members that completed the HLP reported improved scores in ability to manage their chronic health condition after the workshop. In Q4 2023, 78% of members that completed the HLP reported improved scores in ability to manage their chronic health condition after the workshop.

In summary the 50% goal was met and exceeded each quarter.

Controlling Blood Pressure. The focus on the MCAS Controlling Blood Pressure (CBP) measure is due to lowered rates in both reporting populations of Merced County and Santa Cruz/Monterey that have been near the minimum performance level (MPL) at the 50th percentile. Project goals included supporting the Pharmacy Team in initiating the Pharmacist-Led Academic Detailing (PLAD) Hypertension Program to decrease the percentage of members with uncontrolled blood pressures (or BP greater than or equal to 140/90); partnering with provider partners to implement evidenced based practice for members with hypertension; and continued work with Santa Cruz County to increase their rates.

In planning the hypertension PLAD program, provider feedback in the summer of 2023 included asking for a one-time clinician focused training around the latest hypertension guidelines instead of the full PLAD project.
The PLAD hypertension project was placed on hold until June 2024 while continuing to track blood pressure recheck rates monthly. There was no further focus work with providers during Q4.

Diabetes HbA1c >9% (poor control). The purpose of this topic is two-fold. To identify a health care system willing to partner with the Alliance team in implementing clinical practice recommendations on the latest pharmacologic recommendations for managing members with Diabetes Type II (ADA 2023: Pharmacologic Approaches to Glycemic Treatment). The second purpose is to support the Pharmacy Team in initiating the Pharmacist-Led Academic Detailing Diabetes Program which will decrease the percentage of members with uncontrolled diabetes (or A1c > 9%).

The team worked with four clinics and seven providers. Over 40% improvement between pre-post test results. All the participants said they were very satisfied and learned a lot from the program. Additionally, because of their positive experience with the diabetes PLAD Program, all of them wanted to also participate in the new Asthma and HTN PLAD program.

In 2024 we've reduced the number of sessions from 10 to five to make it easier for the providers to participate.

Performance Improvement Projects (State Mandated)

Women's Health Domain SWOT. Regulatory Statewide Department of Healthcare Services (DHCS) Performance Project to improve the Managed Care Accountability Sets (MCAS) Women's Domain measures of Chlamydia Screening in Women (CHL) and Breast Cancer Screening (BCS).

Since May, all providers participating in the CB QIP have completed their Letter of Agreement and received their initial (80%) and second (10%) payment, with their final payment (10%) to be received after participation in the second cohort meeting scheduled for October 24, 2023. The first cohort meeting was held on August 3, 2023, with participating practices joining in the cohort meeting, or for those unable to participate, had a required supplemental submission and project charter form returned to Alliance staff to meet criteria for the second payment. Quality Improvement and Population Health staff shared content on the project, current county performance for pediatric and adult measures compared to the benchmarks, an overview of quality improvement including the model for improvement using SMART AIM statements and PDSA cycles, followed by a breakout room activity to engage practices in evaluating good SMART AIM statements, and updated project submissions as appropriate. Alliance staff then discussed the importance of project charters and had another breakout room walking through the steps to fill one out for the CB QIP. Finally, we discussed how to track improvement, resources for gap closure reports, open forum, and discussed next steps. In the second cohort meeting on October 24, 2023, providers will be presenting to their peers from a template presentation deck to share their project team, measure and SMART AIM statements, project status, three successes and three reflections on the project. Alliance staff in November will be piloting "office hours" available to participating CB QIP providers who expressed interested in their application for additional practice coaching. Due to limited resources, individual time with practice coaches could not be accomplished, therefore a group setting has been designed to provide added support.

For the first progress submission, three providers have been selected for targeted outreach with the following actions taken as of May 31, 2023:

- Determined large group providers for outreach with greatest EP and lowest compliance. Presently Merced Faculty Associates North, Golden Valley Health Centers, and Apex Medical Group are participating. Gettysburg is pending approval as a fourth provider as of May 31, 2023.
- Provided best practice information to clinics for completing breast cancer and chlamydia screening during well-visits.
- Provide member rosters for members due for breast cancer screening. Host bi-weekly check-ins with clinics to address questions and to assist if any barriers arise.

The second progress submission Performance Improvement Projects (PIP) have begun, and the following actions have taken place:

- Chlamydia Screening, we identified a gap in care for members 16-17 years of age due female members receiving prescription for contraceptives to control their menses. We shared CDC's and American Academy of Pediatrics (AAP) best practice for screening all female members at well-visits for chlamydia, with the option to opt out with Merced Faculty Associate (MFA) North and Apex Medical Group.
- MFA presented best practice information to senior leadership for approval before adopting it in their clinic.
- MFA received leadership approval and provided training to all of their clinicians on best practice and implemented workflows.
- The Alliance provided a member list for all 16–17 year-olds linked to MFA North that were due for well-visit and chlamydia screening, as well as a list of those who had their well-visit and missing a chlamydia screening to identify those who should be screened at an upcoming visit. MFA also implemented completing chlamydia screenings for all female members coming in for a UTI.
- Apex was delayed in implementing their chlamydia project due to their work on the CB QIP. The Alliance provided a member list for all 16–17 year-olds due for well-visit and chlamydia screening, as well as a list of those who had their well-visit to identify those who should be screened at an upcoming visit.

Apex project kicked off in the beginning of September, and they have seen the following results:

- 18 patients are scheduled for their well-visit and CHL screening.
- 12 patients have opted out.
- One patient has completed their well-visit and CHL screening.
- 10 patients were not able to be reached by phone, and letters sent to inform the member is due for a well-visit and to call and schedule and appointment.

Breast Cancer Screening, in partnership with Golden Valley Health Center (GVHC), identified members who were due for their mammograms.

GVHC adopted the use of standing orders. Barriers included GVHC QI department unable to implement PIPs. Their operations department is the team who implement the projects. As a result, there has been a delay in the project kick off. Local imaging center has access issues and is booking out several weeks to a month. The Alliance

has contacted local imaging center and were advised they are booking out three weeks, and not able to prioritize GVHC patients going into October Breast Cancer Awareness month. GVHC to implement having the clinic call imaging center to schedule mammogram while member is still in the office. QI leadership researching if the Alliance will be able to assist in funding mobile mammogram bus due to access issues into local imaging centers. GVHC Merced has seen a 5% improvement since the beginning of the partnership.

Drafted letter for specific Black Member recall, tested it for readability, and had it translated as of May 26, 2023. In addition to the letter, the mailer is to include informatic from the United States Preventive Services Task Force related to Black women and their mortality statistics from undiagnosed Breast Cancer. Presently building rosters for a population of about 150 women. Successfully completed Black Member mailing.

The project was closed in Q4 for a final meeting with DHCS on October 25, 2023 to discuss the final material submitted from September 29, 2023.

Children's Domain SWOT. Regulatory Statewide DHCS Performance Project to improve the MCAS Children's Domain measures of Childhood Immunizations - Combo 10 (CIS-10), Child and Adolescent Well-Care Visits (WCV), Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits (W30-6), and Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits (W30-2).

Staff turnover, provider availability, and member education were identified as known barriers for the completion of the preventive services in Merced County. Highlights throughout the 2023 year included a successful member barrier analysis, pediatric best practice webinar, promotion of Alliance infant wellness map. Following project closure, the Alliance will continue to promote and distribute the infant wellness map in Merced County and promote internal and external tech grands/funding to Merced County providers.

The project was closed in Q4 for a final meeting with the DHCS on October 25, 2023 to discuss the final material submitted from September 29, 2023.

Childhood Immunizations. The purpose of the topic is to complete final modules for DHCS PIP and summarize outcomes by April 21, 2023. The goal has been met. CIS PIP Module 4 completed and DHCS PIP submitted. HSAG's final validation findings on the CIS PIP was received on June 12, 2023 and no further submissions were required. Project completed.

Child and Adolescent Well Care Visits in Merced County. The Child and Adolescent Well Care Visits in Merced County PIP goal was to complete the final module (Module 4) and findings for the Well Care Visit Health Equity DHCS PIP. The WCV PIP SMART Goal was that by December 31, 2022, use key driver diagram interventions to increase the percentage of child and adolescent members who receive at least one child and adolescent well-care visit with a PCP or OB/GYN practitioner during the

intervention period among MCO members ages 3-17 years old, linked to Golden Valley Health Centers - Los Banos, from 32.65% to 48.56%.

It was identified that in order to increase rates, providers must have dedicated staff and time blocks to allow recall outreach to schedule members who are non-compliant for a well visit.

Our final rate on December 31, 2022 was 62.61%; 14.05% above our original goal rate. Module 4 was completed and submitted to DHCS on April 21, 2023. On June 2, 2023 DHCS provided the final validation findings for our Module 4. Our confidence level for this PIP was determined to be High confidence (highest score possible) and all other requirements for Module 4 were met. No additional action was needed. No further activity in Q3 and Q4 2023 as the PIP officially ended and goal was met in Q2.

Well-Child Visits in the First 30 Months of Life; Well-Child Visits in the first 15 Months – Six or More Well Child Visits W 30 – 6 Measure. This PIP is a regulatory requirement from DHCS to look at well-child visit rates for members 15 months of age. The purpose of this PIP is to reduce disparity in well-child visits in the first 15 months among Hispanic Population living in Merced County.

The plan pivoted from focusing on Black members, as the original PIP required, to Hispanic members due to denominator size within Merced County.

In Q4, initial validation of the Alliance's 2023–2026 Clinical PIP submission was performed by the Health Services Advisory Group (HSAG) and was shared with the health plan and resubmitted November 1, 2023 with corrections to HSAG.

2023-2026 DHCS W30-6 PIP submission was completed. Analysis performed to identify Merced providers with highest potential for impact. No further requirements from HSAG.

Follow-Up After Emergency Department Visits for Mental Illness – 30 Day Follow-Up; Total and Follow-Up after Emergency Department Visit for Substance Use; 30 day Follow-Up – Total. Regulatory statewide DHCS performance improvement project to improve the percentage of provider notifications for members with SUD/SMH diagnosis or within seven days of emergency department (ED) visit. This project supports the MCAS measures for Follow-Up After ED Visit for Mental Illness - 30 days (FUM) and Follow-Up After ED Visit for Substance Abuse – 30 days (FUA).

Previously identified barriers include patient privacy concerns for protected health information created barriers for notifications. Validation of the 2023-2026 non-clinical PIP September submission was performed by the Health Services Advisory Group (HSAG) and shared with the health plan on October 30, 2023. The Alliance elected to set up a Technical Assistance call with HSAG and DHCS on November 20, 2023 in advance for further clarification of project aim. PIP documentation for steps 1-6 were resubmitted on November 29, 2023 with corrections to HSAG and DHCS.

Discussions with delegated Behavioral Health provider Carelon have been ongoing, and an initial notification file was submitted to Carelon in December, identifying

Alliance members in the ED with a substance use disorder or mental health diagnosis matching the FUA and FUM NCQA HEDIS specifications for the Medi-Cal Accountability Set (MCAS).

Behavioral Health

Eating Disorders. The goal of the eating disorders topic is to by December 21, 2023, improve workflow process for coordinating and expediting eating disorder referrals to Behavioral Health through pilot project and then scaling results to all counties. Competing priorities for key project staff including JIVA and County Expansion. The Alliance designed and initiated a workflow and process with Santa Cruz County Behavioral Health and Administration.

As intended, the initiative has resulted in improved communication with county partners. Project to improve workflow process for coordinating and expediting eating disorder referrals, treatment and coordination is in process. Santa Cruz County Behavioral Health and Administration is following the newly identified process and the Alliance is reviewing and reimbursing per MOU.

Engagement in partnership discussions with County Mental/Behavioral Health department staff and leverage the information learned for process refinement will continue.

Clinical Safety

Grievance and PQI Management. One hundred percent (100%) (154 of 154) PQIs were closed within the timeframe this quarter. Ninety-four percent (94%) (17 of 18) of internally referred PQIs were completed within 90 calendar days, and one hundred percent (100%) (136 of 136) of Member Grievance PQIs were completed within 30 calendar days or less. One hundred percent (100%) (36 of 36) of Quality-of-Service Member Grievances will be audited by the Medical Directors.

A Facility Site Review (FSR) nurse resigned, leaving one FSR nurse certified to perform the DHCS audit tools. To alleviate the need in the FSR team, one nurse, previously DHCS certified, moved from the PQI team to assist the current FSR nurse, when applicable, in meeting regulatory timelines for FSR/MRR. Along with the shift in staffing to support FSR, one PQI RN was on leave of absence. Due to the PQI RN team shortage of two nurses, regulatory Member Grievance processing was prioritized, and internal 90-day PQI case processing was deferred until 1) the FSR nurse was onboarded and 2) the PQI RN returned from a leave of absence. The Clinical Safety Quality Improvement Program Analyst is on leave of absence, causing a shift of work to the Quality Improvement Project Specialist, resulting in delays in operational work impacting IRR, Track & Trend, and audit deliverables.

The PQI team will continue projects in Clinical Safety to enhance operations and eliminate siloed manual work and regulatory reporting. Regarding staffing, the team will work with Humar Resources in Q1 2024 for FSR RN backfill onboarding. The candidate is a DHCS Master Trainer and will come to the team ready to assume the role. Also, in Q1-Q2 2024 we will expand the Clinical Safety team through

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promotional opportunities and the release of two FSR RN positions and a supervisor position.

Facility Site Review (FSR) Management. Eighty-seven percent (87%) (13 of 15) of existing primary care provider sites that had an FSR due this quarter were completed within three years of their last FSR date. One hundred percent (100%) (5 of 5) of practices where Critical Elements Corrective Action Plans (CE CAPs) arising from FSRs are resolved within 10 business days. Seventy-three percent (73%) (11 of 15) of practices with Corrective Action Plans (CAPs) arising from FSR submit a plan to address the CAP within 45 calendar days. One hundred percent (100%) (13 of 13) of practices with a CAP arising from FSR complete all planned actions within 90 calendar days, as evidenced by verification by the FSR team.

The site review team is short-staffed due to the resignation of one FSR RN in November 2023. Only one FSR RN is employed with DHCS certification. Result delays are due to provider staffing and deliverable delays outside of the MCPs control.

One PQI RN was temporarily moved to the FSR team to support the one DHCS-certified FSR RN. Regarding staffing, the team will work with Human Resources to hire for the backfill FSR position. In an attempt to reduce result delays in scheduling provider site reviews, the team will schedule and conduct periodic reviews two months early.

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

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

Attachments.

1. Q4 2023 QIHET Workplan

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Q4 2023 QIH kplan u

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Stat s u	G œl N t Met u
pic u	Health Se vices ivisi n Membe O t each & n a ement Campai ns u
Stat s u	G œl Met u
pic u	Membe S pp t - Call Cente u
Stat s u	G œl Met u
pic u	C lt al an in istics (C&) Se vices & p lati n Nee s Assessment cati n u
Stat s u	G œl Met u
pic u	CAH S: H w ll cte s C mm nicate u
Stat s u	G œl N t Met u
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pic u	vi e Ch ice: In-A ea Ma ket Sha e u
Stat s u	In ess u
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pic u	Utilizati n Review (UR)
Stat s u	G œl Met u
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Stat s u	G œl Met u

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pic u	Chil an A lescent ll-Ca e Visits in Me ce C nty
Stat s u	G œl Met u
pic u	ll-Chil e Visits in the i st 15 M onths—Six M o e ll-Chil e Visits (0–6) 3 meas e u
Stat s u	G œl Met u
pic u	ll w-Up Afte me ency epa tment Visit f Mental Illness—30- ay ll w-Up—tal an F ll w-Up Afte me gency Depa tment Visit f S bstance Use—30-Day F ll w-Up—T tal u
Stat s u	G œl Met u
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pic u	G ievance an Ql Mana ement u
Stat s u	G œl a tially Met u
pic u	acility Site Review (SR) Mana ement u
Stat s u	G œl a tially Met u

ROGR SS SUMMARY

66% u

e cent C mplete u

C mp site Sc e u

4 u

Secti ns ab ve ta et u

Q4 2023 QIS Ian H

SECTION 1: MEMBER EXPERIENCE H

A: MEMBER EXPERIENCE H

T c H	eal h Ca e C llab a ves feedbac f m c mmun y en a emen H
D ma n H	Membe Ex e ence H
P y H	All ance O pe a n Plan H
C H ee H	MSEC H
G oals H	De e ne basel ne e f mance by calcula n he numbe f deas ac ed u n by he an za n (as def ned by: assess n feas b l y f, s a n c H le n a jec , a n d ec ac n) a a ns f deas b u h bac he an za ns by C mmun y Engagemen Team f m eal h Ca e C llab a ve mee ngs H
O p un es f I vemen H	S aff n u he s a us e f ms has n been c ns s en and my need H leade sh su H . H
Resul s Q4 H	0 H
Summa y f Qua e ly Ac v es Na a ve H	Me c has been canceled and will n be measu ed v n f wa d. H
Kn wn Ba e s/R Cause(s) (as a l cable) H	Adequa e s aff e f m ac v es H
Nex S e s H	h s me c will be lled u n O r an za nal ac ns a en by all membe v ce. H

T c H	eal h Se v ces D v s n Membe Ou each & En a emen Ca a ns H
D ma n H	Membe Ex e ence Qual y f Ca e Qual y f Se v ce H
P y H	C e H
C H ee H	QI ET MSEÇ H
G oals H	Membe u each s c cal nf m, f s e d al ue, and su a s All ance membe s. Membe u each will c ns s f call n membe s ac ed by he eme en ssues, ac n access ca e, and membe v ce assessmen s. M ob l ze an n e nal eam den fy membe s, devel sc ng and nf ma n f a iate es u ces and health educati n, and c nduct tele h nic ut each t high- is , vulne able membe s. Activities: 1. In 2023, t ac and m onit all ad h c membe ut each and engagement cam paigns 2. T ac each cam paigns inte venti n, e centage f successful calls (inf mati n I vided/LVM) vs. unsuccessful calls, and membe-H c unts
O p un es f I vemen H	1. C d na ed c llab a n wi h mul le s Hu ces n he devel Hmen f membe w r en ma H als and s aff al n n s H 2. Devel men f membe s e l s s wi h he ve f ca n f he e s e han ne membe n he same h useh ld n he l s 3. Identificati n f the ight level f staff t su t these ut each cam paigns (i.e., clinical vs. n n-clinical) H 4. C dinated a ach f d cumenting, t ac ing, and e ting the utc me f each ut each call 5. Devel en ugh time t t ain staff n tal ing ints and new ut each campaigns
Resul s Q4 H	0% H
Summa y f Qua e ly Ac v es Na a ve H	The e we e n ad h c membe u each ca a ns c le ed n Q3 Q4 2023. H
Kn wn Ba e s/R Cause(s) (as a l cable) H	N a l cable h s qua e . H
Nex S e s H	Teams a e e a n f 2024 c n ac equ emen s and c un y ex ans n. If new H membe u each ca H a ns a e den f ed hey will be e ed acc d n ly. H

T c H	Membe Su Call Cen e H
D ma n H	Membe Ex e ence H
P y H	Re ula y (D CS) H
C ee H	MSEC H
G oals H	1. 95% f Calls Membe Se v ces AHswe ed BHlf e Be n Aband ned H 2. 80% f Calls Membe Se v ces Answe ed h n 30 Sec nds
O p un es f I vemen H	Iden fy add nal ba e s be n able c n nu usly mee h s equ emen . H
Resul s Q4 H	1. 97% 2. 86% H
Summa y f Qua e ly Ac v es Na a ve H	Du n Q4 2023 he All ance Membe Se v ces' Call Cen e f cused n sha n ede e na n nf ma n wi h membe s and ensu n ha he ma l n add ess s u u da ed. have ads s a ed ece ve calls f m ex ans n membe s and I have been v d ng hem wi h bas c All ance nf ma n. H
Kn wn Ba e s/R Cause(s) (as a l cable) H	
Nex S e s H	Kee eyHe n mHmbe wHll n v HumHe H

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Topic x	Cul u l d Li guis ics (C&L) Se vices & Popul io Needs Assessme Educ io x
Domai x	Membe E pe ie ce Qu li of C e Qu li of Se vice x
P io i x	Regul o (DHCS) x
Commi ee x	QIHET Wx
Go ls x	To me su e e pe fo ma ce of e Alli ce C&L Se vices p og m d o make imp oveme s cco di gl (me su e u iliz io pe Cou) 1. I c e se P ovide U iliz io of he Alli ce L gu ge Assis ce Se vices p og m by 5% whe comp ed o he p evious ye 2. I c e se he Alli ce e wo k p ovide 's f mili i y wi h he Alli ce L gu ge Assis ce Se vices P og m
Oppo u i ies fo Imp oveme x	Effec ive commu ic io is c i ic I fo ou membe s o e su e u de s di g, empowe me d p ovide ig qu li c e T e Alli ce L gu ge Assis ce Se vices p og m e su es Alli ce membe s eceive ig qu li d pp op i e l gu ge se vices b educi g he I h disp i ies el ed o l gu ge/cul u l b ie s. 1. E plo e he effec ive ess of cul u l compe e cy se vices p ovided by he Alli ce i e su i g h membe s eceive high-qu li y, pe so -ce e ed c e d ide ifyi g oppo u i ies fo imp oveme whe e ecess y 2. Mo i o elepho ic i e p e i g, f ce- o-f ce i e p e i g, sl io s, d e d bili y eques s 3. Mo i o membe d p ovide compl i s d PQIs 4. Develop He I h Li e cy Tool ki fo he o g iz io (PNA) 5. Coll bo e wi h PS i he developme d l u chi g of p ovide cul u l compe e cy i i g (PNA) 6. Impleme udio i e p e i g se vices fo Telehe I h visi s 7. P omo e he Alli ce L gu ge Assis ce Se vices wi h ou e e l e wo k p ovide s (i.e., qu e ly f bl s s, i i g videos o suppo p ovide s o how o use he se vices) (PNA) x
Resul s Q4 x	11 33% x
Summa of Qu e I Ac ivi ies N ive x	I Q4 2 23 e e w as 11 3% o l i c e se comp ed o Q4 of 2 22 of p ovide s u ilizi g f ce o f ce (i pe so) i e p e i g se vices Cou specific d fo f ce o f ce i e p e i g se vices w as s follows: Me ced Cou y h d 4.18% i c e se i Q4 2023 comp ed o Q4 2022 S C uz Cou y h d 58.77% i c e se i Q4 2023 comp ed o Q4 2022 Mo e ey Cou y h d 50.29% i c e se i Q4 2023 comp ed o Q4 2022 Fo elepho ic i e p e i g se vices he d is o b oke dow nby cou y. I Q4 2023 he e w as 25.82% i c e se of p ovide s d s ff u ilizi g elepho ic i e p e i g se vices comp ed o Q4 2022.
K ow nB ie s/Roo C use(s) (s pplic ble) x	I Q4, e e w as sig ific dec e se i Mo e e Cou f ce o f ce i e p e i g se vices u iliz io , s well s sig ific i c e se i S C uz Cou u iliz io T e e w as i c e se i elep o ic i e p e e us ge, whic could be o he e so fo he dec e se i f ce o f ce i e p e i g se vices us ge. Me ced d Mo e ey Cou y co i ue o show i c e sed u iliz io fo f ce- o-f ce i e p e i g se vices. The C&L e m will co i ue o mo i o u iliz io es o e su e membe ccess.
Ne S eps x	I Q4 e C&L e m wo ked o cou e p sio effo s wi ve do s o e su e ccess o i e p e i g se vices i e ew cou ies s i g i 2 24 All ve do s, p f om U i ed Wa (whic o I se ves Me ced), ve co fi med c p ci wi i he ew e p sio cou ies. I 2024 Q1, he C&L e m will co i ue o wo k closel x wi h ou i e p e i g ve do s o dd ess y l gu ge ccess g ps h may ise

Topic x	CAHPS: How Well Doc o s Commu ic e x
Domai x	Membe E pe ie ce x
P io i x	Regul o (DHCS) x
Commi ee x	QIHET W, MSEC x
Go ls x	1 Ac ieve 94 4% (BoB SRS) i How Well Doc o s Commu ic e C ild 2 Ac ieve 92 7% (BoB SRS) i How Well Doc o s Commu ic e Adul x
Oppo u i ies fo Imp oveme x	Assess CAHPS su ve s dmi is e ed i 2 22 fo MY 2 21, de e mi e go ls, d ide if imp oveme s x
Resul s Q4 x	Decembe 2 23 ewsle e i cluded i fo ma io o ASL i e p e e s d co c i fo ma io fo ou Cul u l d Li guis ics Se vices e m. Resul s fo MY 2022 e below. Adul - 91.6% (fl f om 91.5% i 2022) b w 25 h-50 h %tile io lly Child- 91.7% (dow nf om 93.1% i 2022) below 25 h %ile io lly. This w as ide ified s o e of ou lowes pe fo mi g me su es fo his popul io .
Summa of Qu e I Ac ivi ies N ive x	Decembe 2 23 ewsle e i cluded i fo ma io o ASL i e p e e s d co c i fo ma io fo ou Cul u l d Li guis ics Se vices e m. MY 2022 esul s we e eceived d p ese io s e bei g c e ed o sh e ou x o g iz io lly.
K ow nB ie s/Roo C use(s) (s pplic ble) x	T e esul s of e c ild su ve fo is p icul ques io we e lowe fo Sp is Spe ke s, whic made up 63% of espo de s d ed is ques io 9 6% ve sus e gg eg e 91 7%. T e esul s we e lowes i SC Cou 89 2% d ig es i Me ced 93.0%, The e we e mul iple o he e s i cludi g i g of pe so l doc o d i g of speci lis , i g of he I h c e, d i g of he I h pl cus ome se vice h lso fell ye ove ye , especi lly mo g Sp ish Spe ke s.
Ne S eps x	Repo ou e esul s o elev s ke olde s d develop pl o dd ess e x esul s i 2 24

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SECTION LITY OF SERVICE D

B CCESS & V IL BILITY D

Topic D	nnual cce Plan D
omain D	Member Experience alit of Care alit of Service D
Priorit D	Re ulator , Core D
Committee D	N SC D
Goal D	T e nnual cce Plan focu area and improvement oal are e tabli ed in D Januar of eac ear and are olidified b t e N SC. T e 0 3 cce Plan oal will be finalized in Januar 0 3. D
Opportunitie for Improvement D	T e cce Plan will articulate identified area wit in t e lliaDce provider network where tar eted activitie can increa e or en ance c oice and/or acce . T e 0 3 improvement opportunitie will be identified in Januar 0 3. D
Re ult 4 D	T e committee furt er di cu ed recruitment prioritization and ocialized Provider Sati faction Surve data whic offer additional in i t on t e provider perception of acce to care for t eir member . D
Summar of arterl ctivitie Narrative D	Workin w/ N SC attendee to develop criteria to a i t in en urin appropriate D prioritization of acce plan focu area .
Known Barrier /Root Cau e( ) (a applicable) D	TB D
Next Step D	

Topic D	Provider C oice In- rea Market S are D
omain D	Member Experience alit of Service D
Priorit D	Re ulator , Core D
Committee D	N SC D
Goal D	. 80% Market S are (PCP and Speciali t) tar et wit 75% lower t re old D . Market S are tabilit wit a no more t an 5% decrea e annuall . D
Opportunitie for Improvement D	. Credential non-credentialed provider practicin at contracted location . . En a e provider who ave i toricall declined to contract. D
Re ult 4 D	Effort were foCu ed lar el on t e recruitment of provider in and around Maripo a and Benito countie to upport ervice area expan ion.
Summar of arterl ctivitie Narrative D	St. Mic ael Nep rolo a reed to contract wit t e lliance in t e San Lui Obi po area. dditionall a new p c iatri t in SLO al o a reed to contract. Bot provider ave i toricall declined to contract wit t e lliance. D
Known Barrier /Root Cau e( ) (a applicable) D	ifficult obtainin timel credentialin application for new or exi tin provider , priorit to en a e new entitie in contractin over credentialin provider at D exi tin contracted ite .
Next Step D	

Topic D	C HPS Surve cce Mea ure D
omain D	Member Experience alit of Service D
Priorit D	HCS D
Committee D	H C, HET-W, HET-C D
Goal D	. c ieve 86.7% (C) 80.9% ( ) (BoB SRS) in Gettin Care ickl for C ild and dult C HPS . c ieve 84.4% (C) 8 .3% ( ) (BoB SRS) or old tead at t e 50t percentile in Getting Needed Care for Child and dult C HPS D
Opportunitie for Improvement D	e C HPS urve admini tered in 0 , determine oal , and identif an D impr Dvemen D D
Re ult 4 D	Care ap cl Dnic and rant to fund locum provider and taff overtime were rolled out in .4 . Gettin Care ickl mea ured at 75.9% for t e dult Surve and 8 .3% for t e Child Surve in 0 3. lthough the que tion aw an increa e in performance for adults from 73.4% in 0 , the survey sample was exponentially larger which shows the measure declining overall. Both measures were below the NC ality Compass national benchmark. . Getting Needed Care was measured at 78.9% for the dult survey and 79.4% for the Child Survey in 0 3. mong the Medicaid Child population, Getting Needed Care had one of the biggest decreases compared to last year. Both measures were below the NC ality Compass national benchmark.
Summar of arterl ctivitie Narrative D	MY 0 re ult were received and pre entation and bein created to are out or anizationall . Locum provider rant were funded for multiple provider in Merced Count to clo e care ap . Merced Count provider were c o en becau e thi i where our bigge t di paritie are and the mo t opportunit to rai e health equity and bring preventative services to members who struggle with access.
Known Barrier /Root Cau e( ) (a applicable) D	Provider availabilit i one of the bi e t known barrier . ED fu din additional D provider availabilit we are aimin to improve acce and clo e care ap . D
Next Step D	S are t e re ult wit our provider network team and work collaborativel to addre t e i ue in 0 4. D

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C: PROVI R P RI C y

opic y	Provider Satisfaction y
omain y	Qualit of Service y
Priorit y	Reg lator Core y
Committee y	H SC y
Goals y	arget of 88% of s rve ed providers who are satisfied with the Alliance ann al y meas re based on Satisfaction S rve) lower threshold is 79.2%. y
Opport nities for Improvement y	ngage more providers in responding to the ann al s rve contin e to explore new or evolved q estions to best inform the Alliance as to feedback in targeted areas y
Res ltsyQ4 y	2022 resys lts were 87% overall y satisfaction with the Alliance y
S mmar of Quarterl Activities arrative y	Res lts final presented to SC and CQIW-I in ecember. Overall Provider y Satisfaction for 2022 wasy 87%. y
Known Barriers/Root Ca se s) as applicable) y	one y
ext Stepys y	

S C IO N3: QUALI Y OF CLI ICAL CAR y

: ILIZA IO N y

opic y	nder / Over tilization y
omain y	Clinical Safet Qualit of Care Qualit of Service y
Priorit y	Reg lator y
Committee y	MWG QIH -W, QIH -C Program Integrit /Compliance Committee Claims Advanced Anal tics Health Services Finance Collaborative PS/HS Collaborative y
Goals y	An interdepartmental over/ nder tilization report will be developed b ecember 31 2023. y
Opport nities for Improvement y	1. Coordinated collaboration with all so rces of monitoring for over and y nder tilization. y 2. Linking reporting from multiple so rces to ens re compliance with monitoring. y
Res lts Q4 y	Q4 MWP data reflects the following Claims activit with percentages measured against Claims activit in prior q arter Q3 2023). AC at 14 090 claims a 15.9% y increase over prior q arter n=12 162). Breast Cancer Screening at 6 823 claims a 35.5% increase over prior q arter (n=5 035). Colorectal Cancer Screening at 6 426 claims, a 31.6% increase over prior quarter (n=4,882). MG at 336 claims, a 31.2% increase over prior quarter (n=256). Initial Health Assessment at 76,464 claims, a 18.2% increase over prior quarter (n=64,692). Lead Screening in Children at 5,157 claims, a 8.2% increase over prior quarter (n=4,765). epression screening remains unchanged from prior quarter and likel reflects incomplete capture of screening activit with new metric, consistentl noting fewer than 50 claims/quarter.
S mmar of Quarterl Activities arrative y	Report finalized in Q4 and metrics pdated for y MWP q arterl yreporting. Continued

opic y	Site of Care y
omain y	Clinical Safet Member xperience Qualit of Care y
Priorit y	Organizational actic y
Committee y	P& y CQIC
Goals y	1. Perform Site of Care o treach to 50% of Site of Care eligible members on targeted dr gs in a form of informational letter and inf sion provider phone calls. 2. etermine an barriers for Site of Care transition from members prescribing providers and inf sion providers perspective. y
Opport nities for Improvement y	1. Improve access to home inf sions and o tpatient inf sion center inf sions for members. 2. evelop inf sion provider and member relationship which can event all y improve medication adherence and health o tcomes. y
Res lts Q4 y	100% y
S mmar of Quarterl Activities arrative y	Q4: We collected ideas for how to improve o r Site of Care program for 2024. y
Known Barriers/Root Ca se s) as applicable) y	1. Pharmac staffing 2. Ins fficient Home inf sion and o tpatient inf sion contracted providers 3. Hospital contract limiting transition of inf sions o t of Hospital based o tpatient inf sions center. 4. ifficult to find the best contact information for providers. 5. Administrative tasks such as setting up member/provider letters and referrals are time consuming. 6. ableau reports take time to create and modif . 7. he members who have declined the program have done so for multiple reasons, including not wanting an one in their home or the would like to continue at their current site of care because the receive other services from that site at the same time. 8. It takes a long time for the prescribers to send clinical information and medication orders to the infusion pharmac . he infusion pharmac must follow up with the provider multiple times to obtain all the necessar information from the prescriber.
ext Steps y	We will decide on what changes we wo ld like to implement for o r Site of Care program. y

Topic Q	Dru i iza ion Review (D R) Q
Domain Q	C inica Safe y Member xperience ai y of Care Q
Priori y Q	Re u a ory Q
Commi ee Q	P T, Q H T- Q
Goa s Q	. Perform re rospec ive dru u i iza ion review on a uar er y basis, o assure ha Q dru u i iza ion is appropria e, medica y necessary, and no ike y o resu in adverse even s. Q 2. Based on D R, provide ac ive and on oin ou reach o educa e providers on common dru herapy prob ems (e. ., new prescribin uide ines and advisories) Q wi h he oa s of improvin prescribin and dispensin prac ices, increasin medica ion comp iance, and improvemen of over-a member hea h.
Oppor uni ies for Improvemen Q	Improve awareness among members on prudent use on any drug u i iza ion is no in Q ine wi h curren c inica uide ines. Q
Resu s 4 Q	89% Q
Summary of ar er y Ac ivi ies Narra ive Q	:4 Q Dru u i iza ion review was performed o eva ua e he persis ence of be a-b ocker rea men af er a hear a ack. 74% of members who had a hear a ack received a be a-b ocker. A Provider Di es on "Be a-b ocker use af er myocardia infarc ion (MI) per AHA/ACC uide ines" was pub ished o educa e providers on AHA/ACC uide ines o reinforce appropria e be a-b ocker prescribin af er hear a ack. Dru u i iza ion review was performed o eva ua e an ipsycho ic medica ion use in chi dren. In 2022, 550 pedia ric members were on an an ipsycho ic. We inves i a ed he op medica ions and he op providers, and he conc usion was ha here were no prescribin concerns. Two separa e dru u i iza ion reviews were performed o eva ua e a members on 30 days or on er of over appin opioid and seda ive hypno ics herapy and opioid and benzodiazepine herapy. Of he 240 members wi h over appin herapy, we iden ified 6 hi h-risk members who had 90MME per day or rea er and did no have na oxone co-prescribed. Tar e ed ou reach was performed o he prescribers of he 6 hi h-risk members o encoura e herapy re-eva ua ion, aperin , and/or discon inua ion of medica ions if appropria e and recommend co-prescribin na oxone. A Provider F ash was a so pub ished o a providers abou risks of opioid and CNS depressan s and oo s for aperin and mo iva iona in erviewin . Dru u i iza ion review was performed o eva ua e he percen a e of o der adu s (65 and o der) wi h chronic kidney disease (CKD) who had fi ed a prescrip ion for non-s eroida an i-inf amma ory dru s (NSAIDs) durin he year 2022. The resu s showed ha abou 11% received a eas one prescrip ion for NSAIDs. Majori y of he members had on y one fi main y af er procedures. On y 3 providers had members who were fi in heir NSAIDs on re u ar basis. A reminder ar ic e abou appropria e use of NSAIDs in CKD is oin o be pub ished in Provider Di es . Dru u i iza ion review was performed o eva ua e he percen a e of members 5–64 years of a e wi h persis en as hma who had a ra io of con ro er medica ion o o a as hma medica ions of 50% or rea er durin he year 2022. The avera e AMR for a coun ies was 79%. A sub roup of ado escen s across a 3 coun ies were iden ified wi h ower- han-norma AMR ra io. 42 of hose members had fi ed 4 or more rescue inha ers and no con ro er medica ion. These members were referred o care mana emen o con ac and counse as needed. A ar e ed emai was sen o he provider o offer hem Pharmacis -Led Academic De ai in re ardin new as hma uide ines and upda es in he fie d. A Member News is expec ed o be pos ed on he A iance websi e.
Known Barriers/Roo Cause(s) (as app icab e) Q	. Limi a ion in repor enera ion, re uirin manua ana yses ha are ime-consumin . 2.Compe in priori ies for pharmacis s. 3. Limi ed access o re evan c inica informa ion, such as s a e of heir chronic kidney disease as no eGFR was avai ab e. 4. Medi-Ca Rx repor had errors ha preven ed fur her ana yses.
Nex S eps	: For 2 24, pharmacis s wi be workin wi h Advanced Ana y ics o au oma e many of he ana yses for be er efficiency. D R opics are bein reassessed o mee re u a ory and con rac ua re uiremen s whi e addressin compe in priori ies. Q

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Topic m	Health Education and Disease Manage nt me
Do in m a	Me e Exp e ience Quality of Ca e Quality of Se ice m
io ity m	egulato y (DHCS) m
Co ttee m i	Q HET W
Goals m	To inc ease e e self efficacy in pe fo ng self nagea nt be ha io s by m ha ing m b e s pa ticipate in the Alliance Healthie Li ing og a (Ch onic Disease Self Manage nt eg a) 1. By Dece er 31, 2023, at least 50% of participants in the Healthier Living rogra will have scored "Good/ ery Good/Excellent" for their ability to nagea their chronic health conditions after the workshop 2. Overall increasing i rove p nts o the scores (i.e., poor to fair)
Oppo tunities fo o e p nt me	1 nc ease pa ticipation in the Healthie Li ing og a wo kshop by p o ting the e e incentive and offe ing diffe ent fo t options (Telephonic, i tual, and in pe son) 2. Coo dinated collabo ation with ltiple sou ces to ensu e to expand the quality i rove p nt syste in the co nity by having a greater presence and pro ting Alliance quality initiatives related to wellness and health pro tion o
esults Q4 m	78% m
Su y of Qua te ly Acti ities a ati e m	n Q4 the Quality and Health og a tea sco leted 3 Healthie Li ing og a wo kshops se ies The wo kshop was offe ed in th ee diffe ent dalities i tual, telephonic and in pe son in Salinas m
Known Ba ie s/ oot Cause(s) (as applicable) m	The e were no ba ie s to deli e ing this wo kshop series m
ext Steps m	The QH tea has start ed to prepa e for Q1 2024 wo kshops and discuss out each st ategies to engage m b e s f o the new se ice counties

Topic m	Cont olling Blood essu e m
Do in m a	Quality of Ca e m
io ity m	egulato y (DHCS Health Equity Goals), HED S m
Co ttee m i	Q HET W m
Goals m	1 Suppo t the ha cy Tea in initiating the ha cist Lead Acade c Detailing Hype tension og a which will dec ease the pe centage of e s with uncont olled blood p essu es (o B g eate than o equal to 1 0/90) 2. dentify a health ca e syste willing to pa tne with the Alliance tea in i le pting an evidenced based practice for e s with Hypertension. 3. By 12/31/2023, the Santa Cruz County Clinics proportion of patients with B at m goal (or less than 140/90) will increase fro 52% to 57%.
Oppo tunities fo o e p nt me	1 o ing accu ate B m eadings will allow s clinic ian to e entions such as the m ha cists Lead Acade c Detailing Hype tension og a to be me effecti e in i o ing B cont ol in e s with uncont olled hype tension 2. nc ease m b e s that a e accu ately identified as ha ing hype tension. 3. For those e s with hypertension established accurate readings support the clinical nagea nt of the patient. 4. Establish this best practice in a busy a ulato by care center.
esults Q4 m	1 Goal not m t pha m cy hype tension prog a planning is in prog ess m 2 Goal pa tially t Santa C uz County Clinics decided against pa ticipating in the new LAD Hype tension p og a nstead, equesting a one ti clinician focused t aining a ound the latest hype tension guidelines to be co leted on 11/15/23. 3. Goal t - Santa Cruz County Clincs Q3 2023 CB CB (reported in Q4 2023) = 66.09%
Su y of Qua te ly Acti ities a ati e m	1 oject placed on hold until June while continuing to t ack B echeck ates nthly o 2 e check in with p o ide o ra tee su , they a e not inte ested/able in a full LAD p oject. nstead, equesting a one-ti clinician focused t aining a ound the latest hypertension guidelines co leted on 11/15/23.
Known Ba ie s/ oot Cause(s) (as applicable) m	
ext Steps m	LAD Hype tension prog a planning has been in prog ess and will continue in m 2024 m

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Topic g	Diab bA1c >9% (poor con rol) g
Domain g	Quali y of Car g
riori y g	R ula ory (D CS al Equi y Goal), ED S g
Commi g	QI ET-Wg
Goal g	1 d n ify a al car y m willin o par n r wi Allianc am in impl men in clinical prac ic r commenda ion on la p armacolo ic r commenda ion for mana in memb r wi Diab Typ (ADA 0 3: armacolo ic Approac o Glyc mic Tr a men) 2. Suppor h Pharmacy T am in ini ia in h Pharmaci -L d Acad mic D ailin Digb Pro ram which will d cr a h p rc n a of memb r wi h uncon roll d diab (or A1c > 9%).
Oppor uni i for mprov men g	1 Oppor uni i o n a wi a prac ic wi a co or of memb r wi DM and in r in impr vin and/or xpandin g rvic o memb r For o clinic who do no av a memb r r call proc for rou in diab car follow-up, provid prac ic coac in o mpow r clinic o d v lop a u ainabl y m. 3. Oppor uni y o conn c memb r o Diab S lf-Mana men Educa ion (DSME) and row our n work of C r ifi d Diab Educa or . g
R ul Q4 g	1 Goal me in Q1 g Goal me in Q4 g LAD pro rams wi DoD, G e y bur , and Dr T ao av b n g compl d g
Summary of Quar rly Ac ivi i Narra iv g	1 Conduc clinic ou r ac o id n ify clinic in r d in pro ram par icipa ion D v lop/modify pro ram con n o me clinic r qu 3 Me wi clinic o c dul LAD pro ram. 4. G en ra r i ry li of memb r o rack A1C and f/up vi i rou ou pro ram. 5. Compl g ion wi h clinic. 6. Ga h r pr -po g ion da a o analyz . g
Known Barri r /Roo Cau ( ) (a applicabl) g	1 Clinic ar curr n ly ru lin o main ain aff and con inu o car for memb r wi COV D Limi d capaci y a many primary car offic o adop a n w ini ia iv (For ome clinic (i. . CSVS) av ad o modify in rv n ion by limi in numb r of ion and allowin a lar r roup iz o par icipa) 3. Limi d n work of acc ibl C r ifi d Diab Educa or . g 4. Allianc memb r hav f w r ourc , may b limi d o no havin af ar a for phy ical ac ivi y or uppor o pr par h al hy meal .
N x S p g	1 Ga g r da a o analy g pr -p g ion, progra n, a d A1c da a g lannin for Q1 g0 4 CB LAD ro ram. g

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Topic I	Women's ea t Domain SWOT I
Domain I	Qua ity of a e I
P io ity I	Statewide D S Pe fo mance I
ommittee I	Q I ET WI
Goa s I	To inc ease Bl east ance Sc eenin and amydia Sc eenin ates by p ovidin p actice coac in and ea nin co abo atives to suppo t p ovide imp ementation of Q I nte ventions, and suppo tin p ovide s t ou iance membe eca and ea t education. 1. By 11/11/2022 Submission 1 Technica ssistance PR . 2. By 1/30/2023 Strategies, measurab e action items and short-term objectives. 3. By 5/30/2023 Progress on strategies and action items. 4. By 9/30/2023 Progress on strategies and action items.
Oppo tunities fo mp ovement I	. T e iance c eated a a e Based Qua ity mp ovement P o am (B Q P) wit t e aim to p ovide financia investment fo p actices to make qua ity imp ovement inte ventions. T is p o am is desi ned to assist p actices who a e pe fo min be ow minimum pe fo mance eve s (MPL) on p io itized M C S measu es to make sustained improvements in staffing, processes, and techno ogy. The app ication opened to e igib e contracted network providers on March 14, 2023 and c osed on May 19th, 2023 with a tota of 44 app ications. On y one e igib e provider chose to not app y to the program. I . Three providers have been se ected for targeted outreach. . B ack members had the owest rate of screening of a racia /ethnic groups in 2021 for B S. Faci itate targeted mai ing for this popu ation to educate and to notify member of screening recommendations.
Resu ts Q4 I	D S conc uded a I SWOT activities on September 29t , 2024. lo SWOT activities we e equi ed in Q4.I
Summa y of Qua te y ctivities a ative I	Go den a ey ea t ente Me ced as a eed to pa tne on imp ovin b east cance sc eenin s in co abo ation wit t ei a e Based Qua ity mp ovement P oject app ication. Q P is continuin out eac fo anot e c inic to pa tne on b east cance sc eenings. Q P wi p ovide p actice coac ing, best p actice information and a member reca ist for c inics to outreach to members. -- pex Medica Group has agreed to partner on ch amydia screenings. Merced Facu ty ssociates - orth is requesting their eadership's approva to partner on ch amydia screenings. Q PH wi provide practice coaching, best practice information and a member reca ist for c inics to outreach to members. -- Member etters drafted and USPSTF f yer decided as outreach f yer for B ack members for B S mai er. -- For Q2 Q PH provided best practices information and s ide presentations for Go den a ey Hea th enter and Merced Facu ty ssociates to get eadership approva to participate in SWOTs. Go den a ey Hea th enter is working with their operations team to create a team to work on the Breast ancer Screening SWOT. Q PH met with pex to address questions on the project, and provided best practice information. -- For Q3 Q PH provided member reca rosters for pex Medica Group and MF orth showing members due for ch amydia screening and we -visits. Worked with G VH to identify barriers within organization to imp ement member reca rosters in coordination with Q I and are Management teams. Worked with Q I department to review member reca roster for potentia exc usions to up oad to the iance's Data Submission Too for comp iance. -- For Q4 Q PH met with DH S, reviewing and conc uding a SWOT activities. o further SWOT actions required.
Known Ba ie s/Root ause(s) (as app icab e) I	Due to QIP staff limitations it was decided to focus on inc easin b east cance sc eenin and c amydia sc eenin ates. I Q P staff as competin p io ities wit t e comp etion of B Q P app ications and being ow staffed. -- Breast ancer Screenings: having difficu ty getting an additiona c inic to partner on increasing breast cancer screenings. Looking at c inics who have chosen this measure as part of the B Q P app ication and have ow rates. -- Since ch amydia screenings popu ation starts at age 16, it is a hard popu ation to ca in for screenings since outreach goes to the member, not the parent/guardian. Q PH wi be focusing on members who have not had their we -visit for 2023, and educating partnering c inics to screen a members for h amydia screening with the option to opt out. -- For Q3 staffing heavi y impacted a interventions due to staff on eave or oss of staff. MF was assigned a P from FSR team and focused efforts on addressing P before working on intervention project. G VH departments work in si o; Q I comes up with interventions and then has cha enges getting the necessary staff to imp ement intervention. G VH has a so taken on a ot of projects and is over stretched. -- For Q4 no SWOT activities were required.
ext Steps I	Reac out to additiona c inics to pa tne on inc easin b east cance sc eenin I ates. eate Powe Point p esentation fo MF to take to eade s ip to et t ei app ova to pa tne wit Q P . I -- Generate member ists and provide best practice information. -- For Q2 Q PH wi continue to meet with c inics to address barriers and provide updated member ists based on member enro ment. -- For Q3 Q PH wi continue to meet with c inics and address barriers, and provide updated member reca ists as needed. -- For Q4 no SWOT activities were required.

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Topic G	Chil hoo G nizations G
Do in G a	Q uality of Care G
Priority G	Statewi e DHCS P P G
Co ttee i	Q HET WG
als G	1 By April 21, 2 23, co lete final lesofor DHCS P P an s rize o tco a s
Opport nities for ro e p nt Ge	1 For those pro i ers who in icate that they o not ha e a erere call process for i nizations Pro i er Access S r ey), pro i e practice coaching to e owerp the clinic to e elop a s stainable syste 2 Fl vaccinations are the li ting vaccine in C S co liancp; therefore, con cting foc s gro ps to f rther n erstan the root ca ses of fl vaccine hesitancy in Merce Co nty y help to evelop re effective interventions. G
Res lts Q4 G	N/A G
S ry of Q uarterly Acti ities Narrati e G	HSA s'final ali ation fin ings on the C S P P was recei e on 6/12/23 an no f rther s b ssions were req ire Project co lete p
Known Barriers/Root Ca se s) as applicable) G	al 1: No Barriers G
Next Steps G	Project co lete G

Topic G	Chil ren's Do in SWOT G
Do in G a	Q uality of Care G
Priority G	Statewi e Depart nt of Healthcare Ser ices DHCS) Perfor nce G
Co ttee i	Q HEWG
als G	1) O utreach to high ris racial ethnic gro ps in Merce Co nty who are eficient in C S an /or W3 to a ress barriers to care an connect erewith PCP 2) Pro i e e cation on chil ren's pre entati e ser ices to Merce Co nty clinics to s pport clinic staff in ineco ng s bject tter experts (SME) for their clinic 3) S pport practices in xi zing iata opti zation thro gh the Alliance Portal to pro t provi ers to or er all reco n e preventative services. 1. By 11/11/2022 S b ssion 1 Technical Assistance PRN. 2. By 1/30/2023 Strategies, as rable action ite an short-ter objectives. 3. By 5/30/2023 Progress on strategies an action ite . 4. By 9/30/2023 Progress on strategies an action ite . G s
Opport nities for ro e p nt Ge	Contin e exploring options to collect irect erefed bac on barriers to accessing care in Merce Co nty G
Res lts Q4 G	All goals close o t in Q3 G
S ry of Q uarterly Acti ities Narrati e G	Q1 Q3: SWOT 1 Actions A C: The Me er Barrier o treach project was s ccessf l beca se we gaine insight as to: What the top barriers to accessing care were for this eresab le p The type of e cation Q IPH nee s to provi e to parents/g ar ians to increase their n erstan ing of the i ortance of reg lar well-chil visits an ti ly e i nizations. - Best practices when contacting ers ab sharing infor tion regar ing a potential or act al healthcare eficiency. These lessons learne will be taken into consi eration for f t re o treach efforts e by Q IPH staff. SWOT 2 Action A: Pro ting the istrib tion an se of the Alliance's nfant Wellness Map (WM) to Merce Co nty CBOs, clinics, an ers. b This project was a s ccess beca se Q IPH staff s ccessf lly isse nate i the tool in collaboration with the Merce Co nty office of E cation – Hea Start Progra an Merce Co nty P blic Health. Hea Start receive 200 copies of the WM J ne 2023 (75 Spanish, 100 English an 25 H ng) an are actively istrib ting the tool to their Alliance ins re ers. b A itionally, staff have collaborate with Merce Co nty P blic Health, First Five of California, an lo en Valley Health Centers to host a Health Fair for the Merce co nity. The Health Fair occ re on 10/8/2023 an incl e : - An Alliance infor tional booth to pass o t WM. - Fl vaccinations, bloo gl cose checks, bloo press re checks, eye exa an s re.1 o - 35+ exhibitors with infor tional booths. - 'Passport' car s co lete by visiting an learning abo t each exhibitor. - Co lete car s can be entere into a raffle for prizes an a bon s raffle ticket is given to those that receive a fl vaccine at the fair. - Live ra io broa casting fro a local Merce Spanish ra io station. The fl vaccine has been a highlight for this Health Fair to raise awareness for the Merce co nity on the i ortance of fl vaccinations. SWOT 2 Action B: Pe iatric Best Practices Webinar: This project was a s ccess beca se we t o reg goal of con cting a live-session Pe iatric Best Practices Webinar in Q3 of 2023 an excee e the webinar atten ance goal. 38 o t of 69 (55%) external registrants atten e fro 35 ifferent entities an clinics (incl ing 19 fro Merce Co nty). The Pe iatric Best Practices webinar was hoste by Dr. Car la Sosa, a pro nent an high-perfor ng Merce Co nty Pe iatrician, with assistance fro CCAH staff. The webinar recor ing is poste on the Alliance website as a reso rce for provi ers an office staff. The webinar content incl e : AAP Perio icity Sche le, Early Chil hoo & A olescent Well Visits, nizations, Lea Screening, Fl ori e Application, ACEs Screenings, Alliance Reso rces SWOT 3 Action A: Pro te Healthcare Technology grants to Merce Co nty physicians. This effort was a s ccess beca se there were 3 entities fro Merce Co nty that applie for the Healthcare Technology Progra grant; one application was approve , an two are pen ing. A grant of $50,000 was awar e to lo en Valley Health Centers, who serves approxi tely 65,000 Alliance ers within the co nty, to apply towar s Epic Welco & Tonic Health tablets for patient registration, sche ling, an health s rveys an q estionnaires.As of Septe er 2023, there are 2 pen ing applications fro Merce Co nty provi ers that will be internally reviewe an , if reco n e , go to the Boar for approval in October. G

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	SWOT 3 Ac : As f 9/29/2023, s aff has c duc ed Care ased l ce ve (C l F re s c v s s w i h 9 cl cs fr m Merced C . a d a c pa e fur her v s s h s year. l hese v s s, All a ce s aff share ur res urces such as member ce ves a d pr v der p r al rep r s, a d d scuss da a f r perf rma ce mpr veme . Add ally, Ql PH w ll h s a l ve-sess 2024 C l verv ew Oc ber 2023. Q4: O ne f al mee g w i h he DHCS cl sed he pr jec Oc ber 25, 2023 fr m) he f al submiss Sep ember 29, 2023..
K arr ers/R Cause(s (as a l cable)	S aff ur) er,) r) der a) a lab) l y,)member e)duca)
Nex S e s)	C ue r mo e a d d s r bu e he l fa Well ess Ma Merced C u y. P s r ual Ped a r c es Prac ces Web ar Pr der webs e. C ue r mo e er al a d ex er al ech gra ds/fu d g Merced C u y r ders.)

T c)	Ch ld a d Ad lesce Well Care V s s Merced C u y)
D ma)	Qual y f Care)
Pr r y)	S a e de De ar me f Heal hcare Ser ces (DHCS Perf rma ce Impr eme Pr jec (PIP)
C mmi ee)	QIHET W)
G als)	1. y A r l 21, 2023, c mple e f al modules f r DHCS PIP a d summar ze u c mes: 2. WCV PIP SMART G al: y December 31, 2022, use key dr er d agram er e s crease he erce age f ch ld a d ad lesce members wh) rece ve a leas e ch ld a d ad lesce well-care v s w i h a PCP r OB/GYN prac er dur g he erve per d am o g MCO members ages 3-17 years ld, l ked G de Valley Heal h Ce ers - L s a s, fr m 32.65% 48.56% (ra e f peer be chmark [Tayl r Farms Fam ily Heal h & Well ess Ce er – G o zales, CA] M o erey/refere ce c u y .
Op r u es f r Impr eme)	1. Pr) ders) eed bl) ck u me f r d)ed ca ed s)aff) d) re)call)u re)ach a) d) schedule mem)bers wh) are) c mpl)a f r a wel) care s .) 2. Pr r ze heal h equ y s ra eg es by creas g u reach ula s h) l wer ra es.
Resul s Q4)	N/A) P)jec) C) mple ed; G al Me Q2)
Summary f Quar erly Ac es Narra e)	Our f al ra e f r he WCV PIP was 62.61%; 14.05% ab e ur g al ra e f r h s r jec . M odule 4 was submi ed DHCS A r l 21, 2023. DHCS r ded al da f d gs Ju e 2, 2023. We me all requ reme s a d g e a H gh c f de ce le el ra g f r h s PIP. N fur her ac s eed be ake ; h s PIP) cycle s ff c ally cl sed.)
K arr ers/R Cause(s (as a l cable)	N b)rr ers) de) f ed)
Nex S e s)	N e.)

T c)	Well Ch ld V s s he F rs 15 M o hs—S x r M ore Well Ch ld V s s (W30–6) measure)
D ma)	Qual y f Care)
Pr r y)	S a e de De ar me f Heal hcare Ser ces (DHCS Cl cal Perf rm)a ce Impr eme) Pr jec (PIP 2023 2026
C mmi ee)	QIHET W)
G als)	Reduce d s ar y well ch ld s s he f rs 15 m o hs am o g H s a c P ula l g Merced C u y. 1. y quar er 3 2023, c mple e f rs m odules f r DHCS PIP.
Op r u es f r Impr eme)	1. Pr r ze heal h equ y s ra eg es by creas g u reach ula s h l wer ra es.)
Resul s Q4)	l al)al da f CCAH's 2023–26 Cl cal PIP submiss) erf)rmed by he Heal h Ser ces Ad s ry Gr u (HSAG was shared h he heal h la a d resubm i ed 11/1/23 h c rrec s HSAG.)
Summary f Quar erly Ac es Narra e)	2023 2026 DHCS W30 6 PIP submiss was c mple ed. A alys s erf rmed) de fy Merced r ders h h ghes e al f r mpac . N fur her requ reme s fr m HSAG.
K arr ers/R Cause(s (as a l cable)	T D)
Nex S e s)	Pull basel e da a f r 2023 af er year e d a d all g f r cla m lag (l kely May 2024 . De ermi e r der rk h PIP.)

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Topic S	Follow - p ter Emergency Department Visit or Mental Illness—3 Day Follow - p— Total and Follow - p ter Emergency Department Visit or u stance se—3 Day Follow - p—Total S
Domain S	Quality o Care S
Priority S	tatewide Department o Healt care ervices (DHC Non Clinical Per ormance Improvement Project (PIP 3 6 S
Committee S	QIHET WS
Goals S	By quarte 3 3, complete first modules or DHC SPIP. S
Opportunities or Improvement S	1. Improve t e percentage o provider noti ications or members wit D/ MH diagnoses ollowing or wit in 7 days o emergency department (ED visit. . Increase data s aring to Be avioral Healt Delegate. S
Results Q4 S	1. In progress. 11/ 9/ 3 resu mission o 3 6 Non Clinical PIP tep 1 6 S documents sent to H G and DHC . 2. uccess ul. Initial ED noti ication ile sent to Carelon in December 2 23.
ummary o Quarterly ctivities Narrative S	Validation o t e S 3 6 non clinical PIPS eptember su mission was per ormed y t e Healt ervices dvisory Group (H G) and s ared wit t e ealt plan on Octo er 3 t . lliance elected to set up a Tec nical ssistance (T call wit H G and DHC on 11/2 /23 in advance or urt er clari ication o project aim. PIP documentation or steps 1 6 were resubmitted on 11/29/23 with corrections to H G and DHC . Discussions with delegated Behavioral Health provider Carelon have been ongoing, and an initial noti ication ile was submitted to Carelon in December, identi ying lliance members in the emergency department with a substance use disorder or mental health diagnosis matching the F and F M NCQ AHEDI speci ications or the Medi Cal ccountability et (MC).
Known Barriers/Root Cause(s (as applica le S	Patient privacy concerns or protected ealt in ormation created arriers or noti ications. S
Ne t teps S	First Module su mission due in eptember 3. Resu mission in Q4 or validation indings rom H G. nalize initial and subsequent Emergency Department data noti ication process with Carelon and Behavorial Health team in early 2024.

G: BEH VIOR L HE LTH S

Topic S	Eating Disorders S
Domain S	Clinical a ety Member E perience Quality o Care Quality o ervice S
Priority S	Operating Plan S
Committee S	MWG, CQIC, Beacon Oversig t Committee, Healt ervices Finance Committee S
Goals S	By December 1, 3, improve work low process or coordinating and e pediting eating disorder re errals to Be avioral Healt t roug pilot project and t en scaling results to all counties. S
Opportunities or Improvement S	
Results Q4 S	s intended, t e initiative as resulted in improved communication wit county partners. Project to improve work low process or coordinating and e pediting eating disorder re errals, treatment and coordination is in process. anta Cruz County Be avioral Healt and dministration is ollowing newly identi ied process and lliance is reviewing and reimbursing per MO .
ummary o Quarterly ctivities Narrative S	Designed and initiated a work low and process wit anta Cruz County Be avioral Healt and dministration.
Known Barriers/Root Cause(s (as applica le S	Competing priorities or key project sta including JIVS and County E pansion. S
Ne t teps S	Continue to engage in partners ip discussions wit County Mental/Be avioral Healt department sta and leverage t e in ormation learned or process re inement. S

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SECTION C INIC S ETY t

H C INIC S ETY t

Topic t	Grievance and PQI Mana emen t
Domain t	C inica Safe y t
Priori y t	Re u a ory t
Commi ee t	QIHET Wt
Goa s t	. By December 3 , 2023, 00% of Po en ia Qua i y Issues (PQI) are comp e ed wi hin 90 ca endar days of receip . 2. By December 3 , 2023, 00% member rievances opened as PQIs are c osed wi hin 30 days or ess per re u a ory requiremen . t 3. By December 31, 2023, quar erly MD IRR of QoS grievances shall be in 100% agreemen , indica ing QI RNs are resolving cases wi h consis en me hodology. t Quar erly MD IRR shall be a 10% sample of QoS Grievances resolved by QI RN.
Oppor uni ies for Improvemen t	. Main ain adequa e pro ot ra n staffin t ; expedi e ra n in t of new hires. t 2. Opera iona improvemen t s. t
Resu s Q 4 t	. 5 / 5 (00%) PQIs were c osed wi hin he imeframe his quar er. 2. / 8 (9 %) of in erna y referred PQIs were comp e ed wi hin 90 ca endar days, and 36/ 36 (00%) of Member Grievance PQIs were comp e ed wi hin 30 ca endar days or ess. 3. 36/36 (100%) of Quali y of Service member Grievances will be audi ed by he t Medical Direc ors.
Summary of Quar er y c ivi ies Narra ive t	. The eam con inues par icipa in in JIV rainin and is workin wi h Member Grievances re ardin he QI RN C inica ssessmen e emen s ha shou d ransfer from Esse e o JIV . t 2. The SR eam is mi ra in opera iona work o SharePoin for ransparency of pending reviews, s andardizing processes, and efficiency. 3. The PQI eam has paused he au oma ion of Track & Trend o Tableau due o he Clinical Safe y QI Program nalys being on leave of absence. . S affing cons rain s caused a shif in he eams o priori ize regula ory work in t PQI and SR.
Known Barriers/Roo Cause(s) (as app ica e) t	. n SR nurse resi ned, eavin one SR nurse cer ified o perform he DHCS audi oo s. To a evia e he need in he SR eam, one nurse, previous y DHCS cer ified, moved from the PQI eam o assis he curren SR nurse, when app icab e, in mee in re u a ory ime ines for SR/MRR. 2. long wi h he shif in s affing o suppor SR, one PQI RN was on leave of absence. Due o he PQI RN eam shor age of wo nurses, regula ory Member Grievance processing was priori ized, and in ernal 90-day PQI case processing was deferred un il 1) he SR nurse was onboarded and 2) he PQI RN re urned from a t leave of absence. 3. The Clinical Safe y QI Program nalys is on leave of absence, causing a shif of work o he QI Projec Specialis , resul ing in delays in opera ional work impac ing t IRR, Track & Trend, and audi deliverables.
Nex S eps t	. Con inue o par icipa e in JIV rainin t . t 2. Con inue projec s in C inica Safe y o enhance C inica Safe y opera ions and e imina e si oed manua work and re u a ory repor in . 3. Con inue workin wi h HR in Q1 202 for SR RN backfi onboardin . The candida e is a DHCS Mas er Trainer and will come o he eam ready o assume he role. . Work wi h HR in Q1 202 o expand he Clinical Safe y eam by means of t promo ional oppor uni ies and he release of new SR RN posi ions.

Topic E	Facili i R vi w (F R) Manag men E
Domain E	Clinical af E
Priori E	R gula or E
Commi E	QIH T- E
Goals E	1. D c mb r 31 2023 100 of xis ing primar car provid r si s ha had an F R du his quar r w er compl d wi hin hr ars of h ir las F R da . 2. D c mb r 31 2023 100 of prac ic s wh r Cri ical l men s Corr c iv Ac ion Plans (C CAPs) arising from F Rs ar r solv d wi hin 10 busin ss da s. 3. B D c mb r 31, 2023 100% of prac ic s wi h a Corr c iv Ac ion Plans (CAPs) arising from F R submi a plan o addr ss h CAP wi hin 45 cal ndar da s. 4. B D c mb r 31, 2023 100% of prac ic s wi h a CAP arising from F R compl all plann d ac ions wi hin 90 cal ndar da s as vid nc d b v rifica ion b h F R am.
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DATE: May 22, 2024

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

FROM: Tammy Brass, RN, Utilization Management Director

SUBJECT: Utilization Management Work Plan Report for Q4 2023

Recommendation. Staff recommend the Board accept the Utilization Management Work Plan (UMWP) Report for Q4 2023.

Summary. This document provides an overall summary of the UMWP activities for Q4 2023 as well as a general summary of annual Utilization Management (UM) program review.

Background. The UM Workgroup (UMWG) provides guidance and direction to the UM Program and operates under the authority of the Quality Improvement Health Equity Committee (QIHEC). This quarterly summary continues to reflect the outcomes of the changes to the UMWP established for Q4 2023. In addition, projects and Initiatives carried forward from 2022 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. Annual UM Program review is additionally noted in the metrics outlined below.

Q4 2023 Workplan Outcomes and Evaluation

Project and Initiative Outcomes.

Pediatric Case Management. Total California Children's Services (CCS) members decreased 6% over the year from 8,159 to 7,664 total CCS members. Merced and Santa Cruz saw larger volumes of aging out members and slight decreases in each quarter. Monterey continued to see minor increases quarter over quarter.

- Merced Q4 at 4.89% decrease
- Monterey Q4 at .1% increase
- Santa Cruz at .09% decrease

The Pediatric Complex Case Management team continued work throughout 2023 with the Essette system platform replacement (Jiva/ZeOmega). Optimization for both CCS and case management and other key health services functions is under design as the new platform is developed to best align with National Committee for Quality Assurance standards as well as other requirements.

The Alliance developed processes for county expansion, with the new counties of Mariposa and San Benito joining the Alliance in January 2024. Unlike the existing whole child model counties, the new counties are a classic dependent county CCS service model, in alignment with County CCS programs, as well as the Department of Health

Care Services (DHCS). Outreach to the new county CCS partners was a focus for the team closing out the year.

System Transformation Development: Enhanced Case Management and Community Care Coordination. The Enhanced Care Management (ECM) and Community Supports (CS) program saw growth in provider network and capacity. Network expansion was a priority to support increased enrollment.

- Monterey ECM provider network increased from 10 providers in Q1 to 24 in Q4.
- Santa Cruz ECM provider network increased from 10 providers in Q1 to 21 in Q4.
- Merced ECM provider network increased from seven providers in Q1 to 20 in Q4.

Sustained growth was noted as an important component of the ongoing execution of ECM and CS. There was an overall net improvement in ECM enrollment throughout the year. DHCS enrollment targets were set as the original benchmarks. One of three counties met DHCS enrollment targets.

Q4 (end of year):

- Monterey - ECM 49% of DHCS target for enrollment
- Santa Cruz - ECM 111% of DHCS target for enrollment
- Merced - ECM 61% of DHCS target for enrollment

Operational Performance Outcomes

Authorization Turn Around Times. Prior authorization turnaround times remain near goal of 100% (n=99.8), with a continued decrease in authorization volumes noted in Q4, in part due to the Alliance's continued authorization framework development and automation of low denial in network specialty referrals. Overall utilization remains on par with prior quarters. Denial activity remains low, coming in at 1% with most appeals upheld in favor of the plan (77%) and only 12% of total denials resulting in appeal (n=48).

- Goal: 100%
- Results: 99.8%

Prior Authorization Request Determination Metrics. A reduction in overall authorization volumes with denials remain low at 1% in Q4. The majority of appeals were upheld (n=35) in favor of the plan (77%) with only 12% of total denials resulting in appeal (n=48).

The 2023 UM program review reflects a slight decrease in total authorization volumes compared to 2022 (n=1.5%), with a denial rate average of 1.2% throughout the year. 2023 denials reflect a less than 9% appeal rate, with the majority of denials upheld in favor of the plan (n=76%). Decreases in overall authorization volumes are in part a reflection of the plan's ongoing development of the authorization framework, with authorization requirements removed in select low denial areas to further support member access and reduce provider administrative burden.

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Top 10 Prior Authorization Requests Resulting in Medical Necessity Denials. Denials in genetic testing, panniculectomy and power wheelchair accessories continued to trend in 2023, consistent with prior year data.

Inter-rater Reliability Review-Nurses. 100% pass rate for nurses, MDs and pharmacists, with scoring metric at 90% or higher.

Utilization Performance Outcomes

Inpatient Utilization. The Alliance continued to build upon Transitional Care Services (TCS) with Interdisciplinary Team (IDT) meetings held across the counties, expanding into San Benito and Mariposa counties as of January 1, 2024. Collaborative hospital case conferences and dedicated efforts to enhance Residential Care for the Elderly discharge processes continues to expand across all counties, with increasing ECM and CS an integral part of this work.

Overall bed days for Q4 reflected a slight increase over Q3 activity, but consistent with prior activity. The Alliance's comprehensive and collaborative TCS efforts reflected sustained gains in average length of stay (ALOS) reductions, with Q4 reflecting an ALOS of four days, a continued and progressive decline over prior quarters (n=4 days vs 4.6 days). Total bed days were also decreased from highs seen in Q1 of 2023 (n= 319 vs 375). Sepsis, diabetes, hypertensive heart, and chronic kidney disease were among the top diagnoses contributing to bed days, with acute kidney failure and alcohol related disorders also noted across all facilities as primary admitting diagnoses.

The annual 2023 review reflects overall bed days below goal with total admits reflecting a 59% improvement over state averages. Total 30 day readmits reduced over the year with Q4 ending three percentages lower, and overall 2% lower from Q1.

- Goal: 290 Bed Day per thousand/per year (PKPY)
- Results: 282 (Q4)
- YTD Average: 283

Ambulatory Care Sensitive Admission (ACSC). ACSA is well below target goal and reduced from data seen in Q1 across all three counties, with slight increase when noting SC Q2-3 activity. Reductions remain a positive reflection of member access to ambulatory care services, as well as coordination between UM and CCC processes and the plan's proactive TCS interventions in connecting members to care.

- Goal: Dashboard target goal is 8.0
- Results Q1: Santa Cruz: 5.67%, Monterey 6.56% and Merced 7.19%.
- Results Q2: Santa Cruz: 3.73%, Monterey 6.97% and Merced 5.45%.
- Results Q3: Santa Cruz: 4.57%, Monterey 4.91% and Merced 4.68%.
- Results Q4: Santa Cruz: 4.59%, Monterey 5.22% and Merced 7.05%.
- 2023 YTD: Santa Cruz: 4.61%, Monterey 5.96% and Merced 6.18%.

2023. While Merced averages out lower than the ACSA highs seen in Q1, continued work is needed in this area with Q4 2% above other counties. Monterey and Santa Cruz both

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reflected improvements over the year, with all three counties noting increases in Q1 and Q4, likely a reflection of season impacts with RSV, flu and Covid-19 for members with underlying conditions.

Readmissions. The Alliance's continued engagement with external partners across the various post-acute levels of care has shown a greater collaboration in IDT meetings, focusing on member transitions of care across systems, reducing readmissions, and maximizing use of community resources. While further Transitional Care Pilot (TCS) enhancements were rolled out in October 2023, interdisciplinary effort are showing sustained reductions in total 30-day readmission rates, with 2023 reflecting a sustained 2% reduction in total 30-day quarterly readmission rates (n=12% Q1 vs 10% overall).

Total all cause 30-day readmissions measured in at 7.75% (Q1 23 – Q4) with highest 30-day readmission rates among members over age 55 (n=8%).

Annual assessment of 30-day readmission rates reflects forward movement in almost all categories. Increased work in the Santa Cruz over 55 population is needed, with the total readmission rates in Santa Cruz lagging behind other counties. Overall TCS interventions are demonstrating sustained success with ongoing improvements in interventions to move these metrics.

- Goal: Dashboard target 11%,
- Results: 9% (Q4)
- 2023 Average: 10% (2 points under high of 12% seen in Q1)

Alternatives to Acute Inpatient Days – Skilled Nursing Facilities (SNF) and Short Term Rehabilitation (STR). The CR team continued to focus on improving transitions of care for high-risk members as well as enrollment into either enhanced care management or complex case management.

Q4 2023. SNF bed days dropped by 9% as compared to Q3. SPD PKPY decreased by 10% from Q3. There was a significant decrease of 15% in the number of members being readmitted within 30 days of DC from the SNF. This is a result of implementation of the TCS pilot.

2023. After seeing an increase in SNF bed days for Q1, SNF bed days have trended down the remaining quarters with continued focus on alternative placements and collaborative IDT meetings.

Long Term Care (LTC). Q4 saw new admissions return to baseline. Updated Q3 data with corrected counts. Q4 saw a slight decrease in LTC members.

Annual activity remained stable throughout the year with additional TCS pilots in flight to further identify members needing a lower level of care.

Emergency Department Utilization Metric. Total Emergency Department (ED) visits also declined in Q4, though overall percentage of avoidable visits increased slightly to 15%, on par with data seen in Q4 2022, and likely a seasonal variation due to increases in RSV and

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flu activity noted across the state. ED high utilizers remain consistent with prior quarters with Child and Family (n= 13%) and Affordable Care Act expansion groups (n= 9%) comprising the highest percentages of ED utilization. The top four diagnoses for ED utilization included upper respiratory infections, abdominal and pelvic pain, Covid-19, and other unspecified viral infections.

Annual ED utilization reflected a slight decrease in avoidable Medi-Cal child and family ED utilization over the year, with total visits trending up. While total ED visits for Medi-Cal Seniors and Persons with Disabilities increased slightly over the year, the percentage of avoidable ED visits for this population decreased by approximately 2%, with total visits trending up but on par with activity seen in prior quarters and in range of state averages. Medicaid Expansion ED utilization has remained relatively unchanged and consistent with data seen in the prior year. Review of avoidable ED by county reflects decreases in both Merced and Monterey, with Santa Cruz remaining relatively unchanged and below the avoidable ED activity seen in the other counties.

Pharmacy Utilization. Pharmacy Utilization includes Physician Administered Drugs (PADs). Drugs billed as a pharmacy claim are carved out to Medi-Cal Rx for Medi-Cal line of business (LOB) and delegated to MedImpact for Alliance Care In-Home Supportive Services LOB.

Medical Necessity Pharmacy Denials Per Quarter. In Q4 2023, 1,504 authorization requests for PADs were received, and 107 authorizations (7%) were denied. The authorization request volume decreased by 2.7% from the previous quarter, and the denial rate was slightly lower than overall denial rate for 2022 (8%). In 2023 overall, there was a small increase of 1.7% in total authorization volume and similar denial rate compared to 2022. We will continue to monitor the volume and denial rate.

Top Five Physician Administered Drugs that Result in Medical Necessity Denial. Hyaluronic acid continues to be the top denied drug. Prior authorization criteria was reviewed with the Medical Directors and will be sent for independent medical review for their feedback.

Out of Network (OON) Specialist Utilization Metric. An update in the redirection process for OON requests was implemented in Q4 2023 to aid in bridging members to in-network options through the authorization process. The department moved from processing out-of-network authorizations through the denial process and making a CM referral for redirection to approving out-of-network authorizations as modified, providing an approval for the services provided and redirecting the services to an in-network provider within the authorization. CM referrals for members requiring additional support continues to be part of the authorization process. Total OON approvals decreased in Q4 by 62% with this new process (n=646 Q4 vs 1047 Q1).

2023 Review. Ophthalmology remains a top OON provider in all three counties. Continued network development in orthopedics and surgery is another area of focus. Denials remained stable over the year with increases in modified requests in Q4. Overall averages for OON authorizations are up by approximately 200 with a 1.5% increase in denials compared to 2022 (n=5.5 vs 4%)

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Under/Over Utilization Tracking and Reporting. The most frequently utilized services (EMG, Authorization Redesign, IHA, Breast Cancer Screening, Colon Cancer Screening and ED Utilization) are consistent across all four quarters in 2023. In comparison, IHA, Breast Cancer Screening, Colon Cancer Screening were previously underutilized in 2022. These preventative health measures are now being instituted more frequently by providers when compared year over year. The most under-utilized services (Lead Screening, ACE Screening, Mental Health Visits) continue to trend from 2022 and will continue to be monitored as new interventions to improve these metrics and are applied by the plan.

Emerging Under/Over Utilization Analysis. Review for potential emerging over utilized services (Venipuncture, Case Management, BMI, Visual Screening and Medication Review) indicates that members are receiving preventative care measures. Those most under-utilized services (CHW, Dyadic Care, Doula, Street Medicine, Depression Screening) make up a list of recently added benefits which may be more slowly implemented by providers. Continued monitoring of these services in 2024 will provide additional details on their more consistent use by members as the benefits continue to be promoted by providers and new interventions are applied by the plan to increase utilization.

Delegate Oversight Outcomes

Behavioral Health. Behavioral Health (BH) utilization data is consistent with prior quarters, inclusive of all member BH care. Utilization of Non-Specialty Mental Health (NSMH) outpatient services for Merced, Monterey and Santa Cruz counties fall within or exceed the Alliance goal range. Staff will continue to provide regular oversight to monitor Carelon's performance in the NSMH benefit.

Delegated Oversight Quarterly Report Summary. Carelon provides quarterly reports on the 20th of the month following the end of the quarter. These include 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, Mental Health reporting template Carelon Alliance PG reporting, Provider Utilization Data by County, Member Experience trend Report and Clinicians excepting new patients. No additional concerns noted at this time. See below.

Carelon Behavioral Health (Formerly Beacon) UM and MedImpact UM File Audits
Carelon Behavior Health UM File Audit. For review, 10 files are randomly selected. If the first three files pass, no further review is conducted. If any of the first three fail, then all 10 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, and evidence of transitional care planning. Due to UM audit dates, this reporting area always falls one quarter behind. Because of that Q3 data is being reported. There was overall 96% compliance, however one area (timeliness of decisions) was monitored closely due to four of 10 charts having a potential concern. Carelon was provided an action plan to

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resolve. Carelon did investigate the issue and provided a thorough response. Ongoing oversight will be provided. Q4 will be reported on during the Q1 2024 report.

MedImpact Utilization Management File Audit. Audit of five prior authorization request reviews by MedImpact showed 100% compliance with turnaround time and appropriate clinical review based on MedImpact criteria. A corrective action plan is in progress with MedImpact to improve readability for member letters, with changes to be implemented in Q1 2024. Authorization volume was higher than 2022, which was affected by diabetes and weight loss medications. MedImpact PMPM increase was primarily due to members starting new specialty medications.

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

Attachments.

1. Utilization Management Work Plan Q4 2023

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

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

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

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

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

INITIAL WORK PLAN AND EVALUATION APPROVAL:

Submitted and approved by UMWG	Date:	5/10/2023
Submitted and approved by QIHEC	Date:	5/23/2023
Submitted and approved by Board	Date:	5/24/2023

Dennis Hsieh, MD, Deputy Chief Medical Officer

Dale Bishop, MD, Chief Medical Officer — Date: 5/10/2023

Tammy Brass, RN

Tammy Brass, Utilization Management Director — Date: 5/10/2023

FINAL EVALUATION APPROVAL:

Submitted and approved by UMWG	Date:	8/29/2023
Submitted and approved by CQIC	Date:	
Submitted and approved by Board	Date:	

Dennis Hsieh, MD

Dennis Hsieh, MD, Deputy Chief Medical Officer — Date: 8/29/2023

Dale Bishop, MD, Chief Medical Officer — Date: 8/29/2023

Tammy Brass, RN

Tammy Brass, RN, Utilization Management Director — Date: 8/29/2023

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I. Projects and Initiatives

A. Pediatric Case Management

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

2023 Evaluation								
Time Period	**Total # of Eligible members by County**	**# Newly Eligible by County**	**# Aged Out by County**	**# Approved NICU/PICU by County**	**# High Risk Members**	**# Low Risk Members**	**# ICPs**	**Comments/Recommendations**
1st Quarter	Santa Cruz: 1165 Monterey: 3629 Merced: 3365	Santa Cruz: 65 Monterey: 70 Merced: 166	Santa Cruz: 27 Monterey: 74 Merced: 84	Santa Cruz: 30 Monterey: 74 Merced: 56	5031	9028	3210	Total Eligibility CCS members - 8159 CCS Eligibility Trend: .2% increase from previous quarter (8137-8159)/8137) Eligibility Trends by County - Santa Cruz - .08% decrease Monterey - 1.7% increase Merced - 1.1% decrease
2nd Quarter	Santa Cruz: 1094 Monterey: 3654 Merced: 3151	Santa Cruz: 43 Monterey: 143 Merced: 131	Santa Cruz: 29 Monterey: 63 Merced: 54	Santa Cruz: 40 Monterey: 112 Merced: 87	35	51	40	Total Eligibility CCS members - 7899 CCS Eligibility Trend: 3.3% decrease from previous quarter (8159-7899) Eligibility Trends by County - Santa Cruz - 6.5% decrease Monterey - 0.7% increase Merced - 6.8% decrease
3rd Quarter	Santa Cruz: 1088 Monterey: 3693 Merced: 3019	Santa Cruz: 50 Monterey: 110 Merced: 137	Santa Cruz: 47 Monterey: 87 Merced: 89	Santa Cruz: 23 Monterey: 104 Merced: 87	49	51	54	Total Eligibility CCS members - 7800 CCS Eligibility Trend: 3.3% decrease from previous quarter (7899-7800) Eligibility Trends by County - Santa Cruz - 0.5% decrease Monterey - 1.067% increase Merced - 4.4% decrease
4th Quarter	Santa Cruz: 1089 Monterey: 3697 Merced: 2878	Santa Cruz: 44 Monterey: 121 Merced: 126	Santa Cruz: 33 Monterey: 75 Merced: 78	Santa Cruz: 31 Monterey: 118 Merced: 84	56	26	56	Total Eligibility CCS members - 7664 CCS Eligibility Trend: 1.8% decrease from previous quarter (7800-7664) Eligibility Trends by County - Santa Cruz - 0.09% decrease Monterey - 0.10% increase Merced - 4.89% decrease
Year End								

B. System Transformation Development / Community Care Coordination

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

2023 Evaluation					
Time Period		**Objective**	**Contracted Providers By County: Total Numbers and Capacity**	**Member Enrollment Totals by County**	**Comments/Recommendations**
1st Quarter		Support the ongoing development of contracted providers capacity to provide ECM core services, including for new populations of focus.	**Monterey**- 2450, 8 providers **Santa Cruz**- 1900, 10 providers **Merced**-1403, 6 providers, 1 provider with 0 enrolled members	**Monterey**- ECM: 929, 43% of DHCS target **Santa Cruz**- ECM: 1168, 79% of DHCS target **Merce**d- ECM: 577, 46% of DHCS target	Numbers are in member months. Currently tracking capacity and enrollment based on member months as this is consistent with DHCS enrollment targets. Provider capacity is fluid and ECM team and PS are working to ensure true capacity is accurately reflected. Additional providers added to network 1/1/23 and 4/1/23 to suppor new and existing POFs.

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B. System Transformation Development / Community Care Coordination (Continued)

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

2nd Quarter		Align with PS dept to support the contracting and development of new providers to be prepared to support the incoming pediatric populations and 2 new Community Supports (CS) services for 7/1/23.	**Monterey**- 2553, 10 providers **Santa Cruz**- 2330, 10 providers **Merced**-1897, 7 providers	**Monterey**- ECM: 1253, 49% of DHCS target **Santa Cruz**- ECM: 1495, 87% of DHCS target **Merce**d- ECM: 865, 51% of DHCS target	Numbers are in member months. Currently tracking capacity and enrollment based on member months as this is consistent with DHCS enrollment targets. Provider capacity is fluid and ECM team and PS are working to ensure true capacity is accurately reflected. One large provider recinded contract across all three counties. Merced continues to have a provider with no enrolled members. Providers receive a monthly email to provide real-time updates on capacity. Currently, oo not have enough provider capacity to meet target DHCS enrollment expectations. The team continues to work with providers on onboading/training. Provider onboarding/training takes several months up to a full year, which limits capacity. Providers report initial high-capacity capability, however unable to meet reported initial capacity. It has been noted initial starting capacity significantly less than target capacity. 7/1/23 providers not included in this quarter's provider counts, as go-live began Q3.
3rd Quarter			**Monterey**- 3945, 13 providers **Santa Cruz**- 2769, 15 providers **Merced**-2404, 10 providers	**Monterey**- ECM: 1654, 50% of DHCS target **Santa Cruz**- ECM: 1804, 86% of DHCS target **Merce**d- ECM: 1179, 48% of DHCS target	Numbers are in member months. Number of providers as well as member months has incresed since Q2. Will continue to focus on expansion of provider network as we do not have enough provider capacity to meet the projected 2023 DHCS enrollment expectations. The target percent of enrollment has remained the same despite expanding the provider network. This may be due to disenrollments, which can be that a member has successfully met their goals or is no longer engaged in services. The member months are nuanced and due to disenrollments will continue to fluctuate. The team is focused on sharing ECM services with community providers to increase the enrollment and identification of eligible members. Q3 demonstrated an increase in network capacity with minimal change to enrollment.
4th Quarter		Align with PS dept. to provide contracted and noncontracted potential ECM and CS providers with information about the new populations of focus for 2024. Support the expansion of the ECM/CS network to assist these new populations of focus in 2024.	**Monterey**- 7345, 24 providers **Santa Cruz**- 6737, 21 providers **Merced**-10461, 20 providers	**Monterey**- ECM: 2079, 49% of DHCS target **Santa Cruz**- ECM: 2825 , 111% of DHCS target **Merce**d- ECM: 1984, 61% of DHCS target	Noted sustained enrollment over the last quarters, with growth in Santa Cruz and Merced county for enrollment. Santa Cruz in the 4th quarter exceed the target enrollment goals. Provider capacity has continued to increase, some positive correlation with enrollment, however increased capacity has not accounted for a significant increase in enrollment. Program is focused on increasing enrollment numbers and building provider capacity with quality components in mind moving to 2024. Notably, DHCS decreased enrollment targets for 2024 across all counties. The program will continue to work in collaboration with Provider Services and Community Engagement team to keep real time updates to provider capacity as well as provide more community engagement/awareness to increase enrollment.
Year End					Overall growth in provider network and capacity throughout the year. Network expansion was a prioirity in order to support increased enrollment.There was a net improvement in ECM enrollment throughout the year. DHCS enrollment targets were set as the original benchmarks. 1 of 3 counties met DHCS enrollmnet targets. Sustained growth was noted as part of the ongoing execution of ECM and CS

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C. Reducing Readmissions Initiative

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

2023 Evaluation							
Time Period	**Number Interfacility IDTs**	**UM Transitions of Care**	**Merced County 30 day Readmissions**	**Monterey County 30 day Readmissions**	**Santa Cruz County 30 day Readmissions**	**Total 30 day Readmission**	**Comments/Recommendations**
1st Quarter	480	892	9%	13%	12%	12%	Readmits: Total for MC Child & Family, MC-SPD and New MC Members, ACA Expansion. UM TOC based on SW unique TOC member case counts out of Tableau. IDT totals inclusive of STR: 31 weekly (372 STR total), 55 on site Face to Face, 53 Inpatient IDTs. Added WCH, NMC ARU to IDT schedule in Q1 2023.
2nd Quarter	432	1152	10%	11%	8%	10%	Total IDTs= STR/LTACHs Total=312 Q2 2023 STR IDTs (13 wks X 24 IDTs STR) Total=120 Q2 2023 IP IDTs (13 wks X 5 IP Hospitals) Totals: 432 UM TOC metric is focused on MSW CR specific case counts. Additional UM TOC embedded in CR routine TCS and IDT collaboratives. Cont build/expansion underway for TCS processes across facilities. Outcomes reflected in reductions in total 30 day readmissions.
3rd Quarter	484	1279	9%	8%	11%	9%	TCS work reflects continued reductions in readmission rates. with notable progress in Monterey County, potentially an early reflection of robust IDT processes and increased RCFE plcmts. Total=312 Q3 2023 STR IDTs (13 wks X 24 IDTs STR) Total=120 Q3 2023 IP IDTs (13 wks X 5 IP Hospitals) Total=52 Q3 2023 Face/Face IDTs (13 wks X 4 by MSW) Totals: 484 UM TOC metric is focused on MSW CR specific CM case counts. Additional UM TOC embedded in CR routine TCS and IDT collaboratives. Cont build/expansion underway for TCS processes across facilities. Outcomes reflected in reductions in total 30 day readmissions. Readmission data from Tableau: Inpt Utilization Total for MC Child & Family, SPD, New Members, ACA Expansion
C. Reducing Readmissions Initiative (Continued)							
4th Quarter	403	978	9%	9%	10%	9%	Total IDTs=STR/LTACH/GACH Total= STR IDTs (13 wks X 22 IDTs STR) 286 Total=LTACH IDT (13 wks X 4 IDTs) 52 Total= GACH (13 wks X 5 Hospitals) 65 Grand Total= 403 TCS work reflects continued reduction of readmission in Diagnosis Diabetes/Cardiac Disease across all counties. Earlier identification of these members and outreach by TCS team to promote resources to prevent readmissions.(TCS Pilot Excel spreadsheet)
Year End	450	1075	9%	10%	10%	10%	The Alliance's continued engagement with external partners across the various post-acute levels of care has shown a greater collaboration in interdisciplinary team meetings (IDTs), focusing on member transitions of care across systems, reducing readmissions, and maximizing use of community resources. While further Transitional Care Pilot (TCS) enhancements were rolled out in Oct 2023, interdisciplinary efforts are showing sustained reductions in total 30-day readmission rates, with 2023 reflecting a sustained 2% reduction in total 30-day quarterly readmission rates (n= 12% Q1 versus 10% overall).

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II. Operational Performance

A. Routine Prior Authorization Turn Around Time

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

2023 Evaluation				
Time Period	**Goal**	**Results**	**Assessment & Interventions**	**Recommendation for Future**
1st Quarter	100%	99.7%	Authorization volumes 37,936 of 38,040 auths completed timely for a turnaround (TAT) rate of 99.7% (increase from previous quarter).	Twice daily Tableau report in place for assessing TATs and authorization assignments for near 100% rate. Continued cross training and SME development. Ongoing review for process improvement and overall auth reduction opportunities
2nd Quarter	100%	99.7%	Authorization volumes 40,355 of 40,468 auths completed timely for a turnaround (TAT) rate of 99.7% (increase from previous quarter).	Continue with processes in place: Twice daily Tableau report in place for assessing TATs and authorization assignments for near 100% rate. Continued cross training and SME development. Ongoing review for process improvement and overall auth reduction opportunities
3rd Quarter	100%	99.8%	Authorization volumes 38,183 of 38,256 auths completed timely for a turnaround (TAT) rate of 99.7% (increase from previous quarter).	Continue with processes in place: Twice daily Tableau report in place for assessing TATs and authorization assignments for near 100% rate. Continued cross training and SME development. Ongoing review for process improvement and overall auth reduction opportunities. Q3 with additional focus on automating in network specialty referrals and exploration for ECM auth optimizations.
4th Quarter	100%	**99.8%**	Authorization volumes 30,025 of 30,099 auths completed timely for a turnaround (TAT) rate of 99.75%	99.8% compliance with TATs is consistent with the results throughout the year and aligned with >99% compliance with TAT in 2022. Tableau report refresh frequency was increased from twice a day to every 2 hours from 5 am to 9 pm to ensure compliance with TATs. Supervisory oversight and auth assignment/reassignment to focus the team's attention to auths due soonest . Continued team training to enable all nurses to review all auth types in preparation for system replacement and round robin assignment of authorizations. Continued review of program optimization and opportunities for automation in auth process underway.

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B. Prior Authorization Request Determination Metrics

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

2023 Evaluation						
Time Period	**#PA Volume**	**# Medical Necessity Denials**	**# Appeals**	**#Appeals Upheld**	**# Overturned**	**Assessment & Interventions**
1st Quarter	41,573	535	47	41	6	Continued low denial rates at less than 2% (n=1.3) with the majority of denials upheld and only 13% overturned in appeal. Metrics exclude IP/LTC and Rx activity, though appeal activity is low in both categories.
2nd Quarter	42,648	617	32	20	12	Auth volume increased over Q1 with denial rates continued low at 1.4%. A 3% decrease in appeals noted in Q2 with 63% of appeals upheld.
3rd Quarter	40,063	497	54	40	14	Slight reduction in overall auth volumes with denials remaining low at 1.2%. Majority of appeals upheld in favor of plan (74%) and only 10% denials resulting in appeal.
4th Quarter	34,805	401	48	37	11	Reduction in overall auth volumes with denials remaining low at 1%. Majority of appeals upheld in favor of plan (77%) and 12% denials resulting in appeal.
YTD/Year End	39,772	513	45	35	11	Total auth volumes are down approx 2,000 since 2022 (from 161,527 to 159,089) but denial rate continues to be less than 2% (average of 1.2% in 2023). Of denied auths, only 8.8% were appealed. Of those, 76% of appeals were upheld in favor of the plan for the year.

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

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

2023 Evaluation		
Time Period	**List Denials**	**Assessment & Interventions**
1st Quarter	1-2. Genetic testing: WES 81415 (25), 81416 (24). 3. Panniculectomy: 15830 (14). 4-5. WC Accessories: E1028 (12), E0955 (11), 6. Biofeedback: 90901 (10). 7. Oral Device: E0486 (9). 8. Genetic testing: 81406 (8). 9-10. PWC accessories: E0973 detachable armrest (8), E1012 Leg elevator (8)	Denial activity patterns are similar to those seen in prior quarters with genetic testing and PWC accessories reflecting higher denial rates. Important to note that overall denial activity remains low and highest denial category reflects total of 25 denials over the quarter. Similar to genetic testing denials which comprise 3 of the tope ten denial categories, WC accessories reflected in four of the top ten denial rankings in this report are codes shared on the same authorizations. Continued monitoring for elective surgeries warranted with panniculectomy denials noted at 14 and a denial category seen previously.
2nd Quarter	1. Genetic Testing 81422 (57) 2. Panniculectomy 15830 (15) 3-4. Genetic Testing 81404, 81408 (23) 5. Breast Reduction 19318 (13) 6. Prosthetic Implant L8699 (11) 7. Hearing Aid V5298 (10) 8. Genetic Testing 81407 (9) 9-10. PWC accessories E0973, E1028 (18)	Genetic testing continues to comprise four of the top ten denial categories, though overall volume is relatively low with 57 denials for large panel exome sequencing. Other top denial categories are similar to those seen in prior quarters and with relatively low volumes.

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

3rd Quarter	1-2. Genetic testing: WES 81415 (38), 81416 (36) 3. PWC accessories: E0973 (18) 4. Hearing Aid V5298 (13) 5. Panniculectomy 15830 (12) 6. PWC accessories E1028 (10) 7. Genetic Testing 81404 (9), 81406 (9) 8. PWC accessories: E0973 (9) 9. Panniculectomy 15847(8) 10. PWC accessories E0978 (8)	Denial activity patterns are similar to those seen in prior quarters with genetic testing and PWC accessories reflecting higher denial rates. Important to note that overall denial activity remains low and highest denial category reflects total of 38 denials. Elective surgeries (panniculectomy) as another previously seen denial category, with denied volumes higher in Q3 than seen in prior quarters with requests fo a non-covered code not yet reflected in 2023 denial patterns (n=20).
4th Quarter	1 - 7. Genetic testing: 81406 (15), 81415 (14), 81416 (14), 81404 (13), 81405 (13), 81407 (13), 81408 (13) 8. Panniculectomy: 15830 (14) 9 - 10. Genetic testing: 81403 (12), 81401 (11)	Denials in genetic testing, panniculectomy and PWC accessories continue to trend in 2023 which is consistent with the trends in 2022.

D. Inter-rater Reliability Review – Nurses

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

2023 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**	**100%**	Annual measure - Q4 Results 100% of nurse testers passed with a score of 90% or greater.	Continue with current annual testing at minimum. Review testers results so re-education can occur timely.

F. Inter-rater Reliability Review – Physicians

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

2023 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**	**100%**	Annual measure - Q4 Results in reviewing the results for IRR testing all MD's passed with a score of 90% or greater. The newly hired MD has until Q1 to complete the IRR requirement.	Continue with current annual testing at minimum. Review testers results so re-education can occur timely.

G. Inter-rater Reliability Review – Pharmacists

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

2023 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**	**100%**	Annual measure - Q4 Results	N/A

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III. Utilization Performance

A. Inpatient Utilization

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

IHSS							Goal					
Time Period	2022 Admit/K/Y Reported	2023 Admit/K/Y	Admit/K/Y State Average	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	60	69	N/A	5.5	378	363	200	82%	0%	0%	Membership total 639, slight decrease from Q4 (n=646).	ALOS increased from Q4 (n=3.8); continue to monitor for TOC support
2nd Quarter	69	87	N/A	8.9	769	728	200	264%	14.3	7%	Membership total 647, slight increase from Q1 (n=639). Increase in IHSS admits reflected in BD/K/Y and ALOS variance.	ALOS increased from Q1 (n=5.5); continue to monitor for TOC support. Further exploration of ALOS and member specific interventions to move this metric.
3rd Quarter	62	100	N/A	3.9	393		200	97%	5.9	0%	Membership total 679, slight increase from Q1 (n=647). Reported BD/K/Y down from the peak seen in Q2 and aligns w data noted in Q1. Percentage increased over Goal BD/K/Y will adjust when update totals are computed in Q4.	Continue TCS process development with proactive outreach, interventions specific to IHSS population. Q2 Readmits adjusted to 7%, previously noted at 0%, increase likely reflective of post service activity.
4th Quarter	56	65	N/A	2.3	151		200	32%	0%	0%	Membership total 678, slight decrease from Q3 (n=679).. ALOS had a significant drop over Q3 as did IP admissions.	Continue to monitor for trends in ALOS/Admits. Increase TCS in Q2 2024 supported by the additon of 2 FTE decicated to TCS.
YTD/Year End	63	79	N/A	4.9	389		200	95%	6%	5%	Overall readmission rate droped to an average of 5% in 2023. Higher admit rates seen in Q2-3 normalized back to baseline in Q4.	Aggressive TCS member centric work will continue into 2024 with additonal staffing being brought on in Q2. The Alliance's Stratigic Plan 2022-2026 with health equity and person centered care delivery will continue to be the focus in 2024.

Medi-Cal Child and Family Aid Codes							Goal						
Time Period	2022 Admit/K/Y Reported	2023 Admit/K/Y	Admit/K/Y State Average 06/22	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	40	43	58	3.9	165	168	170	1% (under)	27%	3.6	6%	Membership total 246,512, slight increase over Q4. CCS IPBD with a decrease of 2% from Q4.	ALOS consistent for this population; Admits and BD below state averages and within goal target
2nd Quarter	44	44	58	3.8	166	169	170	1% (under)	23.2	2.9	4%	Membership total 248,610, slight increase over Q1. CCS IPBD with a increase of 0.6% from Q1.	ALOS consistent for this population; Admits and BD below state averages and within goal target. Cont. reduction in readmits likely a reflection of robust Peds CCM TOC processes.

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Medi-Cal Child and Family Aid Codes (Continued)

3rd Quarter	45	51	58	3.6	187	182	170	10%	18%	3.0	4%	Membership total 246,301, slight decrease over Q2. CCS IPBD with a increase of 12.6% from Q2. Overall Q3 activity reflecting 10% over target BD/K/Y while readmissions remain favorable.	Continue TOC/TCS process development and proactive outreach for sustained readmisson reductions. Continue to monitor increases in admits, BD/K/Y for any emerging patterns requiring further CM, provider outreach.
4th Quarter	50	52	58	3.8	198	198	170	17%	25.3	3.0	5%	Membership total 239,531, slight decrease over Q3.	Increase in Bed Days for this population group with a 17% variance over goal, which may reflect an opportunity for increased TOC/TCS support for the pediatric population.
YTD/Year End	45	45	58	4.0	190	190	170	12%	26.6	3.1	5%	Overall increases in plan membership noted in 2023, which have likely impacted increased Be days. Total Admit K/Y still below state averages.	Overall readmits remained low throughout the year, while total bed days increased. This could be a reflection of increased RSV activity noted across the plan's service areas as well as overall increased membership. Continued TCS interventions for pediatric members to further reduce bed days, though ALOS has remained stable and total admits below state averages.

Medi-Cal Seniors and Persons with Disabilities Aid Codes							**Goal**						
Time Period	**2022 Admit/K/Y Reported**	**2023 Admit/K/Y**	**Admit/K/Y State Average 06/22**	**ALOS**	**BD/K/Y Reported**	**BD/K/Y Updated**	**BD/K/Y**	**Variance**	**% CCS**	**ACSA %**	**Readmits %**	**Assessment**	**Interventions**
1st Quarter	224	226	418	6.0	1360	1405	1300	8%	10.8	14%	21%	Membership total 16,615, slight decrease over Q4.Readmits with a 3% increase from Q4 though ALOS decreased from prior 6.4 as did PKPY (Q4 n=243)	Continued TOC support for SPD population. While impacts noted with decreased ALOS, readmission rate reflects potential opportunity for additional post DC support. Metrics below state average; slighly above BD/K/Y goal of 1300.
2nd Quarter	246	230	418	6.1	1405	1387	1300	7%	10.5	12.1	16%	Membership total 16,658, slight decrease over Q1.Readmits with a 31.3% decrease from Q1 though ALOS increased from prior 6.0 as did PKPY (Q1 n=226)	Continued TOC support for SPD population. While impacts noted with slight increase in ALOS, readmission rate reductions reflects potential early impacts of increased TOC support. Metrics below state average; slighly above BD/K/Y goal of 1300.
3rd Quarter	227	223	418	5.4	1194	1194	1300	8% (under)	13.6	8.6	12%	Membership total 16,475, slight decrease over Q2. Readmits with a 33.3% decrease from Q2, a continued reduction from the Q1 high of 21%.	Continued TOC support for SPD population. Impacts noted with slight decrease in ALOS. Readmission rate reductions reflects sustained early impacts of increased TOC support. Metrics below state average; also slighly above BD/K/Y goal of 1300.
4th Quarter	237	229	418	5.5	1259	1262	1300	3.25%	11.5	14	15%	Membership increased in Q4 and overall SPD bed days uynder goal and LOS in line with prior quarters.	Cont TOC support for SPD population. Overall admits well below state averages for this grouping and reflect success of current interventions.
YTD/Year End	234	230	418	5.9	1347	1341	1300	-3%	11.2	12.2	19%	Annual review reflects very slight increase in bed days over goal, with ALOS averaging out below Q1. Total admits remained consistently below state avg.	Cont ongoing TOC supports. Reductions in Readmits were sustained most the year, with a slight increase heading into the 4th quarter and partially reflecting seasonal variances with increased flu, RSV and Covid.

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New Medicaid Expansion Members (i.e. former LIHP, as well as new M aid code and 7U/7W aid code members)							Goal						
Time Period	**2022 Admit/K/Y Reported**	**2023 Admit/K/Y**	**Admit/K/Y State Average 06/22**	**ALOS**	**BD/K/Y Reported**	**BD/K/Y Updated**	**BD/K/Y**	**Variance**	**% CCS**	**ACSA %**	**Readmits %**	**Assessment**	**Interventions**
1st Quarter	71	73	77	5.1	371	377	375	< 1%	1.4	7.7	14%	Membership increased by 3k from Q4 to 118, 675. ALOS down from 5.6 in Q4 along w reduced readmit rate from Q4 rate of 14%. PKPY remains consistent w prior Q.	Cont TOC support with goal of further impacts to 30 day readmit rates. Metrics slightly below state average and remain slighly below BD/KY goal.
2nd Quarter	73	71	77	4.7	332	320	375	14% (under)	1.8	7.2	12%	Membership increased by from Q1 (n=118,675) to 121,763. ALOS down from 5.1 in Q4 along w reduced readmit rate from Q1 rate of 14%. PKPY remains consistent w prior Q.	Cont TOC support with goal of further impacts to 30 day readmit rates, with 2% reduction noted. Metrics slightly below state average and remain slighly below BD/KY goal.
3rd Quarter	76	82	77	4.6	376	376	375	0%	3.3	5.9	10%	Membership decreased from Q2 (n=121,763) to 120,088. ALOS continues to decrease along w reduced readmit rate from Q2.	Cont TOC support with goal of further impacts to 30 day readmitand ALOS rates. Metrics align with state average and remain on target for BD/KY goal.
4th Quarter	72	73	77	4.9	362	358	375	3.60%	3.5	6.8	13%	Q4 reflects stable LOS, bed days below target and consistently higher 30-day readmission rates.	Increased TOC support for this population to impact Readmission rates. Fluctuations in membership noted throughout the year may be a reflection of disenrollments further contributing to increased readmits.
YTD/Year End	73	71	77	5	348	354	375	6%	3	7	13%	2023 review of this population reflects consistent metrics not yet seeing great movement with interventions applied.	Consider alternate strategies to further impact care metrics for this population; increased focus on ECM, CS, street medicine and proactive strategies beyond routine TCS services.

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A. Inpatient Utilization

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

							Goal					
Time Period	**2022 Admit/K/Y Reported**	**2023 Admit/K/Y**	**Admit/K/Y State Average 06/22**	**ALOS**	**BD/K/Y Reported**	**BD/K/Y Updated**	**BD/K/Y**	**Variance**	**ACSA %**	**Readmits %**	**Assessment**	**Interventions**
1st Quarter	57	60	147	4.7	281	287	290	1%	6.9	12%	Membership with 1.5% increase at 381,803. total PKPY reduced from Q4 (n=65) with slight reduction in ALOS and increase in 30 day readmits by a percentage.	Progress noted in reduced PKPY IP admits and IP bed days (281 vs 318). Cont TOC support with added focus on 30 day readmit reduction. Metrics well below state averages and goal.
2nd Quarter	62	60	147	4.5	272	269	290	7%	6.0	9%	Membership with 1.4% increase at 387,031. Decrease in ALOS and decrease in 30 day readmits by a 25%.	Cont to widen TOC interventions as early gains are noted in reduced ALOS, readmits and total BD/K/Y. Metrics well below state averages and goal.
3rd Quarter	62	68	147	4.2	290	290	290	0%	4.9	7%	Membership with 1.08% decrease at 382,864. Decrease in ALOS along with continued decrease in 30 day readmits.	30 day readmission rate average for 2023 coming in at 9%, a 2% reduction from readmit rates seen in 2022. TOC/TCS interventions reflect impacts across the various service lines with additional reductions in ALOS.
4th Quarter	65	67	147	4.4	296	282	290	2.0	6.0	9%	Q4 redmits slightly increased over Q3 but consistent with prior activity. Total bed days lower than goal with total admits well below state average. ALOS consistent w prior quarters	Cont to widen TOC interventions as consistent gains are noted in reduced ALOS, readmits and total BD/K/Y. Metrics well below state averages and goal.
YTD/Year End	62	61	147	5	283	282	290	3%	6.0	10%	Annual Review - Overall bed days favorable, below goal with total admits refelcting a 59% improvement over state averages. Total 30 day readmits reduced over the year with Q4 ending 3 percentages lower.	Cont to widen TOC interventions as consistent gains are noted in reduced ALOS, readmits and total BD/K/Y. Metrics well below state averages and goal. 3% decrease in 30 day readmits when comparing Q1 to Q4.

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

Ambulatory Care Sensitive Admissions (ACSA) per region. The occurrence of hospital admissions due to ACSAs is often considered as an indicator of the effectiveness of primary care services and the accessibility of outpatient care. Lower rates of ACSAs are generally associated with better primary care management and preventive health services, while higher rates may suggest gaps or deficiencies in primary care provision.

Time Period	Santa Cruz ACSA %	Monterey ACSA %	Merced ACSA %	Assessment	Interventions
1st Quarter	5.67	6.56	7.19	Metrics within ranges noted in prior quarters (2022 Merced 7.2%; Monterey 5.8%, SC 4.6%). Slight increase noted in SC and Monterey.	Continue to monitor
2nd Quarter	3.73	6.97	5.45	Metrics continue in range as prior quarters. Slight increase in Monterery, while SC and Merced show early declines.	Cont to widen TOC interventions.
3rd Quarter	4.57	4.91	4.68	ACSA reduced from data seen in Q1 across all three counties, with slight increase when noting SC Q2-3 activity. Reductions a positive reflection of member access to ambulatory care services.	Cont to widen TOC/TCS interventions, including PCP and specialty referral coordination as applicable.
4th Quarter	4.59	5.22	7.05	Merced remains several percentages higher than the other two counties and increases in Q4 may reflect seasonal variances with increased flu, RSV, Covid. Monterey slightly increased over Q3 but much improved over first half of year. SC continuing below 5% as a decreasing trend for the year.	Increased focus on Merced County Primary Care and preventive care access with opportunity for closed loop referrals and increased ECM/CS connections.
YTD/Year End	4.61	5.96	6.18	While Merced averages out lower than the ACSA highs seen in Q1, continued work is needed in this area with Q4 2% above other counties. Monterey and SC both reflected improvements over the year, with all three counties noting increases in Q1 and Q4, likely a reflection of season impacts with RSV, Flu, Covid for members with underlying conditions.	Increase targeted outreach for vulnerable populations: Asthma, COPD, DM, HTN, UTI, CHF. Continue work underway in developing street medicine access and alternative measures to connect members to care, particularly in underserved areas. Explore widened telehealth in 2024 as well as provider incentives to increase acces to preventive services.

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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	**8.05**	10.71	13.18	11.02	0.9	7.24	11.17	14.79	11.24	1.1	9.42	8.94	14.5	10.13	1.1	Similar readmission rates as noted in prior quarters. Opportunity for added focus in > 55 YO populations.
2nd Quarter	7.35	10.11	12.87	10.49	0.9	6.06	10.87	14.24	10.76	0.9	7.31	8.5	13.93	9.43	0.9	Declines noted in all three counties, as well as in all categories. Continue to build upon TOC interventions for sustained reductions.
3rd Quarter	7.18	9.92	12.97	10.36	0.9	6.44	10.10	13.82	10.26	0.9	8.36	8.83	13.93	9.80	0.9	Total readmission rates continue to show favorable declines in all three counties. Additional TOC support to further impact the over 55 population as this group remains in the 13-14% range in all three counties.
4th Quarter	7.27	9.39	14.55	10.43	0.8	5.33	9.66	13.78	9.73	0.5	5.66	8.89	13.65	9.49	0.5	Total readmission rates remain stable or slightly decreased. TCS (TOC) pilot remains in place and additional staff in Q 2 2024 will be added to increase the current efforts in place.
YTD/Year End	7.46	10.03	13.39	10.58	0.88	6.27	10.45	14.16	10.50	0.85	7.69	8.79	14.00	9.71	0.85	Annual Assessment of 30 day readmission rates reflects forward movement in almost all categories. Increased work in the SC over 55 popluation is needed, with the total readmission rates in SC lagging behind other counties. Overall TCS interventions are demonstrating sustained success with sustained improvements in these metrics.

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	1467	353	1360	268	63	Significant (41%) increase in SNF Beddays over prior quarter with Q4 at 1042 and prior PKPY at 251 (+ 41%). Increased membership likely a factor though higher complexity discharges remain as largest predictor for LLOS; Additional increase in STR, though volumes lower than noted in early 2022. CR SNF team has increased IDTs for timely TOC and additionally providing on site reviews for LLOS	Increase IDTs and face to face assessments. Continue to monitor for isolated increase vs ongoing trend. Of note, prior year reflected a Q2 increase with similar metrics.
2nd Quarter	1355	325	1383	270	56	Q 2 saw an 8% decrease in STR Beddays over Q1 and a manual audit of authorizations confirms shorter stays are occuring then in previous quarters. The remaining metrics remain stable with a overall 8% drop in SPD PKPY	IDTs have been increased with CCAH particpating in approximately 300 IDT meetings in Q2 supporitng TOC work required by DSCH.
3rd Quarter	1211	300	1193	300	61	Overall SNF bed days dropped 10% in Q3 as compared to Q2. SPD PKPY decreased by 8% from Q2. There was also a 10% increase in total members placed in short term rehab.	Transitions of care work has brought closer monitoring of STR members and the actual LOS vs difficulty in identifying the least restrictive placements for these members. The TOC work is assisiting with moving members to the next LOC more efficiently.
4th Quarter	1113	272	1259	256	52	SNF bed days dropped by 9% as compared to Q3. SPD PKPY decreased by 10% from Q3. There was a significan decrease of 15% in the number of members being readmitted with in 30 days of DC from the SNF. This is a result of implementaiton of the TCS pilot.	Decrease in readmits is a result of TCS (TOC) pilot and the work of UM and CCC teams managing members closely after DC.
YTD/Year End	5595	1345	1347	273	58	After seeing a spike in SNF bed days for Q1, SNF bed days have trended down in the remaining quarters.	TCS (TOC) has looked at a variety of alternative placments for members rather then placement in a SNF. Home with supportive services, RCFE's Board and Care homes are all alternative options considered.

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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	229	1730	288	1442	New admissions down 6% from Q4 high of 243; however, total still higher than noted in prior quarters and overall # of LTC increased 7% over 2022 metrics, likely a reflection of normalizing post pandemic activity in combination with increased membership	Cont to monitor LTC utilization; IDTs and TOC in place with face to face and on site visits where indicated.
2nd Quarter	234	1731	297	1434	New admissions are stable in Q1 and 2 while admissions remain higher then seen in 2022, again a post pandemic relflection of facilites accepting more members.	Will monitor new admissions for trends. In Q2, increased intensity of TOC activites where put in place to support members moves to more independent LOC.
3rd Quarter	96	1849	293	1551	New admissions are up 7% over the previous quarter.	TOC activites have increased and members eligible for a LLOC have been placed in the least restrict enviroment.
4th Quarter	216	1722	305	1417	New admission are back at baseline, Updated Q3 data with corrected counts. Q 4 saw a slight decrease in LTC members.	Total members in LTC has decreased in Q4. The UM TCS (TOC) pilot team will increase efforts to ID members needing a LLOC.
YTD/Year End	194	1758	295	1396	Q 3 saw the highest increase in LTC authorizations. The remaining quarters were stable across the board.	Continue TCS efforts, increase ECM involement in transfers to LLOC..

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	17.44	536	586	N/A	N/A	N/A	Total ED visits at 85 with total 2022 count at 232; volume consistent w prior quarters.	Cont TOC support to further impact avoidable visits
2nd Quarter	16.16	610	635	N/A	N/A	N/A	Total ED visits at 99 with total 2022 count at 236; volume consistent w prior quarters.	Cont TOC support to further impact avoidable visits

F. Emergency Department (Continued)

3rd Quarter	15.25	347	631	N/A	N/A	N/A	Total avoidable visits for Q3 at 9 (potential claims lag), with Q2 at 16 and Q1 at 18, reflecting a progressive decline. ED PMPM totals higher in Q1-2 and coming in low in Q3, though claims lag likely a factor. 3/25/24 - total updated from 526 to 631	Progressive outreach to HR IHSS members to continue reductions in avoidable ED. Continued TOC supports potentially impacting progressive reductions in percentage avoidable visits.
4th Quarter	17.38	548	659	N/A	N/A	N/A	Total avoidable ED increased over Q3 but consistent with data in prior quarters	TOC outreach to IHSS HR members
YTD/Year End	16.14	507	622	N/A	N/A	N/A	Annual review reflects overall totals coming in lower than the highs noted in Q4. Increased avoidable visits in Q1, Q4 may reflect seasonal variances and an opportunity to further focus interventions.	Potential for increased outreach and preventive health connection for members in higher utilizing quarters Q1, Q4, Further analysis may reflect opportunity to increase flu, covid, rsv vaccine campaigns if this is noted as a contributing factor for seasonal variances.

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Medi-Cal Child and Family				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 06/22	% CCS Visits	Assessment	Interventions
1st Quarter	20.55	266	421	400	-33%	333	21.67	Fewer CCS visits than noted in Q4 (n=26%), PKPY reduced with reduction in avoidable visits overall from Q4.	Below state average and goal metrics for this population, cont. to monitor with TOC and PHM support.
2nd Quarter	19.7	471	486	400	-22%	333	19.7	Fewer CCS visits than noted in Q1 (n=21.67%), PKPY reduced with reduction in avoidable visits overall from Q1. Metrics on target w those seen in prior quarters and down from the Q4 2022 high of 23% avoidable ED.	Below state average and goal metrics for this population, cont. to monitor with TOC and PHM support.
3rd Quarter	17.14	473	527	400	-32%	333	17.14	Fewer CCS visits than noted in Q2 (n=19.7%). Total ED with declines from highs seen in Q2. Variance still reflecting totals above goal, though avoidable continues with downward trend, 3% reduction from Q1 2023.	Extending TCS interventions/outreach for contined reductions in avoidable ED and CCS visits.
4th Quarter	21.62	526	564	400	-41%	333	21.62	Q4 reflects an increase in avoidable visits, with data higher than noted in Q1 highs and corresponds with increased admits for this population.	Increased TCS interventions to support seasonal variances with higher avoidable ED in Q1, Q4. Total visits continued above goal and may need warrant additional review of baseline for and codes captured in this category to ensure data is not overreporting from other aid codes.
YTD/Year End	19.7	477	511	400	-28%	333	19.7	Overall percentage of CCS ED visits remained consistent over the year, with early improvements in avoidable visits that climbed back up in Q4. Continued over state avg for this population.	Further analysis of seasonal variances to maximize TCS opportunities. Additional review of aid codes populating metrics to further assess achieveability of goal.

Medi-Cal Seniors and Persons with Disabilities				Goal					
Time Period	Avoidable Visits %	Total Visits/K/Y Reported	Total Visits/K/Y Updated	Total Visits K/Y	Total visits: Variance	Total Visits K/Y State Average 06/22	% CCS Visits	Assessment	Interventions
1st Quarter	12.59	780	793	900	-12%	975	18.72	Overall visits reduced from highs seen in Q4; Percent avoidable remains consistent w Q4 activity and below state averages.	Avoidable visits > 12% may reflect opportunity for increased SPD support for PHM and TOC.
2nd Quarter	11.63	769	817	900	-9%	975	11.63	Adjusted avoidable visits for Q1 in ast 9.3% with Q2 reduced further at 8.8%.metrics align with activity in prior quarters. Slight increase in ED paid per visit.	Avoidable visits reduced; cont focus on SPD populations for TOC and PHM.
3rd Quarter	9.34	956	831	900	8%	975	9.34	Q3 reflects increase in total visits with a simultaneous decrease in avoidable ED, slighly over 3% from Q1. Overall metrics for SPD population remain slightly above target, but still in below state averages.	Continue TCS interventions.
4th Quarter	11.18	1008	1045	900	-16%	975	11.18	Q4 reflects total ED visits for SPD members above goal with avoidable visits lower than first half of the year but 2 points over prior quarter.	TCS interventions for SPD population to decrease avoidable ED. Increased ECM/CS connection as an opportunity to improve metrics.
YTD/Year End	11.03	919	871	900	3%	975	11.03	Annual summary: overal total visits under goal by 3% with avoidable ED below Q1-2 highs.	Heading into 2024: TCS interventions for SPD population to decrease avoidable ED. Increased ECM/CS connection as an opportunity to improve metrics.

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Medicaid Expansion (i.e. former LIHP, as well as new M aid code and 7U/W aid code members)				**Goal**					
Time Period	**Avoidable Visits %**	**Total Visits/K/Y Reported**	**Total Visits/K/Y Updated**	**Total Visits K/Y**	**Total visits: Variance**	**Total Visits K/Y State Average 06/22**	**% CCS Visits**	**Assessment**	**Interventions**
1st Quarter	11.79	137	553	500	11%	543	22.22	Data consistent w prior quarters. % avoidable reduced from Q4 highs but remains higher than early 2022 rates in the 9-10% ranges. Current visit counts appear lower than recent prior quarters. (total visits q4 1680)	Avoidable visits near 12% and near goal metrics, reflects opportunity for increased ACA support for PHM and TOC.
2nd Quarter	10.91	452	477	500	4.6% (under)	543	10.91	Data on par with prior quarters. Slight increase in total ED paid, similar to that seen in SPD population.	Avoidable visits further decreased at 9.6%, potentially an early reflection of increased PHM and TOC supports.
3rd Quarter	9.77	517	480	500	12%	543	9.77	On target with prior quarters. CCS ED visits with a significant reduction as well as overall avoidable visits.	Continued reductions in avoidable visits with overal total visits near target, slight increase from Q2. Cont with TCS and CM interventions in progress.
4th Quarter	10.42	542	559	500	12%	543	10.42	Total visits over goal by 12% with avoidable visits remaining consistent with prior quarters. Metrics noted in Q4 are very similar to those noted in Q1 and a potential reflection of seasonal variances. Total visits over state avg.	Continued work on proactive outreach, ECM/CS connections to further impact avoidable visits and to bring values below state avg. for this population.
YTD/Year End	11	509	517	500	12%	543	10.56	Annual Summary: 2023 reflects consistent activity with the pop grouping with slight decreases in avoidable visits and total visits averaging lower than state for the year.	Heading into 2024 - cont TCS interventions, proactive outreach and alternative care delivery systems - consider maximizing telehealth, street medicine, ECM/CS utilization to further engage members in preventive and wellness care.

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	11.62	70	18.90	207	17.48	158	Note: weighted average goal for total Medi-Cal ED visits for 2022 (in Alliance Dashboard) is 590. County data consistent w prior quarters, decreases noted in all three counties from highs seen in Q4. Monterey with % avoidable at 19% (35% noted in Q4); SC % avoidable down from high of 18% noted in Q4.	Overal ED PKPY at 436 for Q1, down from 2022 average of 495 and Q4 high of 566 PKPY across all counties and program LOBs. Cont PHM and TOC activities will likely continue to impact further reductions in avoidable ED.
2nd Quarter	14.03	78	18.35	231	15.21	172	Decrease in avoidable ED in SC county with decreases in both Merced and Monterey. Data consistent with prior quarters.	Cont PHM and TOC activities/proactive outreach
3rd Quarter	11.02	81	15.49	234	13.47	173	Decrease in avoidable ED in all 3 counties. Though total visits have increased quarter to quarter/2023, total avoidable ED visits have had up to a 4% decrease (Merced), with data in other counties following similar reduction patterns.	Cont PHM and TOC activities/proactive outreach
4th Quarter	13.25	88	20.45	270	15	197	Q4 with increased avoidable ED visits in all counties, with Monterey exceeding 20% and noting a 5% increase.	Cont PHM and TOC activities/proactive outreach. Leverage alternate delivery systems: Street medicine, telehealth, ECM/CS to further support primary care and wellness connections.
YTD/Year End	12	82	18.18	246	15.1	180	2023 Summary - Avoidable ED visits for all three counties reflect an opportunity for continued focus as well as seasonal variances with increases noted in Q4. Total ED visits per quarter consistent in SC, with Monterey and Merced reflecting sustained increases in activity.	Heading into 2024 - cont TCS interventions, proactive outreach and alternative care delivery systems - consider maximizing telehealth, street medicine, ECM/CS utilization to further engage members in preventive and wellness care. Added focus to Monterey and Merced counties for overall increases in avoidable ED.

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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	1404	77	1	0	1	0	5.5% denial rate, which is less than overall 2022 denial rate of 8%. Auth volume increased by 16% from 1Q2022, and by 9% from previous quarter. Appeal volume remains very low.	Continue to monitor.
2nd Quarter	1589	146	3	0	3	3	9.2% denial rate, which is slightly higher than overall 2022 denial rate (8%). Auth volume increased by 13% from previous quarter. Appeal volume remains low. 1 SFH was withdrawn after the medication was approved via an appeal. 1 SFH and 1 IMR were redirected to Medi-Cal Rx.	Continue to monitor if the trend continues for auth volume and denial rate.
3rd Quarter	1545	155	9	4	5	0	10% denial rate, which is slightly higher than overall 2022 denial rate (8%). Auth volume decreased 2.8% from previous quarter. Appeal volume remains low however has increased since last quarter including 4 upheld and 5 overturned appeals in Q3	Continue to monitor if the trend continues for appeal, auth volume and denial rate.
4th Quarter	1504	107	3	1	2	0	7% denial rate which is a drop from prior 2 quarters. Auth volume decreased by 2.7% from prior quarter. Appeal volume remains low and has decreased since last quarter with 1 upheld and 2 overturned appeals	Continue to monitor if the trend continues for appeal, auth volume and denial rate.
Year End	6042	485	16	5	11	0	1.7% increase in total auth volume from previous year and 8% denial rate overall, which is similar to 2022 (7.5%).	Continue to monitor.

Top 5 Physician Administered Drugs that Result in Medical Necessity Denial

List top 5 Pharmacy prior authorization medical necessity denials, by volume.

Time Period	List of drugs	Comments	Interventions
1st Quarter	1. hyaluronan or derivative (Hyalgan, Supartz, Visco-3) 2. ferric carboxymaltose 3. normal saline, denosumab, pegfilgrastim excludes biosimilar (Neulasta), zoledronic acid	Similar medications as previous year, but with less number of denials. After analyzing PA and claims history, no suggested changes to PA requirement or criteria of ferric carboxymaltose per Pharmacy & Therapeutics Committee.	Continue to monitor.
2nd Quarter	1. epoetin beta (for ESRD on dialysis) 2. hyaluronan or derivative (Hyalgan, Supartz, Visco-3) 3. denosumab 4. ferric carboxymaltose 5. hyaluronan or derivative (Genvisc 850)	Similar medications as previous quarter except for epoetin beta.	Change in PA criteria for epoetin beta has been approved by P&T Committee effective 9/1/23. Montior if it changes the number of denials.
3rd Quarter	1. hyaluronan or derivative (Hyalgan, Supartz, Visco-3) 2. onabotulinimtoxina 3. ferric carboxymaltose 4, denosumab 5. ferumoxytol	Similar medications as previous quarter except onabotulinimtoxina, new Alliance Policy 403-1153 approved 7/31/2023	Continue to monitor
4th Quarter	1. hyaluronan or derivative (Hyalgan, Supartz, Visco-3) 2. ranibizumab 3. denosumab 4. faricimab-Svoa 5. ferumoxytol	Hyalruonic acid continues to be in top 5. Increase seen with anti-VEGF agents (ranibizumab and faricimab).	Prior authorization criteria for hyaluronic acid and denial reasons were discussed with Medical Directors. Peer-to-peer discussion was done by Pharmacy Director with providers with high denial rate.
Year End	1. hyaluronan or derivative (Hyalgan, Supartz, Visco-3) 2. denosumab, epoetin beta, ferric carboxymaltose 5. onabotulinumtoxina	Commonly denied drugs have been mostly consistent throughout the year, with some shift seen after changes in PA criteria and drug-specific policy.	PA criteria for hyalruonic acid will be sent to Independent Medical Review for feedback. PA criteria for ranibizumab and faricimab will be reviewed in 2024 Q2 Pharmacy & Therapeutics Committee. Denosumab will also be reviewed in 2024.

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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	1,369	1,047	67	169	Merced:Surgery ortho (93), Opthalmology (36), Cardiovascular (29), Podiatry 11), Otolaryngology (9), Monterey: Opthalmology (12), Gastroenterology (6), Other (12), Surgery (3) Santa Cruz: Other (6), Neuro (6), Surgery Ortho (4)	Cont. network development, particularly in Merced County. Ortho surgeries an OON access in all three counties
2nd Quarter	1,361	980	83	224	Merced: Opthamology (39), Other (42), Orhtopedic Surgery (40) Monterey: Opthalmology (7), Other (21), Surgery (3), Santa Cruz: Opthalmology (5), Other (7), Surgery-Plastic (8)	
3rd Quarter	1,508	1,089	92	230	Merced: Opthalmology, Other, Orthopedic Surgery Monterey: Opthalmology, Other, Surgery, Santa Cruz: Opthalmology, Other, Surgery-Plastic	Q3 OON utilization similar to activity noted in prior quarters. Increase in overall volumes with subsequent increase in denial activity. Approvals for Q3 on par with volumes noted in Q1. Anticipate continued reductions in this metric with auth optimization and Alliance conifiguration updates to specialty referrals,
4th Quarter	1246	646	64	387	Merced: Opthalmology (21), Other (25), Cardiovascular (22), Otolaryngology (34) Monterey: Opthalmology (9), Other (16), Surgery (6), Santa Cruz: Opthalmology (2), Other (10), Neuro (2)	An update in the redirection process was implemented in Q4 2023 to aid in bridging members to in-network options through the authorization process. The department moved from processing out-of-network auths through the denial process and making a CM referral for redirection to approving out-of-network auths as modified - providing an approval for the services provided and redirecting the services to an in-network provider within the authorization. CM referrals for members requiring additional support continues to be part of the authorization process.
YTD/Year End	1,371	941	76	253	2023 Review - Opthalmology remains a top OON provider in all three counties. Continued network development in orthos and surgery another area of focus.	Average OON auths up approx 200 with a 1.5% increase in denied OON auths (5.5% compared to 4% in 2022).

I. Under / Over Utilization Tracking and Reporting

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

2023 Evaluation				
Time Period	**Monitored Category**	**Over or Under**	**Assessment**	**Interventions**
1st Quarter	1.EMG 2. Auth Redesign Codes (As identified) 3. IHA 4. Breast Cancer Screening 5. Colon Cancer Screening 6. Lead Screening 7. ACE Screening 8. Mental Health Visits 9. ED Utilization	1.Over 2. Over 3. Under 4. Under 5. Under 6. Under 7. Under 8. Under 9. Over	Q1 UMWP data reflects the following Claims activity, with percentages measured against Claims activity in prior quarter (Q4 2022). ACE at 9462 claims, a 48% increase over prior quarter (n=6401). Breast Cancer Screening at 6631 claims, a 2% decrease over prior quarter (n=6773). Colorectal Cancer Screening at 5754 claims, a 3% increase over prior quarter (n=5573). EMG at 422 claims, a 21% decrease over prior quarter (n=531). Initial Health Assessment at 78,442 claims, a 5% increase over prior quarter (n=75658). Lead Screening in Children at 5830 claims, a 17% increase over prior quarter (n=4977). Depression screening remains unchanged from prior quarter and likely reflects incomplete capture of screening activity with new metric, consistently noting fewer than 50 claims/quarter.	Additional metrics being added to further monitor depression screening, dyadic care, doula benefit utilization.
2nd 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	Q2 UMWP data reflects the following Claims activity, with percentages measured against Claims activity in prior quarter (Q1 2023). ACE at 11,105 claims, a 17% increase over prior quarter (n=9462). Breast Cancer Screening at 5273 claims, a 26% decrease over prior quarter (n=6631). Colorectal Cancer Screening at 4768 claims, a 21% decrease over prior quarter (n=5754). EMG at 195 claims, a 46% decrease over prior quarter (n=422). Initial Health Assessment at 58,191 claims, a 35% decrease over prior quarter (n=78,442). Lead Screening in Children at 4856 claims, a 20% decrease over prior quarter (n=5830). Depression screening remains unchanged from prior quarter and likely reflects incomplete capture of screening activity with new metric, consistently noting fewer than 50 claims/quarter.	

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Under / Over Utilization Tracking and Reporting (Continued)

3rd 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	Q3 UMWP data reflects the following Claims activity, with percentages measured against Claims activity in prior quarter (Q2 2023). ACE at 12,162 claims, a 9.5% increase over prior quarter (n=11,105). Breast Cancer Screening at 5,035 claims, a 4.7% decrease over prior quarter (n=5,273). Colorectal Cancer Screening at 4,882 claims, a 2.4% increase over prior quarter (n=4,768). EMG at 256 claims, a 32% increase over prior quarter (n=195). Initial Health Assessment at 64,692 claims, a11% increase over prior quarter (n=58,191). Lead Screening in Children at 4,765 claims, a 2% decrease over prior quarter (n=4,856). Depression screening remains unchanged from prior quarter and likely reflects incomplete capture of screening activity with new metric, consistently noting fewer than 50 claims/quarter.	Continue to monitor for trends. Proactive CM outreach for members needing additional sceening. Additional focus for Breast Cancer screening, Lead screening as a focus closing out the year. MH screening captured in delegate oversight reporting. ED utilization noted under operational performance indicates general increased ED activity and an overall reduction in avoidable ED rates. Increased communication with facilities in Q3 for ED TCS support likely a factor in favorable metric outcomes in this area.
4th 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. Over 4. Over 5. Over 6. Under 7. Under 8. Under 9. Over	Q4 UMWP data reflects the following Claims activity, with percentages measured against Claims activity in prior quarter (Q3 2023). ACE at 14,090 claims, a 15.9% increase over prior quarter (n=12,162). Breast Cancer Screening at 6,823 claims, a 35.5% increase over prior quarter (n=5,035). Colorectal Cancer Screening at 6,426 claims, a 31.6% increase over prior quarter (n=4,882). EMG at 336 claims, a 31.2% increase over prior quarter (n=256). Initial Health Assessment at 76,464 claims, a18.2% increase over prior quarter (n=64,692). Lead Screening in Children at 5,157 claims, a 8.2% increase over prior quarter (n=4,765). Depression screening remains unchanged from prior quarter and likely reflects incomplete capture of screening activity with new metric, consistently noting fewer than 50 claims/quarter.	The most over utilized services (EMG, Auth Redesign, IHA, Breast Cancer Screening, Colon Cancer Screening and ED Utilization) are consistent across all 4 quarters in 2023. In comparison, IHA, Breast Cancer Screening, Colon Cancer Screening were previously under-utilized in 2022. These preventative health measures are now being instituted more frequently by providers. The most under-utilized services (Lead Screening, ACE Screening, Mental Health Visits) continue to trend from 2022 and will continue to be monitored.

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. 1159F (274) MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA) 2. 1160F (274) REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTIT 3. 3008F (233) BODY MASS INDEX (BMI), DOCUMENTED (PV) 4. 36415 (224) COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE 5. 99173 (213) SCREENING TEST OF VISUAL ACUITY, QUANTITATIVE, BIL	1. CHW (8) 2. Dyadic Care (2) 3. Doula (0) 4. Street Medicine (tbd) 5. Depression screening (11)	1. Misc Non Benefit codes (supplies, pdn) 2. Z codes, EPSDT 3. Nerve Conduction tests 4. Misc. Dressings/medical supplies 5. Hearing evals, Z codes	1. T1000-T5999, Not valid for Medicare (496) 2. Z4300 - Z5999, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (321) 3. 95905-95913, Nerve Conduction Tests (308) 4. A6000-A6412, Dressings (278) 5. Z0312-Z5936, Other (247)	Top 5 "over" do not reflect true overutilization; categories are as noted in prior quarters reflective of PCP and wellness care with med reconciliation, lab and vision testing. Top 5 "under" utilizaton are new benefits and/or new screening metrics. Depression screening reporting under further development as are networks for the new CHW, dyadic care, doula and Street Medicine benefits. Though CHW utilization is minimal to date, anticipate an uptick in future quarters with new network development in Q1. Top NTR codes are of benefit types as noted. Utilization is minimal and in similar proportion as noted in previous quarters. Q3 reflects a claims lag, metrics for varoius channels preortin
2nd Quarter	1. 1160F (1831) REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACTIT 2. 1159F (1830) MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA) 3. 3008F (1713) BODY MASS INDEX (BMI), DOCUMENTED (PV 4. G9012 (1223) OTHER SPECIFIEDCASE MANAGEMENTSERVICE NOTELSEWH 5. J0887 (776) INJECTION, EPOETIN BETA, 1MICROGRAM, (FORESRDON	1. CHW 2. Dyadic Care 3. Doula 4. Street Medicine 5. Depression screening	1. Misc Non Benefit codes (supplies, pdn) 2.Nerve Conduction tests 3. Misc. Dressings, medical supplies 4. Z codes, EPSDT 5. Pulmonary rehab	1. T1000-T5999, Not valid for Medicare (1276) 2. 95905-95913, Nerve Conduction Tests (308) 3. A6000-A6412, Dressings (724) 4. Z4300 - Z5999, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (621) 5. Pulmonary Diagnostic Testing, Rehabilitation, and Therapies (520)	

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Emerging Under / Over Utilization Analysis (Continued)

3rd Quarter	1. 3008F (3958) Body Mass Index 2. G9012 (2337) OTHER SPECIFIED CASE MANAGEMENT SERVICE NOT ELSEWHERE 3. 1159F (2241) MEDICATION LIST DOCUMENTED IN MEDICAL RECORD (COA) 4. 1160F (2072) REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACT 5. 2001F (1680) WEIGHT RECORDED	1. CHW 2. Dyadic Care 3. Doula 4. Street Medicine 5. Depression screening	1. Misc Non Benefit codes (supplies, pdn) 2. Misc. Dressings, medical supplies 3. Nerve Conduction tests 4. Z codes, EPSDT 5. Pulmonary rehab	1. T1000-T5999, Not valid for Medicare (1621) 2. A6000-A6412, Dressings (927) 3. 95905-95913, Nerve Conduction Tests (891) 4. Z4300 - Z5999, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (762) 5. Pulmonary Diagnostic Testing,Rehabilitation, and Therapies (673)	Utilization on par with prior quarters, Emerging higher utilization areas reflect combined transitional care services with case management and medication reviews noted in the top five utilizing code categories for all LOB. Continued network development in progress for CHW, street medicine and doula services. EPSDT utilization on track. Pulmonary rehab increases as a continued reflection of covid post recovery activity. Nerve conduction tests an area of continued monitoring and within range for Alliance population.
4th Quarter	1. 36415 (7068) COLLECTION OF VENOUS BLOOD BY VENIPUNCTURE 2. G9012 (6247) OTHER SPECIFIEDCASE MANAGEMENTSERVICE NOTELSEWH 3. 3008F (5573) Body Mass Index 4. 99173 (4856) SCREENING TEST OF VISUAL ACUITY, QUANTITATIVE 5. 1160F (3227) REVIEW OF ALL MEDICATIONS BY A PRESCRIBING PRACT	1. CHW 2. Dyadic Care 3. Doula 4. Street Medicine 5. Depression screening	1. Misc Non Benefit codes (supplies, pdn) 2. Misc. Dressings, medical supplies 3. Nerve Conduction tests 4. Z codes, EPSDT 5. Pulmonary rehab	1. T1000-T5999, Not valid for Medicare (2221) 2. A6000-A6412, Dressings (1271) 3. 95905-95913, Nerve Conduction Tests (1156) 4. Z4300 - Z5999, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (927) 5. Pulmonary Diagnostic Testing,Rehabilitation, and Therapies (863)	The emerging over utilized services (Venipuncture, Case Management, BMI, Visual Screening and Medication Review) indicates that members are receiving preventative care measures. Those most under-utilized services (CHW, Dyadic Care, Doula, Street Medicine, Depression Screening) make up a list of recently added benefits which may be more slowly implemented by providers. Continued monitoring of these services in 2024 will provide additional details on their more consistent use by members as the benefits continue to be promoted by providers.

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IV. UM Delegate Oversight

A. UM Delegate Oversight Quarterly Report (Analysis Summary)

Time Period	Delegate	Report Due Date	Reports Received	Reports Required	Follow-up Plan
Q4-22: Reported - Q1-23	Carelon	3/23/2023	3/22/2023	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	BHT Timely Access Data report requested.
Q1-23: Reported - Q2-23	Carelon	6/20/2023	6/20/2023	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 Mental Health reporting template Carelon CCAH PG reporting Provider Utilization Data by County Member Experience trend Report Clinicians excepting new patients	Identify reports received/ frequency and work with Carelon to specify meaning and context for reporting-BH team to work with Carelon to steamline process.
Q2-23: Reported - Q3-23	Carelon	7/20/2023	7/20/2023	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 Mental Health reporting template Carelon CCAH PG reporting Provider Utilization Data by County	Work with Carelon to identify additional data needs and gaps within reporting. Had some questions and minor corrections on reports for Q2 that carelon fixed/responded to.
Q3-23: Reported - Q4-23	Carelon	10/20/2023	10/20/2023	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 Mental Health reporting template Carelon CCAH PG reporting Provider Utilization Data by County Member Experience trend Report Clinicians excepting new patients	Potential Auth/denial UM audit concern noted regarding ensuring timely notification . Working with carelon to identify concerns and remedy.

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B. Medi-Cal Mental Health Utilization Rates

Carelon Behavioral Health (Carelon), formerly Beacon Health Options (name changed 3/1/2023), is contracted with the Alliance to provide Non-specialty Behavioral health services. Carelon supplies this data in a quarterly report that is presented in quarterly meetings with each County Behavioral Health Department. Utilization percentage rates for children and adolescents and for adults are reported by for each county managed by the Alliance. Utilization rates reflect a rolling 12-month measurement ending at the quarter. Utilization percentage is calculated by dividing the number of unique members in each age cohort within each County into the number of members that have received Carelon services from that same County and age cohort within each quarter. Utilization percentage goals were developed by Carelon and are based on best reviewing data from other states, national benchmark data, historical data on county mental health utilization, and the structure of the California delivery system. The goals are in a mature market of three years of operation (market maturity: lower rates are expected in new markets and higher ranges are typical for mature markets with 3-5 years of Carelon presence)

Time Period	Santa Cruz	Monterey	Merced	GOAL	Assessment	Interventions
1st Quarter					Overall penetration (utilization of outpatient services) Merced, Monterey and Santa Cruz Counties fall within or exceed the Alliance goal range. With the Strategic Plan initiatives, the Alliance is interested in partnering with Carelon to grow BH utilization, especially in Merced and Monterey counties.	Continue Carelon oversight and monitor performanace and reporting.
0-12	8.93%	6.20%	4.96%	2.5% - 4%		
13-18	14.85%	8.58%	7.32%	2.5% - 4%		
19+	14.11%	6.90%	7.02%	4.5% - 6.5%		
2nd Quarter					Overall utilization remains stable and within or above goal range.	Department staff will continue to monitor delegate performance and encourage outreach to bolster equity across service areas.
0-12	9.11%	6.32%	4.99%	2.5% - 4%		
13-18	14.85%	8.54%	7.23%	2.5% - 4%		
19+	13.86%	6.96%	6.97%	4.5% - 6.5%		
3rd Quarter					Data consistent with prior quarters, inclusive of all member BH care. Utilization of Non Specialty Mental Health (NSMH) outpatient services for Merced, Monterey and Santa Cruz Counties fall within or exceed the Alliance goal range.	Active Carelon oversight monitoring of the NSMH Delegate's performance continues.
0-12	8.30%	5.62%	4.39%	2.5% - 4%		
13-18	12.65%	7.12%	5.81%	2.5% - 4%		
19+	12.04%	6.24%	5.68%	4.5% - 6.5%		
4th Quarter					Data consistent with prior quarters, inclusive of all member BH care regardless of whether it falls in the Physical or Behavioral health network . Utilization of Non Specialty Mental Health (NSMH) outpatient services for Merced,	Continue Carelon oversight and close monitoring of the NSMH Delegate's performance continues.
0-12	9.37%	6.56%	5.15%	2.5% - 4%		
13-18	14.63%	8.43%	6.84%	2.5% - 4%		
19+	13.64%	7.88%	6.80%	4.5% - 6.5%		

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C. Carelon UM File Audit

Review occurring every quarter that looks at previous quarter UM work. For review,10 files are selected. If the first three files pass, no further review is conducted. If any of the first three fail then all ten 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	100%	File reviews showed compliance.	Evaluate file review process for improvements to ensure full picture is being presented.
2nd Quarter	100%	File reviews showed compliance.	Continue to review files quarterly; identify areas for growth and improvement
3rd Quarter	96%	File reviews showed compliance.	1 of the 17 areas of audit-Timeliness of UM determination notification, had 4 of 10 charts with area of concern. Specific followup was done with Carelon on this action which led to carelon investigating issue and reporting a mail delivery concern that had impacted email reciept during the dates of the charts in question . Ongoing monitoring of this area will be reviewed closely.
4th Quarter	99%	1 chart had error. All other areas and File reviews showed complaince	Continue to review files quarterly; identify areas for growth and improvement . Identified chart to Carelon of Um area of improvement for timeliness of decision making due to 1 error not meeting standard.

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	100%	N/A	N/A
2nd Quarter	100%	N/A	N/A
3rd Quarter	100%	N/A	N/A
4th Quarter	100%	N/A	Met with MedImpact compliance team regarding the readability of member letters. MedImpact to implement process changes in 2024Q1.

Line of Business	Per Month (PMPM) Cost						Change from 2022
	2022	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2023 YTD	
IHSS	$131.96	$164.62	$192.76	$187.32	$210.69	$188.85	43.11%

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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	28	6	1	1	0	10 auths were for 2 members, to allow different strengths of Wegovy. Otherwise, auth volume and denial rate are similar to previous year.
2nd Quarter	36	7	0	0	0	15 PAs were for 3 members, to allow different strengths of Wegovy. 2 PAs were for vacation supply. Starting 7/1/23, electronic PAs are accepted and would make it easier for prescribers to submit PAs. Recommended to add an exclusion criteria to GLP1 agonists.
3rd Quarter	34	5	0	0	0	5 PAs were for 1 member to allow for different strengths of Wegovy. 7 PAs were for one member early fills (medication lost or stolen). Otherwise, auth volume and denial rate are similar to previous quarters.
4th Quarter	34	9	1	1	0	5 PAs were entered for same member approved for different strengths of Wegovy. Most denials were for formulary exception requests for different drugs.
Year End	132	27	2	2	0	Higher auth volume throughout the year compared to 2022, likely affected by PAs for multiple strengths of Wegovy. Majority of PAs were for weight loss and diabetes medications.

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DATE: May 22, 2024

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

FROM: Tammy Brass, RN, Utilization Management Director

SUBJECT: Alliance Utilization Management: 2023 Annual Program Review

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Recommendation. Staff recommend the Board accept the Alliance Utilization Management (UM) 2023 Annual Program Review. This initiative reflects our commitment to excellence, continuous improvement, and adherence to regulatory standards in UM.

Summary. This document provides an annual program review for UM program activities. An annual program review by the UM Work Group (UMWG) ensures ongoing alignment with best practices, regulatory compliance, and quality improvement within the UM Program. It strengthens our ability to adapt to industry changes and enhance operational efficiency.

Background. The Annual UM Program Review relies on the guidance and oversight provided by the UMWG. The annual review of inpatient key performance indicators (KPIs) provides valuable insights into the impact of utilization management and care coordination activities. The increased effectiveness in reducing admissions and bed days indicates the success of these initiatives. Involving a diverse range of stakeholders in Interdisciplinary Team (IDT) meetings enhances collaboration and promotes holistic care for members.

Annual UM Program review includes factors such as:

- Annual review and recommendation of Program Policy.
- Quarterly review and approval of the work plan.
- Approval and implementation oversight of utilization management criteria and policies.
- Analysis of summary data for actionable recommendations.
- Development and recommendation of medical policies and clinical guidelines.
- Monitoring of delegated utilization management activities per Alliance Policy 105-0004 – Delegate Oversight.

Discussion. Staff recommend continuing the annual review of inpatient KPIs and the involvement of key stakeholders in IDT meetings. These practices have contributed to the program's success in reducing admissions and improving care coordination, aligning with our goal of delivering high-quality, member-centered care.

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

Attachments.

1. Alliance Utilization Management: 2023 Annual Program Review

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Alliance Utilization Management:
2023 Annual Program Review

Inpatient Utilization Data:

The Plan also reviews inpatient Key Performance indicators to identify effectiveness of its utilization management and care coordination activities. In 2023 this program has been increasingly effective in reducing overall admissions and bed days. The Plan has increased its care coordination and transitional care services programs significantly over the last 12 months to involve medical directors, nurses, care managers, care coordinators, enhanced care management and utilization review staff in routine interdisciplinary team (IDT) meetings. The interdisciplinary team discusses complex cases during the IDT meetings and identifies ways to better engage members and support successful care transitions.

Key Performance Indicator	2022	2023	2022/2023 Comparison
No. Inpatient Admits	27,545	26,903	2.33% decrease
Inpatient Admits/thousand	68	64	5.88% decrease
Bed Days	132,012	122,263	7.38% decrease
Average LOS	4.8	4.5	6.25% decrease
Average Members	404,332	421,181	4.17% increase

Key Findings:
Quantitative Analysis

- The Alliance met its goal of reducing ALOS and overall bed days by greater than 5%.
- The Alliance effectively reduced total inpatient admissions by more than 2% while seeing an increase in average membership of over 4%.
- Number of Admissions: There was a slight decrease in the total number of admissions from 27,545 in 2022 to 26,903 in 2023.
- Admissions per Thousand: The admissions per thousand also decreased from 68 in 2022 to 64 in 2023, indicating a lower rate of admissions relative to the population or patient base.

- Bed Days: There was a decrease in bed days from 132,012 in 2022 to 122,263 in 2023, suggesting a reduction in the overall utilization of inpatient beds.
- Average Length of Stay (LOS): The average length of stay decreased from 4.8 days in 2022 to 4.5 days in 2023, indicating that patients spent slightly less time on average in the hospital during the latter year.

Statistical Significance

To determine the statistical significance of the differences between 2022 and 2023 for key performance indicators (No. Inpatient Admits and Bed Days), the Alliance compared the calculated chi-square statistics with the critical chi-square value at a chosen significance level (e.g., 0.05) with appropriate degrees of freedom (df). The degrees of freedom for a chi-square test of independence are calculated as (number of categories - 1). Null hypothesis represents no significant difference between 2022 and 2023 metrics.

In both cases, the chi-square statistics exceed the critical chi-square value at the chosen significance level, indicating that the differences in No. Inpatient Admits and Bed Days between 2022 and 2023 are indeed statistically significant:

No. Inpatient Admits:

- Calculated chi-square statistic: $\chi^2=7.568$
- Degrees of freedom (df): 1 (2 categories - 1)
- Chosen significance level: 0.05
- Critical chi-square value (from chi-square distribution table or calculator) with df = 1 and alpha = 0.05: approximately 3.841
- Since $\chi^2 > 3.841$, we reject the null hypothesis. Therefore, there is a statistically significant difference in the number of inpatient admits between 2022 and 2023.

Bed Days:

- Calculated chi-square statistic: $\chi^2=374.26$
- Degrees of freedom (df): 1 (2 categories - 1)
- Chosen significance level: 0.05
- Critical chi-square value (from chi-square distribution table or calculator) with df = 1 and alpha = 0.05: approximately 3.841
- Since $\chi^2 > 3.841$, we reject the null hypothesis. Therefore, there is a statistically significant difference in bed days between 2022 and 2023.

Conclusion of Quantitative Analysis:
In summary, the Inpatient Utilization Data table represents notable improvements in all KPIs noted, including overall reductions in total admits, inpatient bed days and average length of stay. This is an indicator of the Plan's successful transitions of care support, early discharge intervention and improved member engagement across the care continuum. These sustained and progressive outcomes are reflective of the Alliance's increased focus on transitions of care support, care management interventions and strategic efforts to additionally impact 30-day readmission rates and Emergency Department utilization.

Qualitative Analysis:

Achievements:

1. Improved Outpatient Care: Enhanced outpatient services, preventive care, and proactive management of chronic conditions may have led to a reduction in the number of inpatient admits.
2. Efficient Care Coordination: Effective care coordination among healthcare providers, utilization management teams, and case managers may have optimized patient care pathways, leading to shorter length of stay and reduced bed days.
3. Utilization of Residential Care for the Elderly and Alternative Post Discharge Placement Strategies: Increased utilization of RCFE and Congregate Living might have contributed to better discharge outcomes, post discharge monitoring and management of patient health, reducing the need for inpatient admissions.
4. Patient Education and Engagement: Robust patient education programs and increased patient engagement in self-management strategies could have resulted in better health outcomes, decreasing the need for extended hospital stays.
5. Increased Interdisciplinary Team Meetings: Care conferences for complex members held routinely across the Plan's service areas increase both internal and external engagement in discharge planning, transitional care services, and member focused care, reducing overall bed days and supporting sustained reductions in average length of stay.

Opportunities for Improvement:

1. Enhanced Transitional Care: Strengthening transitional care programs to facilitate smoother transitions between care settings and improve post-discharge support can further reduce readmissions and length of stay.
2. Optimized Utilization Management: Implementing data-driven utilization management strategies and leveraging predictive analytics can help identify at-risk patients early and intervene proactively to prevent unnecessary admissions.
3. Provider Collaboration: Promoting greater collaboration and communication among healthcare providers, including primary care physicians, specialists, and allied health professionals, can enhance care continuity and reduce duplication of services.
4. Patient-Centered Approach: Focusing on personalized care plans tailored to individual patient needs, preferences, and social determinants of health can lead to better outcomes and reduced reliance on inpatient services.

Challenges to Achieving and Sustaining Goals:

1. Limited Access to Timely Care: Challenges in accessing timely outpatient care, diagnostic services, or specialist consultations can delay diagnosis and treatment, leading to higher acuity cases and increased inpatient admissions.
2. Fragmented Care Coordination: Fragmented communication and care coordination among different providers and healthcare settings may result in gaps in care, delayed transitions, and suboptimal outcomes.
3. Resource Constraints: Resource constraints such as limited hospital beds, staffing shortages, or financial pressures may impact the ability to accommodate patients efficiently, affecting bed days and length of stay.
4. Patient Socioeconomic Factors: Socioeconomic factors like lack of access to transportation, housing instability, or financial barriers can hinder patients' ability to adhere to treatment plans, leading to readmissions and prolonged hospital stays.

DATE: May 22, 2024

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

FROM: Tammy Brass RN, Utilization Management Director

SUBJECT: Utilization Management Work Plan – 2024

Recommendation. Staff recommend the Board accept the 2024 Utilization Management Work Plan (UMWP) goal development.

Summary. This document provides an overall summary of the 2024 UMWP projects and initiatives to be monitored and updated for progress toward goals. This initiative will provide a structured framework for achieving excellence in utilization management, operational efficiency, and delegate oversight.

Background. Annual UMWP goal development relies on the guidance and oversight provided by the UMWG. 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.

- The UMWP outlines goals in four key sections:
    1. Projects and Initiatives: Includes strategic initiatives to enhance utilization management effectiveness and member care.
    2. Operational Performance: Focuses on optimizing operational processes to improve efficiency and resource utilization.
    3. Utilization Performance: Aims to monitor and improve utilization metrics, such as admissions, bed days, and readmissions.
    4. Delegate Oversight: Ensures effective oversight and management of delegated utilization management activities.

Discussion. The UMWP goal development aligns with our strategic objectives and organizational priorities. Setting clear goals in these critical areas will drive continuous improvement, enhance member outcomes, and promote cost-effective utilization management practices.

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

Attachments.
1. 2024 Utilization Management Work Plan

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Summary of Changes for 2024 UM Work Plan Template

Added Expansion Counties: San Benito and Mariposa

Projects and Initiatives

A. Pediatric Case Management: No changes
B. System Transformation Development / Community Care Coordination: Objectives updated for 2024
C. Reducing Readmissions Initiative: Updated to reflect 2023 Strategic Goals - Total 30 day HR Readmissions and Total ED visits for HR members

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.

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Central California Alliance for Health
2024 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: _____

Submitted and approved by QIHEC Date: _____

Submitted and approved by Board Date: _____

_____ _____

Mike Wang, MD, Medical Director Date:

_____ _____

Dennis Hsieh, MD, Chief Medical Officer Date:

N/A _____ _____

Tammy Brass, RN, Utilization Management Director Date:

FINAL EVALUATION APPROVAL:

Submitted and approved by UMWG Date: _____

Submitted and approved by QIHEC Date: _____

Submitted and approved by Board Date: _____

_____ _____

Mike Wang, MD, Medical Director Date:

_____ _____

Dennis Hsieh, MD, Chief Medical Officer Date:

_____ _____

Tammy Brass, RN, Utilization Management Director Date:

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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. *Note: data displayed is unique new values per quarter, not "to date"*

2024 Evaluation								
Time Period	Total # of Eligible members by County	# Newly Eligible by County	# Aged Out by County	# Approved NICU/PICU by County	# High Risk Members	# Low Risk Members	# ICPs	Comments/Recommendations
1st Quarter								
2nd Quarter								
3rd Quarter								
4th Quarter								
Year End								

B. System Transformation Development / Community Care Coordination

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

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

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C. Reducing Readmissions Initiative

To support reducing hospital readmissions, UM and CCC will track and evaluate the impact of Population Health Management and Transitions of Care activities as it relates to reductions in readmissions for members participating in these services. **Person Centered Strategic Goal 2: Improve the system of care for members with complex medical social needs. Goal is a 5% change downward year over year for 30-day all-cause readmissions and ED visits (per 1K/PMPY) for high risk members.** **HR READMISSIONS: 2024 Target: 13.4% (2022 Baseline 14.9% / 2023 Target 14.2% / 2025 Target 12.8% / 2026 Target 12.1%)**
HR ED VISITS (per 1000 PMPY): 2024 Target 2,403 (2022 Baseline 2,663 / 2023 Target 2,530 / 2025 Target 2,283 / 2026 Target 2,169)

2024 Evaluation							
Time Period	Total 30 Day Readmissions for HR Members	30 Day Readmits for HR Members Merced County	30 Day Readmits for HR Members Monterey County	30 Day Readmits for HR Members Santa Cruz County	30 Day Readmits for HR Members Mariposa County	30 Day Readmits for HR Members San Benito County	Comments/Recommendations
1st Quarter							
2nd Quarter							
3rd Quarter							
4th Quarter							
Year End							

2024 Evaluation							
Time Period	Total ED Visits for HR Members (per 1000 PMPY)	Total ED Visits for HR Members Merced County	Total ED Visits for HR Members Monterey County	Total ED Visits for HR Members Santa Cruz County	Total ED Visits for HR Members Mariposa County	Total ED Visits for HR Members San Benito County	Comments/Recommendations
1st Quarter							
2nd Quarter							
3rd Quarter							
4th Quarter							
Year End							

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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).

2024 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.

2024 Evaluation						
Time Period	#PA Volume	# Medical Necessity Denials	# Appeals	#Appeals Upheld	# Overturned	Assessment & Interventions
1st Quarter						
2nd Quarter						
3rd Quarter						
4th Quarter						
YTD/Year End						

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

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

2024 Evaluation		
Time Period	List Denials	Assessment & Interventions
1st Quarter		
2nd Quarter		
3rd Quarter		
4th Quarter		

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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.

2024 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**			

F. Inter-rater Reliability Review – Physicians

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

2024 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**			

G. Inter-rater Reliability Review – Pharmacists

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

2024 Evaluation				
Time Period	**Goal**		**Comments**	**Recommendation for Future**
Q4 Yearly	**100%**			

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III. Utilization Performance

A. Inpatient Utilization

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

IHSS									Goal					
Time Period	2023 Admit/K/Y Reported	2024 Admit/K/Y			Admit/K/Y State Average	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	60				N/A				200					
2nd Quarter	87				N/A				200					
3rd Quarter	100				N/A				200					
4th Quarter					N/A				200					
YTD/Year End					N/A				200					

Medi-Cal Child and Family Aid Codes (OTLIC + other)									Goal						
Time Period	2023 Admit/K/Y Reported	2024 Admit/K/Y			Admit/K/Y State Average 12/22	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	43				56				170						
2nd Quarter	44				56				170						
3rd Quarter	51				56				170						
4th Quarter					56				170						
YTD/Year End					56				170						

Medi-Cal Seniors and Persons with Disabilities Aid Codes (SPD+Dual)									Goal						
Time Period	2023 Admit/K/Y Reported	2024 Admit/K/Y			Admit/K/Y State Average 12/22	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	226				453				1300						
2nd Quarter	230				453				1300						
3rd Quarter	223				453				1300						
4th Quarter					453				1300						
YTD/Year End					453				1300						

New Medicaid Expansion Members (i.e. former LIHP, as well as new M aid code and 7U/7W aid code members) (ACA+Other)									Goal						
Time Period	2023 Admit/K/Y Reported	2024 Admit/K/Y			Admit/K/Y State Average 12/22	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	% CCS	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	73				93				375						
2nd Quarter	71				93				375						
3rd Quarter	82				93				375						
4th Quarter					93				375						
YTD/Year End					93				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). (12/22: Admit bed days per K/Y at 11.9 with ALOS of 6)

									Goal					
Time Period	2023 Admit/K/Y Reported	2024 Admit/K/Y			Admit/K/Y State Average 12/22	ALOS	BD/K/Y Reported	BD/K/Y Updated	BD/K/Y	Variance	ACSA %	Readmits %	Assessment	Interventions
1st Quarter	60				71				290					
2nd Quarter	60				71				290					
3rd Quarter	68				71				290					
4th Quarter					71				290					
YTD/Year End					71				290					

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

Ambulatory Care Sensitive Admissions (ACSA) per region.

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

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C. Readmissions (%)

*30-day Readmissions per region

	Santa Cruz %					Monterey %					Merced %					Mariposa %					San Benito%					Assessment & Interventions
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	0-18 YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	0-18YO	19-55 YO	Over 55 YO	Total Readmission %	% CCS	
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 Note: DHCS Popluation Aid Code Groupings may differ slightly from Tableau.

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 12/22	% CCS Visits	Assessment	Interventions
1st Quarter						400		445			
2nd Quarter						400		445			
3rd Quarter						400		445			
4th Quarter						400		445			
YTD/Year End						400		445			

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 12/22	% CCS Visits	Assessment	Interventions
1st Quarter						830		839			
2nd Quarter						830		839			
3rd Quarter						830		839			
4th Quarter						830		839			
YTD/Year End						830		839			

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F. Emergency Department (CONT.)

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 12/22**	**% CCS Visits**	**Assessment**	**Interventions**
1st Quarter						420		426			
2nd Quarter						420		426			
3rd Quarter						420		426			
4th Quarter						420		426			
YTD/Year End						420		426			

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**	**Mariposa Avoidable Visits %**	**Mariposa Total Visits K/Y**	**San Benito Avoidable Visits %**	**San Benito Total Visits K/Y**	**Assessment**	**Interventions**
1st Quarter											Note: weighted average goal for total Medi-Cal ED visits for 2023 (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		

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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).

2024 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	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		
3rd 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		
4th 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		

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					

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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
Q4-23: Reported - Q1-24	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q1-24: Reported - Q2-24	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q2-24: Reported - Q3-24	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	
Q3-24: Reported - Q4-24	Carelon			Auth Approval Log Auth Denial Log Telehealth Utilization Summary Admin 3 Provider OPT Utilization Admin 5 Provider IPT Utilization BHT Utilization Report DHCS BHT Reporting Template UM Summary ICE UM Timeliness Report	

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B. Medi-Cal Mental Health Utilization Rates

Carelon Health Options (Carelon) is contracted with CCAH to provide mild to moderate mental health services. Carelon supplies this data in a quarterly report that is presented in quarterly meetings with each County Behavioral Health Department. Utilization percentage rates for children and adolescents and for adults are reported by for each county managed by CCAH. Utilization rates reflect a rolling 12 month measurement ending at the Quarter. Utilization percentage is calculated by dividing the number of unique members in each age cohort within each County into the number of members that have received Carelon services from that same County and age cohort within each quarter. Utilization percentage goals were developed by Carelon 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 Carelon presence).

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

C. Carelon UM File Audit

Review occurring every quarter that looks at previous quarter UM work. For review,15 files are randomly selected. If the first three files pass, no further review is conducted. If any of the first three fail then 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			

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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 2023
	2023	2024 Q1	2024 Q2	2024 Q3	2023 Q3	2024 Q4	2024 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						

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April 23 DHCS
dashboard: 2023

UMWP Goal	ACA	OTLIC	Other	SPD	Total
22-Dec	4,470,357	1,248,065	5,626,083	668,067	13,281,039
weighted avg	wt 0.34	Combined		wt 0.05	
		wt .52			

ER OTLIC	ER Other	ER SPD	ER ACA	IP OTLIC	IP Other	IP SPD	IP ACA	Total
239	455	1026	543	35	86	440	117	164
694 combined				121 combined				
314 - 317 (2022)		813- 917 (2022)	457-502 (2022)	82-160 (2022)		433-1300 (2022)	122-375 (2022)	53-292 (2022)
wt 0.52		wt .05	wt. 0.34	wt 0.52		wt .05	wt. 0.34	wt. 0.01 (total IP/total pop)
694x.0.52		1026x.05	543x.34 = 358					
333		**975**	543	121		440	117	147
			no weighted avg		58 weighted avg	418 weighted avg	77 weighted avg	147 weighted avg

https://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx

Emergency Room Visits per 1,000 M

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Dual	55.9	52.7	49.6	50.2	49.1	49.2	53.5	46.2	52.4	50.0	53.7	53.8
MO-ACA	50.9	50.2	45.7	44.0	42.8	44.4	46.4	37.5	43.6	42.8	46.0	45.5
MO-OTLIC	19.5	22.8	22.9	21.6	20.8	19.6	19.7	17.8	22.9	22.2	26.7	21.0
MO-SPD	92.8	92.4	86.1	85.0	82.8	84.8	89.6	73.7	85.0	82.7	90.2	86.1
MO-Other	39.7	42.9	40.5	39.0	38.8	39.2	40.4	31.7	39.9	38.9	44.9	40.7
Total	45.6	46.7	43.6	42.3	41.5	42.2	44.0	35.7	42.9	41.8	46.6	43.9

Inpatient Admissions per 1,000 Members (Jun-22)

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Dual	57.1	55.2	53.7	52.5	51.2	54.2	52.0	49.2	55.7	54.2	54.4	55.5
MO-ACA	11.0	11.0	10.5	10.5	9.5	9.4	8.9	8.6	10.1	9.2	9.2	9.3
MO-OTLIC	2.5	2.7	3.2	3.2	3.0	2.7	2.6	2.8	3.9	2.8	2.8	2.4
MO-SPD	40.1	40.7	41.2	41.8	36.6	34.8	34.0	31.2	38.2	33.6	34.2	33.7
MO-Other	7.2	7.5	7.6	7.6	7.3	7.2	6.7	6.5	7.9	6.7	6.8	6.6
Total	14.6	14.6	14.4	14.3	13.5	13.5	12.8	12.2	14.4	13.1	13.2	13.2

Managed Care Member Demographics (Dec-22)

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Dual	1,203,002	1,206,531	1,212,289	1,217,602	1,224,736	1,231,496	1,238,591	1,244,727	1,251,196	1,256,340	1,262,127	1,268,467
MO-ACA	3,939,898	3,967,158	4,005,963	4,041,511	4,105,219	4,161,937	4,285,137	4,325,421	4,357,874	4,391,673	4,438,161	4,470,357
MO-OTLIC	1,254,336	1,254,233	1,256,673	1,254,217	1,248,903	1,247,973	1,247,634	1,245,490	1,244,805	1,245,041	1,247,522	1,248,065
MO-SPD	624,291	623,089	623,286	623,175	629,781	639,771	664,668	665,814	666,390	666,646	668,046	668,067
MO-Other	5,245,978	5,265,510	5,301,419	5,332,710	5,382,693	5,416,578	5,485,781	5,513,927	5,535,983	5,556,966	5,602,005	5,626,083
MC Total	12,267,505	12,316,521	12,399,630	12,469,215	12,591,332	12,697,755	12,921,811	12,995,379	13,056,248	13,116,666	13,217,861	13,281,039

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2024 Goal Development Methodology: https://www.dhcs.ca.gov/services/Documents/MCQMD/MCPM-Dashboard-October-2023-Release.pdf

Inpatient Admits per 1K (Dec 22)

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Dual	52.3	49.7	56.4	55.1	55.2	56.5	51.4	45.6	43.6	42.7	44.0	43.9
MO-ACA	9.0	8.8	10.4	9.6	9.6	9.6	9.3	9.7	9.3	9.2	8.7	8.6
MO-OTLIC	2.7	2.9	4.0	3.0	3.0	2.6	2.3	2.8	3.1	3.2	2.8	2.5
MO-SPD	34.7	32.5	39.9	35.5	36.3	35.6	33.1	34.8	33.2	32.9	32.4	31.7
MO-Other	6.9	6.6	8.1	6.8	7.0	6.8	6.8	7.4	7.5	7.4	7.3	6.9
Total	13.0	12.5	14.8	13.5	13.6	13.6	12.8	12.8	12.5	12.3	12.2	11.9

Source: Enterprise Performance Monitoring System
Note: Data in this dashboard is preliminary and subject to change

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ER Visits per IK (Dec 22)

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Dual	54.2	46.9	53.5	51.6	54.9	55.3	55.2	55.8	53.1	52.6	52.1	52.5
MO-ACA	46.5	37.7	43.8	43.3	46.5	45.9	46.9	46.5	44.3	43.7	43.0	42.6
MO-OTLIC	19.8	17.9	23.0	22.6	27.0	21.1	19.4	22.6	25.8	28.3	32.8	26.0
MO-SPD	90.0	74.2	85.6	83.8	91.6	87.1	87.7	88.6	85.3	85.4	85.5	83.9
MO-Other	40.5	31.8	40.1	39.4	45.4	40.9	39.1	41.1	43.3	47.2	53.8	44.5
Total	44.2	35.9	43.2	42.4	47.2	44.3	43.8	45.0	45.1	46.7	49.7	44.9

Source: Enterprise Performance Monitoring System
Note: Data in this dashboard is preliminary and subject to change

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2024 UMWP Calculations: (total Inpt using grid above)

For Total Admissions (state data above) Using 11.9 as the admissions per thousand per year and an average length of stay of 6 days, the calculation for admissions bed days per thousand per year without applying a weighted average would be as follows:

Admissions Bed Days per Thousand per Year=11.9×6

Admissions Bed Days per Thousand per Year=11.9×6

Admissions Bed Days per Thousand per Year=71.4

Admissions Bed Days per Thousand per Year=71.4

So, when using 11.9 as the admissions per thousand per year and an average length of stay of 6 days as the multiplier, the result is 71.4 admissions bed days per thousand per year.

Inpatient State averages = For ACA - Using OTLIC + ACA, multiplier 6 ALOS; For SPD - Using SPD + Dual (75.6) x 6 ALOS = 454; For Family + Children - Using OTLIC + Other = 9.4 x 6 ALOS

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ED Data - Note any Variances in Tableau vs DHCS Aid codes may impact targets and goal rates

Population Aid Code Groups

Affordable Care Act (ACA): This population consists of the following Adult Expansion aid codes: M1, M2, L1, and 7U.

Optional Targeted Low Income Children (OTLIC): This population consists of the following OTLIC aid codes: 2P, 2R, 2S, 2T, 2U, 5C, 5D, E2, E5, E6, E7, H1, H2, H3, H4, H5, M5, T0, T1, T2, T3, T4, T5, T6, T7, T8, and T9.

Seniors and Persons with Disabilities (SPD): This population consists of the following SPD aid codes: 10, 13, 14, 16, 17, 1E, 1H, 20, 23, 24, 26, 27, 2E, 2H, 36, 60, 63, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, C1, C2, C3, C4, C7, C8, D2, D3, D4, D5, D6, and D7.

Other Populations (OTHER): This population consists of all aid codes not categorized under ACA, OTLIC, or SPD.

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DATE: May 22, 2024

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

FROM: Tammy Brass RN, Utilization Management Director

SUBJECT: Utilization Management Work Group Charter

Recommendation. Staff recommend the Board approve the 2024 Utilization Management Work Group (UMWG) Charter to enhance the efficiency and effectiveness of the Alliance's Utilization Management (UM) Program.

Summary. The UMWG charter enables the establishment of a dedicated group focused on providing guidance, oversight, and strategic direction to the UM Program. This charter aligns with our commitment to continuous improvement and quality assurance within our healthcare services.

Background. The primary objectives of the UMWG charter are as follows:

1. Provide guidance to the UM Program by:
    - Reviewing and making recommendations to the Program Policy annually.
    - Reviewing and approving the work plan quarterly.
    - Reviewing, approving, and ensuring implementation of UM criteria and UM policies in alignment with National Committee for Quality Assurance guidelines.
    - Analyzing summary data and making recommendations for action.
    - Recommending medical policy, protocol, and clinical practice guidelines.
    - Monitoring delegated utilization management activities through regular reports as described in Alliance Policy 105-0004 – Delegate Oversight.

Discussion. The establishment of the UMWG Charter will facilitate a structured approach to the management of utilization, ensuring that policies and criteria are regularly reviewed, updated, and aligned with industry standards and best practices. The charter supports a consistent approach in the plan's vital role in monitoring delegated utilization management activities to ensure compliance with Alliance policies and regulatory requirements.

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

Attachments.

1. Utilization Management Work Group Charter

Utilization Management Work Group (UMWG)

Meeting Charter

Primary Objectives	1. To provide guidance to the Utilization Management Program by: • Reviewing and making recommendations to the Program Policy (annually) • Reviewing and approving the work plan (quarterly) • Reviewing, approving and ensuring implementation of utilization management criteria and UM policies • Analyzing summary data and making recommendations for action • Recommending medical policy, protocol, and clinical practice guidelines • Monitoring delegated utilization management activities through regular reports as described in Alliance Policy 105-0004 – Delegate Oversight 2. The UMWG reports to the Quality Improvement and Health Equity Committee (QIHEC)	
Cadence	The meeting is scheduled for the first and third Tuesday of each month. The Group is required to meet at least 12 times a year, and at least once a quarter.	
Process	Pre-Meeting	1. <u>Agenda Development</u>: • UM Leadership, along with the Medical Director, meets the week before each scheduled meeting to develop the agenda and review minutes for ongoing or proposed topics. • Standing Agenda Items: o Revised Health Services Policies (excluding QI/PH) o Monthly Auth Volume Report o Utilization Management Work Plans o Quarterly Carelon Health Option Updates o Department Updates o Benefit and Utilization Reviews o CAP Updates (as needed) o Auditing Preparation and Review • Ad Hoc Agenda Items o Key divisional /departmental activities impacting Alliance impacting member benefits and utilization o Work group members may submit ad-hoc agenda item requests, at any time, to the meeting chairperson. 2. <u>Material Distribution</u>: UM Admin Assistant (AA) will distribute the agenda, previous meeting minutes, and available materials at least two (2) business days prior to the meeting to enable group member review. 3. <u>Material Review</u>: Members review meeting materials and perform any necessary research and/or consultation to

		facilitate a good working knowledge of the topics being discussed prior to the meeting.
	In-Meeting	4. Consent Agenda: Consent agenda items are provided for awareness and the Group is asked to approve or indicate if concerns exist. 5. Regular Agenda: Regular agenda items are provided for informational and/or discussion purposes and the Committee is asked to observe the "Action Requested" on the agenda (informational or approval),
	Post-Meeting	6. Material Distribution: The AA will prepare and share the meeting minutes with the Group chairperson for review and in preparation for attaching in the next meeting packet.
Composition	1. Chair: • Primary: UM Director • Back-up: Medical Director assigned to UM • Responsibilities: Plans and approves agendas and minutes, facilitates meetings, manages agenda to completion. 2. Staffer: • Primary: UM AA • Back-up: HS Admins • Responsibilities: Drafts and maintains agendas, summaries and minutes. 3. Core Members: • Chief Medical Director • UM/CCM Medical Director • Health Services Directors • UM Manager and Supervisors • CCM Manager and Supervisors • Pharmacy Managers • Community Care Coordination Managers • Responsibilities: Contribute key divisional, departmental and process updates as necessary. Review and approve all consent and regular agenda items in timely manner. 4. Informational Members: • Division Medical Directors • Data Analytics Services Director • Application Services Managers 5. Guests: Additional staff may be requested to attend the meeting by a Core Member to support an agenda item. The AA will be advised of the guest's proposed attendance. 6. Topic Owner: Staff introducing an agenda item is responsible for advancing the topic forward until completion, including collaborating to achieve clarity, identify a plan of resolution, assign tasks, and monitor progress.	
References	• Alliance Policy 404-1101 - Utilization Management Program	

Revision History:

Date	Changes Made By	Approved by Committee
1/25/2024	Tammy Brass	UMWG

Communication with
the Commissioners

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

December 31, 2023

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Communication with the Commissioners

To the Commissioners
Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (the Alliance) as of and for the year ended December 31, 2023, and have issued our report thereon dated April 26, 2024. Professional standards require that we provide you with the following information related to our audit.

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

As stated in our engagement letter dated October 20, 2022, we are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.

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

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

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

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

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated October 20, 2022.

Significant Audit Findings and issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission are described in Note 1 to the financial statements. During 2023, Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission adopted Government Accounting Standards Board No.96, *Subscription-Based Information Technology Arrangements*, under the retrospective approach. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2023. We noted no transactions entered into by the Alliance during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

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

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

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

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

- Management's estimates of the discount rate, useful lives, lease terms related to the lease assets and deferred inflow of resources. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the financial statements taken as a whole.

Financial Statement Disclosures

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

Significant Unusual Transactions

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

Significant Difficulties Encountered in Performing the Audit

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

Disagreements with Management

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

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

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

Corrected and Uncorrected Misstatements

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

Management Representations

We have requested certain representations from management that are included in the management representation letter dated April 26, 2024.

Management Consultation with Other Independent Accountants

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

Other Significant Audit Findings or Issues

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

This information is intended solely for the use of the Commissioners and management of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, and is not intended to be, and should not be, used by anyone other than these specified parties.

Moss Adams LLP

San Francisco, California
April 26, 2024

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April 26, 2024

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

We are providing this letter in connection with your audits of the financial statements of Central California Alliance for Health (the "Alliance"), which comprise the statements of net position, statements of revenues, expenses, and changes in net position, cash flows, statements of fiduciary net position, and statements of changes in fiduciary net position as of December 31, 2023 and 2022 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 $2,550,000 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 26, 2024.

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated October 20, 2022, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.

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

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

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

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

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

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

Information Provided

8. We have provided you with:

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

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

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

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

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

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

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

12. We have no knowledge of any fraud or suspected fraud that affects the entity and involves—

    a. Management,

    b. Employees who have significant roles in internal control, or

    c. Others when the fraud could have a material effect on the financial statements.

13. We have no knowledge of any allegations of fraud or suspected fraud affecting the entity's financial statements communicated by employees, former employees, analysts, regulators, or others.

14. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

15. We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the financial statements.

16. We have disclosed to you the identity of all the entity's related parties and all the related party relationships and transactions of which we are aware.

17. There are no—

    a. Violations or possible violations of laws or regulations, such as those related to the Medicare antifraud and abuse statutes, including but not limited to the Anti-Kickback Act, Limitations on Certain Physician Referrals (commonly referred to as the "Stark law"), and the False Claims Act, in any jurisdiction whose effects should be considered for disclosure in the financial statements or as basis for recording a loss contingency other than those disclosed or accrued in the financial statements.

    b. Possible illegal acts brought to the attention of management.

    c. Unasserted claims or assessments that our lawyer has advised us are probable of assertion and must be disclosed in accordance with GASB 62 section 1500, *Reporting Liabilities*, paragraph .114 and section C50, *Claims and Judgments*, paragraph .115.

    d. Other liabilities or gain or loss contingencies that are required to be accrued or disclosed by GASB 62 section 1500 paragraph .114 and section C50 paragraph .115.

18. The Alliance has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral, except as disclosed to you and reported in the financial statements.

19. The Alliance has complied with all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance.

20. The Alliance has been in compliance with the requirements of licensure under the Knox-Keene Health Care Service Plan act of 1975.

21. Capitation revenue as disclosed in Note 2 of the financial statements is fairly stated in accordance with GAAP.

22. We have complied with all restrictions on resources and all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance.

23. We have disclosed to you any change in the Alliance's internal control over financial reporting that occurred during the Alliance's most recent fiscal year that has materially affected, or is reasonably likely to materially affect, the Alliance's internal control over financial reporting.

24. We have responded fully and truthfully to all inquiries made to us by you during your audits.

25. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the financial statements or on the disclosure in the notes to the financial statements.

26. We have made available to Moss Adams all known reviews, surveys and inquiries from Federal, State and local regulatory authorities completed or ongoing. We confirm that we are not aware of any non-compliance with laws and regulations.

27. No violations or possible violations of laws or regulations, such as those related to the Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements. This is including, but not limited to, the anti-kickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law), and the False Claims Act.

28. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning the investigations or allegations of noncompliance with laws and regulations in any jurisdiction (including those related to the Medicare and Medicaid antifraud and abuse statutes), deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the financial statements.

29. We have appropriately reconciled our books and records (e.g., general ledger accounts) underlying the financial statements to their related supporting information (e.g. sub ledger or third-party data). All related reconciling items considered to be material were identified and included on the reconciliations and were appropriately adjusted in the financial statements. There were no material un-reconciled differences or material general ledger suspense account items that should have been adjusted or reclassified to another account balance. There were no material general ledger suspense account items written off to a statement of net position account, which should have been written off to an income statement account and vice versa.

30. Medical claims liability, including amounts for incurred but not reported claims and estimated recoveries for salvage and subrogation have been determined using appropriate estimated ultimate costs of settling the claims (including the effects of inflation and other societal and economic factors), considering past experience adjusted for current trends and any other factors that would modify past experience. The estimated liability is to the best of our knowledge and belief, an accurate estimate of our incurred but unreported health claims liability as of December 31, 2023 and 2022. 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.

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31. Management has no knowledge of a large pool of impending claims outstanding at December 31, 2023 and 2022 that would materially affect the estimate for liability for health unpaid claims and claims adjustment expenses, including amounts for incurred but not reported claims.

32. All reinsurance transactions entered into by the Alliance are final and there are no side agreements with reinsurers, or other terms in effect, which allow for the modification of term under existing reinsurance arrangements. Furthermore, the Alliance's reinsurance arrangements meet the risk transfer provisions or are accounted for as deposits.

33. Pay for performance, provider incentive, withhold, capitation and other arrangements with providers wherein the Alliance is obligated to provide for a settlement of accounts with providers have been calculated in accordance with the existing arrangements and are included in the statement of net positions at net realizable value, giving consideration to all amounts due under arrangements. We believe provider incentives payable is fairly stated as of December 31, 2023 and 2022, respectively.

34. Board designated reserves have been approved by the Alliance's Board and is complete and accurate.

35. Financial instruments include cash and cash equivalents on deposit with financial institutions, the balances of which frequently exceed federally insured limits. If any of the financial institutions with whom the Alliance does business were placed into a receivership, the Alliance may be unable to access the cash on deposit with such institutions in order to operate its business without adverse effect.

36. The Alliance has accepted the following responsibilities related to the non-attest services provided related to the drafting the financial statements and related footnotes as of December 31, 2023 and 2022:

    a. Make all management decisions and perform all management functions.

    b. Designate an individual with suitable skill, knowledge, and / or experience to oversee the non-attest services.

    c. Evaluate the adequacy and results of the non-attest services performed.

    d. Accept responsibility for the results of the non-attest services performed.

    e. Establish and maintain internal controls including monitoring ongoing activities.

37. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by third-party organizations or other regulatory agencies.

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38. We have the intent and ability to commit the necessary resources to become compliant with the laws and regulations contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") by the required compliance deadlines. We have no information that indicated that a significant vendor may be unable to sell to the Alliance; a significant customer may be unable to purchase from the Alliance; or a significant service provider may be unable to provide services to the Alliance, in each case because of their respective inability to comply with HIPAA.

39. We have reviewed all recently released accounting pronouncements and have evaluated those that may have an effect on the Alliance in the current and subsequent periods and disclosed as appropriate in the financial statements.

40. We are not aware of any reason that Moss Adams LLP would not be considered to be independent for purposes of the Alliance's audit.

41. To our knowledge, there are no instances where any officer or employee of the Alliance has an interest in a company with which the Alliance does business that would be considered a "conflict of interest." Such an interest would be contrary to the Alliance's policy.

42. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the financial statements of the Alliance are properly disclosed.

43. We have performed an analysis of expected future medical expenses and maintenance costs to determine whether such costs will exceed anticipated future revenues under our contracts. We have determined that expected costs do not exceed anticipated revenues. Based on our analysis, we believe no premium deficiency reserves are necessary at December 31, 2023 and 2022, respectively.

44. We acknowledge our responsibility for presenting the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position, in accordance with accounting principles generally accepted in the United States of America and we believe the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position are measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the Management's Discussion and Analysis and Schedule of Revenue and Expenses by Program and Changes in Net Position have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.

45. To the best of our knowledge and belief, as of December 31, 2023 and 2022, there are no liabilities associated with our contract with DHCS for the Adult Expansion, Medical Loss Ratio (MLR) corridor for the periods beyond June 30, 2017.

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46. The Alliance recorded an estimated reduction in receivable and revenue for expected acuity adjustment liability. The DHCS informed managed care plans of an upcoming acuity adjustment factor, resulting from extension of the DHCS re-determination, which impacted rates due to lower acuity of population that may already have other health coverage and/or lower utilization. Management recorded an estimated liability of $29.1 million and $6.6 million, respectively as of December 31, 2023 and 2022

47. There have been no known or suspected breaches of sensitive information caused by cyber-attack or other means where the breach could have a material effect on the financial statements.

48. We have reviewed and evaluated the impact of adopting GASB 96, *Subscription-Based Information Technology Arrangements*, as discussed in Note 2 of the financial statements. Our adoption of GASB 96 recognizes all contracts or equivalents that have a term exceeding one year and the cumulative future payments on the contract exceeding $100,000 that meet the definition of an other than short-term subscription.

49. To the best of our knowledge and belief, no events have occurred subsequent to the balance sheet date and through the date of this letter that would require adjustment to or disclosure in the aforementioned financial statements.

DocuSigned by:
Lisa Ba
F24301267686423...

Lisa Ba, Chief Financial Officer

DocuSigned by:
8413AE9CEC4C43E...

Jimmy Ho, Director of Accounting

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Report of Independent Auditors and
Financial Statements with Supplementary Information

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

December 31, 2023 and 2022

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Management’s Discussion and Analysis

Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission
Management's Discussion and Analysis
Years Ended December 31, 2023, 2022, and 2021

The intent of the management's discussion and analysis of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (the Alliance) is to provide readers with an overview of the Alliance's financial activities for the fiscal years ended December 31, 2023, 2022, and 2021. 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 2023, 2022, and 2021:

Key operating indicators	Fiscal years ended December 31			2023-2022	2022-2021
	2023	2022	2021	Change	Change
		(As restated)			(As restated)
Members (at end of fiscal period):					
Medi-Cal program	405,325	415,668	386,535	(10,343)	29,133
IHSS program	697	654	517	43	137
Average member months:					
Medi-Cal program	420,338	403,315	377,585	17,023	25,730
IHSS program	669	623	514	46	109
Total revenues (in millions)	$ 2,132.4	$ 1,710.7	$ 1,732.7	$ 421.7	$ (22.0)
Capitation revenue (in millions)	$ 2,085.9	$ 1,721.5	$ 1,733.1	$ 364.4	$ (11.6)
Investment and other income (in millions)	$ 46.5	$ (10.8)	$ (0.4)	$ 57.3	$ (10.4)
Operating expenses (in millions):					
Medical expenses (in millions)	$ 1,483.5	$ 1,358.9	$ 1,360.9	$ 124.6	$ (2.0)
Administrative expenses (in millions)	$ 467.7	$ 257.0	$ 243.6	$ 210.7	$ 13.4
Increase (decrease) in net assets (in millions):	$ 168.0	$ 83.9	$ 118.2	$ 84.1	$ (34.3)
Total revenues per member per month	$ 422.1	$ 352.9	$ 381.9	$ 69.2	$ (29.0)
Operating expenses per member per month:					
Medical expenses per member per month	$ 293.6	$ 280.3	$ 299.9	$ 13.3	$ (19.6)
Administrative expenses per member per month	$ 92.6	$ 53.0	$ 53.7	$ 39.6	$ (0.7)
Increase (decrease) in net assets per member per month	$ 33.3	$ 17.3	$ 26.1	$ 15.9	$ (8.7)
Medical loss ratio	71.1 %	78.9 %	78.5 %	(7.80) %	0.40 %
Administrative expense ratio	21.9 %	15.0 %	14.1 %	6.90 %	0.90 %
Administrative expense ratio (excluding premium tax)	4.3 %	4.8 %	4.9 %	(0.50) %	(0.10) %

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, 2023 and 2022. 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 2023, 2022, and 2021. Premium tax expenses are included in administrative expenses.

Financial Highlights Fiscal Year 2023

- Total assets at year-end were $1,629.7 million and exceeded liabilities by $834.7 million.
- Net position increased by $168.0 million or 25.2% during fiscal year 2023.

Financial Highlights Fiscal Year 2022

- Total assets at year-end were $1,055.4 million and exceeded liabilities by $666.7 million.
- Net position increased by $83.9 million or 14.4% during fiscal year 2022.

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

Financial position	As of December 31			2023-2022 Change		2022-2021 Change	
	2023	2022 (As restated)	2021	Amount	Percentage	Amount (As restated)	Percentage
Assets							
Current assets	$ 1,167,011	$ 624,707	$ 546,201	$ 542,304	86.8 %	$ 78,506	14.4 %
Capital assets, net	36,303	39,544	42,236	(3,241)	(8.2)	(2,692)	(6.4)
Board-designated investments and restricted deposit	413,502	384,662	394,098	28,840	7.5	(9,436)	(2.4)
Lease receivable - noncurrent	2,385	1,792	1,277	593	33.1	515	40.3
Subscription assets, net of accumulated amortization	10,510	4,680	-	5,830	124.6	4,680	100.0
TOTAL ASSETS	$ 1,629,711	$ 1,055,385	$ 983,812	$ 574,326	54.4 %	$ 71,573	7.3 %
Liabilities							
Current liabilities	$ 786,427	$ 384,579	$ 399,006	$ 401,848	104.5 %	$ (14,427)	(3.6) %
Subscription liabilities, net of current portion	5,578	1,642	-	3,936	239.7	1,642	100.0
Deferred inflow of resources	2,933	2,437	2,013	496	20.4	424	21.1
Total liabilities and deferred inflow of resources	794,938	388,658	401,019	406,280	104.5	(12,361)	(3.1)
Net position							
Invested in capital assets	36,303	39,544	42,236	(3,241)	(8.2) %	(2,692)	(6.4) %
Restricted	300	300	300	-	-	-	-
Unrestricted	798,170	626,883	540,257	171,287	27.3	86,626	16.0
Total net position	834,773	666,727	582,793	168,046	25.2	83,934	14.4
TOTAL LIABILITIES AND NET POSITION	$ 1,629,711	$ 1,055,385	$ 983,812	$ 574,326	54.4 %	$ 71,573	7.3 %

Capital Assets Fiscal Year 2023

Capital assets, net decreased from $39.5 million to $36.3 million, or by $3.2 million, in 2023 compared to the previous year. This decrease is mainly the net result of $2.5 million in capital additions, $2.6 million of capital sale or disposal, and $3.1 million in depreciation expense. Capital additions are all included in construction in process, which was subsequently transferred and reflected in building additions and in furniture and equipment.

Capital Assets Fiscal Year 2022

Capital assets, net decreased from $42.2 million to $39.5 million, or by $2.7 million, in 2022 compared to the previous year. This decrease is mainly the net result of $0.6 million in capital additions and $3.3 million in depreciation expense. Capital additions are all included in construction in process, which was subsequently transferred and reflected in building additions and in furniture and equipment.

Liquidity Fiscal Year 2023

At December 31, 2023, the Alliance maintained a working capital ratio, including board-designated investments, of 2.01. The increase of $169.3 million in working capital in 2023 compared to the prior year is primarily due to the change in net position.

During 2023, board-designated investments increased by $28.9 million from the prior year. The increase is due to a slight increase in revenues and non-capitated revenues are excluded from board-designated reserve calculation.

Liquidity Fiscal Year 2022

At December 31, 2022, the Alliance maintained a working capital ratio, including board-designated investments, of 2.62. The increase of $83.5 million in working capital in 2022 compared to the prior year is primarily due to the change in net position.

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

ADOPTION OF GASB NO. 96

The Alliance adopted GASB No. 96, *Subscription-Based Information Technology Arrangements* (GASB 96) as of January 1, 2023. The adoption resulted in the recognition of a subscription assets of $4.7 million and subscription liabilities of $3.9 million as of January 1, 2023. The impact to beginning net position was not significant. See Note 9 in the notes to the financial statement.

Results of Operations

The Alliance's fiscal year 2023 operations resulted in a $168.0 million increase in net position compared to a $83.9 million increase in net position in fiscal year 2022. The Alliance's fiscal year 2021 operations resulted in a $118.2 million increase in net position.

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

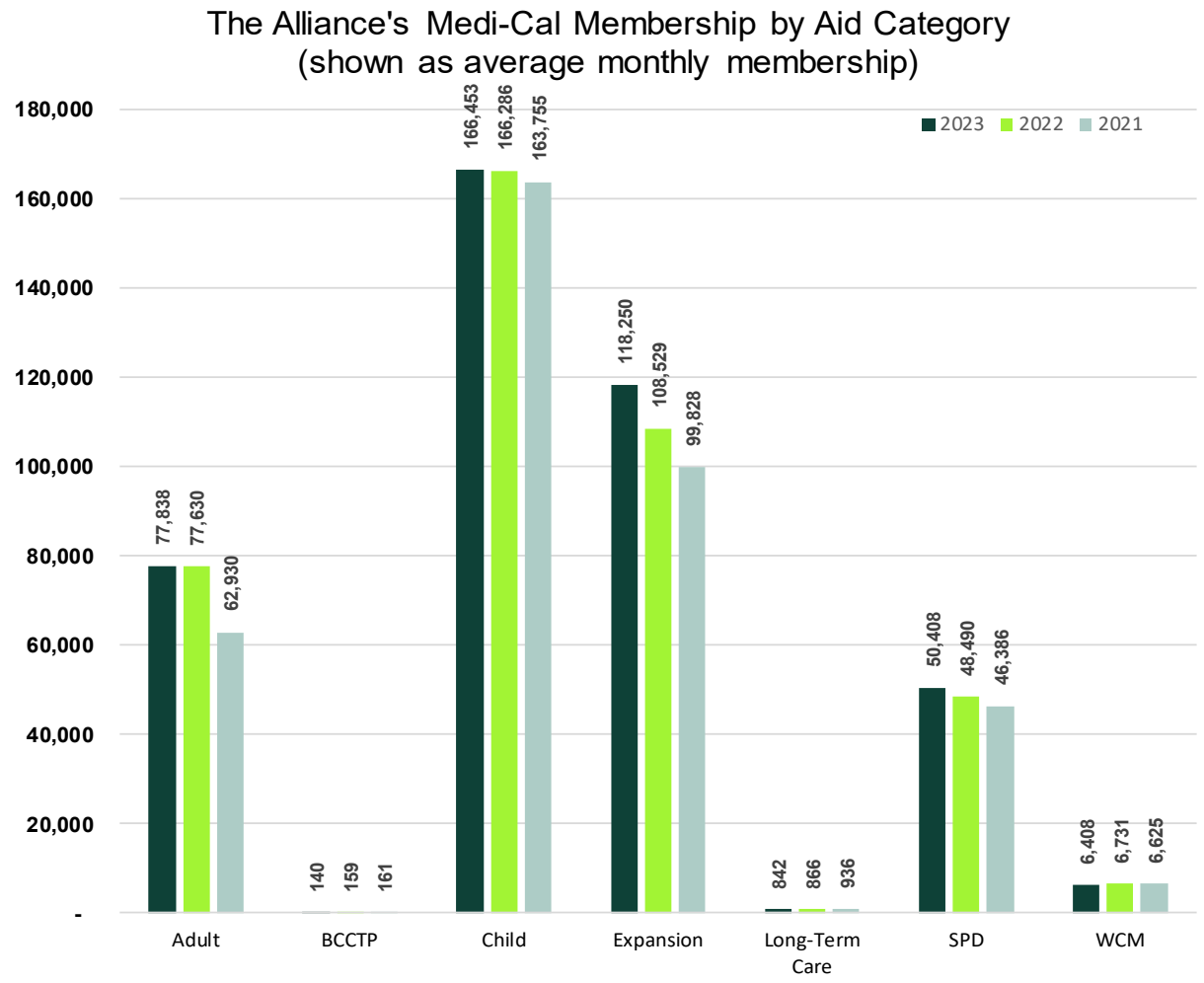
Condensed revenues, expenses, and changes in net position for the years ended (in thousands):

Results of operations	2023	2022	2021	2023-2022 Change Amount	2023-2022 Change Percentage	2022-2021 Change Amount	2022-2021 Change Percentage
Capitation revenue, investment (loss) income, including net realized and unrealized gains and losses, and other income	$ 2,132,397	$ 1,710,652	$ 1,732,733	$ 421,745	24.7 %	$ (22,081)	(1.3) %
Expenses							
Total medical expenses	1,483,504	1,358,877	1,360,894	124,627	9.2	(2,017)	(0.1)
Total administrative expenses	467,665	257,007	243,570	210,658	82.0	13,437	5.5
Grants	13,182	10,834	10,066	2,348	21.7	768	7.6
Total expenses	1,964,351	1,626,718	1,614,530	337,633	20.8	12,188	0.8
Increase (decrease) in net position	168,046	83,934	118,203	84,112	100.2	(34,269)	(29.0)
Total net position, beginning of year	666,727	582,793	464,590	83,934	14.4	118,203	25.4
Total net position, end of year	$ 834,773	$ 666,727	$ 582,793	$ 168,046	25.2 %	$ 83,934	14.4 %

Enrollment

During fiscal 2023, the Alliance served an average of 421,007 members per month compared to an average of 403,940 members per month in 2022. This increase in membership is primarily due to the extension of the Public Health Emergency (PHE) declaration, which temporarily freezes the eligibility redetermination process. The PHE officially ended on May 11, 2023, and the Alliance experienced disenrollment during the second half of 2023. The delay in the PHE and disenrollment was lower than forecast, resulting in a higher average member month compared to the prior year. During fiscal 2022, the Alliance served an average of 403,940 members per month compared to an average of 377,585 members per month in 2021. This increase in membership is primarily due to the PHE declaration.

The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2023, 2022, and 2021:



Operating Revenues Fiscal Year 2023

Revenues in 2023 increased over 2022. Revenue increased despite the PHE period which ended in May of 2023. The decrease in Medi-Cal membership was lower than anticipated from the redeterminations, offset by increases in capitation rates from the Department of Health Care Services (DHCS).

Operating Revenues Fiscal Year 2022

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

Medical Expenses Fiscal Year 2023

Overall, medical expenses increased by 9.2% in 2023, totaling $1,483.5 million compared to $1,358.9 million in 2022. The Alliance's medical expenses, as a percentage of capitation revenues, was 71.1% in fiscal year 2023, compared to 78.9% in fiscal year 2022. Premium tax expenses are included in administrative expenses while the MCO tax revenues are included in capitation revenue, resulting in lower medical expenses to capitation revenue percentages. The Alliance's average medical costs per member per month increased by 4.7% in 2023. Medical expenses include the following:

- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $51.8 million in 2023 compared to $43.3 million in 2022. The increased cost is attributable to a small increase in membership.
- Hospital inpatient and long-term care expenses decreased by $8.9 million, or 1.3%, in 2023. The decreased cost of care was due to enrollment increases offset by delays in the state's redetermination processes, and lower utilization.
- Expenses related to physicians, outpatient facilities, and allied health providers increased by $63.5 million, or 11.4%, in 2023. Most of the increase was due to membership increases and acuity.
- Other medical increased by $59.8 million or 121% in 2023 primarily due to the State Incentive programs of $39 million and internal Care Based Incentive program of $15 million, as well as Care Based Hospital Quality incentives increase of $5 million.
- Prescription drugs expenses increased by $3.5 million or 23.2% during 2023. The increase was related to Physician Admin Drugs, which is not part of the pharmacy carve out to the State.
- Alliance Care IHSS program expenses increased by $0.6 million. The increase was due to an increase in membership.
- Net reinsurance expense decreased by $2.5 million compared to 2022 due to a decrease in recoveries as well as an increase in premiums.

Medical Expenses Fiscal Year 2022

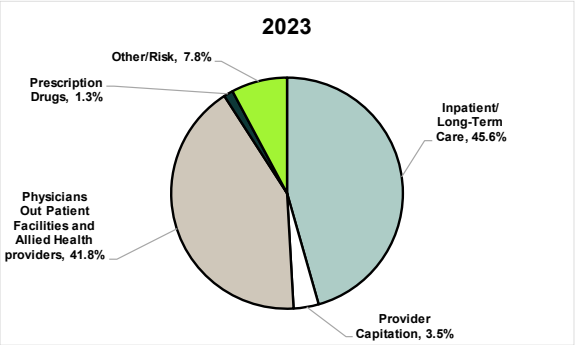
Overall, medical expenses decreased by 0.1% in 2022, totaling $1,358.9 million compared to $1,360.9 million in 2021. The Alliance's medical expenses, as a percentage of capitation revenues, was 78.9% in fiscal year 2022, compared to 78.5% in fiscal year 2021. The Alliance's average medical costs per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

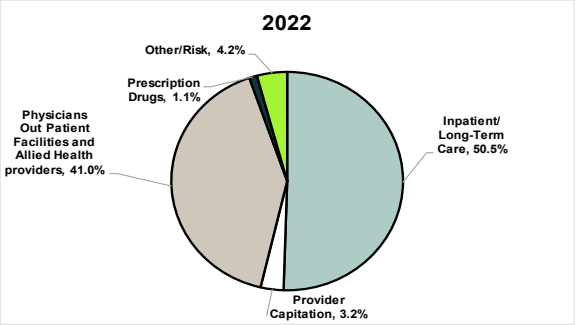
- Provider capitation comprises payments made to primary care and ancillary services providers. Capitation expenses totaled $43.3 million in 2022 compared to $38.6 million in 2021. The increased cost is attributable to a small increase in membership.
- Hospital inpatient and long-term care expenses increased by $115.9 million, or 20.3%, in 2022. The increased cost of care is due to increased membership.
- Expenses related to physicians, outpatient facilities, and allied health providers increased by $66.0 million, or 13.5%, in 2022. Most of the increase is due to increased rates paid to providers. Increased membership also contributed to the increase in expenses.
- Other medical increased by $17.5 million or 55% in 2022 primarily due to the new CalAIM Incentive program of $10 million. In addition, higher utilization in lab and behavioral health services contributed the year over year increase.
- Prescription drugs expenses decreased by $206.7 million or 93.1% during 2022. The decrease was due to the prescription drug services carve out and transfer to State Pharmacy Rx program.

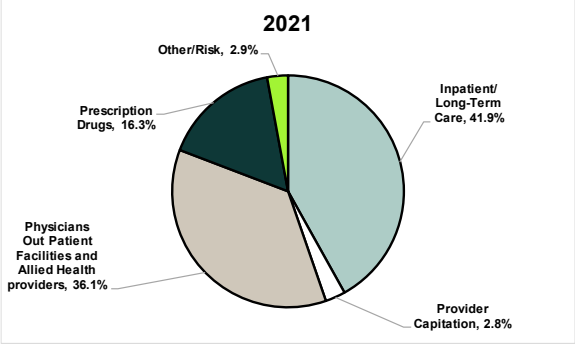
The remaining $15.3 million is related to Physician Admin Drugs, which is not part of the pharmacy carve out to the State.

- Alliance Care IHSS program expenses increased by $1.1 million. The increase was due to an increase in membership.
- Net reinsurance expense decreased by $674 thousand compared to 2021 due to a decrease in recoveries as well as an increase in premiums.

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 2023, 2022, and 2021:







Administrative Expenses Fiscal Year 2023

Total administrative expenses were $467.7 million in 2023 compared to $257.0 million in 2022, for a net increase of $210.7 million or 82%. This increase is primarily due to an increase of $201.8 million in premium taxes in 2023, which are included in administrative expenses. Premium taxes were $376.4 million in 2023, compared to $174.6 million in 2022. Supplies, occupancy, insurance and other decreased $1.5 million or 16.8%, compared to $8.9 million in 2022. In 2023 salaries and benefits expenses were $63.4 million, an increase of $7.1 million compared to 2022.

Overall, professional fees, purchased services and depreciation increased $3.3 million or 19.0% in 2023. Purchased services expenses and consulting costs were up in 2023, offset by reductions in legal fees.

Administrative Expenses Fiscal Year 2022

Total administrative expenses were $257.0 million in 2022 compared to $243.6 million in 2021, for a net increase of $13.4 million or 5.52%. This increase is primarily due to an increase of $16.6 million in premium taxes in 2022. Premium taxes were $174.6 million in 2022, compared to $157.9 million in 2021. Supplies, occupancy, insurance and other decreased $7.1 million or 44.4%, compared to $16.1 million in

2021, primarily due to adoption of GASB 96. In 2022, salaries and benefits expenses were $56.3 million, an increase of $5.3 million compared to 2021.

Overall, professional fees, purchased services and depreciation decreased $1.4 million or 7.5% in 2022. Purchased services expenses, behavioral health fees, and consulting costs were up in 2022, offset by reductions in pharmacy benefit management fees, and supplies expenses.

Economic Factors

The Public Health Emergency (PHE) that was declared by Health and Human Services back in 2020 officially ended on May 11, 2023. The Department of Health Care Services (DHCS) began the redetermination process in April 2023 for the June 2023 renewal month, with the actual enrollment loss starting in July 2023. Although the Alliance anticipated enrollment to decrease, the delay in the PHE and the disenrollment during the second half of 2023 were lower than forecast. As a result, the Alliance experienced an increase in revenue due to the average member months increase of 4.2%, and the final 2023 capitation rates received from DHCS were higher compared to the prior year. Although the Alliance expects the disenrollment to continue into the middle of 2024, the decrease is likely to be offset against new eligibility members for Adult UIS aged 26-29 and due to the county expansion into Mariposa and San Benito effective January 2024.

In 2023, the Alliance continued to expand and improve the Enhanced Care Management (ECM) and Community Supports (CS) benefits. These programs are part of the State's California Advancing and Innovating Medi-Cal (CalAIM) initiatives mandated in 2022. 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):

	2023	2022	2021
TOTAL ASSETS	$ 57,806	$ 46,796	$ 52,893
TOTAL LIABILITIES	-	-	-
TOTAL FIDUCIARY NET POSITION	$ 57,806	$ 46,796	$ 52,893
TOTAL ADDITIONS, NET	$ 12,850	$ (2,684)	$ 11,206
TOTAL DEDUCTIONS	1,840	3,413	1,469
INCREASE (DECREASE) IN FIDUCIARY NET POSITION	11,010	(6,097)	9,737
FIDUCIARY NET POSITION - BEGINNING OF YEAR	46,796	52,893	43,156
FIDUCIARY NET POSITION - END OF YEAR	$ 57,806	$ 46,796	$ 52,893

Total fiduciary fund net position as of December 31, 2023, increased by $11.0 million from December 31, 2022, due to an increase in fair value of investments and contributions. Total fiduciary fund net position as of December 31, 2022, decreased by $6.1 million from December 31, 2021, due to a decrease in fair value of investments and contributions.

MOSSADAMS

Report of Independent Auditors

The Commissioners
Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of the business-type activities and the aggregate remaining fund information of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission, as of and for the years ended December 31, 2023 and 2022, and the related notes to the financial statements, which collectively comprise Santa Cruz-Monterey-Merced-San Benito-Mariposa 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-San Benito-Mariposa Managed Medical Care Commission as of December 31, 2023 and 2022, and the respective changes in net position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Emphasis of Matter – New Accounting Standard

As discussed in Note 2 to the financial statements, Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's adopted Government Accounting Standards Board No. 96, *Subscription-Based Information Technology Arrangements*, as of January 1, 2023. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 through 9 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audits were conducted for the purpose of forming an opinion on the financial statements that comprise the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission's basic financial statements. The supplementary schedules of revenues and expenses by program and changes in net position for the years ended December 2023 and 2022, on pages 40 and 41 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, 2023 and 2022, are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Moss Adams LLP

San Francisco, California
April 26, 2024

Financial Statements

Back to Agenda

Santa Cruz-Monterey-Merced-San Benito-Mariposa
Managed Medical Care Commission
Statements of Net Position
December 31, 2023 and 2022
(in thousands)

	2023	2022 (As restated)
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 21,770	$ 13,086
Short-term investments	615,943	416,886
Capitation receivable from the Department of Health Care Services (DHCS)	515,011	174,658
Prepaid expenses and other assets	13,588	19,330
Lease receivable - current	699	747
Total current assets	1,167,011	624,707
CAPITAL ASSETS, NET		
Nondepreciable	6,070	8,076
Depreciable, net of accumulated depreciation and amortization	30,233	31,468
Capital assets, net	36,303	39,544
Subscription assets, net of accumulated amortization	10,510	4,680
Lease receivable - noncurrent	2,385	1,792
Board-designated investments	413,202	384,362
Restricted deposits	300	300
TOTAL ASSETS	$ 1,629,711	$ 1,055,385
LIABILITIES, DEFERRED INFLOW OF RESOURCES, AND NET POSITION		
CURRENT LIABILITIES		
Medical claims liability	$ 288,373	$ 282,212
Provider incentives payable	40,000	10,000
Subscription liabilities, current portion	3,109	2,221
Accounts payable	7,912	3,415
Accrued liabilities	447,033	86,731
Total current liabilities	786,427	384,579
Subscription liabilities, net of current portion	5,578	1,642
Deferred inflow of resources	2,933	2,437
NET POSITION		
Invested in capital assets	36,303	39,544
Restricted	300	300
Unrestricted	798,170	626,883
Total net position	834,773	666,727
TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES, AND NET POSITION	$ 1,629,711	$ 1,055,385

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa
Managed Medical Care Commission
Statements of Revenues, Expenses, and Changes in Net Position
Years Ended December 31, 2023 and 2022
(in thousands)

	2023	2022 (As restated)
Operating revenues		
Capitation revenue	$ 2,085,911	$ 1,721,476
Operating expenses		
Medical expenses		
Medi-Cal		
Provider capitation	51,838	43,308
Claim payments to providers	1,297,305	1,242,624
Prescription drugs	18,832	15,286
Other medical	108,957	49,164
Alliance Care: In Home Supportive Services (IHSS) program	4,326	3,711
Reinsurance and other, net	2,246	4,784
Total medical expenses	1,483,504	1,358,877
Administrative expenses		
Premium tax expense	376,406	174,563
Salaries, wages, and employee benefits	63,405	56,342
Supplies, occupancy, insurance, and other	7,441	8,944
Professional fees	3,233	3,491
Depreciation and amortization	6,467	5,175
Purchased services	10,713	8,492
Total administrative expenses	467,665	257,007
Total operating expenses	1,951,169	1,615,884
Operating income	134,742	105,592
Investment income (loss), including net realized and unrealized gains and losses	44,560	(12,565)
Other income	1,926	1,741
Grants	(13,182)	(10,834)
Increase in net position	168,046	83,934
Net position, beginning of year	666,727	582,793
Net position, end of year	$ 834,773	$ 666,727

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa
Managed Medical Care Commission
Statements of Cash Flows
Years Ended December 31, 2023 and 2022
(in thousands)

	2023	2022 (As restated)
Cash flows from operating activities		
Capitation and other revenue	$ 2,211,787	$ 2,043,723
Payments to providers	(1,896,619)	(1,643,770)
Payments to vendors	(45,580)	(179,420)
Payments to employees	(61,487)	(55,932)
Net cash from operating activities	208,101	164,601
Cash flows from capital and related financing activities		
Purchases of capital assets	(2,493)	(641)
Proceeds from sale of capital assets	3,015	-
Payments on subscription liabilities	(2,221)	(1,053)
Net cash from capital and related financing activities	(1,699)	(1,694)
Cash flows from noncapital financing activities		
Grants	(13,182)	(10,834)
Net cash from noncapital financing activities	(13,182)	(10,834)
Cash flows from investing activities		
Purchases of investments	(209,082)	(279,169)
Proceeds from sales of investments	24,546	137,869
Net cash from investing activities	(184,536)	(141,300)
Net change in cash and cash equivalents	8,684	10,773
Cash and cash equivalents, beginning of year	13,086	2,313
Cash and cash equivalents, end of year	$ 21,770	$ 13,086
Reconciliation of increase in net position to net cash from operating activities		
Increase in net position	$ 168,046	$ 83,934
Adjustments to reconcile decrease in net position to net cash from operating activities		
Depreciation and amortization	6,467	5,175
Investment (income) loss	(44,560)	12,565
Gain on disposal of capital assets	(369)	-
Grants	13,182	10,834
Changes in assets and liabilities:		
Capitation receivable from the DHCS	(317,736)	74,086
Prepaid expenses and other assets	6,893	2,004
Subscription assets/liabilities	(2,165)	(1,605)
Medical claims liability	5,613	61,194
Directed payments payable	391	(110,831)
Provider incentives payable	30,000	-
Accounts payable	4,497	384
Accrued liabilities	337,842	26,861
Net cash from operating activities	$ 208,101	$ 164,601
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING AND FINANCING ACTIVITY		
Noncash acquisition of subscription assets	$ 7,045	$ 2,833

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa
Managed Medical Care Commission
Statements of Fiduciary Net Position
Years Ended December 31, 2023 and 2022
(in thousands)

	2023	2022
ASSETS		
Investments, at fair value		
Stable value/cash management	$ 6,755	$ 6,339
Bond	1,740	1,577
Guaranteed lifetime income	420	335
Balanced/asset allocation	35,103	28,197
U.S. stock	9,037	6,480
International/global stock	1,658	1,275
Specialty	1,569	1,252
Total investments, at fair value	56,282	45,455
Receivables		
Notes receivable from participants	1,524	1,341
Total receivables	1,524	1,341
NET POSITION AVAILABLE FOR BENEFITS	$ 57,806	$ 46,796

See accompanying notes.

Santa Cruz-Monterey-Merced-San Benito-Mariposa
Managed Medical Care Commission
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2023 and 2022
(in thousands)

	2023	2022
Additions to net position attributed to Investment income		
Net appreciation (depreciation) in fair value of investments	$ 7,456	$ (7,653)
Total investment income (loss)	7,456	(7,653)
Interest income on notes receivable from participants	52	46
Contributions		
Employer and employee contributions	5,207	4,787
Rollover contributions	135	136
Total contributions	5,342	4,923
Total additions, net	12,850	(2,684)
Deductions from net position attributed to		
Benefits paid to participants	1,878	3,647
Miscellaneous credits	(38)	(234)
Total deductions	1,840	3,413
Increase (decrease) in net position	11,010	(6,097)
Net position available for benefits		
Beginning of year	46,796	52,893
End of year	$ 57,806	$ 46,796

See accompanying notes.

Note 1 – Organization

The Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (the Alliance) is a Regional County Organized Health System serving Medi-Cal eligible persons in Santa Cruz, Monterey, 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. In 2024 service will expand into San Benito and Mariposa counties.

The Alliance has contracted with the California Department of Health Care Services (DHCS) to provide healthcare benefits to eligible County residents. In turn, the Alliance has contracted with various healthcare providers to provide or arrange hospital and medical services for its members. The Alliance's contract with DHCS extends through December 31, 2024. Previous to the convening of the new board, the contract with DHCS was with the Santa Cruz-Monterey-Merced Managed Medical Care Commission. Subsequent to the convening of the new board, the contract with DHCS is with the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission.

The Alliance, in partnership with Monterey County In Home Supportive Services (IHSS) Public Authority, operates the Alliance Care IHSS program. Alliance Care IHSS provides comprehensive healthcare to IHSS caregivers in Monterey County.

The Medi-Cal program accounted for approximately 99.8% of the Alliance's revenues for the years ended December 31, 2023 and 2022.

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-San Benito-Mariposa-Managed Medical Care Commission Board. The Alliance has no component units and is not reported as a component unit of any governmental entity.

Accounting standards – The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB). The activities of the Alliance are reported using the economic resources measurement focus and the accrual basis of accounting. Under this method, revenues are recorded when earned and expenses are recorded when the related liability is incurred. As permitted by GASB Statement No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, the Alliance has elected to apply all Financial Accounting Standards Board Statements and Interpretations, Accounting Principles Board Opinions, and Accounting Research Bulletins issued after November 30, 1989, which have been codified under Accounting Standards Codification (ASC), except for those that conflict with or contradict GASB pronouncements.

Statements of net position – Net position is required to be classified for accounting and reporting purposes in the following categories:

Invested in capital assets – This component of net position consists of capital assets including capital assets, net of accumulated depreciation and amortization and reduced by the outstanding balances of any bonds, notes, or other borrowings that are attributable to the acquisition, construction, or improvement of those assets.

Restricted – This component of net position consists of external constraints placed on net position by law. It also pertains to constraints imposed by constitutional provisions or enabling legislation.

Unrestricted – This component of net position consists of net position that do not meet the definition of "restricted" or "invested in capital assets." A portion of the unrestricted net position is board designated.

Use of estimates – The preparation of financial statements in accordance with 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 and amortization is calculated on a straight-line basis over the estimated lives of the assets, which are summarized as follows:

Building	39 years
Building equipment	5 to 15 years
Furniture and equipment	3 to 5 years
Software	3 to 5 years

The Alliance evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset.

Lease receivable and deferred inflow of resources – Pursuant to GASB Statement No. 87, *Leases*, the Alliance as a lessor, recognized a lease receivable and a deferred inflow of resources in the statements of net position. A lease receivable represents the present value of future lease payments expected to be received by the Alliance during the lease terms. A deferred inflow of resources is recognized corresponding to the lease receivable amount and is defined as an acquisition of net position by the Alliance that is applicable to future reporting periods. Amortization of the deferred inflow of resources is based on the straight-line method over the terms of the leases.

The Alliance recognizes lease contracts or equivalents that have a term exceeding one year and the annual receipts on the contract exceed $25,000 for equipment and $75,000 for real estate that meet the definition of another than short-term lease. The Alliance uses the same interest rate it charges to lessee as the discount rate or that is implicit in the contract to the lessee. Short-term lease receipts and variable lease receipts not included in the measurement of the lease receivable are recognized as income when earned.

Subscription assets and liabilities – The Alliance has recorded subscription assets as a result of implementing GASB No. 96. The subscription assets are initially measured at an amount equal to the initial measurement of the related subscription liability plus any contract payments made to the Subscription Based IT Arrangements (SBITA) vendor at the commencement of the subscription term, capitalizable initial implementation cost, less any incentive payments received from the SBITA vendor at the commencement of the subscription term. The subscription assets are amortized on a straight-line basis over the shorter of the subscription term or the useful life of the underlying assets.

The Alliance entered into various agreements for IT subscriptions. These agreements range in terms up to year 2028. Total lease payments were $4.5 million and $2.7 million for fiscal years 2023 and 2022, respectively. Variable payments based upon the use of the underlying IT asset are not included in the subscription liability because they are not fixed in substance—therefore, these payments are not included in subscription assets or subscription liabilities. The Alliance did not enter into any additional subscription agreements that have yet to commence as of December 31, 2023.

The following is a summary of changes in subscription liabilities, net for the years ended December 31:

2023	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
	$ 3,863	$ 7,045	$ 2,221	$ 8,687	$ 3,109

2022	Beginning Balance	Increase	Decrease	Ending Balance	Current Portion
	$ 2,083	$ 2,833	$ 1,053	$ 3,863	$ 2,221

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, 2023 and 2022, the Alliance had accumulated board-designated investments of $413.2 million and $384.4 million, respectively.

Medical claims liability – The Alliance establishes a medical claims liability based on estimates of the ultimate cost of claims in process and provision for claims incurred but not yet reported, which is determined based on historical claims payment experience and other statistics. Such reserves are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known; such adjustments are included in operations. Although considerable variability is inherent in such estimates, management believes that the medical claims liability is adequate and fairly stated; however, this liability is based on estimates and the ultimate liability may differ from the amount provided.
Also included in medical claims liability in the statements of net position are as follows at December 31:

	2023	2022
Proposition (Prop) 56 liability	$ 57,330	$ 62,961
Other program payable	34,066	19,752
Medical claims liability	196,977	199,499
Total	$ 288,373	$ 282,212

Proposition 56 liability – Assembly Bill 120 appropriated Proposition 56 funds in the 2017-18 state fiscal year for specified DHCS supplemental payment expenditures. DHCS developed supplemental payment methodologies that the Alliance is required to execute. The liability was $57.3 million in 2023 compared to $62.9 million in 2022.

Other program payable – In 2023 and 2022, DHCS implemented several State sponsored incentive programs related to behavior health integration, COVID vaccines, student behavior health, enhanced care management, community supports, and housing and homelessness. In 2023, $39 million in revenue and $39 million in incentive expense was recognized. In 2022, $27 million in revenue and $21 million in expenses was recognized.

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 2023, the Board allocated $20.0 million to the PCP Medi-Cal Program CBI incentive budget. For 2022, the Board allocated $10.0 million to the PCP Medi-Cal Program CBI incentive budget. During the years ended December 31, 2023 and 2022, respectively, $15.0 million and $10.0 million were paid out. Additionally, in 2023, the Board allocated $10.0 million for Specialist Care Incentive (SCI) program, which was previously retired in 2020, and $15.0 million for a new Hospital Quality Incentive Program (HQIP) that offers financial incentives for hospitals that meet performance targets. Accrued annual incentive program as of December 31, 2023 and 2022 was $40.0 million and $10.0 million, as included in provider incentives payable in the statements of net position.

Accrued liabilities – included in accrued liabilities on the statements of net position are the following at December 31:

	2023	2022
Managed Care Organization (MCO) tax liability	$ 397,867	$ 67,180
Acuity adjustment liability	29,177	6,561
Other accrued liabilities	9,288	7,974
Enhanced Care Management (ECM) risk corridor reserves	10,701	5,016
Total	$ 447,033	$ 86,731

MCO tax liability – Effective July 1, 2013 until June 30, 2016, Senate Bill 78 added Revenue and Taxation Code Article 5 to impose a 3.9375% sales tax on sellers of Medi-Cal health care services subject to DHCS providing capitation payments that make the Alliance actuarially sound. In 2016, California's Senate Bill X2.2 enacted a new Managed Care Organization tax, effective for a taxing period of July 1, 2016 through June 30, 2019. The approved tax structure is based upon enrollment between specified tiers that are assessed different tax rates. On April 3, 2020, the Centers for Medicare & Medicaid Services (CMS) approved a waiver for the broad-based and uniformity requirements related to the State of California’s Managed Care Organization (MCO) tax, effectively renewing the program effective January 1, 2020 through December 31, 2022. On June 29, 2023, AB 119 (Chapter 13, Statues of 2023) reimposed the MCO premium tax effective April 1, 2023 through December 31, 2026. The premium tax expense totaled $376.4 million and $174.6 million for the years ended December 31, 2023 and 2022, respectively.

ECM risk corridor reserve – Effective January 1, 2022, California launched a multi-year initiative called California Advancing and Innovating Medi-Cal (CalAIM) to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program, and payment reforms across the Medi-Cal program. CalAIM initiatives include the delivery of new Enhanced Care Management (ECM) benefits. DHCS has implemented two-sided risk corridors on ECM services as of January 1, 2022, under which managed care plans are fully at risk for losses up to 95% and gains over 105% on applicable ECM services. Managed care plans will owe a remittance to the State or be owed a payment from the State if gains or losses exceed 5 percent of the applicable ECM rates received. The CalAIM risk corridor reflects the potential amount due to the State for ECM gains in excess of the 105% risk corridor. During the years ended December 31, 2023 and 2022, the reduction of capitation revenue related to ECM risk corridors was $5.6 and $5.0 million, respectively.

Acuity adjustment liability – DHCS informed managed care plans of an upcoming acuity adjustment factor, resulting from extension of the DHCS re-determination, which impacted rates due to lower acuity of population that may already have other health coverage and/or lower utilization. Management recorded an estimated liability of $29.1 million and $6.6 million, respectively as of December 31, 2023 and 2022.

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, 2023 and 2022.

Statements of revenues, expenses, and changes in net position – For purposes of display, transactions deemed by management to be ongoing, major, or central to the serving of their members in Santa Cruz, Monterey, and Merced Counties are reported as operating revenues and expenses. Peripheral or incidental transactions are reported as nonoperating revenues and expenses. These peripheral activities include investment income, changes in unrealized gains and losses on investments, and grant expenditures.

Revenue recognition – Revenue is recognized in the month in which the members are entitled to healthcare services. Capitation revenue is received from DHCS each month following the month of service based on estimated enrollment and capitation rates as provided for in the DHCS contract. Eligibility of beneficiaries are determined by the Counties of Merced, Monterey, and Santa Cruz and validated by the State. The State provides the Alliance the validated monthly eligibility file in support of capitation revenue for the month. Further, the Alliance receives monthly reconciliations reflecting retrospective enrollment amounts from DHCS. As such, capitation revenue includes an estimate for amounts receivable from or refundable to DHCS for these retrospective adjustments. These estimates are continually monitored and adjusted, as necessary, as experience develops, or new information becomes known; such adjustments are included in operations.

Eligibility for the Alliance Care IHSS program is determined by Monterey County In Home Supportive Services Public Agency. A list of covered members is provided to the Alliance each month by the County of Monterey. Premiums are paid by the County to the Alliance in the month coverage is provided. Retroactive additions or deletions are not allowed under the agreement.

Grants – In December 2014, the Alliance Board approved $116.7 million in grant funding. An additional $106.3 million was approved in October 2016. The purpose of the grant program is to further the Alliance's mission by increasing member access to quality healthcare through strategic planning, program development, and responsive Medi-Cal capacity investments. In 2016, the grant program became fully operational. Grant expenditures are classified as nonoperating. For the years ended December 31, 2023 and 2022, a total of $13.2 million and $10.8 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 2023 and 2022) for all lines of business for inpatient claims, which include hospital, sub-acute, skilled nursing, long term care, and durable medical equipment, implants, orthopedics and prosthesis, limited to $1,000,000 in aggregate over all contract years per member. Stop-loss insurance premiums of $11.6 million and $11.3 million are included in reinsurance and other expense in 2023 and 2022, respectively. In 2023 and 2022, there is a total of $9.6 million and $6.5 million, respectively, in recoveries.

Professional liability insurance –The Alliance maintains insurance coverage for professional liability and errors and omissions insurance. The policy is an occurrence-based policy and designed to provide comprehensive professional liability insurance and errors and omissions insurance for Alliance employees. There have been no reductions in coverage or any claims that have exceeded coverage in any of the past three years.

Income taxes – The Alliance operates as a government unit under the purview of Internal Revenue Code Section 501(a) whose income is excluded from taxation under Internal Revenue Code Section 115 and corresponding provisions of the California Revenue and Taxation Code. As such, the Alliance is not subject to federal or state taxes on income.

Reclassifications – Certain amounts relating to prior year have been reclassified to conform with the current-year presentation.

New accounting pronouncements – The GASB issued GASB Statement No. 96, *Subscription Based IT Arrangements* (GASB 96). The statement provides guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs) for government end users (governments). This statement defines a SBITA; establishes that a SBITA results in a right-to-use subscription asset—an intangible asset—and a corresponding subscription liability; provides the capitalization criteria for outlays other than subscription payments, including implementation costs of a SBITA; and requires note disclosures regarding a SBITA. The Alliance adopted GASB No. 96 as of January 1, 2023, applied retrospectively. The Alliance calculated and recognized subscription assets, net, of $4.7 million and subscription liabilities of $3.9 million as of January 1, 2023. The impact to beginning net position was not significant. See Note 9.

In June 2022, the GASB issued Statement No. 101, *Compensated Absences* (GASB 101). The Statement updates the recognition and measurement guidance for compensated absences. This Statement requires that liabilities for compensated absences be recognized for (1) leave that has not been used, and (2) leave that has been used but not yet paid, provided the services have occurred, the leave accumulates, and the leave is more likely than not to be used for time off or otherwise paid in cash or noncash means. In estimating the leave that is more likely than not to be used or otherwise paid or settled, a government should consider relevant factors such as employment policies related to compensated absences and historical information about the use or payment of compensated absences. The statement amends the existing requirements to disclose only the net change in the liability instead of the gross additions and deductions to the liability. The statement is effective for fiscal years beginning after December 15, 2023. The Alliance is currently evaluating the impact of the adoption of this standard on its financial statements.

Note 3 – Cash and Cash Equivalents, Short-Term Investments, and Board-Designated Investments

Cash and cash equivalents and investments as of December 31, 2023 and 2022, consist of the following (in thousands):

	2023	2022
Cash and cash equivalents	$ 21,770	$ 13,086
Short-term investments	615,943	416,886
Restricted deposits	300	300
Board-designated investments, at fair value	413,202	384,362
Total cash, cash equivalents, and investments	$ 1,051,215	$ 814,634

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.

	2023		2022	
	Carrying Amount	Bank Balance	Carrying Amount	Bank Balance
Insured	$ 350	$ 350	$ 450	$ 450
Collateralized	21,720	23,728	12,936	14,809
Total cash and restricted deposits (in thousands)	$ 22,070	$ 24,078	$ 13,386	$ 15,259

Investments – The Alliance invests in obligations of U.S. government agencies, corporate notes, and instrumentalities. The Alliance's investment policy allows only high-quality investments as permitted by the Code and subject to the limitations of the Alliance's Annual Investment Policy (investment policy).

The Alliance also invests in the State of California Local Agency Investment Fund (LAIF). The Local Investment Advisory Board provides oversight for LAIF. The Board consists of five members as designated by statute. The chairman is the state treasurer or his designated representative.

Two members qualified by training and experience in the field of investment or finance, and the state treasurer appoints two members who are treasurers, finance or fiscal officers, or business managers employed by any county, city, or local district or municipal corporation of this state. The term of each appointment is two years or at the pleasure of the appointing authority. The recorded value of the Alliance's investments in LAIF is equal to the Alliance's share of the estimated fair value of the underlying assets.

In 2016, the Alliance invested in the Investment Trust of California (CalTrust) as one of its discretionary advisory partners. Blackrock Financial Management, a registered investment advisor, provides oversight for CalTrust pursuant to Joint Exercise of Powers Agreement. The Board of Trustees consists of ten Trustees, at least seventy-five percent are members of the governing body, officers, or personnel of the Members which are appointed by the initial Members and the Board. The Trustees and Officers currently serve without compensation but are reimbursed for reasonable expenses in connection with their duties. The Board is responsible for setting overall policies and procedures and for the retention and monitoring of all agents acting on behalf of CalTrust. The recorded value of the Alliance's investments in CalTrust is equal to the Alliance's share of the estimated fair value of the underlying assets.

LAIF and CalTrust are external investment pools. Per GASB Statement No. 72, fair value hierarchy disclosure is not required for these external pooled investments.

Government money market funds are required to invest at least 99.5% of their total assets in (i) cash; (ii) securities issued or guaranteed by the United States or certain U.S. government agencies or instrumentalities; and/or (iii) repurchase agreements that are collateralized fully. The Fund is exempt from requirements that permit money market funds to impose a liquidity fee and/or temporary redemption gates. Shares are not restricted as to when they may be redeemed.
The following is a summary of the fair value hierarchy of the Alliance's short-term investments and board-designated investments, as of December 31 (in thousands):

	2023				
Investment Type	**Total**	**Investment Exempt from Fair Value**	**Level 1**	**Level 2**	**Level 3**
Corporate bonds	$ 97,906	$ -	$ 97,906	$ -	$ -
State & local agency bonds	61,191	-	61,191	-	-
U.S. agency bonds	45,541	-	45,541	-	-
Money market funds	240,174	240,174	-	-	-
	444,812	$ 240,174	$ 204,638	$ -	$ -
External Investment Pool					
LAIF	73,225				
CalTrust	511,108				
	$ 1,029,145				

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

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, 2023 the Alliance's short-term and board designated investments have the following related maturity schedule (in thousands):

Investment Type	Fair Value	Less Than 1 Year	1–5 Years
Corporate bonds	$ 97,906	$ -	$ 97,906
State and local agency bonds	61,191	-	61,191
U.S. agency bonds	45,541	-	45,541
Money market funds	240,174	240,174	-
CalTrust	511,108	511,108	-
LAIF	73,225	73,225	-
Total	$ 1,029,145	$ 824,507	$ 204,638

As of December 31, 2022, the Alliance's short-term and board designated investments have the related maturity schedule (in thousands):

Investment Type	Fair Value	Less Than 1 Year	1–5 Years
Corporate bonds	$ 109,866	$ -	$ 109,866
State and local agency bonds	33,865	-	33,865
U.S. agency bonds	18,200	-	18,200
Money market funds	135,715	135,715	-
CalTrust	428,627	428,627	-
LAIF	74,975	74,975	-
Total	$ 801,248	$ 639,317	$ 161,931

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, 2023 the following are the credit ratings of short-term and board designated investments (in thousands):

Investment Type	Fair Value	Unrated	Rating as of Year-End AAA	AA+	AA	A+	A	A-	BBB+	BBB
Money market fund	$ 240,174	$ 240,174	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Corporate bonds	97,906	-	538	13,179	28,782	22,654	29,838	-	1,937	978
F.F.C.B.	6,640	-	-	6,640	-	-	-	-	-	-
Federated Government Obligations Fund	1,924	-	-	-	1,924	-	-	-	-	-
Federal Home Loan Mortgage	21,171	-	-	21,171	-	-	-	-	-	-
State and local bonds	61,191	-	12,283	18,877	23,393	4,787	1,851	-	-	-
United States Treasury Notes	15,806	8,689	6,517	600	-	-	-	-	-	-
LAIF	73,225	73,225	-	-	-	-	-	-	-	-
CalTrust	511,108	511,108	-	-	-	-	-	-	-	-
Total	$ 1,029,145	$ 833,196	$ 19,338	$ 60,467	$ 54,099	$ 27,441	$ 31,689	$ -	$ 1,937	$ 978

As of December 31, 2022, the following are the credit ratings of short-term and board designated investments (in thousands):

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

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.

		Percentage of Portfolio	
Investment	**Issuer**	**2023**	**2022**
Money market funds		23.3 %	16.9 %
U.S. government securities	Federal Home Loan Mortgage	2.1	1.3
	United States Treasury Notes	1.5	0.4
	Federal Farm Credit Bond	0.6	0.3
	Federal Government Obligations Fund	0.2	0.2
Corporate bonds	Various	9.5	13.7
State and local bonds	Various	5.9	4.2
LAIF	State of California	7.1	9.3
CalTrust	CalTrust JPA	49.7	53.5
		100 %	100 %

Note 4 – Capital Assets

Capital assets – Capital assets activity in 2023 consists of the following (in thousands):

	December 31, 2022	Increases	Decreases/ Transfers	December 31, 2023
Capital assets not being depreciated				
Land	$ 7,564	$ -	$ (2,603)	$ 4,961
Construction in process	512	2,493	(1,896)	1,109
Total capital assets not being depreciated	8,076	2,493	(4,499)	6,070
Capital assets being depreciated				
Buildings and building equipment	42,956	-	741	43,697
Furniture and equipment	16,613	-	(6,171)	10,442
Software	16,657	-	3,645	20,302
	76,226	-	(1,785)	74,441
Less accumulated depreciation for				
Buildings and building equipment	14,115	1,552	62	15,729
Furniture, equipment, and software	30,643	1,535	(3,699)	28,479
	44,758	3,087	(3,637)	44,208
Total capital assets being depreciated, net	31,468	(3,087)	1,852	30,233
Total capital assets, net	$ 39,544	$ (594)	$ (2,647)	$ 36,303

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

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

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, 2023 and 2022 (in thousands):

	2023	2022
Beginning balance	$ 282,212	$ 226,063
Incurred		
Current year	1,396,146	1,298,237
Prior years	11,725	32,936
Total	1,407,871	1,331,173
Paid		
Current year	1,139,785	1,039,963
Prior years	261,925	235,061
Total	1,401,710	1,275,024
Ending balance	$ 288,373	$ 282,212

Medical claims payable increased by $6.2 million in comparison to the previous year. $2.6 million of the fluctuation is related to a decrease in the general medical claims payable reserves and is due to the changes between actual payments for medical services and estimated amounts in previous years. In addition, there was a decrease of $5.6 million from the accruals and payments of State directed Proposition 56 supplemental payments. The decreases were offset by an other liabilities increase of $14.4 million which was mainly due to the increases in the State's Incentive payments programs liability.

Amounts incurred related to prior years represent changes from previously estimated liabilities. In 2023, amounts incurred related to prior year results from claims being adjudicated and paid for amounts were more than originally estimated due to adverse claims experience and higher than expected acuity for high-dollar medical services. Liabilities at any year-end are continuously reviewed and re-estimated 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 $65.2 million and $60.6 million at December 31, 2023 and 2022, 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, 2023 and 2022, total net position was $834.8 million and $666.7 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 $4.9 million of retirement plan expense during 2023 and 2022, 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	2023	Level 1	Level 2	Level 3
Investments by fair value level	$ -	$ -	$ -	$ -
	-	$ -	$ -	$ -
Investments not subject to fair value hierarchy				
Collective investment trusts - at NAV	56,282			
Total investments	$ 56,282			

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

Plan description – Participant data for the Plan, as of the measurement date for the year indicated, is as follows:

- All full-time, part-time, and per-diem employees of the Organization are eligible to participate in the Plan. Employees are eligible to receive employer contributions upon completion of one year of service, defined as working 12 months for a minimum of 1,000 hours.
- Participants will receive an employer contribution of 10% of compensation. Employees who wish to make elective contributions may do so through the agency's 457 plan.
- Participants are fully vested in employer contributions.

Employer contribution – The Alliance makes contributions based on the established funding practice.

Notes receivable from participants – Participants may borrow from their accounts a minimum of $1,000 up to a maximum equal to the lesser of $50,000 or 50% of their vested account balance. The maximum loan term is five years unless the loan term qualifies as a home loan, in which case the term of the loan is not to exceed 30 years.

Loans are secured by the balance of the participant's account and bear fixed, reasonable rates of interest, as determined by the custodians. Principal and interest are paid directly by the participant to the custodians through monthly ACH transactions. As of December 31, 2023 and 2022, the rates of interest on outstanding loans with Mission Square was 3.4% and 3.4%, respectively, with maturities extending up to five years. The interest rate is locked in for the term of the loan and established at the onset of the loan. The loan totals as of December 31, 2023 and 2022 were $1.5 million and $1.34 million, respectively.

Rate of return – The Plan is a defined contribution plan with investment returns varying per participant based on investment elections. On a cumulative basis for the years ended December 31, 2023 and 2022, the cumulative rate of return for the 401(a) plan was 15.9% and 14.5%, respectively.

Note 8 – Leases

The Alliance is a lessor for noncancellable leases of multiple leases. Lease revenue from the lease arrangements were $1.5 million and $1.3 million for the years ended December 31, 2023 and 2022, respectively, and were included in other income in the statements of revenues, expenses, and changes in net position. Interest revenue from the lease arrangements was $151,000 and $102,000 for the years ended December 31, 2023 and 2022, respectively, and was included in other income in the statements of revenues, expenses, and changes in net position.

Note 9 – Subscription Based Information Technology Arrangements

The Alliance has the following subscription asset activities as of December 31:

2023	Beginning Balance	Increase	Decrease	Ending Balance
Subscription assets	$ 6,402	$ 9,210	$ 933	$ 14,679
Less accumulated amortization	(1,722)	(3,380)	(933)	(4,169)
Subscription assets, net	$ 4,680	$ 5,830	$ -	$ 10,510

2022	Beginning Balance	Increase	Decrease	Ending Balance
Subscription assets	$ 2,083	$ 4,438	$ 119	$ 6,402
Less accumulated amortization	-	(1,841)	(119)	(1,722)
Subscription assets, net	$ 2,083	$ 2,597	$ -	$ 4,680

For the years ended December 31, 2023 and 2022, the Alliance recognized $3.3 million and $1.8 million, respectively, in amortization expense included in depreciation and amortization expense on the statements of activities and changes in net position.

The future subscription payments as of December 31, 2023, were as follows:

Year Ending December 31	Principal	Interest	Total
2024	$ 3,109	$ 317	$ 3,426
2025	1,847	224	2,071
2026	1,761	151	1,912
2027	1,904	80	1,984
2028	66	3	69
Thereafter	-	-	-
Total	$ 8,687	$ 775	$ 9,462

The Alliance evaluated the subscription assets for impairment and determined there was no impairment for the years ended December 31, 2023 and 2022.

Note 10 – Risks and Uncertainties

The Alliance primarily serves Medi-Cal eligible persons. Laws and regulations governing the Medi-Cal program are complex and subject to interpretation. The Alliance believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. While no such regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medi-Cal programs.

Note 11 – Contingencies

The Alliance is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on the Alliance's financial position or results of operations.

Note 12 – Health Care Reform

There are various proposals at the federal and state levels that could, among other things, significantly change member eligibility, payment rates or benefits. The ultimate outcome of these proposals, including the potential effects of or changes to health care reform that will be enacted cannot presently be determined.

Supplementary Information

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Santa Cruz-Monterey-Merced-San Benito-Mariposa
Managed Medical Care Commission
Schedule of Revenues and Expenses by Program and Changes in Net Position
Year Ended December 31, 2023
(in thousands)

	Medi-Cal					
	Santa Cruz County	Monterey County	Merced County	IHSS Program	Administrative	Total
Operating revenues						
Capitation revenue	$ 415,057	$ 921,419	$ 744,888	$ 4,547	$ -	$ 2,085,911
Operating expenses						
Medical expenses						
Medi-Cal						
Provider capitation	10,345	22,804	18,689	-	-	51,838
Claim payments to providers	345,693	554,643	396,969	-	-	1,297,305
Prescription drugs	7,090	8,416	3,326	-	-	18,832
Other medical	22,408	48,195	38,354	-	-	108,957
Alliance Care: IHSS program	-	-	-	4,326	-	4,326
Reinsurance and other, net	495	906	845		-	2,246
Total medical expenses	386,031	634,964	458,183	4,326	-	1,483,504
Administrative expenses						
Premium tax expense	-	-	-	-	376,406	376,406
Salaries, wages, and employee benefits	-	-	-	-	63,405	63,405
Supplies, occupancy, insurance, and other	-	-	-	-	7,441	7,441
Professional fees	-	-	-	-	3,233	3,233
Depreciation and amortization	-	-	-	-	6,467	6,467
Purchased services	-	-	-	-	10,713	10,713
Total administrative expenses	-	-	-	-	467,665	467,665
Total operating expenses	386,031	634,964	458,183	4,326	467,665	1,951,169
Operating income (loss)	29,026	286,455	286,705	221	(467,665)	134,742
Investment income, including net realized and unrealized gains and losses	-	-	-	-	44,560	44,560
Other income	-	-	-	-	1,926	1,926
Grants	-	-	-	-	(13,182)	(13,182)
Increase (decrease) in net position	$ 29,026	$ 286,455	$ 286,705	$ 221	$ (434,361)	168,046
Net position, beginning of year						666,727
Net position, end of year						$ 834,773

Santa Cruz-Monterey-Merced-San Benito-Mariposa
Managed Medical Care Commission
Schedule of Revenue and Expenses by Program and Changes in Net Position
Year Ended December 31, 2022
(in thousands)

	Medi-Cal					
	Santa Cruz County	Monterey County	Merced County	IHSS Program	Administrative	Total
Operating revenues						
Capitation revenue	$ 360,781	$ 738,301	$ 618,173	$ 4,221	$ -	$ 1,721,476
Operating expenses						
Medical expenses						
Medi-Cal						
Provider capitation	6,607	19,602	17,099	-	-	43,308
Claim payments to providers	270,502	546,371	425,751	-	-	1,242,624
Prescription drugs	6,102	5,901	3,283	-	-	15,286
Other medical	12,418	21,494	15,252	-	-	49,164
Alliance Care: IHSS program	-	-	-	3,711	-	3,711
Reinsurance and other, net	999	2,021	1,764	-	-	4,784
Total medical expenses	296,628	595,389	463,149	3,711	-	1,358,877
Administrative expenses						
Premium tax expense	-	-	-	-	174,563	174,563
Salaries, wages, and employee benefits	-	-	-	-	56,342	56,342
Supplies, occupancy, insurance, and other	-	-	-	-	8,944	8,944
Professional fees	-	-	-	-	3,491	3,491
Depreciation and amortization	-	-	-	-	5,175	5,175
Purchased services	-	-	-	-	8,492	8,492
Total administrative expenses	-	-	-	-	257,007	257,007
Total operating expenses	296,628	595,389	463,149	3,711	257,007	1,615,884
Operating income (loss)	64,153	142,912	155,024	510	(257,007)	105,592
Investment income, including net realized and unrealized gains and losses	-	-	-	-	(12,565)	(12,565)
Other income	-	-	-	-	1,741	1,741
Grants	-	-	-	-	(10,834)	(10,834)
Increase (decrease) in net position	$ 64,153	$ 142,912	$ 155,024	$ 510	$ (278,665)	83,934
Net position, beginning of year						582,793
Net position, end of year						$ 666,727

MOSSADAMS

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DATE: May 22, 2024

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

FROM: Dr. Dennis Hsieh, Chief Medical Officer

SUBJECT: Care-Based Incentive Program 2025

Recommendation. Staff recommend the Board approve the Care-Based Incentive (CBI) Program proposal described below for 2025.

Summary. This report provides an overview of the CBI Program and makes a recommendation for structural program changes to CBI 2025.

Proposed changes to 2025 programmatic measures are:

- Add Chlamydia Screening in Women
- Add Colorectal Cancer Screening
- Add Well-Child Visits for Age 15 months – 30 months
- Retire Health Equity: Child and Adolescents Well Child-Care Visits.
- Retire Performance Improvement.

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 promote 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 the National Committee for Quality Assurance (NCQA)'s Healthcare Effectiveness and Data Information Set (HEDIS), referred to as Medi-Cal Managed Care Accountability Set (MCAS), which includes measures from both HEDIS and the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Measure Sets, Dental Quality Institute (DQI), and the Joint Commission (TJC).

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. Measure selection for CBI has also taken into consideration preventive service measure gaps with a focus on health equity in alignment with DHCS Quality Strategy and the Alliance Strategic Plan as a way to support the Medi-Cal population.

Discussion. For 2025 programmatic Care Coordination – Hospital & Outpatient and Care Coordination – Access measures, staff recommend no change for the measures below.

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

For the proposed 2025 programmatic Quality of Care measures we would like to add Chlamydia Screening in Women, Colorectal Cancer Screening, and Well-Child Visits for Age 15 months – 30 months, transitioning from an exploratory to a programmatic status. The rationale is because both of these are required DHCS MCAS metrics. The following are recommended to remain unchanged: Breast Cancer Screening; Cervical Cancer Screening, Child and Adolescent Well-Care Visit, Diabetic HbA1c Poor Control (>9%); Immunizations: Adolescents; Immunizations: Children (Combo 10); and Well-Child Visit in the First 15 Months.

Measure Category	Measure Name
Quality of Care Measures	Breast Cancer Screening
	Cervical Cancer Screening
	Child and Adolescent Well-Care Visits (3-21)
	Chlamydia Screening in Women
	Colorectal Cancer Screening
	Diabetic HbA1c Poor Control >9.0 %
	Immunizations: Adolescents
	Immunizations: Children
	Lead Screening in Children
	Screening for Depression and Follow-up Plan
	Well-Child Visit in The First 15 Months
	Well-Child Visits for Age 15 months – 30 months

For 2025, it is recommended that the Health Equity: Child and Adolescent Well-Care Visit measure would be retired. This is because this is duplicative of DHCS required MCAS measures. We believe that focusing on other areas of opportunity to support health equity would be more beneficial than how the current measure is designed in CBI. We are also recommending that the Performance Improvement threshold be removed as well, this is duplicative now that other improvements have been added to Care Coordination and Quality of Care measures.

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

Attachments. N/A

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DATE: May 22, 2024

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

FROM: Marwan Kanafani, Health Services Officer

SUBJECT: Request for Letter of Support for Program of All-Inclusive Care for the Elderly

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Recommendation. Staff recommend the Board review and consider the request for a Letter of Support (LOS) from GoldenPACE Health to develop a Program of All-Inclusive Care for the Elderly (PACE) to serve Santa Cruz, Monterey and San Benito counties.

Background. The PACE model of care provides a comprehensive medical and social service delivery system, using an interdisciplinary team approach, within a PACE Center that provides and coordinates all needed preventive, primary, acute, and long-term care services. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model allows eligible individuals to remain independent and in their homes for as long as possible.

Many PACE enrollees are dually eligible for Medicare and Medi-Cal and the PACE program becomes the sole source of Medicare and Medi-Cal benefits for PACE participants. In a Medi-Cal managed care county, dually eligible Medicare/Medi-Cal PACE enrollees are disenrolled from the Medi-Cal managed care plan and are instead enrolled in the PACE program where they receive all necessary medical care.

To be eligible for PACE, participants must be at least 55 years old, reside in a service area or zip code served by a PACE program, and be determined to be eligible for nursing home level of care. The comprehensive service package of the PACE model of care enables individuals to remain living independently within their home and community, rather than receiving care in a nursing home.

In 2016, the California Legislature passed the PACE Modernization Act (Sections 31-36 of SB 833, Chapter 30, Statutes of 2016), which included updates to the payment and regulatory structure of PACE. The updated California PACE statutes, in part, removed the cap on the number of PACE Organizations (POs) that could operate in the state, and allowed for-profit entities to become POs.

In late 2017, the Department of Health Care Services (DHCS) developed guidance regarding its review and approval of PACE for dually eligible Medicare/Medicaid beneficiaries. DHCS subsequently issued PACE Policy Letter (PL 19-01 – superseded by PL 23-01 issued April 14, 2023), documenting this guidance. The purpose of PACE PL 23-01 is to inform POs and potential applicant organizations of DHCS' application review process and timeline for new PO applications and PO Expansion applications. Among other things, this guidance requires that a PO seeking to commence or expand operations in a county served by a County Organized Health System (COHS) must obtain an LOS from the COHS which includes a statement that the COHS supports the establishment of the independent PO in the county, and verification of the COHS' concurrence with the applicant's proposed service area.

Full approval of a PO requires both State and Federal approvals through a defined application process, which begins with the POs submission of a Letter of Intent to DHCS. Based on the information provided by the PO, DHCS will decide whether to move forward with a non-COHS

PACE application in a COHS county. If DHCS approves operation of a non-COHS PO in a COHS county, the non-COHS PO must contract directly with DHCS and Centers for Medicare & Medicaid Services (CMS) as the PACE entity in a three-way program agreement. DHCS does not allow a COHS to contract with DHCS and CMS as the PACE entity in the three-way program agreement, whereby the COHS would delegate operation of the PO to a separate entity.

Discussion. Pursuant to Alliance policy, the Alliance's Board is required to consider and determine a request for an LOS which has either a potential or actual financial/business impact on the Alliance. The Alliance has been asked by representatives of GoldenPACE Health to provide an LOS for their development of a PACE organization to operate a PACE center in Salinas intended to serve eligible beneficiaries within its catchment area (i.e., 60 minute travel time) which includes zip codes in Santa Cruz, Monterey and San Benito counties. This report provides a review of relevant issues for the Board's consideration and determination regarding this request.

The Alliance's offer of support for a third-party PACE means that the Alliance would forego the exclusivity of its contracting authority for a defined set of Alliance eligible members, thereby having both a financial and business impact to the Alliance.

Staff previously identified criteria to inform the Board's consideration of such a request and shared this with GoldenPACE Health for response. See the full list of criteria in Attachment A of this report.

Staff corresponded with GoldenPACE Health representatives to obtain information responsive to the criteria. Key criteria and responsive information submitted by GoldenPACE Health are outlined in the attached letter dated April 12, 2024 from GoldenPACE Health requesting an LOS for operations of a PO within the Alliance's service area to include specified zip codes in Monterey, San Benito and Santa Cruz counties.

Since GoldenPACE Health is not yet operational, nor providing services to members, staff are unable to review areas such as fiscal viability, quality, program integrity, encounter and claims data submission, or contractual compliance which may affect the Board's decision related to the request for support. However, staff will provide the Board with an assessment of the materials provided by GoldenPACE Health at the Board's May 22, 2024 meeting to support the Board's evaluation of the request for a letter of support.

Notably, GoldenPACE Health proposes to begin operations, upon DHCS and CMS approval, on January 1, 2026, which coincides with the anticipated start of operations of the Alliance's Dual Eligible Special Needs Plans (D-SNP) which will also offer coordinated, integrated care for dually eligible Alliance members. Additionally, PACE offers adult day health care services to enrolled individuals. Thus, a PACE center operating in Salinas could conceivably have an impact on existing Community Based Adult Services (CBAS) centers currently operating in Salinas and Watsonville.

Fiscal Impact. While the Alliance would lose the revenue associated with the individuals that elect to enroll in GoldenPACE Health, the plan would also not incur the medical costs for these individuals.

Attachments.

1. Attachment A: Criteria for Assessment of PACE Letter of Support by Central California Alliance for Health
2. Attachment B: Letter of Support request received from GoldenPACE Health dated April 12, 2024
3. Attachment C: Letters of Concern from Community Bridges/Elderday Adult Day Health Care and La Casa Adult Day Health Center, Inc.

Attachment A: Criteria for Assessment of PACE Letter of Support

1. Whether the requesting organization is local with established history of providing services to Alliance members and/or low income residents of the community.

2. Whether the requesting organization has provided a description of the member experience for delivery of services including addressing the following, and any other relevant factors.

    - Which services will to be made available to members within the county in which the member resides and for which services members would be required to travel out of area for services (longer than a 30 minute drive).
    - A description of how transportation will be facilitated for members to services in the county in which the member resides and out of the area.
    - Identification of the physical site at which the PACE will operate and the defined service area.
    - Whether services will be provided by subcontractors to the requesting organization, rather than directly provided by the requesting organization itself.
    - A description of the marketing activities targeting members for enrollment.

3. Whether the requesting organization, if contracted with the Alliance, is in good standing with the Alliance.
    - This includes, but is not limited to, having no identified potential quality issues, no potential issues of fraud, waste or abuse, and, no open quality or fraud waste and abuse investigations.
    - Additionally, the organization must not currently be engaged in contract negotiations with the Alliance or pursuing litigation or arbitration against the Alliance at the time of application.
    - The Alliance Chief Executive Officer or designee may determine that the requesting organization is not in good standing based on the considerations identified above or other business concerns including a record of not providing encounter data or claims submissions in a timely manner.

4. Whether the requesting organization has agreed to establish an MOU with the Alliance addressing:
    - The transition of members out of the managed care plan into the PACE;
    - The transition of members back into managed care should the member determine they no longer want to be enrolled in the PACE; and,
    - A process to resolve and address any issues or conflicts between the PACE and the managed care organization.

5. The requesting organization's provision of its Market Feasibility Study or other data or analyses indicating that entry of the PACE into the market will not disrupt existing delivery systems on which Medi-Cal members rely for community based services.

6. Copies of all necessary Letters of Support obtained, and an identification of any objection raised by a required supporter.

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GoldenPACE Health

April 12, 2024

Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Dear Members of the Board,

GoldenPACE Health is requesting your support of our application to the Department of Health Care Services (DHCS) to establish a Program of All-Inclusive Care for the Elderly (PACE) in Monterey, San Benito, and Santa Cruz counties.

PACE is a comprehensive healthcare model designed to provide coordinated medical and social services for low-income seniors who meet the criteria for nursing home care so that they may continue living in their own homes and communities. Through PACE, participants receive personalized care plans, including medical, therapeutic, and social services, all aimed at improving their quality of life while maintaining independence. PACE is considered the gold standard of care for dual-eligible, nursing-home qualified seniors, resulting in improved outcomes for key metrics such as: increased life expectancy by an average of three years, reduced hospitalizations, reduced readmission rates, and reduced ER visits. PACE collaborates with existing healthcare providers and community-based organizations to deliver cost-effective, fully integrated care. PACE provides these services at no cost to the participant, their family, or the community.

Both our federal and state governments have been encouraging the expansion of PACE to areas that do not currently offer PACE. However, due to the rigorous application process, which includes a significant capital investment and a lead time of 18 to 24 months, few organizations have been willing or able to establish new PACE programs. In response, in 2015, the federal government removed the non-profit requirement, to reduce barriers to establishing new PACE programs.

GoldenPACE Health is a mission-driven business that functions in the framework of a public-private partnership, with no religious affiliation. Accountability and oversight are inherent in establishing and operating our PACE program. Throughout the application review process, GoldenPACE Health's plans will be examined by DHCS to determine program experience, technical and regulatory expertise, and financial viability. Upon approval and acceptance by the state, GoldenPACE Health's application will be forwarded to the Centers for Medicare & Medicaid Services (CMS) for two ninety-day review periods and a required review of the PACE facility by DHCS in between these review periods. Finally, once the application is approved by both DHCS and CMS, GoldenPACE Health will enter into a three-way contract between CMS, DHCS, and GoldenPACE Health.

Today, PACE exists in 27 of California's 58 counties, but it is not available in Monterey, San Benito, and Santa Cruz counties. The areas without PACE are California's traditionally underserved and rural

communities, and GoldenPACE Health is committed to advancing health equity and access in these areas. GoldenPACE Health's mission is *to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities*.

GoldenPACE Health's mission aligns with CCAH's mission to provide *accessible, quality health care* to residents within its service area, and supports the CCAH vision of healthy people, healthy communities. Additionally, GoldenPACE Health will further CCAH's strategic priorities of Health Equity and Person-Centered Healthcare Delivery. GoldenPACE will advance Health Equity by providing low-income, medically complex, elderly residents in the CCAH service area access to comprehensive and culturally appropriate care. GoldenPACE Health shares CCAH's priority to extend Person-Centered Healthcare Delivery and embodies the "4 M's" of Age-Friendly Health Systems (AFHS), by addressing what Matters, improving Mobility, managing Medications, and conducting routine cognitive assessments to support healthy Mentation for participants and their caregivers.

GoldenPACE Health will support existing CCAH partners in coordinating care and managing risk for their most frail and chronically ill patients in a fully integrated, home and community-based care model that coordinates primary, acute, and long-term care services. Our leadership team has been meeting with local providers, community-based organizations, and government leaders to discuss GoldenPACE Health and our goal to bring PACE services to the area. From these conversations it is clear the community understands the need and is eager for us to move forward quickly. You will see in our responses to the assessment criteria (Attachment A) that we have a great deal of support already; for example, we have received letters of support from the cities of Santa Cruz, Monterey, Salinas, and Seaside, as well as from local providers such as Dientes Community Dental, Salinas Valley Health, and the Blind & Visually Impaired Center of Monterey County, and community-based organizations including Alliance on Aging, Community Health Trust of the Pajaro Valley and the Alzheimer's Association of Northern California. All of these letters will accompany our application packet to DHCS.

As the County Organized Health System in these counties, your support is key, and a letter of support from the CCAH is the only element keeping us from moving forward with our application. In the spirit of removing barriers to health equity for our most vulnerable populations, we respectfully request a letter of support from the CCAH Board.

To meet the DHCS timelines and begin providing PACE services in January 2026, GoldenPACE Health requests this letter by May 15.

Sincerely,

Alicia Rodriguez
CEO, GoldenPACE Health

40 Penny Lane, Suite 207B, Watsonville, CA 95076

Attachment A: GoldenPACE Health Response to Criteria for Assessment of PACE Letter of Support

1. Whether the requesting organization is local with established history of providing services to Alliance members and/or low income residents of the community.

   GoldenPACE Health, headquartered in Watsonville, actively participates with numerous local service organizations and efforts to support low-income seniors and their caregivers in our communities. These include the Seniors Commission of Santa Cruz County, the Area Agency on Aging for Monterey County, the Santa Cruz & San Benito Seniors Council, and San Benito County Aging and Long-Term Care Commission.

   While GoldenPACE Health does not provide services to Alliance members, its founder has extensive experience in community health, including twelve years of leadership in one of California's largest Federally Qualified Health Centers (FQHC), where she implemented multiple Medicaid-specific programs for low-income seniors, such as the Home & Community Based Waiver Program and Comprehensive Care Management (CCM), now Enhanced Care Management (ECM) under CalAIM. She also set up the first FQHC-operated, now the largest PACE program, in San Diego County, San Diego PACE.

   GoldenPACE Health has developed relationships with city and county government leaders, service providers, and community-based organizations throughout the service area. These alliances position GoldenPACE Health to collaborate with existing service providers in the region as GoldenPACE Health establishes its PACE program to serve at-risk, nursing home qualified seniors in the tri-county area.

2. Whether the requesting organization has provided a description of the member experience for delivery of services including addressing the following, and any other relevant factors.

   o Which services will be made available to members within the county in which the member resides and for which services members would be required to travel out of area for services (longer than a 30 minute drive).

   GoldenPACE Health will establish the initial PACE Center in Salinas, which is centrally located in the proposed PACE service area. The PACE Center location was selected to minimize the travel time for participants on transportation vans. All required PACE Interdisciplinary Team services will be administered at the PACE Center, and GoldenPACE Health will contract with providers in all three counties to minimize the travel time for services not offered on-site at the PACE Center, such as medical specialists, hospitals, and skilled nursing facilities. As GoldenPACE Health grows, additional PACE Centers or Alternative Care Settings will be implemented to further reduce the routine travel times for participants coming to the PACE Center.

   o A description of how transportation will be facilitated for members to services in the county in which the member resides and out of the area.

   The zip codes in the service area for GoldenPACE Health were selected to ensure the participants can reach the PACE Center from their residence within the sixty (60) minute travel time mandated by CMS and DHCS. GoldenPACE Health will begin PACE operations using a hybrid model of directly providing transportation services and contracting with a local transportation service. When possible GoldenPACE Health will

utilize its own transportation vans and employ drivers to transport participants to and from their residences and to appointments. When this demand cannot be met using GoldenPACE Health vans and drivers, a local contracted vendor will be used to transport participants. All employees of the contracted vendor will be treated as directly employed transportation drivers and will be held to the same standards of experience, background checks, immunizations, and PACE specific training before providing transportation to PACE participants. The vans of the contracted vendor will be maintained at the same level as the directly owned transportation vans and the maintenance records and daily inspection reports will be available to GoldenPACE Health as requested.

o Identification of the physical site at which the PACE will operate and the defined service area.

GoldenPACE Health is evaluating commercial properties that are available in Salinas for a facility. The defined service area, detailed in Attachment B, includes Monterey, San Benito, and Santa Cruz counties.

o Whether services will be provided by subcontractors to the requesting organization, rather than directly provided by the requesting organization itself.

GoldenPACE Health will directly employ the Interdisciplinary Team and supporting staff members. The use of subcontractors in the service area may include transportation drivers, in-home care aides (skilled and unskilled), medical specialists, routine specialists, and arrangements with skilled nursing facilities, assisted living facilities, and inpatient hospitals. For a list of PACE services GoldenPACE Health will provide please see the following table:

Required Services	D=Direct C=Contract
Physician services	Directly Provided by GoldenPACE Health
Nursing services	Directly Provided by GoldenPACE Health
Social work	Directly Provided by GoldenPACE Health
Physical therapy	Directly Provided by GoldenPACE Health
Occupational therapy	Directly Provided by GoldenPACE Health
Speech therapy	Directly Provided by GoldenPACE Health
Services in the home	Hybrid of Directly Provided and Contracted
Personal care and supportive services	Directly Provided by GoldenPACE Health
Nutritional counseling	Directly Provided by GoldenPACE Health
Recreational therapy	Directly Provided by GoldenPACE Health

Attachment A: GoldenPACE Health Response to Criteria for Assessment of PACE Letter of Support

Transportation	Hybrid of Directly Provided and Contracted
Meals	Contracted for by GoldenPACE Health
Medical specialty services including but not limited to:	
Anesthesiology	Contracted for by GoldenPACE Health
Audiology	Contracted for by GoldenPACE Health
Cardiology	Contracted for by GoldenPACE Health
Dentistry	Contracted for by GoldenPACE Health
Dermatology	Contracted for by GoldenPACE Health
Gastroenterology	Contracted for by GoldenPACE Health
Gynecology	Contracted for by GoldenPACE Health
Internal medicine	Contracted for by GoldenPACE Health
Nephrology	Contracted for by GoldenPACE Health
Neurosurgery	Contracted for by GoldenPACE Health
Oncology	Contracted for by GoldenPACE Health
Ophthalmology	Contracted for by GoldenPACE Health
Oral surgery	Contracted for by GoldenPACE Health
Orthopedic surgery	Contracted for by GoldenPACE Health
Otorhinolaryngology	Contracted for by GoldenPACE Health
Plastic surgery	Contracted for by GoldenPACE Health
Pharmacy consulting services	Contracted for by GoldenPACE Health
Podiatry	Contracted for by GoldenPACE Health
Psychiatry	Contracted for by GoldenPACE Health
Pulmonary disease	Contracted for by GoldenPACE Health
Radiology	Contracted for by GoldenPACE Health
Rheumatology	Contracted for by GoldenPACE Health
Surgery	Contracted for by GoldenPACE Health
Thoracic and vascular surgery	Contracted for by GoldenPACE Health
Urology	Contracted for by GoldenPACE Health
Laboratory tests, x-rays and other diagnostic procedures	Contracted for by GoldenPACE Health
Drugs and biologicals	Contracted for by GoldenPACE Health
Prosthetics and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures, and repairs and maintenance for these items	Contracted for by GoldenPACE Health
Acute inpatient care	Contracted for by GoldenPACE Health
Nursing facility care,	Contracted for by GoldenPACE Health

o A description of the marketing activities targeting members for enrollment.

GoldenPACE Health will utilize a combination of digital and traditional marketing to reach seniors in the service area. Examples include social media posts, a company website, event participation, earned media, and vehicle wrapping. Referrals will be processed by GoldenPACE Health marketing staff who will be trained according to DHCS and CMS requirements.

3. Whether the requesting organization, if contracted with the Alliance, is in good standing with the Alliance.

o This includes, but is not limited to, having no identified potential quality issues, no potential issues of fraud, waste or abuse, and, no open quality or fraud waste and abuse investigations.

GoldenPACE Health has not had any contractual arrangements with the Alliance to date.

o Additionally, the organization must not currently be engaged in contract negotiations with the Alliance or pursuing litigation or arbitration against the Alliance at the time of application.

GoldenPACE Health has not had any contractual arrangements with the Alliance to date.

o The Alliance Chief Executive Officer or designee may determine that the requesting organization is not in good standing based on the considerations identified above or other business concerns including a record of not providing encounter data or claims submissions in a timely manner.

4. Whether the requesting organization has agreed to establish an MOU with the Alliance addressing:

o The transition of members out of the managed care plan into the PACE;

o The transition of members back into managed care should the member determine they no longer want to be enrolled in the PACE; and,

o A process to resolve and address any issues or conflicts between the PACE and the managed care organization.

GoldenPACE Health intends to enter into an MOU with CCAH to include the points described in this section.

5. The requesting organization's provision of its Market Feasibility Study or other data or analyses indicating that entry of the PACE into the market will not disrupt existing delivery systems on which Medi-Cal members rely for community based services.

Based on the market analysis, using the average PACE market penetration rate of 10%, GoldenPACE Health would enroll an estimated 283 participants. This number across all three counties would result in minimal impact to existing Medi-Cal service providers. Please see Attachment B for details.

6. Copies of all necessary Letters of Support obtained, and an identification of any objection raised by a required supporter.

GoldenPACE Health has obtained all necessary Letters of Support required by DHCS. Copies of the letters are included in Attachment C, and include:

- **City of Santa Cruz**
- **City of Monterey**
- **City of Salinas**
- **City of Seaside**
- **Community Health Trust of Pajaro Valley**
- **Alliance on Aging**
- **Dientes Community Dental**
- **Salinas Valley Health**
- **Blind & Visually Impaired Center of Monterey County**
- **Alzheimer's Association of Northern California**

No objections have been identified.

PACE DEMOGRAPHIC MARKET ANALYSIS

This analysis evaluates the potential for operating a PACE program to serve portions of Santa Cruz, Monterey and San Benito Counties. The map below represents the forty-three (43) zip codes contained within the service area (mapped below) that will be referred to in this report as the Golden PACE Service Area.

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A PACE demographic market analysis estimates the number of PACE eligibles in a specific geographic service delivery area and focuses on three primary data sets in the Golden PACE Service Area:

(1) **Age:** total households age 65 and over,

(2) **Medi-Cal eligibility**: total households age 65 and over with household income less than $35,000, and,

(3) **Clinical eligibility:** an estimate of those persons aged 65 and over who would self-report at least one self-care limitation **and** at least one mobility limitation.

The **age** category focuses on those persons and households in the Golden PACE Service Area 65 years of age and older. While PACE eligibility begins at age 55, national PACE experience has demonstrated most persons enrolled in PACE are 65 years of age and over, primarily because 65 years of age is when Medicare eligibility is attained for most beneficiaries. Although **Medi-Cal financial eligibility** is not an eligibility requirement for enrollment in PACE, currently most PACE enrollees across the country are eligible for both Medicare and Medi-Cal/Medi-Cal ("dual eligible"). Those not eligible for Medi-Cal must pay the monthly Medi-Cal capitation and Medicare Part D cost-share privately, which potential enrollees view as cost prohibitive under most circumstances. Therefore, this demographic analysis focuses on a low-income population - those individuals who are currently Medi-Cal eligible or those who are likely to spend down quickly to meet financial eligibility criteria.

The **clinical eligibility** category is determined based on the self-reported health status of persons living in the defined PACE service area. U.S Census Bureau estimates for 2020 provide information on persons aged 65+ who self-report mobility and self-care limitations. Although such reporting does not ensure that these individuals will meet California Medi-Cal's criteria for nursing home placement, it does represent a reasonable proxy for nursing home eligibility. Because PACE most often enrolls a low-income population where the likelihood of poor health and functional impairment is greater than among the older population in general, an approach that uses these data points should result in a moderately conservative estimate of the actual number of frail elderlies in the targeted geographic area. The two categories used in the final analysis to calculate PACE eligible estimates are:

- Self-Reported, *Self-Care limitation*; this category results in a more conservative estimate for PACE eligibility in a service area;

- Self-Reported, *Independent Living Difficulty limitation*; this category results in a more aggressive estimate for PACE eligibility in a service area;

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Estimated PACE Eligibles
Golden PACE Service Area
Conservative and Aggressive Estimates

	65+	65+ Households	65+ Households, less than $35,000 Annual Household Income	Estimated Clinically Eligible	Estimated PACE Eligible Households Range (Conservative – Aggressive)
Golden PACE Service Area	**109,784**	**64,986**	**15,946**	**8,079 – 13,519**	**2,132 – 3,528 ("mid-point" of 2,830)**

Golden PACE Service Area Zip Codes (43)

Zip Code		PACE Eligible Households (Mid-Point Estimate)
93901	Salinas	205
93905	Salinas	233
93906	Salinas	306
93907	Salinas	57
93908	Salinas	20
93921	Carmel by the Sea	16
93923	Carmel	86
93924	Carmel Valley	16
93925	Chualar	2
93926	Gonzales	15
93927	Greenfield	44
93930	King City	46
93933	Marina	108
93940	Monterey	119
93943	Monterey	0
93944	Monterey	0
93950	Pacific Grove	45
93953	Pebble Beach	8
93954	San Lucas	0
93955	Seaside	197
93960	Soledad	27
93962	Spreckels	0
95003	Aptos	75
95004	Aromas	1
95005	Ben Lomond	12
95007	Brookdale	0
95010	Capitola	56
95012	Castroville	19

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	Davenport	**1**
95018	**Felton**	**13**
95019	**Freedom**	**70**
95023	**Hollister**	**167**
95039	**Moss Landing**	**2**
95041	**Mount Hermon**	**0**
95045	**San Juan Bautista**	**10**
95060	**Santa Cruz**	**180**
95062	**Santa Cruz**	**192**
95064	**Santa Cruz**	**0**
95065	**Santa Cruz**	**21**
95066	**Scotts Valley**	**52**
95073	**Soquel**	**16**
95075	**Tres Pinos**	**0**
95076	**Watsonville**	**395**
	TOTALS	**2,830**

Please refer to **Appendix 1** for detailed demographic PACE eligible tables for the Golden PACE Service Area.

Please refer to **Appendix 2** for the color-coded density map of PACE eligibles in the Golden PACE Area based on the mid-point estimate.

Market Penetration Analysis
Golden PACE Service Area
Based on the Mid-Point Clinical Eligibility Estimate

Estimated PACE Eligible Base (Clinically Eligible and Financially Eligible for Medi-Cal)	2,830
If the assumed demographic penetration is:	PACE enrollment:
4%	113
6%	170
8%	226
10%	283

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General market conclusions:

- Based on the **conservative** clinical eligibility estimate, the Golden PACE Service Area is estimated to contain at least **2,132 PACE eligible households;** based on the **aggressive** clinical eligibility estimate alone the Golden PACE Service Area could contain as many as **3,528 PACE eligible households**;

- Based on estimated current market penetration rates for operational PACE programs, the number of projected PACE eligible households would appear to lie closer to the average of the conservative and aggressive estimates. For the Golden PACE Service Area, the average or mid-point of the conservative and aggressive estimate is **2,830 PACE eligible households**.

- The number of PACE eligibles in the service area would appear to necessitate an initial PACE Center of approximately 15,000 square feet with the ability to support a maximum census of 283 participants and a maximum average daily attendance of 110 participants.

- Assuming census growth and referral trends support program expansion, planning for additional PACE Center(s) would need to occur and there are possible secondary markets within in the service area that could support the expansion of PACE Centers or Alternative Care Settings.

Source: 2022 US Census Bureau

Golden PACE Demographic Market Assessment Map

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PACE Eligibles by ZIP Code

- 301 to 400
- 201 to 300
- 101 to 200
- 51 to 100
- 0 to 50

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Demographic Market Assessment by Zip Code for Golden PACE Service Area

Zip Code/ County		Clinical Eligibility Estimate				Income Eligibility Estimate			Estimated Clinically Eligible Population		Estimated Clinically and Financially Eligible Population		MidPoint for Projected PACE Eligibility
		Self-Care	%	Independent Living Difficulty	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Independent Living Difficulty	Self-Care	Independent Living Difficulty	
93901	4228	569	13.46%	705	16.67%	2584	832	32.20%	569	705	183	227	205
93905	3816	605	15.85%	638	16.72%	1721	645	37.48%	605	638	227	239	233
93906	7121	815	11.45%	1138	15.98%	3816	1197	31.37%	815	1138	256	357	306
93907	3904	143	3.66%	411	10.53%	2084	429	20.59%	143	411	29	85	57
93908	2414	141	5.84%	191	7.91%	1365	163	11.94%	141	191	17	23	20
93921	1218	56	4.60%	130	10.67%	862	150	17.40%	56	130	10	23	16
93923	5313	280	5.27%	626	11.78%	3279	622	18.97%	280	626	53	119	86
93924	2133	43	2.02%	118	5.53%	1245	241	19.36%	43	118	8	23	16
93925	110	0	0.00%	11	10.00%	57	20	35.09%	0	11	0	4	2
93926	634	19	3.00%	41	6.47%	335	173	51.64%	19	41	10	21	15
93927	1328	53	3.99%	148	11.14%	655	284	43.36%	53	148	23	64	44
93930	1555	175	11.25%	161	10.35%	758	206	27.18%	175	161	48	44	46
93933	3569	332	9.30%	525	14.71%	2092	526	25.14%	332	525	83	132	108
93940	6549	416	6.35%	687	10.49%	4193	902	21.51%	416	687	89	148	119
93943	0	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0
93944	0	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0
93950	4012	146	3.64%	299	7.45%	2713	543	20.01%	146	299	29	60	45
93953	1743	65	3.73%	125	7.17%	1148	95	8.28%	65	125	5	10	8
93954	28	0	0.00%	0	0.00%	10	10	100.00%	0	0	0	0	0
93955	4265	695	16.30%	857	20.09%	2438	619	25.39%	695	857	176	218	197
93960	1566	61	3.90%	97	6.19%	655	222	33.89%	61	97	21	33	27
93962	160	0	0.00%	0	0.00%	95	26	27.37%	0	0	0	0	0
95003	5685	243	4.27%	605	10.64%	3531	625	17.70%	243	605	43	107	75

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Demographic Market Assessment by Zip Code for Golden PACE Service Area

Zip Code/ County		Clinical Eligibility Estimate				Income Eligibility Estimate			Estimated Clinically Eligible Population		Estimated Clinically and Financially Eligible Population		MidPoint for Projected PACE Eligibility
		Self-Care	%	Independent Living Difficulty	%	Total 65+ House-holds	65+ Households below income level	%	Self-Care	Independent Living Difficulty	Self-Care	Independent Living Difficulty	
95004	650	0	0.00%	22	3.38%	334	20	5.99%	0	22	0	1	1
95005	1494	59	3.95%	90	6.02%	920	143	15.54%	59	90	9	14	12
95007	0	0	0.00%	0	0.00%	0	0	0.00%	0	0	0	0	0
95010	2127	221	10.39%	263	12.36%	1376	317	23.04%	221	263	51	61	56
95012	998	66	6.61%	132	13.23%	515	101	19.61%	66	132	13	26	19
95017	170	6	3.53%	6	3.53%	98	18	18.37%	6	6	1	1	1
95018	1215	66	5.43%	97	7.98%	825	128	15.52%	66	97	10	15	13
95019	924	20	2.16%	176	19.05%	608	436	71.71%	20	176	14	126	70
95023	6638	455	6.85%	945	14.24%	3777	899	23.80%	455	945	108	225	167
95039	381	41	10.76%	41	10.76%	116	7	6.03%	41	41	2	2	2
95041	138	0	0.00%	0	0.00%	72	8	11.11%	0	0	0	0	0
95045	830	30	3.61%	103	12.41%	453	70	15.45%	30	103	5	16	10
95060	7636	523	6.85%	892	11.68%	4814	1224	25.43%	523	892	133	227	180
95062	6811	440	6.46%	876	12.86%	4379	1279	29.21%	440	876	129	256	192
95064	39	10	25.64%	10	25.64%	12	0	0.00%	10	10	0	0	0
95065	1476	59	4.00%	159	10.77%	1020	195	19.12%	59	159	11	30	21
95066	3106	161	5.18%	345	11.11%	2070	422	20.39%	161	345	33	70	52
95073	2307	60	2.60%	92	3.99%	1543	322	20.87%	60	92	13	19	16
95075	127	0	0.00%	7	5.51%	68	6	8.82%	0	7	0	1	0
95076	11366	1005	8.84%	1750	15.40%	6350	1821	28.68%	1005	1750	288	502	395
TOTALS	**109784**	**8079**		**13519**		**64986**	**15946**		**8079**	**13519**	**2132**	**3528**	**2830**

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Attachment C: GoldenPACE Health Letters of Support

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alliance on aging

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aaa

Thursday, March 28, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of the Alliance on Aging, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) in our region. We are the oldest non-profit in Monterey County serving the needs of seniors.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. As the Ombudsman for Monterey County, we encounter seniors every day who would have preferred to receive care in their own home if that was an option. Therefore, I strongly support bringing this PACE program to our region, and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at jmcpherson@allianceonaging.org.

Sincerely,

John McPherson
Executive Director

280 Dickman Avenue
Monterey, CA 93940
831-646-1458 Phone
831-646-1232 Fax

247 Main Street
Salinas, CA 93901
831-655-1334 or 831-758-4011 Phone
831-655-8781 Fax

Spirals Consignment & Benefit Shop
570 Lighthouse Avenue
Pacific Grove, CA 93950
831-383-5030 Phone

AllianceOnAging.org

alz.org®

24/7 helpline
800.272.3900

Northern California
& Northern Nevada
Chapter Headquarters
2290 N. First St., Suite 212
San Jose, CA 95131
408.372.9900

ALZHEIMER'S ASSOCIATION®

April 11, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of the Alzheimer's Association Northern California and Northern Nevada Chapter, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region. Since its founding in 1980, the Alzheimer's Association's Northern California and Northern Nevada Chapter has grown into one of the largest in an 80-chapter network serving more than 25,000 individuals through our 24/7 Helpline, one-on-one care consultations, community and caregiver education classes, and more than 150 support groups. Our vision of improving health equity, assess and care is paramount to the community, especially in the Monterey/Santa Cruz/San Benito region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. Accessing a timely and accurate diagnosis, as well as receiving high quality care continue to be drivers in the need for systems change for people living with dementia and their care partners.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter. If you have any questions, please feel free to contact me at 831.647.9890.

Sincerely,

Philip M. Geiger

Philip M Geiger
Regional Director
Greater Monterey Bay Region
2 Lower Ragsdale Dr., Ste. 150, Monterey, CA 93940

THE BLIND & VISUALLY IMPAIRED CENTER
OF MONTEREY COUNTY INC.

ENVISIONING INDEPENDENCE

April 11, 2024

Ms. Michelle Baass
Director
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, California 95899

Re: Letter of Support for GoldenPACE Health

Dear Ms. Baass:

On behalf of The Blind and Visually Impaired Center of Monterey County, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

Incorporated in 1971, The Blind and Visually Impaired Center of Monterey County is a 501(c)(3) non-profit agency that has provided free services to Monterey County residents who are visually impaired. The mission of the Center is to empower these individuals toward independent living through education, support services and skills training. We are the only low vision clinic in Monterey County working directly with 400 clients on an annual basis.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at 831-649-3505 or via email at steven@blindandlowvision.org

Sincerely,

Steven Macias
Executive Director

cc: Alicia Rodriguez
Founder and CEO
GoldenPACE Health

225 LAUREL AVENUE, PACIFIC GROVE, CA 93950
TEL (831) 649-3505 | FAX (831) 649-4057 | vision@blindandlowvision.org | www.blindandlowvision.org

CITY OF MONTEREY

Colton Hall, California Constitution Hall 1849

April 11, 2023

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

RE: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley,

On behalf of the City of Monterey, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for Elderly (PACE) services in our region. Approximately 18% of Monterey's residents are over the age of 65 and would benefit from GoldenPACE Health's Program.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our county, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Monterey County, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at tyller@monterey.gov.

Sincerely,

Tyller Williamson
Mayor, City of Monterey

Cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

City of Salinas
OFFICE OF THE CITY MANAGER • 200 Lincoln Ave • Salinas, California
93901 (831) 758-7201 • (831) 758-7368 (Fax) • www.cityofsalinas.org

March 25, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of The City of Salinas, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at 831-758-7201.

Sincerely,

Jim Pia

Jim Pia
Interim City Manager

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

Back to Agenda

CITY OF
SANTA CRUZ

MAYOR AND CITY COUNCIL

809 Center Street, Room 10, Santa Cruz, CA 95060 • (831) 420-5020 • Fax: (831) 420-5011 • citycouncil@cityofsantacruz.com

March 28, 2024

Mr. Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

RE: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

At its meeting on March 12, 2024, the Santa Cruz City Council passed a motion expressing support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) for Santa Cruz, San Benito, and Monterey Counties.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. It has the high level of cultural competency and PACE expertise that our communities need. PACE is renowned as a high-touch, team-based model of care and is considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. The City of Santa Cruz faces significant challenges in meeting the health care needs of its aging population, including access barriers, limited resources, and disparities in health outcomes among diverse communities. GoldenPACE Health's commitment to culturally competent care and its focus on traditionally underserved and rural areas aligns closely with our community's needs.

Studies have shown that PACE programs lead to improved health outcomes, reduced hospitalizations, and enhanced quality of life for participants. By bringing a PACE program to our region, GoldenPACE Health will not only address the immediate health care needs of our senior residents but also contribute to the overall well-being and vitality of our community.

We strongly support bringing this PACE program to our region and appreciate your consideration of this letter. If you have any questions, please feel free to contact me.

Sincerely,

Fred Keeley
Mayor

cc: Alicia Rodriguez, Founder and CEO of GoldenPACE Health (alicia@goldenpace.org)
City Clerk

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OFFICE OF THE MAYOR
440 Harcourt Avenue
Seaside, CA 93955
www.ci.seaside.ca.us

Telephone 831-899-6701
Fax 831-624-5839

March 11, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of City of Seaside, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in Monterey County. Approximately, 15% of Seaside's residents are between the ages of 60-79 years old, and would benefit from a resident care facility, allowing them to remain in their homes that they've resided in for a majority of their lives.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our county, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Monterey County, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at ioglesby@ci.seaside.ca.us or (831) 899-6703.

Sincerely,

Ian N. Oglesby
Mayor

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

4/11/2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of the Community Health Trust of Pajaro Valley, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at *djames@pvhealthtrust.org*

Sincerely,

DeAndre James
Executive Director

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

dientes
COMMUNITY DENTAL

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Dear Mr. Billingsley:

On behalf of Dientes Community Dental Care, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region. Dientes 30 plus years providing dental services to low-income residents of Santa Cruz County places us in an important role as partner to the PACE program and we highly recommend it be established in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. Dientes, in partnership with Salud Para La Gente, and Delta Dental Foundation, recently completed a survey of Seniors in our area which showed the significant need for services at home or in a nursing facility. We strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at laura@dientes.org or 831-252-0120.

Sincerely,

Laura Marcus, CEO
Dientes Community Dental

Salinas Valley HEALTH

April 5, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of Salinas Valley Health, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) in our region. Salinas Valley Health has served Monterey County since 1953 as a public-district hospital and comprehensive healthcare system providing quality care to everyone in our community.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. A significantly disproportionate percentage of our patient population, 75%, is government insured. In addition, Monterey County is widely recognized as one of the least affordable places to live in the country.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me.

Sincerely,

Allen Radner, MD
Interim CEO

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

Dave Potter

Tuesday, April 16, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

As the Mayor of Carmel-by-the-Sea, I am writing to express my personal support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. I am personally aware of the challenges faced by our senior community. Given my family's personal experience with my wife's 102-year-old aunt and her 100-year-old mother, we are seeing first-hand the challenges and issues that PACE works with every day.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at *831-646-9053.*

Sincerely,

Dave Potter
Mayor of Carmel-by-the-Sea

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

Post Office Box 4317
Carmel-by-the-Sea, CA 93921

Back to Agenda

MONTEREY COUNTY

BOARD OF SUPERVISORS ▪ 168 West Alisal Street, 2nd Floor, Salinas, CA 93901
LUIS A. ALEJO, SUPERVISOR ▪ District One ▪ Chief of Staff, Linda J. Gonzalez
Telephone: (831) 755-5011 ▪ Fax: (831)755-5876 ▪ Email: district1@co.monterey.ca.us

April 12, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

As a Monterey County Supervisor for District 1 in Salinas and a former State Assemblymember in the Monterey Bay Region, I am writing in support of the GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers. Monterey County's aging population continues to grow with an increase of 11% since 2016.

For these reasons, I support bringing this GoldenPACE Health Care program to our region. I thank you for your time and consideration, should you have any further questions, please do not hesitate to contact me at my district office at (831) 755-5511 or via email at District1@co.monterey.ca.us.

Sincerely,

Luis A. Alejo
Monterey County Supervisor, District 1
State Assemblymember, 30th District (Ret.)
Mayor, City of Watsonville (Ret.)

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

County of Monterey
Board of Supervisors

Luis A. Alejo, District 1
Glenn Church, Chair, District 2
Chris M. Lopez, Vice Chair, District 3
Wendy Root Askew, District 4
Mary L. Adams, District 5

Clerk of the Board
168 West Alisal St. 1st Floor
Salinas, CA 93901
831 755 5066
cob@co.monterey.ca.us

April 15, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of the County of Monterey, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

For these reasons, the County of Monterey supports bringing this PACE program to our region. Thank you for your consideration.

Sincerely,

Glenn Church, Chair
Board of Supervisors

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

WWW.CO.MONTEREY.CA.US

PO Box 1458
4450 Capitola Rd, Suite 106
Capitola, CA 95010
tel 831.479.5466
fax 831.479.5477
www.unitedwaysc.org | www.211ca.org

United Way of Santa Cruz County

April 9, 2024

Joseph Billingsley
California Department of Health Care Services
P.O. Box 997437; MS 0018
Sacramento, CA 95899

Re: Letter of Support for GoldenPACE Health

Dear Mr. Billingsley:

On behalf of United Way of Santa Cruz County, I am writing to express support for GoldenPACE Health's application to establish a Program of All-Inclusive Care for the Elderly (PACE) services in our region. Since 1941, United Way of Santa Cruz County ignites our community to give, advocate and volunteer so that our youth succeed in school and life, our residents are healthy and our families are financially independent. We believe that we will create a healthy, thriving and safe Santa Cruz County for by focusing on the building blocks of an exceptional life – education, economic mobility, and health.

GoldenPACE Health will bring high-quality, affordable health care services to low-income seniors in our region, with sensitivity and care for our diverse communities. GoldenPACE Health is driven by a mission to protect, promote, and enhance the quality of life for seniors and their caregivers in California's traditionally underserved and rural communities. They have the high level of cultural competency and the PACE expertise our communities need. PACE is renowned as a high-touch, team-based model of care, and considered the gold standard of care delivery for community-dwelling, nursing home-qualified seniors. GoldenPACE Health will bring this model of care to Santa Cruz, San Benito, and Monterey Counties, bridging a critical gap between living independently at home and entering a nursing home facility.

Due to the rapid and ongoing growth in our senior population and the shortage of high-quality, affordable care options to serve their complex health needs, the PACE model is well-positioned to serve and positively impact many eligible area residents and their caregivers.

We know that within 5 years, senior adults will be the largest demographic in Santa Cruz County. It is imperative that we have programs and services in place to address the needs of our senior adults to ensure their quality of life.

I strongly support bringing this PACE program to our region and appreciate your consideration of this letter.

If you have any questions, please feel free to contact me at *kbrowder@unitedwaysc.org*

Sincerely,

Keisha

Keisha Browder
Chief Executive Officer – United Way of Santa Cruz County

cc: Alicia Rodriguez, Founder & CEO of GoldenPACE Health; alicia@goldenpace.org

COMMUNITY BRIDGES
PUENTES DE LA COMUNIDAD

519 Main Street
Watsonville, CA 95076

P | 831.688.8840
F | 831.688.8302

To the Alliance Board:

As the only provider of adult day health care (CBAS) services in Santa Cruz County, we have some concerns about the impacts of establishing this PACE center in our community, although PACE is generally an excellent model of care for older adults with complex medical conditions.

First and foremost, there is still capacity at Elderday to provide services to more older adults in our community. Elderday is now licensed for up to 120 participants a day and is currently running an average of about 65 participants a day (although we are quickly adding new participants now that we are settled in our new building in Watsonville). We are not convinced that there is a need for an additional program for older adults at this time in our community and fear that having programs compete will result both in poor outcomes for older adults as well as negative financial issues for both PACE and CBAS, resulting in a total loss scenario for our community.

Secondly, the community is already struggling with a lack of medical providers at all levels, and an additional program could stress the system even further, resulting in a closed system of care that would be inaccessible for participants unless fully enrolled in PACE.

Additionally, we have concerns about the fit of a large organization, with very deep pockets which is opening centers around the state, choosing to locate in our community. The PACE model has its roots in San Francisco and was developed to provide all-inclusive care for a very specific population that was well known to the founders of the PACE program. Since this GoldenPACE has no roots in our community nor any prior experience in opening, operating and maintaining such services, it is hard to understand their ability to operate successfully. We also share a concern that the program has not fully sought partnership from other established older adult partners and oversight entities such as Area Adult on Aging (AAA), Human Service Department of Monterey and Santa Cruz nor engaged in honest partnership discussion with CBAS like us to potentially provide a small segment of the required operations such as the Adult Day Program component. This goes to say that they appear to be unfamiliar with the full and complex web of partners including local leaders or the local community. It would be difficult for them to understand and respond to the particular needs of our community.

Additionally, from a client care perspective, we also share concerns about the transportation time for Santa Cruz clients going to Salinas for care. As you may be aware, there are strict requirements of how long a trip must be for older adults due to federal transportation restrictions. The location itself will place a undue hardship on more than half of all Santa Cruz County residents and therefore not provide fair and equal access to those services.

If GoldenPACE were to establish themselves in our county, they could choose to contract with Elderday to provide the adult day portion of their service, as some PACE centers do with local CBAS

centers. This would, at least, give them a relationship with a long-standing provider who knows the community.

Again, although we are not opposed to PACE as a concept, we are not certain this PACE program would be the best choice for our community.

Thank you for the opportunity to share our thoughts.

Raymon Cancino, CEO
Community Bridges

Lois Sones, Program Director
Elderday, Community Bridges

May 13, 2024

Alliance Board,

Upon reviewing the information pertaining to the potential introduction of a PACE program in our county, we have concluded that it would have adverse implications for our CBAS/ADHC center.

I have a query - will PACE now fall under managed care? If so, wouldn't this also impact CCAH? If it does, then it will consequently have implications for us. Therefore, we do not support the notion of a PACE program being introduced in our county.

Respectfully,

La Casa Adult Day Health Center, Inc.
909 B Blanco Circle, Suite B
Salinas, CA 93901
T: (831) 998-8130 | F: (831) 676-0189
Website: http://www.lacasaadhc.com/

Information Items: (13A. – 13C.)

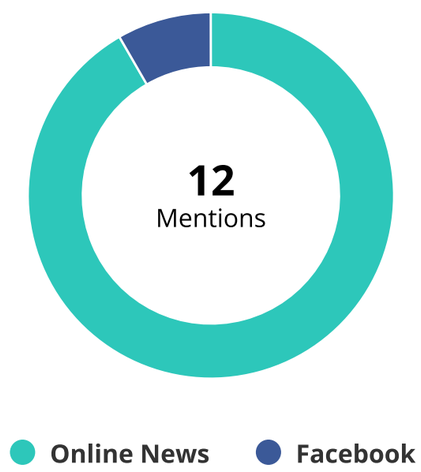
A. Alliance in the News	Page 13A-01
B. Alliance Fact Sheet – April 2024	Page 13B-01
C. Membership Enrollment Report	Page 13C-01

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

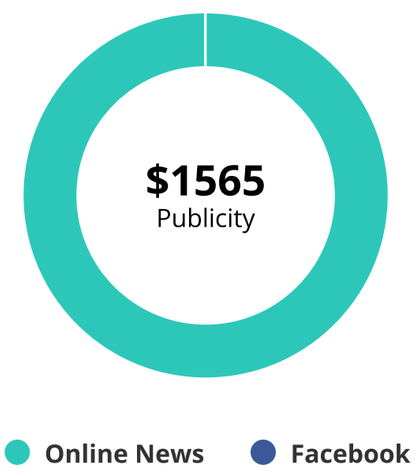
May 2024 Board Report

Mention Analytics

Mentions by Media Type



Publicity by Media Type



Total Online + Print Audience
89,790

Total Online + Print Publicity
USD $1,565

Total Social Followers
679

Total Number of Clips 12

Santa Cruz Sentinel

(Requires Critical Mention login)

Health care; Dignity Health and Aetna reach agreement

1

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Date Collected Apr 27, 2024 7:38 AM EDT
Category Print
Source Santa Cruz Sentinel (California)
Author PK Hattis ; pkhattis@santacruzsentinel.com

Est. Audience 14,664
Est. Publicity Value USD $246
Market Santa Cruz, CA
Language English

... than 400 care centers across California, Nevada and Arizona, according to the release. Dignity's parent company is CommonSpirit Health, which delivers a similar network of health care services on a national level.

Last month, Dignity announced it had reached a three-year contract renewal with **Central California Alliance for Health**, a nonprofit health plan. The agreement was meant to ensure the alliance's almost 500,000 members in five regional counties, including Santa Cruz, continue to have access to Dignity Health hospitals and physicians through 2026.

Aetna is a health insurance provider that offers medical, pharmacy, ...

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Online News

Dignity Health, Aetna reach partnership agreement [Santa Cruz Sentinel, Calif.]

2

Date Collected Apr 27, 2024 12:51 AM EDT
Category Digital News
Source Insurance News Net
Author Santa Cruz Sentinel CA

Est. Audience 26,628
Est. Publicity Value USD $553
Market United States
Language English

... more than 400 care centers across California, Nevada and Arizona, according to the release. Dignity's parent company is CommonSpirit Health, which delivers a similar network of health care services on a national level.

Back to Agenda

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Aetna is a health insurance provider that offers medical, pharmacy, ...

Valley schools and health centers are partnering to meet state health mandates. What's behind the trend?

3

Date Collected Apr 26, 2024 10:05 PM EDT
Category Digital News
Source Westsideconnect.com
Author VIVIENNE AGUILAR

Est. Audience 543
Est. Publicity Value USD $6
Market Newman, CA
Language English

From mental health checkups to streamlining vaccinations, school districts and health systems across the Valley are forming more partnerships to create pathways for K-12 preventable care.

Last week Merced County Office of Education announced its partnership with Dignity Health and **Central California Alliance for Health**, a Medi-Cal qualified health plan.

For example, last week MCOE and Dignity promoted "Well-Child Checkups," a campaign aimed at getting parents back on track with vaccination schedules for youth after the pandemic.

The collaborative campaign is designed to raise awareness of the health plan, ...

Santa Cruz Sentinel

Dignity Health, Aetna reach partnership agreement

4

Date Collected Apr 26, 2024 7:01 PM EDT
Category Digital News
Source Santa Cruz Sentinel
Author PK Hattis

Est. Audience 28,259
Est. Publicity Value USD $515
Market Santa Cruz, CA
Language English

... more than 400 care centers across California, Nevada and Arizona, according to the release. Dignity's parent company is CommonSpirit Health, which delivers a similar network of health care services on a national level.

Last month, Dignity announced it had reached a three-year contract renewal with **Central California Alliance for Health**, a nonprofit health plan. The agreement was meant to ensure the alliance's almost 500,000 members in five regional counties, including Santa Cruz, continue to have access to Dignity Health hospitals and physicians through 2026.

Aetna is a health insurance provider that offers medical, pharmacy, ...

Online News

Enhanced Care Management at Golden Valley Health Centers

5

Date Collected Apr 25, 2024 12:24 PM EDT
Category Digital News
Source Escalon Times
Author Escalon Times

Est. Audience 489
Est. Publicity Value USD $9
Market Oakdale, CA
Language English

Through a grant from DHCS, in partnership with Central California Alliance for Health, Golden Valley Health Centers (GVHC) is implementing a program called "Enhanced Care Management" or "ECM." This is a new program that will help complex needs patients live healthier lives and avoid higher, more costly care.

Enhanced Care Management is a statewide Medi-Cal benefit available to select members with complex needs. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental health, and ...

Enhanced Care Management at Golden Valley Health Centers

6

Date Collected Apr 25, 2024 12:24 PM EDT
Category Digital News
Source Oakdale Leader
Author Oakdale Leader

Est. Audience 2,717
Est. Publicity Value USD $55
Market Oakdale, CA
Language English

Through a grant from DHCS, in partnership with Central California Alliance for Health, Golden Valley Health Centers (GVHC) is implementing a program called "Enhanced Care Management" or "ECM." This is a new program that will help complex needs patients live healthier lives and avoid higher, more costly care.

Enhanced Care Management is a statewide Medi-Cal benefit available to select members with complex needs. Enrolled members receive comprehensive care management from a single lead care manager who coordinates all their health and health-related care, including physical, mental health, and ...

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Monterey County secures $11M in state grants to combat homelessness in King City and Soledad

7

Date Collected Apr 24, 2024 2:07 PM EDT
Category Digital News
Source Salinas Valley Tribune

Est. Audience 489
Est. Publicity Value USD $4
Market King City, CA
Language English

Funding aims to transition homeless individuals into stable housing

-

29

A homeless encampment tucked away in the woods. (Michael Barajas/Shutterstock.com)

SOLEDAD — The County of Monterey has been awarded two significant grants under California's Encampment Resolution Funding program, allocating more than $11 million to address homelessness in King City and Soledad.

"The funding will facilitate crucial efforts to address homelessness in the region and assist in the resolution of two major encampments," according to a County news release April 18.

These grants, totaling more than $6.4 ...

Monterey County secures $11M in state grants to combat homelessness in King City and Soledad

8

Date Collected Apr 24, 2024 12:55 PM EDT
Category Digital News
Source King City Rustler

Est. Audience 217
Est. Publicity Value USD $2
Market King City, CA
Language English

KING CITY — The County of Monterey has been awarded two significant grants under California's Encampment Resolution Funding program, allocating more than $11 million to address homelessness in King City and Soledad.

"The funding will facilitate crucial efforts to address homelessness in the region and assist in the resolution of two major encampments," according to a County news release April 18.

These grants, totaling more than $6.4 million for King City and $4.7 million for Soledad, will support comprehensive strategies aimed at transitioning individuals experiencing homelessness into ...

Online News

(Requires Critical Mention login)

Valley schools and health centers are partnering to meet state health mandates

9

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Date Collected Apr 20, 2024 1:47 PM EDT
Category Print
Source The Sentinel (Hanford, California)
Author Parker Bowman

Est. Audience 11,600
Est. Publicity Value USD $124
Market Hanford, CA
Language English

From mental health checkups to streamlining vaccinations, school districts and health systems across the Valley are forming more partnerships to create pathways for K-12 preventable care.

Last week Merced County Office of Education announced its partnership with Dignity Health and **Central California Alliance for Health**, a Medi-Cal qualified health plan.

For example, last week MCOE and Dignity promoted "Well-Child Checkups," a campaign aimed at getting parents back on track with vaccination schedules for youth after the pandemic.

The collaborative campaign is designed to raise awareness of the health plan, ...

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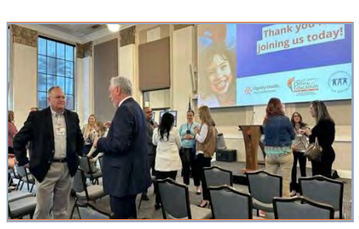

Valley schools and health centers are partnering to meet state health mandates

10

Date Collected Apr 19, 2024 7:21 PM EDT
Category Digital News
Source Hanford Sentinel
Author Parker Bowman

Est. Audience 4,184
Est. Publicity Value USD $51
Market Hanford, CA
Language English

From mental health checkups to streamlining vaccinations, school districts and health systems across the Valley are forming more partnerships to create pathways for K-12 preventable care.

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Last week Merced County Office of Education announced its partnership with Dignity Health and **Central California Alliance for Health**, a Medi-Cal qualified health plan.

For example, last week MCOE and Dignity promoted "Well-Child Checkups," a campaign aimed at getting parents back on track with vaccination schedules for youth after the pandemic.

The collaborative campaign is designed to raise awareness of the health plan, ...

Bright Beginnings Monterey County

11

Time Apr 19, 2024 12:07 PM EDT
Type Post
Language English

Followers 679

Central California Alliance for Health – the Medi-Cal provider for Monterey, Santa Cruz, San Benito, Mariposa and Merced counties – signed on to provide doula services and nearly a year later, starting April 1, two doulas will be available in Monterey County for Alliance members. ❤

The agency is actively recruiting for more doulas to join as providers!

"Joining [CCAH] benefits the doulas, the health care system, the mother, child and the community as a whole. Including doula services for members of the community who might not be able to afford the services on their own elevates the ...

Sunday marks Live Oak farmers market's last day at East Cliff Village after lease talks fail

12

Date Collected Mar 28, 2024 8:49 AM EDT
Category Digital News
Source Lookout Santa Cruz
Author Lily Belli, More Lily Belli, Food, Drink Correspondent

Market United States
Language English

Quick Take Santa Cruz Community Farmers' Markets is searching for a new home for its Sunday market in Live Oak after the nonprofit organization was unable to agree to new lease terms with property owner Swenson Builders. Sunday will be the last market at the East Cliff Village shopping center, where it's been held for 22 years.

The farmers market in the East Cliff Village shopping center in Live Oak bustles with shoppers every Sunday, eager to bring home fresh seasonal produce from a local farmer, grab breakfast or a coffee at one of its many food vendors, or just take a moment to enjoy the ...

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Alliance Fact Sheet

April 202 4

ABOUT THE ALLIANCE

The Alliance is an award-winning regional non-profit health plan, established in 1996, with **over 28 years** of successful operation. Using the State's County Organized Health System (COHS) model, we currently serve **452,976 members** in Mariposa, Merced, Monterey, San Benito 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

568
Number of Employees

$504.9M
YTD Revenue

4.9%
Spent on Administration

Service Area:
Mariposa, Merced, Monterey, San Benito and Santa Cruz counties.

Membership by Program

Total Membership: **452,976[3]**

452,256
Medi-Cal

720
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

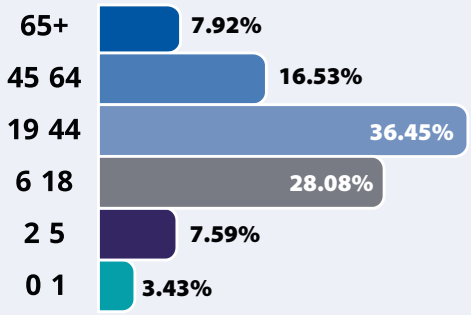
Our members represent 42 percent[1] of the population in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income mothers and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled, and low-income, childless adults ages 19–64.

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

PROVIDER PARTNERSHIPS

The Alliance partners with more than **12,996** providers to form our provider network, with **99** percent of primary care physicians and **98** percent of specialists within our service area contracted to provide services to our members. The Alliance also partners with more than **4,506** providers to deliver behavioral health and vision services.

Membership by Age Group



EXECUTIVE LEADERSHIP

Michael Schrader
Chief Executive Officer

Lisa Ba
Chief Financial Officer

Scott Fortner
Chief Administrative Officer

Omar Guzmán,
Chief Health Equity Officer

Dennis Hsieh, MD
Chief Medical Officer

Jenifer Mandella,
Chief Compliance Officer

Cecil Newton
Chief Information Officer

Van Wong
Chief Operating Officer

GOVERNING BOARD

The Alliance's 18-member governing board, the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan.
In alphabetical order, current Board members are:

- **Leslie Abasta-Cummings,** Chief Executive Officer, Livingston Community Health
- **Anita Aguirre,** Chief Executive Officer, Santa Cruz Community Health
- **Ralph Armstrong, DO FACOG,** Hollister Women's Health
- **Supervisor Wendy Root Askew,** County of Monterey
- **Tracey Belton,** Health and Human Services Agency Director, San Benito County
- **Dorothy Bizzini,** Public Representative
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas
- **Janna Espinoza,** Public Representative
- **Supervisor Zach Friend,** County of Santa Cruz
- **Donaldo Hernandez, MD,** Health Care Provider Representative
- **Elsa Jimenez,** Director of Health, Monterey County Health Department - Alliance Board Chairperson
- **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
- **James Rabago, MD,** Merced Faculty Associates Medical Group
- **Allen Radner, MD,** Salinas Valley Memorial Healthcare System
- **Vacant**, County Health Department Representative

AWARDS

The Alliance is a multi-award winning organization for outstanding health plan performance, quality and leadership in health care.

State Quality Awards:

Over the years, the Alliance has received numerous awards including the Department of Health Care Services (DHCS) Quality Awards for performance in the state's annual Healthcare Effectiveness Data Information Set (HEDIS®) measures for Medi-Cal managed care plans. The recent awards include:

DHCS 2021

- Consumer Satisfaction Award for going above and beyond in children's care for medium-sized health plans in 2021

2019

- Outstanding Performance for Medium-sized Plan

2018

- Most Improved Runner Up for Santa Cruz and Monterey Counties
- Innovation Award for Academic Detailing

Customer Service Honors:

- DHCS 2011 Gold Quality Award for Outstanding Service and Support

Employer Workplace Distinctions:

- American Heart Association 2016 Workplace Health Achievement Gold Level Award as a "Fit and Friendly Workplace"
- Second Harvest Food Bank, Santa Cruz County – CEO Cup 2018, 2017; Titanium Award 2015, 2014, 2013
- United Way of Santa Cruz County 2018, 2013 Corporate Campaign Gold Award
- 2020 Certified California Green Business - Program Participant since 2008
- 2020 Blue Zones Project Approved Worksite
- Recognized by the Santa Cruz County Breastfeeding Coalition and Community Bridges WIC for being a model for employee lactation accommodation, 2021

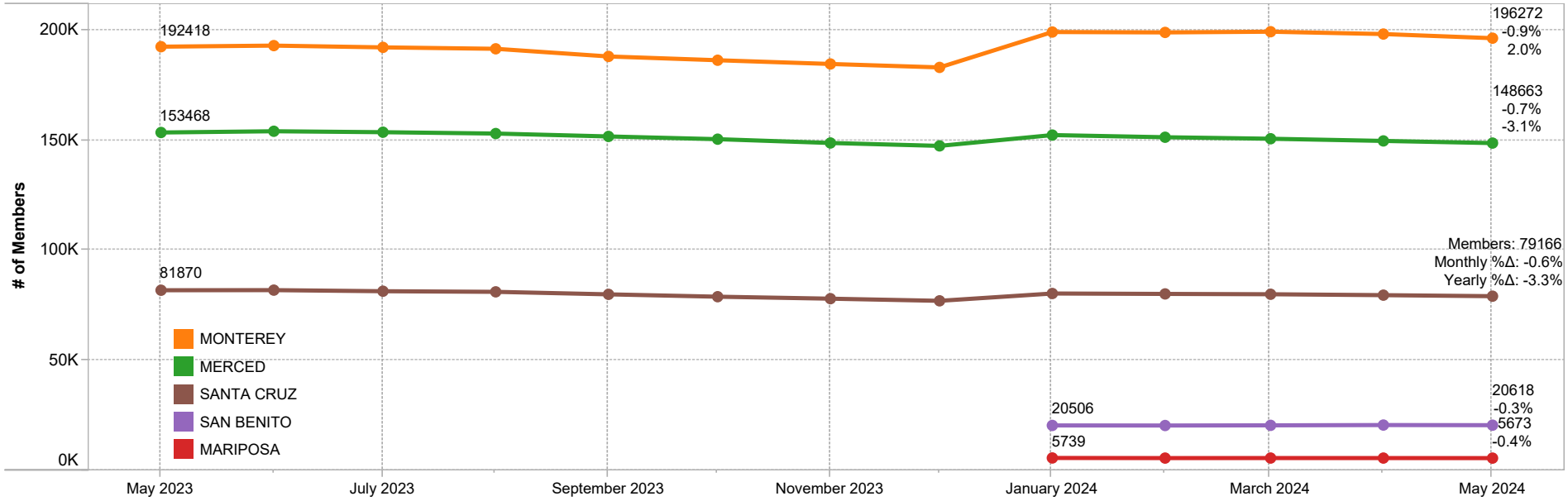
[1]County population data source: U.S. Census Bureau 2023 population estimate (as of Jul. 1, 2023).
Membership percentage by county: Mariposa (34 percent); Merced (51 percent); Monterey (46 percent); San Benito (30 percent); Santa Cruz (30 percent).A
[2]Fact sheet data as of April 1, 2024. [3]Fact sheet data as of April 1, 2024.A

Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *5/6/2024 6:37:06 AM*

Enrollment Month
5/1/2023 to 5/31/2024

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



LOB	County	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024
Medi-Cal	SANTA CRUZ	81,870	81,917	81,422	81,144	80,006	78,936	78,039	77,065	80,386	80,201	80,048	79,638	79,166
	MONTEREY	191,762	192,236	191,428	190,774	187,299	185,581	183,879	182,314	198,372	198,191	198,508	197,432	195,546
	MERCED	153,468	154,029	153,600	152,988	151,678	150,435	148,710	147,391	152,297	151,312	150,634	149,644	148,663
	MARIPOSA									5,739	5,685	5,701	5,693	5,673
	SAN BENITO									20,506	20,472	20,548	20,678	20,618
IHSS	MONTEREY	656	670	674	681	682	683	691	697	700	700	705	720	726
Total Members		**427,756**	**428,852**	**427,124**	**425,587**	**419,665**	**415,635**	**411,319**	**407,467**	**458,000**	**456,561**	**456,144**	**453,805**	**450,392**

Back to Agenda