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

The meeting and the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission is held in accordance with the requirements of the Ralph M. Brown Act.

Meeting Agenda

Wednesday, August 26, 2026

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.
    a. Computer, tablet or smartphone via Microsoft Teams:
        i. Click here to join the meeting
        ii. Meeting ID: 223 759 357 652 57
        iii. Enter your name if promoted (optional)
        iv. You may join as a guest without a Teams account
    b. Or by telephone at:
    United States: +1 872-242-9041
    Phone Conference ID: 170 668 186#

2. Members of the public wishing to provide public comment on items not listed on the agenda that are within jurisdiction of the commission or to address an item that is listed on the agenda may do so in one of the following ways.
    a. Email comments by 5:00 p.m. on Monday, August 24, 2026, to the Clerk of the Board at clerkoftheboard@thealliance.health.
        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 Oral Communications section of the meeting for items not listed on the agenda or during the meeting when that item is announced.
   i. State your name and organization prior to providing comments.
   ii. Comments are limited to three minutes.

c. Via telephone by dialing:
   i. United States: +1 872-242-9041
   ii. Phone Conference ID: 170 668 186#
   iii. Press *5 to raise your hand.
   iv. The Clerk will call on you by using the last four digits of your phone number.
   v. Press *6 to unmute your line.
   vi. Comments are limited to three minutes.
   vii. Press *5 again to lower your hand when you are done speaking.

d. Via Microsoft Teams:
   i. Click here to join the meeting
   ii. Meeting ID: 223 759 357 652 57
   iii. Enter your name if prompted. Please identify yourself however you wish to be addressed as this appears online and is how we notify you when it is your turn to speak.
   iv. When the Board Chair calls for the item on which you wish to speak, select the "raise hand" icon in the meeting controls
   v. The Clerk will activate and unmute speakers in turn. Speakers will be notified shortly before they are called to speak.
   vi. Comments are limited to three minutes.
   vii. Select the "raise hand" icon again to lower your hand when you are done speaking.

1. Call to Order by Chairperson Pedrozo. 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.– 9D.): 3:15 p.m.

5. Accept Chief Executive Officer (CEO) Report.

- Reference materials: Chief Executive Officer (CEO) Report

Pages 5-1 to 5-15

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6. **Accept Alliance Dashboard for Q2 2026.**

- Reference materials:
  - Staff report on above topic
  - Q2 20206 Alliance Dashboard

Pages 6-1 to 6-3

7. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the sixth month ending June 30, 2026.**

- Reference materials:
  - Staff report on above topic
  - Financial statements as above

Pages 7-1 to 7-14

Minutes: **(8A. – 8F.):**

8A. **Approve Commission regular Meeting Minutes of June 24, 2026.**

- Reference materials: Minutes as above.

Pages 8A-1 to 8A-7

8B. **Accept Compliance Committee Meeting Minutes of June 3, 2026 and July 1, 2026 .**

- Reference materials: Minutes as above.

Pages 8B-1 to 8B-10

8C. **Accept Physicians Advisory Group (PAG) Meeting Minutes of March 6, 2026.**

- Reference materials: Minutes as above.

Pages 8C-1 to 8C-5

8D. **Accept Finance Committee Meeting Minutes of March 25, 2026.**

- Reference materials: Minutes as above.

Pages 8D-1 to 8D-4

8E. **Accept Whole Child Model Clinical Advisory Committee Minutes of April 22, 2026.**

- Reference materials: Minutes as above.

Pages 8E-1 to 8E-5

8F. **Accept Quality Improvement Health Equity Committee Meeting Minutes of March 19, 2026.**

- Reference materials: Minutes as above.

Pages 8F-1 to 8F-15

Reports: **(9A. – 9D.)**

9A. **Approve revisions to Alliance Donations and Sponsorship of Events and Organizations Policy 100-0001.**

- Reference materials:
  - Staff report and recommendation on above topic
  - Alliance Donations and Sponsorship of Events and Organizations Policy 100-0001 Redlined

Pages 9A-1 to 9A-6

9B. **Authorize the Chair to sign an amendment to the Alliance's contract with the Department of Health Care Services (DHCS) to extend the term of the agreement through December 31, 2027.**

- Reference materials: Staff report and recommendation on above topic

Page 9B-1

9C. **Approve Quality Improvement Health Equity Transformation Program Workplan for Q1 2026.**
- Reference materials:

Pages 9C-1 to 9C-28

9D. **Approve amendments to the 2026 Quality Improvement Health Equity Transformation Program Description.**
- Reference materials:
  - Staff report and recommendation on above topic
  - QIHET Program Description 2026 Amended

Pages 9D-1 to 9D-81

Regular Agenda Items: (10. – 13.): 3:20 p.m. – 5:00 p.m.

10. **Consider and approve the proposed changes to the CY 2027 Enhanced Care Management (ECM) Payment Methodology. (3:20 – 3:55 p.m.)**

A. Ms. Kay Lor, Director of Payment Strategy, will review and board will consider and approve transition of the payment method from a Fee-for-service case rate model to a fee-for-service (FFS) structure.

- Reference materials: Staff report on above topic.

Pages 10-1 to 10-3

11. **Consider and approve the proposed changes to the CY 2027 incentive programs. (3:55 – 4:25 p.m.)**

A. Ms. Kay Lor, Director of Payment Strategy, and Dr. Mai Bu-Buy, Medical Director, will review, and Board will consider and approve changes to the CY 2027 Incentive Programs.

- Reference materials: Staff report on above topic.

Pages 11-1 to 11-7

12. **Receive the Alliance's Compliance Program Report for Q1-Q2 2026 and consider and approve Revisions to the Alliance Compliance Plan and Code of Conduct. (4:25 p.m. – 4:40 p.m.)**

A. Ms. Jenifer Mandella, Chief Compliance Officer, will present and Board will receive the Alliance's Compliance Program Report for Q1-2 2026 and consider and approve revisions to the Alliance Compliance Plan and Code of Conduct.

- Reference materials:
  - Staff report and recommendation on above topic
  - Alliance Policy 105-6767 - Compliance Plan
  - Alliance Policy 105-0101 - Code of Conduct

Pages 12-1 to 12-34

13. **Operational and Workforce Planning Update. (4:40 p.m. – 5:00 p.m.)**

A. Ms. Van Wong, Chief Operational Officer, and Mr. Scott Fortner, Chief Administrative Officer, will update the Board on workforce planning, including organizational and financial impact from projected membership decline.

- Reference materials: Staff report on above topic.

Pages 13-1 to 13-2

Information Items: (14A. – 14D.)

A. Alliance in the News Pages 14A-1 to 14A-4
B. Alliance Fact Sheet Pages 14B-1 to 14B-2
C. Membership Enrollment Report Page 14C-1
D. Member Appeals and Grievance Report Page 14D-1 to 14D-2

Announcements:

Meetings of Advisory Groups and Committees of the Commission

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

- Finance Committee
  Wednesday, October 28, 2026; 1:30-2:45 p.m.

- Member Services Advisory Group
  Thursday, November 5, 2026; 10:00 – 11:30 p.m.

- Physicians Advisory Group
  Thursday, September 3, 2026; 12:00 – 1:30 p.m.

- Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
  Wednesday, October 28, 2026; 12:00 – 1:00 p.m.

- Whole Child Model Family Advisory Committee [R*emote teleconference only*]
  Monday, October 26, 2026; 1:30 – 3:00 p.m.

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

The next regular meeting of the Commission, after this August 26 meeting, unless otherwise notified.

Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
Wednesday, September 23, 2026, 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) 430-2568 to verify meeting date and location prior to the meeting.

The complete agenda packet is available for review on the Alliance website at https://thealliance.health/about-the-alliance/public-meetings/. The Commission complies with the Americans with Disabilities Act (ADA). Individuals who need special assistance or a disability-related accommodation to participate in this meeting should contact the Clerk of the Board at least 72 hours prior to the meeting at (831) 430-2568. Board meeting locations in Salinas and Merced are directly accessible by bus. As a courtesy to persons affected, please attend the meeting smoke and scent free.

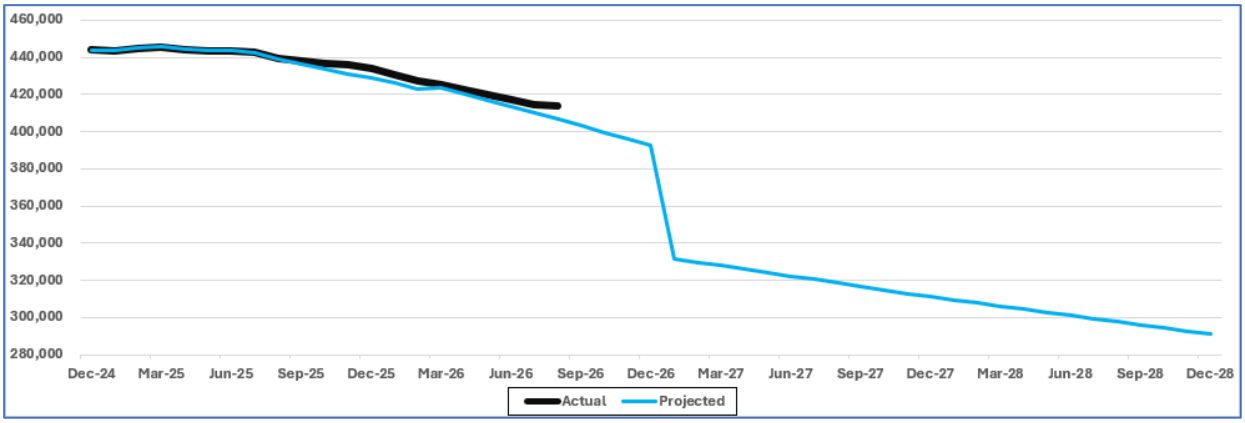
HEALTHY PEOPLE. HEALTHY COMMUNITIES.

DATE August 28, 2026
TO Governing Commission of the Central California Alliance for Health
FROM Michael Schrader, Chief Executive Officer
SUBJECT CEO Report

Alliance Medi-Cal Enrollment Trends. Alliance enrollment is projected to continually decline through December 2028. The causes include the end of COVID-19 unwinding flexibilities, the implementation of federal H.R. 1 requirements, provisions in the FY2025–26 and FY2026-27 state budgets, and the carveout of members with Unsatisfactory Immigration Status (UIS).

Month of Service	Santa Cruz	Monterey	Merced	Mariposa	San Benito	Total MCal Enroll	Actual % Chg	Projected % Chg
Aug-25	77,269	188,191	148,008	5,656	20,606	**439,730**	**-0.66%**	**-0.66%**
Sep-25	76,899	186,924	147,724	5,616	20,658	**437,821**	**-0.43%**	**-0.43%**
Oct-25	76,407	186,563	147,310	5,599	20,675	**436,554**	**-0.29%**	**-0.29%**
Nov-25	76,269	186,231	147,161	5,590	20,656	**435,907**	**-0.15%**	**-0.15%**
Dec-25	75,841	185,611	146,663	5,561	20,584	**434,260**	**-0.38%**	**-0.38%**
Jan-26	74,474	184,901	145,244	5,490	20,454	**430,563**	**-0.85%**	**-0.85%**
Feb-26	73,223	183,855	144,247	5,452	20,370	**427,147**	**-0.79%**	**-0.79%**
Mar-26	72,728	183,432	143,624	5,478	20,333	**425,595**	**-0.36%**	**-0.80%**
Apr-26	72,079	182,234	142,578	5,469	20,252	**422,612**	**-0.70%**	**-0.81%**
May-26	71,420	181,307	141,596	5,397	20,147	**419,867**	**-0.65%**	**-0.82%**
Jun-26	70,534	179,821	141,383	5,373	20,082	**417,193**	**-0.64%**	**-0.82%**
Jul-26	69,809	178,597	140,754	5,344	20,036	**414,540**	**-0.64%**	**-0.83%**
Aug-26	69,478	178,513	140,820	5,347	20,046	**414,204**	**-0.08%**	**-0.84%**

The table illustrates the monthly decline in Alliance Medi-Cal enrollment across each of our five counties and in total. Since August 2025, overall Alliance Medi-Cal enrollment has decreased from 439,730 to 414,304 members, a decline of 5.8%.



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The graph shows the projected decline in Alliance Medi-Cal enrollment through the end of 2028 (blue line) alongside the actual enrollment decline to date (black line), which reflects the data presented in the table.

The sharp decline in the projection (blue line) reflects the DHCS carve-out of members with UIS from the Alliance to State Fee-for-Service on January 1, 2027.

Between January 1, 2025, and December 31, 2028, Alliance enrollment is projected to decline by 39%, including a 25% reduction by January 1, 2027.

Alliance Member Outreach and Retention (MOR). Our MOR strategy focuses on supporting Medi-Cal members through their annual renewals, also known as redeterminations, by providing proactive outreach and assistance. Our goal is to ensure members complete their renewals accurately and on time, helping them maintain coverage. We aim to prevent unnecessary loss of Medi-Cal benefits due to avoidable procedural issues

General Member Outreach. Flight two of our bilingual paid media campaign wraps up August 23, when we will then pause radio and television ads. We resume these ads with a brand-new campaign in early October. During the first half of the year, our campaign delivered over 19 million ad impressions, including just over 3,600 television ads, contributing to significant growth in new and engaged website traffic to the landing page and a growth in organic search traffic. Changes to the current flight included a modest investment in FIFA World Cup advertisements, as well as a small reallocation to Tik Tok and placements in local locations (laundromats, groceries, gas stations, convenience stores). We are currently finalizing a revised communications plan, which focuses on "Complete it, Check it, Return it.", which also includes a strong call to action for members to get help from our renewal partners if they need help with their renewal. We expect to launch tactics with revised messaging soon, with a new paid media campaign to align with the October launch.

Focused Member Outreach. In June and July, we sent out just over 10,500 text messages to members who were up for renewal. In addition to these efforts, we revised text messages to members who have not yet completed their renewal, to encourage them to call the AI renewal support line for assistance. We will be evaluating new messaging opportunities to address possible barriers members may be facing to return renewal paperwork, as well as preparing materials outlining the 2027 Medi-Cal changes.

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Community Partner Trainings. As part of the Alliance's Member Outreach and Retention (MOR) efforts, staff continued to strengthen community partner capacity through county-based trainings and collaborative planning. In Merced County, the Alliance partnered with the Human Services Agency (HSA) to host six trainings (five in English and one in Spanish) at the Alliance office, reaching nearly 200 community partners with updates on Medi-Cal coverage changes, new eligibility requirements, and application guidance. In Mariposa County, Alliance staff participated in a similar training hosted by the Mariposa County Health and Human Services Department. Additionally, in Monterey County, the Alliance convened an MOR Innovation Session, bringing together community partners engaged in member retention outreach to share updates, identify outreach opportunities, and coordinate strategies to better support members through the renewal process.

Grant Funding. The Alliance's Medi-Cal Member Outreach and Retention (MOR) grant program continues successful implementation following the April 2026 award cycle. All 23 funded organizations are on track, having initiated activities and submitted initial implementation reports. All Tier 2 grantees are now accepting warm transfers from the Alliance's Careforce outbound call campaign and are listed on member-facing materials to provide direct renewal assistance. The Alliance distributed a communications toolkit to grantees, including co-branded outreach flyer template, to support consistent messaging and community engagement. Grant-funded training efforts are underway, with Monterey County Department of Social Services launching a series of community partner trainings in late August. In partnership with UC Merced, the Alliance is finalizing a self-paced online Medi-Cal renewal assistance training for community partners in all five counties, with the English version expected to launch in mid-August followed by Spanish in early September. The Alliance is also implementing a grant-funded pilot with select primary care providers to offer weekend Medi-Cal renewal events, expanding opportunities for members to receive in-person renewal assistance outside of traditional business hours.

Strategic Plan. The Alliance Strategic Plan is our multiyear roadmap that guides organizational priorities, performance measurement, and resource allocation. Each year, we review progress with the Board to assess performance, refine targets, and focus on improvement efforts where they will most benefit our members.

Development of Our New Strategic Plan. Staff continue to advance the Alliance's 2027–2029 Strategic Plan through an iterative process shaped by Board, stakeholder, member, community, and leadership input. The current draft has progressed from emerging themes into a defined strategic framework centered on ***Member Access,***

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Community Partnership, and Plan Performance, with goals focused on meaningful access to care, safety-net stability, Medi-Cal retention, community engagement, program integrity, operational efficiency, and financial management.

The strategic plan is also being integrated into the Alliance's 2027 planning cycle, informing downstream processes including operational readiness, workforce planning, technology roadmap development, and budget planning. The draft remains on track for presentation to the Board in September, with final Board approval anticipated in December.

Key Alliance Initiatives.

Claims System Replacement. The Alliance's Claims System Replacement project remains on schedule and has progressed from requirements development into vendor evaluation. Staff completed extensive stakeholder engagement and developed a comprehensive set of business, technical, and regulatory requirements that are used to evaluate vendor proposals. The project has entered the proposal review phase, with cross-functional teams preparing for vendor demonstrations and final scoring.

A comprehensive vendor evaluation and recommendation report is expected to be completed in the 2nd half of August. Staff will present the outcome of the procurement process, including the recommended vendor, implementation approach, and expected costs, at the September Board meeting. Subject to Board approval, implementation planning remains targeted to begin in January 2027.

TotalCare Medicare D-SNP. We launched our Medicare D-SNP program, TotalCare, on January 1, 2026, with 454 members. Through this program, dual-eligible individuals can now receive both their Medi-Cal and Medicare coverage from a single health plan, the Alliance, ensuring a fully integrated experience. Dual-eligible individuals include seniors with low incomes and those living with disabilities.

Marketing, Sales & Enrollment. Since TotalCare's launch, enrollment has steadily increased, reaching 1,065 enrolled lives for August 1st. This represents a 134.6% growth in TotalCare since our launch. We continue to execute our monthly direct mail schedule, where monthly mailers are sent to dual eligibles with an in-network PCP. To maximize response rates, we are rotating the topic and visual creative. August's mailer is a new piece highlighting the benefits of "One Card, One Plan.

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Coordinated Care." Our paid advertising tactics are well underway, which include radio, television, social media, and paid Google search ads. To date, marketing efforts have provided more than 600 sales leads, with July being our strongest month to date.

Member Management & Engagement. TotalCare has moved from launch implementation into active member management. Early care management results are strong, with preliminary Q2 performance showing 97.72% of new members receiving case management outreach within 30 days of enrollment and 100% of members with complex needs having an individualized care plan within 90 days. Staff are also preparing to add TotalCare member representation to the existing Member Services Advisory Group (MSAG) to meet the Enrollee Advisory Committee requirement and inform ongoing program improvement.

Operational Stabilization. Staff are transitioning TotalCare from implementation workgroups into steady-state governance. The new TotalCare Operations Forum supports cross-department coordination, issue resolution, regulatory readiness, and member experience improvement. Early outcome monitoring is also underway, including avoidable emergency department utilization and same-member before-and-after trends, establishing a baseline to evaluate the program's impact over time.

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

Final State Budget. The Legislature adopted, and the Governor signed, the final State Budget prior to the July 1 constitutional deadline. Key provisions include: (1) the transition of individuals with Unsatisfactory Immigration Status (UIS) from Medi-Cal managed care to the fee-for-service delivery system effective January 1, 2027; (2) a reduction in allowable asset limits for Seniors and Persons with Disabilities, effective July 1, 2027; (3) a delay of the elimination of Prospective Payment System (PPS) supplemental payments for services provided to the UIS population until July 1, 2027; (4) a delay of the elimination of certain dental benefits for the UIS population until July 1, 2027; and (5) delegation to the next Governor of the authority to determine Medi-Cal premiums for the UIS population beginning in State Fiscal Year (SFY) 2027–28. Please see attached memo provided by the Local Health Plans of California with more detailed information on these and other relevant provisions.

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DHCS All Plan CEO Meeting. On July 8, CEO Micheal Schrader and Government Affairs Director Danita Carlson joined the DHCS quarterly All Plan CEO meeting. Also in attendance were Director Michelle Baass, Medi-Cal managed care plan chief executive officers, and plan association representatives, including Local Health Plans of California and the California Association of Health Plans. These meetings provide a forum for direct and candid dialogue between DHCS leadership and plan executives. Key topics included: proposed clinical efficiency adjustments for 2027, development of statewide Key Performance Indicators, the upcoming UIS transition to fee-for-service effective January 1, 2027, and a multi-year effort to fully implement federal Ordering, Referring, and Prescribing (ORP) provider enrollment requirements across Medi-Cal delivery systems. Plan leadership provided operational insights and feedback for DHCS consideration across each of these areas.

UIS Transition. As previously reported, the enacted SFY budget includes the transition of UIS individuals from Medi-Cal managed care to the state fee-for-service system effective January 1, 2027. This change is intended to ensure compliance with federal requirements and protect federal financial participation. DHCS has issued a UIS Transition Policy Guide outlining expectations for managed care plans, including requirements related to member and provider communications, data exchange, transition of care, care coordination, and plan deliverables. This transition represents a significant operational undertaking. Staff have initiated a cross-departmental project structure to coordinate activities, allocate resources, and ensure readiness for the January 1, 2027 implementation.

H.R. 1 – Work and Community Engagement Requirements (WCER). On June 1, 2026, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period (IFC) establishing Medicaid Work and Community Engagement Requirements (WCER), which was published in the Federal Register on June 3, 2026, and became effective July 31, 2026. The Interim Final Rule (IFR) establishes more prescriptive federal requirements than anticipated, including a narrower definition of medical frailty for purposes of qualifying for a WCER exemption. These changes require California to reassess its planned implementation approach, and the Department of Health Care Services (DHCS) is reevaluating its previously released draft implementation plan in light of the new federal requirements. California, led by Attorney General Rob Bonta and joined by 25 other states, challenged the IFR in federal court; however, the court denied the request for a preliminary injunction, meaning the rule remains in effect while litigation proceeds. As a result, California must continue implementation planning and operational preparations while monitoring the outcome of the ongoing legal challenge.

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County Indigent Care. On August 7, CEO Michael Schrader met with Nicole Coburn and Connie Morena-Peraza of Santa Cruz County. In light of the potential impacts of H.R. 1 on Medi-Cal eligibility, counties have begun exploring options to meet their obligations to provide indigent care under Welfare and Institutions Code Section 17000. One option under consideration is an Administrative Services Organization (ASO) arrangement in which the Alliance would provide administrative services, including claims payment functions for providers. Discussions remain preliminary, no decisions have been made, and the County will continue to evaluate its options.

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

Outreach. The Alliance continues to maintain a strong and visible outreach presence across all five counties, with a deliberate focus on meeting members where they are and adapting strategies to respond to emerging community needs. Recent outreach event participation includes:

- Mariposa Back to School Health and Resource Fair, Mariposa County
- Planada Back to School Vaccinations, Merced County
- Soledad Community Health Fair, Monterey County
- San Benito Back to School Resource Fair, San Benito County
- Back to School Bash, Santa Cruz County

Collaboratives and Coalitions. The Alliance participates in local collaboratives and coalitions to remain responsive to community needs, strengthen coordination with local partners, and support members' access to integrated, community-based services. Recent and on-going participation includes:

- Mariposa Medi-Cal Renewal Training, Mariposa County
- Public Information Officer Roundtable, Merced County
- Aging and Disability Resource Connection, Monterey County
- Master Plan for Aging, San Benito County
- Health Workforce Council, Santa Cruz County

Communications and Marketing. The Alliance continues to prioritize timely, engaging and effective messaging to our members and providers on a variety of topics to ensure optimal awareness of issues impacting health and wellness. This year, we launched our "Care Can't Wait" campaign, ensuring members understand the importance of timely care. Our current messaging is aimed at urging members stay on track with vaccination schedules, in alignment with Immunization Month in

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August. Future efforts include flu vaccine and Nurse Advice Line reminders. To support this campaign, we will continue to develop materials for members including flyers, newsletter articles, on-hold messaging, text messaging, social media posts, and website content.

Health Leadership Collaborative. On July 16, CEO Michael Schrader and Community Engagement Specialist Adourin Malco attended the quarterly Health Leadership Collaborative meeting at the Merced County Department of Public Health. The meeting brought together leaders from community organizations across Merced County to discuss key health issues, with a focus on upcoming Medi-Cal changes and efforts to support Medi-Cal members in the years ahead. United Way of Merced County presented its Community Health Worker Hub model, which is supported by the Alliance. Merced County Public Health and Human Services Agency shared county-specific updates regarding H.R. 1, and Adourin Malco highlighted the MOR targeted stakeholder trainings taking place in July. Participants found the updates valuable and requested that similar information be included in future quarterly Health Leadership Collaborative meetings.

Health Improvement Partnership (HIP) Council. On July 9, CEO Michael Schrader participated in the HIP Council of Santa Cruz County. The primary agenda item was a roundtable discussion during which participants shared the top one to three actions their organizations have prioritized for immediate or near-term implementation in response to the evolving Medicaid landscape and its impact on the community. Attendees included local leaders from Janus of Santa Cruz, the County of Santa Cruz, Sutter Maternity & Surgery Center, Dominican Hospital, Salud Para La Gente, Santa Cruz Community Health Centers, First 5 Santa Cruz County, Hospice of Santa Cruz County, the University of California, Santa Cruz, Pajaro Valley Prevention & Student Assistance, Cabrillo College, Encompass Community Services, Dientes Community Dental Care, and other community organizations.

OB-GYN Convening. By request, CEO Michael Schrader is convening local healthcare leaders to discuss OB-GYN and labor and delivery services in Santa Cruz County. Recent and anticipated changes in the local delivery system may affect how and where community members access these services. The Alliance has heard concerns from multiple partners and believes a coordinated conversation is both timely and necessary. CEOs and senior leaders from Dominican Hospital, Sutter Maternity & Surgery Center, Watsonville Community Hospital, Salud Para La Gente, Santa Cruz Community Health Centers, and Kaiser Permanente have agreed to participate. The convening will focus on identifying opportunities to protect and strengthen full-scope OB-GYN and labor and delivery services in Santa Cruz County. To support this

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effort, the Alliance has engaged Rafael Gomez of El Cambio Consulting to facilitate a partner session in September. The goal is to bring local partners together to deepen understanding of the issues and explore potential local solutions. Prior to the convening, Mr. Gomez has been conducting individual interviews with participants.

Health Services Updates. The Alliance continues to build on its commitment to delivering high-quality care while actively addressing health disparities, ensuring every member regardless of language, background, or health status can access meaningful education and navigate care without barriers.

Joint Operations Committees (JOCs) & Clinic Joint Operations Committees (cJOCs). The Alliance continued engagement with hospital and clinic partners through JOCs and cJOCs to strengthen care coordination, quality performance, access to care, and support for high-risk members. Discussions included hospital utilization trends, transitions of care, emergency department utilization, readmissions, discharge planning, specialty access challenges, ambulatory quality performance, chronic disease management, preventive care, care gap closure, and health equity initiatives. Providers were also updated on Alliance Care Management services, including Enhanced Care Management (ECM) and Community Supports referral pathways, with additional education on evolving ECM eligibility requirements and appropriate referral practices. County-based Medi-Cal redetermination activities and Alliance Member Outreach and Retention (MOR) efforts remained standing discussion topics to help members maintain coverage and access to care.

Provider recruitment continues to be a consistent priority across both hospital and clinic partners. Organizations frequently report workforce and specialty access challenges while expressing appreciation for Alliance investments through Provider Recruitment Grants, Capital Grants, Care Gap Closure initiatives, and MOR funding. These investments continue to support local healthcare infrastructure, expand provider capacity, strengthen workforce recruitment and retention efforts, and improve member access to care across the region.

Enhanced Care Management (ECM) and Community Supports (CS). Within Enhanced Care Management, significant effort was directed toward ECM sustainability initiatives, including phased reassessments of low and medium-risk ECM members to ensure alignment with DHCS eligibility requirements and strengthen program integrity. The team also continued to optimize ECM authorization processes through provider education, analysis of approval and denial trends, and evaluation of streamlined renewal workflows. In parallel, planning advanced for anticipated ECM

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payment and operational model changes associated with a potential transition to future fee-for-service reimbursement structures.

For Community Supports, the team reviewed and analyzed proposed DHCS policy updates with a particular focus on program integrity requirements, provider oversight expectations, and operational implications for health plans. Continued attention was given to housing-related Community Supports programs, including Housing Transition Navigation Services (HTNS), Housing Tenancy and Sustaining Services (HTSS), and Personal Care and Homemaker Supports (PCHS), as well as emerging state guidance related to housing benefit administration and coordination.

Behavioral Health Treatment (BHT). The Alliance continues to strengthen oversight of Behavioral Health Treatment (BHT) services in response to increased DHCS focus on utilization management, medical necessity, and program integrity. During the reporting period, Health Services enhanced authorization oversight through expanded audits, targeted review of approval patterns, and increased monitoring of provider-level utilization trends. New reporting and dashboard capabilities were implemented to improve visibility into authorization outcomes and support data-driven oversight.

The Alliance also continued comprehensive medical necessity reviews, strengthened documentation standards, and expanded provider education related to frequently authorized but underutilized services. Updated staff review guidelines and decision-support tools were deployed to improve consistency in authorization determinations and support regulatory compliance. Collectively, these efforts strengthen program integrity, promote appropriate utilization, and help ensure BHT services remain evidence-based, clinically appropriate, and aligned with member treatment goals.

Managed Care Accountability Set (MCAS). The Quality and Health Equity team completed the NCQA HEDIS and DHCS Managed Care Accountability Set (MCAS) audits for Measurement Year (MY) 2025 with no audit findings. The audit validated the Alliance's strong quality reporting and commitment to accountability. Results directly guide quality activities to reach strategic goals to eliminate health disparities and achieve optimal health outcomes for children and youth.

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Central California Alliance for Health

MY2025 DHCS MCAS - Final Rates

Performance Levels

<50	50 - 65	66 - 89	90+

Performance Measure	Plan Rate	Santa Cruz	Monterey	Merced	San Benito	Mariposa
Asthma Medication Ratio - Total	70.39%	69.20%	71.50%	70.02%	72.00%	61.90%
Breast Cancer Screening	61.61%	67.84%	62.62%	56.60%	65.12%	0.00%
Controlling High Blood Pressure	72.75%	77.00%	72.89%	69.44%	76.00%	68.00%
Cervical Cancer Screening - Total	64.66%	64.71%	68.84%	61.14%	57.33%	34.35%
Chlamydia Screening in Women - Total	65.12%	72.61%	68.75%	57.54%	59.46%	41.35%
Childhood Immunizations - Combo 10	34.90%	44.51%	44.17%	20.07%	26.39%	5.80%
Developmental Screening in the First Three Years of Life	53.41%	49.16%	62.32%	43.09%	18.97%	25.79%
Follow-Up After Emergency Department Visit for Substance Use	49.55%	53.61%	51.60%	39.90%	64.00%	31.82%
Follow-Up After Emergency Department Visit for Mental Illness	66.63%	70.77%	68.34%	62.45%	69.09%	67.21%
Immunizations for Adolescents - Combo 2	56.40%	55.08%	68.87%	44.27%	37.85%	16.22%
Lead Screening in Children	82.77%	80.29%	90.76%	75.70%	68.17%	39.13%
Timeliness of Prenatal	90.75%	91.00%	90.29%	89.63%	89.00%	91.67%
Postpartum Follow Up	91.24%	95.00%	94.17%	84.44%	94.00%	79.17%
Topical Fluoride for Children - Dental or Oral Health Services	25.33%	14.64%	27.36%	28.42%	16.28%	9.94%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits	83.09%	86.74%	88.83%	76.81%	68.73%	36.51%
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	67.95%	79.81%	75.04%	56.38%	31.09%	45.95%
Child and Adolescent Well-Care Visits	63.57%	64.92%	70.26%	55.83%	58.40%	37.05%
Glycemic Status Assessment for Patients With Diabetes (>9%)	24.82%	26.00%	21.89%	30.00%	23.00%	30.00%

Health Education Workshops for Members. The Alliance launched 14 health education workshops in June and July, enrolling 107 members in chronic condition management, diabetes, and healthy weight programs. Workshops are offered in English and Spanish via telephonic, virtual, and in-person formats. Interest in health education programs continues to grow. Q1–Q2 saw 300 online sign-ups, a 6% increase year-over-year, driven largely by text campaigns linking members directly to program sign-up forms. As part of NCQA requirements, the Alliance surveys workshop participants throughout the year. In 2025, 51 members completed satisfaction surveys across three programs: Healthier Living Program (28 respondents, 93% satisfied), Healthy Weight for Life (8 respondents, 100% satisfied), and Live Better with Diabetes (15 respondents, 100% satisfied). The large majority also reported high satisfaction with Health Educators and the usefulness of program content.

Cultural and Linguistic Services (C&L). Provider utilization of language assistance services continues to rise. The C&L team launched an online interpreter request form, giving providers a digital alternative to faxed requests. In Q1–Q2, providers submitted 4,872 interpreter requests for in-person and Virtual Remote Interpreting (VRI) services, a 30% increase over Q1–Q2 last year

Regulatory and Operational Readiness. From a Regulatory and Operational Readiness perspective, Health Services engaged in multiple discussions with county behavioral health departments, hospitals, community-based organizations, and health information exchange partners regarding data-sharing opportunities and barriers. The division also continued audit readiness activities, policy development

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work, and compliance efforts supporting ECM, Community Supports, D-SNP implementation, and broader Health Services operational requirements.

Overall, the month's work reflected a continued emphasis on program integrity, regulatory compliance, provider engagement, housing and community-based service integration, and strengthening partnerships across the healthcare delivery system to improve member outcomes.

Provider Network. The Alliance maintains contracts with thousands of providers across and beyond the five counties we serve. Our network includes hospitals, primary care clinics, specialists, ancillary service providers, and long-term care facilities, ensuring comprehensive access to care for our members.

Network Update. The Alliance continues to strengthen provider network access across the service area through targeted recruitment efforts. During the reporting period, the Alliance added many new specialty providers to the network, including:

- Four dermatology providers, with two serving San Luis Obispo County to improve access for South Monterey County members and two serving Merced County.
- Two OB-GYN providers to enhance access for members in San Benito County.
- Three psychologists and eight psychiatrists to expand access to behavioral health services across the network.

These additions support the Alliance's ongoing efforts to improve timely access to specialty and behavioral health care for members.

CommonSpirit Negotiation. Negotiations with CommonSpirit are underway for hospital, primary care, specialty, and ambulatory surgery center agreements. CommonSpirit has issued termination notices for the current agreements, effective December 31, 2026. The Alliance is working toward execution of new agreements prior to the termination date and will provide ongoing updates to the Board as negotiations progress.

Alliance Workforce. Our robust culture is built on the premise that the Alliance exists to serve Members. Our guiding principles are simple: we put members first, we are here to serve, and we work as one team. Most of our employees live in the communities we serve across our five counties. To enrich our culture there are All-Staff meetings, interactive town halls, coffee talks with executives, annual employee engagement surveys, and biannual performance reviews.

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CEO Townhalls. CEO Michael Schrader hosted leadership and employee Town Halls to provide updates on key organizational priorities. Topics included an overview of the 2027-2029 Strategic Plan, the State's UIS transition and the Alliance's commitment to supporting affected members, ongoing department assessments to identify options for aligning the workforce with projected membership changes, and an update on contract negotiations with CommonSpirit/Dignity Health. The sessions provided employees with information regarding significant organizational initiatives and opportunities to ask questions and engage in dialogue with leadership.

Mid-Year Check-In Process. Human Resources completed the Alliance's 2026 Mid-Year Check-In process, providing employees and supervisors an opportunity to discuss performance, goal progress, competency development, achievements, and areas for continued growth. Conducted through Workday, the process included employee self-reflections, supervisor evaluations, and follow up discussions focused on planning for the remainder of the year. The Mid-Year Check-In supports the Alliance's commitment to ongoing feedback, employee development, and alignment with organizational goals.

Annual Employee Engagement Survey. The Alliance launched its annual Employee Engagement Survey in August 2026 to gather employee feedback regarding engagement, workplace culture, leadership, and the overall employee experience. Administered confidentially through Culture Amp, the survey supports the Alliance's commitment to listening to employee voices, identifying strengths and opportunities for improvement, and developing action plans that enhance employee engagement and organizational effectiveness. Results will be reviewed and shared with leadership and staff later this year

Regulatory Audits and Compliance. The Alliance has structured processes to ensure that we operate in an ethical and compliant manner, so that we protect our members' rights. Like all Managed Care Plans, the Alliance is in a continuous state of preparing routine audits, experiencing them, or following up on regulators' requests. In addition, the Alliance's regulators routinely monitor plan activities to confirm compliance with requirements. Where regulators have found the Alliance to be non-compliant, they may issue warning letters or notices of non-compliance, may implement corrective action plans (CAPs), and may impose sanctions.

2024 DMHC Medical Audit Follow-up. The final report for the 2024 DMHC audit of performance in providing health care benefits and meeting the health care needs of

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enrollees for the Alliance's Alliance Care In-Home Supportive Services (IHSS) line of business identified 7 findings that remained uncorrected pending DMHC's re-review. As a standard process, DMHC considered findings uncorrected until their efficacy can be assessed via documentation and/or case review. Accordingly, DMHC will conduct their follow-up review in September to validate that prior corrections remain in place and are addressing the concern. Plan staff have submitted relevant documentation and are preparing for anticipated interviews.

2026 CMS Triennial Network Validation Review. CMS periodically validates Medicare Advantage organizations networks to ensure adequate, accessible provider networks to meet enrollee needs. The Alliance underwent its first network validation review for TotalCare and passed the review without findings or the need to submit exception requests.

DMHC Grievance Report Enforcement. Plan staff failed to submit the required Q4 2025 grievance report with DMHC. In response, the DMHC imposed an administrative penalty of $2,750 and requested a CAP be submitted. Plan staff intend to accept the penalty and are developing a CAP to submit.

Alliance Medi-Cal Capacity Grant Program (MCGP). The Alliance makes investments to strengthen health care and community organizations across the five counties we serve. The purpose is to pursue the Alliance's vision of heathy people and healthy communities. These investments focus on increasing the availability, quality and access of health care and supportive resources for Medi-Cal members. They also address that social drivers influence health and wellness.

Funding Opportunities. Round 3 is open for applications for Provider Recruitment, Community Health Worker Recruitment, and Healthcare Technology programs. The deadline is August 18, 2026. Award decisions will be distributed on October 30, 2026. Round 3 includes the launch of a one-time funding opportunity aimed at maintaining timely access to primary, specialty, and hospital services for Medi-Cal members by stabilizing essential safety net providers facing financial challenges.

Trends in the Number of Awards and Total Spend. The MCGP has paid out $19M year to date in 2026 for active grant awards, compared to $28.5M for all of 2025. New MCGP awards year-to-date in the five-county service area total $12.6M, which is 63% of the 2026 total award amount target of $20M.

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Alliance Housing Fund. In 2024, the Alliance launched a one-time Housing Fund to expand interim and permanent housing opportunities for Medi-Cal members experiencing homelessness or housing instability. The program invested $40M to support the development, acquisition, renovation, and furnishing of housing and recuperative care projects across the service area. These projects reflect the Alliance's continued investment in housing as a key driver of health outcomes and the strong partnerships that make these community-based solutions possible. To date, the Housing Fund has reached 13% completion of the expected 494 units to be made available to Medi-Cal members.

Housing Fund Project Celebrations. In July, CHISPA broke ground on Mills Ranch Apartments, where the Alliance's $1 million investment is helping bring 40 new affordable housing units to King City. This development, expected to open in September 2027, will co-locate supportive services and have convenient access to parks, schools, and healthcare services.

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DATE: August 26 2026

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

FROM: Van Wong, Chief Operating Officer

SUBJECT: Q2-26 Alliance Dashboard

Recommendation: This report is informational only.

Background: The Alliance Dashboard is a performance measurement system that emphasizes high level, mission-driven goals. It organizes processes by scope, scale, and category. The objective of this effort is threefold: to create focus surrounding performance, measure what matters most, and identify areas to improve effectiveness over time.

Discussion: The Q2 2026 Alliance Dashboard provides a structured overview of the organization's performance for the second quarter of the year, highlighting areas of strength along with operational and financial challenges. Overall performance remained strong with over 93% of organizational processes in good or excellent control.

Across our broader support functions — spanning data management, technology, communications, and administrative services — performance has remained consistently strong over the last couple of quarters. Our Support processes continue to provide a stable foundation for the organization, enabling efficient and effective Core processes and operation.

That stable performance also helps clarify where targeted operational focus is still needed. Two operational processes that did not meet the 95% standard are outlined below:

Engage and Support Members performance in Q2 2026 was 93.6% of target, improving from 91.4% in Q1 2026, but remaining below the 95% standard. Key drivers of below-target performance continue to be *New Member Welcome Calls* (27.9%, up from 17.2% in Q126) and *Calls to Member Services answered within 30 seconds* (81.4%, up from 67.4% in Q126), reflecting sustained high call volume alongside staffing shortages and longer call resolution times due to increased complexity and evolving member needs. To mitigate these pressures, both the Alliance and its vendor Harte Hanks have been hiring additional staff members to increase capacity.

Pay Providers performance in Q2 2026 was 90.4% of target, up from 88.0% in Q1 2026, with performance impacted by both payment and dispute-resolution timeliness measures. Below-target metrics include *% of providers receiving 75% or full CBI payment* (Mariposa County 0.0%; San Benito County 25.0%), reflecting the difficulty of achieving strong performance in these geographic areas where access to high-quality providers is more limited, as well as the additional development work needed in Mariposa and San Benito counties, which joined the Alliance in 2024 and are still maturing relative to the three longer-standing counties.

In addition, *dispute resolution letter* timeliness remains below target—54.3% (up from 47.9% in Q126) for *contracted disputes mailed within 30 business days* and 70.8% (up from 67.8% in Q126) for *non-contracted disputes mailed within 45 business days*. Targeted process improvement interventions have resulted in more streamlined processes over the last quarter for case review and case assignments. Performance below threshold is primarily due to the backlog of aged provider dispute cases. Staff are advancing a focused backlog reduction plan that includes cross-training for coverage, accelerated escalation of aging cases for Medical Director review, and use of mass case closures when case patterns support efficient and appropriate resolution.

Staff continue to implement mitigation plans and performance in the noted areas is expected to improve over the coming quarters, supporting the Alliance's continued focus on operational excellence, member experience, and long-term financial stability.

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

Attachments.

1. Q2 2026 Alliance Dashboard

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Alliance Dashboard

Quarter 2, 2026

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

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

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

Core Processes

Deliver value to our members, providers and community

Engage & Support Members

93.6% Of Target

SUBPROCESSES
- 100 Help Members Engage
- 83.3 Help Members Navigate
- 97.6 Member Experience

Manage & Improve Care

97.4% Of Target

SUBPROCESSES
- 95.2 Manage Member Benefits
- 98.0 Manage Care Use
- 99.0 Improve Care

Develop & Maintain the Provider Network

98.9% Of Target

SUBPROCESSES
- 99.3 Develop the Network
- 98.4 Maintain the Network

Pay Providers

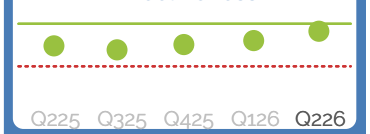
90.4% Of Target

SUBPROCESSES
- 100 Payment Strategy
- 80.4 Make Payments
- N/A Payment Integrity
- 90.7 Resolve & Settle Payments

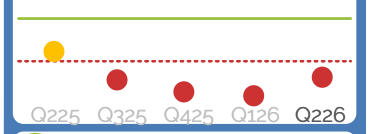
Managerial Processes

Guide core and support processes

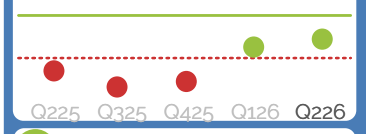
98.4 Enhance Operational Effectiveness



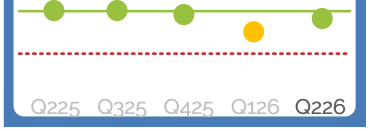
82.8 Manage Compliance Commitments



95.9 Manage Finances

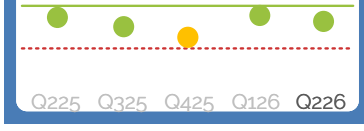


98.5 Manage Governmental & Community Relations



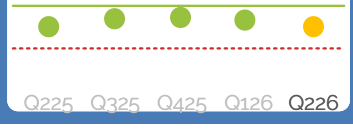
Support Processes *Enable core processes to work*

97.5 Optimize Alliance Workforce

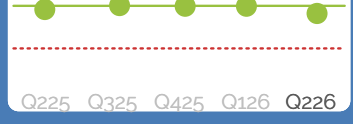


99.8 Manage Data

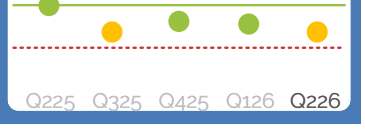
94.3 Manage Technology



98.5 Provide Administrative Services



90.7 Communications & Organizational Branding



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DATE: August 26, 2026

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Sixth Month Ending June 30, 2026

Consolidated (All Lines of Business)

For the month ending June 30, 2026, the Alliance reported Operating Income $14.0M. The Year-to-Date (YTD) Operating Loss is $2.7M, with a Medical Loss Ratio (MLR) of 95.2% and an Administrative Loss Ratio (ALR) of 5.1%. The Net Loss is $9.1M after accounting for Non-Operating Income/Expenses.

The budget expected a $1.0M Operating Loss for YTD June. The actual result is unfavorable to the budget by $1.7M, driven by rate variances.

Jun-26 Income Statement
Consolidated ($ In 000s)

Key Indicators	MTD Actual	MTD Budget	MTD Var $	MTD Var %	YTD Actual	YTD Budget	YTD Var $	YTD Var %
Membership	*420,716*	*415,410*	*5,306*	*1.3%*	*2,567,426*	*2,528,431*	*38,995*	*1.5%*
Revenue	$188,992	$186,614	$2,377	1.3%	$1,1,59,110	$1,139,290	$19,820	1.7%
Medical Expenses	164,337	176,120	11,783	6.7%	1,103,251	1,075,630	(27,621)	-2.6%
Admin Expenses	10,646	11,177	531	4.8%	58,563	64,626	6,063	9.4%
Operating Income/(Loss)	**14,009**	**(683)**	**14,691**	**100.0%**	**(2,705)**	**(966)**	**(1,738)**	**-100.0%**
Net Income/(Loss)	$14,123	$1,417	$12,706	100.0%	($9,064)	$11,633	($20,697)	-100.0%
MLR %	87.0%	94.4%	7.4%		95.2%	94.4%	-0.8%	
ALR %	5.6%	6.0%	0.4%		5.1%	5.7%	0.6%	
Operating Income %	7.4%	-0.4%	7.8%		-0.2%	-0.1%	-0.1%	
Net Income %	7.5%	0.8%	6.7%		-0.8%	1.0%	-1.8%	

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Medi-Cal Line of Business (Including IHSS)

For the month ending June 30, 2026, the Alliance reported Operating Income of $13.8M. The Year-to-Date (YTD) Operating Income is $2.1M, with a Medical Loss Ratio (MLR) of 95.1% and an Administrative Loss Ratio (ALR) of 4.7%. The Net Loss is $4.2M after accounting for Non-Operating Income/Expenses.

The budget expected an Operating Income of $8.0M for YTD June. The actual result is unfavorable to the budget by $5.9M or 73.7%, driven by rate variances.

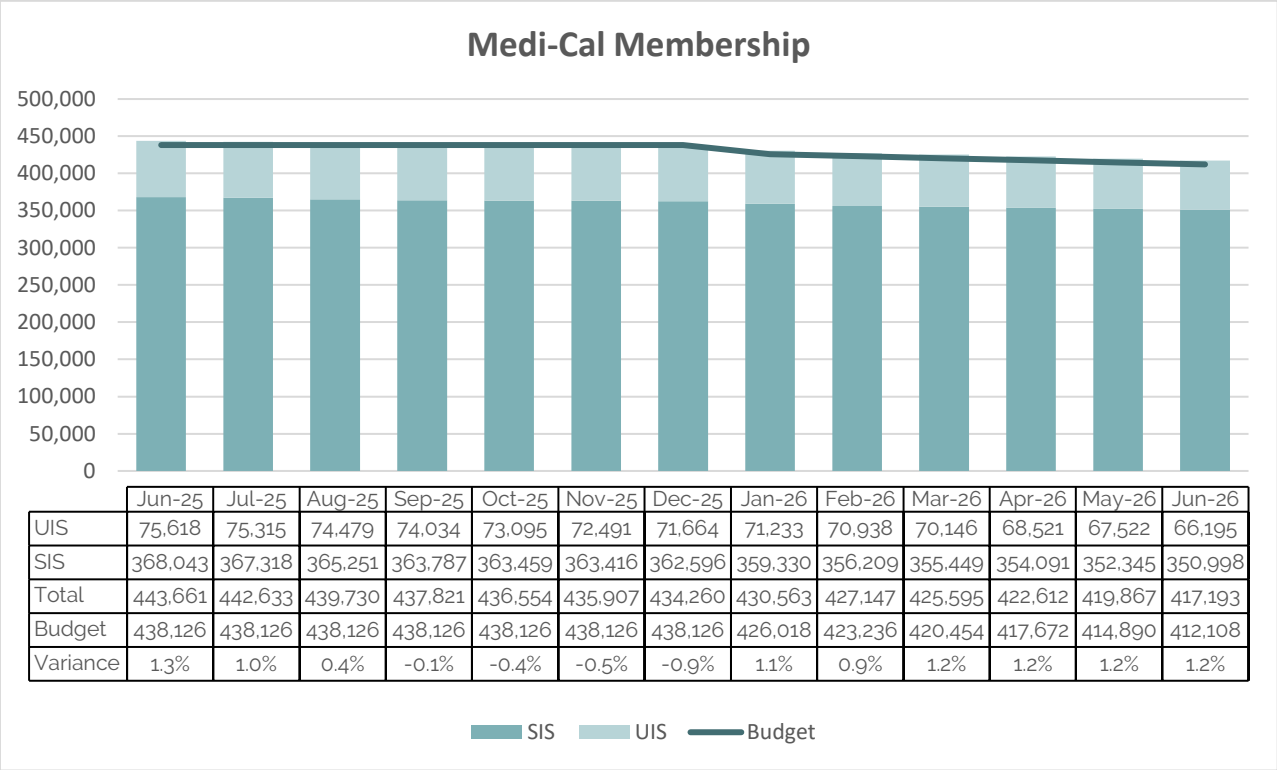
Jun-26 Income Statement
Medi-Cal ($ In 000s)

Key Indicators	MTD Actual	MTD Budget	MTD Var $	MTD Var %	YTD Actual	YTD Budget	YTD Var $	YTD Var %
Membership	*419,738*	*412,834*	*6,904*	*1.7%*	*2,563,410*	*2,518,744*	*44,666*	*1.8%*
Revenue	$187,191	$182,149	$5,041	2.8%	$1,151,658	$1,122,498	$29,159	2.6%
Medical Expenses	163,082	171,010	7,928	4.6%	1,095,280	1,055,965	(39,314)	-3.7%
Admin Expenses	10,286	10,054	(232)	-2.3%	54,265	58,484	4,218	7.2%
Operating Income/(Loss)	**13,823**	**1,085**	**12,738**	**100.0%**	**2,113**	**8,049**	**(5,936)**	**-73.7%**
Net Income/(Loss)	$13,937	$3,185	$10,752	100.0%	($4,247)	$20,649	($24,895)	- 100.0%
PMPM								
Revenue	$445.97	$441.22	$4.75	1.1%	$449.27	$445.66	$3.61	0.8%
Medical Expenses	388.53	414.23	25.70	6.2%	427.27	419.24	(8.03)	-1.9%
Admin Expenses	24.51	24.35	(0.15)	-0.6%	21.17	23.22	2.05	8.8%
Operating Income/(Loss)	32.93	2.63	30.30	100.0%	0.82	3.20	(2.37)	-74.2%
Net Income/(Loss)	$33.20	$7.72	$25.49	100.0%	($1.66)	$8.20	($9.85)	-100.0%
MLR %	87.1%	93.9%	6.8%		95.1%	94.1%	-1.0%	
ALR %	5.5%	5.5%	0.0%		4.7%	5.2%	0.5%	
Operating Income %	7.4%	0.6%	6.8%		0.2%	0.7%	-0.5%	
Net Income %	7.4%	1.7%	5.7%		-0.4%	1.8%	-2.2%	

Membership: June 2026 Medi-Cal membership is favorable to the budget by 1.2%. The 2026 budgeted Medi-Cal enrollment assumed a 7.8% decline by year-end from projected December 2025 levels, driven by the expiration of federal flexibilities, changes to the state budget, and the implications of federal H.R. 1 legislation.

Starting in January 2026, two new provisions were implemented: an Unsatisfactory Immigrant Status (UIS) enrollment freeze, with no new enrollments among members aged 19 to 64, and the reinstatement of a Medi-Cal asset limit for our SPD population. Those provisions are estimated to lower membership by 6% and 2.4%, respectively, in their aid category. These items, along with the ongoing redetermination process and the unwinding of COVID-19

flexibilities, are causing both Satisfactory Immigration Status (SIS) and UIS membership to trend downward and are projected to continue the remainder of the year.



	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
UIS	75,618	75,315	74,479	74,034	73,095	72,491	71,664	71,233	70,938	70,146	68,521	67,522	66,195
SIS	368,043	367,318	365,251	363,787	363,459	363,416	362,596	359,330	356,209	355,449	354,091	352,345	350,998
Total	443,661	442,633	439,730	437,821	436,554	435,907	434,260	430,563	427,147	425,595	422,612	419,867	417,193
Budget	438,126	438,126	438,126	438,126	438,126	438,126	438,126	426,018	423,236	420,454	417,672	414,890	412,108
Variance	1.3%	1.0%	0.4%	-0.1%	-0.4%	-0.5%	-0.9%	1.1%	0.9%	1.2%	1.2%	1.2%	1.2%

Revenue: The 2026 revenue budget was based on the Department of Health Care Services (DHCS) 2026 Prospective rate package (dated 11/12/2025). The budget also includes a 1% quality withhold with a 75% performance earn-back assumption. The budget assumes risk corridors will continue for Enhanced Care Management (ECM) and UIS State in CY 2026. In addition, a 1% reserve was included in the budget to account for a potential decrease in the final rate, as the Prospective rates do not incorporate the State Budget changes for 2026.

Jun-26 YTD Medi-Cal Capitation Revenue Summary ($ In 000s)

Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	$875,729	$845,246	$30,483	$23,506	$6,977
CEC UIS	212,106	215,696	(3,591)	(7,422)	3,831
SBN SIS	50,092	49,086	1,006	1,973	(967)
SBN UIS	9,117	9,469	(352)	(475)	123
Total*	**$1,147,044**	**$1,119,497**	**$27,547**	**$17,583**	**$9,964**

*Excludes Jun-26 In-Home Supportive Services (IHSS) premiums revenue of $3.2M and State Incentives of $1.4M.

As of June YTD, capitation revenue exceeded the budget by $27.5M, representing a positive 2.5% variance. This variance is primarily driven by higher-than-expected SPD-LTC membership, which is 27.2% above budget. Additionally, the budget did not account for the reclassification of

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SPD members aged 0–20 from the Child category to SPD, implemented in 2026, further contributing to the positive variance. These favorable enrollment impacts are partially offset by rate variance associated with risk corridors, including the UIS and San Benito programs. In May, an updated calculation for the CY 2024 San Benito risk corridor resulted in an incremental $1.2M payable. Furthermore, the calculation methodology for the ECM Risk Corridor was updated from an encounter-based approach to a service unit-based approach.

Medical Expenses: The 2026 budget assumed a 2.7% increase in utilization over the 2025 forecast, based on data from 2022 through September 2025, and a 1.4% increase in unit cost driven by changes in case mix and fee schedule adjustments, excluding ECM and Community Supports (CS). The 2026 incentives include $20M for the Hospital Quality Incentive Program (HQIP), $15M for Care-Based Incentive (CBI), $12.5M for the Specialist Care Incentive (SCI), $4M for Data Sharing Incentives, and $3.7M for Behavioral Health Value-Based Program (BH VBP).

Jun-26 YTD Medi-Cal Medical Expense Summary ($ In 000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	$299,109	$279,297	($19,812)	($4,953)	($14,859)
Inpatient LTC	111,967	109,002	(2,965)	(1,933)	(1,032)
Physician Services	223,499	243,566	20,067	(4,319)	24,386
Outpatient Facility	133,863	117,008	(16,855)	(2,075)	(14,780)
ECM	72,126	79,744	7,618	(1,414)	9,032
Community Supports	37,978	30,567	(7,411)	(542)	(6,869)
Behavioral Health	60,682	46,905	(13,778)	(832)	(12,946)
Other Medical*	154,684	149,876	(4,808)	(2,658)	(2,150)
State Incentives	1,372	-	(1,372)	-	(1,372)
TOTAL COST	**$1,095,280**	**$1,055,965**	**($39,314)**	**($18,726)**	**($20,588)**

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

June 2026 Medical Expenses of $163.1M are $7.9M or 4.6% favorable to the budget.
June 2026 YTD Medical Expenses of $1,095.3M are above budget by $39.3M or 3.7%. Of this amount, $18.7M is due to higher enrollment and $20.6M due to rate variances. The unfavorability is primarily driven by CS due to higher cost trends, followed by Inpatient Hospital and Outpatient, reflecting high prior-year adjustments made in January through March, and Behavioral Health (BH), driven by an increase in BH utilizers as well as higher utilization of Mental Health Outpatient (MHOP) and Behavioral Health Treatment (BHT) services.

At a PMPM level, YTD Medical Expenses are $427.27, which is $8.03 or 1.9% unfavorable compared to the budget.

Jun-26 YTD Medi-Cal Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$116.68	$110.89	($5,80)	-5.2%
Inpatient Services - LTC	43.68	43.28	(0.40)	-0.9%
Physician Services	87.19	96.70	9.51	9.8%
Outpatient Facility	52.22	46.45	(5.77)	-12.4%
ECM	28.14	31.66	3.52	11.1%
Community Supports	14.82	12.14	(2.68)	-22.1%
Behavioral Health	23.67	18.62	(5.05)	-27.1%
Other Medical	60.34	59.50	(0.84)	-1.4%
State Incentives	0.54	-	(0.54)	-100.0%
TOTAL MEDICAL COST	**$427.27**	**$419.24**	**($8.03)**	**-1.9%**

Inpatient Services: Inpatient Services are unfavorable to the budget, driven by higher-than expected prior-period adjustments in earlier months and the resulting impact on the expected completed PMPM within IBNR.

Inpatient Services—Long Term Care (LTC): Utilization and unit cost are slightly trending above budget.

Physician Services: Specialty utilization is trending slightly lower, while primary care and FQHC utilization continue to trend slightly higher, resulting in a favorable overall variance. The Specialty Physicians category includes $4.3M per month in provider supplemental payments (PSP), funded by Board-approved strategic use of reserves.
Outpatient Facility: The Outpatient Facility category consists of both Outpatient and Emergency Room (ER) services. This reflects a continued upward trend in both utilization per 1k and unit cost.

ECM: Overall, ECM performance is over budget and should be evaluated holistically, considering both revenue and expenses. The performance is over budget, primarily driven by ECM enrollments experiencing an extended period of low-intensity services, as well as unrecognized costs associated with lower encounter service units that must be absorbed by the plan.

In May, we maintained a neutral risk corridor position while evaluating encounter-based adjustments within the ECM risk corridor. In June, we transitioned to service unit-based adjustment to better align with the actual service delivery. We will update the methodology once the State publishes its final methodology. In the meantime, the Alliance plans to deploy targeted initiatives aligned with DHCS ECM program guidance in the second half of this year to strengthen sustainability, emphasizing high-touch, community-based care, reducing low-value utilization, tighter eligibility and utilization management, and a focus on members with the greatest needs.

Under this approach, costs will only be recognized when supported by documented service units reflecting intensity and dosage. Lower service units will therefore reduce eligible ECM expense recognition and increase exposure to unreimbursed costs. *As previously noted, a*

shift toward a fee-for-service (FFS) reimbursement structure will be needed to better align payment with service intensity and dosage requirements.

Community Supports: Community Supports costs increased in June, primarily due to Personal Care and Homemaker Services (PCHS). However, upcoming policy changes are expected to mitigate ongoing PCHS cost volatility, with further stabilization anticipated as provider education continues. Declining CS enrollments and the implementation of program integrity initiatives, including Medically Tailored Meals (MTM), housing services, and the transition to case-rate reimbursement for housing effective March 2026, continue to drive improved performance.

Behavioral Health: Behavioral Health expenses are unfavorable to the budget, primarily driven by higher-than-expected utilization of Mental Health Outpatient (MHOP) and Behavioral Health Treatment – Applied Behavior Analysis (BHT ABA) services. While the budget anticipated increased utilization following the in-sourcing initiative implemented in July 2025, recent trends have exceeded projections. This is largely due to efforts to transition members from the prior vendor's waitlist, which is anticipated to be completed by August. Recent analysis also indicates a rise in unique users receiving treatment in both MHOP and BHT, further contributing to elevated cost trends. The budget also reflects higher unit costs associated with the inclusion of TRI services, which partially offset the variance but keep overall performance above projected spending.

Other Medical: Other Medical expenses are very close to budget, with a slight unfavorable variance overall. Budget development appropriately accounted for historical utilization growth in Transportation and Hospice services, helping to keep performance largely in line with expectations. To help manage elevated non-medical transportation utilization, we implemented several operational controls in March to promote appropriate use, and we expect a decline in the coming months. Allied Health is seeing a modest unfavorable utilization trend, primarily driven by higher use of home health and physical therapy services, and we will continue to monitor it closely.

Dual Eligible Special Needs Plan (D-SNP) Line of Business

Beginning January 2026, the Alliance launched the TotalCare (HMO D-SNP), a Medicare Advantage Dual Special Needs Plan (D-SNP) for people 65 years old and over, and for some people with certain disabilities who are enrolled in both Medicare and Medi-Cal.
For the month ending June 30, 2026, the Alliance reported Operating Income of $0.2M. The Year-to-Date (YTD) Operating Loss is $4.8M, with a Medical Loss Ratio (MLR) of 107.0% and an Administrative Loss Ratio (ALR) of 57.7%.

The budget expected an Operating Loss of $9.0M for June YTD. The actual result is favorable to the budget by $4.2M or 46.6%, due to the lower enrollment.

Jun-26 Income Statement D-SNP ($ In 000s)								
Key Indicators	MTD Actual	MTD Budget	MTD Var $	MTD Var %	YTD Actual	YTD Budget	YTD Var $	YTD Var %
Membership	*978*	*2,576*	*(1,598)*	*-62.0%*	*4,016*	*9,687*	*(5,671)*	*-58.5%*
Revenue	$1,801	$4,465	($2,664)	-59.7%	$7,452	$16,791	($9,339)	-55.6%
Medical Expenses	1,255	5,110	3,854	75.4%	7,972	19,665	11,693	59.5%
Admin Expenses	360	1,123	763	68.0%	4,298	6,142	1,844	30.0%
Operating Income/(Loss)	$186	($1,768)	$1,954	100.0%	($4,818)	($9,016)	4,198	46.6%
PMPM								
Revenue	$1,841.52	$1,733.19	$108.33	6.3%	$1,855.59	$1,733.33	$122.26	7.1%
Medical Expenses	1,283.72	1,983.63	699.91	35.3%	1,985.01	2,029.99	44.98	2.2%
Admin Expenses	367.79	435.85	68.06	15.6%	1,070.19	634.02	(436.17)	-68.8%
Operating Income/(Loss)	$190.02	($686.29)	$876.30	100.0%	($1,199.61)	($930.68)	($268.92)	-28.9%
MLR %	69.7%	114.4%	44.7%		107.0%	117.1%	10.1%	
ALR %	20.0%	25.1%	5.2%		57.7%	36.6%	-21.1%	
Operating Income %	10.3%	-39.6%	49.9%		-64.6%	-53.7%	-11.0%	

Membership: June 2026 D-SNP membership is unfavorable to the budget by 62.0%. D-SNP enrollment was projected to begin the year at approximately 635 members in January, with anticipated growth of about 350 members per month reaching an estimated 4,500 by year-end. However, the revised membership forecast assumes monthly membership growth of approximately 154 per month beginning in May, inclusive of 8% attrition rate, resulting in a projected membership of 1,892 by year-end.

Actual June membership totaled 978 and is now tracking closely to the revised membership forecast.

Revenue: The 2026 D-SNP revenue budget was based on the bid submitted in June 2025, prepared by our actuary partners. It uses 2026 county-level benchmarks released by CMS and reflects that the plan is considered a "New Plan" for Star rating purposes for three years. The risk score is derived from the Medicare FFS sample and adjusted using CMS's CY 2026 county-level risk score projections.

Jun-26 YTD D-SNP Revenue Summary ($ In 000s)					
CMS CAP	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Part C	$6,393	$13,609	($7,215)	($7,967)	$752
Part D	1,059	3,183	(2,124)	(1,863)	(261)
Total	**$7,452**	**$16,791**	**($9,339)**	**($9,830)**	**$491**

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As of June, actual revenue is $2.7M below budget, or 59.7%. As of June YTD, actuals are $9.3M below budget, representing a negative variance of 55.6%. This shortfall is primarily attributable to lower-than-anticipated enrollment, partially offset by a favorable variance in the risk-adjusted rate. The early months are expected to be highly volatile until enrollment stabilizes for this newly launched D-SNP line of business.

Medical Expenses: The 2026 budget is based on the bid submitted in June 2025 by our actuarial partners, which covers Medicare Parts A and B services, including Part D pharmacy benefits, as well as supplemental benefits not offered through the traditional Medicare FFS program. Supplemental benefits include fitness, an allowance for over-the-counter (OTC) medications and supplies, routine vision and eyewear, and worldwide emergency coverage. The budget incorporates medical cost management savings converted from traditional FFS, provider reimbursement aligned with in-network rates, and D-SNP-related non-claims medical expenses, including $1M Risk Adjustment Incentives.

Jun-26 YTD D-SNP Medical Expense Summary ($ In 000s)

Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	$1,929	$4,689	$2,760	$2,745	$15
Inpatient Services - LTC	373	1,084	711	635	77
Physician Services	945	5,018	4,072	2,937	1,135
Outpatient Facility	1,020	3,391	2,370	1,985	385
CMS Pharmacy Part D	1,291	3,230	1,939	1,891	48
Other Medical*	2,414	2,254	(160)	1,319	(1,479)
TOTAL COST	**$7,972**	**$19,665**	**$11,693**	**$11,513**	**$181**

*Including Ambulance, DME, Other Medicare Part B, Supplemental Benefits, and UM/QA/CC

June 2026 Medical Expenses of $1.3M are below budget by $3.9M or 75.4%, primarily due to lower than anticipated enrollment.

June YTD 2026 Medical Expenses of $8.0M are below budget by $11.7M or 59.5%, primarily due to lower than anticipated enrollment.

Jun-26 YTD D-SNP Medical Expense by Category of Service (In PMPM)

Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$480.24	$484.04	$3.81	0.8%
Inpatient Services - LTC	92.89	111.95	19.05	17.0%
Physician Services	235.35	517.94	282.59	54.6%
Outpatient Facility	254.06	350.02	95.95	27.4%
CMS Pharmacy Part D	321.43	333.40	11.97	3.6%
Other Medical*	601.04	232.65	(368.39)	-100.0%
TOTAL MEDICAL COST	**$1,985.01**	**$2,029.99**	**$44.98**	**2.2%**

*Including Ambulance, DME, Other Medicare Part B, Supplemental Benefits, and UM/QA/CC

At the PMPM level, Medical Expenses are $1,985.01, favorable by $44.98 or 2.2% compared to the budget. The PMPM variance is unfavorable because costs are spread across a smaller membership base than projected, resulting in a favorable dollar variance. The actual results

are heavily Incurred but Not Reported (IBNR)- driven, using the bid submission as the basis. As claims are fully processed and more complete data becomes available, a clearer picture of the underlying medical expense experience will emerge.

Administrative Expenses: June YTD Consolidated Administrative Expenses are favorable to the budget by $6.1M or 9.4% with 5.1% ALR. Salaries are favorable by $2.1M or 4.7%, driven by savings from vacant positions. Non-salary administrative expenses are favorable at $4.0M, or 19.7%, due to timing differences between actual and budget.

Non-Operating Revenue/Expenses: June YTD Net Non-Operating Loss totaled $6.4M, unfavorable to budget by $19.0M. Of this amount, $13.9M was attributable to unrealized investment losses due to lower bond prices. Since the investments are expected to be held to maturity, these losses are not anticipated to be realized. In addition, higher grant distributions contributed approximately $5.0M to the unfavorable variance.

Summary of Results: Overall, the Alliance generated a Consolidated Net Loss of $9.1M, with an MLR of 95.2% and an ALR of 5.1%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Sixth Month Ending June 30, 2026
(In $000s)

Assets	
Cash	$273,867
Restricted Cash	309
Short Term Investments	813,419
Receivables	387,649
Prepaid Expenses	32
Other Current Assets	3,768
Total Current Assets	**$1,479,043**
Building, Land, Furniture & Equipment	
Capital Assets	$83,646
Accumulated Depreciation	(47,859)
CIP	817
Lease Receivable	2,799
Subscription Asset net Accum Depr	10,673
Total Non-Current Assets	**50,076**
Total Assets	**$1,529,119**
Liabilities	
Accounts Payable	$221,679
IBNR/Claims Payable	339,085
Provider Incentives Payable	27,329
Other Current Liabilities	7,263
Due to State	77,282
Total Current Liabilities	**$672,637**
Subscription Liabilities	7,963
Deferred Inflow of Resources	2,556
Total Long-Term Liabilities	**$10,520**
Fund Balance	
Fund Balance - Prior	$855,027
Retained Earnings - CY	(9,064)
Total Fund Balance	**845,962**
Total Liabilities & Fund Balance	**$1,529,119**
Additional Information	
Total Fund Balance	**$845,962**
Board Designated Reserves Target	565,379
Strategic Reserve (DSNP)	51,882
Medi-Cal Capacity Grant Program (MCGP)*	128,803
Value Based Payments	9,949
Provider Supplemental Payments	81,423
Total Reserves	**837,437**
Total Operating Reserve	**$8,525**

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-LOB Summary
For The Sixth Month Ending June 30, 2026
(In $000s)

	Medi-Cal				D-SNP				Consolidated			
	YTD Actual	YTD Budget	Var $	Var %	YTD Actual	YTD Budget	Var $	Var %	YTD Actual	YTD Budget	Var $	Var %
Member Months	*2,563,410*	*2,518,744*	*44,666*	*1.8%*	*4,016*	*9,687*	*(5,671)*	*-58.5%*	*2,567,426*	*2,528,431*	*38,995*	*1.5%*
Dollars												
Revenue	$1,151,658	$1,122,498	$29,159	2.6%	$7,452	$16,791	($9,339)	-55.6%	$1,159,110	$1,139,290	$19,820	1.7%
Medical Expenses	1,095,280	1,055,965	(39,314)	-3.7%	7,972	19,665	11,693	59.5%	1,103,251	1,075,630	(27,621)	-2.6%
Administrative Expenses	54,265	58,484	4,218	7.2%	4,298	6,142	1,844	30.0%	58,563	64,626	6,063	9.4%
Operating Income/(Loss)	2,113	8,049	(5,936)	-73.7%	(4,818)	(9,016)	4,198	46.6%	(2,705)	(966)	(1,738)	-100.0%
Total Non-Op Income/(Expense)	(6,360)	12,599	(18,959)	-100.0%	-	-	0	0.0%	(6,360)	12,599	(18,959)	-100.0%
Net Income/(Loss)	($4,247)	$20,649	($24,895)	-100.0%	($4,818)	($9,016)	$4,198	46.6%	($9,064)	$11,633	($20,697)	-100.0%
PMPM												
Revenue	$449.27	$445.66	$3.61	0.8%	$1,855.59	$1,733.33	$122.26	7.1%	$451.47	$450.59	$0.88	0.2%
Medical Expenses	427.27	419.24	(8.03)	-1.9%	1,985.01	2,029.99	44.98	2.2%	429.71	425.41	(4.30)	-1.0%
Administrative Expenses	21.17	23.22	2.05	8.8%	1,070.19	634.02	(436.17)	-68.8%	22.81	25.56	2.75	10.8%
Operating Income/(Loss)	0.82	3.20	(2.37)	-74.2%	(1,199.61)	(930.68)	(268.92)	-28.9%	(1.05)	(0.38)	(0.67)	-100.0%
Total Non-Op Income/(Expense)	(2.48)	5.00	(7.48)	-100.0%	-	-	-	0.0%	(2.48)	4.98	(7.46)	-100.0%
Net Income/(Loss)	($1.66)	$8.20	($9.85)	-100.0%	($1,199.61)	($930.68)	($268.92)	-28.9%	($3.53)	$4.60	($8.13)	100.0%
MLR	*95.1%*	*94.1%*			*107.0%*	*117.1%*			*95.2%*	*94.4%*		
ALR	*4.7%*	*5.2%*			*57.7%*	*36.6%*			*5.1%*	*5.7%*		
Operating Income %	*0.2%*	*0.7%*			*-64.6%*	*-53.7%*			*-0.2%*	*-0.1%*		
Net Income %	*-0.4%*	*1.8%*			*-64.6%*	*-53.7%*			*-0.8%*	*1.0%*		

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-Consolidated
For The Sixth Month Ending June 30, 2026
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*420,716*	*415,410*	*5,306*	*1.3%*	*2,567,426*	*2,528,431*	*38,995*	*1.5%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$186,340	$181,650	$4,690	2.6%	$1,147,044	$1,119,497	$27,547	2.5%
CMS D-SNP	1,801	4,465	(2,664)	-59.7%	7,452	16,791	(9,339)	-55.6%
State Incentive Programs	273	-	273	100.0%	1,372	-	1,372	100.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	577	499	78	15.6%	3,242	3,001	241	8.0%
Total Operating Revenue	**$188,992**	**$186,614**	**$2,377**	**1.3%**	**$1,159,110**	**$1,139,290**	**$19,821**	**1.7%**
Medical Expenses								
Inpatient Services (Hospital)	$45,157	$47,001	$1,844	3.9%	$301,037	$283,986	($17,051)	-6.0%
Inpatient Services (LTC)	18,114	18,144	30	0.2%	112,340	110,086	(2,253)	-2.0%
Physician Services	30,395	41,238	10,843	26.3%	224,444	248,583	24,139	9.7%
Outpatient Facility	21,930	20,070	(1,860)	-9.3%	134,883	120,399	(14,484)	-12.0%
ECM	10,114	11,078	964	8.7%	72,126	79,744	7,618	9.6%
Community Supports	7,245	5,008	(2,237)	-44.7%	37,978	30,567	(7,411)	-24.2%
Behavioral Health	9,773	7,684	(2,089)	-27.2%	60,687	46,905	(13,782)	-29.4%
CMS Pharmacy Part D	269	859	590	68.7%	1,291	3,230	1,939	60.0%
Other Medical**	21,068	25,038	3,970	15.9%	157,093	152,130	(4,963)	-3.3%
State Incentive Programs	273	-	(273)	-100.0%	1,372	-	(1,372)	-100.0%
Total Medical Expenses	**$164,337**	**$176,120**	**$11,783**	**6.7%**	**$1,103,251**	**$1,075,630**	**($27,621)**	**-2.6%**
Gross Margin	**$24,654**	**$10,494**	**$14,160**	**100.0%**	**$55,859**	**$63,659**	**($7,801)**	**-12.3%**
Administrative Expenses								
Salaries	$7,393	$7,689	$296	3.9%	$42,339	$44,425	$2,086	4.7%
Professional Fees	741	493	(249)	-50.4%	2,453	2,807	354	12.6%
Purchased Services	612	1,148	536	46.7%	3,478	4,955	1,477	29.8%
Supplies & Other	942	863	(78)	-9.1%	4,896	6,496	1,601	24.6%
Occupancy	116	136	20	14.8%	674	855	181	21.2%
Depreciation/Amortization	842	848	6	0.7%	4,724	5,088	364	7.1%
Total Administrative Expenses	**$10,646**	**$11,177**	**$531**	**4.8%**	**$58,563**	**$64,626**	**$6,063**	**9.4%**
Operating Income/(Loss)	**$14,009**	**($683)**	**$14,691**	**100.0%**	**($2,705)**	**($966)**	**($1,738)**	**-100.0%**
Non-Op Income/(Expense)								
Interest	$3,432	$3,330	$102	3.1%	$20,320	$19,980	$340	1.7%
Gain/(Loss) on Investments	(1,504)	833	(2,337)	-100.0%	(9,145)	5,000	(14,145)	-100.0%
Bank & Investment Fees	(54)	(38)	(15)	-40.2%	(368)	(230)	(138)	-59.7%
Other Revenues	282	308	(27)	-8.6%	1,866	1,849	16	0.9%
Grants	(2,042)	(2,333)	292	12.5%	(19,032)	(14,000)	(5,032)	-35.9%
Total Non-Op Income/(Expense)	**114**	**2,100**	**(1,986)**	**-94.6%**	**(6,360)**	**12,599**	**($18,959)**	**-100.0%**
Net Income/(Loss)	**$14,123**	**$1,417**	**$12,706**	**100.0%**	**($9,064)**	**$11,633**	**($20,697)**	**-100.0%**
MLR	*87.0%*	*94.4%*			*95.2%*	*94.4%*		
ALR	*5.6%*	*6.0%*			*5.1%*	*5.7%*		
Operating Income %	*7.4%*	*-0.4%*			*-0.2%*	*-0.1%*		
Net Income %	*7.5%*	*0.8%*			*-0.8%*	*1.0%*		

**Other Medical includes Pharmacy and IHSS.

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget-Consolidated
For The Sixth Month Ending June 30, 2026
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*420,716*	*415,410*	*5,306*	*1.3%*	*2,567,426*	*2,528,431*	*38,995*	*1.5%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$442.91	$437.28	$5.63	1.3%	$446.77	$442.76	$4.00	0.9%
CMS D-SNP	4.28	10.75	(6.47)	-60.2%	2.90	6.64	(3.74)	-56.3%
State Incentive Programs	0.65	-	0.65	100.0%	0.53	-	0.53	100.0%
Prior Year Revenue*	-	-	-	0.0%	-	-	-	0.0%
Premiums Commercial	1.37	1.20	0.17	14.2%	1.26	1.19	0.08	6.4%
Total Operating Revenue	**$449.21**	**$449.23**	**($0.01)**	**0.0%**	**$451.47**	**$450.59**	**$0.88**	**0.2%**
Medical Expenses								
Inpatient Services (Hospital)	$107.33	$113.14	$5.81	5.1%	$117.25	$112.32	($4.94)	-4.4%
Inpatient Services (LTC)	43.06	43.68	0.62	1.4%	43.76	43.54	(0.22)	-0.5%
Physician Services	72.25	99.27	27.02	27.2%	87.42	98.32	10.90	11.1%
Outpatient Facility	52.12	48.31	(3.81)	-7.9%	52.54	47.62	(4.92)	-10.3%
ECM	24.04	26.67	2.63	9.9%	28.09	31.54	3.45	10.9%
Community Supports	17.22	12.06	(5.16)	-42.8%	14.79	12.09	(2.70)	-22.4%
Behavioral Health	23.23	18.50	(4.73)	-25.6%	23.64	18.55	(5.09)	-27.4%
CMS Pharmacy Part D	0.64	2.07	1.43	69.1%	0.50	1.28	0.77	60.6%
Other Medical**	50.08	60.27	10.20	16.9%	61.19	60.17	(1.02)	-1.7%
State Incentive Programs	0.65	-	(0.65)	-100.0%	0.53	-	(0.53)	-100.0%
Total Medical Expenses	**$390.61**	**$423.97**	**$33.35**	**7.9%**	**$429.71**	**$425.41**	**($4.30)**	**-1.0%**
Gross Margin	**$58.60**	**$25.26**	**$33.34**	**100.0%**	**$21.76**	**$25.18**	**($3.42)**	**-13.6%**
Administrative Expenses								
Salaries	$17.57	$18.51	$0.94	5.1%	$16.49	$17.57	$1.08	6.1%
Professional Fees	1.76	1.19	(0.58)	-48.5%	0.96	1.11	0.15	13.9%
Purchased Services	1.45	2.76	1.31	47.4%	1.35	1.96	0.61	30.9%
Supplies & Other	2.24	2.08	(0.16)	-7.7%	1.91	2.57	0.66	25.8%
Occupancy	0.28	0.33	0.05	15.8%	0.26	0.34	0.08	22.4%
Depreciation/Amortization	2.00	2.04	0.04	1.9%	1.84	2.01	0.17	8.6%
Total Administrative Expenses	**$25.30**	**$26.91**	**$1.60**	**6.0%**	**$22.81**	**$25.56**	**$2.75**	**10.8%**
Operating Income/(Loss)	**$33.30**	**($1.64)**	**$34.94**	**100.0%**	**($1.05)**	**($0.38)**	**($0.67)**	**-100.0%**
Non-Op Income/(Expense)								
Interest	$8.16	$8.02	$0.14	1.8%	$7.91	$7.90	$0.01	0.2%
Gain/(Loss) on Investments	(3.57)	$2.01	(5.58)	-100.0%	(3.56)	1.98	(5.54)	-100.0%
Bank & Investment Fees	(0.13)	(0.09)	(0.04)	-38.4%	(0.14)	(0.09)	(0.05)	-57.3%
Other Revenues	0.67	0.74	(0.07)	-9.8%	0.73	0.73	(0.00)	-0.6%
Grants	(4.85)	(5.62)	0.76	13.6%	(7.41)	(5.54)	(1.88)	-33.9%
Total Non-Op Income/(Expense)	**$0.27**	**$5.05**	**($4.78)**	**-94.6%**	**($2.48)**	**$4.98**	**($7.46)**	**-100.0%**
Net Income/(Loss)	**$33.57**	**$3.41**	**$30.16**	**100.0%**	**($3.53)**	**$4.60**	**($8.13)**	**-100.0%**
MLR	*87.0%*	*94.4%*			*95.2%*	94.4%		
ALR	*5.6%*	*6.0%*			*5.1%*	5.7%		
Operating Income %	*7.4%*	*-0.4%*			*-0.2%*	-0.1%		
Net Income %	*7.5%*	*0.8%*			*-0.8%*	1.0%		

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

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CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Sixth Month Ending June 30, 2026
(In $000s)

	MTD	YTD
Net Income	$14,123	($9,064)
Items not requiring the use of cash: Depreciation	446	2,044
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	0
Receivables	2,492	9,746
Prepaid Expenses	(185)	(1,653)
Current Assets	(333)	1,261
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**1,973**	**9,354**
Changes to Payables:		
Accounts Payable	63,863	14,118
Other Current Liabilities	586	(2,071)
Incurred But Not Reported Claims/Claims Payable	4,100	(121,711)
Provider Incentives Payable	(11,714)	(13,780)
Due to State	0	(70,377)
Subscription Liabilities	0	0
Net Changes to Payables	**56,834**	**(193,820)**
Net Cash Provided by (Used in) Operating Activities	**73,376**	**(191,486)**
Change in Investments	(1,243)	(6,024)
Other Equipment Acquisitions	202	(626)
Net Cash Provided by (Used in) Investing Activities	**(1,040)**	**(6,651)**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**72,336**	**(198,137)**
Cash & Cash Equivalents at Beginning of Period	**196,090**	**394,722**
Cash & Cash Equivalents at June 30, 2026	**$273,867**	**$273,867**

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

Meeting Minutes

Wednesday, June 24, 2026
3:00 p.m. – 5:00 p.m.

In Santa Cruz County:
Central California Alliance for Health
1600 Green Hills Road, Suite 101, Scotts Valley, California
In Monterey County:
Central California Alliance for Health
950 East Blanco Road, Suite 101, Salinas, California
In Merced County:
Central California Alliance for Health
530 West 16th Street, Suite B, Merced, California
In San Benito County:
San Benito County Health and Human Services Agency
1111 San Felipe Road, Building B, Hollister, CA
In Mariposa County:
Mariposa County Health and Human Services
5362 Lemee Lane, Mariposa, California

Commissioners Present:

Ms. Leslie Abasta-Cummings	At Large Health Care Provider Representative
Dr. Ralph Armstrong	At Large Health Care Provider Representative
Supervisor Wendy Root Askew	County Board of Supervisor
Supervisor Kim De Serpa	County Board of Supervisor
Dr. Maximiliano Cuevas	Health Care Provider Representative
Dr. Donaldo Hernandez	Health Care Provider Representative
Ms. Katrina Hodges	Public Representative
Ms. Elsa Jimenez	County Director of Health Service
Mr. Michael Molesky	Public Representative
Ms. Connie Moreno-Peraza	County Health Department Representative

Supervisor Josh Pedrozo	County Board of Supervisor
Dr. Allen Radner	At Large Health Care Provider Representative
Dr. Kristynn Sullivan	County Health Department Representative
Mr. Ye Thao	Public Representative

Commissioners Absent:

Ms. Anita Aguirre	At Large Health Care Provider Representative
Ms. Tracey Belton	County Health and Human Services Agency
Dr. Kristina Keheley	County Health Department Representative
Dr. James Rabago	Health Care Provider Representative

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Ms. Lisa Ba	Chief Financial Officer
Ms. Jenifer Mandella	Chief Compliance Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
Dr. Mike Wang	Chief Medical Officers
Ms. Anne Brereton	Deputy County Counsel, Monterey County
Ms. Danita Carlson	Government Relations Director
Mr. Jimmy Ho	Accounting Director
Ms. Hayley Tut	Clerk of the Board

1. Call to Order by Chair Pedrozo.

Chairperson Pedrozo called the meeting to order at 3:02 p.m.

Roll call was taken and a quorum was present.

There were no supplements or deletions to the agenda.

2. Oral Communications.

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

There was no public comment.

3. Comments and announcements by Commission members.

Chair Pedrozo opened the floor for Commissioners to make comments.

There was no comment.

4. Comments and announcements by Chief Executive Officer. 3:05 p.m.

Mr. Michael Schrader, CEO, reported that in light of the potential impacts of HR 1 on Medi-Cal eligibility, counties have begun exploring options for meeting their indigent care obligations under Welfare and Institutions Code Section 17000. At the request of

Commissioners Morena-Peraza and Sullivan, Alliance staff recently met with county representatives to discuss potential partnership opportunities. One concept under discussion is for the Alliance to provide administrative services to support the reestablishment and ongoing operation of county indigent care programs through an Administrative Services Organization (ASO) agreement. Under this model, the Alliance would perform administrative functions on behalf of participating counties. These discussions have been limited, preliminary, and remain ongoing. Each county operates under different circumstances and continues to evaluate its available options. An Alliance-administered solution may be considered as one of those options. No decisions have been made at this time.

Consent Agenda Items: (5.- 9B.): 3:07 p.m.

MOTION: Commissioner Sullivan moved to approve Consent Agenda items 5-9B seconded by Commissioner Hernandez.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta Cummings, Armstrong, Askew, Cuevas, Hernandez, Hodges, Jimenez, Molesky, Pedrozo, Radner, Sullivan and Thao

Noes: None.

Absent: Commissioners, Aguirre, Belton, De Serpa, Keheley, Moreno-Peraza, and Rabago

Abstain: None.

Regular Agenda Items: (10. – 13.): 3:08 p.m.

10. Specialty Access Ad Hoc Committee Report Out. 3:08 p.m.

Ms. Van Wong, Chief Operating Officer and Ms. Jessica Finney, Community Grants Director presented the outcomes of the Specialty Access Ad Hoc Committee, recommending a multi-pronged, budget-neutral strategy to address specialty care gaps across the Alliance's five-county service area, with the board approving a $20 million reallocation from the provider supplemental payment program to expand specialist recruitment grants.

The ad hoc committee, formed in February and comprising six board commissioners, conducted a three-month process to assess specialty access gaps. They analyzed member utilization patterns, network adequacy, and funding options, concluding that access gaps persist, with 30% of specialty authorizations occurring outside the Alliance's service area. The committee determined that no single intervention would suffice and recommended a flexible, regionally tailored approach.

Five solution options were identified:

- Hospital-led recruitment with clinic deployment
- Part-time hybrid specialist coverage
- Targeted recruitment grants
- Selective telehealth
- Improved referral/coordination infrastructure.

The committee recommended bundling these solutions and adjusting their application based on county-specific needs, with rural areas focusing on recruitment and telehealth, and urban areas emphasizing wait time reduction.

Ms**.** Finney detailed the effectiveness of provider recruitment grants, which brought 63 new specialists into the network between 2023 and 2025. The board was asked to approve reallocating $20 million in projected savings from the provider supplemental payment program to expand specialist recruitment grants, aiming to double the annual number of new specialists in 2027 and 2028.

A discussion ensued among Commissioners.

MOTION:	Commissioner Abasta-Cummings moved to approve reallocation of $20 million to specialist recruitment grants and staff proceeding with local convenings on identified, data-driven solutions, seconded by Commissioner Hodges.
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners, Abasta Cummings, Armstrong, Askew, Cuevas, Hernandez, Hodges, Pedrozo, Radner, Sullivan and Thao
Noes:	Commissioner Molesky.
Absent:	Commissioners Aguirre, Belton, Keheley, Moreno-Peraza, and Rabago
Abstain:	Commissioner De Serpa and Jimenez

.

[Commissioner De Serpa arrived at 3:53pm]

12. Community Reinvestment Plan. 3:55 p.m.

Ms. Jessica Finney, Community Grants Director reviewed the new Department of Health Care Services (DHCS) community reinvestment plan requirement, explaining the Alliance's obligation to invest a portion of net income in local communities, the calculation of county-level obligations, and alignment of requirement implementation with the Medi-Cal Capacity Grant Program, with the board approving the approach to meet the requirement and submit the initial plan to DHCS .

DHCS now requires Medi-Cal managed care plans to contribute a minimum percentage of annual net income to local communities, with the Alliance's base obligation for 2024 set at $3.2 million and an additional $1.7 million for quality achievement obligation in Merced County. The plan covers investments to be expended in 2027-2029 and requires attestations from county public health and behavioral health directors.

Investments must fall into one of five DHCS-defined categories, such as cultivating improved health or healthcare workforce development, though direct provider recruitment grants are excluded. The Alliance will align these requirements with its existing Medi-Cal Capacity Grant Program, using annual planning and stakeholder input, including county behavioral health and public health agency partners, to guide investments.

A gap of $1.4 million was identified between eligible voluntary investments and the required obligations combined in Santa Cruz and Merced counties. The Alliance plans to address these gaps through targeted grantmaking in 2027, focusing on the cultivating improved health category in Merced to meet the quality achievement obligation and on shared priorities in Santa Cruz that meet other categories. The Alliance will continue to refine the plan annually based on net income requirements and stakeholder engagement.

A discussion ensued among Commissioners.

[Commissioner Moreno-Peraza arrived at 4:04pm]

MOTION:	Commissioner Jimenez moved to approve the initial community reinvestment plan for submission to DHCS, with the understanding that future investments will prioritize Alliance members but may also benefit the broader community, seconded by Commissioner Cuevas.
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners, Abasta Cummings, Armstrong, Askew, De Serpa, Cuevas, Hernandez, Hodges, Molesky, Moreno-Peraza, Pedrozo, Radner, Sullivan and Thao
Noes:	None.
Absent:	Commissioners Aguirre, Belton, Keheley and Rabago
Abstain:	None

11. TotalCare D-SNP Operations Update. 4:20 p.m.

Mr. Scott Crawford, Medicare Program Executive Director and Ms. Lisa Ba, Chief Financial Officer, provided an update on the D-SNP program's first six months, reporting slower-than-expected enrollment growth, high startup administrative costs, and a projected $21 million loss for the year, while outlining key success factors and strategies for long-term sustainability.

The D-SNP program grew from 450 to over 865 members in six months, with projections to exceed 1,000 by August. Key operational metrics included 78% health risk assessment completion at enrollment, over 98% outreach within 30 days, and 95% care plan completion within 90 days. Network adequacy was achieved with a 78.6% overlap between Medicare and Medi-Cal networks.

Year-to-date, D-SNP reported a $4.1 million loss, favorable to the budgeted $5.6 million loss, but with a high per member per month loss due to low enrollment and high fixed startup costs. The full-year forecast anticipates a $20-21 million loss, with much of the medical cost estimate based on incurred but not reported (IBNR) claims.

Mr. Crawford outlined six key success factors: membership growth, administrative cost management, provider network development, star ratings, risk adjustment, and medical cost management. The plan is to leverage existing infrastructure, deepen provider partnerships, and focus on quality and risk adjustment to improve financial sustainability as enrollment grows.

The slower-than-expected enrollment was discussed noting that it was attributed to challenges in establishing a sales organization and vendor issues. Plans are in place to increase agent capacity and improve traction for the upcoming enrollment period. The board was assured that administrative costs are expected to normalize as membership increases.

A discussion ensued among Commissioners.

13. 2026-27 State Budget Update. 4:38 p.m.

Mr. Michael Schrader, CEO provided an update on the state budget, focusing on the DHCS proposal to carve out members with unsatisfactory immigration status (UIS) from managed care, the competing LHPC alternative, and the potential impact on Alliance membership and provider reimbursement, with advocacy efforts ongoing but the DHCS proposal likely to prevail.

The DHCS proposal would move UIS and certain non-citizen members from managed care to the state fee-for-service system, resulting in lower provider payments and reduced member access. The LHPC alternative would keep members assigned to managed care but carve out hospital and pregnancy-related services, allowing providers to continue billing the Alliance for other services at higher rates.

A coalition of health plans, provider associations, and advocacy groups has lobbied for the LHPC alternative, emphasizing the negative impact of the DHCS proposal on member access and provider reimbursement. The Assembly supports the LHPC alternative, while the Senate and Governor's office back the DHCS proposal. As of the meeting, the DHCS proposal is likely to prevail, with ongoing discussions about possible compromises.

If implemented, the DHCS carveout proposal, combined with other state and federal policy changes, is expected to reduce Alliance membership by approximately 25% by January 2027 and 39% by December 31, 2028.

A discussion ensued among Commissioners.

The Commission adjourned its meeting of June 24, 2026, at 4:55 p.m. to the regular meeting of August 26, 2026, at 3:00 p.m. via videoconference from county offices in Scotts Valley, Salinas, Merced, Hollister and Mariposa unless otherwise noticed.

Respectfully submitted,

Ms. Hayley Tut
Clerk of the Board
Minutes were supported by AI-generated content.

Meeting Minutes
Wednesday, June 3, 2026
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Anita Guevin	Medicare Compliance Program Manager
Cecil Newton	Chief Information Officer
Danita Carlson	Government Relations Director
Lisa Ba	Chief Financial Officer
Michael Schrader	Chief Executive Officer
Michael Wang	Chief Medical Officer
Ryan Markley (chair)	Compliance Director
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Tammy Brass	Health Services Executive Director
Van Wong	Chief Operating Officer

Committee Members Excused:

Jenifer Mandella	Chief Compliance Officer

Staff Present:

Jill Drake	Compliance Manager
Lilia Chagolla	Member Services Director
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Paige Harris	Compliance Specialist
Rebecca Seligman	Program Integrity Manager
Robin Sihler	Administrative and Data Reporting Assistant
Sarah Sanders	Grievance and Quality Manager

1. **Call to Order by Chair Markley**

   Chairperson Ryan Markley called the meeting to order at 9:03 a.m.
   A quorum was present.

Consent Agenda

2. **Approve Minutes of 05/06/2026 Committee Meeting**
3. **Program Integrity Snapshot**

ACTION: Committee reviewed and approved items 2-3 of the Consent Agenda with 11 Ayes and 0 Noes.

4. Follow-up on Action Items

Markley reviewed outstanding action items from the previous Compliance Committee meetings:

- Markley to submit policy 105-0002 for publication and distribution.
  - RESOLUTION: Policy submitted for publication 5/20/26.
- Crawford and Guevin to identify existing operational reports to enable review of high-impact DSNP functions and provide written update.
  - UPDATE: Existing dashboard reports are operational in nature and do not inform of needed compliance metrics. Additional metrics identified and development of reports are in process by Data Analytics subject to cross-functional departmental review.
- Markley to implement CAP to Compliance and Provider Services to resolve overdue Delegate Oversight Credentialing Reviews.
  - RESOLUTION: CAP implemented 5/20/26. Compliance and PS Managers to report back at July Compliance Committee meeting.
- Weatherly and Markley to discuss and resolve the specifics of PHI access needed by sales team.
  - UPDATE: Requirements discussed and identified 5/20/26. Weatherly to work with Analytics to determine access and next steps
- Seligman to prepare Compliance policy edits to clarify Compliance and Program Integrity involvement in call monitoring and script review.
  - UPDATE: Edits to policies in process.
- Weatherly, Seligman, Wang and Chagolla to review and update sales scripts related to processes for clarity, compliance and member-friendliness
  - UPDATE: Group discussion 5/20/26 Weatherly to update scripts by 6/15/26.
- Mandella and Compliance staff to conduct analysis of sales-related grievance volume and notify the account manager of ongoing investigation.
  - NO UPDATE: Mandella excused. Mandella to provide update at July meeting.

Regular Agenda

7. Compliance Quarterly Report

Drake, Compliance Manager, presented the Q1 2026 Compliance Quarterly Report, highlighting Internal and External Audits, Corrective Action Plans (CAPs), Delegate Oversight and CMS Reporting Oversight.

Internal Audit & Monitoring

Drake reported that 10 internal audits were completed during the reporting period with 1 failed audit related to Behavioral Health Case Management. 8 internal audits are scheduled for Q2.

Regulatory (External) Audits

DMHC:

The 2024 DMHC Follow-Up Survey was issued on 5/22/26 of the and informed the Committee that pre-audit deliverables are actively being gathered and reviewed and will be submitted on 6/5 and 6/22. The Survey is scheduled to take place on 09/21/2026.

DHCS:

The DHCS Pre-CAP response was completed on 4/1/26. No response has been received.

CMS:

CMS initiated 1 audit in January 2026 for Encounter Data Validation (EDV). This audit is being managed by the Medicare Operations team with Compliance oversight.

Corrective Action Plans (CAPs)

Drake noted 1 CAP opened during the reporting period for Behavioral Health Case Management and 1 CAP remains open from Q425 for Employee Permissions.

Delegate and FDR Oversight

Drake reported 20 of 21 incomplete reviews were completed during the reporting period with 1 remaining open pending receipt of documentation. Drake noted that, while this is a substantial improvement, the sustained multi-quarter backlog increases the risk of future audit findings and weakens the defensibility of delegated oversight controls.

CMS Reporting Oversight

ODAG Reporting:

Drake reported a 70% failure in timeliness for Organization Determination for the time period, noting the issue being related to weekend auto approval mailings, which have since been re-configured. Current results show a 5% increase in timeliness for the month of April with likelihood of continuing to increase in Q2. Drake described improvements in reporting, with the implementation of Tableau and Readily tools for compliance oversight and ongoing training and configuration for automated KPI reporting.

Identified Risks

Drake described improvements in reporting, including a reduction in untimely determinations and the implementation of Tableau and Readily tools for compliance oversight and ongoing training and configuration for automated KPI reporting.

Drake highlighted the following key risks: Failed employee permissions audits

- Medicare sales calls compliance due to member complaints
- Credentialing review backlog
- ECM program instability (Markley noted that substantial progress is being made toward ECM program maturity despite known opportunities to improve the ECM Program overall).

Full details can be found in the report included in the agenda packet.

COMMITTEE ACTION: Committee reviewed and approved Q1 2026 Compliance Quarterly Report with 11 Ayes and 0 Noes.

8. Regulatory Affairs Report

Krupp provided an update on regulatory activity for the reporting period of March-May 2026 noting that regulatory activity remained stable across all lines of business with 113 new mandates issued during the reporting period 36 of which were high risk.

Krupp reported an overall moderate to low regulatory posture from all regulators.

Krupp reviewed four high-impact mandates received during the time period as follows:

- DHCS APL 26-004 – MCP Responsibilities for BH Data Sharing
- DHCS APL 26-007 – MCP Guidance on Network Provider Agreements
- HPMS Memo – California AIP DSNPs: Updates to CY 2026 Material Modifications
- DSNP MOC Submission

Krupp discussed an overall assessment of the Plan's regulatory risk and readiness noting that noting and 88.4% success rate for timely implementation of high and medium risk mandates – up form 77.8% in the previous quarter. Krupp also noted ongoing cross-functional efforts to manage increased workload.

Full details can be found in the report included in the agenda packet.

COMMITTEE ACTION: Committee reviewed and approved Q2 2026 Regulatory Affairs Quarterly Report with 11 Ayes and 0 Noes.

10. Department Risk Reporting

Timely AG Member Reimbursement/DMR

Sanders, Grievance and Quality Manager, presented an overview of timely appeals and grievance-related member reimbursements, noting that the newly implemented metric provides visibility into performance trends and currently measures the time from approval of a reimbursement to issuance of payment. Sanders clarified that the metric is limited to approved appeals and grievance-related reimbursements and does not yet reflect the full reimbursement universe, such as mileage reimbursements.

Sanders reported that current performance remains low, primarily due to significant growth in appeals and grievance volume, which has increased more than 40% from the prior quarter and more than 100% from the previous year. Sanders stated that reimbursement processing has not been prioritized at the same level as appeals and grievances because of the greater regulatory risk associated with those functions. Additional delays were attributed to incomplete supporting documentation and process inefficiencies related to pending receipts and validation.

To mitigate the issue, Sanders stated that the team is refining intake expectations, closing incomplete requests more promptly, and conducting recovery efforts to improve turnaround times. Sanders indicated that measurable improvement is anticipated within 90 days.

Sanders also raised the need to evaluate whether Appeals and Grievances remains the appropriate long-term owner of the member reimbursement function, noting that the process was intended to be temporary when assumed in 2018-2019. Chagolla supported escalation of the issue and agreed that future ownership of the process should be discussed. Markley noted that the metric is still maturing operationally and stated that the Committee did not identify the issue as a systemic compliance concern at this time but supported continued stabilization and monitoring.

ACTION:

- Relevant operational leaders to evaluate long-term ownership of the member reimbursement function and identify whether an alternate business area is better suited for the process.

ODAG Pre-Service Determinations

Brass, Health Services Executive Director, presented an update on ODAG pre-service determinations for Utilization Management (UM) and Pharmacy, noting overall improvement in timeliness performance and progress on previously identified mailing and reporting issues.

UM:
Brass reported Q2 timeliness at 79%, with year-to-date results continuing to reflect Q1 performance, stating that updated analysis excluded pending cases that had previously been counted as late and identified primary root causes. Brass noted that report logic updates are in progress, staff education has been completed, and a Jiva pop-up alert for D-SNP cases is pending implementation, and the auto-approval letter mailing fix went into production on April 16, 2026, resulting in a post-implementation compliance rate of nearly 85%, with continued monitoring and auditing underway.

Pharmacy:
Brass reported Q2 timeliness at 71% and explained that the majority of non-compliant cases involved expedited prior authorizations that could not meet the current 24-hour KP mailing timeline. Additional issues included weekend mailing delays and an isolated file submission error. Brass stated that mitigation efforts are underway and noted that full recovery is anticipated during Q2.
Sachdeva added that Pharmacy review time itself is not the primary issue, as most authorizations are reviewed promptly, and that delays are largely tied to mailing and related operational processes.
Brass also noted that weekend coverage and mailing workflows for both UM and Pharmacy remain ad hoc and will require additional process standardization as the D-SNP line of business continues to mature.

Markley sought and received clarification that the timeliness lag at issue does not impact Alliance members' receipt of care, and that this is a regulatory compliance matter only.

11. Wrap Up and Assignments

Action items are as follows:

- Context – Compliance Dashboard Metrics Development
  - Crawford and Guevin to provide monthly updates on the implementation of newly developed reports by Data Analytics.
- Context – Delegate Oversight and Provider Services Corrective Action Plan
  - Drake and Kerr to provide update on CAP at July meeting.
- Context – Sales Scripts and Process Improvement
  - Weatherly to update scripts by 6/15/26.
- Context – Grievance Volume Analysis
  - Mandella and Compliance staff to conduct an analysis of sales-related grievance volume and notify the account manager of ongoing investigation.
- Context – Timely AG Member Reimbursement/DMR
  - Relevant operational leaders to evaluate long-term ownership of the member reimbursement function and identify whether an alternate business area is better suited for the process.

The meeting adjourned at 9:59 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

Meeting Minutes
Wednesday, July 1, 2026
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Anita Guevin	Medicare Compliance Program Manager
Danita Carlson	Government Relations Director
Jenifer Mandella (chair)	Chief Compliance Officer
Lisa Ba	Chief Financial Officer
Michael Schrader	Chief Executive Officer
Michael Wang	Chief Medical Officer
Ryan Markley	Compliance Director
Scott Crawford	Medicare Program Executive Director
Scott Fortner	Chief Administrative Officer
Tammy Brass	Health Services Executive Director
Van Wong	Chief Operating Officer

Committee Members Excused:

Cecil Newton	Chief Information Officer

Staff Present:

Nicole Krupp	Regulatory Affairs Manager
Rebecca Seligman	Program Integrity Manager
Robin Sihler	Administrative and Data Reporting Assistant
Sarah Sanders	Grievance and Quality Manager

1. **Call to Order by Chair Markley**

   Chairperson Jenifer Mandella called the meeting to order at 9:03 a.m.
   A quorum was present.

Consent Agenda

2. **Approve Minutes of 06/03/2026 Committee Meeting**
3. **Program Integrity Snapshot**

ACTION: Committee reviewed and approved items 2-3 of the Consent Agenda with 11 Ayes and 0 Noes.

4. Follow-up on Action Items

Mandella reviewed outstanding action items from the previous Compliance Committee meetings:

- Crawford and Guevin to identify existing operational reports to enable review of high-impact DSNP functions.
  - RESOLUTION: Complete. Dashboard development is in progress with plans to incorporate additional metrics as they are finalized.
- Delegate Oversight and Provider Services CAP - Credentialing Reviews.
  - UPDATE: CAP implemented 5/20/26 and response still ongoing. Markley to report back at August Compliance Committee meeting.
- Weatherly, to review and update sales scripts related to processes for clarity, compliance and member-friendliness
  - RESOLUTION: revised scripts to be reviewed for submission 7/2/26.
- Mandella to conduct analysis of sales-related grievance volume and notify the account manager of ongoing investigation.
  - RESOLUTION: Overall analysis of grievance volume complete. The assessment suggested the concern was because DSNP is a new line of business and operations are stabilizing. Opportunities to improve were identified and are being addressed with targeted training, revised sales scripts, and formalized department monitoring procedures. The resolution work remains ongoing and is tracked via a separate CAP.

Regular Agenda

7. Program Integrity Quarterly Report

Seligman delivered the Q2 Program Integrity report for the reporting period of March-June highlighting increased fraud, waste and abuse (FWA), HIPAA referrals and investigation management and Compliance violations.

Fraud, Waste and Abuse
Seligman reported a tripling of FWA referral volume over the reporting period.
184 FWA referrals were received, 96 of which resulted in the opening of a matter under investigation (MUI), 41 investigations were closed and 163 remain under investigation.

Key Risks
As previously reported, the ongoing enhanced federal oversight of and related state efforts related to program integrity are at the forefront and are driving the prioritization of work. Staff continue to focus on the identified high-risk services including transportation, Enhanced Care Management (ECM) and Community Supports (CS), and lab services, confirming appropriate controls to prevent overutilization and refining reporting and technological support to ensure anomalies are identified and addressed.
In addition, Compliance staff reviewed organizational processes in the areas of federal focus, and the Program Integrity Alignment project has been initiated to address any gaps and/or strengthen existing controls.
Finally, Seligman reviewed outcomes of investigative activities for Q2 2026, including identified and recouped overpayments.

HIPAA Privacy & Security Oversight
62 HIPAA referrals were received during the report period, 18 of which were classified as incidents impacting 24 members. 28 cases were closed. There were no breaches during the report period.

Compliance Violations
5 reports of non-compliance were received during the report period resulting in 4 opened investigations and 1 founded determination; the founded determination was reported to CMS. Per policy

Seligman noted that a Security Update for the time period will be presented at the August Committee meeting

ACTION: McMurray to present Q2 26 Security Update at August meeting.

COMMITTEE ACTION: Committee reviewed and approved the Program Integrity Quarterly Report for March-June with 11 Ayes and 0 Noes.

10. Department Risk Reporting

D-SNP Pre-Service Reconsiderations

Sanders, Grievance and Quality Manager, reported that timeliness of D-SNP Pre-Service Reconsiderations did not meet performance expectations due to misclassifications and confusion with part B and part C request types. Due to Pharmacy recommendation, authorization class for CGM, lancets, etc. should follow a DME authorization classification, versus prior drug classification. As a result, standard appeals involving CGM, lancets, etc., would follow a Part C classification and thirty (30) day timeframe.
To mitigate the issue, Sanders reported that live reporting has been instituted for closer monitoring and system enhancements to automate the IRE workflow are underway. Additionally, Pharmacy review and evaluation of adjustments will occur on the D-SNP Auth class. Once finalized, additional AG staff training will be conducted to better identify classifications and expedite implementation of new processes.

ACTION: Sanders and Mandella to collaborate and assign tasks for system fixes related to short and long term automation fixes for D-SNP appeals timeliness issues.

11. Wrap Up and Assignments

Action items are as follows:

- Delegate Oversight and Provider Services CAP – Credentialing Reviews
  - Markley to provide update at August Compliance Committee meeting.
- Quarterly Security Update
  - McMurray to present Q2 26 Security Update at August meeting.
- D-SNP Pre-Service Reconsiderations
  - Sanders and Mandella to collaborate and assign tasks for system fixes related to short and long term automation fixes for D-SNP appeals timeliness issues.

- Program Integrity Alignment
  - Markley to report Program Integrity Alignment findings to Operations Committee in Q3 26.

The meeting adjourned at 9:56 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

Physicians Advisory Group

Date: March 6, 2025

Time: 12:00 – 1:30 p.m.

Location:

Santa Cruz County:
Central California Alliance for Health – Board Room
1600 Green Hills Road, Suite 101, Scotts Valley, CA
Monterey County:
Central California Alliance for Health - Board Room
950 East Blanco Road, Suite 101, Salinas, CA
Merced County:
Central California Alliance for Health – Board Room
530 West 16th Street, Suite B, Merced, CA
Mariposa County:
Mariposa County Health & Human Services – Cathey's Valley Room
5362 Lemee Lane, Mariposa, CA
San Benito County:
Community Foundation Epicenter- San Benito Board Room
440 San Benito Street, Hollister, CA

MINUTES

Chair: Mike Wang, MD, CMO			**Minutes by:** Jacqueline Van Voerkens
	Members Present:	Dr. Caroline Kennedy, Dr. Cheryl Scott, Dr. Cristina Mercado, Dr. Devon Francis, Dr. James Rabago, Dr. Misty Navarro, and Dr. Ralph Armstrong,	
	Members Absent:	Dr. Charles Harris, Dr. Donaldo Hernandez, Dr. Jason Novick, Dr. Mimi Carter, Dr. Salvador Sandoval, and Dr. Shirley Dickinson.	
	Public Attendees:	Cassandra Kartashov, CEO of Community Foundation for San Benito	
	Central California Alliance for Health staff:	Dr. Mai Bui-Duy, Dr. Gray Clarke, Ms. Alex Sanchez, Ms. Amber Schnitzius, Ms. Andrea Swan, Ms. Ashley McEowen, RN, Ms. Cassie Russo, Ms. Christy Pool, Ms. Jessie Dybdahl, Ms. Kelsey Riggs, Mr. Jim Lyons, Dr. Navneet Sachdeva, Ms. Nicole Gend, BCBA, Ms. Rebecca McMullen, LPCC, Ms. Sabryna Sherman, Mr. Travis Moody,	
Item No.	**Agenda Item**		
I.	**Call to Order**	Chairperson Dr. Mike Wang called the meeting to order at 12:05 p.m. Roll call was taken.	

II.	**Oral Communications**	Chairperson Wang opened the floor for any members of the public to address the Group on items not listed on the agenda. No members of the public addressed the Group.	
Items for Approval		**Discussion**	**Action/Recommendation**
III.	**Review & Approve Minutes**	**The Minutes from the December 4, 2025, Meeting were reviewed.** **Dr. Kennedy motioned to approve the minutes from the PAG 12/04/25 meeting.* **Dr. Rabago 2nd the motion for approval.* **Group approved the December 4, 2025 meeting minutes as presented.*	*The **Physicians Advisory Group** approved the December 4, 2025, meeting minutes.*
Action Item Follow-Up			
	DSNP Gym Membership Network Expansion	Identify and contract with local, non-national gyms within the service area to expand the Silver and Fit network for Dual Eligible Special Needs Plan (DSNP) members, ensuring accessibility in rural and metro areas. **Action Complete:** A list of new fitness centers (as provided by our members) was provided to American Specialty Health (ASH) for outreach and contracting.	*Sherri Katz*
Regular Agenda			
	Agenda item		
III.	**Access to Psychological Testing: Current Challenges and Mitigation Strategies**	Nicole Gend presented on the current challenges in accessing comprehensive diagnostic evaluations (CDEs) for psychological testing, covering workforce shortages, referral processes, triage, provider practices, and mitigation efforts including expanded testing time and provider recruitment. California faces a significant shortage of licensed psychologists, resulting in extended wait times for CDEs, especially in rural and underserved areas. Families often experience delays exceeding six months, leading to system strain for members, caregivers, providers, and managed care organizations. CDEs differ from clinical diagnostic assessments by incorporating formal psychometric testing and standardized instruments, which require specialized training. These evaluations are essential for diagnostic clarity, especially in complex cases, and are often required for educational planning and access to specialized services. Dr. Rabago inquired about how referrals are managed. Dr. Clarke noted that both physician referrals and self-referrals are accepted. Information and member materials are available on the Alliance website. The Behavioral Health Treatment (BHT) manager oversees the CDE waitlist and categorizes referrals based on clinical need, sometimes contacting members for additional information.	

		Past inconsistencies in provider practices, such as evaluations exceeding standard time limits, and the implementation of standardized guidelines and medical necessity criteria to ensure equitable access and preserve psychologist capacity for complex cases were reviewed. Mitigation efforts include expanding allowable testing time for CPT code 96113, recruiting bilingual psychologists, supporting telehealth, and educating providers and members about appropriate referral pathways. The expected outcomes are shorter wait times, better alignment of members to provider types, and more efficient use of psychologist resources. Dr. Kennedy and Dr. Frances discussed ongoing efforts to contract with providers such as Stanford, and address concerns about provider quality. The group was informed that there is presently a waitlist of 800–1000 members. The team is reviewing self-referrals to determine if full CDEs are necessary, aiming to reduce the waitlist by directing members to appropriate services.	
IV.	**ECM and Community Supports Updates**	Sabryna Sherman presented data showing that Enhanced Care Management (ECM) enrollment has stabilized after significant growth, with about 6% of Alliance members enrolled, exceeding the state's expected 3%. The majority of ECM members are homeless, and there is notable overlap between ECM and Community Supports (CS) participants. Recent Housing Supports policy updates reintroduced clinical risk factor requirements for housing benefits, clarified documentation standards, and refined definitions of homelessness and at-risk status. These changes aim to ensure that only members with significant clinical and social needs qualify for housing supports. The Medically Tailored Meals (MTM) benefit expanded its list of qualifying conditions and includes clarified documentation requirements for both initial and renewal requests. Clinical documentation must come from a physician, nurse practitioner, or physician assistant, and renewals require evidence of ongoing need and treatment impact. Providers are expected to ensure members meet criteria before referral, supply supporting clinical documentation, and respond to requests for additional information. Vendors are being monitored to ensure accurate advertising and referral practices, with ongoing communication to address any discrepancies.	**Action:** Sabryna Sherman agreed to review and potentially revise the MTM referral form to better support providers in renewal processes. **Action:** Medically Tailored Meals will be brought back as a topic to the next PAG meeting. (Dr. Wang)

		Implementation of stricter documentation requirements led to a temporary decline in approvals for housing and MTM, but approvals are recovering as providers adapt. Upcoming focuses include refining eligibility for personal care homemaker services and home modifications, with an emphasis on high-risk members and in-home evaluations. Dr. Rabago and Dr. Francis highlighted confusion among members due to aggressive vendor marketing and the need for clearer referral forms. **Action:** Sabryna Sherman agreed to review and potentially revise the MTM referral form to better support providers in renewal processes. **Action:** Medically Tailored Meals will be brought back as a topic to the next PAG meeting. (Dr. Wang)	
V.	**Care-Based Incentive (CBI) Program Proposed Changes for 2027**	Dr. Bui-Duy outlined proposed changes to the CBI program for 2027, including streamlining programmatic measures, aligning with state and federal requirements, adjusting member reassignment policies, and addressing data quality concerns. To implement streamlining of Programmatic Measures the CBI program will reduce the number of programmatic measures from 21 to 19, removing measures such as ambulatory care sensitive conditions and chlamydia screening to align with state reporting requirements and provider feedback. Several CBI measures will overlap with D-SNP STARS measures for the Total Care line of business, with increased weighting for these measures to incentivize clinic performance in areas such as reducing readmissions, cancer screenings, and chronic disease management. The policy on provider-initiated Member Reassignments was updated to clarify that documented case management referrals for certain behaviors will prevent negative impacts on CBI points, and exclusions remain for cases such as fraud, abuse, or medication agreement violations. The proposed changes were presented for feedback in March, with plans to finalize in June and seek board approval in August, ensuring contracts are in place for the 2027 CBI year. Dr. Kennedy raised concerns about the accuracy and completeness of data for measures like hypertension control, emphasizing the need for improved data integration and validation before further expanding performance-based incentives.	

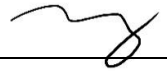
		Dr. Mercado and Dr. Kennedy inquired requested clarifications on Exclusion Criteria for readmissions. Dr. Bui-Duy confirmed that hospitalizations for maintenance chemotherapy, pregnancy, or organ transplant are excluded from readmission metrics, and that member-initiated reassignments do not affect provider CBI points.	
VI.	**Manifest MedEx (MX)**	The Manifest MedEx (MX) topic will be presented at the next PAG meeting in June.	The Manifest MedEx (MX) topic will be presented at the next PAG meeting in June. (Dr. Wang)

Action Items

Agenda Item	**What is the action item**	**Due date**	**Responsible staff**
ECM and Community Supports Updates	Review and potentially revise the MTM referral form to better support providers in renewal processes. **Pending:** Work has not begun work on the form as the anticipated date is still a significant time away.	6/4/26	Sabryna Sherman
ECM and Community Supports Updates	Medically Tailored Meals will be brought back as a topic to the June 2026 PAG meeting.	6/4/26	Dr. Wang
Manifest MedEx (MX)	The Manifest MedEx (MX) topic will be presented at the next PAG meeting in June. **Action Compete:** Topic will be presented at June 2026 meeting.	6/4/26	Dr. Wang
Discussion	**Covid Vaccine Billing Support:** Navneet Sachdeva (pharmacy director) to send details of denied Covid vaccine administration fee claims for assistance with DHCS coordination to Dr. Mercado. **Action complete** – Dr. Sachdeva connected with Dr. Mercado on March 5, 2026.	n/a	Dr. Sachdeva

Meeting adjourned at 1:29 pm

Next Meeting:

Approved by Committee Date: June 11, 2026	***Signature:*** 	**Date**: June 11, 2026

Chair: Mike Wang, MD	Minutes by: Jacqueline Van Voerkens

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

Meeting Minutes

Wednesday, March 25, 2026

Commissioners Present:

Ms. Anita Aguirre,	At Large Health Care Provider Representative
Ralph Armstrong, DO,	At Large Health Care Provider Representative
Mr. Michael Molesky,	Public Representative
Allen Radner, MD,	At Large Health Care Provider Representative
Ms. Kristynn Sullivan,	County Health Department Representative

Commissioners Absent:

Ms. Elsa Jiménez,	County Director of Health Services
Supervisor Josh Pedrozo,	County Board of Supervisors

Staff Present:

Ms. Lisa Ba,	Chief Financial Officer
Mr. Michael Schrader,	Chief Executive Officer
Ms. Jenifer Mandella,	Chief Compliance Officer
Mr. Jimmy Ho,	Accounting Director
Ms. Dulcie San Paolo,	Finance Administrative Specialist

1. Call to Order. (1:30 – 1:31 p.m.)

Chairperson Molesky called the meeting to order at 1:30 p.m. Roll call was taken. A quorum was present.

[Commissioner Aguirre arrived at this time: 1:32 p.m.]

2. Oral Communications. (1:32 – 1:32 p.m.)

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

No members of the public addressed the Committee.

Consent Agenda Items:

3. Approval of the Minutes of the October 22, 2025 Finance Committee Meeting. (1:32 – 1:34 p.m)

FINANCE COMMITTEE ACTION: Chairperson Molesky opened the floor for approval of the minutes of the October 22, 2025 meeting.

MOTION: Commissioner Radner moved to approve the minutes, seconded by Commissioner Armstrong

ACTION: The motion passed with the following vote:

Ayes: Commissioners Aguirre, Armstrong, Molesky, Radner, Sullivan

Noes: None

Absent: Commissioners Jimenez and Pedrozo

Abstain: None

Regular Agenda Items:

4. Preliminary 2025 Financial Results (Unaudited as of 2/27/2026). (1:34 – 1:54 p.m.)

Ms. Lisa Ba, Chief Financial Officer (CFO), reported that the preliminary 2025 financial statement showed a $76M, or 3.3% operating loss, which was close to the budgeted figure of 3.6%. Revenue was favorable due to an additional $100M received from favorable rates, but this was offset by increased medical costs. The Medical Loss Ratio (MLR) was 98.3%, and the Administrative Loss Ratio (ALR) was 5.0%.

Ms. Ba explained that medical costs are unfavorable due to higher utilization in Enhanced Care Management (ECM) and Community Supports (CS) expenses, as well as elevated costs in transportation and hospice services. ECM enrollment reached over 24K by year-end, or 5.6% of total membership, resulting in a loss of approximately $116.1M prior to the risk corridor. The net loss was $8.3M after applying the risk corridor. The loss from CS is expected to be approximately $41.8M in 2025.

Ms. Ba informed commissioners that DHCS now expects ECM to deliver about 5-6 service hours monthly per member, with a revised risk corridor calculation planned for 2026 based on this standard. For 2025, DHCS is reviewing encounter data and may adjust ECM costs if they find excessive or unsupported expenses. The Alliance, having the highest ECM enrollment, may be affected, and staff is assessing the potential impact, possibly requiring updates to 2025 financials. The Alliance shifted ECM reimbursement from capitation to a case rate with at least two encounters starting January 1, 2026. However, new intensity requirements mean the Alliance will likely need to move to a fee-for-service model to meet those requirements, with staff set to propose a new FFS rate to the Board in August.

Ms. Ba reported that the estimated operating reserve at year-end was roughly $61.0M below the target, leaving no excess reserve for the Board to allocate this year. The typical range for

Tangible Net Equity (TNE) is six to eight times. Our reserve decreased from 13 to 10 times TNE in just two years. Even if we fully eliminate losses from ECM and CS in 2026, we still forecast continued losses through 2028, and we need adequate reserves to remain financially sustainable.

The independent auditors will present the final audited financial results at the May Board meeting.

5. SFY 24/25 RDT Findings for CY 2027 Rate Setting. (1:54 – 2:10 p.m.)

Ms. Ba provided an overview of the Rate Development Template (RDT) process and timeline, noting that 2027 rates will be based on claims experience from July 2024 through June 2025, creating an 18- to 30-month lag between experience and rate setting. She reported that the submitted RDTs reflected a 17.4% increase when ECM and CS were included and a 9.3% increase excluding them, driven by significant growth in ECM and CS and elevated utilization and unit-cost trends in behavioral health and professional services.

Ms. Ba noted that ECM revenue is expected to decrease due to DHCS intensity/dosage requirements, and staff will need to shift reimbursement from the current case rate to a fee-for-service model, with a new methodology planned for Board consideration in August. She also highlighted that behavioral health insourcing is a planned cost increase and operating loss intended to improve member access, with additional cost pressure evident in the second-half 2025 experience.

Ms. Ba emphasized that state budget impacts and federal policy changes—particularly potential Medicaid financing and eligibility shifts, along with items such as the transition of physician-administered drugs and clinical efficiency adjustments—will continue to create volatility and uncertainty for 2027 rate adequacy. She stated it is highly unlikely the State will approve rate increases of this magnitude and that the Alliance will need to draw on reserves to offset losses in 2027 and beyond, while aiming to maintain reserves at six to eight times TNE.

6. Alliance Investment in Property. (2:10 – 2:23 p.m.)

Ms. Jenifer Mandella, Chief Compliance Officer, introduced Mr. Michael Daponde, Outside Counsel, to clarify whether the Alliance may purchase real estate for investment purposes, as opposed to property necessary for operational functions.

Mr. Daponde explained that the California Government Code strictly limits the types of investments permitted for local government entities such as the Alliance. Statutory requirements differ depending on the type of public entity. For the Alliance, permissible investments are limited to low-risk, highly liquid assets (e.g., Treasury bonds, municipal bonds, money market securities), with primary objectives of preserving principal and maintaining liquidity. Real estate is not included among allowable investment vehicles under these provisions; therefore, it is impermissible to invest in real estate for the purpose of generating a return on investment.

Counsel further noted that the Welfare and Institutions Code, which governs the Alliance as a statutory entity, allows the purchase of real property only when necessary for the performance of the Alliance's operational needs.

It was noted that the Alliance's existing Investment Policy aligns with the Government Code and similarly restricts investments to allowable financial instruments, excluding real estate.

Additionally, Counsel highlighted that governing board members are held to a prudent investor standard, and deviations from statutory investment restrictions could expose board members to potential personal liability.

Discussion ensued among the committee, and the question was raised as to whether this legal interpretation may be overly restrictive and whether purchasing or developing clinics to support provider capacity and member access could be consistent with the Alliance's mission, even if incidental financial returns were to occur.

Counsel reiterated that the statutory language limits property ownership to what is necessary for Alliance operations as a health plan and does not extend to ownership for the purpose of supporting third-party provider operations or generating investment returns.

Legal counsel agreed to discuss the issue with other counsel if requested.

[Commissioner Armstrong departed at this time: 2:23 p.m.]

7. CY 2025 Investment Update Through December 2025. (2:23 – 2:38 p.m.)

Mr. Jimmy Ho, Accounting Director, shared the Alliance's 2025 investment update, outlining how Federal Reserve rate cuts, a drop in CPI from 9.1% in June 2022 to 2.7% in December 2025 and higher unemployment affected investment choices and portfolio results.

Mr. Ho pointed out that staff manage the investment portfolio based on the Alliance's board-approved investment policy, which prioritizes the safety of principal, liquidity, social responsibility, and total return, in accordance with the California Government Code and prudent management standards.

He noted that the Pooled Money Investment Account (PMIA) has been utilized to manage investments; these accounts are specifically designed for public agencies and feature low fees. Their investment objectives are closely aligned with those of the Alliance, prioritizing safety above all else.

As of December 25, the Alliance reported an unrealized gain of $14.3M. Staff plan to hold all bonds until maturity, ensuring that any negative market fluctuations will not be realized.

Additionally, changes in interest rates have provided opportunities to reinvest cash at yields exceeding pre-pandemic levels. As of December 25, the Alliance had accumulated $59.4M in investment income, including unrealized gains, yielding a 3.84% annual rate of return.

The Finance Committee adjourned its meeting of March 25, 2026, at 2:38 p.m.

Respectfully submitted,

Ms. Dulcie San Paolo
Finance Administrative Specialist

Minutes were supported by AI-generated content

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Wednesday, April 22, 2026
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members Present:

Cal Gordon, MD	Provider Representative
Camille Guzel. MD	Provider Representative
John Mark, MD	Provider Representative

Committee Members Absent:

Aditi Mhaskar, MD	Provider Representative
Hue Nguyen, MD	Provider Representative
James Rabago, MD	Board Representative
Jennifer Yu, MD	Provider Representative
Michelle Perez, MD	Provider Representative
Nicole Shelton, PA	Provider Representative

Guest Speakers:

Staff Present:

Clyde Wesp, MD	Chair
Ashley McEowen, RN	Complex Case Management Supervisor – Pediatric
Christy Pool	Temporary HS Administrative Assistant
Jana Brodock	Lead Clinical Analyst - BCBA
Jacqueline Morales	Provider Relations Representative
Jenna Stromsoe, RN	Complex Case Management Supervisor - Pediatric
Lisa Moody, RN	Senior Complex Case Manager
Sarah Sanders	Grievance & Quality Manager
Jacqueline Van Voerkens	Clerk of the Committee

Other Representatives Present:

Dale Urbelis	Call the Care
Janna Espinoza	WCMFAC Chair
Kevin Smith	Director, MCSD

1. **Call to Order by Chairperson Dr. Clyde Wesp.**
   Chairperson Wesp called the meeting to order at 12:05 p.m.
   Roll call was taken.

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

No members of the public addressed the Committee.

3. Consent Agenda Items.

A. Approval of WCMCAC Minutes
Minutes from the February 19, 2026, meeting were reviewed.

B. Grievance Update
Sarah Sanders provided the grievance update, noting that quarter one data for PCS was included in the PowerPoint and that volume remains stable with no specific trends identified. Common themes for grievances continue to be transportation, quality of care, quality of service, provider billing issues, and provider communications. Ms. Sanders invited committee members to reach out directly if they have questions or want to discuss specific grievances.

M/S/A Consent agenda items approved as written.

4. New Business

A. Age Out Process:
The age out process from CCS to adult care was discussed as a critical challenge, with over 200 youth transitioning annually. Jenna Stromsoe explained that the Alliance starts targeted transition outreach at age 17, or earlier if conservatorship is needed, using assessments, mailed letters, and risk stratification to prepare members. The process involves interdisciplinary teams and collaboration with county CCS partners, with monthly and ad hoc meetings to address case reviews and process improvements.

Key gaps identified include difficulty connecting members to adult specialists familiar with complex pediatric conditions, limited local provider availability (often requiring families to travel), and a lack of continuity in nursing care and in-home support after age 21. Families and providers expressed concern about reduced services post-transition, especially for nursing hours, and the challenge of navigating adult systems. The need for better coordination, more robust relationships with adult teams, and improved resource sharing was emphasized, with ongoing efforts to collect data, share best practices, and advocate for system-level improvements.

Dr. Cal Gordon raised concerns about connecting youth to adult specialists, noting that internal medicine doctors often feel uncomfortable with chronic pediatric conditions and that family medicine doctors are better suited for transitions. Ms. Stromsoe agreed, acknowledging provider network limitations and the need for families to travel for care, and stated that while gaps exist, the Alliance does its best to recruit providers.

Janna Espinoza, speaking as a parent and chair of the Whole Child Model Family Advisory Committee, shared fears about loss of services after age 21 and praised improvements in pediatric case management. She asked about the biggest complaints from members, especially regarding reduced nursing hours post-transition. Lisa Moody responded that the main complaint is access to providers familiar with complex needs, and promised to bring feedback from the adult team about nursing care to future meetings.

Dr. John Mark from Stanford described ongoing challenges in finding adult specialists for complex cases, sometimes continuing to follow patients into adulthood due to lack of suitable providers, and highlighted variability in specialist willingness to accept aged-out patients. Dr. Wesp and Dr. Mark discussed the need to identify specialists with relevant expertise and improve coordination for complex cases.

The group agreed on the importance of robust relationships with adult teams, better resource sharing, and ongoing advocacy for system improvements.

B. Medical Therapy Unit in Specialty Centers:
The Medical Therapy Unit (MTU) coordination in specialty centers was discussed by Dr. Wesp, Janna Espinoza, Kevin Smith, Dr. Camille Gonzalez, and Dr. Cal Gordon. Dr. Wesp described operational challenges, including duplication of services, delays, conflicting equipment requests, and lack of coordination between MTU, schools, and outside providers.

Ms. Espinoza highlighted confusion among parents about service rules and the need for better resources, noting variability in school district coordination and rural gaps. Mr. Smith, as a special education director, explained differences between medical and educational PT/OT and offered collaboration.

Ms. Gonzalez, a physiatrist, raised issues with accessing MTU records for adult transitions and families seeking more therapy than maintenance plans allow. Dr. Gordon pointed out the lack of a common EMR across counties, making records access inconsistent.

The main gaps identified were fragmented communication, inconsistent documentation, and unclear ownership of therapy goals, especially for families navigating multiple systems.

C. Transgender Care for Pediatrics:
Transgender pediatric care in Northern California was discussed by Dr. Wesp, who noted that while gender-affirming care remains legal and recognized by Medi-Cal and state policy, access has significantly narrowed due to federal funding threats and hospital policy changes. Major programs at UCSF, Stanford, Sutter, and Kaiser have limited services, with no hospitals performing surgery for those under 19. UCSF remains the most comprehensive, offering medical and psychological therapy but not surgery.

Dr. Wesp highlighted a gap between what state law permits and what hospitals feel safe providing, resulting in limited options for minors. Data shared included 285,300 trans youth in Shield Law States, with care increasingly concentrated at UCSF. The practical advice was to refer pediatric patients to UCSF, as other systems have reduced or closed their programs.

Old Business

A. Auto Authorizations:
Lisa Moody explained that auto authorizations for specialty providers have increased, with over 4,500 auto authorizations in Q1 identified as potentially linked to CCS diagnoses. The CCS referral volumes have remained stable (about 1,600–1,650 per year across five counties), but the Alliance is now proactively using auto auth data to identify more CCS-eligible members. The Peds team launched a new workflow in April, prioritizing high-risk or urgent diagnoses from auto authorizations, with social work and nursing staff sorting cases. The process is phased to avoid overwhelming county partners and ensure quality referrals.

Dr. Cal Gordon noted that CCS client numbers are declining statewide, and staffing resources have dropped by 80% since the Whole Child Model transition. There is concern about balancing quality referrals with limited county capacity, avoiding high denial rates from irrelevant cases.

The team plans to review referral conversion rates and county absorption in future meetings.

B. WCM Family Advisory Committee Update:
Janna Espinoza provided an update on the Whole Child Model Family Advisory Committee, focusing on the development of a resource guide for families, available in multiple languages and formats. The guide aims to address gaps in accessible information for families, especially in rural counties like Mariposa and San Benito, where resources are limited.

Ms. Espinoza emphasized the need for contributions from committee members to expand the guide and offered to distribute it directly to clinics and offices. Lisa Moody confirmed the guide's availability in Hmong for Merced. The discussion highlighted the importance of practical, tangible support for families navigating complex care, and invited ongoing suggestions for resource distribution.

Action: Whole Child Model Family Resource Guide is available in English, Spanish, and Hmong. Guide will be shared digitally and distributed in print upon request.
Action complete: California Children's Services (CCS) Whole Child Model Program - Central California Alliance for Health

5. Open Discussion

Janna Espinoza discussed challenges with duplicative therapy services across regional centers, medical therapy units, and schools, noting confusion about eligibility and rules, especially for new parents.

Dr. Clyde Wesp asked about coordination with school districts, and Ms. Espinoza explained variability in special education support across districts, with rural areas facing more gaps.

Kevin Smith, as Director of Special Education for Merced City School District, clarified differences between medical and educational PT/OT, offering collaboration and insight into school district capabilities.

Dr. Camille Guzel raised issues with accessing CCS MTU records for adult transitions and families seeking more therapy than maintenance levels, noting both accidental and intentional duplication.

Dr. Cal Gordon responded to Dr. Guzel, highlighting the lack of a common EMR across MTUs as a barrier to record sharing and coordination, with Santa Cruz recently moving to Epic.

6. Future Topics

The Committee did not request any topics at this time.

7. Adjourn

The meeting adjourned at 12:50 p.m.

Respectfully submitted,

Ms. Jacqueline Van Voerkens
Clerk of the Advisory Committee

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

Action Item	Owner	Due Date	Status	Notes
Whole Child Model Family Resource Guide is available in English, Spanish, and Hmong. Guide will be shared digitally and distributed in print upon request.	Janna Espinoza	July 22, 2026	Completed	

Quality Improvement Health Equity Committee

Date: March 19, 2026

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

Chair: Mai Bui-Duy, MD			**Minutes by: Jacqueline Van Voerkens**
	Members Present:	Dr. Caroline Kennedy, Family Medicine, Dr. Eric Sanford, Family Medicine, Dr. Minoo Sarkarati, Internal Medicine/Pediatrics, Dr. Stephanie Graziani, Pediatrics, Adriana Ceja, and Vanessa Valedez-Pantoja.	
	Members Absent:	Dr. Oguchi Nkwocha, Family Medicine, and Dr. Stephanie Chang, Family Medicine.	
	Central California Alliance for Health staff:	Ms. Amber Schnitzius — Medicare Stars Program Manager. Ms. Alissa Gil — Provider Network Development Manager Ms. Carissa Grepo — UM Manager – Prior Authorizations Ms. Cassie Russo — Quality Improvement and Health Equity Supervisor Ms. DeAnna Leamon — Clinical Safety Quality Manager Ms. Desirre Herrera — Quality and Health Programs Manager Ms. Emily Kaufman — Clinical Safety Supervisor Ms. Jessie Newton — Clinical Safety Supervisor Ms. Kate Nester — Community Health Integration Manager Ms. Linda Gorman — Marketing and Communications Director Ms. Lizette Podwalny — Health Services Operations Manager Dr. Mai Bui-Duy, MD — Medical Director, Internal Medicine Ms. Navneet Sachdeva — Pharmacy Director Ms. Rebecca McMullen — Behavioral Health Prgrm. Mgr. Ms. Regina Randolph — Senior Program Analyst, Health Services Operations Ms. Sarah Sanders — Grievance and Quality Manager Ms. Sarina King — Quality & Performance Improvement Manager Mr. Scott Fortner — Chief Administrative Officer Ms. Tammy Brass — HS Operations Exec Director Ms. Vanessa Paz — Health Equity Program Mgr. Ms. Veronica Olivera — Member Services Call Center Manager Ms. Yasuno Sato — Clinical Pharmacy Manager	
Item No.	**Agenda Item**		
I.	**Call to Order**	Dr. Bui-Duy called the meeting to order at 12:05 PM and welcomed the members. Dr. Bui-Duy opened the floor for any announcements.	

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		Vanessa Valdez-Pantoja was introduced as a new member representing Los Banos at the Rural Health Clinic.	
Items for Approval		**Discussion**	**Action/Recommendation**
II.	**Review & Approve Minutes**	**The Minutes from the December 18, 2025 QIHEC Meeting were reviewed.** **Dr. Sanford motioned to approve the minutes from the QIHEC meeting.* **Dr. Kennedy 2nd the motion for approval.* **Committee approved December 18, 2025 QIHEC as presented.*	*The QIHEC approved the December 18, 2025 QIHEC meeting minutes.*
Action Item Follow-Up			
III.		**No action items were identified or carried over at the previous meeting.**	
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*
		• Utilization Management Workgroup (UMWG) Minutes	*Approved at UMWG*
		QIHEC Roles and Responsibilities	*Approved*
		2026 QIPH Program Description	*Approved*
		P&T Committee Charter	*Approved*
		2026 UM Program Description	*Approved*
		2026 UMWP	*Approved*
Policies: Require QIHEC Approval			
Number/Title		**Significant Changes**	**Action/Recommendation**

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401-1510 Medical Record Review and Requirements	The Plan states that the policy "s]supports QA standards and systems by confirming provider sites maintain legible, current, detailed, and organized medical records to ensure the safe and effective provision of clinical services in support of Section 1300.70(b)(2)(I)(1)." However, the section cited by the Plan appears to be incorrect. Clarified what statutory provision(s) is/are applicable to this policy. This policy supports the Alliance's Quality Assurance Program by establishing medical record documentation standards that support the evaluation of continuity of care and assist in identifying deviations from professionally recognized standards of practice, thereby enabling correction of quality-of-care issues (See Procedure Section 6). These standards align with the requirements of Title 28 CCR § 1300.70(a)(3) and (b)(1)(A) and (b)(1)(B). Please disregard the previous reference to: "1300.70(b)(2)(I)(1)." revised the definition of "provider" to conform with the "health care provider" definition under AB 118 and APL 25-004 and/or explain how the Plan complies.	*Approved*
401-1515 Nurse Midwife: Scope of Practice and Supervision	Annual Review - Updated policy: MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.11 These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS APL 22-017.	*Approved*
401-1521 Physical Accessibility Review	Annual review, no content changes.	*Approved*
401-1523 Non-Physician Medical Practitioner Guidelines	Annual Review - Updated policy: MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.11 These requirements must be communicated by each MCP to all Subcontractors and Network Providers. DHCS APL 22-017	*Approved*
401-1524 County FSR Collaboration	Minor content changes. Annual review	*Approved*
Policies: Informational		
Number/Title	**Significant Changes**	**Action/Recommendation**
401-1607 HEDIS	Policy updated in pursuant to APL 25-013 for QIP entities; added definition of QIP; and updated procedures.	*Approved at QIHEW*

Quality Improvement Health Equity Committee

Date: March 19, 2026

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

401-5001 Local Planning and Population Health Management Strategy Deliverable	New policy. Policy transitioned from Program Development to Quality Improvement and Population Health. Updated to align with Behavioral Health Services Act reforms and to clarify and streamline requirements, including renaming "Population Needs Assessment" requirements to "Local Planning," clarifying intersections with Community Reinvestment, and eliminating historical requirements no longer relevant for MCPs.	*Approved at QIHEW*
404-1108 Monitoring of Over Under Utilization of Services	Removed Title 28 California Code of Regulations § 1300.70(b)(2)(H)(2) and (c) and added §1300.70(a)(1) and (a)(3) per 20242950 DMHC CT01 #11 01.28.2026.docx	*Approved at UMWG*
404-1136 Enteral Nutrition Products	Definitions: • Added the different types of nutrition products, e.g., elemental, and semi-elemental enteral nutrition products to the definition. Added because the definition of formula seemed to be too narrow-see policy. Okay to remove. • Added definition of formula for treatment of PKU for B6 Minor format changes Procedures: Added coverage for PKU for B5	*Approved at UMWG*
404-1149 Medical Nutrition Therapy + MNT Attachment	Changes made were to align with some of the criteria that is outlined in "Alliance Policy 404-1745 "Community Supports Policy for Medically Tailored Meals/Medically Supportive Food." Pertinent changes to the Medical Nutrition Therapy Benefit and Quick Reference Guide was edited to now include: Adult members Obesity for adults will now be covered with no restrictions as long as their BMI is greater than 30 -Lipid level thresholds for members have been lowered for those members with hyperlipidemia -Prediabetes and diabetes will now be covered for adults as long as their A1C is greater than 5.7% Pediatric Members -Added prediabetes and hypertension as qualifying diagnosis Codes for billing are now added to the benefit policy. Previously they were only included in the Quick Reference Guide	*Approved at UMWG*
404-1306 Extended and Standing Referral Authorizations	Policy Section: Updated the first through third paragraphs to align with Health and Safety Code section 1374.16(a) and (b)	*Approved at UMWG*

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	Minor sentence edits for clarity and readability Definitions: Revised the definitions of "standing referral" and "specialty care center" Procedure: Added reference to Policy 404-1758 References: Updated revision history	
404-1307 Medical Second Opinions	Adding TotalCare verbiage	*Approved at UMWG*
404-1525 Skilled Nursing Facility Program for Medi-Cal	Updated MCG Careweb references to clinical care guidelines and Alliance policy. Clarified definitions that included Medicare terminology. Added CFR 409.33 (examples of skilled nursing and rehabilitation services for Medicare). Updated claims and finance policies regarding coordination of benefits (COB) and crossover claims, including information about retroactive Medicare claims. Added Medicare Part B to coverage considerations and included payor of last resort information.	*Approved at UMWG*
404-1601 Durable Medical Equipment (DME) Authorization	•Split out & added review criteria for IHSS, MC and D-SNP. Also added definitions for DSNP •Added information regarding COB •Added coverage, prescription/SWO,and face-to-face criteria and prior auth required documentation. •Added quick reference link to NCD 280.1 & Noridian's website. •Added documentation requirements for DMEPOS supplied as refills •Added for D-SNP •Added regulatory links and references •Updated reference section to align with Compliance's new template set up.	*Approved at UMWG*
404-1611 Transcutaneous Electrical Nerve Stimulation (TENS) Unit Authorization Review Process	To RETIRE	*Approved at UMWG*
404-1702 Provision of Family Planning Services to Members	Purpose: Minor grammar correction. Policy	*Approved at UMWG*

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	Updated "Treatment for Infertility and Fertility Services" to align with language in APL 25-021 (high level coverage overview) *Added a standalone "Standard Fertility Preservation Services" section to highlight coverage for both infertility/fertility services and iatrogenic infertility. As well as call out that neither coverage overrides the other. Definition *Added Donor, Infertility, and surrogate definitions Policy *Added section 5-"Infertility and Fertility Services – Coverage and Utilization Review | IHSS" section which pulls coverage details directly from APL 25-021, including, but not limited to cryopreservation and storage requirements and responsibilities if coverage ends/changes to other plans. *Added section 6-"Member Notices | IHSS" which outlines noticing requirements (note call out of new plan noticing requirements in section 5) References *Added AB116, 28 CCR 1300.74.551 & APL 25-021 *Added revision history	
404-1754 Continuity of Care for D-SNP Members	Removed the MOC training language from this policy updated for CY 2026 Policy Guide	*Approved at UMWG*
404-1756 Inpatient Review for D-SNP Members	NEW	*Approved at UMWG*
404-1757 Discharge Planning for D-SNP Members	NEW	*Approved at UMWG*
404-1758 Authorization Request Process for D-SNP Members	Updated Nondiscrimination notice Updated coverage hierarchy and added reference to 404-1811 Removed MCG definition Added reference to 42 CFR 422.629(k)(3) applicable to AIPs Removed duplicative language Slightly reformatted due to hierarchy update Updated reference to 404-1752 to 200-9108 Removed reference to 404-1112	*Approved at UMWG*
Regular Agenda		**Action/Recommendation**
IV. Topic		

Quality Improvement Health Equity Committee

Date: March 19, 2026

Time: 12pm – 1:30pm

Location: MS Team Meeting

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	2026 and Q4 2025 QIHET Workplan Review	DeAnna Leamon presented the 2026 and Q4 2025 QIHET work plans noting that the 2026 goals generally align with the 2025 goals, with added emphasis on population health management and health equity. Key areas of focus include expanded Facility Site Review oversight into long-term care, continued support for ECM and Community Supports, further integration of health education, and ongoing process improvements, reporting optimizations, and workflow refinements across programs. Q4 2025 Workplan Highlights: Pediatric Care Gap Closure (MCAS): Sarina King reported on progress in Merced and Mariposa counties, with a focus on well-care visits and pediatric quality measures. Efforts included care gap closure grants to provider sites, provider partnerships, and nearly $5 million in funding distributed across 20 practices. Preliminary results showed improvement in some measures; however, additional work is needed in areas that did not meet improvement targets or minimum performance levels. • Gaps: Some pediatric measures, especially well care visits and chlamydia screening, did not reach the 5% improvement or minimum performance level (MPL). Data lag and incomplete data from providers were noted as challenges. • Actions: Care Gap closure grants, provider partnerships, outreach to large practices, and nearly $5 million in funding across 20 practices. Ongoing engagement with providers and updating training materials to address staff turnover. Behavioral Health Follow-Up: Efforts continued to improve follow-up after emergency department visits for mental illness and substance use, with an emphasis on strengthening data sharing among hospitals, counties, and the Alliance. Preliminary rates showed improvement; however, data lag and validation challenges remain ongoing barriers. • Gaps: Difficulty in tracking follow-up after ED visits for mental illness and substance use due to data sharing barriers between hospitals, PCPs, and Alliance. • Actions: Improved data transmission, collaboration with county health plans, and ongoing work to enhance data engineering for more accurate assessment. Dr. Sanford asked what constitutes follow-up after ED visits for mental illness or substance use—whether it is a phone call, visit, or something else. Dr. Bui-Duy clarified it is a visit, which could be with a PCP or behavioral health provider, and noted data sourcing challenges, especially for specialty mental health follow-up.	*Approved*

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		Care-Based Incentive Goals: Cassie Russo reported on targeted measures in Mariposa and San Benito counties, including provider outreach, training videos, and improvements to data collection processes. Some measures met established goals, while others demonstrated partial progress. Provider engagement and support will continue to help improve performance outcomes. • Gaps: Some measures (e.g., controlling blood pressure, developmental screening) showed partial progress or declined, often due to data collection issues and provider engagement timing. • Actions: Provider outreach, investigative meetings, creation of training videos, and support for point-of-care A1C machines to improve compliance. Dr. Kennedy commented on the 11% compliance rate for hypertension, questioning if a 5% improvement might just reflect data collection, and asked about data accuracy. Cassie Russo confirmed the rate reflects controlling blood pressure values received from providers, not uncontrolled cases, and acknowledged data collection improvements since the measure became paid. Dr. Kennedy noted developmental screening rates appeared to go down but were marked green for improvement and asked for clarification. Cassie Russo explained the green indicates improvement from Q3 to Q4, not from the previous year. Dr. Sanford asked about A1C trends and whether seasonal work patterns affect results. Cassie Russo agreed, noting trends in different populations and efforts to support providers in capturing A1C at the point of care. Dr. Sanford asked if self-collected HPV tests count for cervical cancer screening compliance. Cassie Russo confirmed providers must submit these via DST, and they count for compliance. Dr. Kennedy added that Epic logic allows for HPV-only screening, regardless of collection method, with interval differences. Dr. Sarkarati asked if billing codes alone satisfy cervical cancer screening compliance or if DST submission is needed. Cassie Russo: Confirmed lab claims satisfy the measure unless done outside the regular facility; Q code for specimen handling is no longer accepted. Population Health Management & Health Education: Desirre Herrera reported on member engagement activities, including workshops, newsletters, text campaigns, and online self-referral forms. Member	

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		feedback surveys reflected high satisfaction, and presentations were completed for both internal and external partners. • Gaps: Need for expanded goals and improved member engagement. 30:50 • Actions: Member workshops, newsletters, text campaigns, online self-referral forms, and presentations to partners. Planned expansion in 2026 to include broader population health management. Facility Site Review & PQI: DeAnna Leamon reported that Facility Site Review staff achieved full DHCS certification, allowing the team to conduct reviews independently. She also noted that PQI volumes increased due to audit findings and process improvements. Staffing adjustments are planned for 2026 to support continued oversight and timely case resolution. • Gaps: PQI closure rates for non-grievance cases were below target due to increased volumes and staffing strain. 35:27 • Actions: Onboarding additional nurse staff, prioritizing regulatory timelines, and planning restoration of broader oversight in 2026. Member Grievances: Sarah Sanders reported on grievance and appeal activity, noting continued high grievance volumes while all regulatory timeframes were met. Key grievance trends included quality of care, access, and attitude/service concerns. The increase in grievance volume was attributed in part to regulatory changes related to intake practices. Appeals were primarily associated with Community Supports services, with approximately 25% overturned. • Gaps: Increased grievance volumes due to regulatory changes requiring intake of all expressions of dissatisfaction. 43:50 • Actions: Staff training, process improvements, trend analysis, and outreach to providers for corrective actions. Dr. Kennedy commented on seasonal spikes in well-child and sports physicals, noting difficulties in scheduling and patient attendance. Sarah Sanders acknowledged the trend and its alignment with school enrollment periods. Dr. Sanford asked what "attitude and service" grievances mean and if trends are tracked by clinic or staff type. Sarah Sanders explained it covers all touchpoints (Alliance, front desk, providers), and trends are analyzed for targeted outreach and corrective actions.	

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		Dr. Sarkarati asked about the timing and impact of regulatory changes that increased grievance volumes. Sarah Sanders noted major training shifts in Q2 2025 and Q2 2023, which led to higher grievance intake. Dr. Kennedy suggested normalizing grievance data by zip code and discussed provider-level coaching based on complaint counts. Sarah Sanders Agreed and mentioned ongoing efforts to normalize and analyze data for meaningful trends. Member Satisfaction (CAHPS): Sarina King reported that ongoing efforts are focused on improving doctor communication scores, with particular attention to pediatric measures. Activities will continue to support improvement in member satisfaction outcomes. Dr. Sanford asked about the CAHPS survey percentage—what the numerator and denominator are, and why 94% is considered low. Sarina King explained the percentage is based on survey responses and compared to national benchmarks, 94% is below the quality standard. Provider Services & Call Center: Alissa Gil and Veronica Olivera reported on provider satisfaction results by county, including improvements in survey scores. They also noted ongoing call center challenges related to staffing shortages and high call volume. Corrective actions are underway to improve call response times, reduce abandonment rates, and support overall service performance. • Gaps: Call center did not meet goals for call answer times and abandonment rates due to staffing shortages and high volume. • Actions: Hiring additional staff, implementing workforce management tools, call audits, and scheduling adjustments 2026 Workplan Additions & Focus • Discussion & Feedback Dr. Sanford asked if there is a way to analyze if institutions with shorter bed days also have higher readmissions. Tammy Brass confirmed they have the data and will consider this analysis for a future meeting. Decisions • Motions for approval were made and passed for both the Q4 2025 and 2026 QIHET work plans.	
	Q4 2025 UMWP Review	Program Highlights • Strong growth in CCS referrals and adult case management cases.	*Approved*

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		• ECM (Enhanced Care Management) and Community Supports (CS) became major focus areas, with operational performance improvements and increased activity. • DSNP (Dual Special Needs Plan) operations remained stable, with excellent turnaround times and high provider satisfaction scores. • Inpatient and ED utilization remained stable, with some reductions in overall inpatient numbers throughout the year. NOAA Performance and Appeals • Denials and appeals remained stable, with behavioral health insourcing not causing significant increases in activity Post-Acute and SNF Trends • SNF (Skilled Nursing Facility) and post-acute utilization rates were consistent quarter over quarter. • Readmission rates remained stable, with ongoing monitoring and new initiatives planned for 2026 to further impact ED utilization and readmissions. Annual Program Review • Prior authorization turnaround times and interrater reliability (IRR) compliance remained strong (100%). • Notices of Action (NOA) letters to members and providers were clear and compliant. • Care management and ECM showed strong finish, with adult NCQA cases at 685. • ACM (Adult Case Management) enrollment exceeded targets, reaching 6% (goal was 5%), prompting a new focus on disenrollment and graduation from ECM in 2026. • Pharmacy utilization was steady, with increased authorizations for GLP-1 medications in the IHSS line of business. Projects and Initiatives • DSNP work drove improvements across programs, including behavioral health insourcing and access/engagement. • Authorization optimization project planned for 2026 to reduce provider burden. Delegate Oversight • Pharmacy delegate audits passed, and changes in ECM payment methodology and DSNP readiness were successfully implemented. Key Metrics • Decreases in bed days and inpatient per member per month costs.	

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		• Slight increase in readmission rate, which will be monitored and analyzed further. • Avoidable admissions (ACSA) and inpatient costs showed improvement, attributed to collaborative IDT (Interdisciplinary Team) and transitions of care efforts. Discussion: Dr. Sanford asked about the impact of GLP-1 medication discontinuation under Medi-Cal RX and whether there was increased authorization activity. Tammy Brass confirmed increased authorizations for GLP-1 medications in the IHSS line of business and ongoing monitoring of cost and utilization. Dr. Sanford asked if there is a way to analyze whether institutions with shorter bed days per admission are the same ones with higher readmission rates. Tammy Brass confirmed the data is available and committed to providing a snapshot analysis in a future meeting. Dr. Sanford commented on the value of statistical significance and error bars in the annual program review, asking for clarification on what percent change is considered significant. Tammy Brass acknowledged the feedback and agreed to refine future reports to clarify meaningful metrics and statistical significance. Gaps Identified • Slight increase in readmission rates, requiring further analysis to determine causes and institutional trends. • Need for improved reporting on statistical significance and error bars to clarify which changes are meaningful. • ECM (Enhanced Care Management) disenrollment process not fully optimized, with some members remaining in the program longer than necessary. • Call for more granular analysis of bed days and readmission rates by institution. Actions Taken/Planned • Additional analysis of readmission rates and institutional trends to be presented in future meetings. • Incorporation of statistical significance and clearer metrics in future annual program reviews. • New focus in 2026 UM Work Plan on ECM disenrollment and graduation metrics to ensure members exit the program when appropriate. • Ongoing monitoring of GLP-1 medication utilization and costs in IHSS line of business. Next Steps • Continued focus on ECM disenrollment, DSNP metrics, and ED utilization in 2026.	

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		Further analysis of readmission rates and institutional trends requested for future meetings. Actions and Approvals • Motions for approval of the Q4 2025 UM Work Plan were passed. • Feedback on statistical significance and error bars for future reporting was acknowledged and will be incorporated into the annual UMWP review.	
	2025 UM Program Evaluation	The UM program demonstrated stable operational performance, with strong prior authorization turnaround times and 100% interrater reliability compliance. Notices of action (NOA) remained clear and timely, supporting both members and providers. Enhanced Care Management (ECM) enrollment exceeded targets, but a new focus for 2026 will be on appropriate disenrollment and graduation from the program. Inpatient and ED utilization showed slight decreases, with a minor increase in readmission rates flagged for further analysis. Pharmacy utilization was steady, with increased GLP-1 authorizations in the IHSS line of business noted for ongoing monitoring. Delegate oversight audits were passed, positioning the program well for 2026 changes, including DSNP readiness and authorization optimization. The annual review highlighted the need for more granular analysis of institutional trends and clearer reporting of statistical significance in future evaluations. Actions and Approvals • Motions for approval of the 2025 UM Program Evaluation were passed.	*Approved*
	Utilization Management Criteria	Utilization Management Criteria • Alignment with CMS/DHCS: The UM criteria were updated to align with CMS (Medicare) and DHCS (Medi-Cal) recommendations, ensuring consistency across benefit determinations. Where CMS or	

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		DHCS recommended no authorization requirement, the Alliance reduced provider burden by removing unnecessary prior authorizations. • Coding Updates: Numerous coding updates were made, including additions and modifications per DHCS guidance. These updates are tracked and monitored through the UM work plan to ensure compliance and effectiveness. • Authorization Requirement Adjustments: For codes where DHCS or CMS recommended an authorization requirement, the Alliance reviewed risk and, when appropriate, opted to reduce provider burden by removing the requirement if risk was deemed low. This approach is continually reassessed and brought back to the committee for input. • Age-Related Physical Disability (R54) Code: The diagnosis code for age-related physical disability (R54) previously had a lower age cutoff at 21. The committee recommended adjusting the age range to start at 20, allowing providers to dispute denials with relevant documentation, thus improving access and flexibility. • Committee Review and Approval: All UM criteria changes, coding updates, and benefit adjustments were presented to the committee and received formal approval through motions and seconds. • Ongoing Monitoring: The Alliance committed to ongoing monitoring of these criteria and coding changes, with regular review and feedback from the committee to ensure continued alignment with regulatory guidance and provider needs. Gaps • Some coding updates and authorization requirements may still need ongoing review to ensure they do not create unnecessary provider burden or risk. • The age cutoff for the R54 code was previously set too high, potentially limiting access for younger members. **Actions** • The committee approved adjusting the age range for the R54 code to allow disputes with relevant documentation, addressing access issues. • UM recommendations are continually monitored and brought back to the committee for further review and input, especially when regulatory guidance changes or provider feedback indicates a need. • The Alliance committed to ongoing tracking of coding updates and authorization requirements through the UM work plan, with regular committee oversight. Decision:	

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		• Member benefits criteria updates were passed.	
	Future Topics	Topics of interest discussed during the meeting include: AI in Healthcare Quality and Operations • Discussion on how AI is being used or could be used by the Alliance, including analytics, authorization optimization, and provider-facing tools. • Overview of where AI is and is not used in plan operations, and potential impacts on quality work and patient experience. Readmission and Bed Day Analysis • Deeper dive into whether institutions with shorter lengths of stay are also experiencing higher readmission rates, with data breakdowns by facility. Statistical Significance in Reporting • Clarification and education on what percentage changes in metrics are considered statistically significant in annual program reviews.	

Action Items

Agenda Item	**What is the action item**	**Due date**	**Responsible staff**
2025 UM Program Evaluation	Quarterly Data Analysis - provide a snapshot analysis of readmission rates and bed days by institution for the September QIHEC meeting, using available claims data.	September 17, 2026	Tammy Brass
Meeting adjourned at 1:25 pm			
Next Meeting June 18, 2026			
Approved by Committee Date: June 18, 2026	***Signature:***		**Date:** June 18, 2026

DATE: August 26, 2026

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

FROM: Ronita Margain, Community Engagement Director

SUBJECT: Alliance Donations and Sponsorship of Events and Organizations Policy

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

Summary. The Alliance Donations and Sponsorship of Events and Organizations was revised to reflect changes due to the transition of lead department to Community Engagement.

Background. The Alliance Donations and Sponsorship of Events and Organizations policy describes Central California Alliance for Health's (the Alliance) policy and procedure for financial donations to non-profit 501(c)(3) community organizations and sponsorship of such organizations' events within the Alliance's service area. The revised policy reflects the new lead department and a streamlined process.

Discussion. Impacted departments reviewed and provided input in the revised policy.

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

Attachments.

1. Alliance Donations and Sponsorship of Events and Organizations Policy

	POLICIES AND PROCEDURES
Policy #: 100-0001	**Lead Department:** Community Engagement ~~Administration~~
Title: Alliance Donations and Sponsorship of Events and Organizations	
Original Date: 11/07/2021	**Policy Hub Approval Date:** ~~04/16/2024~~
Approved by: ~~Michael Schrader, Chief Executive Officer~~	

Purpose:
To describe ~~the~~ Central California Alliance for Health's (the Alliance) policy and procedure for financial donations to non-profit 501(c)(3) community organizations and sponsorship of such organizations' events within the Alliance's service area.

Policy:
It is the policy of ~~the~~ Central California Alliance for Health to be responsible stewards of public funds. The Alliance, its Board members, and employees shall not make gifts of public funds or assets or lend credit to private persons or entities. Donations to a non-profit 501(c)(3) organization or sponsorship of such organization's event must serve a direct and substantial public purpose and make appropriate use of public funds and Alliance staff time.

As such, the Alliance may donate to non-profit 501(c)(3) organizations and/or sponsor their events which further a Medi-Cal purpose~~,~~; the Alliance's strategic priorities~~,~~; align with the Alliance's mission, vision, and values~~,~~; and comply with the Alliance's Code of Conduct. Sponsorships and donations may only be awarded to the extent funds budgeted for such donations/sponsorships are available, and there is no guarantee of Alliance sponsorships or donations.

Alliance funds will not be used responsive to specific employee personal volunteer interests, including specific employee family and friend volunteer or associated non-profit organizations or their events (i.e. children's school fundraisers, etc.) in accordance with Policy 101-1038 – Solicitation.~~,~~

Definitions:

1. Donation: Financial contributions by the Alliance to support a non-profit 501(c)(3) organization that serves a public purpose that is aligned with the Alliance's vision, mission, values, and strategic priorities. Donations support the organization and are not restricted to a specific purpose ~~, nor are they subject to specific terms and conditions~~ beyond the general requirement that they are used by a 501(c)(3) for a public purpose, aligned with the Alliance's Vision/Mission/Values. Donations may also include time provided by Alliance staff during business hours.

2. Sponsorship: Financial contributions by the Alliance~~,~~ to a non-profit 501(c)(3) organization for an event hosted by the organization which serves a public purpose~~,~~ and that is aligned with the Alliance's vision, mission, values, and strategic priorities. Sponsorship can also include contribution of goods or tangible items in support of an event and may also include time provided by Alliance staff to support the event during Alliance business hours.

	POLICIES AND PROCEDURES
Policy #: 100-0001	**Lead Department:** Community Engagement ~~Administration~~
Title: Alliance Donations and Sponsorship of Events and Organizations	
Original Date: 11/07/2021	**Policy Hub Approval Date:** ~~04/16/2024~~
Approved by: ~~Michael Schrader, Chief Executive Officer~~	

Procedures:

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

2. Requests.
    a. An organization requesting donation or sponsorship shall submit a request and any applicable supporting documents utilizing the mandatory Alliance request form~~,~~ detailing how the requested funds are intended to be used, outlining the scope and purpose of the organizational donation or event sponsorship, and agreeing to the Alliance's requirements around benefits and recognition for any event sponsorship.
        i. The non-profit will assume the responsibility of securing signed photo releases from any individuals included in photos or other visual material provided to the Alliance by the non-profit.

3. Action on Requests.
    a. For documentation purposes, the Administrative Specialist - Community Engagement ~~Executive Assistant/Clerk of the Board (EA/COB)~~ will track all requests~~,~~ with data including but not limited to: organization, date of event, type of request, staffing information, amount of request, and ultimate ~~disposition~~ decision of the request.
    b. The Administrative Specialist will confirm if the request is within the donation/sponsorship budget.
    ~~a.~~c. The Administrative Specialist will forward the request and determination if budget is available to the Community Engagement Director (CED) for confirmation of alignment with this policy and recommendation for action.
    ~~b. If the request is aligned with criteria and there is adequate budget available, the CED will submit requests for recommended approval to the CEO. The CEO has the authority to approve or deny all requests.~~
    d. If approved by CED, Administrative Specialist will submit the purchase request.
    e. If not approved by CED, CED or Administrative Specialist will notify the CEO.
    f. ~~The CEO will notify the CED, the Executive Assistant and Finance of any approval.~~ Administrative Specialist will prepare and send a letter via email indicating approval of the request and sponsorship/donation amount or denial.

i. Approval letter emails will also include W-9 form, ACH form, and Funded Partners Promotional Toolkit.

~~c.~~g. Finance will prepare the check for the approved sponsorship/donation. ~~The Executive Assistant will prepare a letter indicating approval of the request and enclosing the sponsorship/donation.~~

~~d. The CEO will notify the CED and the Executive Assistant of any denial. The Executive Assistant will prepare a letter for the organization notifying the organization of the denial.~~

4. Benefits and recognition.
   a. ~~Event sponsorship may be promoted by the Alliance~~The Alliance may promote the event sponsorship in their communications channels as deemed appropriate~~,~~ including the web site, social media, press releases, print and electronic newsletters and other collateral.
   b. The non-profit will promote the sponsorship/donation.
      i. Promotional material may include website, press releases, public event recognition, social media, newsletters, and other collateral.
      ii. The material will include the Alliance's name and approved logo. The Alliance will provide the Promotional Toolkit for Funding Partners with approved logos.
      ~~i~~iii. Material will be approved by the Alliance's Marketing and Communications Director prior to distribution.

   ~~b. The non-profit will assume the responsibility of securing signed photo releases from any individuals included in photos or other visual material provided to the Alliance by the non-profit.~~

   ~~c. As a benefit of sponsorship, the non-profit agrees to promote the sponsorship on the non-profit's and/or event promotional material, including website, press releases, public event recognition, social media, newsletters and other collateral~~

   ~~d. The non-profit agrees to include the Alliance's name and approved logo in such promotional materials as deemed appropriate and agreed upon via the sponsorship terms and with advance approval from the Alliance's Communications Department or by following specific guidelines outlined in the Promotional Toolkit for Funding Partners. The Alliance may provide this toolkit to the non-profit at their request.~~

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

5. Reporting.

	POLICIES AND PROCEDURES
Policy #: 100-0001	**Lead Department:** Community Engagement ~~Administration~~
Title: Alliance Donations and Sponsorship of Events and Organizations	
Original Date: 11/07/2021	**Policy Hub Approval Date:** ~~04/16/2024~~
Approved by: ~~Michael Schrader, Chief Executive Officer~~	

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

~~6. Executive Line of Succession.~~

a. ~~Authority may be delegated in accordance with this policy if the CEO is unavailable. Please refer to Alliance Policy 105-0012 – Administrative Decision-Making Controls, for the "Executive Line of Succession".~~

References:

Alliance Policies:
- Policy 101-1038 –- Solicitation

Impacted Departments:
- ~~Administration~~Executive
- ~~Regional Operations~~ Community Engagement
- Marketing and Communications
- Finance

Regulatory:
Legislative:
Contractual:
DHCS All Plan or Policy Letter:
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)
☒ TotalCare D-SNP (Medicare HMO)	(01/01/2026 – present)

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
06/07/2023	06/22/2023	Kathy Stagnaro, Clerk of the Board	Michael Schrader, Chief Executive Officer

	POLICIES AND PROCEDURES
Policy #: 100-0001	**Lead Department:** Community Engagement ~~Administration~~
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Approved by: ~~Michael Schrader, Chief Executive Officer~~	

4/9/2024	4/5/24	Kathy Stagnaro, Clerk of the Board	Michael Schrader, Chief Executive Officer
07/24/2026	07/24/2026	Kayla Zoliniak, Administrative Specialist – Community Engagement	Ronita Margain, Community Engagement Director

DATE: August 26, 2026

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

FROM: Michael Schrader, Chief Executive Officer

SUBJECT: Department of Health Care Services Contract Amendment: Term Extension

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Recommendation. Staff recommend the board authorize the Chair to sign an amendment to the Alliance's contract with the Department of Health Care Services (DHCS) to extend the term of the agreement through December 31, 2027.

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Background. The Alliance contracts with DHCS to provide Covered Services to eligible and enrolled Medi-Cal beneficiaries in Santa Cruz, Monterey, Merced, San Benito and Mariposa counties. The Alliance entered into the primary Agreement 23-03421 with DHCS on January 1, 2024. The agreement has subsequently been amended via written amendments A 01 through A 011.

Discussion. DHCS has notified Medi-Cal Managed Care Plans (MCPs) that it is preparing a contract amendment to extend the term of existing agreements through calendar year (CY) 2027. The amendment requires Board approval prior to execution.

Fiscal Impact The is no fiscal impact.

Attachments. N/A

DATE: August 26, 2026

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

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

SUBJECT: Q1 2026 Quality Improvement Health Equity Transformation Workplan

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Recommendation. Staff recommend the Board approve the Quality Improvement Health Equity Transformation Workplan for Q1 2026.

Summary. This informational report provides a summary of the activities planned for the Q1 2026 QIHET workplan. The workplan includes contractual required Performance Improvement Projects, operational performance metrics, health programs and cultural and linguistic services, health equity and population health management. Refer to the QIHET Workplan attachment for additional details.

Background. The Alliance is contractually required by the Department of Healthcare Services (DHCS) to maintain a quality improvement system to monitor, evaluate, and take effective action on any improvements needed 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 actions and improvements meet the overall Alliance mission.

Discussion. Approve the Q1 2026 Quality Improvement Health Equity Transformation Workplan.

Q1 2026 QUALITY IMPROVEMENT AND POPULATION HEALTH WORKPLAN
QUALITY PROGRAM STRUCTURE

Populations Health Management Program
Reporting purpose: Provide an update on Q1 PHMP activities.

Report Previously Identified Issues /Highlights:

- The PHM work within the Alliance was siloed and a comprehensive compliance tracking process did not exist.
- Where Alliance policies were aligned with regulatory requirements, the Alliance's system for mapping process documentation remained ad hoc by workstream owner.

- The Alliance needed to launch a formal PHM Program to align various workstreams and ensure regulatory compliance. The formal PHM program needed to consist of the documentation of program activities and requirements within a workgroup setting.

Report Changes / Updates:

- PHM Program compliance tracker (aka "regulatory crosswalk") was created and is in progress.
- LHD MOU compliance tracker is also in progress.
- Staff have revived the quarterly LHD MOU meetings and process.
- Staff have joined existing workstream meeting series to track and support ongoing work.
- Staff are identifying and addressing compliance gaps and process gaps.
- Staff have begun tracking and creating process documentation and have stored it on the process map repository created by OpEx on ACE.
- PHM QIHETP tasks have transitioned to work plan tasks in APT to improve visibility and organization.

Health Equity
Reporting purpose: Provide an update on Q1 Health Equity activities.

Report Previously Identified Issues /Highlights: CCAH needed to develop a health equity plan.

Report Changes/Updates:

- Reviewed current PNA. It was decided to continue population of focus with PNA findings.
- Comms ticket submitted and HEP plan posted on Alliance website.

QUALITY OF CLINICAL CARE
Medi-Cal Managed Care Set (MCAS) Intervention:

Reporting purpose is to: Provide an update on MCAS intervention progress.

Report Previously Identified Issues/Highlights:
Provider and staff shortages, coupled with limited locum availability and prolonged recruitment timelines, continue to constrain appointment access and provider efficiency. These challenges, along with increasing workload pressures, are further compounded by vaccine hesitancy and access barriers, negatively impacting vaccination rates across practices.
During planning to expand practice coaching efforts to adult measures (GSD, CBP) it was obvious data for DSNP enrollers would not provide a viable estimate for provider engagement. Therefore, data was used based on Medi-Cal enrollment and CBI performance. Reevaluation of DSNP population performance in GSD and CBP expected for end of 2026 when population is sufficient.

Report Changes/Updates:
A comprehensive analysis of 2025 data by provider, measure, and geography informed a targeted improvement strategy. Priority measures, providers, and regions were identified,

resulting in the engagement of 15 providers through Provider Partnerships and Care Gap Grants across Merced and Mariposa counties.

Practice Coaches were assigned and successfully launched partnerships through structured kick-off meetings, established charters, defined meeting cadence, and confirmed baseline data.

All grant agreements are fully executed, and community impact is underway through WIC and school-based immunization events in Merced County.

Planning began to incorporate GSD and CBP into practice coaching, as preparatory work for eventual DSNP interventions. Practices identified who fell below MPL, coaching assignments were made, and CCAH pharmacy was brought into the project to promote the PLAD program.

Care Base Incentive
Reporting purpose is to: To decrease the overall number of low performing providers (3 or more measures below the 25th percentile) by the end of Q4 2026.

Report Previously Identified Issues/Highlights:
For Quarter 1, the CBI team has gathered preliminary data for the providers performance in Quarter 4. The validated Q4 data will not be available until April 2026. Roles, responsibilities, and assignments were outlined with the group along with expectations for targeted outreach. In

Quarter 2, the team will begin outreaching and practice coaching with providers who are low performing in attempt to increase the measure rates to >25th percentile or MPL.

Report Changes/Updates: No additional report changes or updates identified at this time.

Health Education
Reporting Purpose: Provide an update on health education/Basic Population Health goals and activities.

Report Previously Identified Issues/Highlights: No additional previously identified issues / highlights identified at this time.

Report Changes/Updates:

Goal 1:
Provide chronic disease management programs and wellness programs for members. A minimum of 4 workshops will be offered per quarter.

- **Q1 progress:** A total of **10 member workshops** were completed in Q1. Modalities provided included:
    - 6 telephonic workshops
    - 3 virtual workshops
    - 1 in-person workshop

Goal 2:
On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2026.

- **Q1 progress:**
    - **Member Newsletter:** The project team included 1 article in the March 2026 Member Newsletter informing members of health and wellness programs available.
    - **Text message campaign:** A text message campaign was sent to members in Q1 informing them of workshops available and how to sign up.
    - **Member online sign-ups:** As a result of member informing activities in Q1, the team received 138 member sign-ups online. This was a 33% increase compared to Q1 in 2025.

Goal 3:
On a bi-annual basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact.

- **Q1 progress:** Surveys will be collected in Q2.

SAFETY OF CLINICAL CARE

Reporting purpose is to outline key activities, goals, performance results, and updates for Facility Site Review (FSR).

Facility Site Review:
Report Previously Identified Issues /Highlights:

Identified Issues

1. External factors, such as weather conditions, may impact the timely completion of scheduled site reviews despite planning.

Goal Results

1. 7 of 8 (87.5%) Facility Site Reviews due in Q1 2026 were completed within required timeframes, exceeding the 80% target.
2. 100% of corrective action plans (12 total: 6 FSR and 6 MRR) were submitted within required regulatory timeframes.

Report Changes / Updates
The FSR program exceeded the timeliness target for site reviews and achieved full compliance for CAP submissions in Q1 2026. The one delayed review was scheduled in advance but was impacted by severe weather conditions and has since been completed. Tracking and scheduling processes supported timely completion, with continued focus on proactive scheduling and monitoring.

Potential Quality Issues
Reporting purpose is to outline key activities, goals, performance results, and updates for Potential Quality Issues (PQI).

Report Previously Identified Issues /Highlights:
Identified Issues

1. Significant growth in PQI volume has increased workload and required sustained coordination to maintain timeliness.

2. Non-grievance PQIs are often more complex and require additional investigation and coordination.
3. Even though Q1 targets were met, volume and complexity continue to present a risk to sustained performance.

Goal Results

1. 245 of 245 (100%) grievance-related PQIs were completed within the 30-day regulatory timeframe.
2. 29 of 32 (91%) non-grievance PQIs were completed within 120 calendar days, exceeding the 80% target.

Report Changes / Updates:
The PQI program maintained full compliance for grievance-related PQIs in Q1 2026 despite high volume. Non-grievance PQIs exceeded the timeliness target, reflecting effective prioritization and oversight. The focus remains on sustaining performance through continued monitoring, prioritizing aging cases, and managing workload.

Long Term Support Services
Reporting purpose is to outline key activities, goals, performance results, and updates for LTSS oversights.

Report Previously Identified Issues /Highlights:
Identified Issues

1. Variability in facility response required follow-up after initial outreach.
2. QAPI program evaluation is in early stages, with baseline measurement in progress.

Goal Results

1. 21 of 34 (61%) LTSS facilities submitted QAPI programs in Q1 2026.
2. QAPI evaluation process implemented; baseline review of CMS-required elements in progress.

Report Changes / Updates:
LTSS oversight activities in Q1 focused on outreach, submission tracking, and establishing a standardized QAPI evaluation process. Follow-up was conducted with all facilities after initial outreach. Evaluation of submitted QAPI programs has begun, with baseline results to be reported in Q2. Continued outreach and escalation will support increased submission rates and compliance.

Appeals and Grievance Review
Reporting purpose: To provide an update and review of AG performance, trends, and activities for the Appeals and Grievance program during Q1 2026.

Report Previously Identified Issues/Highlights

Identified Issues:

1. Increased AG volume continues to strain staff capacity and limited resources across the organization.

Highlights

Goal 1:
Meet regulatory requirements 98% of the time for timely acknowledgments and resolutions.
Enhanced operational monitoring continued to support timeframes.

- Q1 Results: The AG team met this requirement during this quarter. Missed deadlines continued to occur due to AG volume increases and staffing deficiencies.
- Actions: New AG temporary staff began supporting case work in early March.

Goal 2:
Maintain the AG rate below 2 for QOC and QOS with the Medi-Cal LOB.

- Q1 Results: MCAL LOB achieved this goal.

Goal 3:
Improve AG data quality and reporting.

- Q1 Results: QA activities and development of QOS trending report supported this goal.

Goal 4:
Improve monitoring and documented oversight.
Q1 Results: Grievance Resolution and Oversight Workgroup (GROW) and documented process or system issues supported this goal.

Report Changes/Updates: No additional report changes or updates identified at this time.

MEMBER EXPERIENCE

Member Satisfaction Survey – CAHPS

Reporting purpose is to: Update the group on the progress of the CAHPS work and 2026 focus areas.

Report Previously Identified Issues/Highlights.

Q1 Updates: In-person member feedback at the Member Services Advisory Group continues to be limited with no representation from Merced County for Q4 2025.
Continued shortage or certified translators in provider offices and retention of care providers/specialists with rural counties.

Report Changes/Updates:
Quarter 1 Updates: Analysis of MY2024 results, engaging departments on current and new interventions related to doctor's communication and access to care, a newly developed timeline for CAHPS intervention work spanning a 2-year cycle, as well as approval of work from Member Experience Committee and Operations Committee. Overall, goals are on track for the quarter.

QUALITY OF SERVICE

Access and Availability

Reporting purpose is to: Quarter 1 Updates: Analysis of MY2024 results, engaging departments on current and new interventions related to doctor's communication and access to care, a newly developed timeline for CAHPS intervention work spanning a 2-year cycle, as well as approval of work from Member Experience Committee and Operations Committee. Overall, goals are on track for the quarter.

Report Previously Identified Issues/Highlights:

- Conducted quarterly Provider Appointment Monitoring Survey (PAMS) to assess compliance with access standards.
- Maintained compliance for routine (13.5 days) and urgent (1.6 days) appointment access.
- Identified opportunity for improvement in 3rd next available appointments (22.3 days).
- Tracked and monitored LOA utilization to identify specialties and geographies with network gaps.
- Increased visibility into telehealth adoption (110 providers) and Nurse Advice Line awareness (111 providers).
- All planned Q1 monitoring and reporting activities were completed.
- Provider outreach was partially impacted by seasonal/holiday timing.
- LOAs were at times executed without prior opportunity to pursue contracting and limiting long-term network growth.
- High ineligible survey rate and no participation in Mariposa County impacted data completeness.
- Specialty access constraints affecting 3rd next available appointments.
- Provider Satisfaction Survey feedback indicates opportunities to strengthen alignment in core operational processes and provider experience.

Report Changes/Updates:

- Collaborate closely with Finance, Contracts, and Credentialing to ensure Network Development involvement in the LOA process.
- Establish oversight and guidelines for LOA duration to promote timely transition to contracted status.
- Prioritize targeted provider recruitment in identified gap areas.
- Improve survey timing and provider engagement strategies to increase participation and data accuracy.

Telephone Access
Reporting purpose is to: To ensure timely assistance for members when connecting with the plan, through Member Services Call Center.

Report Previously Identified Issues/Highlights:
Goals for Q1 were not met due to increased call volume within the Member Services Call Center. Although overall membership has decreased, the complexity of member inquiries and overall call handle times have increased, contributing to delays in telephone access performance metrics.

Report Changes/Updates:
Member Services Recruitment is ongoing. Six additional MSR's have been hired to support the call volume and continued member walk-in traffic with the goal of improving response times and overall member access to services.

Culture and Linguistics

Reporting purpose is to: Provide an update on cultural and linguistic (C&L) program goals and activities.

Report Previously Identified Issues/Highlights: No additional previously identified issues / highlights identified at this time.

Report Changes/Updates:
Goal 1:
Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2024 baseline utilization data.

Q1 progress:

- Phone Interpreting Services: There was a total of 9,887 calls in Q1 by provider sites. This reflects a 19% increase compared to Q1 2025.

- In-Person interpreting services: There was a total of 2,403 requests for in-person interpreting services in Q1. This reflects a 38% increase compared to Q1 2025.

- Virtual Remote Interpreting (VRI) services: There was a total of 45 requests for VRI services in Q1. VRI services were not available until Q3 2025, baseline comparison will be shared in Q3.

- Monterey County providers were the highest utilizers of in-person interpreting services.

- Merced County providers were the highest utilizers of Virtual Remote Interpreting services.

Goal 2:
On a quarterly basis, inform members and/or providers of language assistance services utilizing at least 1 member and/or 1 provider informing modality.

Q1 progress:

- Member Newsletter: The project team included 1 article in the March 2026 Member Newsletter informing members of language assistance services available to them.

- Provider Bulletin: The project team included 1 article in March 2026 Provider Bulletin informing providers of language assistance services and how to access the services to support communication with members.

Goal 3:
Collect member feedback on their experience with language assistance services in a clinical setting.

Q1 progress:
Surveys will be collected in Q2.

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.

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

Attachments.

1. Q1 2026 Quality Improvement and Health Equity Transformation Program Workplan Master Updates

SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Execute completed Annual QI Evaluation meeting DHCS and NCQA standards. Finalize Annual Evaluation for presentation to QIHEC.	1. Update the 2026 Evaluation document, ensuring any regulatory updates, and assignment of sections for each respective business owner. 2. Monitor progress of evaluation update by business owners and provide feedback. 3. Create business requirements for a new section of the Alliance website to share evaluation.	8/1/2026-8/30/2026 9/1/2026-12/31/2026 12/1/2026-12/31/2026	Kristen Rohlf, MPH, Quality and Population Health Manager	1st update-	1:	1.	☐ Yes ☐ No	

PROGRAM DESCRIPTION (GEORGIA GORDON)

Goals/Objectives for Calendar Year 2026	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 2026 Program Description for presentation to QI stakeholders.	1. Ensure all required sections of the workplan meet DHCS and NCQA requirements.	1/31/2026 - 2/13/2026	Georgia Gordon, Quality Improvement Program Advisor II	1st update: 2026 Program Description was finalized and approved by QIHEC March 2026. An amended Program Description will be presented in June 2026 QIHEC meeting for approval of the integration of the QI Health Equity Plan.	1: No previously identified issues	1: Once board approves, the program description will be posted on the Alliance website per DHCS and NCQA guidelines.	☑ Yes ☐ No	
2. Presentation of the Program Description to both the QIHEW, and QIHEC for approval.	1. Submission of Program Description to QIHEW staff after the creation of structure in APT for a Bi-annual update.	3/1/2026 - 3/31/2026	Georgia Gordon, Quality Improvement Program Advisor II				☑ Yes ☐ No	
3. Develop a comprehensive 2026 Quality improvement Program Description that outlines all required DHCS and NCQA requirements.	1. Review all DHCS and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2026 - 12/31/2026	Georgia Gordon, Quality Improvement Program Advisor II		2: No previously identified issues	2: Once board approves, the program description will be posted on the Alliance website per DHCS and NCQA guidelines.	☐ Yes ☐ No	

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ANNUAL WORKPLAN (SARINA KING)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Execute a QI annual work plan that captures ongoing activities throughout the year and addresses all DHCS and NCQA requirements	1. Create a workplan that captures yearly activities, time frame for each activity's completion, staff members responsible for each activity, monitoring of previously identified issues, and evaluation of QI program in APT.	1/1/2026 - 2/24/2026	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 1: Q4 of the QIHETP – Work Plan was successfully completed and approved at the Q4 QIHEW and QIHEC. Qtr. 2: Qtr. 3: Qtr. 4:	1: No issues identified in Q1	1: Continue to capture activities in a timely manner and work with stakeholders according to NCQA and DHCS standards.	☑ Yes ☐ No	Cross-functional quality work across the organization is captured and tracked via the QIHETP - WP quarterly to ensure adherence to quality standards.
2. Ensure all workplan elements are properly documented and reflect appropriate follow-up by each business owner.	1. Regularly quarterly check-ins to review workplan entries with regular feedback provided to business owners when applicable.	1/1/2026 - 3/30/2026 4/1/2026 - 6/30/2026 7/1/2026 - 9/30/2026 10/1/2026 - 12/31/2026	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II				☑ Yes ☐ No	
3. Review and approval of workplan quarterly by QIHEC.	1. Review of all workplan entries prior to each committee to ensure appropriate documentation.	1/1/2026 - 3/30/2026 4/1/2026 - 6/30/2026 7/1/2026 - 9/30/2026 10/1/2026 - 12/31/2026	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II				☑ Yes ☐ No	

POPULATIONS HEALTH MANAGEMENT PROGRAM (KATE NESTER)

Goals/Objectives for Calendar Year 2026	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. By the end of Q4 2026, ensure all teams responsible for PHM-related work are aware of DHCS and NCQA PHM requirements, have clearly defined and applicable goals aligned to those requirements, align all existing and new PHM initiatives to DHCS and NCQA PHM goals, and contribute to centralized PHM reporting.	1. Create a PHM Program compliance tracker, cross walking compliance requirements outlined in PHM associated DHCS APLs, the DHCS PHM Policy Guide, and NCQA PHM Standards, with processes and procedures in place to achieve each requirement. 2. Build, document, and activate processes and procedures to achieve requirements that remain out of compliance as of January 1, 2026.	1/1/2026-12/31/2026	Kate Nester, Community Health Integration Manager Christy Celis Puga, Senior Community Health Analyst Katie Morataya-Picazo, Community Health Specialist	Qtr.1: PHM Program compliance tracker (aka "regulatory crosswalk") in progress. LHD MOU compliance tracker in progress. Staff have revived the quarterly LHD MOU meetings and process. Staff have joined existing workstream meeting series to track and support ongoing work. Staff are identifying and addressing compliance gaps and process gaps. Staff have begun tracking and creating process documentation and have stored it in the process map repository created by OpEx on ACE.	Qtr.1: The PHM work within the Alliance was solved and a comprehensive compliance tracking process did not exist. Where Alliance policies were aligned with regulatory requirements, the Alliance's system for mapping process documentation remained ad hoc by workstream owner.	Qtr.1: Continue to build out the PHM Program compliance tracker, including the LHD MOU compliance tracker, and mapping process documentation to Alliance policies and corresponding regulatory requirements. Begin building workflows or other process documentation where they are currently lacking within PHM Program workstreams.	☐ Yes ☑ No	PHM Program compliance tracker created in alignment with regulatory requirements. Staff are currently working to identify where requirements remain out of compliance to bring the program fully into compliance by end of Q4 2026.
1. By end of Q4 2026, execute an annual PHM work plan that captures ongoing activities throughout the year and addresses	1. Create a yearly work plan in APT. Ensure all required sections of the work plan meet DHCS and NCQA requirements.	1/1/2026-3/31/2026	Kate Nester, Community Health Integration Manager Christy Celis Puga, Senior Community Health Analyst	Qtr.1: PHM QIHETP tasks have transitioned to work plan tasks in APT to improve visibility and organization.	Qtr.1: The Alliance needed to launch a formal PHM Program to align various workstreams and ensure regulatory compliance. The formal PHM program needed to consist of the documentation of	Qtr.1: Launch the PHM Program Workgroup in Q2. Ensure all required sections of the work plan meet DHCS and NCQA requirements.	☑ Yes ☐ No	PHM Program work plan created in APT, with tasks being assigned to business owners

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all DHCS and NCQA requirements.	2. Assign each task to a business owner and include start and end dates.		Katie Morataya-Picazo, Community Health Specialist		program activities and requirements within a workgroup setting.	Assign tasks to business owners and align work completion dates with regulatory requirements.		including start and end dates.

HEALTH EQUITY (VANESSA PAZ)

Goals/Objectives for Calendar Year 2026	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. By end of Q1 2026, create a comprehensive Health Equity Plan that meets DHCS Regulatory requirements including posting on external Alliance website.	1. Review DHCS contract requirements for HEP plan to ensure all components are met. 2. Review current PNA, HEDIS rates, and Quality Evaluation to identify populations of focus for the HEP. 3. Submit Comms ticket to post HEP. All three you say by the end of QI 2026.	1/1/2026-3/31/2026	Andrea Swan, QIHETP Director Kate Nester, Community Health Integration Manager Vanessa Paz, Community Health Program Manager	Qtr.1: Fully developed and posted annual Health Equity Plan.	Qtr.1: CCAH was out of compliance with Medi-Cal contract due to not having a Health Equity Plan. Reviewed current PNA. It was decided to continue population of focus with PNA findings. MarCom ticket was submitted and HEP plan is now posted on the Alliance website.	Qtr.1: Implement Health Equity Plan. Identify SMART Health Equity goals for each unit.	☑ Yes ☐ No	Health equity regulatory requirements continue to be defined by state and local regulators. Health Equity work will be integrated into all Alliance units with identified owners. Disparity identifications and data analysis will be captured by future health equity dashboard.
1. By the end of Q2 2026, create a workplan within APT to track all DMHC, DHCS, CMS Health Equity requirements. 2. By end of Q4 2026, ensure equity principles are embedded into strategic plans, regulatory compliance activities, and quality improvement efforts.	1. Assign each task to a business owner and include start and end dates. 2. Ensure all work plan elements are properly documented and reflect appropriate follow-up by each business owner. 3. Hold quarterly check-ins to review work plan entries with regular feedback provided to business owners when applicable. 4. Support each dept to develop their own Health Equity goals (PS, CM, UM, Grievance, etc.). by end of Q3 2026 5. Create a communication plan to ensure Health Equity work plan goals are distributed to Alliance wide staff by end of Q4 2026.	1/1/2026-9/30/2026 9/30/2026-12/31/2026	Andrea Swan, QIHETP Director Kate Nester, Community Health Integration Manager Vanessa Paz, Community Health Program Manager	Qtr.2:	Qtr.2:	Qtr.2:	☐ Yes ☐ No	

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SECTION 2: QUALITY OF CLINICAL CARE

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

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Close pediatric care gaps in Merced and Mariposa County to have all pediatric measures at or above MPL or have a 5% increase in the measure rate. • Child and Adolescent Well-Care Visits (WCV) • Childhood Immunizations - Combo 10 (CIS-10) • Immunizations for Adolescents - Combo 2 (IMA–2) • Lead Screening in Children (LSC) • Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6) • Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) • Developmental Screening in the First 3 years	1. Analyze data for Q4 2025. 2. Identify providers that need support to increase their rates. 3. Provide workforce care gap closure grants to providers with large member populations in Merced and Mariposa 4. Continue Provider Partnership program in Merced and Mariposa Counties to support providers in their interventions that focus on measures that are below MPL Q4. 5. Explore mobile unit use in rural areas	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor III Georgia Gordon, Quality Improvement Program Advisor II Jada Edwards, Quality Improvement Program Advisor II Juan Velarde, Quality Improvement & Health Equity Supervisor Annecy Majoros, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III Britta Vigurs, Quality Improvement Program Advisor III Cassie Russo, Quality Improvement & Health Equity Supervisor Daryl Ford, Quality Improvement Program Advisor III	Qtr.1: Analyzed 2025 data by provider, measure, and geographic area. Determined which measures, providers, and areas to focus on. Invited 8 providers across the 5 services area to participate in Provider Partnerships and 7 Providers in Merced and Mariposa to participate in Care Gap Grants. Assigned Practice Coaches to Providers. Practice Coaches held kick-off meetings and established charters, meeting cadence, and baseline data. Grant agreements are signed. WIC Immunization events held in Merced County & School based immunization events	Qtr.1: Provider and provider staff shortages impact appointment availability and provider efficiency. Limited availability of locum providers and lengthy recruitment processes where applicable. Vaccine Hesitancy and access affect vaccine rates. Increasing workload pressures for practices.	Qtr.1: Practice Coaching: Continue to meet with providers and provide monthly data. Lunch and Lean: Topics focusing on county needs and data trends. Care Gap Grant: Release grant funding & Care Gap Data with best practices. Member facing workshop for IZ and Well-Care Visits.	☑ Yes ☐ No	Things moving forward, good engagement with all our practices

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			Villyginn Morris, Quality Improvement Program Advisor II Pa Moua, Quality Improvement Program Advisor II					
2. Increase overall rates for Controlling Blood Pressure (CBP) and Comprehensive Diabetes Care: HgbA1c Poor Control >9% (GSD) by 5% or reach MPL from Q4 2025 to Q4 2026.	1. Develop a list of providers who are below MPL in either one or both measures (CBP & GSD) 2. Assign Practice Coaches and outreach to Providers 3. Begin practice coaching and implement best practices for these measures 4. Review rates and adjust interventions as needed	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Juan Velarde, Quality Improvement & Health Equity Supervisor Hugh Jones, Quality Improvement Program Advisor II Luz Hernandez, Quality Improvement Program Advisor II	Qtr.1: Using Q4 CBI data and March continuous enrollment data, practices were identified that fell below MPL. An outreach plan was developed in collaboration between the project lead, QPI manager, and CBI supervisor, which included assigning practice coaches to various practices. CCAH pharmacy staff was also brought into the project – determined that our coaches would mention PLAD in their outreach and include pharmacy in any scheduled meetings to discuss the program.	Qtr.1: Data used was based on Medi-Cal enrollment as D-SNP population is too limited to address currently. Reevaluation of DSNP population performance in GSD and CBP expected for end of 2026 when population is sufficient.	Qtr.1: Next steps for April include engaging practice coaches, educating them on elements of project, completing outreach to practices. The goal is to complete an initial meeting with practices during the month of May 2026.	☐ Yes ☑ No	Goal is ongoing.

CARE-BASED INCENTIVE (CBI) (KRISTEN ROHLF/CASSIE RUSSO)

Goals/Objectives for Calendar Year 2026	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. Decrease the total number of providers with 3 or more CBI measures below the 25th percentile via targeted campaigns offering education, support and practice coaching referrals by the end of CY2026. The goal is to have less providers with 3 or more measures below the 25th percentile.	2. The CBI team will generate a list of providers with 3 or more measures below the 25th percentile once 2025 Q4 rates have been finalized. 3. Analyze the list of providers' performance reports from Q4 2025 and develop a strategy to approach outreach assignments. 4. Outreach to targeted providers offering resources, CBI Forensic meetings, practice coaching referrals, and/or measure specific training (in-person or virtual). 5. Distribute the 2026 CBI Intro video directly to providers and incorporate a survey to evaluate effectiveness of materials presented in the video.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Cassie Russo, Quality Improvement & Health Equity Supervisor. Pa Moua, Quality Improvement Program Advisor II Villyginn Morris, Quality Improvement Program Advisor II Britta Vigurs, Quality Improvement Program Advisor III Jo Pirie, Quality Improvement Program Advisor III Daryl Ford, Quality Improvement Program Advisor III Annecy Majoros, Quality Improvement Program Advisor IV	Qtr.1: 1-2) The team is developing roles and responsibilities, and a project plan in the planned activities. In early April, we will have validated Q4 2025 data to pull from to identify which providers need targeted outreach. #3) The targeted outreach will begin in Q2. #4) The CBI intro video will be recorded, posted, and sent to providers in Q2 as well.	Qtr.1: No issues to report in Q1	Qtr.1: Continue to move forward in our project and begin outreach efforts to our target providers. Begin the work in recording, posting and distributing the CBI 2026 Intro video.	☐ Yes ☑ No	As of Q1, this goal or planned activities has not been completed. We anticipate full completion by end of calendar year 2026.

HEALTH EDUCATION (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2026	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

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1. Provide chronic disease management and wellness programs. A minimum of 4 member workshops will be provided per quarter.	1. The Health Educators will conduct a minimum of 4 member workshops per quarter. 2. Health Educators will lead recruitment and outreach efforts to members to enroll in the programs.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: A total of **10 member workshops** were completed in Q1. The following workshop modalities were completed: • 6 telephonic workshops • 3 virtual workshops • 1 in-person workshop in Merced	Qtr.1: No issues to report in Q1	Qtr.1: The project team will continue to schedule workshops in Q2.	☑ Yes ☐ No	There was a significant increase in the number of workshops provided in Q1 2026 compared to Q1 2025. A total of 10 workshops were completed compared to 4 completed last year in Q1 2025. This was due to staff cross training efforts in 2025.
2. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them.	1. The project team will conduct outreach and education activities to inform members of services available to them via: • Member outreach calls • Member newsletter articles • Sharing materials such as flyers • MSAG presentation • Social media and/or texting campaigns	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Kevin Lopez, Program Advisor – Quality and Health Programs Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: The following activities were completed in Q1 to inform members of Health and Wellness programs: • Member Newsletter: The project team included 1 article in the March 2026 Member Newsletter informing members of health and wellness programs available to them. • Member text campaign: A text message was sent out to members in Q1 to inform them of workshops available. The text linked to the Alliance website page where members can sign-up with the online form. • Online member sign-ups received: A total of 138 sign-ups were received in Q1 as a result of informing activities. • PCP referrals: A total of 74 PCP referrals were received in Q1. • MSAG: The project team provided 1 presentation on health education programs to the MSAG group on 2/12/26.	Qtr.1: No issues to report in Q1	Qtr.1: The project team will continue to conduct member informing activities quarterly in 2026.	☑ Yes ☐ No	Text message campaigns continue to successfully engage members and result in member online sign-ups. There was a 33% increase of member online sign-ups in Q1 2026 compared to last year Q1 2025.
3. On a bi-annual basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact. A minimum of 50 surveys will be collected annually.	1. The project team will conduct member satisfaction surveys to evaluate: • Information about the overall program • Usefulness of the information shared	1/01/2026 – 6/30/2026 7/01/2026 – 12/31/2026	Kevin Lopez, Program Advisor – Quality and Health Programs Veronica Lozano, Quality and Health Programs Supervisor	Qtr. 1: Updates will be provided in Q2 and Q4 from member surveys collected. Member survey responses are reported annually in the NCQA Population Needs Assessment evaluation and the NCQA	Qtr.1: No issues to report in Q1	Qtr.1: The project team will schedule surveys to be completed in Q2.	☐ Yes ☑ No	Evaluation will be completed in Q2.

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	• Percentage of members indicated that the program helped them achieve health goals. 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning health education activities.		Desirre Herrera, Quality and Health Programs Manager	Population Health Outcomes report.				

SECTION 3: SAFETY OF CLINICAL CARE

FACILITY SITE REVIEW (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2026	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. Complete 80% of primary care provider site reviews due in the quarter within three years of the prior review date, as measured through Facility Site Review tracking.	1. Maintain centralized tracking of FSR due dates, scheduling activity, and completion status. 2. Prioritize scheduling of primary care provider site reviews approaching the three-year review cycle. 3. Conduct site reviews using Department of Health Care Services audit tools and standards, for facility, medical record, and physical accessibility reviews performed by the FSR team. 4. Monitor site review completion rates through routine oversight and internal reporting.	01/01/2026 – 03/31/2026	Tisha Criswell, FSR Supervisor Joana Castaneda, Quality Improvement Program Advisor II Yvette Sullivan, Quality Improvement Nurse Aaron Varela, Quality Improvement Nurse	Qtr.1: In Q1 2026, 7 of 8 required primary care provider site reviews (87.5%) were completed within the required three-year review cycle, exceeding the 80% target. One site review (Yosemite Medical Clinic) was not completed within the required timeframe due to circumstances outside of plan control. The review was scheduled in advance for 12/5/2025, with a due date of 1/18/2026; however, severe weather delayed completion until 4/17/2026. All other site reviews were completed on time using DHCS audit tools and standards, including facility, medical record, and physical accessibility components. Centralized tracking mechanisms were maintained to monitor due	Qtr.1: External factors, such as severe weather, may affect the ability to complete scheduled site reviews within required timeframes despite planning. Limited flexibility in scheduling windows for certain geographic areas may also pose challenges.	Qtr.1: Continue proactive scheduling of site reviews in advance of due dates, with additional contingency planning for facilities in regions prone to environmental or access-related disruptions. Maintain centralized tracking and monitoring to ensure timely completion. Evaluate opportunities to build flexibility into scheduling processes where feasible.	☑ Yes ☐ No	The goal was met, with performance exceeding the 80% threshold. The delayed review was appropriately scheduled in advance and was impacted by uncontrollable external factors, indicating that internal processes are functioning effectively.

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				dates, scheduling, and completion status, which supported proactive scheduling and timely completion of reviews.				
2. Ensure that 100% of primary care providers issued corrective action plans submit them within the required regulatory timeframes, as measured by corrective action plan tracking.	1. Issue corrective action plan requirements in accordance with DHCS standards and established timelines. 2. Track corrective action plan submission and due dates using standardized monitoring tools. 3. Provide education and technical assistance to primary care providers to support timely and complete corrective action plan submissions. 4. Escalate overdue corrective action plans in accordance with established internal escalation protocols.	01/01/2026 – 03/31/2026	Tisha Criswell, FSR Supervisor Joana Castaneda, Quality Improvement Program Advisor II Yvette Sullivan, Quality Improvement Nurse Aaron Varela, Quality Improvement Nurse	Qtr.1: In Q1 2026, 100% compliance was achieved for the timely submission of corrective action plans. A total of 12 corrective action plans were issued, including 6 related to Facility Site Reviews and 6 related to Medical Record Reviews. All primary care providers submitted their corrective action plans within the required regulatory timeframes. Timely submission was supported through standardized tracking of due dates, ongoing monitoring, and proactive communication with providers. Education and technical assistance were provided as needed to ensure clarity of expectations and completeness of submissions.	Qtr.1: Providers may require clarification on corrective action plan expectations or timelines; however, no delays were observed in Q1 due to effective communication and follow-up processes.	Qtr.1: Continue monitoring corrective action plan submissions using standardized tracking tools. Maintain proactive outreach and education to providers to support timely and complete submissions. Sustain escalation processes for any future risk of non-compliance.	☑ Yes ☐ No	The goal was fully met, with 100% of corrective action plans submitted within required timeframes. Current tracking, communication, and support processes are effective and should be maintained to ensure continued compliance.

POTENTIAL QUALITY ISSUES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2026	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. Resolve 100% of member grievances related to PQIs within regulatory timeframes, as measured through grievance and PQI coordination tracking.	1. Maintain structured coordination with Grievances and Appeals to ensure timely identification of grievances requiring clinical quality-of-care review. 2. Track quality-of-care–related grievances through established PQI workflows to support timely review and resolution. 3. Monitor grievance resolution timeliness through routine oversight and reporting mechanisms. 4. Use grievance trend analysis, collaboration, and process improvement efforts to inform workflow refinement.	01/01/2026 – 03/31/2026	Emily Kaufman, Clinical Safety Supervisor Eleni Pappazisis, Quality Improvement Program Advisor III Naomi Kawabata, Senior Quality Improvement Nurse Katie Lutz, Senior Quality Improvement Nurse Sandy Clay, Senior Quality Improvement Nurse Karen de Leon, Quality Improvement Nurse Bethany Fung, Quality Improvement Nurse	Qtr.1: In Q1 2026, 100% of grievance-related PQIs (245 of 245) were completed within the required 30-day regulatory timeframe. This was achieved through structured coordination with Grievances and Appeals, ensuring timely identification and routing of cases requiring clinical quality-of-care review. Established PQI workflows supported efficient case progression, and routine monitoring of timeliness allowed for real-time oversight and issue resolution. Continued collaboration and process refinement helped maintain compliance despite high case volume.	Qtr.1: High and increasing grievance volume requires sustained coordination and workflow efficiency to maintain compliance.	Qtr.1: Continue close coordination with Grievances and Appeals to ensure timely case identification and routing. Maintain monitoring and reporting processes to sustain 100% compliance. Continue refining workflows to support efficiency and consistency.	☑ Yes ☐ No	The goal was fully met, with 100% compliance achieved. Current workflows, coordination, and oversight processes are effective in supporting the timely resolution of grievance-related PQIs.
2. Complete 80% of non-grievance PQIs within 120 calendar days, as measured through PQI timeliness monitoring.	1. Utilize standardized PQI case management workflows to support timely progression from intake through closure. 2. Strengthen management of non-grievance PQIs through routine oversight.	01/01/2026 – 03/31/2026	Emily Kaufman, Clinical Safety Supervisor Eleni Pappazisis, Quality Improvement Program Advisor III Naomi Kawabata, Senior Quality Improvement Nurse Katie Lutz, Senior Quality Improvement Nurse	Qtr.1: In Q1 2026, 29 of 32 non-grievance PQIs (approximately 91%) were completed within 120 calendar days, exceeding the 80% target. Timely completion was supported by standardized case management workflows, routine oversight of open cases, and ongoing efforts to identify and	Qtr.1: Significant and sustained growth in PQI volume throughout 2025 increased workload and impacted capacity. Grievance-related PQIs nearly doubled year-over-year, while non-grievance PQIs, which are often more complex (P2 and P3), require extended investigation,	Qtr.1: Continue routine review of open non-grievance PQIs to identify and address delays early. Maintain focus on timely case progression using standardized workflows and prioritization of aging cases. Support onboarding and	☑ Yes ☐ No	The goal was exceeded, with 91% of non-grievance PQIs completed within 120 days. Current workflows and oversight processes are

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	3. Conduct periodic review of open PQIs to identify and address barriers to timely completion. 4. Monitor PQI timeliness trends to support continuous process improvement. 5. Support workload capacity and timeliness through onboarding and integration of additional Quality Improvement Registered Nurse.		Sandy Clay, Senior Quality Improvement Nurse Karen de Leon, Quality Improvement Nurse Bethany Fung, Quality Improvement Nurse	address barriers to progression. Team coordination and prioritization of aging cases contributed to improved timeliness performance. Integration of additional staffing resources supported workload management and case throughput.	coordination, and follow-up. Even though the Q1 target was met, these underlying factors continue to present a risk to sustained performance. To maintain compliance with grievance-related PQI requirements, supervisory resources were leveraged for direct case processing, which limited capacity for broader oversight, trend analysis, and proactive quality improvement activities.	integration of additional staff to strengthen capacity and reduce reliance on supervisory case processing. Monitor PQI volume and complexity trends to adjust workload distribution and sustain performance proactively.		effective in supporting timeliness; however, sustained performance will depend on maintaining adequate staffing capacity and managing increasing case volume and complexity. Continued monitoring and resource alignment will be important to mitigate risk and support ongoing compliance.

LONG-TERM SUPPORT SERVICES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2026	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. Obtain 100% of required Quality Assurance and Performance Improvement (QAPI) program submissions from applicable LTSS facilities, as measured through LTSS oversight tracking.	1. Identify LTSS facilities subject to QAPI submission requirements. 2. Conduct outreach to request QAPI submissions and communicate submission expectations. 3. Track receipt of QAPI submissions and conduct follow-up as necessary. 4. Document submission status through routine LTSS oversight monitoring.	01/01/2026 – 03/31/2026	Tisha Criswell, FSR Supervisor Joana Castaneda, Quality Improvement Program Advisor II Yvette Sullivan, Quality Improvement Nurse Aaron Varela, Quality Improvement Nurse	Qtr.1: In Q1, LTSS oversight activities focused on establishing the foundation for full QAPI submission compliance. All 34 applicable facilities were identified and included in a structured outreach process. A mass communication was distributed outlining QAPI submission requirements, followed by individualized follow-up via calls and emails to ensure receipt and reinforce expectations. As a result of these efforts, 21 of 34 facilities (61%) submitted QAPI programs by the end of the quarter. Submission tracking was implemented and maintained through LTSS oversight monitoring tools, allowing for real-time visibility into facility status. Progress toward the goal reflects successful initial engagement and confirms that facilities are responsive to direct outreach and clear expectations.	Qtr.1: Incomplete baseline submissions from facilities indicate variability in awareness and readiness related to QAPI requirements. Some facilities required multiple follow-ups, suggesting inconsistent internal processes for QAPI program management.	Qtr.1: Continue targeted outreach to non-submitting facilities with increased frequency and escalation as needed. Engage the LTSS liaison to support escalation efforts for non-responsive facilities, including direct outreach and reinforcement of submission expectations. Refine tracking mechanisms to support prioritization of high-risk or non-responsive facilities. Begin integrating submission status with broader LTSS risk stratification to inform oversight focus.	☐ Yes ☑ No	Progress is on track for early-phase implementation. Achieving 61% submission in the first quarter demonstrates an effective outreach and engagement infrastructure. Continued follow-up and escalation strategies are expected to close remaining gaps and support achievement of the annual goal.
2. Ensure 50% of reviewed LTSS QAPI submissions include all five Quality Assurance and	1. Review submitted QAPI programs for inclusion of all CMS-required elements.	01/01/2026 – 03/31/2026	Tisha Criswell, FSR Supervisor	Qtr.1: In Q1, foundational infrastructure was developed to support standardized evaluation	Qtr.1: Lack of a standardized evaluation process prior to Q1 limited the ability to	Qtr.1: Expand review of submitted QAPI programs using the standardized	☐ Yes ☑ No	Q1 activities appropriately prioritized the

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Performance Improvement elements required by the Centers for Medicare and Medicaid Services, as measured through documented QAPI review.	2. Provide technical assistance to facilities requiring support to establish or strengthen QAPI programs. 3. Re-review revised submissions to confirm alignment with CMS requirements. 4. Monitor completion and compliance through documented follow-up and oversight.		Joana Castaneda, Quality Improvement Program Advisor II Yvette Sullivan, Quality Improvement Nurse Aaron Varela, Quality Improvement Nurse	of QAPI submissions against CMS requirements. A structured QAPI evaluation tool was created and implemented in SharePoint Online to capture review findings, specifically assessing inclusion of the five required CMS QAPI elements. Initial reviews have begun using this tool; however, full quantitative reporting is not yet available due to the tool's early implementation phase. Activities this quarter focused on building a consistent, auditable review process and initiating assessments of submitted QAPI programs. This work establishes the framework necessary to accurately measure compliance and identify facility-level gaps in subsequent quarters.	consistently assess QAPI program completeness against CMS requirements. Variability in submitted QAPI program structure and content is anticipated.	tool. Quantify the number of submissions meeting all five CMS elements. Initiate targeted technical assistance and feedback to facilities with identified gaps. Begin tracking improvement over time by re-reviewing updated submissions.		development of a standardized review and data capture process, which is critical for valid measurement of this goal. While outcome metrics are not yet available, the infrastructure established supports reliable evaluation and targets quality improvement efforts in Q2 and beyond.

GRIEVANCE & APPEALS REVIEW (SARAH SANDERS)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Meet regulatory requirements 98% of the time for timely acknowledgments and resolutions.	1. Monitor appeal and grievance (AG) inventory for daily, weekly and monthly oversight. 2. Ensure standard appeals and grievances are acknowledged within 5 days and resolutions occur within 30 calendar days.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor Ruth Zuniga, Grievance Supervisor	Qtr.1: Monitoring occurred to support timeframes and oversight. During Q1 achieved 99% with acknowledgment and 98% resolution due to AG leadership support and interventions.	Qtr.1: High volume	Qtr.1: Continue monitoring as heavy volume is likely to impact.	☑ Yes ☐ No	Met Q1 goal due to AG leadership support due to the ongoing heavy volume.
2. Monitor and maintain Appeal and Grievance (AG) rates below 2 per 1,000 members per month for Quality of Care (QOC) concerns; below 2 per 1,000 members per month for Quality of Service (QOS) concerns (NCQA standards)	1. Track and trend appeal and grievance data by both NCQA categories for Quality of Care (QOC) and Quality of Service (QOS) and Access issues. 2. Track appeal and grievances for emerging trends including system issues and document corrections.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor Ruth Zuniga, Grievance Supervisor	Qtr.1: Appeal and Grievance trends satisfied for MCAL LOB. Emerging trends documented.	Qtr.1: Monitor DSNP LOB for NCQA thresholds.	Qtr.1: Continue monitoring and tracking to identify any remediations needed.	☑ Yes ☐ No	Met Q1 goal by tracking and continuing the oversight workgroups.
3. Improve Appeal and Grievance (AG) data quality and reporting.	1. Identify reporting recalibrations, gaps and common data entry errors for corrections 2. Develop report for trending QOS levels to inform systemic issues, actions and repeat patterns.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor Ruth Zuniga, Grievance Supervisor	Qtr.1: QA continued to identify recalibrations. QOS trending report on development during Quarter 1.	Qtr.1: no previously identified issues	Qtr.1:	☑ Yes ☐ No	Met Q1 goal due to ongoing QA efforts and development of service trending report.
4. Improve monitoring and documented oversight	1. Document and monitor report of	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026	Sarah Sanders, Grievance and Quality Manager	Qtr.1: Monitoring of oversight activities continued.	Qtr.1: no previously identified issues	Qtr.1:	☑ Yes ☐ No	Met Q1 goal by tracking issues

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	oversight activities to improve transparency with oversight. 2. Develop automated reports with data analytics team to identify concerns.	7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Lee Xiong, Grievance Supervisor Ruth Zuniga, Grievance Supervisor	Initial development underway for additional automations with data analytics.				and documenting them in the oversight workgroups.

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SECTION 4: MEMBER EXPERIENCE

MEMBER SATISFACTION SURVEY – CAHPS (SARINA KING)								
Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start& end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Improve the measure How Well Doctors Communicate in Merced to be at the NCQA Quality Compass Benchmark or by 2 percentage points.	1. Lunch and Learns 2. Provider touchpoint meetings (Provider partnership, CBI forensics, EPT program. Merced Co. Provider Meeting, **Practice Coaching**, **DEIB Provider Training, Monthly Provider Office Hours**) 3. Promotion of Cultural and Linguistic Services. 4. Annual Review of Provider Satisfaction Survey for C&L Services. 5. Attend Member Services Advisory Group to get additional member feedback.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor III Jada Edwards, Quality Improvement Program Advisor II	Qtr. 1: Quarter 1 included analysis of MY2024 results, engaging departments on current and new interventions related to doctor's communication, a newly developed timeline for CAHPS intervention work spanning a 2-year cycle, as well as approval of work from Member Experience Committee and Operations Committee. • Lunch and Learns have been planned for each quarter of 2026. 4 total including pediatrics, access to care in rural communities, trauma informed care, and GSD. • 14 EPT sites, 8 PP sites, 1 PC site • Q1 Merced County Provider Meeting took place on 3/24. • Provider Office Hours held by PS began in January. • C&L Services advertised in March Member Newsletter and Provider Bulletin.	Qtr. 1: In-person member feedback at the Member Services Advisory Group continues to be limited with no representation from Merced County. Continued shortage of certified translators in provider offices – i.e. providers, nurses, MA staff.	Qtr. 1: Continue to maintain interdepartmental awareness and collaboration on CAHPS intervention planning.	☑ Yes ☐ No	Goal is on track. After system wide engagement of MY2024 results and intervention planning, next steps were approved by MEC. Ongoing interventions will continue to be tracked quarterly.

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2. Improve the measure Getting Needed Care in Merced to be at the NCQA Quality Compass or by 2 percentage points.	1. Medi-Cal Capacity Grant Program 2. Alternative Places of Medicine (Mobile Mammography, Immunization events, Sprinter, **Mariposa County Mobile Care**, Tri-County **Immunization Network**) 3. **Care Gap Incentive Implementation** 4. Non-Emergency and Non-Medical Transportation Services 5. Behavioral Health Incentives 6. Attend Member Services Advisory Group to get additional member feedback.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor III Jada Edwards, Quality Improvement Program Advisor II	Qtr. 1: Quarter 1 included analysis of MY2024 results, engaging departments on current and new interventions related to patient access, a newly developed timeline for CAHPS intervention work spanning a 2-year cycle, as well as approval of work from Member Experience Committee and Operations Committee. 7 practices involved in care gap grant totaling $943,108.00 in rewards. 9 events completed mobile mammography services. Engaged with Mariposa office of Ed. And grants team on mobile van discussion. Pending application.	Qtr. 1: In-person member feedback at the Member Services Advisory Group continues to be limited with no representation from Merced County. Continued shortage of care providers and specialists in rural counties along with retention.	Qtr.1: Continue to maintain interdepartmental awareness and collaboration on CAHPS intervention planning.	☑ Yes ☐ No	Goal is on track. After system wide engagement of MY2024 results and intervention planning, next steps were approved by MEC. Ongoing interventions will continue to be tracked quarterly.

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SECTION 4: QUALITY OF SERVICE

ACCESS & AVAILABILITY (AA) (JIM LYONS/ALISSA GIL)

Goals/Objectives for Calendar Year 2026	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. Monitor Timely Access to Care by ensuring timely access to needed high volume and high-risk specialties.	1. Conduct Quarterly Provider Appointment Monitoring Surveys	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Jim Lyons, Provider Relations Manager	Qtr. 1: Provider Appointment Monitoring Survey was conducted to Allergy & Immunology, Neurological Surgery, and Obstetrics/Gynecology providers.	Qtr. 1: It was found that Allergy & Immunology and OBGYN met the standard for average routine appointment and urgent appointment availability, while Neurological Services did not meet any of the standards. No surveyed provider types met the standard for 3rd available appointment timeframe.	Qtr. 1: Next steps include analyzing the survey results to evaluate network capacity and determine where additional recruitment opportunities lie as well where there are opportunities to provide additional educational opportunities regarding the Timely Access of Care standards within the network.	☑ Yes ☐ No	Provider appointment availability and access standards were reviewed and monitored to ensure compliance with regulatory and contractual requirements. Findings were tracked and follow-up activities were initiated as needed to address identified access concerns and support ongoing network adequacy.
2. Monitor Non-Contracted Letters of Agreements for areas of Provider Recruitment	1. On a quarterly basis monitor Letters of Agreement to ensure recruitment for new providers is done timely w/ access needs	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Alissa Gil, Network Development Manager	Qtr. 1: During Q1, we monitored Non-Contracted Letters of Agreement (LOAs) to identify gaps in network adequacy and access to care. LOAs were tracked by specialty and geography to highlight areas with limited contracted provider availability, helping to inform targeted recruitment efforts. Trends in LOA utilization were used to prioritize outreach and support	Qtr. 1: An issue identified in Q1 was that some LOAs were executed without first exploring an opportunity to contract with the provider. This limited our ability to strengthen the network long-term and highlighted the need for improved coordination between LOA processing and provider recruitment efforts.	Qtr. 1: Next steps include partnering closely with Finance, Contracts, and Credentialing to ensure Network Development is involved early in the LOA review process. This will allow for better oversight, create an opportunity to pursue contracting upfront, and help establish parameters around the	☑ Yes ☐ No	Timely access monitoring activities were completed during the review period. Provider appointment availability and access standards were reviewed and monitored to ensure compliance

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				network expansion in high-need areas.		duration of LOAs to support timely conversion of providers into fully contracted network participants.		with regulatory and contractual requirements. Findings were tracked and follow-up activities were initiated as needed to address identified access concerns and support ongoing network adequacy.

GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL/ALISSA GIL)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Semi-Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with DHCS Network Adequacy requirements.	1. Comply with DHCS Network Certification Annual Filing by Running ArcGIS geo access reports. 2. Monitor quarterly geo access reports	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Emily Ren,	Qtr. 2:	Qtr. 2:		☐ Yes ☐ No	
2. Comply with CMS Network Adequacy Requirements	1. Participating in CMS Triennial Network Adequacy Survey 2. Submit HSD Tables and any exception requests when needed.	1/01/2026 – 3/31/2026 – practice survey 4/01/2026 – 6/30/2026 – Triennial Survey	Alissa Gil, Network Development Manager Jessie Dybdahl, Provider Service Director	Qtr. 2:	Qtr. 2:		☐ Yes ☐ No	

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL/JIM LYONS)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Annual Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Improve Overall Provider Satisfaction by 2% for the 2026 Provider Satisfaction survey	1. Identify Trends in each county and build out quarterly plans for improvements. 2. Create a provider touch point map and share with internal staff to coordinate external provider communication	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Jim Lyons, Provider Relations Manager Jessie Dybdahl, Provider Service Director	Qtr. 4:	Qtr. 4:	Qtr. 4:	☐ Yes ☐ No	

TELEPHONE ACCESS (VERONICA OLIVARRIA)

Goals/Objectives for Calendar Year 2026	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.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026	Veronica Olivarria, Call Center Manager	Qtr. 1: The call center did not meet goal: 53.53% We experienced higher call volumes despite a decline in	Qtr. 1: Q1, Go live DSNP Total Care benefits that require staff to be available to respond to calls quickly. STARS	Qtr. 1: The Call Center hired 6 additional MSRs to support the call volume.	☐ Yes ☑ No	Call center metrics have steadily improved monthly. The support of additional staff has limited walk-in hours, and queue management have been a key

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	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 are adhering to Alliance updates and processes.
	• Developing additional call circles (queues) to:
	  • Optimize resource availability.
	  • Improve speed to answer.
	  • Reduce representative training time.
	  • Increase member satisfaction.
	• Computer Telephone Enhance HSP/FIVE 9 by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time spent on phone for the MSR and will make each call more efficient. Integration:
	• Assess staffing needs due to increased call volume and greater call complexity, resulting in longer average talk times.
		10/01/2026 – 12/31/2026		overall membership. In addition, calls are becoming more complex, resulting in longer handle times.
				
				Member walk-in volumes were also higher than expected, which further impacted performance.
				
				With the addition of DSNP/TC, we are also supporting the Sales queue and serving as overflow coverage, which has further contributed to the increased demand on the team.
				
				Utilize the Workforce Management Tool to coordinate staff schedules and ensure we are staff correctly during high peak times.
				
				Schedule meetings, training, huddles in smaller groups to maximize staff availability
					measure, prep and prepare for "Secret Shopper" calls.	We are reviewing current state to determine if we need to continue with limited member walk-in hours.		factor in supporting our caller's needs.
								
								Call Center Supervisors are focused on real time coaching, updating staff resources and mai ntaining maximum queue coverage throughout the day.

2. Call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Veronica Olivarria, Call Center Manager	Qtr. 1: Q1-The call center did not meet goal: 92.16% We experienced higher call volumes despite a decline in overall membership. In addition, calls are becoming more complex, resulting in longer handle times. Member walk-in volumes were also higher than expected, which further impacted performance. With the addition of DSNP/TC, we are also supporting the Sales queue and serving as overflow coverage, which has further	Qtr. 1: Go live DSNP Total Care benefits that require staff to be available to respond to calls quickly. STARS measure, prep and prepare for "Secret Shopper" calls.	Qtr. 1: The Call Center hired 6 additional MSRs to support the call volume. We are reviewing current state to determine if we need to continue with limited member walk-in hours	☐ Yes ☑ No	Call center metrics have steadily improved monthly. The support of additional staff has limited walk-in hours, and queue management have been a key factor in supporting our caller's needs. Call Center Supervisors are focused on real time coaching, updating staff resources and maintaining maximum que ue coverage throughout the day.

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				contributed to the increased demand on the team. Utilize the Workforce Management Tool to coordinate staff schedules and ensure we are staff correctly during high peak times. Schedule meetings, training, huddles in smaller groups to maximize staff availability				
3. New Member Welcome calls	1. The Call Center will contact and orient 30% of our new membership to: • Educate members on their benefits • Orient members to available services • Assign and connect members to a Primary Care Provider (PCP) • Offer a warm transfer to a provider when appropriate	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Veronica Olivarria, Call Center Manager	Qtr. 1: The call center did not meet goal: 6.87% We experienced higher call volumes despite a decline in overall membership. In addition, calls are becoming more complex, resulting in longer handle times. Member walk-in volumes were also higher than expected, which further impacted performance. With the addition of DSNP/TC, we are also supporting the Sales queue and serving as overflow coverage, which has further contributed to the increased demand on the team. Utilize the Workforce Management Tool to coordinate staff schedules and ensure we are staff correctly during high peak times.	Qtr. 1: Go live DSNP Total Care benefits that require staff to be available to respond to calls quickly. STARS measure, prep and prepare for "Secret Shopper" calls.	Qtr. 1: The Call Center hired 6 additional MSRs to support the call volume. We are reviewing current state to determine if we need to continue with limited member walk-in hours. Explore scheduling outbound calls toward the end of the week, as this is typically the least busy period. This may improve staff availability, increase successful member engagement, and support more efficient call outcomes.	☐ Yes ☑ No	Call center metrics have steadily improved monthly. The support of additional staff has limited walk-in hours, and queue management have been a key factor in supporting our caller's needs. Call Center Supervisors are focused on real time coaching, updating staff resources and maintaining maximum que coverage throughout the day.

CULTURE & LINGUISTICS (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2026	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Increase provider utilization of language assistance services quarterly by a minimum of 5% in comparison to 2025 baseline utilization data.	1. The project team will track utilization for the following services: • Phone interpreting services. • Face-to-Face (F2F) interpreting services • Virtual Remote Interpreting (VRI) 2. Use quarterly utilization data to identify potential need to training	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Ivonne Muñoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: Provider Utilization for Q1 was as follows: **Phone interpreting services:** There was a total of **9,887 total calls** in Q1 by provider sites. This reflects a **19% increase** compared to Q1 2025.	Qtr. 1: No issues to report in Q1.	Qtr. 1: The C&L team will continue informing providers of the services available and offer training and support services as requested.	☑ Yes ☐ No	There continues to be increases overall in utilization of language assistance services by providers.

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	provider network on language assistance services.			**In-Person and Virtual Remote Interpreting (VRI):** There was a total of **2,403 in-person interpreting services requests** in all service counties for Q1. This reflects a **38% increase** compared to Q1 2025. There was a total of **45 VRI requests** in Q1. This service was not available in Q1 2025 so there is no baseline to compare. VRI services started in Q3 2025. **Utilization trends:** **Monterey County** providers were the highest utilizers of in-person interpreter requests: • 1,067 Monterey County • 884 Santa Cruz County • 469 Merced County • 28 San Benito County • 0 Mariposa County **Merced County** providers were the highest utilizers of VRI requests: • 30 Merced County • 14 Monterey County • 1 Santa Cruz County • 0 San Benito County • 0 Mariposa County				The data trends show there are differences in utilization of in-person interpreting versus Virtual Remote Interpreting (VRI). Monterey and Santa Cruz County providers utilize in-person interpreting services more than the other counties. Merced and Monterey County providers utilize Virtual Remote Interpreting services more than other counties.
2. On a quarterly basis, inform members and/or providers of language assistance services utilizing at least 1 member and/or 1 provider informing modality.	1. The C&L team will conduct outreach and educational activities to inform members and providers of services available using the following options: • Member newsletter articles • Provider bulletins or provider digest • Sharing education materials such as flyers • MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning of C&L interventions.	1/01/2026 – 3/31/2026 4/01/2026 – 6/30/2026 7/01/2026 – 9/30/2026 10/01/2026 – 12/31/2026	Kevin Lopez, Program Advisor – Quality and Health Programs Ivonne Muñoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: The following activities were completed in Q1 to inform members of C&L Services: • **Member Newsletter:** The project team included 1 article in the March 2026 Member Newsletter informing members of language assistance services available to them. • **Provider Bulletin:** The project team included 1 article in March 2026 Provider Bulletin informing providers of language assistance services and how to access the services to support communication with members.	Qtr. 1: No issues to report in Q1.	Qtr. 1: The project team will continue to work on planning efforts to increase awareness of language assistance services to members and the provider network in 2026.	☑ Yes ☐ No	The project team has seen an increase in members calling the Health Education line to request interpreting services to be set up at their appointments. The project team developed an updated workflow to ensure follow up is completed with the provider, the member and documentation completed in Jiva. The team has been trained in the workflow in Q1 to ensure services are coordinated and

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								documented effectively.
3. On a bi-annual basis, collect member feedback on their experience with language assistance services in a clinical setting. A minimum of 50 surveys will be collected annually.	1. The project team will conduct satisfaction surveys with members to evaluate: • Individual ratings of access to language services. • Overall rating of interpretation services. • Access to language services at a health care encounter. • Gather individual experiences with the services. 2. Request input from members regarding programs and services. 3. Incorporate member feedback into planning and identifying areas of improvement for the services.	1/01/2026 – 6/30/2026 7/01/2026 – 12/31/2026	Kevin Lopez, Program Advisor – Quality and Health Programs Ivonne Muñoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 1: Updates will be provided in Q2 and Q4 from member surveys collected. Member survey responses are reported annually in the NCQA Health Equity CLAS evaluation report Member survey responses are reported annually in the NCQA Population Needs Assessment evaluation and the NCQA Health Equity CLAS evaluation report.	Qtr. 1: No issues to report in Q1.	Qtr. 1: The project team will schedule surveys to be completed in Q2	☐ Yes ☑ No	Evaluation will be completed in Q2.

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DATE: August 26, 2026

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 (QIHET) Program Description 2026, Amended

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Recommendation. Staff recommend the Board approve the Amended QIHET Program Description.

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

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

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

Discussion. The June 18, 2026 Quality Improvement Health Equity Committee reviewed and approved amendments to the **2026 Quality Improvement Health Equity Transformation Program (QIHETP) Description** to formally integrate the Alliance's **Health Equity Plan (HEP)** into the Quality Improvement Program framework required by DHCS. The amendments strengthen the organization's commitment to quality, population health, and health equity by establishing a formal structure for health equity planning, implementation, monitoring, and accountability.

- Key changes include:
- Integration of the **Health Equity Plan** into the QIHET Program structure.

- Inclusion of defined **health equity goals, priority populations, and targeted interventions** informed by Population Needs Assessment findings
- Establishment of a formal process for **tracking and monitoring health equity initiatives** and intervention outcomes.
- Enhanced alignment of quality improvement, population health management, and health equity activities across the organization.
- Support for the development of department-specific health equity goals, reporting structures, and future health equity performance monitoring.

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

Attachments.

1. QIHET Program Description 2026_Amended

Quality Improvement & Health Equity Transformation

Program Description

DRAFT:
QIHEC Committee Approval:
CCAH Board:

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INTRODUCTION

Central California Alliance for Health is contracted with the State of California Department of Health Care Services (DHCS) to serve as the local initiative in Santa Cruz, Monterey, Merced, San Benito, and Mariposa Counties for the Medi-Cal beneficiaries and the Medi-Cal Access Program (MCAP). The MCAP offers full scope health benefits for pregnant women who qualify for the program in the Alliance service areas.

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

MISSION, VISION, AND VALUES

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

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

STATEMENT OF PURPOSE

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

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

DEFINITION AND SCOPE

The QIHE Program is designed to monitor, evaluate, and take timely action to address necessary improvements in the quality of care delivered by all providers in any setting, and take appropriate action to improve Health Equity to improve all aspects of care to all CCAH members. It is comprehensive and addresses both the quality and safety of medical and

behavioral health care provided to our members and participants for all lines of business and health equity activities.

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

ANTI-DISCRIMINATION STATEMENT

Discrimination is against the law. Central California Alliance for Health (the Alliance) follows State and Federal civil rights laws. The Alliance does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. The Alliance provides: Free aids and services to people with disabilities to help them communicate better, such as: Qualified sign language interpreters. Written information in other formats (large print, audio, accessible electronic formats, other formats) Free language services to people whose primary language is not English, such as: Qualified interpreters Information written in other languages.

QUALITY AND HEALTH EQUITY INDICATORS

The Quality Improvement and Population Health Program includes an array of indicators to measure critical clinical processes and outcomes. The QIHEC Work Plan delineates the

critical performance measures that define the scope and range of the Quality Management Program. Components addressed include:

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

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

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

QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM GOALS

The goals of the QIHETP are:

- Promote an organization-wide commitment to quality of care and service through strong leadership involvement in improving quality.
- Link Strategic DHCS Quality Goals to CCAH's Strategic QI Objectives and performance improvement activities via quality improvement initiatives.
- Collaborate with CCAH health services departments to enhance continuity and coordination of care among behavioral healthcare and primary health care providers.
- Respond actively to customer expectations and patient feedback concerning the quality of patient care delivered and services provided.
- Improve the care and service delivered by our staff, network providers, and delegated entities.
    - Promoting member/patient safety as a high-level priority by minimizing patient and organizational risk of adverse occurrences.
    - Improving and enhancing the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and implementation of initiatives.
    - Promoting processes to ensure the availability of "safe, timely, effective, efficient, equitable, patient-centered care" and provide oversight within the network.
- Comply with legislative regulations, accreditation standards, and professional liability requirements.
- Ensure that medically necessary covered services are:
    - Available and accessible.
    - Provided in a culturally and linguistically appropriate manner.
    - Provided by qualified, competent practitioners and providers who are committed to CCAH's mission and vision.

- Promote collaborative relationships between CCAH, providers, delegates, and community partners.
- Promote and create condition specific health education and disease prevention materials that are age, culturally, and linguistically appropriate that encourages optimal health behaviors for members, participants, and staff.
- Ensure that members' protected health information (PHI) is protected, utilized, and released in accordance with state and federal law and regulation.
- Continue implementation of adequate computerized information management systems to support complete data entry, aggregation, display, analysis, and reporting needs for all quality management activities.
- Incorporate responsibilities for quality improvement into management performance standards.

QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM OBJECTIVES

The objectives of QIHE Program are:

- Align all organizational-wide performance improvement activities with strategic goals.
- Review the authority, responsibility, and information flow for the measurement, analysis, and improvement process and redefine as necessary.
- Ensure continued leadership and staff understanding of the tenets of quality/ performance management and improvement to be utilized by all teams.
- Charter and retain cross functional teams for each approved Strategic Quality Initiative, organization function, and/or prioritized improvement activity.
- Manage and improve the quality and safety of care provided to members, confirming compliance with the QI Program and applicable standards.
- Foster a supportive environment to ensure our practitioners and providers improve the safety of their professional practice through providing education.
- Identify actual or potential opportunities to decrease medical errors and /or improve patient safety through quality review, data collection, and risk factor analysis.
- Identify opportunities for patient care and service improvement, then implement and monitor interventions as appropriate.
- Establish priorities and outcomes for conducting focused review studies, emphasizing preventive services, high-volume low-performing practitioners/providers, and high-risk services.
- Promote outcome-driven and cost-effective care/health management programs, including preventive screening and health awareness, education, patient safety, and cultural and linguistic programs complementing QI interventions.
- Establish, maintain, and enforce policies, procedures, criteria, standards for:
    - Monitoring plan practitioner credentialing and recredentialing.
    - Confidentiality regarding member and practitioner/provider information.
    - Addressing conflict of interest staff and practitioners.
    - Resolution of actual or perceived member access or appeals and grievances.
- Establish quality standards and educate practitioners regarding performance expectations and provide compliance feedback.
- Communicate the QI process to both practitioners and members.
- Ensure availability, accessibility, delivery, coordination, support, and review as appropriate of:
- Continuity of care within the network, including effectiveness.
- Health education services.
- Cultural and linguistic services.
- Members with complex needs.
- Members with behavioral health needs.

- Establish medical and behavioral health standards reflecting current literature and benchmarks, design and implement strategies to improve compliance, and evaluate and monitor performance and adherence to guidelines.
- Identify, monitor, and address quality of care issues and trends affecting the healthcare and safety of members.
- Implement and monitor results of corrective actions and interventions; document practitioner/provider performance.
- Respond timely to address and resolve patient-specific issues.
- Assess the patient safety culture and develop the Patient Safety Program accordingly.
- Review and revise the organization wide Compliance Program as necessary.
- Demonstrate meaningful improvement in clinical and non-clinical care and services including behavioral health care.
- Reinforce Continuous Quality Improvement (CQI) principles through systematic monitoring of processes, data collection, qualitative and quantitative analysis of data, design of interventions for process improvement and determination of actual effectiveness of interventions.
- Evaluate current case management systems, identify care coordination issues for the organization, and design a patient-focused system that integrates care, case, quality, and utilization management.
- Demonstrate compliance with the quality improvement standards of regulators and accrediting organizations.
- Evaluate the Quality Improvement Program annually, modifying as necessary to achieve organizational effectiveness.
- Collaborate organizationally with the QIPH team to increase DHCS's Managed Care Accountability Set (MCAS) measures compliance rates. The above goals and objectives are tied to the QIHEC Work plan. Performance against these goals and objectives are continuously monitored to help determine if stakeholder expectations are met. The MCAS goals set forth by DHCS. Focus planning and interventions on measures included on the DHCS' four MCAS domains for the measurement year.

MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE STEWARD	MEASURE TYPE METHODOLOGY	HELD TO MPL[i]
Behavioral Health Domain Measures				
Follow-Up After ED Visit for Mental Illness – 30 days[*, iv]	FUM	NCQA	Administrative	Yes
Follow-Up After ED Visit for Substance Abuse – 30 days[*]	FUA	NCQA	Administrative	Yes
Children's Health Domain Measures				
Child and Adolescent Well – Care Visits[*]	WCV	NCQA	Administrative	Yes
Childhood Immunization Status – Combination 10[*]	CIS-10-E	NCQA	ECDS	Yes
Developmental Screening in the First Three Years of Life	DEV-CH	CMS	Administrative	Yes[iii]
Immunizations for Adolescents – Combination 2[*]	IMA-2-E	NCQA	ECDS	Yes

Lead Screening in Children	LSC	NCQA	Hybrid/Admin**	Yes
Topical Fluoride for Children	TFL-CH	DQA	Administrative	Yes[iii]
Well-Child Visits in the First 30 Months of Life – 0 to 15 Months – Six or More Well-Child Visits*	W30-6+	NCQA	Administrative	Yes
Well-Child Visits in the First 30 Months of Life – 15 to 30 Months – Two or More Well-Child Visits*	W30-2+	NCQA	Administrative	Yes
Chronic Disease Management Domain Measures				
Asthma Medication Ratio*	AMR	NCQA	Administrative	Yes
Controlling High Blood Pressure*, [iv]	CBP	NCQA	Hybrid/Admin**	Yes
Glycemic Status Assessment for Patients with Diabetes (>9%)*, [iv]	GSD	NCQA	Hybrid/Admin**	Yes
Reproductive Health Domain Measures				
Chlamydia Screening in Women	CHL	NCQA	Administrative	Yes
Prenatal and Postpartum Care: Postpartum Care*	PPC-Pst	NCQA	Hybrid/Admin**	Yes
Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	NCQA	Hybrid/Admin**	Yes
Cancer Prevention Domain Measures				
Breast Cancer Screening*	BCS-E	NCQA	ECDS	Yes
Cervical Cancer Screening	CCS-E	NCQA	ECDS	Yes
Report Only Measures to DHCS				
Adults' Access to Preventive/Ambulatory Health Services[iv]	AAP	NCQA	Administrative	No
Colorectal Cancer Screening*	COL-E	NCQA	ECDS	No^^
Depression Remission or Response for Adolescents and Adults	DRR-E	NCQA	ECDS	No^^
Depression Screening and Follow-Up for Adolescents and Adults*	DSF-E	NCQA	ECDS	No^^
Low-Risk Cesarean Delivery*	LRCD	CMS	Administrative	No[iii]
Pharmacotherapy for Opioid Use Disorder*	POD	NCQA	Administrative	No^^

Plan All-Cause Readmissions[*,ii,iv]	PCR	NCQA	Administrative	No
Postpartum Depression Screening and Follow Up	PDS-E	NCQA	ECDS	No^^
Prenatal Depression Screening and Follow Up	PND-E	NCQA	ECDS	No^^
Prenatal Immunization Status	PRS-E	NCQA	ECDS	No^^
LTC Report Only to DHCS				
Number of Out-patient ED Visits per 1,000 Long Stay Resident Days[*, iv]	HFS	CMS#	Administrative^	No^^
Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization[*, iv]	SNF HAI	CMS#	Administrative^	No^^
Potentially Preventable 30-day Post-Discharge Readmission[*, iv]	PPR	CMS#	Administrative^	No[iii]

i MCPs held to the MPL for the HEDIS© total rates only; the National Committee for Quality Assurance (NCQA) Quality Compass© Medicaid HMO 50th and 90th percentiles represent the MPLs and high-performance levels (HPLs), respectively. MCPs will only be held to the MPL for historically established benchmarks.
ii Stratified by Seniors and Persons with Disabilities (SPDs)
iii CMS calculated national median is considered the MPL.
iv Stratified by Dual eligible Members

ECDS: Electronic Clinical Data Systems (electronic reporting method for certain HEDIS measures)
* Measures must be stratified by race/ethnicity per NCQA categorizations.
** Hybrid/Admin: MCPs/PSPs have the option to choose the methodology for reporting applicable measure rates
# CMS modified measures to reflect Medi-Cal and dual data sources
^ Measures to be calculated at the facility level for each MCP that can be aggregated to the plan level
^^ Measure possibly held to MPL in the future

Integration of QI and MOC
The D-SNP Model of Care (MOC) is integrated with the organization's Quality Improvement Transformation Program (QIHETP) where applicable. MOC elements within the scope of the current QIHETP program are subject to established QI processes for measurement, monitoring, and evaluation through the organization's QI infrastructure and performance improvement activities. MOC components that fall outside the scope of the QIHETP program are managed through other operational and governance processes and are reported through established oversight structures. Collectively, these mechanisms provide enterprise-level visibility into MOC implementation and outcomes, supporting ongoing evaluation and continuous improvement to achieve the goals of the MOC for the D-SNP population.

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

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

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

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

Plan-Do-Study- -Act (PDSA)

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

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

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

SWOT Analysis

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

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

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

Performance Improvement Projects (PIPs)

A Performance Improvement Project (PIP) is an approach being utilized by CCAH to the continuous study and improvement of the processes of delivering healthcare services to meet the needs of its members. A PIP's main purpose is to impact healthcare delivery and outcomes of care. It involves a concentrated effort on a particular area of concern affecting our members. The goal of this methodology can be to enhance and improve the outcomes of care, to ensure member safety, to increase efficiency of member care and related processes, to reduce costs and to reduce risks and liability. For such projects to achieve real improvements in care, and to ensure confidence in reported improvements, CCAH PIPs are designed, conducted, and reported in a methodologically sound manner that meets all state and federal requirements. CCAH works with Health Services Advisory Group (HSAG) in

the validation of its PIPs, according to CMS' EQR protocol. PIPs are also made in accordance with 42 CFR §438.330, that requires Managed Care Plans (MCPs) to have a quality program that includes at a minimum, two ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction, focuses on clinical and/or nonclinical areas that involve the following:

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

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

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

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

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

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

Performance Goal Methodology

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

A. Data Collection

Performance data for measures are collected, aggregated, and presented to the QIHEW and QIHEC Committees for review and recommendations at least four (4) times a year. Multiple data points are displayed together on graphs to show historical

performance and facilitate data analysis and trending. Every qualitative and quantitative analysis includes evaluating the effectiveness of previous interventions. This part of the analysis influences the next step in planning. The entire process is conducted as close in time as possible to the events being measured. Interventions are planned and implemented based on the data analysis.

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

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

B. Data Resources

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

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

Analytical Resources

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

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

Evaluation of Effectiveness of Interventions

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

NCQA ACCREDITATION

Over the past several years, the Alliance has been diligently committed to responding to the 2024 DHCS contract that requires health plans to achieve Health Plan Accreditation (HPA) and Health Equity Accreditation (HEA) from the National Committee for Quality Assurance (NCQA) standards. This effort reflects our organization's dedication to improving the

quality of care, promoting equitable health outcomes, and ensuring the highest level of compliance and operational excellence.

The Alliance launched a comprehensive accreditation readiness initiative focused on meeting all health plan and health equity requirements listed in the standards. This multi-departmental effort included systematic internal reviews, gap analyses, process improvements, policy and procedure updates, and targeted staff education and training. Throughout 2023 and 2024, teams across Utilization Management, Quality Improvement, Population Health Management, Credentialing, Provider Network, and Member Service teams worked collaboratively to align organizational practices with NCQA rigors standards.

By 2025, the Alliance completed the full submission of accreditation materials for both programs to NCQA. The Alliance successfully participated in providing NCQA with a collection of internal documentation that details and describes our compliances with the NCQA Standards. Selected departments successfully participated in a live on-site file review for Health Plan Accreditation, conducted by the NCQA survey team. This review confirmed that our documentation and operational practices met or exceeded NCQA's national benchmarks and metrics.

As a result of this collective effort and documentation evidence, the Alliance was awarded both Health Plan and Health Equity Accreditations. These recognitions will be valid through the 2028 survey renewal. At that time, we will undergo a full renewal survey for both Health Plan and Health Equity Accreditation renewal surveys. The Alliance remains dedicated to maintaining compliance with the NCQA standards within our operations, sustaining improvement initiatives and advancing health outcomes for all those we serve.

HEALTH EQUITY ORGANIZATIONAL INTEGRATION
QIHETP will now work to embed equity principles across all strategies, in partnership with all divisions, as well as our external stakeholders, addressing systemic barriers to care and tracking progress toward reducing disparities in outcome. Health Equity will live within each of our units across the organization.

Health Equity Program Objectives

I. Purpose and Scope
The Central California Alliance for Health ("the Alliance") Quality Improvement & Health Equity Plan (QIHEP) is designed to advance health equity by identifying and addressing disparities in access, quality, and health outcomes among our members. QIHEP supports initiatives that improve care, remove barriers, and promote the well-being of populations experiencing inequities. This QIHEP applies to all members served by the Alliance, including our Medi-Cal population, and covers clinical programs, community-based interventions, population health management, and organizational governance aimed at reducing health disparities. QIHEP is integrated across all internal programs and processes and aligns with the corresponding regulatory requirements. The QIHEP incorporates data-driven strategies, including analysis of our Population Needs Assessment (PNA), HEDIS rates, and MCAS measures, to identify gaps and inform disparity reduction activities. The QIHEP establishes accountability through assigned owners, measurable outcomes, and ongoing monitoring to ensure continuous improvement in health equity across both organizational operations and member-facing programs.

II. Mission

The Alliance is committed to advancing health equity in alignment with the Department of Health Care Services (DHCS) requirements by identifying and addressing disparities in access, quality, and health outcomes among its members. Through its QIHEP, the Alliance utilizes robust data collection, stratification, and analysis to identify priority populations and inequities across key measures. The Alliance implements targeted, evidence-based interventions, including Enhanced Care Management (ECM), Community Supports, Population Health Management, and HEDIS-driven quality improvement efforts—to reduce disparities and improve outcomes for populations experiencing inequities.

These efforts are supported by a comprehensive evaluation framework that ensures ongoing monitoring, measurement, and continuous quality improvement to track progress toward equitable outcomes. At the organizational level, the Alliance has embedded health equity into its governance structure, strategic priorities, and accountability mechanisms, ensuring leadership oversight and cross-departmental alignment in advancing equity goals.

The Alliance partners with providers, community-based organizations, and members to deliver culturally and linguistically appropriate services, remove barriers to care, and ensure equitable access to high-quality services. Through sustained collaboration and a person-centered approach, the Alliance strives to provide members with the opportunity to achieve optimal health outcomes in a manner that is equitable, inclusive, and responsive to community needs.

III. Guiding Principles

1) Equity-Centered Approach. The Alliance prioritizes the identification and elimination of disparities in access, care, and outcomes, ensuring resources and interventions are directed to populations with the greatest need.

2) Population Data Review and Analysis. Annual data review and gap analysis are done via the Population Needs Assessment (PNA), evaluate disparities at the intersection of race, ethnicity, and social drivers of health, and identify significant inequities affecting Black, Hispanic, and other disproportionately impacted communities within Alliance counties. Data informs all programmatic and operational decisions to ensure interventions are targeted and evidence based.

3) Development and Implementation of Disparity Reduction Activities. The Alliance designs and executes targeted strategies to mitigate inequities in chronic disease prevalence, healthcare access, and other health outcomes across priority populations. These activities are monitored and adjusted based on measurable outcomes and impact to ensure continuous progress toward reducing disparities.

4) Community Partnership and Engagement. We collaborate with members, providers, community-based organizations, and regional stakeholders to co-design solutions that reflect the needs, strengths, and voices of the communities we serve. Member feedback is incorporated into internal policies and programs, and health equity goals and outcomes are shared with QIHEW, QIHEC, and Member Experience Committees.

5) Culturally and Linguistically Responsive Care. The Alliance promotes services that are respectful of and responsive to diverse cultural, linguistic, and accessibility needs to improve member experience and outcomes.

6) Accountability and Continuous Improvement. The Alliance establishes clear goals, performance measures (including HEDIS), and evaluation processes to ensure ongoing monitoring, transparency, and continuous quality improvement of disparity reduction efforts.

7) Organizational Commitment & Integration. The Alliance embeds health equity across all internal programs, projects, and operational processes to ensure alignment with regulatory guidelines, state, and federal requirements. Program-specific health equity goals, measurable indicators, and assigned owners support accountability and transparency. Quarterly check-ins review work plan entries, provide regular feedback, and ensure health equity is integrated across internal operations and member-facing programs.

IV. Embedding Health Equity Across Alliance Programs and Processes

The Alliance is embedding health equity activities into all programs and processes through our newly established Community Health Integration (CHI) Unit. CHI staff play a critical role in translating strategy into actionable initiatives, aligning regulatory requirements with operational processes, and ensuring that population health, quality improvement, and health equity efforts are fully integrated across the organization. These activities include tracking progress toward measurable goals and monitoring outcomes to assess the impact of health equity integration. By embedding health equity throughout all workspaces—rather than concentrating responsibility within a single team—the Alliance fosters cohesion, collaboration, and accountability across all operational and programmatic workflows.

Key strategic integration activities include:

1) Operational Integration. Aligning health equity initiatives with regulatory requirements, organizational processes, and all program workflows.

2) Data-Driven Monitoring. Tracking measurable goals, monitoring outcomes, and evaluating the impact of health equity integration across programs.

3) Population Health Alignment. Ensuring that population health, quality improvement, and health equity initiatives are coordinated and mutually reinforcing.

4) Cross-departmental Collaboration. Promoting organizational-wide responsibility for health equity rather than concentrating within a single team, fostering cohesion and collaboration across all Alliance workspaces.

5) Continuous Improvement. Using regular check-ins, feedback loops, and performance metrics to refine health equity strategies and operational processes.

6) Member & Community Engagement. Incorporating member feedback and community insights into internal policies, programs, and equity-focused initiatives.

To operationalize this integration and ensure accountability across the organization, the Alliance has developed a Health Equity Program Workplan. This workplan translates strategy into actionable activities, embeds equity principles throughout all programs and processes, and provides measurable goals, assigned ownership, and structured monitoring. The following activities represent the key areas of focus to advance health equity across organizational operations, policy, programs, and data-driven initiatives.

Activity 1: Annual Health Equity Workplan

- Develop and execute a consolidated annual workplan capturing ongoing health equity activities.
- Align with all applicable DHCS, DMHC, CMS, and NCQA requirements.

- Use the workplan as a tool to monitor progress, identify gaps, and streamline collaborative efforts across departments.

Activity 2: Embedding Equity in Strategic and Operational Goals
- Integrate health equity principles into strategic plans, regulatory compliance activities, and quality improvement efforts.
- Support departments in setting specific health equity goals aligned with the organizational QIHETP program, ensuring coordinated integration of quality, population health, and health equity principles across the Alliance.

Activity 3: Policy and Program Integration
- Incorporate equity principles into Alliance policies and programs.
- Integrate member and community feedback into policy development to ensure relevance and responsiveness to community needs.

Activity 4: Accountability and Process Ownership
- Assign processes and owners to all policies and regulatory guidelines to ensure true organizational integration of health equity.
- Promote transparency and accountability across all programs and departments.

Activity 5: Data Stratification and Monitoring
- Build a regulatory data repository and dashboard to track disparities and monitor progress over time, aligned with MCAS metrics.
- Catalog and integrate existing reports to inform interventions, support decision-making, and guide continuous improvement through oversight by QIHEC, QIHEW, and Member Experience Committees.

VI. Population Disparity Analysis and Identification of Priority Disparities

Findings from the PNA highlight areas of success as well as opportunities for improvement, including geographic disparities, particularly within Merced County. Multiple internal and external data sources are leveraged to provide a holistic view of member needs. These insights inform the Alliance's Quality Strategy, supporting targeted initiatives, resources, and interventions aimed at reducing health disparities. Categories of analysis include:

1) Areas of success and effective interventions.

2) Gaps in access, quality of care, and outcomes among vulnerable populations.

3) Differences in health outcomes and service utilization are associated with race, ethnicity, language, disability status, and geography.

Based on these findings, the Alliance has identified key disparities to target through its Health Equity Program, focusing on populations where interventions can have the greatest impact:

1) Seniors and Persons with Disabilities (SPD). Disparities in access to preventive care, chronic disease management, and care coordination.

2) Children with Special Healthcare Needs. Gaps in care management, care plan adherence, and access to specialty services.

3) Members with Limited English Proficiency (LEP). Barriers to communication, culturally and linguistically appropriate services, and health education.

4) Racial and Ethnic Minority Populations (e.g., Black and Hispanic members). Higher prevalence of chronic conditions, service utilization gaps, and social determinant-related health inequities.

5) Geographic Disparities. Specific focus on populations in Merced County experiencing higher rates of health disparities across multiple conditions and services.

These priority disparities directly inform the Alliance's Health Equity Workplan, guiding targeted interventions, measurable goals, and program development. This integrated approach ensures that data-driven insights translate into actionable strategies, aligning all operational, clinical, and community-facing activities with the goal of reducing health inequities.

VII. Targeted Health Equity Interventions

Building on the identification of priority disparities and the Health Equity Program Workplan, the Alliance implements targeted interventions designed to reduce inequities and improve health outcomes for specific populations. These interventions focus on outreach, support, and resources to increase access to care, reduce avoidable emergency department visits, and address social and cultural barriers. Programs are designed to meet the needs of identified subpopulations across all counties served.

Key intervention strategies include:

1) Community Reinvestment Grants. Support community-based initiatives to address local health needs and disparities.

2) Provider Population Analysis. Analysis of the Alliance's provider network to assess the composition and cultural competency of providers relative to the populations we serve, ensuring equitable access and culturally responsive care.

3) Equity Training Programs. Provide training on DEI, Trauma-Informed Care (TGI), Cultural and Linguistic Competency, and Behavioral Health equity.

4) Community Engagement and Partner Collaboration. Strengthen partnerships and networking with community organizations and stakeholders.

5) HEDIS and CAHPS Rates Review and Analysis. Monitor quality metrics and member experience to guide interventions.

6) Care Management Programs. Targeted support for high-need members, including chronic disease management and care coordination.

7) Enhanced Care Management (ECM) and Community Supports (CS) Programs. Deliver integrated, member-centered services to address medical, behavioral, and social needs in alignment with health equity priorities.

8) Insourced Behavioral Health (BH) Services. Manage member BH needs internally to provide coordinated care, reduce access barriers, and ensure culturally competent interventions.

9) Health Programs. Disease prevention, wellness promotion, and chronic condition support initiatives.

10) Equity and Practice Transformation (EPT) Program. Support clinical practices integrating health equity into care delivery.

11) Member Outreach. Direct engagement to connect members with resources and services.

12) Population Needs Assessment (PNA). Ongoing analysis of member health needs to inform intervention planning.

13) NCQA Health Equity Accreditation Activities. Culturally and linguistically appropriate services to meet accreditation standards.

14) Health Outcomes and Survey. Tracking member-reported outcomes to identify areas for improvement.

15) Pilot Programs. Innovative approaches to improve access and outcomes.

16) Annual and Quarterly Data Reporting. Review of disparities, data, and program performance to guide continuous improvement.

17) Clinical Safety and Facility Site Reviews. Ensure quality and equity in care delivery environments.

VIII. Advancing Health Equity Across the Alliance

The Alliance is committed to embedding health equity across all aspects of its operations, programs, and services. From the identification of population disparities to the development of targeted interventions, the Alliance integrates a comprehensive, data-informed approach that addresses the needs of its most vulnerable and underserved members.

Through the work of the Quality Improvement and Health Equity teams, and in collaboration across all Alliance departments, staff weave health equity principles into strategic planning, policy development, care management, community engagement, and quality improvement efforts. Priority disparities identified through the Population Needs Assessment (PNA) and other data sources guide targeted interventions designed to improve access, outcomes, and culturally competent care for members across all counties served.

The Alliance's robust health equity efforts include initiatives such as Enhanced Care Management, Community Supports, insourced behavioral health services, provider population analysis, and equity-focused training. Together, these interventions are designed to reduce inequities, improve health outcomes, and advance organizational accountability and transparency.

This comprehensive approach demonstrates the Alliance's ongoing commitment to systematically addressing health disparities, fostering inclusion, and promoting equitable health outcomes. The Alliance strives to serve all members with fairness, quality, and culturally responsive care. By integrating the QIHEP with work plan activities, targeted interventions, and cross-departmental collaboration, the Alliance ensures that health equity is not a standalone effort, but a core component of its mission to provide accessible, quality health care guided by local innovation.

CULTURAL AND LINGUISTIC (C&L) PROGRAM

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

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

The C&L needs of our members are identified through membership data reporting; this report identifies ethnicity, gender, age, and language preference. CCAH relies on membership characteristic data distributed by the Department of Health Care Services (DHCS) to aid in the assessment of characteristics and needs of our member population. The threshold language as determined by DHCS is based on reported members' demographics. English and Spanish are threshold languages for the counties of Merced, Monterey, San Benito, and Santa Cruz. Merced County has English and Spanish as threshold languages and Hmong as a concentration language. Mariposa county has English as the only threshold language. In order to meet member's linguistic needs CCAH provides interpretation and translation services to our members at no cost.

The objectives of the C&L program are to:

- Ensure members with limited English proficiency (LEP) have meaningful access to language assistance services at all key points of contact with the health plan and while accessing health plan services.
- Ensure our providers and staff can integrate culturally and linguistically appropriate services into daily activities and continuously provide quality care to our members.
- Provide staff and providers with information through training to support culturally competent communication and services.
- Ensure the Alliance Community Advisory Committee (CAC) includes participation from members of diverse cultural and ethnic backgrounds, Seniors, and Persons with Disabilities (SPDs), Limited English Proficient (LEP) members and members with chronic health conditions to better understand the needs of the community we serve. The Alliance CAC is the Member Services Advisory Group (MSAG).
- Identify and analyze health disparities in our membership population.
- Ensure that outreach and health education materials for members are reviewed for readability, suitability and translated to threshold and concentration languages.

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

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

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

Objectives for serving members with complex health needs are to:

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

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

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

The health education program serves the following purposes:

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

Care Management Support

- Support Social Work, Case Management, and Disease Management programs by way of educational materials, CCAH Health Education programs, and outreach connection to community resources.

Member Communications and Health Messages

- Member Bulletin
- Provider Bulletin
- Benefit and Health Promotion on the Alliance's social media pages
- Messaging on the Alliance's website and monthly key messages on the website's home page
- Provider Digest
- The Beat (community newsletter)
- SMS Member Text messages
- Paid media campaign**s**
- The Quality and Health Programs team provides oversight with a Qualified Health Educator to support creating and reviewing health education messages and materials.

BEHAVIORAL HEALTH

As of July 1, 2025, CCAH manages the Non-Specialty Mental Health Services (NSMHS) benefit for Medi-Cal members and provides the full array of behavioral health services, including substance use disorder (SUD) services and specialty services for the IHSS line of business. CCAH also supports members needing Behavioral Health Treatment or Applied Behavioral Analysis services, such as, but not limited to those with a diagnosis of autism or pervasive developmental disorder through our Utilization Management (UM) team of Board-Certified Behavior Analysts (BCBAs). CCAH has a large network of providers to manage these members. In addition, we maintain a robust telehealth network to assist and ensure adequate members' access to necessary services.

CCAH provides behavioral health services for members with mild and moderate functional impairment for Medi-Cal. The services for members with severe impairment are carved out to the County Behavioral Health Services Agencies. CCAH works closely with all five county partners through executed Memorandums of Understanding (MOUs), to coordinate member care, including sending and receiving referrals and transitions of care.

CCAH has a dedicated Behavioral Health Case Management team, comprised of care coordinators and licensed clinical care managers, that provide linkage, referral, care coordination and ongoing care management, as necessary.

Prior to July 1, 2025, this benefit was managed by Carelon Behavioral Health of California, as our previous Managed Behavioral Health Organization (MBHO). All previously delegated activities are managed internally at CCAH and integrated among existing departments.

Through the Behavioral Health Department at CCAH, in coordination with other applicable departments, such as QI and Care management, ongoing assessment, monitoring, and improvement occur to assess care and services for members that access the behavioral health benefit. The diverse populations served represent multiple cultural and linguistic groups, and includes pediatric, adult, and geriatric individuals with mental health and substance use disorders, as well as individuals with developmental disabilities and other special needs across our service areas.

CCAH Behavioral Health Medical Director is the designated Behavioral health practitioner who is a licensed Medical Doctor who participates in the Alliance Quality Improvement Health Equity Committee helping to review behavioral health initiatives and activities.

Behavioral Health Initiative

CCAH QIPH department continuously works on increasing HEDIS compliance rates which also includes meeting the Medi-Cal Managed Care Accountability Set (MCAS) goals set forth by DHCS. Through internal quarterly meetings through the QIHEW and MCAS workgroup, applicable departments collaborate to help develop any areas that can help the network providers improve the compliance for these measures.

The following behavioral health measures are being focused on:

- **.**
- **FUA/FUM (Follow-Up After ED Visit for Substance Use** -30 days/ **Follow-Up After ED Visit for Mental Illness** -30 days)
- **FUH (IHSS LOB)-part of HEDIS set and adult measure.**
- **Depression Screening**

ORGANIZATIONAL STRUCTURE

CCAH's organizational structure is the framework for QIHETP activities. The Quality Improvement and Population Health Department is a multi-faceted department with multiple functional areas, and programs.

Accountability

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

1. Annual review and approval of the QIHETP and applicable QIHETP reports
   - Appointment of an accountable entity or entities to provide oversight of the QIHETP.
   - Routine review of written progress reports from the QIHEC
   - Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and DHCS Comprehensive Quality Strategy.
   - The Alliance Board has delegated direct supervision, coordination, and oversight of the QIHETP by the Quality Improvement Health Equity Committee (QIHEC), with the Chief Executive Officer (CEO) and Alliance Quality Improvement and Population Health (QIPH) Department under the supervision of the Chief Medical Officer (CMO) in collaboration with the Health Equity Officer or designee. The CMO regularly provides QIHETP operational reports to the Alliance Board.

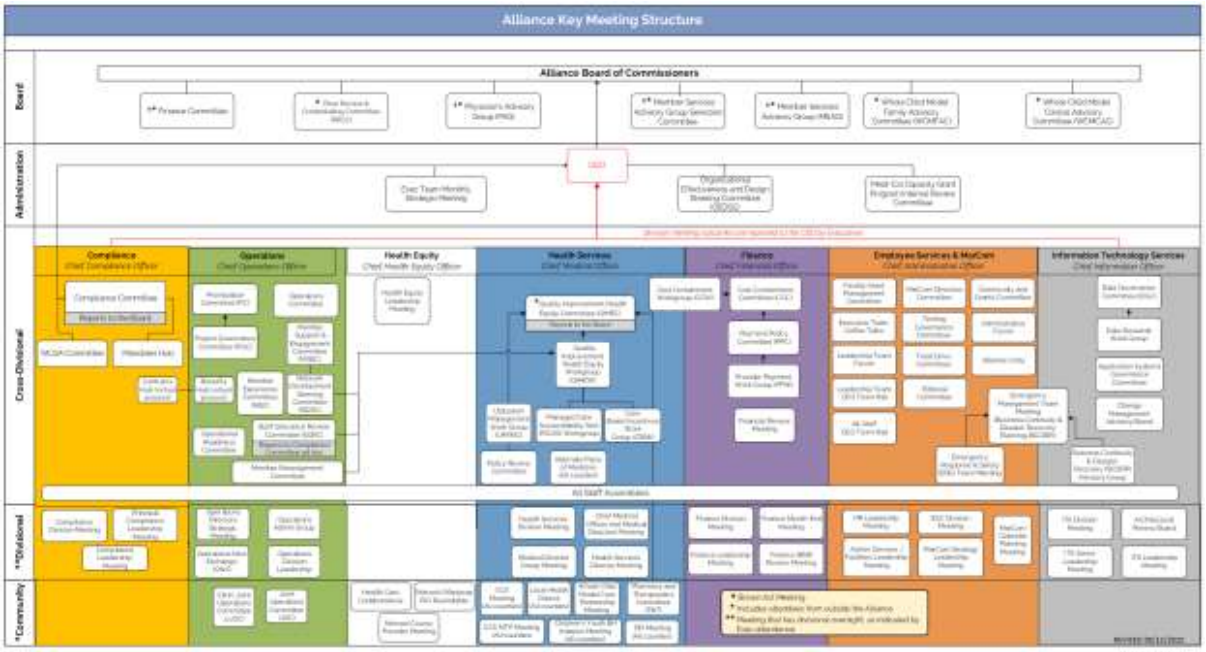
The Board assigns the authority and responsibility to implement the Quality Improvement Health Equity Transformation Program to the Chief Medical Officer who chairs the QIHEC

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

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

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

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



Key Personnel

Chief Medical Officer (MD)

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

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

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

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

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

- professional medical community and maintains and enhances communications with similar Health Plan organizations. Providing clinical leadership for medical decisions regarding hospital Concurrent Review on

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

Community Health Integration Manager

- Leads the Community Health Unit, overseeing the alignment and integration of strategic initiatives across Population Health Management, Quality Improvement, and Health Equity.
- Translates regulatory guidance and organizational priorities into actionable workflows, operational strategies, and program plans.

- Supervises the Health Equity Program Manager, Senior Program Development Analyst, and Program Development Analyst, providing guidance, support, and performance oversight.
- Leads cross-functional project teams to implement initiatives and track outcomes, ensuring alignment with regulatory, contractual, and organizational requirements.
- Drives process standardization, continuous improvement, and integration of equity principles across programs.

Community Health Program Manager

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

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

- Ensures equity principles are embedded into strategic plans, regulatory compliance activities, and quality improvement efforts.
- Oversees measurement and reporting of equity-related outcomes, including disparities analysis and progress toward organizational equity goals.
- Acts as a subject matter expert on DHCS, CMS, and NCQA requirements related to health equity.
- Collaborates with internal teams and external partners to design culturally responsive and community-informed programs.

Senior Community Health Analyst

- Supports the Program Development Manager in coordinating and implementing strategic initiatives and regulatory requirements.
- Conducts data analysis, performance monitoring, and reporting to guide decision-making and evaluate program effectiveness.
- Maintains documentation of regulatory intake, implementation plans, and program updates to ensure compliance and organizational accountability.
- Identifies opportunities for process improvement and assists in integrating lessons learned into organizational practices.
- Provides subject matter support for quality and population health metrics, including HEDIS, CMS, and DHCS requirements.

Community Health Specialist

- Supports the team in operationalizing strategic initiatives, ensuring timely execution of program deliverables.
- Collects, analyzes, and reports on data to track progress on population health, quality improvement, and equity measures.
- Assists with regulatory intake, documentation, and dissemination of guidance to relevant stakeholders.
- Helps develop tools, templates, and communications to facilitate program implementation and staff understanding.
- Provides administrative and analytic support to ensure smooth coordination across initiatives.

Community Engagement Director

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

- Planning, implementing, and evaluating new programs, services and lines of business
- Ensuring existing programs, services and lines of business for the assigned geographical area aligning with community needs
- Planning, developing, implementing, and evaluating the community relations program
- Identifying and analyzing quality and customer service issues and overseeing the implementation of recommended improvements to programs, services, and lines of business

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

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

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

- Developing contracts or other legal documents in collaboration with staff and attorneys
- Overseeing the development of communications materials to promote the grant program and Alliance investments in the community
- Staying informed about current research, policy activities, and trends related to Alliance priorities in order to identify new opportunities for grant program development
- Developing and evaluating new programs and projects and presenting to staff and the Board of Commissioners, as directed by the Chief Executive Officer (CEO)
- Preparing reports for the Board of Commissioners package for review by the CEO
- Providing support to the CEO on strategic projects and operational initiatives related to grant funding in the community

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

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

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

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

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

- Developing and recommending plans to utilize internal resources and techniques to improve clinical outcomes, such as practice coaching, process improvement tools or academic detailing.
- Leading clinical initiatives designed to build a culture of high performance through learning sessions, webinars and on-going collaboratives with multiple network providers and community-based organizations
- Remaining current and knowledgeable of applicable mandates from oversight agencies, such as DHCS, CMS, DMHC, NCQA and other regulatory/accrediting bodies as applicable.
- Manages quality improvement projects, initiatives and activities including NCQA Accreditation.
- Is responsible for compliance with NCQA and regulatory standards.
- Managing and supervising staff, setting goals and objectives, delegating, and assigning work.
- Identifying, overseeing, and assisting with objectives, priorities, assignments, and work-related tasks and reviewing work products as needed

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

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

- Maintaining knowledge of applicable State and Federal laws and regulations, monitoring legislative and legal changes related to Alliance functions, and ensuring compliance with same.
- Providing support to the Quality Improvement and Population Health Director and may act for the Director in the Director's absence.
- Overseeing or conducting staff training, including the development and maintenance of training materials, in conjunction with the Training and Development team
- Identifying training gaps and opportunities for improved performance

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

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

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

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

Facility Site Review Supervisor

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

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

Quality and Health Equity Supervisors

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

- Overseeing the daily operations performed by a team within the Quality Improvement and Health Equity Department
- Monitoring the day-to-day work of staff to ensure compliance with program guidelines
- Conducting regular staff meetings and ensuring staff is informed of program updates in a timely manner

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

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

- Develops and measures a comprehensive preventive healthcare strategy in collaboration with the internal stakeholders and network providers to promote best evidence-based practices and improve member health outcomes.
- Collaborates with Quality Improvement and Population Health Department Team and other departments to evaluate and report observed and/or measured trends in individual and group provider performance. CCAH Evaluates patient safety and quality issues by promoting an environment of transparency with internal stakeholders, network providers and community partners.
- Coordinating communication regarding PQI to Grievance, Provider Services and other departments as indicated.
- Developing and delivering presentations on the PQI process and providing data, analysis, and trends to various internal and external audiences

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

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

- Managing and coordinating health promotion and chronic disease management programs within the health plan
- Developing and implementing health promotion and disease management programs to meet the needs of members in multiple lines of business.
- Identifying the health education and cultural and linguistic needs within the member population
- Investigating potential project areas and recommending appropriate intervention
- Collaborating with internal staff, including Quality Improvement and Population Health Director,
  Medical Directors, and Chief Medical Officer to identify members that may qualify for Health Programs services.
- Collaborating with providers and other external customers to develop interventions for high-risk members.
- Preparing health and disease management program promotional materials, including newsletter articles, pamphlets, and brochures in collaboration with the Communications Department
- Preparing promotional materials for the Alliance's Cultural and Linguistic services
- Coordinating Health Education/Disease Management and Cultural and Linguistic activities with Utilization Management and Complex Case Management, Quality Improvement and Population Health, and Community Care Coordination staff to improve health outcomes and promote appropriate use of resources.
- Directing Health Programs staff activities and mentoring staff in Health Programs

- Maintaining Health Programs policies and procedures to meet Alliance goals and ensure regulatory/contractual compliance.
- Performing ongoing monitoring of Health Programs and activities to evaluate plan's effectiveness and determine follow-up needed.
- Maintaining current knowledge of regulatory requirements pertinent to health education/disease management and cultural and linguistic services (DHCS, CMS, DMHC)
- Tracking, analyzing, and developing strategies to address outlier performance of Health Programs metrics.
- Maintaining and coordinating relationships with clinical and social service agencies as needed (County Health Departments, community health organizations, etc.)
- Assisting in Quality Improvement activities, including annual HEDIS studies and CBI
- Participating in preparation of DHS/DMHC Audit and Investigation audits for all aspects of health education/disease management and cultural and linguistic services

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

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

- Ensuring that policies, procedures, and workflows are current and reflect Alliance practice and industry standards.
- Working with the Quality and Health Programs Manager and assigned staff to identify training opportunities for the department on topics such as chronic diseases, cultural competency, outreach strategies, program evaluation, software, customer service, and team building.
- Working with the Training and Development team to develop and implement training opportunities, coordinating, and participating in staff training activities, and tracking staff participation.
- Supervising the C&L staff in the delivery of the Alliance Cultural and Linguistic Services in specified health services areas, such as telephonic, face-to-face, and audio interpreting, and translations services, such as readability, suitability, and translation
- Supervising the Health Education staff in the delivery of the Alliance health education and disease management programs in specified health services areas, such as chronic health conditions, adult and pediatric weight management, pediatric preventative health care, and parental and postpartum care

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

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

based health promotion interventions and ensuring that such interventions are culturally and linguistically appropriate for the Alliance's diverse membership.
- Identifying and promoting low cost, low health-literacy, culturally and linguistically appropriate health education materials
- Coordinating telephonic member referrals to external programs such as Women, Infants and Children (WIC), and other social and community services.

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

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

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

- Coordinating programmatic support to advance the Alliance's health equity strategies related to C&L, Health Education and Member Incentive programs.
- Serving as a consultant in internal and external stakeholder meetings.
- Responding to operational issues and questions from Alliance staff and Alliance network providers related to C&L, Health Education and Member Incentive programs.
- Reaching out to primary care providers, specialists, community agencies, and Alliance staff in order to maximize C&L and Health Education program participation.
- Establishing relationships with internal and external stakeholders to gain a clear understanding of provider and member needs.
- Providing subject matter expertise and knowledge of regulatory requirements related to C&L, Health Education and Member Incentive programs, including monitoring contractual, legal, and regulatory requirements.
- Coordinating the implementation of new C&L, Health Education and Member Incentive program regulatory requirements, including interventions in response to member needs
- Providing operational guidance to ensure alignment with Medi-Cal, Knox-Keene, and other regulatory and accreditation standards.

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

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

- Acting as the QI key knowledge holder on process changes as they relate to the National Committee for Quality Assurance's (NCQA) HEDIS process HEDIS teams.
- Ensuring necessary steps are taken to achieve a successful year-over-year improvement of HEDIS measures, including working with internal and vendor resources on process improvement initiatives.
- Identifying preventative care areas with declining or plateauing compliance rates over time, including conducting statistical and root cause analysis of contributing factors
- Taking proactive and strategic actions to plan, design and oversee research and analytical projects that support HEDIS, CBI, and QI projects.

- Conducting analysis and providing strategic recommendations to executives and professional clients related to improving health care quality, provider satisfaction and member health outcomes.
- Developing new algorithms and modifying existing algorithms related to QI projects to address complicated business problems, such as stratification, provider benchmarking, and program evaluations.
- Transforming business goals into hypotheses and tangible QI data mining goals
- Pulling and integrating data from disparate sources, such as claims and clinical data.
- Utilizing data visualization tools to produce data that is easily interpreted by non-technical audiences.
- Using data to demonstrate program performance and opportunities for improvement.
- Maintaining audit readiness through ongoing training, competency assessment, auditing, monitoring of metrics, and development of corrective action plans, as needed
- Setting expectations and goals for program inputs, processes, and outputs
- Developing, implementing, monitoring, and improving programmatic process and outcome metrics to ensure continuous quality improvement.
- Acquiring, analyzing, and synthesizing programmatic information to make recommendations to leadership regarding program modifications.
- Taking the lead in assigning and coordinating work and monitoring work assignments
- Acting as a technical resource to staff
- Providing mentoring and coaching to staff
- Conducting staff training, including the development and maintenance of training materials
- Acting as a subject matter expert in healthcare quality, efficiency, and value-based payment models · Maintaining and updating work process, policy, and reference documents

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

- Leading or participating in the development of expectations and goals for QI program inputs, processes, and outputs
- Developing, implementing, monitoring, and improving programmatic process and outcome metrics to ensure continuous quality improvement.
- Ensuring timely and accurate communication with program stakeholders
- Identifying preventative care areas with declining or plateauing compliance rates over time, including conducting root cause analysis of contributing factors
- Monitoring and ensuring the validity of data and accuracy of data analyses.
- Analyzing large claim data sets to develop conclusions about data integrity, accuracy, and general relationships, and making related recommendations.
- Analyzing large claim data sets to develop conclusions about data integrity, accuracy, and general relationships, and making related recommendations.
- Investigating and analyzing database and data processing issues in relation to HEDIS and CBI in order to identify causes and recommend solutions.
- Identifying QI business issues and challenges, forming hypotheses, planning, and conducting interviews and whiteboard sessions, and performing reporting and analysis to synthesize conclusions, develop solutions and make recommendations.
- Identifying reporting and quality improvement opportunities

- Providing day-to-day consultation to business users and participating in and contributing to cross-functional project teams
- Managing assigned workflows and ensuring reliability, integrity, and timeliness of end products
- Developing project plans and strategies and executing assigned project plans to deliver solutions.
- Gathering information regarding customer expectations to develop goals and meet expectations.
- Collaborating with Lead QI Program Advisors and supervisor and requesting review as needed to ensure reliability, integrity, and timeliness of end products.
- Summarizing findings to develop and propose appropriate solutions to QI program and project challenges.
- Preparing and delivering formal presentations of work to customers

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

- Coordinating and submitting convenience and overread samples to the External Quality Review Organization (EQRO) to ensure quality data.
- Submitting Interactive Data Submission System (IDSS) data to National Committee for Quality Assurance (NCQA)
- Acting as a resource on HEDIS technical specifications and training staff in the use of HEDIS certified software
- Collaborating with other County Organized Health Systems (COHS) regarding joint HEDIS activities and reporting
- Serving as point person for HEDIS staff regarding correct Health Insurance Portability and Accountability Act (HIPAA) protocols related to transporting Protected Health Information (PHI)
- Maintaining HEDIS member exclusion data
- Maintaining a problem log of certified HEDIS software issues
- Reviewing and validating accurate location and contacts for medical record requests
- Participating in on-site visits for Physical Accessibility Reviews (PAR) with providers, in collaboration with QI nurse
- May assist FSR Team engagement with providers, including scheduling reviews and monitoring visits related to Medical Record Review (MRR), FSR and PAR
- Performing outreach to providers for corrective action plan (CAP) follow-up
- Preparing documentation and provider-specific reports to assist QI nurses with providing educational information and assistance with CAP completion to providers.
- Act as practice coach to providers to improve effectiveness of health care delivery through various modalities such as on-site support, trainings, analysis, and one-on-one coaching.
- Develop, participate in, and lead provider collaboratives across counties including but not limited to, in-person events and virtual meetings.
- Develop and support provider improvement plans and programs.
- Responding to inquiries from internal stakeholders regarding regulatory and accreditation activities by researching, summarizing, and presenting findings and recommendations
- Coordinating Health Services (HS) Division continuous audit readiness program efforts
- Coordinating production of pre-audit deliverables and conducting review and analysis of various data sources to determine potential audit focal points.

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

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

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

- Documenting and communicating action items to staff assigned to QI-related projects.
- Coordinating between the Care-Based Incentive (CBI) and HEDIS programs, acting as a liaison between HEDIS vendors and provider offices, and coordinating and scheduling HEDIS audit activities.

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

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

- Utilizing advanced knowledge of procedural coding to review and recommend changes to systems, policies or procedures to guarantee current and appropriate coding guidelines are maintained.
- Providing mentoring and coaching to staff across all departments on procedural coding activities including billing and documentation requirements.
- Conducting staff orientation and providing training to positions across the organization that are responsible for performing procedural coding or supporting coding-related activities.
- Developing and maintaining training materials related to Alliance systems and procedural coding-related activities, and facilitating training sessions, in coordination with the Learning and Development Team.
- Identifying coding issues and providing or implementing strategic consultative solutions.

- Advising stakeholders regarding system configuration and contractual billing requirements based on procedural coding standards and regulatory requirements.
- Leading development and maintenance of work processes, procedures, policies, and reference documents.
- Assisting with continuous quality improvement activities, including preparing quality assurance and performance improvement reports to verify program and data integrity.
- Researching, analyzing, and presenting on coding-related agenda items, and representing the Quality Improvement and Population Health Department on internal committees.
- Reviewing new and updated All Plan Letters (APLs) to determine the potential impact upon the Health Effectiveness Data Information Set (HEDIS), Care Based Incentives (CBI) and other Quality Improvement and Population Health initiatives.
- Working directly with stakeholders in analyzing current and future systems configuration to ensure procedural coding methodology and modifier rules are appropriately applied for proper reimbursement and adhere to applicable regulations.

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

- Performing duties and tasks related to specific departmental business needs and activities.
- Providing administrative assistance to management staff on program activities and special projects.
- Supporting, coordinating and/or completing departmental and organizational projects, such as those related to reports, presentations, newsletters, departmental metrics, staff communications, and special event administration.
- Gathering, coordinating, and preparing materials in support of responses to internal and external audits and the preparation of regulatory reports
- Assisting with the development, documentation, implementation and maintenance of administrative support procedures and processes.
- Composing correspondence, performing general research, creating, and updating spreadsheets, building, and maintaining files and databases, and preparing written reports.
- Coordinating and scheduling training, conferences, retreats, and travel for department staff.
- Creating, preparing, and producing presentation materials for internal and external presentations Providing administrative support to department leadership in the development and maintenance of the department budget.
- Ordering office supplies and preparing and submitting purchase orders and expense request forms for department purchases.
- Processing vendor contracts and invoices and communicating with vendors.
- Tracking petty cash expenditures, reconciling balances, and submitting a monthly final detailed accounting report.
- Assisting with the development and maintenance of department pages and information on the intranet.
- Developing and maintaining filing systems, maintaining accurate records, and coordinating records retention/destruction projects in consultation with department leadership.
- Answering, directing, and placing telephone calls and scheduling telephone and video conference calls.

- Representing the department at internal and external meetings.
- Assisting with the development of departmental training and resource materials and assisting with training staff, as assigned.
- Coordinating departmental facilities maintenance requests.
- May coordinate the work of other departmental clerical/support staff and assist with training and developing procedures and guidelines for clerical/support staff.
- May assist with processing personnel and payroll records and resolving related issues.

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

- Leading development of UM strategy by leveraging the use of data/analytics to inform and technology solutions to streamline operational efficiencies while also building a cost-benefit methodology to rationalize decisions on UM reviews to be performed based upon staffing costs, productivity, and projected medical cost savings.
- Identifying opportunities to create efficiencies in the UM program and activities, incorporating innovative approaches and solutions, and leading process redesign work necessary to implement improvements.
- Directing the utilization management, concurrent review, prior authorizations medical claims review, appeals and grievances functions.
- Providing leadership in the design and implementation of UM policies, processes and procedures needed to meet National Commission on Quality Assurance (NCQA) and Utilization
- Review Accreditation Commission (URAC) accreditation requirements for both a Medi-Cal and Medicare line of business (D-SNP)
- Establishing and measuring productivity metrics in order to support workforce planning methodology and rationalization of services to perform UM reviews.
- Developing approach to auto-approvals where appropriate and partnering with the Provider Services team to implement strategies to reduce unnecessary administrative burden for Alliance care delivery partners related to UM processes.
- Developing and maintaining protocols for Treatment Authorization Request (TAR) authorization criteria
- Designing, developing, implementing, and maintaining programs, policies and procedures in order to meet regulatory, contractual, accreditation, and performance standards.
- Evaluating and overseeing the implementation recommendations on program changes relative to covered services.
- Maintaining knowledge of the UM software program functionality and leading the clinical team responsible for advising on replacement, upgrades, and user testing
- Advising and collaborating with the Chief Medical Officer (CMO) and Medical Directors on strategic issues involving Utilization Management Department programs
- Developing and maintaining collaborative working relationships with clinical and social service agencies in the community
- Collaborating with Community Care Coordination, Quality Improvement/Population Health, Pharmacy, and Health Programs to improve health outcomes and promote appropriate use of resources.

- Maintaining knowledge of regulatory and accreditation agencies and related requirements pertinent to case management and integrated behavioral health, such as Department of Health Care Services (DHCS), Centers for Medicare and Medicaid Services (CMS), Department of Managed Health Care (DMHC), and Knox Keene
- Ensuring that staff advocates for members within the scope of the role of the health plan by arranging for, or directly reaching out to, Primary Care Providers (PCPs), specialists, hospitals, local mental health services, the managed care behavioral health organization (MCBHO), local care management programs, and community agencies in order to maximize program participation and outcomes.
- Assisting with quality improvement activities, including annual HEDIS studies
- Drafting, recommending, and implementing administrative policies and processes and procedures related to Utilization Management Department operations.
- Maintaining current knowledge of relevant Federal and State laws, policies and directives, and organizational policies and procedures, including regulatory requirements pertinent to population health, case management and disease management (DHCS, CMS, DMHC, and Major Risk Medical Insurance Board), communicating changes to staff, and ensuring that all requirements are met.
- Monitoring legislative and legal changes related to Alliance functions and ensuring appropriate communication of same
- Reviewing and assessing overall department functions, core work, goals, and structure, developing and implementing short- and long-term planning to achieve strategic objectives, and completing an annual department assessment.

Case Management Director

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

- Designing, developing, implementing, and maintaining programs, policies, and procedures in order to meet regulatory, contractual, accreditation, and performance standards
- Designing, developing, and maintaining Behavioral Health (BH) policies and procedures that relate to Care Management
- Leading the development and oversight of Alliance Care Management efforts including those required by the Medi-Cal CalAIM initiative and the Alliance's Strategic Plan
- Advising and collaborating with the Health Services Executive Director, Chief Medical Officer (CMO), and Medical Directors on strategic issues involving Care Coordination and Care Management programs
- Participating in development and implementation of electronic systems and modules that support case management and best practice and accreditation standards
- Collaborating with all departments, within Health Services and across the organization, to improve health outcomes and promote appropriate use of resources
- Tracking, analyzing, and developing strategies to address outlier performance of care management metrics and reporting on metrics at a regular cadence
- Preparing reports for the Board of Commissioners package for review by the HSO and/or CMO
- Developing performance measures related to strategic goals and new projects and presenting to staff and the Board of Commissioners, as directed by the HSO and/or CMO

- Drafting, recommending, and implementing administrative policies, processes and procedures related to Care Management Department operations
- Maintaining current knowledge of relevant federal and state laws, policies and directives, and organizational policies and procedures, including regulatory requirements pertinent to case management and disease management issued by Department of Health Care Services, Centers for Medicare and Medicaid Services, Major Risk Medical Insurance Program, or Department of Managed Health Care, communicating changes to staff, and ensuring that all requirements are met.

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

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

- Maintaining current knowledge of relevant federal and state laws, policies and directives, and organizational policies and procedures
- Monitoring legislative and legal changes related to Alliance functions and ensuring appropriate communication of same
- Reviewing and assessing overall department functions, core work, goals, and structure, developing and implementing short- and long-term planning to achieve strategic objectives, and completing an annual department assessment.
- Overseeing the preparation and maintenance of records, reports, and related documents
- Developing and managing the Pharmacy Department operations, work plans, and budget
- Attending and participating in internal and external meetings related to Alliance business operations.
- Providing support to the Health Services Executive Director and CMO

Behavioral Health Medical Director

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

- Oversees behavioral health activities as they pertain to utilization management, quality improvement and care management.
- Directing and organizing planning of the Behavioral Health program amongst integrated Alliance departments.
- Leading and participating in meetings about proposed mental health administrative models through Department of Health Care Services (DHCS), tracking developments, and keeping organization informed.
- Designing, developing, implementing, and managing behavioral health program performance to align with existing and future needs of Alliance members.
- Planning for and directing the service delivery components for members' behavioral health needs, considering current and future integration needs, not limited to mental health and/or substance use disorder.
- Developing and maintaining policy and procedures in order to meet regulatory, contractual, and accreditation standards.
- Overseeing the development of new Medi-Cal behavioral health benefits within the Alliance and providing executive level oversight of Alliance behavioral health projects.
- Collaborating with other Alliance departments on behavioral health initiatives/activities to improve health outcomes and appropriate use of resources Oversee the development of programming to support the education of the health services division, providers, members and their families on behavioral health issues including symptoms, relapse prevention, stress reduction, lab work, and healthy lifestyle choices.
- Tracking, analyzing, and developing strategies to address outlier performance in behavioral health metrics.
- Tracking, analyzing, developing, and reporting on Administrative Quality Indicators (AQI's) pertaining to behavioral health initiatives.
- Participating in strategic planning and implementation of the Behavioral Health Department's operational goals related to the growth and development of Alliance business operations.
- Ensuring that Behavioral Health Department's goals and activities are in alignment with the Alliance strategic plan.
- Conducting complex research and analysis related to behavioral health strategies.

- Assisting in formulating strategic plans and goal setting in support of Alliance programs.
- Modeling and promoting effective interdepartmental communication.
- Preparing narrative and statistical reports and making presentations Developing performance measures related to strategic goals and new projects and presenting to staff and the Board of Commissioners, as directed by the Chief Medical Officer (CMO).
- Preparing reports for the Board of Commissioners package for review by the CMO.
- Drafting, recommending, and implementing administrative policies, and processes and procedures related to Behavioral Health Department operations.
- Maintaining current knowledge of relevant Federal and State laws, policies and directives, and organizational policies and procedures.
- Monitoring legislative and legal changes related to Alliance functions and ensuring appropriate communication of same.
- Overseeing the preparation and maintenance of records, reports, and related documents.
- Overseeing and coordinating meetings to promote effective communication between the Alliance, , County Behavioral Health Departments, Regional Centers, and Community Partners.
- The Behavioral Health Medical Director also serves as the Behavioral Health Program Director, overseeing program activities and providing direct utilization review activities as well as oversight to the program.

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

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

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

Quality Improvement and Heath Equity Resources
The QIPH Program has staff and analytical resources available to achieve program objectives. The Quality Improvement and Populations Health Department has overall responsibility for all QIPH activities. The Department has adequate staff to fulfill its role. Departments within CCAH provide significant amounts of time for QIPH activities and responsibilities. Leadership ensures adequate resources to implement and maintain all QIPH Program activities. Additional external resources such as, HEDIS auditors for medical record review and data abstraction and analysis, and accreditation of readiness are available as needed.

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

Position/Title

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

Quality Improvement Project Specialist (1)
Coding Analyst (1)
Administrative Specialist (1)

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

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

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

- Member Services
- Provider Services
- Provider Services Relations
- Provider Services Contracts/Provider Quality and Network Development
- Compliance/Privacy and Security
- Community Engagement
- Claims
- Finance
- Application Services
- Pharmacy
- Utilization Management
- Community Care Coordination
- Community Grants
- Communications
- Data Analytics Services
- Behavioral Health

Functional Areas and Their Responsibilities

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

Member Services

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

- Serving as first responders to member inquiries and first call resolution when possible or if not possible, forwarding issues to designated staff to follow-up.

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

Provider Services

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

- Assisting QIPH with developing and managing communication with practitioners/providers.
- Proposing ways to improve practitioner/provider satisfaction with CCAH.
- Assisting with the coordination of practitioner/provider office staff QIPH educational trainings.

Collaboration and facilitation of the Physician Partnership Program for the enhancement of Quality initiatives.

Provider Contracting and Network Development

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

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

Compliance / Privacy and Safety

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

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

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

Key Responsibilities:

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

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

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

- Providing data regarding timeliness of claims for care and services according to the member Evidence of Coverage criteria.
- Providing data regarding accuracy and timeliness of claim submission.
- Identifying and communicating suspected fraudulent billing practices.
- Identifying over utilization of services.

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

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

Information Technology Services

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

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

Pharmacy

- The QIHE Program collaborates closely with the Pharmacy Department to enhance the quality, safety, and equity of medication-related services. The Pharmacy Department Promotes clinically appropriate and evidence-based prescribing practices aligned with national guidelines and supports providers and members through education delivered via newsletters, mailings, academic detailing, and website updates. The pharmacist-led Academic Detailing Program focuses on improving member outcomes by working directly with providers to optimize medication therapy, address adherence issues, and reduce medication-related complications for members.
- Conducts routine analysis of prescribing trends and medication utilization to identify opportunities for improvement. Through its comprehensive Drug Utilization Review (DUR) Program, the team evaluates patterns such as opioid over-utilization, opioid and benzodiazepine co-prescribing, and behavioral health medication used in children. Findings are used to implement interventions, such as provider outreaches and education. Reviews pharmacy claims and utilization data to detect potential fraud, waste, and abuse concerns, reporting cases to Compliance as required. They collaborate with the Quality department on medication-related PQIs and serve as subject matter experts in designing and implementing corrective actions or quality interventions.
- Identify members at risk of opioid misuse, high-dose opioid therapy, or dangerous opioid/benzodiazepine combinations. implements safety interventions (e.g., prescriber/pharmacy lock-in, case management review) and reduces avoidable hospitalizations, overdoses, and medication-related complications for D-SNP members in their Drug Management Program (DMP).
- Provides an oversight of Medication Therapy Management (MTM) Program, which improves medication adherence, optimizes disease management for chronic conditions and prevents medication-related problems. MedImpact's vendor Aspen RxHealth identifies members who are eligible for MTM program per CMS guidance, completes Comprehensive medication Reviews (CRM) and Targeted medication reviews (TMR), identify a medication-related risks, and conduct real-time pharmacist intervention. Develops, implements, and maintains policies and procedures t.in accordance with Federal and State requirements, Medicare Part D guidance, Medi-Cal regulations, and CMS D-SNP regulatory expectations. This includes supporting compliance with the Model of Care (MOC), D-SNP integration standards, care coordination requirements, and quality improvement program provisions.

- Provides clinical and quality oversight of MedImpact and Medi-Cal Rx to ensure timely access to medications, promote appropriate use, and support improved outcomes for members.

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

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

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

Community Grants
The Alliance makes investments to health care and community organizations in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties through the Medi-Cal Capacity Grant Program (MCGP) to realize the Alliance's vision of heathy people, healthy communities. These investments focus on:
- Increasing the availability, quality and access of health care and supportive resources for Medi-Cal members.
- Addressing social drivers that influence health and wellness in our communities.

The MCGP furthers the strategic priority of health equity through a variety of investments:
- Healthcare Workforce: Strengthen and expand the provider workforce to address provider shortages. Increase the number of providers who reflect the diversity of the Alliance's membership and provide culturally and linguistically competent care. Close care gaps, increase quality scores and improve members' overall health. Build capacity for Community Health Workers to provide the CHW Benefit and support members in staying Medi-Cal enrolled.
- Healthcare Delivery System Infrastructure: Invest in new and expanded health care facilities and technology to improve access to high quality care, care coordination and data sharing.
- Parent/Child Health & Wellness: Empower parents and caregivers through education and support, ensuring access to timely prenatal and postnatal care, preventative health services, and community resources.
- Community Education and Engagement: Invest in trusted, community-based organizations serving historically marginalized communities to educate and engage members about Medi-Cal services, improve access to health care and supportive

resources, promote the importance of preventative care and regular screenings and create supportive networks and environments.
- Social Drivers of Health: Invest in strategies that reduce health disparities, investments along the housing continuum (i.e., permanent supportive housing, recuperative care facilities and short-term post-hospitalization housing).

Communications
The QIHE Program provides aggregate data to the Communications Department regarding the effectiveness of practitioner/provider outreach strategies and processes as part of customer engagement. Communications is responsible for:
- Communicating the Alliance's value proposition as it relates to local access, diverse provider network and other services and programs available to members.
- Engaging members and potential members at outreach events to answer questions on member benefits and advising on how to contact their state agency for enrollment information.
- Engaging with new members to provide an understanding and overview of benefits and services and provide information on how to choose a doctor and how to use their Alliance card. Reaching and engaging members through omnichannel messaging on digital, print and other communications channels.
- Messages include information they need to be as healthy as possible, including messaging on the Nurse Advice Line, transportation benefits, the importance of well-checks and vaccines, information on important health screenings, behavioral health services, language assistance services, information on upcoming vaccine clinics and more.
- Ensuring members understand Medi-Cal changes in 2026 and 2027, including redetermination requirements. Messaging to members about these changes and the need to keep their contact information current and return their renewal packet as soon as they receive it.
- Maintaining content strategy across all communications channels, ensuring an aligned communications approach across member, provider, and community audiences.
- Overseeing the publication and delivery of print and digital newsletters and bulletins for members, providers, and communities. These include the Member Bulletin, The Provider Bulletin, Provider Digest, Provider Flash and The Beat.
- Overseeing the text messaging (SMS) program to communicate and engage with members directly on a variety of topics related to their overall health and wellness and the benefits and services available to them.
- Executing paid media campaigns targeted to members and the public, promoting various messaging on redetermination requirements and the importance of seeing their doctor.

Data Analytics
The QIHE Program works with the Data Analytics Services Department under ITS to understand the data and statistics to assist in developing the standard methodologies to achieve targeted and accurate results. The Data Analytics Department are responsible for:
- Provides quantitative and qualitative analyses or evaluation on a variety of complex and diverse strategic and operation issues.
- Collaborates with Business Intelligence, Finance and Contracting for data compilation.
- Measures rates and analyzes patterns of utilization to aid in quality improvement projects. Providing technical support for the provider incentive programs, ad hoc

data requests, and report generation. Produces dashboards that are used to measure quality improvement projects, effectives of care, utilization and to provide data for comparison.

QUALITY IMPROVEMENT AND HEALTH EQUITY COMMITTEE AND SUBCOMMITTEES

Quality Improvement Health Equity (QIHEC) Committee

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

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

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

The QIHEC is designated as, and fully serves as, the Utilization Management (UM) Committee required by CMS pursuant to 42 CFR § 422.137, for the Alliance's Total Care (HMO D-SNP) (Contract H5692) line of business.

Primary duties of the QIHEC include the following:

- Annually reviewing and approving the draft Quality Improvement and Health Equity and Utilization Management Work Plans (QIHEWP and UMWP).
- Quarterly reviewing progress against active QIHEWP and UMWP goals.
- A written summary of QIHEC activities, as well as QIHEC activities of its fully delegated subcontractors and downstream fully delegated subcontractors, findings, recommendations, and actions are prepared after each meeting.
- Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings of the activities of other committees such as the Community Advisory Committee (CAC)
- Institute actions to address performance deficiencies, including policy recommendations.
- Ensure appropriate follow-up of identified performance deficiencies.
- Providing leadership and oversight in the implementation of quality improvement principles and activities in the daily operations of the Alliance.
- Facilitating communication on the status and progress of Alliance QIHETP activities to the Alliance Board on a scheduled basis.
- Participating in the development and/or adoption of specific utilization management criteria and benefit parameters.
- Monitoring the activities of, and providing direction to, all QIHEC subcommittees/ workgroups.
- Stimulating the highest degree of commitment to quality health care and to the goal of continuous improvement.

- Recommending and approving changes to select QIHETP related Alliance policies, practice guidelines, and subcommittees' proposed action plans.
- Overseeing the QIHETP and UM Program policies (Alliance Policies 401-1101 and 404-1101 respectively), and the QIHEWP and UMWP for annual submission to the Alliance Board.
- Reviewing, approving, and submitting the Quality Improvement and Health Equity (QIHE) Annual Report to the Alliance Board.
- Reviewing and advising on QIHETP related Corrective Action plans (CAP), not including credentialing/recredentialing oversight related CAPs. Individual provider issues may be referred to the PRCC and/or Program Integrity Unit depending on the nature of the issue.
- Reviewing standards of care guidelines, as described in Alliance Policy 401-1501 – Standards of Care.
- Oversight of language assistance and interpreter services as described in Alliance Policy 401-4101 – Cultural and Linguistic Services Program
- Directing necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity standards and the DHCS Comprehensive Quality Strategy
- For fully delegated subcontractors and downstream fully delegated subcontractors, ensure maintenance of a QIHEC and reporting to the Alliance on a quarterly basis, at a minimum; and
- Partnering with the Compliance Committee to meet QIHETP delegate oversight requirements.
- Perform all responsibilities required in 42 CFR 422.137(d)(1)-(5), including, but not limited to:
- At least annually reviewing and approving utilization management policies and procedures (including prior authorization) to ensure compliance with Traditional Medicare coverage rules (NCDs, LCDs, statutes, and regulations), 42 CFR §§ 422.101(b) and (c)(1), 422.138, 422.202(b)(1), and current clinical guidelines.
- Receiving and acting upon recommendations from the UMWG.
- Documenting in meeting minutes all decisions, rationales, conflict-of-interest disclosures, recusals, and objective determinations of conflicts, with such documentation made available to CMS upon request.

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. Members collectively represent the provider network and provide health care services to members affected by health disparities, Limited English proficiency (LEP), Children and Youth with Special Health Care Needs (CYSHCN), Seniors and Persons with Disabilities (SPDs) and persons with chronic conditions (e.g., diabetes, asthma, and congestive heart failure). QIHEC core members actively participate on the QIHEC or medical subcommittee that reports to the QIHEC. A network behavioral health practitioner also attends QIHEC and / or other subcommittees to discuss transitions of care. Committee members must be in good standing with the Alliance.

Additionally, the QIHEC membership satisfies, and shall continue to satisfy, the Medicare Advantage UM Committee composition requirements under 42 CFR § 422.137(c)(1)-(4) for the Alliance's Total Care (HMO D-SNP) line of business (Contract H5692), including

- A majority of members who are practicing physicians;
- At least one independent physician free of conflict;
- Clinical expertise regarding the care of elderly or disabled individuals; and

- Representation from various specialties.

Core Committee Members (voting) External to CCAH

- Medical Director, Santa Cruz Community Health Centers, Santa Cruz County
- Family Medicine Physician, Dominican , Santa Cruz County
- Pediatrician, Dominican, Santa Cruz County

- Medical Director, Monterey County Department of Health, Monterey County
- Medical Director Clinica De Salud Del Valle, Monterey County Chief Clinical Officer, Merced Faculty Associates, Merced County

Core CCAH Staff:

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

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

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

Pharmacy and Therapeutics (P&T) Committee

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

The functions of the P&T Committee:

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

- Utilize newsletters and the Alliance website to distribute drug information to prescribers and communicate drug policy decisions made by the P&T Committee.
- Participate in quality assurance activities related to drug prescribing, adverse drug reactions, and drug interactions.

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

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

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

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

The workgroup meets quarterly. Ongoing review and approval of the QIHEWP, including refining interventions to address barriers and incorporate feedback from the QIHEC, and the QIHE Annual Report
- Annual review and approval of various QIPH policies and related processes and functions.
- Analysis of HEDIS/Managed Care Accountability Set (MCAS) measures and the development of strategies to improve performance.
- Development of QIHETP related provider and member communications.

- Development of disease management initiatives.
- Ongoing oversight of delegated QIHE activities of subcontractors.
- Review of language assistance and interpreter services as described in Alliance Policy 401-4101 – C*ultural and Linguistic Services Program*
- Review and analysis of provider and member survey results; and
- Review and approval of QIHETP-related standing reports, and state mandated PIPs.

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

- Care-Based Incentives Work Group (CBIWG)
- DSNP /STARS Rating Workgroup
- Member Reassignment Committee
- Network Development Steering Committee
- Staff Grievance Review Committee

Care-Based Incentives Work Group (CBIWG)

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

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

Member Reassignment Committee

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

- Alleged/Actual Member Fraud or Theft **-** The PCP alleges that the member fraudulently sought or received covered services for him or herself or another party. The PCP alleges that the member has committed theft from the practice.
- Alleged Abusive/Disruptive Behavior by Member **-** The PCP alleges that the member behaves in a threatening, abusive, or disruptive manner to provider or office personnel. <u>This may include abusive language, threats of bodily harm, or threat of property damage</u>.
- Violation of Medication Management Agreement - A member violates the Medication Management Agreement s/he has agreed to with the PCP and which the PCP has submitted to the Alliance.
- Request for Non-Medically Necessary Orders **-** A member repeatedly requests orders (e.g. medication, imaging, referrals) that the PCP determines is not medically necessary<u>, despite member referral to either PCP case management or Alliance Case Management or ECM provider to support member.</u>
- Non-Compliance with Treatment Plan - The member refuses to comply with PCP's recommended treatment, despite member referral to either PCP case management or Alliance Case Management or ECM provider to support member, and the PCP

believes the refusal endangers the health of the member or significantly aggravates a medical condition.

- Ineffective Relationship – There has been an irremediable breakdown of the physician/patient relationship such that ongoing effective communication and patient care is impossible, despite member referral to either PCP case management or Alliance Case Management or ECM provider to support member.
- Failure to Keep Appointment **-** The member fails to keep three or more scheduled appointments with the PCP within a rolling 12-month period, despite referral to either PCP case management or Alliance Case Management or ECM provider. Evidence of failure to keep appointments is required for this request, along with any PCP documentation regarding member outreach/reasons why member failed to keep appointments.
- Other **-** Other circumstances, supported by documentation, not identified herein which the PCP believes justify the reassignment of the member from their practice to a different PCP.

Network Development Steering Committee

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

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

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

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

The SGRC meets regularly and reviews:

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

The Chief Operations Officer (COO) is the Officer of the plan with primary responsibility of the grievance system. Grievance reports and selected SGRC content are submitted to the

Quality Improvement Health Equity Workgroup (QIHEW). The COO continuously reviews the operation of the Appeal and Grievance system to identify any emergent or systemic issues with appeals and grievances, and/or patterns of improper service denials through participation in the QIHEW.

Dual-eligible Special Needs Plan (DSNP) / STARS Workgroup
The Star Ratings Workgroup (SRW), under the direction and guidance of the Quality Improvement & Health Equity Workgroup (QIHEW) and Medicare Steering Committee, is responsible for ensuring quality performance and compliance with both Medicare and Medicaid requirements. It is a forum to share and work through updates, challenges, and improvement opportunities for Star Ratings measures and improvement projects. The Star Ratings Workgroup is an interdisciplinary meeting to work across departments and divisions.

http://www.leapfroggroup.org/cp

CLINICAL SAFETY PROGRAM
Program Overview

The 2026 Clinical Safety strategy defines the Alliance's integrated approach to protecting member safety through efficient, compliant, and coordinated oversight. Clinical Safety activities include Potential Quality Issues (PQIs), Facility Site Reviews (FSRs), and Long-Term Services and Supports (LTSS), all operating within a single Clinical Safety framework.

These activities are intentionally aligned to provide multiple, reinforcing views of safety risk, from early signals and case-level concerns to system-level validation and facility-based oversight. Together, they support early risk identification, timely corrective action, and sustained improvement, while maintaining clear accountability and regulatory compliance.

Across all Clinical Safety activities, standardized workflows and collaborative oversight are used to improve timeliness and regulatory compliance, with the ultimate goal of preventing harm and protecting member safety. Within this integrated framework, PQI activities support early identification of potential safety concerns, FSR activities provide system-level validation of provider compliance and safety practices, and LTSS oversight extends clinical safety into higher-risk, facility-based and community-based settings through Quality Assurance Performance Improvement (QAPI) review, PQI, critical incident monitoring, utilization metric analysis, and targeted performance improvement efforts.

Unifying Clinical Safety Goal

Ensure timely identification, mitigation, and resolution of clinical safety risks through standardized, compliant oversight across PQI, FSR, and LTSS programs, with member safety as the primary outcome.

This unifying goal establishes a consistent purpose across all Clinical Safety activities and provides the foundation for how each component contributes to the overall program.

Clinical Safety Strategy to Achieve Program Goals

The Program's goals are grounded in integrating early risk identification, system-level validation, and targeted improvement activities. Clinical Safety leverages standardized

workflows, defined accountability, and structured collaboration to translate program goals into consistent operational practice.

This strategy is operationalized through an integrated set of activities that translate program goals into consistent operational practice. Clinical Safety prioritizes early identification and timely resolution of potential quality-of-care concerns through the PQI process; validates provider compliance and patient safety standards through FSR activities guided by Department of Health Care Services (DHCS) audit tools and standards, including facility, medical record, and physical accessibility reviews; advances facility-level quality oversight and data-informed performance improvement through LTSS QAPI review and targeted Performance Improvement Projects (PIP); and relies on cross-departmental and inter-plan collaboration to promote transparency, reduce duplication, and support preventive intervention. Ongoing governance and monitoring ensure regulatory compliance, clear accountability, and sustained focus on member safety outcomes.

Together, these strategic approaches ensure that Clinical Safety goals are achieved through a coordinated, prevention-focused program that supports providers, strengthens systems, and protects members.

Guiding Principles

The following principles guide the Clinical Safety Program:
Member safety is the primary outcome of all Clinical Safety activities
Regulatory compliance is foundational and embedded in workflows
Standardized, efficient processes reduce variation and risk
Collaboration supports early identification and prevention
Providers are engaged through a supportive, performance-focused framework
These principles ensure that PQI, FSR, and LTSS oversight are executed with shared expectations, consistent intent, and aligned accountability, even as each addresses different types of risk.

Potential Quality Issues (PQI)
2026 Focus: Workflow Efficiency and Regulatory Compliance

PQIs allow the Alliance to identify and assess potential quality-of-care concerns at the case level and to intervene before issues escalate or recur.

In 2026, the PQI focus emphasizes efficiency and consistency to reduce prolonged exposure to unresolved safety risks and to support timely clinical intervention, while maintaining regulatory compliance.

Collaboration to Support Early Awareness and Prevention

PQIs may originate from multiple sources, including internal referrals, clinical review, and collaborative discussions with partner departments. While Grievances and Appeals remain a separate function, structured collaboration supports transparency into incoming concerns that may inform PQI prioritization and preventive action.
Through routine communication and cross-departmental discussion, Clinical Safety gains visibility into and conducts a holistic review of provider performance by considering:

- Quality-of-care-related grievances requiring clinical review
- Quality-of-service concerns (e.g., access delays, referral coordination issues, communication barriers) that may indicate potential risk to member safety if unaddressed

- Patterns or trends that suggest systemic issues requiring further evaluation
- PQI activity and case-level findings
- FSR results for primary care providers include prior review outcomes and corrective action history.
- Quality-of-care HEDIS performance and related clinical quality indicators
- Provider Partnerships engagement, including practice coaching, technical assistance, and other performance improvement activities

Quality-of-service concerns are not clinical determinations; however, they may serve as early indicators of risk. When identified through collaboration, these concerns may prompt preventive outreach, process improvement, or increased monitoring intended to reduce the likelihood of PQIs or member safety events.

PQI Goals, Objectives, and Planned Activities

The goal of the PQI function is to identify, assess, and resolve potential quality-of-care concerns promptly to reduce the risk of harm and prevent escalation. Performance is monitored through routine tracking of PQI volume, timeliness, and outcomes to ensure sustained compliance and effectiveness. PQI objectives focus on maintaining acceptable rates of quality-of-care concerns, ensuring timely resolution of cases, and sustaining regulatory compliance.

Planned activities to achieve these objectives include standardized intake and triage of PQIs, consistent application of review criteria, strengthened management of Corrective Action Plans through updated work instructions, and ongoing collaboration with partner departments to identify early risk signals and support preventive interventions. The effectiveness of these activities is evaluated through ongoing monitoring, case review oversight, and trend
analysis to ensure consistent regulatory compliance and the timely resolution of safety concerns.

While PQIs provide case-level insight into potential safety concerns, trends, or recurring findings, they may also indicate broader operational or compliance gaps. When this occurs, the Clinical Safety Program advances from individual case review to system-level validation through Facility Site Reviews conducted by the FSR team, ensuring concerns are evaluated within the broader context of provider operations and regulatory expectations.

Facility Site Review (FSR)
2026 Focus: Regulatory Compliance, MOU-Based MCP Collaboration, and Statewide Alignment

FSR activities serve as the Clinical Safety Program's primary mechanism for validating primary care provider compliance with regulatory and contractual requirements that support safe care delivery. Reviews conducted by the FSR team include Facility Site Reviews, Medical Record Reviews, and Physical Accessibility Reviews, which together assess primary care provider systems, workflows, staffing, clinical documentation, accessibility, and the safety of the care environment.

FSR oversight is guided by the DHCS audit tool and applicable DHCS FSR standards, which establish the criteria for review methodology, scoring, and corrective action expectations for

primary care provider sites. Use of these DHCS tools ensure reviews are conducted in a consistent, objective, and regulator-aligned manner.

MOU-Based and Statewide MCP Collaboration

When primary care providers operate in shared networks, MOU-based collaboration and statewide MCP coordination support alignment on DHCS standards and reduce duplicative oversight. At the same time, each plan retains independent regulatory accountability. Statewide collaboration further promotes standardization across MCPs, supports a more unified voice on shared operational issues, and enables joint process-improvement initiatives, including projects with DHCS to enhance oversight and review processes statewide.

FSR Goals, Objectives, and Planned Activities

The goal of the FSR function is to validate primary care provider compliance with regulatory and contractual requirements that support safe care delivery. Performance is measured through routine monitoring of review timeliness, corrective action plan submission, and adherence to DHCS standards. Objectives include timely completion of required reviews, prompt corrective action planning, and consistent application of DHCS standards across primary care provider sites.

Planned activities include conducting reviews using DHCS audit tools and standards, providing education and technical assistance to primary care providers, monitoring corrective action plan submission and follow-up, and collaborating with partnering managed care plans to promote consistency, reduce duplication, and support standardization efforts. Ongoing oversight and internal quality checks are used to assess effectiveness and identify opportunities for improvement.

While FSR activities primarily focus on primary care provider sites, LTSS oversight extends the same safety framework into higher-risk, facility-based environments, where members often experience increased clinical complexity and require enhanced coordination across systems of care.

Long-Term Services and Supports (LTSS)
2026 Focus: Facility QAPI Oversight, Performance Improvement, and Regulatory Compliance

LTSS oversight supports member safety by strengthening facility-level quality systems, monitoring critical incidents, and ensuring regulatory compliance. In 2026, the primary focus of LTSS oversight is to ensure that all applicable LTSS facilities submit a QAPI program to the Alliance for review and that each submission includes all five QAPI elements required by the Centers for Medicare and Medicaid Services (CMS).

Previous QAPI submission requests identified opportunities for performance improvement and technical assistance, including instances in which facilities required support to establish a fully defined, operational QAPI program consistent with CMS requirements. In response, the Alliance has designated this effort as an MCP-led Performance Improvement Project for LTSS, focused on supporting facilities in developing, documenting, and maintaining QAPI programs that meet regulatory expectations and meaningfully support member safety.

Clinical Safety and LTSS oversight activities include outreach to applicable LTSS facilities, review of submitted QAPI programs to ensure inclusion of the five CMS elements, and provision of technical assistance and guidance as needed to support facilities in establishing

compliant, sustainable QAPI structures. Progress is monitored through routine review and follow-up to ensure completion and continued alignment with program expectations.

Once facilities have established QAPI programs that incorporate all five CMS elements, the Alliance will leverage PQIs, including critical incident data, CDPH citation and violation information, utilization metrics, and trend analysis, to assess whether facility QAPI and PIP activities are appropriately aligned with identified risks and opportunities for improvement. This data-informed review supports alignment of facility-level QAPI activities with areas most likely to enhance member care, safety, and quality outcomes.

Collaborative Care Coordination and Oversight
To further support member safety and continuity of care, Clinical Safety participates in structured, collaborative meetings with external and internal partners involved in LTSS member care. These meetings include county mental health agencies, Regional Centers, and internal departments such as Care Management, Utilization Management, Quality Improvement, and Behavioral Health.

These discussions promote shared understanding of roles and responsibilities across systems, support coordination during transitions of care, review member-level concerns, identify systemic barriers impacting LTSS members, and inform preventive interventions and targeted improvement efforts. Insights from these discussions may further inform LTSS oversight activities, facility engagement, and data-driven performance improvement efforts.

LTSS Goals, Objectives, and Planned Activities
The goal of LTSS oversight is to strengthen facility-level quality systems and reduce safety risks for members receiving long-term services and supports. Performance is monitored through routine reviews of QAPI submissions, PQIs, critical incident reports, utilization of metric analyses, and follow-up activities. Objectives focus on achieving comprehensive QAPI program implementation across applicable facilities, ensuring alignment with CMS requirements, and using data to guide targeted improvement efforts.

Planned activities include outreach and collection of LTSS QAPI submissions; review of QAPI programs for inclusion of all five CMS elements; provision of technical assistance and education as needed; quarterly tracking and analysis of PQIs, critical incidents, and utilization metrics; and use of CDPH data and trend analysis to inform facility engagement and targeted Performance Improvement Projects. Effectiveness is evaluated through ongoing monitoring, collaborative reviews, and assessments of the alignment between facility QAPI activities and identified safety risks.

Governance and Oversight
Clinical Safety activities are monitored through established governance structures that ensure member safety remains the central focus, regulatory and contractual requirements are met, identified risks are addressed promptly, and escalation pathways are consistently applied. Governance structures ensure alignment among Clinical Safety goals, operational execution, and regulatory expectations, with a sustained focus on member safety outcomes.

COLLABORATIVE CCAH QUALITY INITIATIVES

Equity Practice and Transformation Program (EPT)

The Equity Practice and Transformation (EPT) Program started in 2024. The EPT Program is for primary care practices to advance health equity and reduce health outcome disparities. The DHCS program incentivizes participating primary care practices to implement practice transformation and improve quality of service delivery. The Alliance is supporting 15 primary care providers (the fourth most projects out of all health plans in the state) in this pass-through payment program. The State Budget for Fiscal Year 2024/25 substantially reduced funding for the EPT program. As such, DHCS shortened the program duration from five to three years, cut down the total number of milestones from over 100 to 25, and reduced the amount earned per milestone. The Alliance has decided to supplement the funding lost from the State budget reduction and add in additional deliverables that will allow practices to earn the original allocation

In 2025, all 15 practices successfully completed the first year of the three-year program and met required milestones. Across participating practices, $24M in total funding is available ($17.3M DHCS and $6.7M Alliance), with $4.9M paid to date.

The Provider Partnership Program

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

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

Goals of this program include:

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

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

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

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

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

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

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

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

Practice Coaching

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

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

CLINICAL QUALITY IMPROVEMENT

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

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

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

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

- Availability of Practitioners (PCP, Specialists and Behavioral Health providers)
- Appointment access (routine and urgent appointments)
- Availability of PCPs by Language
- Language Assistance Services (In-Person Interpreter, Language Line and Hearing Impaired)
- Telephone access
- After-hours access to care
- Health Reach 24/7 Nurse Advice Line
- Transportation services
- Availability of Practitioners via Telehealth

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

Delegation Oversight
CCAH delegates responsibility of the utilization management, credentialing, rights and responsibilities, member engagement, and appeals and grievance, and quality to selected organizations. CCAH maintains accountability and ultimate responsibility for the associated activities by overseeing performance for the delegated functions. CCAH retains the right to revoke any delegated function if compliance with standards is not met. CCAH has a process in place to assess and ensure delegated entities have the ability to perform the delegated functions. All delegates, which are not NCQA accredited are required to pass an initial pre-delegation audit, and an annual delegation oversight audit are required to pass an initial pre-

delegation audit and an annual delegation oversight audit. An initial assessment is conducted pre-contractually to determine the organization's ability to provide delegated services and at least annually thereafter. CCAH attains all these through its DOC's:

- Review and approve the CCAH Delegation Oversight program charter, policies, and procedures at least annually, or more frequently depending upon business needs or changes to the Delegation Oversight Program requirements.
- Designate the staff that will participate in Delegates' audits.
- Review and approve the results of Delegates' annual audits.
- Review and approved pre-delegation audit results of prospective Delegates and make delegation recommendations.
- Review and approve scope of annual oversight audits.
- Make recommendations for conducting ad hoc audits.
- Review and approve sources of industry standard and guidelines use to evaluate Delegates' compliance with the Delegation Agreement.
- Review recommendations for monitoring activities.
- Participate in the review of corrective action plans, monitor, and evaluate their implementation.
- Escalate recurrent cases of non-compliance to the Compliance Committee.
- Make penalty recommendations when delegates do not consistently meet requirements.
- Report oversight activities to Compliance Committee and QIHE Committee.
- Provide annual audit report to QIHE Committee

The QIHEC continuously monitors delegated entities and reviews their performance on a quarterly basis. The Committee has the authority to place any delegated entity on a corrective action plan for deficiencies in performance. CCAH has a collaborative, supportive, relationship with its contracted delegates and meets with them at least quarterly to review reports and performance.

MEMBER SATISFACTION

In addition to HEDIS clinical measures, the QIHE program supports company-wide efforts to improve the member's experience with the plan's services and the provider network. CCAH uses Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores to evaluate member experience.

The plan contracts with NCQA certified vendors to conduct an annual CAHPS to monitor members' satisfaction with health care services, accessibility of care, continuity of care, quality of care and service, cultural and linguistic issues, and to identify and pursue opportunities to improve member satisfaction and the processes, which impact satisfaction. CCAH will conduct CAHPS surveys at least annually and the results will be presented to the QIHEC committees. CCAH will evaluate the survey results to develop an improvement plan to address areas identified. The report will include a drill down analysis of the CAHPS survey results at the clinic level to identify high and low performing clinics. This analysis will help CCAH to learn best practices form high performing groups and work with low performing groups to improve performance.

In addition to the CAHPS survey, CCAH also has a robust grievance process that monitors patient satisfaction with the Plan's services and providers on an ongoing basis. The Plan will be working with the internal departments involved to collaborate on methods to improve member satisfaction and to focus on any findings from grievances for resolution.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)
The QI program supported companywide efforts to improve the members' experience with our service and our provider network. CCAH uses Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores to evaluate member experience. Providers are evaluated against the following CAHPS measures:

- Rating of the health Plan
- Customer Service
- Getting Care Needed
- Getting Care Quickly

Providers are evaluated against the following CAHPS measures:

- Rating of Personal Doctor
- Rating of Health care quality
- Appeal and Grievance
- Access and availability

Provider Performance Results
In line with CCAH's mission of continuously improving the health of the community, the health plan's QIHE program aims to:

- Improve the quality and efficiency of health care provided to CCAH members.
- Improve members' experiences with services and care received.
- Improve members' health outcomes.
- Provide culturally sensitive and linguistically appropriate services.
- Promote the safety of all members in all treatment settings.
- Ensure timely access and availability of services for all members, including those with complex or special needs, including physical or developmental disabilities, multiple chronic conditions, and severe mental illness.
- Promote processes to ensure the availability of "safe, timely, effective, efficient, equitable, patient centered care" and provide oversight within the network.

The following strategies are being adapted to achieve above goals:

- Focus on managing chronic conditions by adhering to and providing best practices in the care of their condition(s)
- Focus on improving patient safety by ensuring that evidenced-based clinical practice guidelines are followed in providing care and best practices are implemented at inpatient care settings.
- Focus on preventive health for the members by ensuring that they get access to preventive services in a timely manner and by adopting evidence-based medicine in prevention and health promotion.
- Focus on improving performance of different quality measures during the measurement year including, but not limited to:
- NCQA HEDIS Measures – CCAH utilizes select HEDIS measures to monitor and implement quality improvement projects for NCQA health plan and health equity accreditation
- Managed Care Accountability Set (MCAS) - CCAH's goal is to calculate the rates required for MCAS, stratify DHCS-selected MCAS measures, and exceed the minimum performance level (MPL) as determined by DHCS.

Initial Health Appointment
CCAH recognizes the importance of improving Initial Health Appointments (IHA) rate as a key initiative to providing better care to members. CCAH has developed training for providers on IHA requirements that are conducted during the new provider in-service. To effectively monitor the accuracy of completed IHAs, CCAH has also identified the appropriate claims and encounter codes used to identify initial health appointments. In addition, the Coding Analyst conducts a medical record audit twice yearly to ensure that providers are accurately completing and documenting all the elements required as part of the IHA in the medical records. The QIPH department will track and trend the IHA rates and findings from the medical record audit and develop interventions as necessary to improve quality of care. IHA's are also tracked and addressed during the Facility Site Review (FSR) and Medical Records Review (MRR) onsite visit of the Providers office by our QM nurses.

Member Engagement Standards
CCAH has established Health and Wellness Programs to provide the members with a variety of opportunities to improve health. The purpose of the health and wellness programs is to provide opportunities for members to improve their health by participating in wellness activities available to them. The Health and Wellness Programs are available to all members that are enrolled with CCAH. Members have access to all the tools, activities, programs, and incentives that are part of the Health and Wellness Programs. All members are informed about the Health and Wellness Programs at the time of enrollment and at least annually thereafter. CCAH also promotes the Health and Wellness Programs on the website. The program is evaluated annually for effectiveness.

CCAH rewards its members for taking steps to be healthier with the Health Rewards program – an incentive program that rewards members for getting routine care, managing chronic conditions, adopting healthy lifestyle habits through raffles and direct incentives. Through this program, members that complete the requirements for the incentive will earn a Target Gift Card, the values vary. CCAH identifies eligible winners two ways: 1. Monthly list of eligible winners for each incentive is created using claims and supplemental data. 2. Attendance records for completion of workshops. CCAH will work with its internal finance team to mail out gift cards to raffle winners and workshop attendees. Our direct incentives are managed by a vendor, CCAH sends a list of eligible members, and the vendor mails out the gift cards. CCAH Health Rewards program incentivizes the following services:

- Well Visits for 0-15 months of age, 30 months of age, and 18-21 years of age.
- Immunizations: Childhood Immunizations (CIS-10), Flu Second Dose, and Adolescent Immunizations {IMA-2)
- Prenatal & Postpartum visits
- Use of Nurse Advice Line
- Healthier Living Program workshop series.
- Live Better with Diabetes Program workshop series.
- Healthy Weight for Life workshop series

- Comprehensive Member Portal
  CCAH has worked in driving its members more to use the health plan's portal through developing a comprehensive website where member related information and updates can be seen. CCAH Member Portal offers the following:
  - Member Tools
  - Customer Service
  - Creating an Account
  - Provider Directory
  - Medical EOC

- Formulary

- Member Information
  - Benefits and Services
  - Appeals and Grievance
  - Medi-Cal Redetermination
  - Medi-Cal Eligibility
  - Rights and Responsibilities
  - Case Management
  - Member Portal information are being constantly updated to deliver the latest, most valuable information that may serve its members. For better CCAH experience, there is also the MyCCAH App that members can download from the APP store or Android Market.

- Social Media Platform
  - CCAH also facilitates the sharing of ideas, thoughts, and information via Facebook, where its members can follow for identity, conversations, sharing, relationships, presence, and support.

- Diversity, Equity, Inclusion and Belonging Committee
  - In view of the current national awareness on racial equality, CCAH is working with a consultant to form a permanent working group for this committee to achieve inclusion and belonging through implementing and maintaining DEIB best practices. Our goal is to develop a framework by partnering with consultants with expertise in Diversity, Equity Inclusion, and Belonging to influence and sustain DEIB practices within the organization. A comprehensive and clear framework is needed to address DEIB comprehension and review our policies and practices to support an inclusive culture. In addition to promoting equity, this framework will help our workforce develop the skills needed to support health equity in our diverse membership. Additionally, this committee will work toward providing ongoing: Provider education and Training.
  - Member support and programs
  - Employee training and activities.

- Provider Engagement
  - CCAH's QIHE program works hand in hand with the plan's Provider Services Department for provider involvement/engagement. This department has representatives for providers. This team helps ensure that network providers are engaged through:
  - Soliciting provider input to the health plan for the development and implementation of health plan's policies and standards,
  - Identification of provider needs and gaps.
  - Assistance on other areas in which provider input and engagement are critical.
  - Coordination of provider feedback on matters relevant to health plan and quality improvement activities that impact providers.
  - Educate providers on member benefits and available programs.

- QIHE program's Strategies for Provider Engagement includes:
  - Provider Partnership and Coaching opportunities
  - Provider Incentives
  - Care-Based Incentive (CBI) for PCPs
  - Hospital Incentive

- Data Sharing Incentive
- Specialty Care Incentive (SCI)
- Clinic JOC (clinic and hospital)
- Provider Satisfaction Survey
- HEDIS Provider Awards
- Provider Portal

- CCAH has worked on driving its network providers more to use the health plan's portal through developing a CCAH Provider Portal offers the following:
  - Home Page
    - Important Information for Providers
    - Portal News
    - Provider News
    - Quick Links
    - Provider Events Calendar

  - Main
    - Claims Search
    - Overpayment Letters Search
    - Eligibility Search
    - Provider Directory
    - Prescription History
    - Data Submissions

  - Auths and Referrals
    - Jiva (Care Management Software)
    - Procedure Code Lookup
    - Authorization/Referral Search – Prior to 7/15/2024

  - Reports
    - Linked Member List
    - Quality Reports
    - Care Based Incentives (CBI)
    - HEDIS (MCAS) Reports

- The Alliance Website offers provider related information, updates, and resources:
  - Manage Care
  - Behavioral Health
  - California Children's Services
  - Clinical Resources
  - Cultural and Linguistics Services
  - Enhanced Care Management and Community Supports
  - Health Education and Disease Management
  - Pharmacy
  - Quality of Care
  - Provider Incentives
  - Health Assessments
  - HEDIS
  - Immunization Resources
  - Member Incentives
  - Site Reviews

- Resources

- COVID-19
- Claims
- Forms
- Provider Credentialing Applications and Policies
- News
- Provider Directory
- Provider Manual
- Timely Access to Care
- Webinars and Training
- Emergency Preparedness
- Provider Portal

ANNUAL QUALITY IMPROVEMENT AND HEALTH EQUITY EVALUATION

An evaluation of the QIHET Program is completed at the end of each calendar year. The annual evaluation is conducted by the QIPH staff in conjunction with designated department leaders. The evaluation includes:

- A description of completed and ongoing QIHETP and Culturally and Linguistically Appropriate Services (CLAS) activities.
- Trending of measures and goals to assess performance in the Consumer Assessment of Healthcare Providers and Systems (CAHPS); Utilization, Member experience, and staff experience of language services; Healthcare Effectiveness and Data Information Set (HEDIS) Program; Care-Based Incentive (CBI) Program; stratified measure review; clinical safety; Member complaints and appeals; access to care; geo-access to practitioners; population health management strategy; and additional activities in relation to quality of service.
- Assessment of barriers and/or limitations when performance does not meet goals.
- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Analyses of demonstrated improvements, including assessing whether there was meaningful improvement in a measure.
- An analysis of the overall effectiveness of the program, including progress toward influencing network-wide safe clinical practices.
- An evaluation of delegated activities, if any.
- Recommendations for changes to be incorporated into the subsequent QIHETP Description and annual QIHE work plan.

QUALITY IMPROVEMENT AND HEALTH EQUITY WORKPLAN

The QIHET work plan is the schedule of activities for the QIHET Programs. The QIHET work plan includes the main tasks that cover the scope of the QIHET Program including quality program structure, quality of clinical care, safety of clinical care, member experience, and quality of service yearly goals; yearly objectives; yearly planned activities; time frames for completion of each task; the person responsible for the task; monitoring of previously identified issues; and scheduled evaluation of the quality improvement program. It is prepared as a calendar with a rolling schedule. At any point in time a full year of activities is visible. QIHET activities and indicators are ongoing and continuous. They are not discontinuous at the end of the year.

The QIHET work plan is not a static document. It is approved annually by the QIHEC Committee but is revised and developed more fully in response to the analysis of performance data, interventions, remeasurement timeframes and the addition and deletion of indicators on an ongoing basis.

DATE: August 26, 2026

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

FROM: Kay Lor, Director, Provider Payment Strategy

SUBJECT: Proposed 2027 Enhanced Care Management (ECM) Payment Methodology

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Recommendation. Staff recommend the Board approve the payment methodology and rates for Enhanced Care Management (ECM) as outlined below:

1. ECM: Transition provider reimbursement to a Fee-For-Service (FFS) payment structure
2. Outreach: $25 per outreach, $150 maximum.

Background:

Since the launch of Enhanced Care Management (ECM) in 2022, the Alliance has adjusted its provider payment methodology in phases to support program implementation, maintain provider participation, and respond to evolving Department of Health Care Services (DHCS) expectations. From 2022 through 2025, ECM providers were reimbursed by the Alliance through a capitated payment model. This approach provided predictable funding during the early years of the program, when providers were building capacity, establishing workflow maturity, and serving new ECM populations of focus.

As the program matured, DHCS increased its focus on encounter-based reporting, service intensity, appropriate utilization, and alignment between payments and services delivered. In response, the Alliance began moving away from capitation in 2026 and implemented a case-rate model that required a minimum of two encounters. To minimize disruption for providers and members while beginning to strengthen accountability for service delivery and encounter submission, the reimbursement rate was not reduced. However, the Alliance revenue from DHCS was reduced by approximately one-fourth.

The 2026 case-rate model was intended as a bridge rather than a final payment structure. It helped providers begin adapting to encounter-based billing while preserving financial stability during a period of program and revenue change. At the same time, it allowed the Alliance to assess whether payment levels, service utilization, and provider billing patterns were consistent with the direction DHCS was setting for ECM.

In the first half of 2026, DHCS shared program guidance that further reinforced the need for plans to regularly assess ECM service delivery and payment methodologies. Meanwhile, as reported to the Board on May 27, 2026, staff observed that ECM referrals and enrollment had grown faster than expected and many ECM enrollees were falling into medium- or low-risk populations. To better align with DHCS expectations that ECM prioritize the highest-risk

members, the Alliance began strengthening program integrity and operational practices, including re-assessment for low- and medium- risk members, clarification of eligibility, and updates to provider training materials and sessions.

Discussion:
The recommended 2027 rates are intended to better align ECM reimbursement with DHCS expectations, observed service utilization, and the actual cost of delivering eligible ECM services. As described above, the Alliance used the 2026 case-rate model as a transition step to help providers move toward encounter-based billing while minimizing disruption. For 2027, staff recommend completing that transition by moving to a full fee-for-service methodology to meet DHCS utilization expectations.

This change is needed because early 2026 utilization data shows that current ECM service patterns differ significantly from the assumptions used in DHCS revenue calculations. During the first quarter of 2026, members receiving ECM services utilized an average of 1.10 service hours and 2.50 visits per month. Approximately 60% of services were delivered through non-clinical telehealth, and 94% were provided by non-clinical providers. By comparison, current DHCS revenue assumptions are based on an average of five service hours per month, with 40% of service hours delivered by clinical providers.

These differences indicate that the current payment approach does not sufficiently distinguish between the type, intensity, and setting of services provided. The recommended 2027 fee schedule addresses this by establishing separate rates for clinical and non-clinical services, as well as in-person and telehealth encounters. This structure better connects payment to the services delivered and creates clearer encounter data to support program oversight, future rate development, and alignment with DHCS expectations.

To develop these rates, staff reviewed updated DHCS policy guidance and worked with external actuaries to assess utilization, provider costs, and service requirements. The proposed fee schedule incorporates a 5% trend adjustment, 3% wage adjustment, and 30% allowance for indirect services. Staff recommend this approach because it supports appropriate reimbursement for ECM activities while encouraging the program to focus on high-touch, person-centered care for members who meet ECM eligibility criteria.

2027 Provider Rates: Fee-For-Service Fee Schedule

Proposed 2027 FFS Rate	Hourly Rate
Clinical ECM (in-person)	$204
Clinical ECM (Telehealth)	$163
Non-Clinical (in-person)	$102
Non-Clinical (Telehealth)	$82
Outreach	$25 per outreach, $150 max

Overall, the proposed methodology is designed to:

- Align rates with the type, intensity, and setting of ECM services delivered.
- Support DHCS expectations for encounter reporting, appropriate utilization, and service delivery.

- Distinguish between clinical and non-clinical services and between in-person and telehealth encounters.
- Allow reimbursement for indirect care management activities that support member engagement and care coordination.
- Improve the data needed for future program oversight, rate development, and sustainable funding.

Fiscal Impact.
The changes will be included in the 2027 Medical Budget for Board approval in December.

Attachments. N/A

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DATE: August 26, 2026

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

FROM: Kay Lor, Director, Provider Payment Strategy

SUBJECT: Proposed CY2027 Incentive Program Changes

Recommendation. Staff recommend the Board approve the proposed modifications to the calendar year 2027 incentive programs and rate methodology.

1. Hospital Quality Incentive Program (HQIP): Change the payment rate for the Emergency Department (ED) follow-up measure.

2. Behavioral Health Incentive Program (BHIP): Removal of seven measures.

3. Specialty Care Incentive: Removal of one measure.

4. Care Based Incentive (CBI): Removal of three measures and addition of five exploratory Dual Eligible Special Needs Plan (D-SNP) measures.

Background: The Alliance's quality incentive programs aim to encourage providers to improve care by aligning financial rewards and partnership with Managed Care Plans (MCPs) to further improve transitional care services, reduce unnecessary healthcare costs, and improve service delivery, with a focus on improving members' access to comprehensive care based on member needs.

Effective January 2026, the Department of Health Care Services (DHCS) requires MCP provider incentive programs to include a defined performance period, a signed contract before the performance period, clear performance metrics, and specified payment amounts tied to achievement. To comply with the new requirements, existing measures have been designated as either incentive-based or fee-for-service add-ons. This classification change does not alter the programs themselves, rather a classification of each measure within each program. The Alliance currently has six programs, summarized below:

- Hospital Quality Incentive Program (HQIP): Hospital clinical data exchange program to further advance transitional care services, coordinate care across settings and maintain engagement with high needs Medi-Cal members during transition.

- Specialty Care Incentive (SCI): Improving specialty access, enhancement of quality through timely referrals, faster diagnosis and treatment, and fewer care gaps.

- Behavioral Health Incentive Program (BHIP): The program was developed as part of the Behavioral Health benefit in-sourcing effort, effective July 1, 2025. Its goal is to improve access to behavioral health services and strengthen outcomes by supporting early treatment, reducing language-related disparities, and preventing avoidable crises.

- Risk Adjustment (RA): As part of the Dual Eligible Special Needs Plan (D-SNP) program effective January 1, 2026, the RA program is designed to encourage providers to improve quality through care gaps closure and improve patient quality through earlier intervention and more appropriate, and timely care.

- Data Sharing (DS): The Alliance's Data Management Strategy provides a framework for creating, acquiring, storing, sharing, processing, and governing data. The DS program supports this strategy by incentivizing providers to participate in a Health Information Exchange (HIE), which serves as the primary mechanism for data exchange between the Alliance and its partners. This program is designed to target providers (except for hospitals) to participate in the data exchange.

- Care Based Incentive (CBI): Since 2010, the Alliance's CBI program has supported primary care providers in adopting and advancing the Patient-Centered Medical Home (PCMH) model. The program encourages delivery of high-quality, coordinated care by incentivizing providers to complete key care activities, close care gaps, and ensure appropriate, timely services that improve overall patient outcomes.

1. Hospital Quality Incentive Program (HQIP)

Discussion:
For performance year 2027, staff recommend reducing the incentive for the Emergency Department (ED) follow-up visit measure from $50 to $25 per electronic record submitted after discharge. This change reflects the expansion from high-risk discharges to all ED discharges, with the goal of obtaining electronic records for all ED visits.

Final 2027 HQIP Program Measures:

Measurement	Objective	FFS (add-on) or Incentive
Transitional Care Services (TCS)	Clinical data exchange	FFS (add-on)
	Decrease 30-Day all-cause readmissions	Incentive
	Increase Post discharge f/u within 14 days	Incentive
ED follow-up visit	Clinical data exchange	FFS (add-on)
	Decrease avoidable ER visits	Incentive
HIE Connection Data Submission	Data connection with CCAH HIE of choice	FFS (add-on)

Recommendation. Staff recommend the Board approve the ED follow-up visit measure to $25 per electronic medical record.

2. Behavioral Health Incentive Program (BHIP)

Discussion:
As part of the Behavioral Health benefit in-sourcing effective July 1, 2025, the program was designed to support the strategic goal of improving behavioral health services by increasing access, better managing members' mental health needs, improving quality of life, and ensuring timely treatment for mental and behavioral health conditions. After implementation, staff further evaluated each measure and recommended removing seven measures. For performance year 2027, staff recommend removing seven measures, as described below.

Removal of two measures: Provider Completion of Survey and Provider Completion of DHCS Training Measure: The SCI program removed both measures in calendar year 2026, and to align the BHIP program with SCI, staff recommend removal of this measure for 2027.

Removal of Sign-on Provider & Retention Bonus:
This measure was designed to support network development efforts during the early phase of the in-source efforts and has successfully achieved its objective; therefore, staff recommend its removal.

Removal of Provider Bilingual Bonus: This measure was originally established to support network development during the early phases of the in-sourcing effort. When staff developed the supplemental payment methodology approved by the Board on August 28, 2024, this measure was incorporated into the "*advance health equity"* component of the methodology. To align the programs and avoid duplication, staff recommend removing this measure from the BHIP program, as it is already included in the supplemental payment methodology for 2027.

Removal of DHCS Adverse Childhood Experiences (ACEs) Aware Training Measure:
The ACEs training measure is designed to encourage primary care providers (PCPs) to screen for Adverse Childhood Experiences (ACEs) and incorporate trauma-informed care into clinical practice. The training is intended for clinicians who are most likely to conduct ACE screenings as part of routine primary care services. For the Alliance, the ACEs measure is already included in the CBI program for primary care providers (PCPs). Staff recommend removing this measure from BHIP, as behavioral health providers do not typically perform ACE screenings and are therefore not the primary target of the measure.

Removal of the ED Utilization Measure:
Primary care providers (PCPs) are typically a member's first point of contact within the healthcare system and are best positioned to influence and reduce inappropriate emergency department (ED) utilization. Compared with behavioral health providers, PCPs play a more direct role in managing members' overall care, coordinating services, and directing members to appropriate care settings. To align with the way members are managed through their PCPs, staff recommend removal.

Removal of Access – Community Setting
The goal of this measure is to encourage BHIP providers to deliver services in a community setting when appropriate. Because behavioral health services are not typically delivered or

coordinated through community-based primary care settings, and as of today, there's no service provided for this measure, staff recommend removal.

Final 2027 BHIP Program Measures:

Measurement	Objective	FFS (add-on) or Incentive
PCP Coordination	Respond to prompts from DMHC & DHCS to increase data sharing and PCP and BH provider collaboration	FFS (add-on)
Member Access (Above Average Member Engagement)	Expand provider acceptance of members and increase number of members seen with timely access to care	FFS (add-on)
ABA Therapy Access - After hours and weekends	Bridge availability disconnects and increases member access to care through extended availability by providers	FFS (add-on)
Bilingual Visit "add-on"	Improve member quality of care through closing language barriers	FFS (add-on)

Recommendation. Staff recommend the Board approve the removal of seven measures.

3. Specialty Care Incentive (SCI)

Discussion:
The Specialty Care Incentive (SCI) Program aims to further improve access and outcomes for traditionally medically underserved populations while benefiting the broader community. For 2027, staff recommend removing one measure, as described below.

Removal of Increase Palliative Care Referrals
The measure was intended to encourage referrals from providers not affiliated with the same physician group or financial relationship. As the program matures, utilization referral patterns have increasingly involved affiliated providers, creating potential legal risk. To mitigate this risk, management recommends discontinuing the measure.

Final 2027 SCI Program Measures:

Measurement	Objective	FFS (add-on) or Incentive
Reduce OB C-Section Rate	Encourage appropriate delivery methods that drive better outcomes for members	Incentive

Increase California Children's Services (CCS) Referral Rate	Timely diagnostics and treatment for children with eligible medical conditions (i.e. cystic fibrosis, cerebral palsy, heart diseases) through referrals	FFS (add-on)
Specialist Coordination with PCP	Respond to prompts from DMHC & DHCS to increase data sharing and PCP and BH provider collaboration.	FFS (add-on)
Above Average Member Engagement (increase timely access)	Expand provider acceptance of members and increase number of members seen with timely access to care	FFS (add-on)
ED f/u visit	Reduce ED utilization and inpatient admissions through 14-days	FFS (add-on)
Increase OB Doula Referrals	Increase referrals for Doula's	FFS (add-on)

Recommendation. Staff recommend that the Board approve the removal of the Increase Palliative Care Referrals measure.

4. Care Based Incentive (CBI)

Discussions:
The proposed 2027 CBI updates include the removal of three measures and the addition of five exploratory Dual Eligible Special Needs Plan (D-SNP) measures. The exploratory measures are not tied to payment; the goal is to establish performance baselines, gain experience with providers serving the dual-eligible population and inform the development of future incentive programs.

The following measures are removed for the 2027 program:

- Removal of Ambulatory Care Sensitive Admissions: This measure is not a part of the regulatory reporting requirements. In removing this measure, the providers would be able to prioritize their focus on the remaining hospital measures.

- Removal of Chlamydia Screening: To align with MCAS, this measure is removed from the MCAS measure set for reporting in MY2026 and recommended to remove to achieve alignment.

- Removal of Diagnostic Accuracy and Completeness Training: With the launch of the D-SNP Risk Adjustment (RA) incentive program, this measure should be removed to avoid duplication, as it is now included in the RA program.

The following five exploratory measures are added to the D-SNP program:

Measures that overlap between CBI and D-SNP star rating program were selected to help providers transition to D-SNP. Using familiar CBI metrics reduces complexity and supports early success.

List of Five Exploratory Measures

- Breast Cancer Screening:
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Diabetic Poor Control >9%
- Plan All-Cause Readmissions

Final 2027 CBI Program Measures:

Measure Category	Measure Name	FFS (add-on) or Incentive
Care Coordination – Access Measures	Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents	Incentive
	Application of Dental Fluoride Varnish	Incentive
	Developmental Screening in the First 3 Years	Incentive
	Initial Health Appointment	Incentive
	Post-Discharge Care	Incentive
Care Coordination – Hospital & Outpatient Measures	Plan All-Cause Readmission	Incentive
	Preventable Emergency Visits	Incentive
Quality of Care Measures	Breast Cancer Screening	Incentive
	Cervical Cancer Screening	Incentive
	Child and Adolescent Well-Care Visits (3-21)	Incentive
	Colorectal Cancer Screening	Incentive
	Controlling High Blood Pressure	Incentive
	Diabetic Poor Control >9%	Incentive
	Immunizations: Adolescents	Incentive
	Immunizations: Children (Combo 10)	Incentive
	Lead Screening in Children	Incentive
	Screening for Depression and Follow-up Plan	Incentive
	Well-Child Visit in The First 15 Months	Incentive
	Well-Child Visits for Age 15 months–30 months of Life	Incentive
Fee-For-Service	Adverse Childhood Experiences (ACEs) Training and Attestation	FFS (add-on)

	Behavioral Health Integration	FFS (add-on)
	Cognitive Health Assessment Training and Attestation	FFS (add-on)
	Patient-Centered Medical Home (PCMH) Recognition	FFS (add-on)
	Quality Performance Improvement Projects	FFS (add-on)
	Social Determinants of Health (SDOH) ICD-10 Z Code Submission	FFS (add-on)

Recommendation. Staff recommend the Board approve the removal of three measures and add five exploratory D-SNP measures.

Fiscal Impact.
The changes will be included in the 2027 Medical Budget for Board approval in December.

Attachments. N/A

DATE: August 26, 2026

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

FROM: Jenifer Mandella, Chief Compliance Officer

SUBJECT: Q1-2 2026 Compliance Program Reporting

Recommendation. Staff recommend the Board receive the Compliance Program Report for Q1-2 2026 and approve revisions to the Compliance Plan and Code of Conduct.

Summary. This report summarizes the Alliance's Compliance Program activities and key risk areas for Q1-2 2026 and includes a recommendation to receive the Compliance Program Report and approve revised guiding documents.

Background. The Alliance is required to implement an effective Compliance Program that meets the requirements set forth in 42 C.F.R. §§ 438.608. 422.503(b)(4)(vi), and 422.504(b)(4)(vi). Modeled off the United States Federal Sentencing Guidelines' (FSG's) seven elements of an effective compliance program, and articulated in the Compliance Plan, the Alliance's Compliance Program takes a systematic and strategic approach to decreasing risk posed by non-compliance.

The FSG states "The organization's governing authority shall be knowledgeable about the content and operation of the compliance and ethics program and shall exercise reasonable oversight with respect to the implementation and effectiveness of the compliance and ethics program."

The Board retains responsibility for oversight of the Compliance Program and has delegated that oversight authority to the Compliance Committee with periodic reporting to the Board. Updates on the implementation and effectiveness of the Compliance Program occur through the routine submission of Compliance Committee minutes, inclusion of relevant content in the monthly CEO memo, the inclusion of key Compliance Program metrics in the Alliance Dashboard, and the receipt of semi-annual reporting from the Chief Compliance Officer.

Discussion. The following content serves to inform the Board of the Alliance's Compliance Program activities for Q1-2 2026 and affirm that the Alliance's Compliance Program is effective in preventing, identifying, addressing, and mitigating risk.

Legal and Regulatory Updates

Compliance staff continue to monitor, assess, and coordinate implementation of new regulatory requirements, including legislation, contract amendments, state regulations, and

sub-regulatory guidance. Significant regulatory developments which shape the environment in which we operate are summarized below for Board awareness.

- Program Integrity - Federal regulators continue to be focused on Medicaid program integrity, in turn resulting in DHCS' increased scrutiny on areas like adequacy and efficacy of managed care plans in preventing, identifying, and addressing FWA; provider screening, enrollment, and eligibility for participation in federally funded programs, and certain high-risk benefits such as hospice, home health, laboratory, behavioral health therapy, enhanced care management, and community supports. In preparation for potential increased plan scrutiny, staff completed a comprehensive Program Integrity assessment, to identify any gaps in process, controls, or oversight of these risk areas. The assessment confirmed the Alliance has robust processes, and as is to be expected when regulatory expectations change frequently and rapidly, opportunities to enhance reporting and improve operational consistency across programs. As an outcome, staff have developed a prioritized, phased roadmap focused on ensuring the Alliance remains well-positioned as program integrity expectations continue to evolve.
- Enhanced Care Management and Community Supports – At the state level, DHCS continues to evolve programmatic and financial policy related to ECM AND CS. With the newly invigorated federal focus on PI, especially in programs that are not strictly clinical in nature, DHCS has been focused on ensuring that benefits are producing the expected return on investment; that plans are offering the expected intensity of services to the population most at need, and that funding is tied to encounter data and outcomes.
- Privacy, Consent, and Information Sharing - The regulatory environment governing health information exchange continues to expand as California simultaneously advances initiatives intended to improve care coordination and interoperability across the healthcare system while promulgating rules that provide added protections on sensitive health information. Maintaining compliance with federal privacy rules, including HIPAA and 42 CFR Part 2, adds a layer of challenge. In response, the Alliance is advancing a coordinated enterprise approach to privacy, consent management, and information sharing. This work takes a complicated maze of rules that dictate what data must, can, and cannot be shared, with whom, and systematizes this in a way that lets line staff do their work while being confident that they are respecting the member's wishes around disclosure of PHI.
- NCQA Health Equity Accreditation - NCQA recently substantially revised its Health Equity Accreditation (HEA) program, removing a number of requirements and rebranding the accreditation as Health Equity Optimization (HOA). DHCS has indicated that, because the revised HOA standards are no longer aligned with the State's health equity strategy, Medi-Cal managed care plans are no longer required to maintain HEA or pursue HOA. DHCS instead intends to incorporate relevant health equity requirements into managed care plan contracts, potentially as early as 2027. The Alliance's current NCQA HEA accreditation remains in effect through 2028. Based on DHCS' direction, the reduced scope of the HOA standards, the potential for misalignment between HOA and forthcoming DHCS contract requirements, staff have decided not to pursue HOA and will instead align with DHCS' contractual health equity requirements.

Regulatory Audits

The Alliance undergoes routine audits and examinations of its finances and operations by regulatory oversight agencies and independent auditing organizations. External regulatory oversight during the reporting period largely produced favorable results. The Alliance completed four external audits or reviews with minimal findings, closed the remaining findings from the 2025 DHCS Medical Audit, received formal closeout of the 2022 DHCS Targeted Behavioral Health and Transportation Audit, and continued timely preparation for upcoming regulatory reviews. The following summarizes external audit activity and notable audit status updates reported during this reporting period, including the closure of findings from prior audits.

External Audits/Reviews Completed	7
New Findings	2
Findings Closed During Reporting Period	1
Audits In Progress / Upcoming	2

<u>Audits Concluded</u>

- CMS Enrollment Data Validation (EDV) Audit – CMS conducts Enrollment Data Validation to confirm that certain Medicare enrollment and disenrollment transactions are accurate and supported by appropriate documentation. CMS began conducting EDV in January of 2026 and to date, with findings identified in 2 of the 5 reviews. The January EDV audit received findings, which were the result of staff not receiving CMS communications on the audit until the results were provided. Most recently, the audit of May data identified findings related to lacking supporting documentation. The plan has since mitigated these findings and addressed the related documentation issue.
- CMS Triennial Network Adequacy Review – Every three years, CMS evaluates Medicare Advantage (MA) plan networks to confirm adherence to federal network adequacy and geographic access standards. In June 2026, CMS determined that the Alliance TotalCare network met requirements with no need to submit a service area exemption.
- 2025 DHCS Medical Audit – DHCS formally closed out the two findings from the 2025 DHCS Medical Audit, related to the timely and complete resolution of member grievances, indicating that corrective actions implemented were sufficient to resolve any concerns.
- DHCS Targeted Behavioral Health and Transportation Audit – recently, DHCS issued a formal closeout notification indicating that all findings, which we had resolved from an operational standpoint in late 2024, were deemed corrected. The audit was a statewide review conducted in 2022 to assess the adequacy of care coordination for members receiving services from both plans and the county mental health plans, as well as a review of transportation services focused on ensuring broad access.
- NCQA HEDIS / MCAS Audit – The Alliance successfully completed the annual NCQA HEDIS and DHCS Managed Care Accountability Set (MCAS) audit cycle for

Measurement Year (MY) 2025, which validates the accuracy and integrity of the Alliance's quality performance reporting. All audit activities were completed on schedule with no findings, deficiencies, or corrective actions.

- 2025 Network Adequacy Validation Audit – Annually, DHCS engages an External Quality Review Organization (EQRO) to independently validate plan network adequacy, including the methodology used to collect, validate, analyze, and interpret provider network data. The Alliance received a 100% validation score with no findings or corrective actions.
- Annual Independent Financial Audit – The Alliance's independent audit of 2025 financial statements confirmed adherence to generally accepted accounting principles (GAAP). Baker Tilly issued an unmodified ("clean") audit opinion, concluding that the Alliance's financial statements present fairly, in all material respects, the Alliance's financial position, results of operations, and cash flows, providing independent assurance regarding the accuracy and reliability of the Alliance's financial reporting.

Audits In Progress / Upcoming

- DMHC 2024 Medical Survey Follow-Up – This is a routine DMHC follow-up review to verify corrective actions for the 7 out of 12 deficiencies that were deemed uncorrected on the 2024 Medical Survey Final Report. The uncorrected deficiencies spanned Quality Assurance, Grievances and Appeals, Utilization Management, and Prescription Drug Coverage. Compliance is coordinating the review, and the Alliance has completed all required pre-onsite submissions on schedule in preparation for the September 2026 validation.
- DHCS 2026 and 2027 Annual Audit – The Alliance's routine DHCS Annual Audit for 2026 was deferred to 2027 in coordination with DHCS to accommodate the Alliance's D-SNP implementation. The Alliance's next DHCS audit is scheduled for early 2027 and will include a two-year lookback period.

Regulatory Notices of Non-Compliance

Federal and state regulators routinely monitor the Alliance's operations for compliance with contractual and regulatory requirements through audits, ongoing oversight, and enforcement activities. During Q1–Q2 2026, the Alliance's regulatory compliance posture remained satisfactory. Regulatory activity consisted primarily of isolated administrative compliance matters, including one formal CMS Notice of Non-Compliance, two DMHC administrative findings requiring corrective action, and one DHCS quality performance monetary sanction. No operational sanctions affecting the Alliance's participation in federal or state programs were imposed.

Formal Regulatory Notices / Enforcement Actions	5
Corrective Action Plans (CAPs) or Pre-CAPs Required	3
Administrative Penalties	1
Monetary Sanctions	1

Regulatory Activity Details

- CMS Notice of Non-Compliance - CMS issued a Notice of Non-Compliance after identifying an impermissible formulary tiering change during the CY 2026 formulary submission process. The issue was corrected promptly by the PBM prior to the formal CMS notice. The finding occurred before enrollment began under the contract, resulting in no member impact. No sanctions or corrective action requirements were imposed and this matter is resolved.
- DHCS Medi-Cal Managed Care Accountability Set (MCAS) Monetary Sanction (Measurement Year 2024) – In late 2025, DHCS imposed a $25,000 monetary sanction, the minimum amount authorized under the applicable enforcement framework, as the Alliance did not achieve the minimum performance level for select MCAS quality measures in Merced. The sanction, paid in November 2025, was based on quality performance outcomes rather than operational or administrative compliance deficiencies. The Alliance has continued implementing quality improvement initiatives to improve measure performance.
- DHCS Pre-CAP for Transitional Rent Implementation – In December 2025, DHCS issued a statewide Pre-CAP to all California managed care plans regarding the slow progress in execution of transitional provider contracts. The Alliance submitted all required responses timely and has executed the required provider agreements across all five service area counties**.** After the Plan provided its final update, DHCS issued a final approval to implement Transitional Rent for the Behavioral Health population of focus.
- DMHC Enforcement Action regarding timely Grievance Report submission – DMHC issued an enforcement action after the Alliance submitted its Q4 2025 grievance report after the regulatory filing deadline. DMHC proposed an administrative penalty of $2,750 and required the Alliance to implement a CAP addressing the root cause of the late submission and strengthening processes to ensure timely regulatory filings. The Alliance has implemented corrective action, submitted its CAP, and intends to accept the settlement.
- DMHC Health Equity Performance Findings CAP – DMHC issued a CAP after finding that the Plan failed to timely report the Health Plan Demographic Data Metric required by the Health Equity and Quality Program for its IHSS line of business. The Alliance is in process of preparing a CAP response.

Program Integrity and Investigations

Privacy and Security

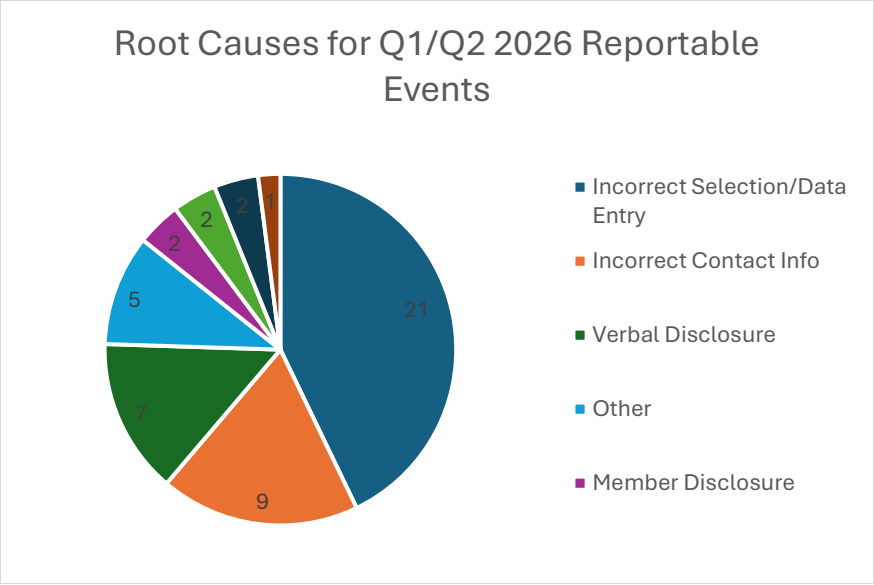
The Alliance ensures appropriate controls are in place to prevent inappropriate access to Alliance systems and data, as well as to prevent unnecessary disclosure of protected health information (PHI), with both Compliance and Information Technology Services (ITS) staff maintaining the organization's privacy and security posture. Where inappropriate access or disclosure does occur, the Alliance maintains a robust program to investigate, mitigate, resolve, and report disclosures to relevant oversight bodies. The table below summarizes HIPAA Program activity for Q1 – Q2 2026.

		Q3 2025	Q4 2025	Q1 2026	Q2 2026	Immediate Trend
Referrals Received		59	56	46	62	Stable; elevated
Investigation Outcome	Breach	0	1	0	0	Stable
	Incident	20	15	17	23	Stable
	Non-Reportable	39	40	27	25	Decrease
	Pending	6	4	6	8	Stable
Members Impacted		21	5,733	301	54	Decrease

Referral volume remained elevated in the first half of 2026, with 46 referrals in Q1 and 62 referrals in Q2, both above the historical three-year average. 45% of referrals received resulted in DHCS notification, compared with 37% in the second half of 2025.

During the reporting period, 355 Alliance members were impacted by reportable privacy incidents; no breaches were identified in 2026. The majority of the impacted members are associated with three events: (1) the disclosure of information to an Alliance vendor with whom a BAA had not yet been signed; (2) multiple faxes to the incorrect provider due to an error in the fax number configuration; and (3) disclosure via email to an incorrect provider. As a routine practice, mitigation and corrective actions are put in place to prevent further disclosure and recurrence. In this instance, Corrective action pursued during the report period included training and education, disciplinary actions, and changes to established processes.

Where a referral is found to be reportable (incident or breach), Compliance staff conduct root cause analyses to determine if upstream intervention can prevent future disclosures. Incorrect selection/entry, lost/stolen wallets, and verbal disclosures are typically the main drivers of HIPAA referrals, and remain so in Q1-2.



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The Alliance also continued its routine HIPAA privacy and security compliance oversight activities, including remediation efforts related to the completed 2025 HIPAA/NIST gap audit, initiation of the routine HIPAA Risk Assessment, and the assessment of the cross functional Privacy Security Collaborative forum, considering roles and responsibilities, function and content, and frequency to ensure the appropriate level of communication and collaboration between the Alliance's privacy and security functions.

New privacy related requirements were or are being implemented through the Alliance's mandates workflow, or parallel to this in multi-departmental workgroups. Q1 and Q2 2026 implementation efforts included behavioral health data sharing requirements, enhanced consumer privacy protections, and CMS electronic claims attachment standards.

FWA Prevention, Detection, Investigation and Reporting

As with privacy and security, the Plan maintains controls to prevent and detect fraud, waste and abuse (FWA), and to investigate, report, and resolve suspected and/or actual FWA. In limited instances. delegates may conduct some FWA prevention or resolution-related activities at the Alliance's direction; those activities are also reflected in this report. The table below summarizes Program Integrity activity for Q1-2 2026.

	Q3 2025	Q4 2025	Q1 2026	Q2 2026	Immediate Trend
Referred	162	135	126	121	Decrease
Opened	86	78	60	57	Decrease
Reported	86	77	59	40	Decrease
Closed	77	44	26	39	Decrease
Founded	N/A	N/A	23	16	N/A
Founded Rate	N/A	N/A	43.3%	68.4%	N/A

Program Integrity staff receive referrals from many sources, including internal staff, data analytics and reporting, credible allegations of fraud from regulators and law enforcement agencies, Alliance members, contracted providers, anonymous reporters, and most recently, CMS HPMS FWA alerts which are assessed for plan impact. Despite declines in referral and associated investigation and reporting activity, Program Integrity volume in Q1 and Q2 2026 remained elevated when compared to three-year historical norms. Referral volume and investigative activity continued to be driven by member and provider-related referrals linked to Enhanced Care Management (ECM) and Community Supports, non-medical transportation (NMT), laboratory, and hospice/palliative care. Addition, with the go-live of TotalCare, the team has received a high volume of sales-related referrals, largely a result of member complaints alleging marketing/sales misrepresentation. In line with CMS' expectations, these types of complaints indicate potential FWA and are referred to the SIU to audit and confirm the call was conducted in accordance with CMS sales requirements.

Of the 247 referrals received in the first half of 2026, 38% were reportable per the Alliance's DHCS Medi-Cal and Monterey County IHSS contracts. To date, no concerns have been

identified relative to TotalCare that would require regulatory reporting. Additionally, staff began tracking investigation outcome (i.e., whether the concern was founded) in 2026; as shown in the table above, a substantial percentage of investigations were determined to be founded, demonstrating that a meaningful share of investigated matters resulted in confirmed findings.

When investigations indicate overpayments were made, the Alliance pursues recoupment as expected and required by DHCS and CMS. The table below includes the Program Integrity-related claim recoveries for Q1 and Q2 2026.

Recoupment	**Q1 2026**	**Q2 2026**
Identified Overpayments	$121,978	$124,375
Completed Recoupment	$97,833	$147,424
Recovery Rate	83%	144%

Finally, Program Integrity staff collaborate with regulators and other plans through activities such as attendance at the DOJ quarterly and statewide Managed Care Anti-Fraud Trainings. Discussion at the 2026 meetings have largely focused on plan processes for FWA identification and prevention, as well as specific FWA schemes related to laboratory, hospice, and ECM providers, and information shared through these forums has informed multiple internal investigations.

Compliance Violations

The Plan also investigates reports of potential compliance violations that do not fall within the scope of the HIPAA/Privacy or FWA programs. These investigations address alleged violations of applicable laws, regulations, contractual requirements, and/or Alliance policy, and are intended to ensure concerns are appropriately investigated, resolved, and corrective action implemented where warranted. Each referral is evaluated to determine whether a compliance violation occurred and whether corrective action is warranted. For founded violations, Compliance partners with business owners to implement appropriate remediation, which may include staff education, process improvements, policy revisions, enhanced monitoring, or CAPs. The table below summarizes Compliance Violation activity for Q1–Q2 2026.

	Q1 2026	**Q2 2026**
Referrals Received	6	2
Investigations Opened	6	2
Founded	3	3
Unfounded	0	0
Closed	1	4
Pending	6	4

During the reporting period, Compliance received 8 compliance violation referrals and opened 8 investigations. Staff has determined that 6 of the cases contained founded

compliance violations, all of which related to TotalCare operations, including misclassified materials and inconsistent adherence to approved sales scripts. Program Integrity partnered with key stakeholders to identify appropriate mitigation and corrective actions. Many of those action are implemented, and the remaining open items are tracked via pending case status.

Confidential Reporting

To ensure effective lines of communication from staff to the Compliance Officer, the Alliance contracts with a vendor to provide an externally managed confidential hotline where staff may report concerns anonymously. During the reporting period, 1 report was received through the hotline, related to an employee relations issue. Low utilization is typical; historically, almost all compliance concerns were reported directly to compliance staff and the hotline is used mostly to report human resources issues.

Delegate Oversight

The Compliance department provides oversight of the Alliance's delegated entities to ensure delegated administrative and health care functions are performed in accordance with applicable contractual, regulatory and, where applicable, NCQA accreditation requirements. During the first half of 2026, the Delegate Oversight (DO) program expanded significantly to support the Alliance's inaugural D-SNP line of business, including implementation of Medicare First Tier, Downstream, and Related Entity (FDR) oversight requirements. To align with the concept of integration that is at the heart of D-SNP and to streamline the Alliance's expanded oversight responsibilities, the delegate review process was redesigned to incorporate Medicare FDR and DO requirements into the existing Medi-Cal-centric oversight framework. In addition, staff continued implementation of a new governance platform, configuring audit workflows, delegate inventories, and centralized documentation processes to provide greater consistency in reviews and improve visibility into delegate and FDR performance.

With the launch of D-SNP on January 1, 2026, the Alliance completed its inaugural Medicare FDR oversight cycle. During Q1 and Q2, annual FDR attestations were completed for 32 applicable delegated entities, confirming required CMS compliance attestations were obtained.

During Q1 and Q2, seven (7) annual delegate reviews were initiated, including six (6) Credentialing delegates and MedImpact, our Pharmacy Benefit Manager (PBM). As of June 30, 2 reviews had been completed, with the remaining reviews substantially complete and pending final documentation from delegates or internal subject matter expert review of those materials. This timeline is not atypical for annual delegate reviews.

In addition to annual reviews, the DO program coordinates quarterly oversight reviews across delegated functions. During the reporting period, 21 of 21 scheduled quarterly reviews were completed in Q1, while 20 of 22 reviews were completed in Q2. The remaining two reviews are pending receipt of corrected delegate reporting.

Quarterly Reviews	Opened	Closed
Q1 2026	21	21

Q2 2026	22	20

Pursuant to the Alliance's Medi-Cal contract with DHCS, Compliance staff annually compile and submit the Alliance's Exhibit J: Delegation Reporting and Compliance Plan, documenting delegated functions, oversight responsibilities, and applicable downstream subcontracting arrangements. During the reporting period, Compliance coordinated completion of the filing for both the Alliance and its applicable delegated entities, including 11 Medi-Cal delegates and their downstream subcontractors. The submission was completed timely and approved by DHCS.

CAPs are a routine component of an effective compliance program and are implemented when circumstances are identified to strengthen controls, improve operational performance, or address compliance risks. Compliance monitors CAPs through completion and validates their effectiveness to promote sustained compliance. As such, there were two corrective actions initiated during the reporting period related to the DO program.

1. A CAP was self-imposed on the Compliance and Provider Services departments after a backlog of quarterly Credentialing oversight reviews was identified. Of the 21 overdue reviews identified across three quarters, 20 have now been completed, as noted above. Based on progress to date, management believes the corrective actions are effective and will continue monitoring review timeliness to confirm sustained compliance.
2. A behavioral health provider to which the Alliance delegated credentialing, notified the Alliance of a provider network adjustment resulting from a subset of its providers not being Medi-Cal enrolled. As member access will be impacted, Compliance is coordinating with the delegate, affected operational departments, and providers to support continuity of care and ensure compliance with applicable contractual and regulatory requirements throughout the member transition.

Finally, planning continues for the impending de-delegation of Grievance from our existing delegate who administers the Medi-Cal vision benefit. Compliance is collaborating with Grievance and Legal Services on a transition plan as the changes are effective in 2027.

Internal A&M Program

The Alliance's Internal Audit & Monitoring (IA&M) Program proactively assesses compliance with regulatory and contractual requirements, evaluates whether effective internal controls are in place to prevent and detect noncompliance, and initiates corrective action when deficiencies are identified. The program combines targeted audits of higher-risk operational areas with routine monitoring of compliance-related metrics reported through the Alliance Dashboard.

Compliance staff conduct an annual Compliance Risk Assessment and develop the IA&M Work Plan (Work Plan) identifying areas selected for audit and monitoring. The Risk Assessment and Work Plan are reviewed and approved by the Compliance Committee and updated throughout the year when regulatory changes, audit findings, performance trends, emerging risks, or other issues warrant. The Compliance Manager oversees execution of the Work Plan, including completion of audits, identification and reporting of deficiencies, and implementation of corrective actions. When noncompliance is confirmed, the Alliance

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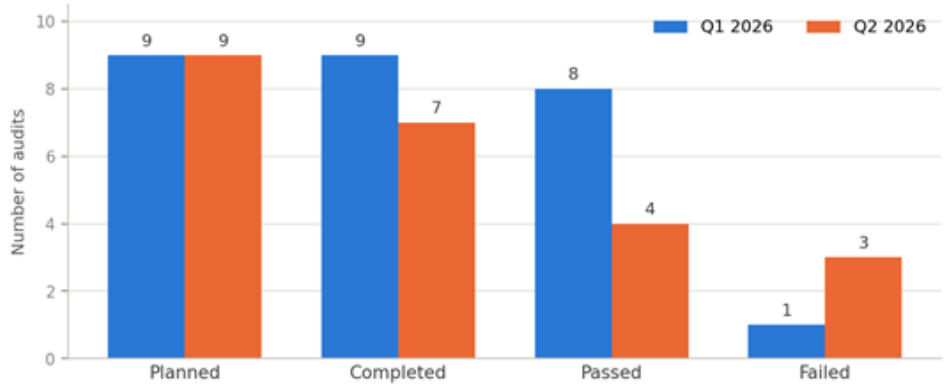
develops corrective action designed to address the root cause, support durable remediation, and reduce the likelihood of recurrence. The Compliance Committee oversees the development, timeliness, and effectiveness of CAPs.

The 2026 Work Plan includes 18 audit focus areas spanning the Alliance's Medi-Cal, IHSS, and D-SNP lines of business. The Work Plan is risk-based, concentrating oversight activities in areas with the greatest potential regulatory, financial, operational, and member impact. Planned audits address care management, utilization management, member grievances and appeals, claims processing and payment integrity, pharmacy operations, provider network management, delegated entity oversight, privacy, and regulatory governance, with ongoing monitoring performed in lower-risk areas.

This year, the Alliance's Work Plan considers the risk areas identified by CMS and the Office of Inspector General (OIG) in its MA industry-specific compliance program guidance, released in February of 2026. Consistent with this guidance, our Work Plan emphasizes encounter data integrity, risk adjustment and diagnosis validation, sales and enrollment practices, provider directory accuracy and network adequacy, and utilization management and grievance and appeal requirements. Overall, 9 High-Risk, 7 Medium-Risk, and 1 Low-Risk audit areas have been included in the Work Plan, with six of the nine High-Risk areas focused on D-SNP, reflecting both the Alliance's first year of MA operations and heightened federal oversight of Medicare Advantage organizations.

During Q1–Q2 2026, 18 internal audits were planned and 16 were completed (89%); 12 passed and 4 failed. Completion and pass rates both declined in Q2, driven by 1) recurring failures in D-SNP sales agent call monitoring, and 2) two audits deferred or in process at period end.



- Q1: 9 audits planned, 9 completed (100%)
  - Passed (8): Grievances & Appeals; Call Inquiry (Member Dissatisfaction Escalation); Pharmacy Authorizations; Concurrent Review Care Plan Agreements; Utilization Management Authorizations; Non-Medical Transportation; Sales Agent Calls (2 monthly reviews)
  - Failed (1): Behavioral Health Case Management
  - Deferred or outstanding: None
- Q2: 9 audits planned, 7 completed (78%)

- Passed (4): Claims Denials; Utilization Management Authorizations; Continuity of Care; D-SNP Encounter Data
- Failed (3): Sales Agent Calls (3 monthly reviews)
- Deferred or outstanding (2): ECM Program Audit deferred to Q4 pending the ECM process improvement project; D-SNP Provider Directory review in process

Compliance staff monitor Alliance Dashboard metrics on a monthly basis to assess for performance issues and trends and potential escalation for discussion at Compliance Committee. Two metrics were escalated for discussion at Compliance Committee during the reporting period, related to timely member reimbursement for out of pocket costs and completion of annual policy reviews, neither resulted in the imposition of a CAP.

Eight total CAPs were active during the reporting period; one closed, two deferred, two monitored, and three remaining open at period end. Compliance continues addressing timeliness or responses through more frequent escalation to accountable business owners.

Training and Education

All Alliance staff receive web-based compliance training, which reviews FWA prevention, HIPAA policies and procedures, the Alliance's Compliance Plan and Code of Conduct, the Alliance's DHCS Medi-Cal contract, CMS requirements for MA plans, and mechanisms for reporting non-compliance. New hires must complete training within two weeks for staff-level positions, or four weeks for supervisory-level positions. Existing staff are enrolled in the web-based module annually as a refresher.

Compliance staff partner with Learning & Development (L&D) staff to maintain training materials and ensure timely completion of required trainings, including Compliance training. The teams routinely review training content and delivery method to ensure training materials remain accurate, relevant, and engaging. L&D staff also manage the delivery and tracking of required training, using Compliance as an escalation point when staff fail to timely complete their training. These escalations are rare and completion of training generally occurs quickly after compliance leadership follow-up.. During the reporting period, 607 of 618 (98%) required compliance training modules were completed timely as assigned; of the 11 outstanding trainings that compliance followed up on, only 3 remain in progress.

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

Attachments.

1. Alliance Policy 105-6767 - Compliance Plan
2. Alliance Policy 105-0101 - Code of Conduct

	POLICIES AND PROCEDURES
Policy #: 105-6767	**Lead Department:** Compliance
Title: Compliance Plan	
Original Date: 2012	**Date Published:** 02/04/2026

Purpose:

The Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission, operating as Central California Alliance for Health (the Alliance) maintains a Compliance Program to ensure that the organization and its staff operate in compliance with contractual, regulatory and statutory requirements. Through its Compliance Program, the Alliance maintains its business operations to ensure alignment with these requirements. The Alliance exercises due diligence to prevent and detect criminal conduct, and when necessary, takes corrective action to ensure that its business operations are compliant with governing requirements. The Alliance promotes an organizational culture that encourages ethical conduct and a commitment to compliance with the law. The Alliance takes appropriate steps to ensure that its staff members are knowledgeable of requirements and that they consistently work towards meeting them. To maintain its independence, the Alliance's Compliance Program acts independently of operational and program areas without fear of repercussions for identifying non-compliance.

Following is a description of how the Alliance aligns with the Effective Compliance and Ethics Program guidance published by the United States Sentencing Commission.

Written Policies, Procedures and Standards of Conduct

Policies and procedures ensure that Board members, employees, and contractors, including Network Providers, Subcontractors and Downstream Subcontractors, understand and perform their responsibilities in compliance with regulatory and contractual obligations and applicable law. The Alliance maintains policies and procedures that demonstrate compliance with relevant requirements and updates are made as needed to reflect alignment with changing operations and requirements. Compliance Department staff regularly reviews proposed changes to policies and procedures and responds to needs identified through program monitoring. Policies and procedures are developed within the applicable departments, are reviewed and approved through the Policy intake process. Compliance staff leverage compliance's management software to ensure that all Alliance policies are reviewed and/or revised at least annually. Policies and Procedures are available to all staff through the Alliance's Policy Library located on its Intranet.
The Compliance Department maintains a suite of policies that implement this Compliance Plan, including, but not limited to the following:

- Policies describing the obligations of plan Board members, employees, and contractors to maintain the confidentiality of protected health information (PHI) in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and HIPAA Program operations;
- Policies describing the Alliance's Program Integrity Program, including procedures in place to prevent, detect, investigate, and resolve fraud, waste, and abuse (FWA);
- Policies related to reporting, investigation, and resolution of non-compliance;
- Policies related to the oversight of delegated entities, including Subcontractors and Downstream Subcontractors, and the operations of the Delegate Oversight Program; and
- Policies regarding regulatory audits and the operations of the Internal Audit and Monitoring Program

A full listing of Compliance Department policies can be found in Appendix A.

In addition, the Compliance Plan includes a Code of Conduct, included in a separate document, which guides Alliance Board members, employees, and contractors in conducting their business activities in a professional, ethical, and legal manner. The Human Resources Department also reflects these expectations in its Employee Handbook. In addition to being made available to Alliance staff, this Compliance Plan and Code of Conduct are publicly posted on the Alliance's Intranet.

Structure and Oversight

Alliance Governing Board – The Alliance Governing Board (Board) is responsible for oversight of the Compliance Program. The Board receives and approves reports from the Compliance Program, including: (1) a verbal update no less frequently than annually; (2) quarterly written reports on compliance trends, risks, activities, and outcomes escalated through the Compliance Committee; and (3) ad hoc escalations of significant non-compliance, as warranted. These reports include a review of activities of the Compliance Program, results of internal and external audits, and reporting of other compliance-related issues. To ensure that the Board is aware of the content and operation of the Alliance's Compliance Program, the Board receives compliance training, including FWA prevention training, on appointment and annually thereafter. The Board is also responsible for review and approval of revisions to the Alliance's Compliance Plan and Code of Conduct, which are made at minimum annually.

Chief Executive Officer – The Chief Executive Officer (CEO) provides executive oversight of the Compliance Program and participates in the Compliance Committee to support cross-functional accountability, prioritization, and risk resolution. The Chief Compliance Officer (CCO) reports directly to the CEO, while also maintaining direct access to the Alliance Governing Board, including the ability to escalate significant compliance matters independent of management when necessary.

Compliance Committee – The Compliance Committee serves as the Alliance's primary governance forum for assessing, prioritizing, and directing resolution of organizational compliance risks, trends, and compliance issues. Committee members possess sufficient oversight and decision-making authority to ensure identified compliance issues are acted upon timely, completely and effectively. The Committee reports to the Board, is comprised of permanent Director and Chief level representatives from across the organization and is chaired by the CCO. In addition to permanent members, ad hoc Director-level members are required to participate when compliance risks, audits, investigations, or regulatory issues implicate their functional areas.
The Compliance Committee oversees and governs the Alliance's Compliance Program and directs and supports the CCO in the development, implementation, and ongoing effectiveness of the Compliance Program. The Compliance Committee typically meets monthly, but no less frequently than quarterly and may convene additional meetings as necessary to address emerging or urgent compliance issues. Additional responsibilities of the Compliance Committee include, but are not limited to:

- Reviewing information regarding new requirements or changes to existing requirements that are brought before it by the CCO, Compliance Department staff, or Government Relations Department staff, and determining necessary steps for implementation;
- Reviewing and acting upon escalated compliance risks and issues, including determining appropriate disposition, required participants, corrective actions, and internal and external reporting pathways;

- Reviewing and approving an annual Compliance and FDR Risk Assessment developed by Compliance staff; overseeing the outcomes of auditing and monitoring activities identified in the Internal Audit and Monitoring Workplan, and re-evaluating risk ratings and workplans as necessary based on monitoring outcomes, audit results, and emerging risk indicators;
- Annually reviewing and, as necessary, updating the Code of Conduct and Compliance Plan;
- Ensuring that Compliance and FWA training and education are effective and appropriately completed;
- Reviewing areas of non-compliance and overseeing the development, implementation, timeliness, and effectiveness of CAPs, whether corrective or preventive to mitigate compliance concerns, or those imposed by regulators;
- Overseeing the performance of delegated entities, including the Alliance's Subcontractors, Downstream Subcontractors, First-Tier, Downstream, and Related Entities (FDRs), to ensure their performance on delegated functions meets contractual, legal, and regulatory obligations, and Alliance standards;
- Overseeing the Alliance's Program Integrity activities to ensure that the organization deters, identifies, investigates and resolves potential and actual FWA, both internally and through delegated entities and providers; and,
- Ensuring the Alliance implements appropriate safeguards, including administrative policies and procedures, to protect the confidentiality of PHI and ensure compliance with HIPAA requirements.

The Compliance Committee provides oversight of the Alliance's Compliance Program as set forth in this Compliance Plan across all lines of Alliance business, including Medi-Cal, Medicare Advantage (TotalCare (HMO D-SNP)), and In-Home Supportive Services (IHSS), ensuring that compliance risks, audits, monitoring activities, and corrective actions are appropriately identified, escalated, and addressed within each line of business.

In addition to the Compliance Committee, the Alliance has other committees that oversee its contractual, legal, and regulatory obligations, including the following:

Quality Improvement and Health Equity Committee
The Quality Improvement and Health Equity Committee (QIHEC) monitors progress on the Quality Improvement work plan, oversees Utilization Management activities, and receives reports from the Pharmacy and Therapeutics Committee. In addition, the Committee oversees various plan activities including: care-based incentives, HEDIS results, analysis and suggested interventions, disease management and educational programs, cultural and linguistic initiatives, grievances and potential quality issues, emergency department utilization projects, and the annual review of Alliance's preventive health guidelines. The QIHEC reports its activities to the Board on a regular basis.

Staff Grievance Review Committee
The Staff Grievance Review Committee (SGRC) monitors and reports on trends in member complaints and provider disputes to assess timeliness, appropriateness of resolution, and opportunities for upstream process improvement. The SGRC focuses on identifying recurring issues and systemic drivers of dissatisfaction and recommending operational improvements

to prevent repeated concerns. SGRC reports its activities to the Interdisciplinary Clinical Quality Improvement Workgroup and the Board on a regular basis.

Chief Compliance Officer – The CCO, under the guidance of the CEO, directs the Compliance Program in support of Alliance goals, provides executive leadership in developing, implementing, and monitoring the Alliance's Compliance Program, serves as the HIPAA Privacy Officer and Fraud Prevention Officer, and chairs the Compliance Committee in accordance with its Charter. The CCO executes the Compliance Program under the governance, oversight, and direction of the Compliance Committee. The CCO maintains a direct reporting relationship to the Board, providing routine reports and updates to the Board on Compliance Program activities, including matters escalated through the Compliance Committee. The CCO is responsible for overseeing the implementation of the Compliance Program, including defining the program structure, educational requirements, reporting and complaint mechanisms, response and correction procedures, and compliance expectations of all staff and contractors. In the event the CCO is unavailable, the Compliance Director serves as the backup Compliance Officer, Privacy Officer, and Fraud Prevention Officer. The CCO, in coordination with the Compliance Committee and staff, ensures the following activities are performed:

- Ensuring that updates from the Compliance Program are presented to the CEO and the Board on a periodic basis;
- Escalating significant compliance risks, investigations, audit findings, and systemic issues to the Compliance Committee and/or Board, as needed;
- Ensuring that the Alliance's Compliance Programs, including the Delegate Oversight Program, HIPAA Program, Internal Audit and Monitoring Program, and Program Integrity Program adhere to relevant state and federal requirements, are responsive to the Alliance's needs, and are effective in identifying and mitigating, and ultimately preventing compliance risk;
- Ensuring processes and reporting mechanisms are in place that encourage staff to report suspected noncompliance, FWA, PHI disclosures, or other misconduct without fear of retaliation;
- Ensuring that effective compliance training is in place and that staff are aware of the Alliance's Compliance Program, Code of Conduct, and all applicable statutory and regulatory requirements as applicable to their roles;
- Ensuring effective processes are in place to allow two-way communication between the Compliance Division and Alliance staff such that staff are aware of new and changing requirements and are knowledgeable about how to report noncompliance, suspected FWA, or other misconduct without fear of retaliation; and
- Ensuring corrective action plans (CAPs) are implemented when non-compliance is identified, consistent with direction and oversight provided by the Compliance Committee, and that the CAPs address the identified root cause for durable remediation.

Compliance Director – The Compliance Director, under the guidance of the CCO, executes and oversees the Compliance Program in support of Alliance goals, directs the Alliance's Compliance function. The Compliance Director is responsible for implementing Compliance Program, including ensuring that the Compliance Plan is implemented, maintaining reporting and complaint mechanisms, directing response and correction procedures, and recommending revisions to the

Compliance Program to meet organizational need. The Compliance Director, in coordination with the Compliance Committee and staff, ensures the following activities are performed:

- Escalating compliance risks, investigations, and systemic issues to the Compliance Committee in accordance with the established risk-based triage and escalation framework;
- Directing and overseeing the Alliance's Compliance Programs, including the Delegate Oversight Program, HIPAA Program, Internal Audit and Monitoring Program, and Program Integrity Program to ensure alignment with the CCO's stated objectives;
- Interacting with the operational units of the company and being involved in and aware of the daily business activities;
- Maintaining processes that encourage staff to report potential compliance concerns without fear of retaliation;
- Ensuring reports of potential instances of FWA, disclosures of PHI, and noncompliance are resolved, including overseeing internal investigations and developing corrective or disciplinary actions, if necessary;
- Maintaining documentation for each report of potential noncompliance or FWA received;
- In partnership with the Alliance's Human Resources Department, developing training programs to ensure that staff are aware of the Alliance's Compliance Program, Code of Conduct, and all applicable statutory and regulatory requirements;
- Maintaining the compliance reporting mechanism and initiating audits through the Internal Audit and Monitoring Program, operational departments, and the Program Integrity function, where applicable;
- Ensuring that the Alliance does not employ or contract with individuals excluded from participation in federal programs. This function has been delegated to the Alliance's Human Resources Department, Provider Services Department, and Administrative Contracts Unit; and,
- Overseeing development and implementation of CAPs.

Compliance Manager – The Compliance Manager reports to the Compliance Director and is responsible for managing the day-to-day activities of the core Compliance Program functions, including the Internal Audit and Monitoring Program Delegate Oversight Program, and regulatory audit coordination.

Compliance Specialists – Compliance Specialists are responsible for conducting day-to-day operational work related to implementation of the Alliance's Delegate Oversight Program and Internal Audit and Monitoring Program. Compliance Specialists are also responsible for managing regulatory audits, including pre-onsite and onsite document requests and logistics, and coordinating any required CAPs. Other duties may be assigned as appropriate.

Program Integrity Manager – The Program Integrity Manager reports to the Compliance Director and is responsible for managing the day-to-day activities of the Alliance's Program Integrity and HIPAA Privacy Programs, including oversight of FWA prevention; investigations and related resolution activities; regulatory reporting; HIPAA privacy incident intake and breach risk assessment; and coordination of corrective actions and mitigation efforts. In coordination with Compliance leadership, this Manager also oversees investigations of Compliance Concerns, as reported and received through the Alliance's reporting channels defined in this Compliance Plan.

Program Integrity Specialists - Program Integrity Specialists are responsible for conducting day-to-day operational work in support of the Alliance's Program Integrity and HIPAA Privacy Programs, including investigation of potential FWA; HIPAA privacy incident investigations and breach risk assessments; review of claims, medical records, and protected health information; documentation of investigative findings; and coordination with internal and external parties. Specialists escalate investigative and privacy-related matters in accordance with the Compliance Department's risk-based triage and escalation framework.

Regulatory Affairs Manager– The Regulatory Affairs Manager reports to the Compliance Director and is responsible for managing the day-to-day activities of the Alliance's regulatory affairs function, which includes analyzing and monitoring state and federal policy, legislation and regulations affecting the Alliance; maintaining systems and procedures to intake, assessing and implementing regulatory policies and legislative information; and ensuring the submission of timely and accurate program reporting to regulators.

Regulatory Affairs Specialists – Regulatory Affairs Specialists are responsible for conducting day-to-day operational work related to implementation of new requirements, policy development and maintenance, regulatory reporting, and regulatory filings. Other duties may be assigned as appropriate.

Medicare Compliance Program Manager - The Medicare Compliance Program Manager reports to the CCO and is responsible for supporting the day-to-day operations of the Alliance's Medicare-integrated compliance program, including Medicare Advantage and D-SNP requirements. Responsibilities include oversight and support of Medicare-specific compliance monitoring, auditing, issue tracking, regulatory reporting, and corrective actions, and ensuring overall alignment with CMS requirements and guidance. The Medicare Compliance Program Manager coordinates with Compliance department staff and operational departments and escalates Medicare-related compliance risks and issues in accordance with the Compliance Department's risk-based triage and escalation framework.

NCQA Compliance Program Manager - The NCQA Compliance Program Manager reports to the Compliance Director and is responsible for managing the day-to-day operations of the Alliance's NCQA compliance and accreditation programs. Responsibilities include oversight of NCQA Survey readiness, NCQA Standards implementation, evidence management, compliance monitoring, corrective actions, and regulatory submissions related to NCQA requirements. The NCQA Compliance Program Manager coordinates with Compliance department staff and operational departments and escalates NCQA-related compliance risks and issues in accordance with the Compliance Department's risk-based triage and escalation framework.

Government Relations Director – The Government Relations Director is the primary health plan contact with external regulatory and government agencies. The Government Relations Director monitors legislative, regulatory, and contractual requirements to identify new or changing, policies, standards, laws and regulations that may impact plan operations and ensures that these are brought to the relevant departments for review and implementation.

Education and Training

As part of their orientation and training, Alliance staff are informed of the Alliance's commitment to compliance with contractual, regulatory and legal standards. New employees receive general compliance training and receive a copy of the Compliance Plan, Code of Conduct, and policies and procedures pertinent to that individual's job responsibilities, where applicable.

General compliance trainings are conducted via the Alliance Learning Center (ALC), a web-based training module, for all employees upon initial hiring. The Learning & Development Unit ensures that all employees are trained on the Alliance's Code of Conduct and Compliance Plan within 90 days of the date of hire and annually thereafter.

Staff are trained on the Alliance's Code of Conduct and Compliance Plan, including but not limited to:

- Policies and procedures relevant to their job functions to ensure compliance with requirements;
- The Alliance's Program Integrity function, including information regarding the False Claims Act and the Anti-kickback Statute;
- HIPAA compliance training, with emphasis on confidentiality of PHI;
- An overview of compliance issues and how to report potential non-compliance or FWA; and
- How to report suspected non-compliance with law or policy to Compliance Department staff.

To gauge the effectiveness of this training, staff are required to take a pre-test prior to the specific training module and a post-test after the completion of the training. The results of these tests indicate enhanced understanding of the Alliance's Compliance Program through effective training. Staff must attain a passing score of 80% in the post-test to complete the training module.
Board members receive a copy of the Compliance Plan, Code of Conduct, and policies and procedures pertinent to their appointment as part of their orientation. In addition, Board members receive general compliance training, including FWA prevention training, as part of their orientation and on an annual basis thereafter.
Compliance staff also monitor reports on an ongoing basis to ensure the following required training is occurring:

- For Member Services staff, training must cover Alliance policies and procedures; contractually required services for all members; how to utilize services in the Medi-Cal program; how to access carved out services; how to obtain referrals to community resources; how to assist members with disabilities and chronic conditions; and diversity, equity and inclusion (DEI) training.
- For staff carrying out obligations under MOUs, training must cover how complaints can be raised and how to resolve disputes between the parties in the MOU.
- For Network Providers, training includes an overview of the Medi-Cal Managed Care program; covered services, policies and procedures for clinical protocols governing prior authorization and utilization management; how to refer to and coordinate care for carved out services; preventive healthcare services including Early Periodic Screening, Diagnosis and Testing (EPSDT); medical record and coding requirements; Population Health Management program requirements; member access, including appointment wait time standards, telephone access, translation and language access services; secure data sharing methods; member rights; DEI training; and advanced health care directives.

	POLICIES AND PROCEDURES
Policy #: 105-6767	**Lead Department:** Compliance
Title: Compliance Plan	
Original Date: 2012	**Date Published:** 02/04/2026

Effective Lines of Communication

The Alliance has formal and routine mechanisms of communication available to staff, contractors, and members. The Alliance promotes communication through a variety of meetings and processes, including Board meetings, Compliance Committee meetings, Operations Committee, the Administrative Contract Review Process, the Policy intake process, all-staff assemblies, regular departmental meetings, internal committee meetings, and ad-hoc provider and member communications. Additionally, information is communicated to Board members, employees, contractors, and members by email distributions, internal and external websites, reports, newsletters, and handbooks.

Policies and procedures ensure that staff members understand and perform their responsibilities in compliance with their positions and applicable law. Staff members are responsible for complying with the policies and procedures relevant to job descriptions and contractors are responsible for complying with their contractual obligations.

The Alliance expects that all Board members, employees, and contractors report compliance issues including noncompliant, unethical and/or illegal behavior. All compliance issues regarding potential FWA or HIPAA concerns are required to be reported immediately to the Compliance Department for investigation by Compliance Department staff. Reports of non-compliance with standards are investigated by supervisors and/or Compliance Department staff and leadership, as appropriate. Additionally, reports of non-compliance or other significant compliance concerns are escalated through the Compliance Department's risk-based triage and escalation framework and referred to the Compliance Committee when escalation thresholds are met. The Compliance Committee reviews these reports and ensures corrective actions are implemented and monitored for effectiveness.

The Alliance encourages staff to discuss issues directly with their supervisor or manager, Compliance Department staff, the Human Resources Director, or the Chief Administrative Officer. Should staff not feel comfortable reporting concerns directly, they may do so anonymously through the Confidential Disclosure Hotline. Staff can be assured that they may report compliance issues or concerns without risk of retaliation. The Alliance has a zero-tolerance policy for retaliation or retribution against any employee who in good faith reports suspected misconduct.

The Alliance's Confidential Disclosure Hotline is accessible 24 hours a day to report violations, or suspected violations of the law and/or the Compliance Program as well as concerns with Alliance personnel practices, such as allegations of discrimination, harassment or poor treatment. Additionally, staff may use the Alliance's Confidential Disclosure website.

TOLL FREE CONFIDENTIAL DISCLOSURE HOTLINE
844-910-4228
CONFIDENTIAL DISCLOSURE WEBSITE
https://ccah.ethicspoint.com

Additional reporting information is located on the Compliance Intranet page. The Alliance takes all reports of violations, or suspected violations, seriously and is committed to investigating all reported concerns promptly and confidentially to the extent possible.

The Alliance also maintains a reporting mechanism on its public website that allows members, Network Providers, Subcontractors, or any other person or entity to submit reports of non-compliance, including anonymous reports if desired.

Monitoring and Auditing to Identify Compliance Risk

The Alliance conducts monitoring and auditing activities to test and confirm the effectiveness of the Compliance Program, to ensure that plan operations align with contractual, legal, and regulatory requirements, and to identify the Alliance's organizational risk areas. This includes the evaluation of delegated entities – Subcontractors and Downstream Subcontractors – for compliance with standards, in alignment with the Delegation Reporting and Compliance Plan.

To comply with regulatory and contractual requirements, the Alliance conducts routine internal auditing in identified risk areas and routinely monitors plan performance through the Alliance Dashboard. The Alliance is also subject to external audits by federal and state agencies in connection with the Medi-Cal Program and its IHSS line of business.

Compliance Department staff conduct the Compliance Risk Assessment and develop the Internal Audit and Monitoring Work Plan identifying areas selected for audit and monitoring. The annual Compliance Risk Assessment and Internal Audit and Monitoring Work Plan, as well as material modifications prompted by escalated compliance issues, emerging risks, audit results, or other triage outcomes identified through the Compliance Department's risk-based escalation framework, are reviewed and approved by the Compliance Committee. The Compliance Manager oversees the Internal Audit and Monitoring Work Plan, ensuring that internal audits are conducted, deficiencies are identified, reports are developed, and corrective action is taken, as needed.

Disciplinary Standards

The Alliance does not condone any conduct that negatively affects the operation, mission, or image of the Alliance. The Alliance ensures that standards and policies and procedures are consistently enforced through disciplinary mechanisms. Any employee or contractor engaging in a violation of laws or regulations (depending on the magnitude of the violation) will be disciplined up to, and including, termination from employment or their contract.

In the event of discovery of such activity, the Alliance will implement prompt action to correct the problem and may institute appropriate disciplinary action given the facts and circumstances.

Response to Compliance Issues

Upon verification of non-compliance of a particular standard or requirement, the Alliance will take appropriate action steps to correct and prevent repeat non-compliance. These steps may include disclosing the incident to applicable regulatory agencies, retraining staff, and amending Alliance

policies and procedures in an effort to avoid future recurrence. Compliance staff will initiate and document oversight of corrective action to ensure the instance of noncompliance has been effectively mitigated. Matters meeting defined escalation criteria are brought to the Compliance Committee for review, direction, and oversight of corrective action.

Definitions: N/A
Procedures: N/A
References:
Regulatory:
42 C.F.R. §§ 438.608. 422.503(b)(4)(vi), and 422.504(b)(4)(vi)
Legislative:
Medi-Cal Contract:
DSNP:
DHCS All Plan Letter:
DMHC All Plan Letter:
NCQA:
Alliance Policies:
Impacted Departments:
All Departments
Other References:
Attachments:
Policy 105-0100 – Attachment A Compliance Policies and Procedures
Policy 105-0101 – Code of Conduct
Policy 105-4003 – No Retaliation or Waiver

Supersedes:

Lines of Business This Policy Applies To

☒ DSNP
☒ Medi-Cal
☒ Alliance Care IHSS

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
	8/24/2021	Jenifer Mandella, Compliance Officer	Alliance Board
	8/19/2022	Jenifer Mandella, Compliance Officer	Alliance Board
	8/10/2023, with changes	Jenifer Mandella, Chief Compliance Officer	Alliance Board

	effective 1/1/2024		
	8/14/2024	Jenifer Mandella, Chief Compliance Officer	Alliance Board
	4/24/2025	Jenifer Mandella, Chief Compliance Officer	Alliance Board
	02/04/2026	Jenifer Mandella, Chief Compliance Officer	Compliance Committee, pending Alliance Board approval
	8/4/2026	Jenifer Mandella, Chief Compliance Officer	

	POLICIES AND PROCEDURES
Policy #: 105-6767	**Lead Department:** Compliance
Title: Compliance Plan	
Original Date: 2012	**Date Published:** 02/04/2026

ATTACHMENT A – COMPLIANCE POLICIES AND PROCEDURES

Policy Number	Policy Title
105-0001	Policy Development, Maintenance, Review and Submission
105-0004	Delegate Oversight
105-0005	Federal Funding Suspension and Debarment
105-0009	Mandated Reporting of Suspected Abuse and Neglect
105-0011	Internal Audit & Monitoring
105-0014	Subcontractor Sanctions
105-0500	External Audits
105-1000	Certification of Data, Information and Documentation
105-1001	Medicare Part C and Part D Plan Reporting
105-1002	Review of Marketing and Communications Materials
105-1003	Medicare Advantage Regulatory Review, Tracking and Distribution
105-2000	Compliance Violations
105-2001	Self-Reporting to CMS
105-2002	Prohibition of False Claims
105-2003	Investigation of Sales Allegations
105-3001	Program Integrity: Fraud Waste and Abuse Prevention Program
105-3002	Program Integrity: Special Investigations Unit Operations
105-3002	Program Integrity: Special Investigations Unit Operations
105-3003	Suspended, Excluded, and Ineligible Providers
105-3004	Verification of Billed Services by Network Providers
105-4000	HIPAA-HITECH Privacy and Security Glossary
105-4001	Notice of Privacy Practices
105-4002	Accounting of Disclosures
105-4003	No Retaliation or Waiver
105-4004	Privacy Officer Designation and Responsibilities
105-4007	Safeguarding Protected Health Information
105-4009	Minimum Necessary Use and Disclosure
105-4010	Verification of Requester Authority Prior to Release of PHI
105-4011	De-identification and Re-identification of Health Information
105-4012	Use and Disclosure of PHI, including Member Authorizations to Disclose
105-4013	Request to Access Records
105-4014	Requests for Amendment of Protected Health Information

	POLICIES AND PROCEDURES
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105-4017	Permission to Leave Messages with PHI
105-4018	Personal, Authorized and Member Representatives
105-4020	Official Statement: Need for Information About Possible Victim of Crime
105-4020	Disclosures to Law Enforcement and Government Officials
105-4026	Communication with Minors
105-4027	Disclosures of Protected Health Information of Members with Mental Incapacities
105-4029	Breach Risk Assessment and Response
105-4030	Internal Reporting: Compliance Concerns
105-4031	Data Sharing with County Mental Health Plans
105-4039	Access to and Confidentiality of ePHI
105-4043	Compliance Training and Education
105-4044	Disclosing Sensitive Personal Health Information
105-4045	Requests for Confidential Communications and Restrictions on Uses and Disclosures
105-4046	Enforcement Sanctions: Administrative & Monetary Sanctions
105-4047	Uses and Disclosures for Protected Health Information

	POLICIES AND PROCEDURES
Policy #: 105-0101	**Lead Department:** Compliance
Title: Alliance Code of Conduct	
Original Date: 2012	**Date Published:**

The Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission's, operating as Central California Alliance for Health's (the Alliance's) values, articulated in this Code of Conduct, are standards that guide our behavior and conduct.

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

The Alliance's Code of Conduct contained herein applies to its Medi-Cal Program, Medicare Part-C and Part-D lines of business, and to its In-Home Supportive Services (IHSS) line of business. The Code of Conduct provides guidelines to Board members, employees, and Contractors, including sub-Contractors, downstream sub-Contractors, First Tier Entities, Downstream Entities, Related Entities, and network providers (all collectively referred to as "Contractors" in this document), on appropriate ethical and legal standards. The Code of Conduct is an important component of the Compliance Program and reflects the Alliance's commitment to comply with all applicable Federal and State laws, regulations, and contractual obligations. Compliance is everyone's responsibility; thus, it is the Alliance's expectation that all Board members, employees, and Contractors be familiar and comply with all requirements of the Code of Conduct, avoid actions and relationships that may violate these standards, and seek guidance from appropriate staff when necessary.

The information contained in the Alliance Code of Conduct is not all inclusive or encompassing. The Alliance reserves the right to evaluate any and all situations pertaining to an actual or perceived ethical or legal conflict or misconduct and then make a determination as to appropriate disciplinary action, policy and procedures, etc., given the facts and circumstances.

This Code of Conduct must be approved by the Alliance Board annually, is made available to Alliance staff and Board members, and is publicly posted on the Alliance's website.

COMPLIANCE WITH LAW

The Alliance is committed to conducting all activities and operations in compliance with applicable laws.

Fraud Waste & Abuse

With oversight from the Compliance Committee, the Alliance's Program Integrity function prevents, detects, evaluates, investigates, reports and resolves all potential/actual fraud, waste and abuse issues, in addition to other compliance concerns and compliance violations. Board members, employees, and Contractors shall obey laws that prohibit direct or indirect payments in exchange for the referral of patients or services, which are paid by Federal and/or State health care programs.

Political Activities

The Alliance's political participation is limited by the Political Reform Act. Alliance funds, property, and resources are not to be used to contribute to political campaigns, political parties, or organizations. Board members, employees, and Contractors may participate in the political process on their own time and at their own expense but are not to give the impression that they are speaking on behalf of or representing the Alliance during these activities.

	POLICIES AND PROCEDURES
Policy #: 105-0101	**Lead Department:** Compliance
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Original Date: 2012	**Date Published:**

Anti-Trust
All Board members, employees, and Contractors must comply with applicable antitrust, unfair competition, and similar laws which regulate competition. The types of activities that involve antitrust laws include agreements to fix prices, bid rigging, and related activities; boycotts, exclusive dealings, and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors that determine prices at trade association meetings.

MEMBER RIGHTS

The Alliance is committed to meeting the health care needs of its members by providing access to high quality, equitable health care services.

Access
Alliance policies and procedures have been developed to be consistent with applicable laws governing member choice and access to health care services. Employees and Contractors shall comply with all requirements for coordination of medical and support services for Alliance members. Employees and Contractors shall provide culturally and linguistically appropriate services to plan members to ensure effective communication regarding diagnosis, medical history and treatment, and health education.

Health Equity
In alignment with its value of equity, the Alliance strives to reduce health inequities and provide all its members a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Complaint Process
Alliance employees and Contractors shall inform members of their grievance and appeal rights through member handbooks and other communications in accordance with Alliance procedures and applicable laws. Alliance member grievances and appeals shall be investigated in a prompt and nondiscriminatory manner in accordance with Alliance policies and applicable laws.

BUSINESS ETHICS

The Alliance is committed to the highest standards of business ethics. Employees and Contractors shall accurately and honestly represent the Alliance and not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.

Candor and Honesty
Board members, employees, and Contractors shall be candid and honest in the performance of their responsibilities and in all communications.

Financial Reporting
All financial reports, accounting records, research reports, expense accounts, timesheets and other documents are to accurately and clearly represent the relevant facts or the true nature of a transaction. The Alliance maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets.

Regulatory Agencies and Accrediting Bodies
Alliance employees and Contractors shall deal with all regulatory agencies and accrediting bodies in a direct, open, and honest manner.

PUBLIC INTEGRITY

The Alliance and its Board members and employees shall comply with laws and regulations governing public agencies.

Public Records
The Alliance shall provide access to records to any person, corporation, partnership, firm or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq., the Health Insurance Portability and Accountability Act (HIPAA), and Alliance policies.

Public Funds
The Alliance, its Board members, and employees shall safeguard and not make gifts of public funds or assets or lend credit to private persons without adequate consideration that they serve a purpose within the authority of the Alliance.

Public Meetings
The Alliance, and its Board members and employees, shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act.

CONFIDENTIALITY

Board members, employees, and Contractors shall maintain the confidentiality of all confidential information in accordance with applicable laws and shall not disclose confidential information except as specifically authorized by Alliance policies, procedures, and applicable law.

No Personal Benefit
Board members, employees, and Contractors shall not use confidential or proprietary Alliance information for their own personal benefit or for the benefit of any other person or entity, while employed at or engaged by the Alliance, or at any time thereafter.

Duty to Safeguard Member and Medical Confidential Information
Board members, employees, and Contractors shall safeguard Alliance member protected health information, identity, eligibility, and medical information, peer review, and other confidential

information in accordance with HIPAA regulations, California law, and the Alliance's policies and procedures.

Personnel Files
Personal information contained in employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable law.

Proprietary Information
Alliance Board members, employees, and Contractors shall safeguard confidential proprietary information including, without limitation, contractor information and proprietary computer software, in accordance with, and to the extent required by, contract or law. The Alliance shall safeguard confidential provider information including social security numbers.

CONFLICTS OF INTEREST

Board members and employees have a duty to be loyal to the Alliance.

Conflict of Interest Code
Designated employees as identified in the Conflict of Interest Code, including Board members, shall comply with the requirements of Alliance Conflict of Interest Code and associated policies to avoid impropriety or the perception of impropriety, which might arise from their influence on business decisions or disclosure of Alliance business operations.

Outside Services and Interests
Employees shall not perform work or render services for any contractor, association of Contractors, or other organizations with which the Alliance does business or which seek to do business with the Alliance without prior approval (See Outside Employment section in Employee Handbook). Employees shall not permit their names to be used in any fashion that would indicate a business connection with any contractor or association of Contractors, including vendors. All employees shall report all Board-level volunteer activities to the Alliance's Human Resources Department upon consideration and on an annual basis thereafter.

BUSINESS RELATIONSHIPS

Business transactions with vendors, Contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements, and in accordance with applicable law and ethical standards.

Business Inducements
Board members, employees, Contractors, and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, the Alliance, or Alliance members.

Gifts to the Alliance
Board members and employees shall not solicit or accept personal gratuities, gifts, favors, services, entertainment or any other things of value from any person or entity that furnishes items or services

to the Alliance unless specifically permitted under Alliance Policies. Please see Alliance Policy 105-0015 – Conflict of Interest for specific guidance on acceptance of gifts by Alliance staff members.

Provision of Gifts by the Alliance
Employees may provide gifts, entertainment or meals of nominal value to the Alliance's current and prospective business partners and other persons when these activities have a legitimate business purpose, are reasonable, and are consistent with applicable law and Alliance policy. In addition to complying with statutory and regulatory requirements, it is important to avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with the Alliance.

Third-Party Sponsored Events
The Alliance will not participate in any joint contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, the Alliance or its operations. Employees' attendance at contractor, vendor or other third- party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose subject to prior approval by the Department Manager or Director. To align with California Fair Political Practices Commission requirements, third party sponsorship of events or travel is not permitted, unless the meeting attendee is a speaker or honoree at the event. Additionally, employees will not participate in raffles at third party sponsored events.

Provision of Gifts to Government Agencies
Board members, employees, and Contractors shall not offer or provide money, gifts or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws.

PROTECTION OF ALLIANCE ASSETS

Board members, employees, and Contractors shall strive to preserve and protect Alliance assets by making prudent and effective use of Alliance resources and properly and accurately reporting its financial condition.

Personal Use of Alliance Assets
The assets of the Alliance are not for personal use. Board members, employees, and Contractors are prohibited from the unauthorized use or taking of Alliance equipment, supplies, materials or services.

Communications
All communication systems, electronic mail, internet access, or voicemail are the property of the Alliance. Employees should assume that the communications are not private. Board members, employees, and Contractors shall adhere to the highest standards of professional conduct and personal courtesy in the type, tone, and content of all written, verbal and electronic communications and messages.

Electronic Mail and Social Media
Employees may not use internal communication channels or access to the internet at work to post, store, transmit, download, or distribute any information or material which is threatening, knowingly,

recklessly, or maliciously false, obscene, or which constitutes or encourages criminal offenses, gives rise to civil liability or otherwise violates any laws or Alliance policies. The internal communication channels or access to the internet may not be used to send spam mail, or copyrighted documents that are not authorized for reproduction. Board members, employees, and Contractors must adhere to the Alliance's Code-of-Conduct and policy 640-0005 – Social Media Policy when using social media in reference to the Alliance.

Generative Artificial Intelligence (AI)
To mitigate risk of generating outputs that are factually untrue, biased, potentially harmful or illegal, and to ensure Alliance's protected data remains secure at all times, Board members, employees, and Contractors may only use AI in accordance with applicable laws and regulations, principles and requirements contained in the Alliance's Code of Conduct, and the Alliance's Generative AI policy 500-2002 – Generative AI Use, Sourcing, and Adoption.

DISCRIMINATION

The Alliance acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.

No Discrimination
Board members, employees, and Contractors shall not unlawfully discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age or perceived age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, family care leave status, veteran status, marital status, genetic information, pregnancy, political affiliation, or any other legally protected status. The Alliance is committed to providing a work environment free from discrimination and harassment based on any classification noted above.

PARTICIPATION STATUS

The Alliance requires that network providers have valid and current licenses, certificates, and/or registration, as applicable, and that employees, Contractors, and members of the Alliance Board of Commissioners are able to participate in Federal and State-funded programs.

Participation Status
The Alliance has policies that ensure network providers, employees, Contractors, and members of the Alliance Board of Commissioners are not currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program.

Disclosure of Participation Status
Contractors shall disclose to the Alliance whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State health care program; if they have ever been excluded from participation in Federal and/or State health care programs based on a Mandatory Exclusion; and/or have met the Alliance's Felony Conviction status requirements as set forth in Alliance policy, as applicable.

Delegated Third Party Administrator Review

	POLICIES AND PROCEDURES
Policy #: 105-0101	**Lead Department:** Compliance
Title: Alliance Code of Conduct	
Original Date: 2012	**Date Published:**

The Alliance requires that its Contractors review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes.

Licensure
The Alliance requires that all employees and Contractors who are required to be licensed, credentialed, certified or registered in order to furnish items or services to the Alliance and its Members have valid and current licensure, credentials, certification or registration as applicable.

GOVERNMENT INQUIRIES

Employees shall notify the Alliance upon receipt of government inquiries and shall not destroy or alter documents in response to a government request for documents or information.

Notification of Government Inquiry
Employees are to notify the Government Relations and Compliance Directors immediately upon the receipt of a formal government inquiry for information regarding Alliance business practices.

No Destruction of Documents
Employees shall not conceal, destroy or alter Alliance information or documents in anticipation of, or in response to, a request for documents by any governmental agency or court.

COMPLIANCE PROGRAM REPORTING

Board members, employees, and Contractors have a duty to comply with the Alliance Compliance Program. Compliance is a condition of appointment, employment, and/or engagement.

Seeking Guidance
Board members, employees, and Contractors may seek additional guidance and clarity on any requirements outlined in this Code of Conduct by contacting the Alliance's Chief Compliance Officer, Compliance Director, or any Compliance Department staff.

Reporting Requirements
All Board members, employees, and Contractors must report suspected violations of any statute, regulation, or guideline applicable to Federal and/or State health care programs or Alliance policies. Staff can be assured that they may report suspected and actual compliance or fraud issues or concerns without retaliation or retribution. Such reports may be made to a supervisor or manager, the Chief Compliance Officer, the Chief Administrative Officer, Human Resources Director, Compliance staff, or anonymously to the Confidential Disclosure Hotline.

Employees can call the Alliance's toll-free Confidential Disclosure Hotline at **1-844-910-4228**, or use the Alliance Confidential Disclosure website: **https://ccah.ethicspoint.com**. Additional reporting information is located on the Compliance Intranet page.

	POLICIES AND PROCEDURES
Policy #: 105-0101	**Lead Department:** Compliance
Title: Alliance Code of Conduct	
Original Date: 2012	**Date Published:**

Contractors, network providers Contractors, and members may report compliance concerns by contacting their designated Alliance contact person, contacting Compliance Department staff directly, or through the Compliance Concern Report form on the Alliance's website

References:
Regulatory:
Legislative:
Medi-Cal Contract:
DSNP:
DHCS All Plan Letter:
DMHC All Plan Letter:
NCQA:
Alliance Policies:
Impacted Departments:
All Departments
Other References:
Attachments:

Supersedes:

Lines of Business This Policy Applies To

☒ DSNP
☒ Medi-Cal
☒ Alliance Care IHSS

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
	3/20/2018	Jenifer Mandella, Compliance Officer	Alliance Board
	12/18/2019		Alliance Board
	1/13/2021	Jenifer Mandella, Compliance Officer	Alliance Board
	3/23/2022	Jenifer Mandella, Compliance Officer	Alliance Board
	9/20/2023	Jenifer Mandella, Compliance Officer	Alliance Board
	8/31/2023, with changes effective 1/1/2024	Jenifer Mandella, Chief Compliance Officer	Alliance Board
	8/14/2024	Jenifer Mandella, Chief Compliance Officer	Alliance Board

	POLICIES AND PROCEDURES
Policy #: 105-0101	**Lead Department:** Compliance
Title: Alliance Code of Conduct	
Original Date: 2012	**Date Published:**

	02/03/2025	Jenifer Mandella, Chief Compliance Officer	Alliance Board
Reviewed Date	Revised Date	Changes Made By	Approved By
	8/24/2021	Jenifer Mandella, Compliance Officer	Alliance Board
	8/19/2022	Jenifer Mandella, Compliance Officer	Alliance Board
	8/10/2023, with changes effective 1/1/2024	Jenifer Mandella, Chief Compliance Officer	Alliance Board
	8/14/2024	Jenifer Mandella, Chief Compliance Officer	Alliance Board
	4/24/2025	Jenifer Mandella, Chief Compliance Officer	Alliance Board
	02/04/2026	Jenifer Mandella, Chief Compliance Officer	Compliance Committee, pending Alliance Board approval
	8/4/2026	Jenifer Mandella, Chief Compliance Officer	

DATE: August 26, 2026

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

FROM: Van Wong, Chief Operating Officer; Scott Fortner, Chief Administrative Officer

SUBJECT: Operational Readiness and Workforce Realignment

Recommendation. This report is informational only.

Summary. Compared to December 31, 2024, Alliance Medi-Cal enrollment is projected to decline by approximately 25% by January 1, 2027, with a continued gradual decline thereafter to a level approximately 39% below the December 31, 2024, baseline. Because membership decline is expected to reduce both workload and DHCS Medi-Cal revenue, staff are planning for an organization wide operational assessment focused on membership and financial impact, together with evaluation of corresponding workforce reductions, severance support, and a longer-term approach to align staffing with future operational needs.

Background. The Alliance is preparing for a substantial decline in Medi-Cal membership and associated revenue beginning in 2026 and accelerating into early 2027. Projected membership decline will reduce workload and revenue, requiring the organization to reduce staffing in a thoughtful and financially responsible manner while maintaining operational stability and service to members. The Alliance Annual Planning Process was formally launched at the Operations Committee meeting in June and will serve as the primary forum for evaluating operations and staffing needs across all departments, including member-facing functions, and administrative and support areas. To align staffing levels with projected membership reductions, workload, and revenue, staff are planning for a workforce reduction of approximately 25% by the end of 2027.

Discussion. Staff will present the Board with the major drivers, timing, and planning assumptions for the operational assessment and workforce planning effort.

We are pursuing a multi-pronged workforce strategy designed to balance organizational needs with flexibility and employee support. In anticipation of changing business conditions, the Alliance began increasing its use of contingent workers in 2025 in lieu of adding regular full-time positions. This approach has provided greater flexibility to adjust staffing as organizational needs evolve. As workforce requirements are refined, the Alliance will reduce contingent assignments where appropriate while continuing to rely on contingent workers selectively until targeted workforce reductions are achieved. Over the longer term, disciplined vacancy management, selective use of contingent workers, and natural attrition will help maintain staffing levels within budget. As we address the impacts of membership decline, our preferred approach is to minimize involuntary workforce actions whenever possible. The strategy will align staffing levels with declining membership by first evaluating and eliminating vacant positions where appropriate, reducing the use of contingent workers, and relying on natural attrition. Based on

current assumptions, no involuntary staffing changes are anticipated before January 1, 2027. Staff support programs, including severance, benefits, and outplacement services are being developed to assist employees affected by either voluntary or involuntary separations.

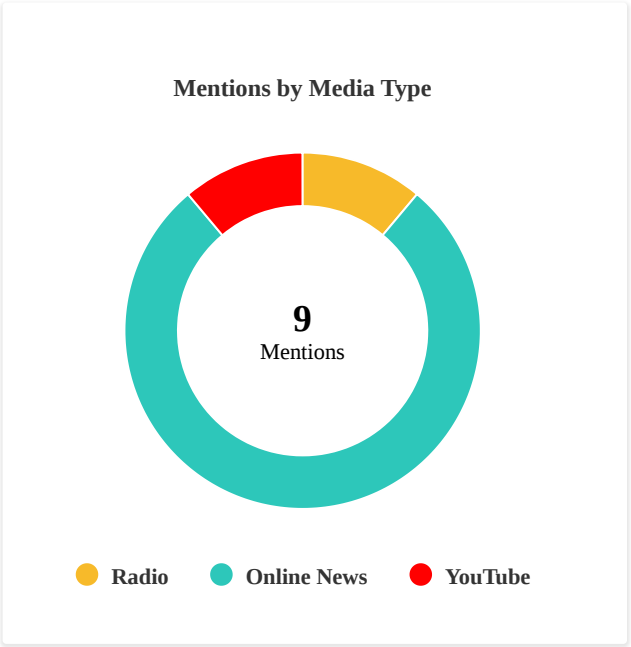
Fiscal Impact. The primary financial impact will be separation-related costs associated with planned workforce actions. Staff anticipate that any 2026 incurred costs can be managed within existing administrative savings, with the year projected to end at an administrative loss ratio of approximately 6%.

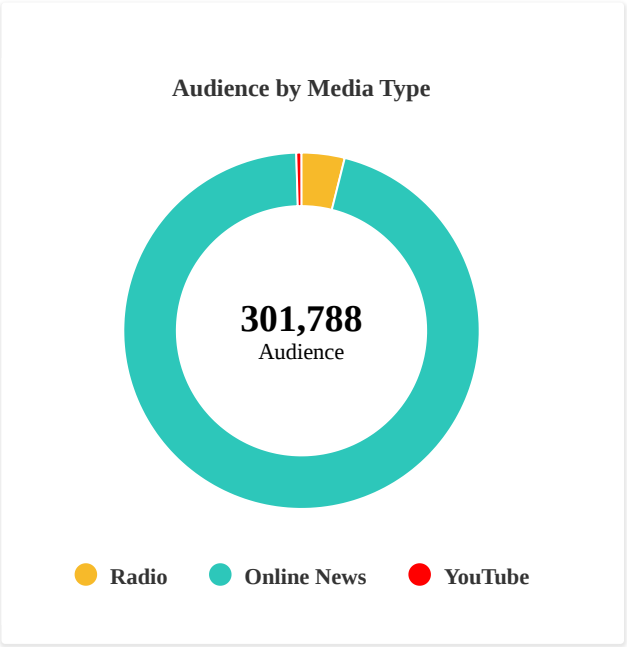
Costs associated with 2027 are expected to be addressed as part of the 2027 budget and transition planning.

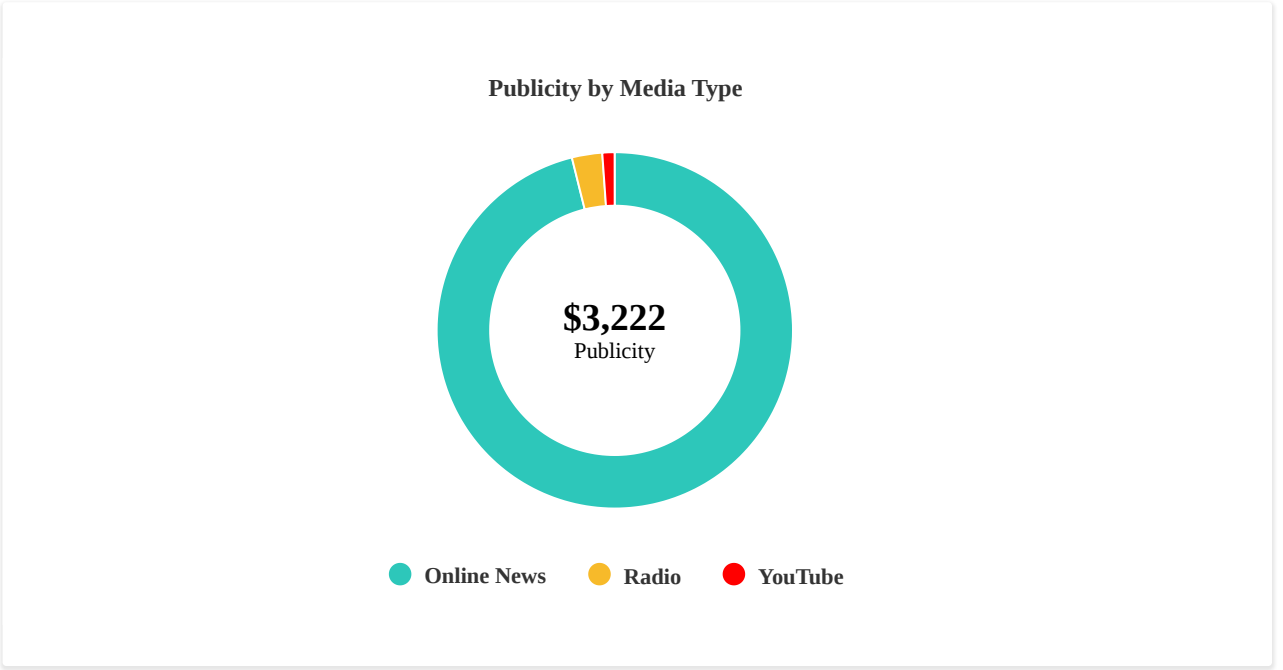
Attachments. N/A

August 2026 Board Report

Mention Analytics







Impact Metrics

11.8k Total Radio Audience	**$89** Total Radio Publicity
289k Total Online Audience	**$3.097k** Total Online Publicity
1.42k Total Social Audience	**$36** Total Social Publicity

9 Total Mentions

Mentions 9 **Audience** 301,788 **Publicity** USD $3,222

Jul 22, 2026 1:21 PM EDT Pos. 1

CHISPA breaks ground on affordable housing project in King City

Source King City Rustler **Market** King City, CA **Type** Digital News **Category** Local

... housing is a lot more than low-cost housing. Affordable housing is an investment into our future," he said. The project received support from several funding partners, including the City of King City, the California Department of Housing and Community Development, U.S. Bank, National Equity Fund, **Central California Alliance for**

Jul 20, 2026 2:39 PM EDT Pos. 2

KERN-AM

Station KERN-AM (Westwood One Network) **Market** Bakersfield, CA DMA: 121

Central. California Alliance for Health. And what that indicate was that. These medical groups where we're loving the taxes that because they they increase their they're they're cash flow through the medical system. So in our California voters Greenlight proposition 30. You know another example where where if you offer

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Jun 30, 2026 6:08 PM EDT Pos. 3

Health Trust and Community Foundation launch Cross-Sector Partnership to protect Medi-C…

Source Benito Link **Market** United States **Type** Digital News

... , without a shared strategy or consistent communication across sectors. This initiative creates the structure for that coordination to happen. As a trusted community convener, CFFSBC is well positioned to bring together partner organizations including the Community FoodBank of San Benito County, **Central**

Jun 11, 2026 7:37 AM EDT Neu. 4

Guest Commentaries; State proposal to move Medi-Cal members will disrupt healthcare

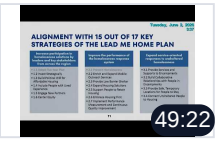
Source Santa Cruz Sentinel (California) **Market** Santa Cruz, CA **Type** Print **Category** Local

California spent years building a Medi-Cal program that goes beyond a card in your wallet. For millions of Californians, Medi-Cal managed care is not just coverage; it is a coordinated system of care that helps people access the right services at the right time. Like other managed care plans, **Central California Alliance for Health**

Jun 10, 2026 8:45 PM EDT Pos. 5

Homelessness Strategies and Initiatives Division Accomplishments FYs 2024-26 in Montere…

Channel John Doe13k **Market** United States **Category** People & Blogs **Subscribers** 1.4k



... , CAO-HSI coordinated a multi-agency effort to recover and reposition a previously stalled Homekey project in King City. Through strategic partnerships with the Housing Authority of the County of Monterey (HACM), the Health Department, Department of Social Services, the Continuum of Care (CoC), **Central California**

Jun 10, 2026 7:04 PM EDT Neu. 6

Guest Commentary | State proposal to move Medi-Cal members will disrupt healthcare

Source Santa Cruz Sentinel **Market** Santa Cruz, CA **Type** Digital News **Category** Local

... California spent years building a Medi-Cal program that goes beyond a card in your wallet. For millions of Californians, Medi-Cal managed care is not just coverage; it is a coordinated system of care that helps people access the right services at the right time. Like other managed care plans, **Central California**

Jun 10, 2026 2:13 PM EDT Neu. 7

Letter to the editor: We must maintain Medi-cal benefits

Source Lookout Santa Cruz **Market** Santa Cruz, CA **Type** Digital News **Category** Local

... . California spent years building a Medi-Cal program that goes beyond a card in your wallet. For millions of Californians, Medi-Cal managed care is not just coverage; it is a coordinated system of care that helps people access the right services at the right time. Like other managed care plans, **Central California**

Jun 10, 2026 5:00 AM EDT Neu. 8

Letter to the editor: We must maintain Medi-cal benefits

Source Lookout Santa Cruz **Market** United States **Type** Digital News

... . California spent years building a Medi-Cal program that goes beyond a card in your wallet. For millions of Californians, Medi-Cal managed care is not just coverage; it is a coordinated system of care that helps people access the right services at the right time. Like other managed care plans, **Central California**

Jun 5, 2026 5:11 PM EDT Neu. 9

Unlocking Every Door: Rethinking Housing Access Beyond Section 8 at Housing California

Source Los Angeles Weekly **Market** Culver City, CA **Type** Digital News **Category** Local

... Anayancy Rosillo-Contreras, Director of Programs & Services ; Ruqayyah Muhammad, Partnerships Liason ,Regional Ambassador and Community–Government Relations Consultant; Meaghan Highwood, Director of Case Management; and Paul Hall, Assistant Director . While Mysti's operates in California

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Alliance Fact Sheet
Q3 2026

About the Alliance

The Central California Alliance for Health is an award-winning regional managed care health plan. The Alliance has provided trusted, no cost Medi-Cal health care from local teams to families since 1996. Using the State's County Organized Health System (COHS) model, we currently serve more than **416,298 members** in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We have a local presence in the communities we serve, so we understand the unique needs of these communities and our members. Together with our contracted providers, we work to promote prevention, early detection and effective treatment and to improve access to quality, equitable health care. The Alliance is governed with local representation from each county on our Board of Commissioners.

Quick Facts

1996
Year Established

681
Number of Employees

$2.25B[1]
Annual Revenue

5.8%[1]
Administrative Overhead

$32.6M[2]
Community Grants

VISION

HEALTHY PEOPLE.
HEALTHY COMMUNITIES.

MISSION

Accessible, quality health care guided by local innovation.

VALUES

Collaboration:
Working together toward solutions and results.

Equity:
Eliminating disparity through inclusion and justice.

Improvement:
Continuous pursuit of quality through learning and growth.

Integrity:
Telling the truth and doing what we say we will do.

What We Do

The Alliance is a local health ally for compassionate and trusted health care that supports the whole person. We ensure quality care for all ages and stages of life and for any health condition. We go beyond just providing health care, connecting our members to day-to-day resources.

Who We Serve

Our members represent 39%[3] of the population in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. We serve seniors, persons and children with disabilities, low-income parents and their children, children who were previously uninsured, pregnant women, home care workers who are caring for the elderly and disabled and low-income, childless adults ages 19–64.

Provider Partnerships

The Alliance partners with 100% of hospitals in our service areas and a network of approximately 14,977 providers (99% of primary care physicians and 98% of specialists within our service areas) to ensure members receive timely access to the right care, at the right time. The Alliance also partners with more than 4,980 providers to deliver behavioral health (4,965) and vision services (21). Effective July 1, 2025, the Alliance has insourced Behavioral Health Services.

Our Members[4]

1 out of every 3
Mariposa County residents.

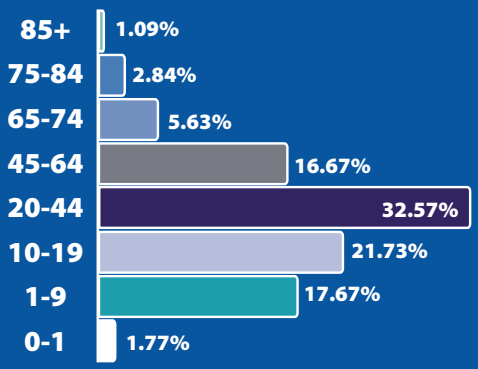
1 out of every 2
Merced County residents.

1 out of every 2
Monterey County residents.

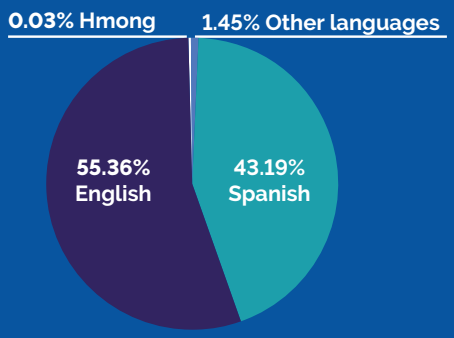
1 out of every 3
San Benito County residents.

1 out of every 3
Santa Cruz County residents.

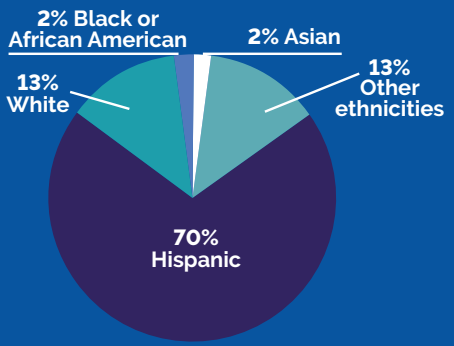
Membership by Age Group



Preferred Language



Race/Ethnicity



Executive Leadership

Michael Schrader
Chief Executive Officer

Lisa Ba
Chief Financial Officer

Cecil Newton
Chief Information Officer

Scott Fortner
Chief Administrative Officer

Dr. Mike Wang
Chief Medical Officer and
Chief Health Equity Officer

Jenifer Mandella
Chief Compliance Officer

Van Wong
Chief Operating Officer

Governing Board

The Alliance's governing board, the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Alliance Board), sets policy and strategic priorities for the organization and oversees health plan service effectiveness. The Alliance Board has fiscal and operational responsibility for the health plan.

In alphabetical order, current Board members are:

- **Leslie Abasta-Cummings,** Chief Executive Officer, Livingston Community Health, At Large Health Care Provider Representative
- **Anita Aguirre,** Chief Executive Officer, Santa Cruz Community Health, At Large Public Representative, Alliance Board Vice Chairperson
- **Ralph Armstrong,** DO FACOG, Hollister Women's Health, At Large Health Care Provider Representative
- **Supervisor Wendy Root Askew,** County of Monterey, County Board of Supervisors Representative
- **Tracey Belton,** Health and Human Services Agency Director, San Benito County, County Health Department Representative
- **Maximiliano Cuevas, MD,** Executive Director, Clinica de Salud del Valle de Salinas, Health Care Provider Representative
- **Supervisor Kimberly De Serpa,** County of Santa Cruz, County Board of Supervisors Representative
- **Donaldo Hernandez, MD,** Health Care Provider Representative
- **Katrina Hodges,** Public Representative
- **Elsa Jimenez,** Director of Health Services, Monterey County Health Department, County Health Department Representative
- **Kristina Keheley, PhD,** Health and Human Services Agency Director, Mariposa County Health and Human Services Agency, County Health Department Representative
- **Michael Molesky,** Public Representative
- **Connie Moreno-Peraza,** County Health Services Agency Director, Santa Cruz County, County Health Department Representative
- **Supervisor Josh Pedrozo,** County of Merced, County Board of Supervisors Representative, Alliance Board Chairperson
- **James Rabago, MD,** Merced Faculty Associates Medical Group, Health Care Provider Representative
- **Allen Radner, MD,** President/CEO, Salinas Valley Health, At Large Health Care Provider Representative
- **Kristynn Sullivan, PhD,** Public Health Director, Merced County, County Health Department Representative
- **Ye Thao,** Public Representative

Unless otherwise stated, Fact Sheet data as of July 1, 2026.

[1]Amounts based on 2026 annual budget.

[2]Represents 2025 investments through the Alliance's Medi-Cal Capacity Grant Program.

[3]County population data source: U.S. Census Bureau 2024 population estimate (as of Jul. 1, 2025).

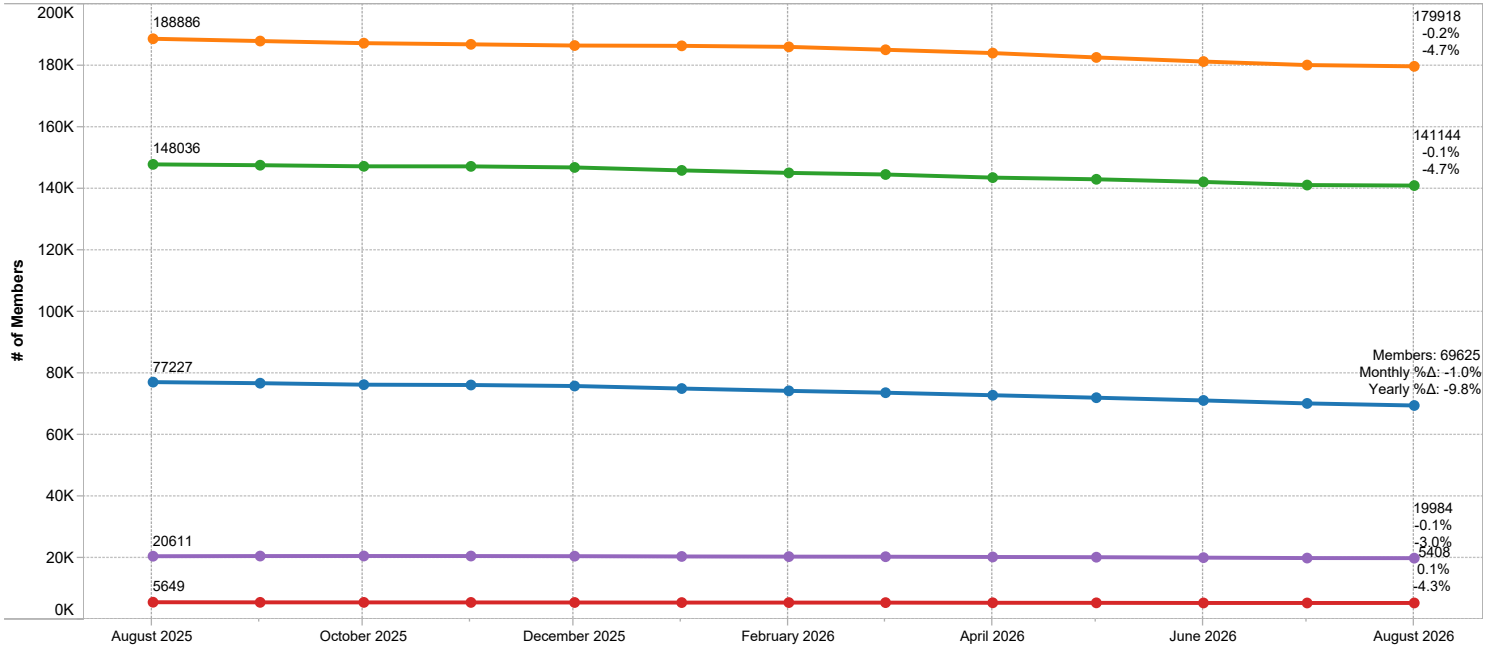
[4]Represents an approximate visual representation. Membership percentage by county: Mariposa (32 percent) Merced (48 percent); Monterey (42 percent); San Benito (29 percent); Santa Cruz (27 percent).

Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *8/3/2026 6:31:52 AM*

Enrollment Month
8/1/2025 12:00:00 AM to 8/31/2026 11:59:59 PM

Membership Totals by County and Program, % Change Month-over-Month and % Change Year-over-Year



LOB	County	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026	Aug 2026
Medi-Cal	SANTA CRUZ	77,227	76,875	76,393	76,286	75,958	74,947	74,183	73,527	72,686	71,863	70,951	69,958	69,266
	MONTEREY	188,206	187,415	186,724	186,337	185,952	185,689	185,342	184,380	183,161	181,654	180,288	179,087	178,618
	MERCED	148,036	147,765	147,405	147,385	147,040	146,000	145,182	144,647	143,613	143,061	142,183	141,161	140,977
	MARIPOSA	5,649	5,608	5,593	5,584	5,560	5,520	5,514	5,501	5,449	5,430	5,390	5,382	5,384
	SAN BENITO	20,611	20,663	20,680	20,667	20,623	20,516	20,461	20,430	20,344	20,269	20,121	19,985	19,959
	Total	**439,729**	**438,326**	**436,795**	**436,259**	**435,133**	**432,672**	**430,682**	**428,485**	**425,253**	**422,277**	**418,933**	**415,573**	**414,204**
IHSS	MONTEREY	680	727	731	738	731	735	725	721	819	833	824	824	816
	Total	**680**	**727**	**731**	**738**	**731**	**735**	**725**	**721**	**819**	**833**	**824**	**824**	**816**
DSNP Total Care	SANTA CRUZ						192	199	254	277	294	316	343	359
	MONTEREY						158	182	205	251	323	365	423	484
	MERCED						77	86	100	119	126	145	151	167
	MARIPOSA						15	17	18	19	18	17	21	24
	SAN BENITO						17	18	19	21	22	25	25	25
	Total						**459**	**502**	**596**	**687**	**783**	**868**	**963**	**1,059**
Total Members		**440,409**	**439,053**	**437,526**	**436,997**	**435,864**	**433,866**	**431,909**	**429,802**	**426,759**	**423,893**	**420,625**	**417,360**	**416,079**

MONTEREY
MERCED
SANTA CRUZ
SAN BENITO
MARIPOSA

Back to Agenda

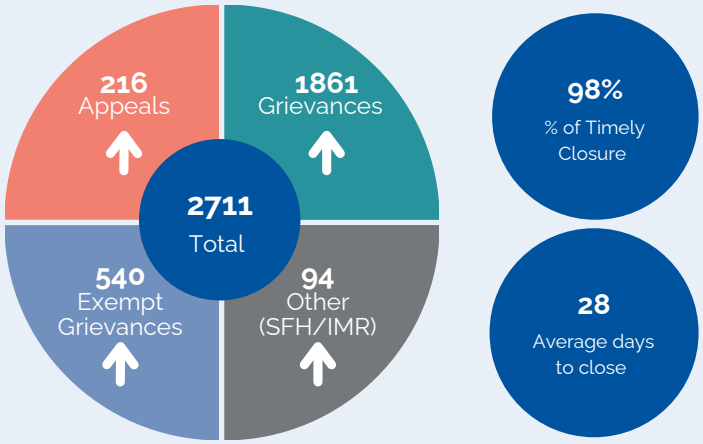
Appeals and Grievances

April - June
2026 Quarter 2

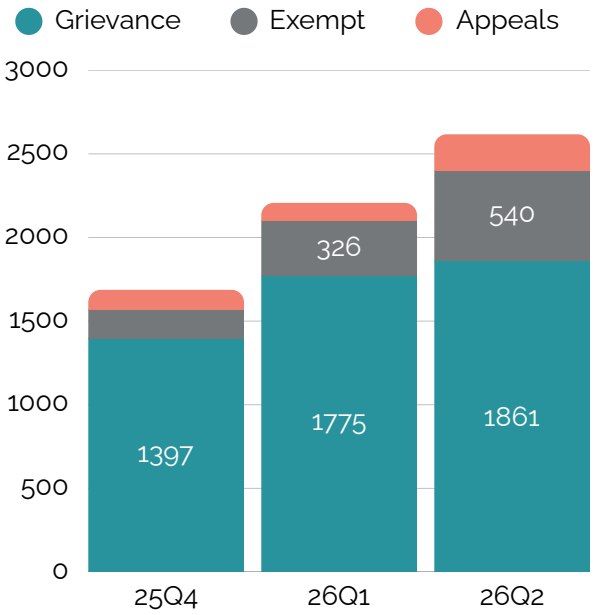
Highlights from Quarter 2:

- TotalCare (D-SNP) enrollment, linkage and supplemental benefit education opportunities.
- Continued increases with volume
- Trends within customer service, provider availability, and scheduling
- Transportation issues involve driver punctuality and administrative controls
- Appeal trends with Community Support Services (medically tailored meals and housing benefits)

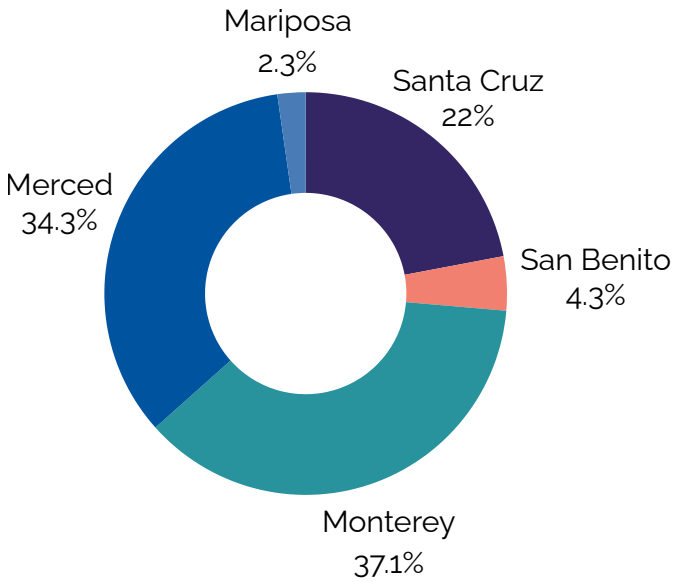
Total AG data



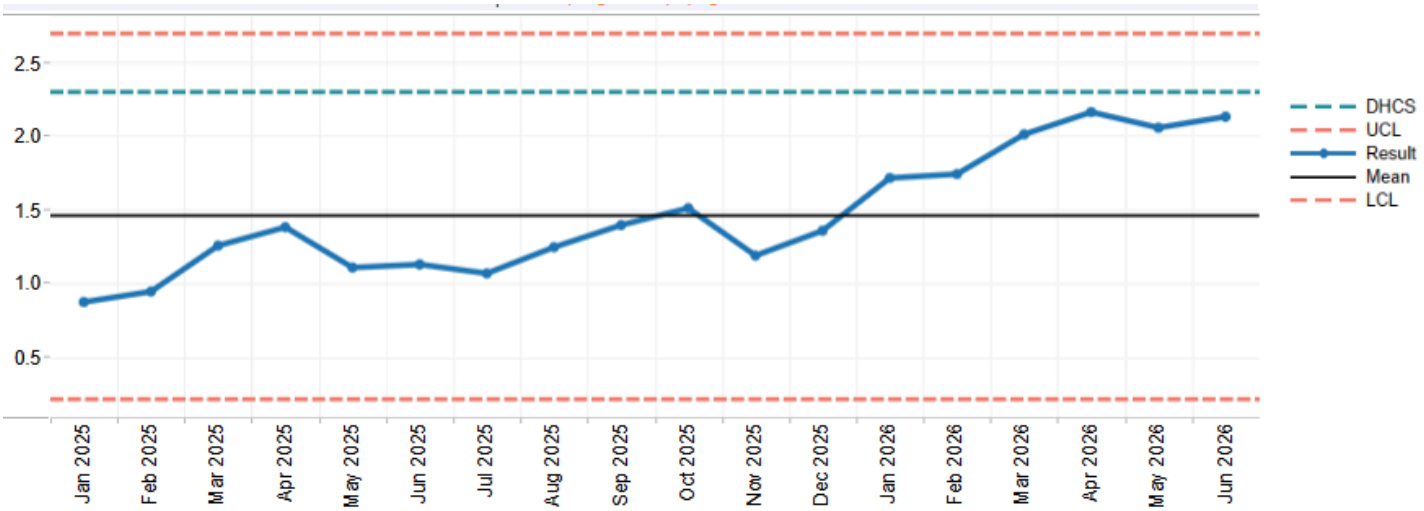
Case Rate: Review



Grievances by County



Appeals and Grievance



AG Trends and Summary

- NMT: Increase of driver punctuality issues resulting in missed rides and scheduling complaints about new process for rides.
- CCAH: Complaints about closed providers and clinics to new members.
- Provider Availability: Complaints about scheduling access and dissatisfaction for long wait times for annual visits.
- Redirections for Medi-Cal eligibility, Denti-Cal and Medi-Cal Rx concerns.

Provider Attitude ↓

Call the Car NMT ↑

Provider Linkage ↑