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, January 28, 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. Note: Livestreaming for the public listening/viewing only.
    a. Computer, tablet or smartphone via Microsoft Teams:
       Click here to join the meeting
    b. Or by telephone at:
       United States: +1 872-242-9041
       Phone Conference ID: 631 014 378#

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, January 26, 2025, 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 meeting when that item is announced.

       i. State your name and organization prior to providing comment.

      ii. Comments are limited to three minutes.

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.– 6.): 3:25 p.m.

5. **Accept Chief Executive Officer (CEO) Report.**
   - Reference materials:
     - Chief Executive Officer (CEO) Report
     - LHPC Memo – Governor's Proposed Budget 2026

   Pages 5-1 to 5-19

6. **Accept Alliance Financial Highlights, Balance Sheet, Income Statement and Statement of Cash Flow for the eleventh month ending November 30, 2025.**
   - Reference materials: Financial Statements as above.

   Pages 6-1 to 6-11

Minutes: (7A. – 7E.):

7A. **Approve Commission Special Meeting Minutes of December 10, 2025.**
   - Reference materials: Minutes as above.

   Pages 7A-1 to 7A-7

7B. **Accept Quality Improvement Health Equity Committee Meeting Minutes of September 25, 2025.**
   - Reference materials: Minutes as above.

   Pages 7B-1 to 7B-16

7C. **Approve Whole Child Model Clinical Advisory Committee Meeting Minutes of September 30, 2025.**
   - Reference materials: Minutes as above.

   Pages 7C-1 to 7C-4

7D. **Approve Physicians Advisory Group Meeting Minutes of September 4, 2025.**
   - Reference materials: Minutes as above.

   Pages 7D-1 to 7D-9

7E. **Approve Compliance Committee Meeting Minutes of October 15, 2025.**
   - Reference materials: Minutes as above.

   Pages 7E-1 to 7E-4

Reports: (8A. – 8G.)

8A.   **Ratify changes to CY 2026 Specialty Care Incentive (SCI) Program.**
-   Reference materials: Staff report and recommendation on above topic.

<div align="right">Pages 8A-1 to 8A-2</div>

8B.   **Authorize the Chairperson to sign two separate amendments to the Alliance's State-only Secondary Contract 23-30273 to incorporate language adding a Risk Corridor (RC) for Unsatisfactory Immigration Status (UIS) population and incorporate CY 2026 Prospective Rates for services covered under the Secondary Contract.**
-   Reference materials: Staff report and recommendation on above topic.

<div align="right">Page 8B-1</div>

8C.   **Accept report on Medi-Cal Capacity Grant Program (MCGP) Annual Impact Report.**
-   Reference materials:
    · Staff report on above topic
    · MCGP Performance Dashboard
    · MCGP 2025 Grant Awards Portfolio
    · MCGP Focus Areas, Goals, and Priorities

<div align="right">Pages 8C-1 to 8C-23</div>

8D.   **Accept report on 2025 Community Atlas.**
-   Reference materials: Annual Community Impact Report (publication).

<div align="right">Pages 8D-1 to 8D-5</div>

8E.   **Approve Quality Improvement Health Equity (QIHET) Transformation Workplan – Q3 2025.**
-   Reference materials:
    · Staff report and recommendation on above topic
    · Q3 2025 Quality Improvement and Population Health Transformation Program Workplan

<div align="right">Pages 8E-1 to 8E-32</div>

8F.   **Approve revisions to Alliance Policy 401-1101 Quality Improvement and Health Equity Transformation Program (QIHET).**
-   Reference materials:
    · Staff report and recommendation on above topic
    · Policy 401-1101 – Quality Improvement and Health Equity Transformation Program
        A.   Quality Improvement Health Equity Transformation Reporting Structure
        B.   Quality Improvement and Population Health Organizational Chart

<div align="right">Pages 8F-1 to 8F-30</div>

8G.   **Approve revisions to Alliance Policy 401-1201 Quality Improvement Health Equity Committee (QIHEC).**
-   Reference materials:
    · Staff report and recommendation on above topic
    · Policy 401-1201 – Quality Improvement Health Equity Committee

<div align="right">Pages 8G-1 to 8G-14</div>

Regular Agenda Items: (9. – 10.): 3:35 p.m. – 5:00 p.m.

9.   **Discuss Alliance 2022-2026 Strategic Plan Update. (3:35 – 4:20 p.m.)**
    A.   Ms. Van Wong, Chief Operations Officer and Dr. Mike Wang, Chief Medical Officer will discuss 2025 strategic performance and the 2026 strategic objectives.
-   Reference materials: Staff report on above topic.

<div align="right">Pages 9-1 to 9-3</div>

10. **Consider and approve 2026 Medi-Cal Capacity Grant Program Investment Plan. (4:20 – 4:40 p.m.)**
    A. Ms. Jessica Finney, Community Grants Director, will review and Board will consider and approve the 2026 Medi-Cal Capacity Grant Program (MCGP) Investment Plan.
    -    Reference materials: Staff report and recommendation on above topic.

                                                                                    Pages 10-1 to 10-3

Information Items: (11A. – 11E.)
A. Alliance in the News   Pages 11A-1 to 11A-5
B. Membership Enrollment Report   Page 11B-1
C. Provider Bulletin – December 2025   Page 11C-1 to 11C-12
D. Member Newsletter – December 2025 (English)   Page 11D-1 to 11D-12
E. Member Newsletter – December 2025 (Spanish)   Page 11E-1 to 11E-8

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, March 25, 2026; 1:30-2:45 p.m.

•   Member Services Advisory Group
     Thursday, February 12, 2026; 10:00 – 11:30 p.m.

•   Physicians Advisory Group
     Thursday, March 5, 2026; 12:00 – 1:30 p.m.

•   Whole Child Model Clinical Advisory Committee [R*emote teleconference only*]
     Tuesday, February 19, 2026; 12:00 – 1:00 p.m.

•   Whole Child Model Family Advisory Committee [R*emote teleconference only*]
     Monday, April 27, 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 January 28 meeting, unless otherwise notified.

Santa Cruz – Monterey – Merced – San Benito – Mariposa Managed Medical Care Commission
Wednesday, February 25, 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.

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HEALTHY PEOPLE. HEALTHY COMMUNITIES.

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

Projected Declines in Alliance Medi-Cal Enrollment. Alliance enrollment is expected to decline between August 2025 and December 2028 due to the expiration of the COVID-19 unwinding flexibilities, federal HR1 law, and the FY2025/26 state budget. This section summarizes the actual enrollment declines observed to date and the projections for the period ahead.

Alliance 2025 Medi-Cal Enrollment. The table below presents the actual changes in Alliance Medi-Cal enrollment throughout 2025. The right-hand column shows the monthly percentage decline in Alliance total membership. The bottom row highlights the year-over-year decrease in membership, comparing December 2025 to December 2024, both by county and across our total Medi-Cal population. **The decline in Alliance Medi-Cal enrollment for 2025 was a modest 2.3%, as shown in the table**, a decrease tempered by the Overlapping Member Outreach Campaign discussed in the following section.

	SANTA CRUZ	MONTEREY	MERCED	MARIPOSA	SAN BENITO	Total Alliance MCal Enroll	Monthly Change in MCal Enroll
Dec 2024	78,574	188,781	150,138	5,769	20,612	443,874	
Jan 2025	78,269	189,363	149,742	5,763	20,611	443,748	-0.03%
Feb 2025	78,444	190,307	149,935	5,766	20,716	445,168	0.32%
Mar 2025	78,328	190,581	150,230	5,698	20,695	445,532	0.08%
Apr 2025	77,549	190,810	149,740	5,681	20,634	444,414	-0.25%
May 2025	77,492	190,502	149,625	5,657	20,707	443,983	-0.10%
Jun 2025	78,231	190,068	149,088	5,704	20,723	443,814	-0.04%
Jul 2025	77,868	189,574	148,936	5,709	20,741	442,828	-0.22%
Aug 2025	77,273	188,359	147,999	5,657	20,603	439,891	-0.66%
Sep 2025	76,892	187,544	147,697	5,617	20,654	438,404	-0.34%
Oct 2025	76,385	186,793	147,224	5,599	20,667	436,668	-0.40%
Nov 2025	76,211	186,169	146,929	5,588	20,643	435,540	-0.26%
Dec 2025	75,729	185,412	146,372	5,553	20,571	433,637	-0.44%

Annual Change	-3.62%	-1.78%	-2.51%	-3.74%	-0.20%	**-2.31%**

A driver of the decrease in Alliance enrollment in the year 2025 was the expiration of COVID-19 Unwinding Flexibilities. Since the expiration of the COVID-19 unwinding flexibilities on June 30, 2025, Medi-Cal members have more often been required to complete renewals for themselves rather than relying on ex parte (automatic) reviews. Counties have returned to "normal" eligibility operations, meaning the temporary flexibilities that allowed broader use of ex parte renewals are no longer in effect. With flexibilities gone, the risk of procedural disenrollment increases if members don't complete renewals on time. Members must actively complete renewal forms, increasing the chance of losing coverage for paperwork reasons.

Alliance 2026 Medi-Cal Enrollment. In calendar year 2026, Alliance Medi-Cal enrollment is expected to decline at a rate generally aligned with statewide Medi-Cal trends. **According to DHCS projections, the statewide Medi-Cal caseload is anticipated to decrease from 14.5 million to 14.0 million in calendar year 2026, a reduction of approximately 3.4%**. This projection is illustrated in the graph on page 9 of the November 2025 Medi-Cal Local Assistance Estimate.

For 2026, the projected decline in statewide Medi-Cal enrollment is primarily driven by three factors:
- Ongoing impacts from the end of COVID-19 unwinding flexibilities
- A freeze on new full-scope Medi-Cal enrollments for individuals classified as having Unsatisfactory Immigration Status (UIS), effective January 1, 2026, as enacted in the FY 2025–26 state budget.
- The reinstatement of Medi-Cal asset limits for individuals seeking long-term care coverage, also effective January 1, 2026, under the FY2025-26 state budget.

The table below presents the actual changes in Alliance Medi-Cal enrollment for 2026 year to date.

	SANTA CRUZ	MONTEREY	MERCED	MARIPOSA	SAN BENITO	Total MCal Enroll	Monthly Change in MCal Enroll
Jan 2026	74,220	184,510	144,974	5,497	20,434	429,635	-0.92%

Alliance 2027 Medi-Cal Enrollment. Alliance Medi-Cal enrollment is expected to decline at a rate generally aligned with statewide Medi-Cal trends. **According to DHCS projections, the statewide Medi-Cal caseload is anticipated to decrease**

from 14.0 million to 13.6 million *in the first half* of 2027, a reduction of approximately 2.9%. This projection is also illustrated in the graph on page 9 of the November 2025 Medi-Cal Local Assistance Estimate.

For 2027, the projected decline in statewide Medi-Cal enrollment is primarily driven by the following policy changes:

- Medicaid Expansion adults will be subject to redetermination every six months, beginning January 1, 2027, as required under the federal HR1 law.
- Medicaid Expansion adults aged 19-64 without dependents must meet new work requirements, also effective January 1, 2027, under the federal HR1 law.
- Medi-Cal members with UIS aged 19-59 will be required to pay a $30 monthly premium, taking effect July 1, 2027, as specified in the FY 2025–26 state budget.

On September 30, 2025, CMS issued guidance to state Medicaid directors indicating that monthly capitation payments made by states to managed care plans for individuals with unsatisfactory immigration status do not qualify for federal financial participation for emergency Medi-Cal coverage. As a result, DHCS may need to carve out Medi-Cal enrollees with UIS from managed care plans and assume responsibility for their coverage directly. For the Alliance, this could translate into an abrupt loss of roughly 17% of our membership on January 1, 2027. Additional clarity may not be available until the May Revision of the State Budget.

Overlapping Member Outreach Campaigns. The Alliance and Monterey County launched member-outreach campaigns in 2025, and DHCS will in 2026.

DHCS Campaign. The DHCS campaign will span the entire state. DHCS intends to begin rolling out a text message campaign on HR1 beginning in 2026, focusing on work requirements and including light messaging on six-month renewals, both of which become effective on January 1, 2027. The timing of the text messages will align with the member's renewal and begin one year in advance. The message will be high-level, encouraging members to start planning and visit the DHCS website for more information.

Monterey County Campaign. In October 2025, the Board of Supervisors approved a $250,000 outreach plan to expand education and application assistance. The campaign is coordinated by the Department of Social Services (DSS) and the Health Department (HD), The proposed spending plan divides the $250,000 roughly into

three parts: training and support for community-based organizations (estimated $5,000–$10,000), direct community outreach and application assistance delivered by selected CBOs (the bulk, about $190,000–$195,000), and a focused media/social marketing campaign (about $50,000–$60,000).

Alliance Campaign. In October 2025, the Alliance kicked off a campaign, spanning our five counties and including five tracks:

- Convenings. In November, the Alliance hosted a virtual convening, across all five counties, drawing 434 participants from counties, clinics, hospitals, and community organizations.

- General Member Outreach. The Alliance's member outreach campaign kicked off in late October 2025. It included advertisements on TV, radio, mobile devices, social media (including TikTok), and digital screens in public places (convenience stores, grocery stores and laundromats). On TV, we secured more than 700 spots, each 15-30 seconds in length, airing from late-October to the end of December, across six local stations that collectively covered all five counties and included ABC, NBC, Univision, and Estrella. On radio in Merced County, we had an advertisement that aired 300 times in December, featuring a holiday greeting and promoting enrollment and renewal, We also promoted messaging on our Alliance website, member and provider bulletins, community email newsletter (the Beat), and social media. We delivered flyers to provider offices across our 5 counties, requesting display in their patient waiting areas. This outreach campaign will continue in the year 2026 in modified forms.

- Focused Member Outreach. We continued sending monthly text messages to members who were within 45 days of their annual renewal deadline. We also launched a pilot initiative using outbound AI-supported calls to approximately 3,800 members in the same renewal window. Notably, 86% of recipients answered and engaged, aided by caller ID indicating the call was from the Alliance.

- Member Assistance. Our intention is to train community health workers to assist members with enrollment and renewals. In November, the Monterey County Department of Social Services and the Health Department conducted a half-day training session in our Salinas office, attended by more than 50 community health workers. Additional training was held in Santa Cruz on December 11 and in Watsonville on January 21 in partnership with Santa Cruz

County. Additionally, the Alliance team held multiple sessions on member outreach for clinics, schools, and community organizations, and will hold two training sessions in January and February for CHWs in collaboration with the Merced County Human Services Agency.

- <u>Alliance Grant Program</u>. Staff have begun development of a new funding opportunity to support community-based organizations and providers to conduct member outreach and enrollment and renewal assistance. These funding opportunities would fall under the Community Resources, Engagement & Empowerment strategy as part of the 2026 MCGP Investment Plan, recommended for Board approval at the January 28, 2026 meeting.

TotalCare Medicare D-SNP. We are proud to announce the launch of our Medicare D-SNP program, TotalCare. 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.

Enrollment for our TotalCare program began on October 15, 2025, aligning with the start of the national Annual Enrollment Period (AEP) for Medicare. Unlike standard Medicare enrollment, dual-eligible individuals are not limited to the AEP when transitioning to an Exclusively Aligned Medicare D-SNP program, such as TotalCare. As a result, although the national AEP concluded on December 7, 2025, we continued enrolling members beyond that date, with coverage effective January 1, 2026. **The starting enrollment for TotalCare was 454 members on January 1, 2026**.

Furthermore, enrollment will continue throughout 2026 as members transition from Original Medicare or other Medicare Advantage plans into our TotalCare program. We are currently developing a marketing plan to support 2026 growth and retention goals. Initial tactics include monthly age-in mailings, a spring "benefits at a glance" letter to eligibles, thank you letters to recently enrolled members, direct mail postcards to dual eligibles during AEP, and content on social, the website, member, provider and community newsletters.

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.

<u>2026 Legislative Session.</u> The legislature reconvened for the second year of its 2-year legislative session on January 5, 2026. Staff anticipates a flurry of legislative activity leading up to the February 20, 2026, bill introduction deadline. Staff will continue to monitor and track bills of interest and provide reports to your board throughout the session.

<u>Meetings with elected officials.</u> On January 8, 2026, I met with Assemblymember Esmerelda Soria in her Merced office accompanied by Chair Pedrozo, Commissioner Rabago and Alliance Government Relations Director, Danita Carlson. We discussed our concerns regarding the many federal and state budget changes impacting Medi-Cal enrollment and providers and described activities underway to work with counties, community organizations and providers to support member eligibility, enrollment and retention. The Assemblymember showed interest and concern with potential loss of access to care for members in the community and the potential impact on providers and the health care delivery system in the Central Valley. We agreed to keep an open line of communication regarding these issues and potential solutions.

We have a meeting scheduled for January 23, 2026 for a discussion with Senator Caballero and will continue our efforts to engage, inform and advocate with our elected representatives.

<u>State Budget</u>. On January 9, 2026, Governor Newsom released his proposed budget for the upcoming State Fiscal Year (SFY) 2026-27. The proposed budget does not include any significant changes to the Medi-Cal program other than those already anticipated due to the expected implementation of provisions of federal HR 1 and the 2025-26 State budget. According to the Governor, revenue projections are higher than expected due to higher cash receipts, stock market levels and improved economic outlook. However, the Governor acknowledges risk factors that could impact this outlook including federal policy changes and potential stock market fluctuations. Other issues, such as federal guidance prohibiting risk-based payment models for emergency Medi-Cal and MCO tax assumptions, also require clarification and confirmation to inform the final budget. With this, it is likely that the May Revise will more accurately reflect the final budget as these factors will need to be contemplated and/or confirmed prior to finalizing the budget. Staff will continue to monitor budget developments and provide reports to the board on relevant key issues. Attached is a summary of the Governor's proposed budget for 2025-26 developed by the Local Health Plans of California (LHPC) that highlights key health and human services proposals of most relevance to the Alliance.

Community Engagement, Health Education, 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. In January, the Alliance collaborated with Alinea Mobile Mammography to host mobile clinics in **Watsonville** and **Seaside**, expanding access to preventive services while connecting members to Alliance resources. The Alliance also coordinated with the Dignity Health Mobile Unit in **Merced** to provide outreach and enrollment support alongside clinical care. In addition, the Alliance continues to host targeted pop-up outreach events to educate members about upcoming Medi-Cal changes and to support coverage retention.

Trainings and Meetings. In January, the Alliance convened its Quarter 1, 2026 Public Information Officer (PIO) Roundtable. The forum served as a space to share key Alliance updates and policy changes, while strengthening collaboration with partner agencies to align messaging, communication priorities, and outreach efforts. The PIO Roundtable brings together representatives from the Merced City School District, Merced County Office of Education, UC Merced, the City of Merced, United Way, Mercy Medical Center, Golden Valley Health Centers, County Public Health, County District Attorney, and Fire Departments.

Quality and Health Equity. This section showcases the Alliance's commitment to delivering high-quality care while actively addressing health disparities.

DHCS Quality Withhold. **The Alliance earned 100% of the Quality Withhold for 2024**, meaning we recovered every dollar that DHCS held from our monthly capitation payments. Each year, DHCS withholds a portion of funding from all Medi-Cal health plans and evaluates performance on key quality measures such as well-child visits, diabetes care, blood pressure control, and member experience. Plans earn back the withhold by meeting statewide benchmarks or demonstrating year-over-year improvement. The Alliance met the required performance thresholds, enabling us to fully reclaim the entire withhold amount for the year.

Super Performers Fund. **The Alliance also earned an additional $1.5 million from the DHCS "Super Performers" incentive pool**. This fund consists of withhold dollars that other plans did not earn back, which DHCS reallocates to plans demonstrating

the greatest improvement in child and adolescent preventive-care visits for specific racial and ethnic groups. DHCS measures performance against a national benchmark and rewards plans that close gaps most rapidly. Because the Alliance achieved the highest possible improvement scores for both targeted racial and ethnic groups, and because one of those groups represents a significant portion of our membership, we secured a meaningful share of the statewide "Super Performers" incentive pool.

Merced Quality. *See the table below*. Preliminary results indicate that in Measurement Year 2025, we sustained, and in some areas improved upon, the gains achieved in MY2024. These advances resulted in higher quality scores for children in Merced County and contributed to reducing geographic health disparities across our five-county service area. The improved scores reflect increased access to preventive care services, including immunizations, lead screenings, well-child visits, and well-care visits. Notably, four of the five children's domain quality measures for MY2025 exceeded the national 50th percentiles for Measurement Year 2024, as HEDIS has not yet released the MY2025 benchmarks. Additionally, three of the five measures showed year-over-year improvement in MY2025. These preliminary results reflect the impact of targeted provider engagement and focused care gap closure efforts. The Alliance offered care gap grants, focused on provider lunch-and-learns, arranged point-of-service member incentives, and explored pilot efforts related to alternative places of medicine. Thank you to the primary care clinics in Merced County that have engaged us in these efforts.

MEASURE (MERCED COUNTY)	MY2024	DEC 2025	2025 MPL
Child and Adolescent Well-Care Visits (WCV)	56.59%	50.66%	55.41%
Immunizations for Adolescents - Combo 2* (IMA-2)	42.13%	45.14% ↑	34.14%
Lead Screening in Children (LSC)*	64.75%	75.68% ↑	69.96%
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6+)	55.19%	56.25%	63.38%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2+)	71.71%	76.57% ↑	72.32%

DHCS Quality Award. The Quality Improvement team is proud to share that the Alliance was recently honored with two Quality Awards from the California

Department of Health Care Services (DHCS) for Measurement Year 2024 performance:

- Managed Care Plan Outstanding Performance in the Children's Health Domain
- Managed Care Plan Outstanding Performance

These awards recognize the Alliance's strong overall quality performance, with particular distinction in children's health outcomes. The Alliance attributes this success to its Provider Partnership and Care Gap Grants program, which focused on building strong relationships with and providing holistic support to the largest pediatric providers in Merced County. Together, these results and recognitions highlight the effectiveness of sustained investment in provider partnerships, data-driven quality improvement, and community-focused strategies to advance equitable outcomes for Alliance members.

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.

Change in Provider Rates for Community Supports. With the launch of California's CalAIM initiatives in 2022, the Department of Health Care Services (DHCS) gave Managed Care Plans (MCPs) the option to offer a broad range of Community Supports benefits. The Alliance chose to participate in the program by providing 12 such benefits, excluding the mandatory Transitional Rent benefit. Enabling these optional Community Supports benefits moves toward the broader goal of shifting to whole-person, preventive, and community-based care. DHCS published payment policies for reimbursing contracted community-based providers. Most of the rate guidance is on a range, lower, middle, and upper bounds, and the Alliance chose to negotiate within these ranges.

Since these are optional benefits, there was no guarantee of sufficient revenue from DHCS to cover the program costs; as a result, the Alliance lost $34.6M for Community Supports Services in 2025. The board policy is to operate within the revenue we receive from DHCS. This means the Alliance aggregate payments to providers need to fall within the revenue we get from the state. To help mitigate these losses, on December 10, 2025, at the Alliance Board approved areduction of rates for most Community Supports after having been reviewed by the Board Finance Committee.

The recent payment adjustment aligns MTM (Medically Tailored Meals) Nutritional Assessments, MTM: Groceries, MTM Meals, Respite Services, Personal Care and Homemaker Services, Housing Transitional Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, to the lower end of the DHCS-approved rate range. Providers that were already reimbursed at the lower rate did not receive a contract amendment. Providers whose rates exceeded the lower range were issued an amendment to reflect this adjustment in the first week of January 2026. Staff continue to have conversations with impacted providers to discuss the March 1, 2026, effective date of these changes. After the first week of sending out these amendments 43 out of the 80 amendments have been returned. Amendments must be signed and returned by January 31, 2026. Staff will continue to keep the board updated as to changes with this benefit.

Alliance Workforce. Our robust culture is built on the premise that the Alliance exists to serve Members. 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.

All Staff Meeting. On December 11, the Alliance held a virtual All-Staff Meeting with employees from all five counties and beyond. The year-end celebration opened with a warm welcome to our new hires and recognition of our service award recipients. CEO Michael Shrader then delivered the State of the Alliance Address, followed by important updates on Member Outreach & Retention and the launch of our TotalCare Medicare D-SNP program. The day featured uplifting Mission in Motion stories, including a presentation by Ray Cancino from Community Bridges, an Alliance provider offering adult day health care, non-emergency medical transportation, and enhanced care management. The event concluded with the celebration of our Employee of the Year, Emily Greenberg, Lead Provider Services Contracts Analyst, and our Leader of the Year, Sabryna Sherman, UM Manager, Authorizations & Coordination.

Coffee Talk. On December 9, the Alliance hosted a Coffee Talk featuring a conversational introduction to Mike Wang, MD, the Alliance's new CMO, and Van Wong, the COO. They shared what inspired their careers in healthcare and offered insights into their leadership styles. Key discussion topics included opportunities to enhance quality and member experience through cross-divisional collaboration, the importance of trust and mission-driven work, and ways staff can effectively engage with leadership. The session concluded with a light rapid-fire question-and-answer round and a reaffirmed commitment to staff engagement and organizational alignment.

Workforce. As of December 29, 2025, the Alliance has 727 budgeted positions, with 688 currently filled. An additional 48.9 temporary employees support our workforce needs, bringing overall staffing to 94.1%. The Board-approved administrative budget for calendar year 2026 includes the elimination of 43 temporary and vacant positions, aligning staffing levels with decreasing membership and service volumes associated with HR1 and the annual state budget.

Year End Evaluations and Annual Compensation Review (ACR). Referred to as Check-Ins, the Alliance conducts two performance evaluations each year: one in July for the first half of the year and one in December to review overall annual performance. Immediately following these evaluations, the Annual Compensation Review (ACR) process begins. The ACR includes merit increases, promotions, and a comprehensive review of compensation range placement, with adjustments made as appropriate. The year-end Check-In process began in December with employees completing their self-evaluations and will conclude on January 9, when supervisors finalize their evaluations. ACR meetings will commence in mid-January through early February, and final merit and compensation changes will be awarded on February 28, 2026.

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. The following is a summary of regulatory audit activity that occurred since my last report.

2026 DHCS Medi-Cal Audit. In November 2026, DHCS notified the Plan of its prospective annual Medi-Cal Audit, scheduled to occur virtually from January 26 to February 6, 2026. DHCS was amenable to the Plan's requested that DHCS reschedule the audit, considering the substantial effort needed to ensure a successful launch of the DSNP program, and has indicated the audit will occur in 2027, with a 2-year lookback.

2024 DMHC Medical Survey: The DMHC's Final Report and the Plan's response are now posted to DMHC's website. In October, the Plan provided a supplemental response addressing one outstanding deficiency, as requested by DMHC. With no additional inquiries received, the Plan considers the Survey closed. A Follow-Up Survey to reassess any deficiencies previously deemed uncorrected is expected in September 2026.

Cybersecurity. The Alliance takes a comprehensive approach to safeguarding our members' protected health information (PHI) through advanced technologies, robust practices, and strict policies. We proactively address cyber threats and are committed to continuously improving and strengthening our security posture.

Employee Training and Safeguards. We regularly train our staff to recognize and respond to common cyber risks, such as suspicious emails, unsafe links, and attempts to gain unauthorized access to information. In addition to training, we have safeguards in place on employee devices that help prevent compromise even if a user inadvertently clicks on an unsafe link or visits a suspicious site. We also screen all outgoing emails to detect PHI and will automatically convert those emails to secure encrypted emails, if required. Through ongoing education, simulated exercises, and clear reporting processes, employees learn how to safely handle protected health information (PHI) in their daily work. These efforts help ensure that everyone understands their role in keeping sensitive information private and secure, reducing the risk of accidental exposure or misuse.

HIPAA Privacy Breach. Conduent Business Services LLC (Conduent), a vendor that provides the Alliance's claims management software and related healthcare information systems, notified us of a breach that occurred on January 6, 2025. They indicated that a single complex data file containing the PHI of approximately 1500 Alliance members' PHI was exfiltrated from their environment and potentially compromised. While Conduent initially discovered the incident in February of 2025, they did not identify the Alliance as an impacted customer until late in 2025. Plan staff are currently developing a plan to make all required regulatory reports, including reporting to DHCS, the United States Department of Health and Human Services, and relevant state Attorney Generals, required media notification, and notification to impacted members.

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 social drivers that influence health and wellness.

MCGP Annual Investment Plan. The Board will consider and take action at the January 28, 2026 Board meeting on staff recommendations for the MCGP 2026

Investment Plan. The Board-approved annual plan serves as a roadmap for MCGP investments, defining grantmaking priorities to address Medi-Cal capacity needs in the Alliance's service area and allocating funding to advance the goals of each focus area and strategy through new and continuing existing funding opportunities in 2026.

Trends in the Number of Awards and Total Spend. The MCGP paid out $28.5M in 2025, comparable to $29M paid out in 2024. New MCGP awards in 2025 totaled $33M, which is 94% of the 2025 total award target of $35M for the five-county service area. All 2025 awards are included in the 2025 MCGP Impact Report in the January 28, 2026 Board packet. There will be three regular rounds of funding in 2026 with application deadlines on January 20, May 5 and August 18. Dates and details for new and updated funding opportunities will be phased in the first half of 2026.

To: Board of Directors & Plan Staff

From: LHPC Staff

Subject: Highlights from Governor's Proposed Budget for 2026-27

Date: January 9, 2026

This memo includes highlights from Governor Newsom's Proposed Budget for 2026-27, specifically health and human services proposals of relevance to local plans. See the Governor's Budget Summary, DHCS Budget Highlights, and the DHCS Medi-Cal Estimate for additional details (references and page numbers are provided throughout the memo). LHPC will continue to review and analyze Budget proposals impacting local plans and provide additional information as it becomes available. Please contact Rebecca Sullivan at rsullivan@lhpc.org, Katie Andrew kandrew@lhpc.org or Beau Bouchard bbouchard@lhpc.org with any questions.

State Budget Overview
The following highlights provide a snapshot of California's overall State Budget:
- *Total Budget*: $348.9 billion total fund ($248.3 billion General Fund) in FY 2026-27 (Summary Chart, p. 11). This reflects General Fund revenues that are $42.3 billion above what was projected for the current budget window (2024-2025 to 2026-2027) in the 2025 Budget Act.
- *Reduced Revenues and Budget Shortfall*: The FY 2026-27 budget anticipates a shortfall of $2.9 billion. The Governor presented a balanced budget by proposing the following:
  - *Reserves* —$23 billion
    - $14.4 billion in Budget Stabilization Account (BSA)
    - $4.5 billion in the Special Fund for Economic Uncertainties (SFEU)
    - $4.1 billion in the Public School System Stabilization Account

The Governor noted that this budget reflects general fund revenues that are higher by more than $42 billion due to higher cash receipts, higher stock market levels, and improved economic outlook. Although general fund revenues are higher than expected, this budget projects a general fund shortfall due to constitutional funding requirements, the need for adequate budget reserves and higher program costs. The Governor warns that there are several risk factors that could negatively affect the states revenues, including federal policy changes stemming from H.R. 1 as well as risks around stock market and assets price declines due to artificial intelligence investments being unsustainable, unpredictable federal policies, and uncertainty regarding tariffs and immigration. H.R. 1 is projected to cost $1.4 billion ($1.1. billion is from Medi-Cal policy changes). The Governor also notes that the budget is predicted to have a shortfall of roughly $22 billion in the next two fiscal years.

Reference: Governor's Budget Summary, pp. 1-6

Significant Medi-Cal Budget Items
Overall Medi-Cal Budget
- *2026-27 Budget estimate*: $222.4 billion ($48.8 billion General Fund) (DHCS Budget Highlights, p.12).
- *Total projected enrollment*: The FY 2026-27 projected average monthly caseload is 14.0 million, a decrease of 3.5% from FY 2025-2026. (DHCS Budget Highlights, p. 7)

Reference: DHCS Medi-Cal Estimate, p. 6; DHCS Budget Highlights, p. 12

Caseload Impacts Related to Redeterminations and Residency Verification
For the Governor's Budget, DHCS projects that Medi-Cal enrollment will be lower than assumed in the 2025 Budget Act due to steeper caseload decline August 2025 through June 2026 as a result of the COVID-19 unwinding flexibilities sunset in July 2025. The budget reflects a caseload of 14.5 million for the Medi-Cal program in 2025-26, a decrease of 307,600 from the 2025 Budget Act, and estimates a 14-million-member caseload in 2026-27.

Residency verification improvements will impact caseloads downward, however implementation shifted from FY 2025-26 to FY 2026-27, resulting in increased GF costs of $90.6 million in 2025-26. Although caseloads were lower than anticipated this delay resulted in increased GF costs of $63.8 million compared to assumptions in the 2025 Budget Act.

The Governor's budget assumes continued impact from the sunset of unwinding flexibilities will result in a year-over-year increase of $1.2 billion ($783.2 million GF) savings in 2026-27 and an additional $114 million GF savings as result of implementation of residency verification.

Reference: DHCS Budget Highlights, p. 5-6; Governor's Budget Summary, p. 75

H.R 1 Impacts
The Governor's proposed budget recognizes the significant impact that the passing of H.R. 1, signed into law by President Trump on July 4, 2025, will have on the Medi-Cal program, estimating $471.9 million GF increase for H.R. 1 policies effective in 2026-2027 and an overall reduction in caseload of 1.8 million. Note that the budget expressly indicates that the key eligibility provisions of H.R. 1 will be applicable to both UIS and SIS populations.

UIS Emergency Affordable Care Act (ACA) Federal Medical Assistance Percentage (FMAP) Adjustment. Change in FMAP from 90% to 50% for emergency services for UIS ACA Adult Expansion population (effective October 1, 2026). Estimated increase of $658 million GF in 2026-2027. Note that the budget does address CMS guidance re: Emergency Medicaid articulated in State Medicaid Director # 25-003.

Work and Community Engagement Requirement. Estimate that the caseload reductions (233,000 in 2026-2027 and 1.4 million in outyears) resulting from new requirements (effective January 1, 2027) will result in a cost reduction of $373.3 million ($102.4 million GF) in 2026-2027.

ACA Adult Expansion Population 6-month Redetermination. Estimate that the caseload reductions (~289,000, increasing to 395,000) from increased frequency of redeterminations from every 12 months to every 6 months (effective January 1, 2027) will result in a cost reduction of $463.3 million ($74.1 million GF) for 2026-2027.

Reduced Retroactive Medi-Cal Timeframes. Reduction of retroactive Medi-Cal coverage for ACA Adult Expansion population (M1 aid code) from 3 months before an individual's application date to 1 month and 2 months for all other eligible groups (effective January 1, 2027) will result in an estimated savings of $23 million ($9.6 million GF) in 2026-2027.

Restrictions on Immigrant Eligibility. Expect a reduction in federal funding due to the narrowing of the definition of qualified non-citizens eligible for federal funds. Governor's Proposed Budget proposes to move non-citizens that are no longer eligible for federal funds to restricted scope Medi-Cal, impacting an estimated 200,000 Medi-Cal members. The administration estimates that keeping this population on full-scope Medi-Cal would cost $786 million GF in 2026-2027 and $1.1 billion GF ongoing.

County Administration. Increased frequency of redeterminations and implementation of Work and Community Engagement requirements will put a strain on county eligibility workers. DHCS is engaging with counties to evaluate additional county support needs.

Reference: DHCS Budget Highlights, p. 4; Governor's Budget Summary, p.76-77

Other Federal Impacts to Budget
Improvements & Efficiencies. In part, related to the increased federal scrutiny on fraud, waste, and abuse (FWA) in the Medicaid program, the Governor's Proposed Budget notes DHCS' intention to explore ways to achieve General Fund savings by identifying improvements and efficiencies through 1) enhancing oversight, monitoring, and enforcement of managed care plans; 2) improving program integrity; and 3) aligning provide payments with value. Estimate to save $120 million GF in 2026-2027. DHCS has engaged a consulting group to carry out this work, which will be further defined in the upcoming months.

Reference: DHCS Budget Highlights, p. 5

Managed Care Organization (MCO) Tax
The current MCO Tax is not consistent with H.R. 1 requirement that prohibits taxing Medicaid providers at higher rates than non-Medicaid providers. Under recent federal guidance, states will have a transition period through June 30, 2026, which is anticipated to cost the general fund

roughly $1.1 billion in FY 2026-27. However, this Budget assumes California will receive a full transition period through December 31, 2026. We anticipate more insight after next week's PAHCA-SAC meeting. Additionally, the Governor notes that H.R. 1 and Proposition 35 requirements significantly limit the size of any future MCO Tax, which results in a substantial reduction in ongoing support for the Medi-Cal program.

Reference: DHCS Budget Highlights, p. 12; Governor's Budget Summary, p. 77

Hospital Quality Assurance Fee (HQAF)
Compared to the 2025 Budget Act, this budget projects a decrease in HQAF funding to support the Medi-Cal program of roughly $92 million in FY 2025-26 and $142.1 million in FY 2026-27 attributed to the federal government's notification that California's waiver request would not be approved as submitted. California has until mid-March to submit a revised model to the federal government.

As a reminder, HQAF includes an administrative assessment by the state which supports the General Fund.

Reference: DHCS Budget Highlights, p. 5; Governor's Budget Summary, p. 78

CalAIM
The Governor's Budget estimates $2.75 billion in expenditures for CalAIM ECM and Community Supports, an increase of $412.0 million from FY 2025-26. This increase is due to increases in ECM, Community Supports, and Transitional Rent costs.

	Total Fund	General Fund	Federal Funds
Community Supports	$1,143,121,000	$468,813,000	$674,308,000
Enhanced Care Management	$1,380,950,000	$582,169,000	$798,780,000
Transitional Rent	$224,675,000	$91,789,000	$132,887,000
Total for FY 2025-26	**$2,748,746,000**	**$1,142,771,000**	**$1,605,975,000**

Reference: DHCS Medi-Cal Local Assistance Estimate, pp. 138-140

Behavioral Health
Behavioral Health Funding. Includes $150 million (placeholder) in Behavioral Health Services Fund for HCAI and CDPH for workforce and prevention programming. This will be updated at May Revise.

Reference: Governor's Budget Summary, p. 84

Community-Based Mobile Crisis Services. DHCS' enhanced federal funding for community-based mobile crisis response services will expire December 31, 2026, and the mobile crisis

services will sunset March 31, 2027 (pending submission and approval of SPA). The Governor's Budget proposes to make mobile crisis services as an optional benefit beginning April 1, 2027. Includes $431.5 million total funds ($50.7 million Prop 35 funds, $347 million federal funds, $28.2 million 988 funds, and $5.6 million GF) to continue this benefit across 2025-26 and 2026-27.

Reference: DHCS Budget Highlights, p. 5

Other Human Services Proposals

H.R. 1 Impacts on CalFresh
Cost-Sharing Provisions. Due to the federal share of CalFresh administrative costs reduction from 50% to 25%, the Governor's Proposed Budget assumes a General Fund increase of $382.9 million in 2026-2027.

Eligibility Provisions. Eligibility changes (i.e., ineligibility for certain lawfully present non-citizens; updated Able-bodied Adults without Dependents work requirements, and State Utility Assistance Subsidy limitations) at the federal level will result in fewer individuals being eligible for CalFresh benefits, resulting in a reduction of $66.2 million GF in 2026-2027.

Federal Rural Health Transformation Program
Includes $233.6 million in federal funds for federal fiscal year 2026 for HCAI to support the expansion of access to care, workforce development, and health care infrastructure in rural and frontier communities.

Reproductive Health Grant Program
Includes $60 million one-time GF to HCAI to provide grants to reproductive health care providers (note that this is in addition to $90 million MCO Tax funds and $56 million Abortion Access Fund in 2025-26 to support reproductive health care providers). Highlighting that based on conversation with the Department, this will be the solution for funding planned parenthood during the funding ban and we do not anticipate proposal for plans to pay Planned Parenthood through a claims based approach.

Menopause Services
Includes $3.4 million (~$3 million GF) in 2026-2027 and $391,000 Managed Care Fund ongoing to support health care coverage for perimenopause and menopause related services.

In-Home Supportive Services (IHSS)
Includes a reduction of $86 million in 2026-27 by aligning Medi-Cal and IHSS eligibility processes. The Governor's budget also proposed to reduce $3.5 GF to eliminate the IHSS Backup Provider system due to low utilization of these services and further savings of $233.6 million GF to remove state's share of cost for IHSS hours per case growth beginning in 2027-28.

Reference: Budget Summary, p. 84

TBL Section

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

- H.R. 1 – Conforming State to Federal Law
- Community-Based Mobile Crisis Intervention Services
- Skilled Nursing Facility Financing Reauthorization

DATE: January 28, 2026

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

FROM: Lisa Ba, Chief Financial Officer

SUBJECT: Financial Highlights for the Eleventh Month Ending November 30, 2025

For the month ending November 30, 2025, the Alliance reported an Operating Loss of $10.4M. The Year-to-Date (YTD) Operating Loss is $63.1M with a Medical Loss Ratio (MLR) of 98.0% and an Administrative Loss Ratio (ALR) of 5.0%. The Net Loss is $27.5M after accounting for Non-Operating Income/Expenses.

The budget expected an Operating Loss of $66.0M for November YTD. The actual result is favorable to the budget by $2.9M or 4.4%, driven by rate variances.

Nov-25 MTD ($ In 000s)			
Key Indicators	Current Actual	Current Budget	Current Variance	% Variance to Budget
Membership	*437,400*	*438,776*	*(1,376)*	*-0.3%*
Revenue	$193,998	$173,830	$20,167	11.6%
Medical Expenses	196,204	175,647	(20,557)	-11.7%
Administrative Expenses	8,192	9,398	1,206	12.8%
Operating Income/(Loss)	(10,398)	(11,215)	816	7.3%
Net Income	($7,503)	($11,122)	$3,618	32.5%
MLR %	*101.1%*	*101.0%*	*-0.1%*	
ALR %	*4.2%*	*5.4%*	*1.2%*	
Operating Income %	*-5.4%*	*-6.5%*	*1.1%*	
Net Income %	*-3.9%*	*-6.4%*	*2.5%*	

HEALTHY PEOPLE. **HEALTHY** COMMUNITIES.

Nov-25 YTD (In $000s)			
Key Indicators	YTD Actual	YTD Budget	YTD Variance	% Variance to Budget
Member Months	*4,868,329*	*4,826,842*	*41,487*	*0.9%*
Revenue	$2,078,330	$1,912,138	$166,192	8.7%
Medical Expenses	2,037,322	1,869,761	(167,561)	-9.0%
Administrative Expenses	104,077	108,349	4,272	3.9%
Operating Income/(Loss)	(63,070)	(65,973)	2,903	4.4%
Net Income/(Loss)	($27,482)	($52,084)	$24,602	47.2%
PMPM				
Revenue	$426.91	$396.15	$30.76	7.8%
Medical Expenses	418.48	387.37	(31.12)	-8.0%
Administrative Expenses	21.38	22.45	1.07	4.8%
Operating Income/(Loss)	($12.96)	($13.67)	$0.71	5.2%
MLR %	98.0%	97.8%	-0.2%	
ALR %	5.0%	5.7%	0.7%	
Operating Income %	-3.0%	-3.5%	0.4%	
Net Income %	-1.3%	-2.7%	1.4%	

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

At a PMPM level, revenue is $426.91, which is favorable to the budget by $30.76 or 7.8%. Medical cost PMPM is $418.48, which is unfavorable by $31.12 or 8.0%. This results in an unfavorable gross margin of $0.36 or 4.1% compared to the budget. The operating loss PMPM is ($12.96), compared to the budget of ($13.67).

Membership: November 2025 membership is unfavorable to the budget by 0.3%. The 2025 budget assumed a flat budget with 438k members per month for all of 2025. As of recent trends, Satisfactory Immigration Status (SIS) membership continues to decline as the redetermination process progresses. While Unsatisfactory Immigrant Status (UIS) enrollment had demonstrated consistent growth earlier in the year, that trajectory began to soften in June, with a slight decline in July and continued month-over-month decreases through November.

SIS Membership

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Budget	341,268	340,927	373,030	373,030	373,030	373,030	373,030	373,030	373,030	373,030	373,030	373,030	373,030
Actual	362,135	384,572	372,395	372,699	372,081	369,053	368,416	368,576	367,345	365,221	363,920	363,385	364,214
Var	20,867	43,645	(635)	(331)	(949)	(3,977)	(4,614)	(4,454)	(5,685)	(7,809)	(9,110)	(9,645)	(8,816)
Var %	6.1%	12.8%	-0.2%	-0.1%	-0.3%	-1.1%	-1.2%	-1.2%	-1.5%	-2.1%	-2.4%	-2.6%	-2.4%

Budget ● Actual

UIS Membership

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Buget	55,594	55,545	65,096	65,096	65,096	65,096	65,096	65,096	65,096	65,096	65,096	65,096	65,096
Actual	69,632	69,990	71,363	72,834	73,668	75,528	75,909	75,742	75,388	74,539	73,753	72,322	72,448
Var	14,038	14,445	6,267	7,738	8,572	10,432	10,813	10,646	10,292	9,443	8,657	7,226	7,352
Var %	25.3%	26.0%	9.6%	11.9%	13.2%	16.0%	16.6%	16.4%	15.8%	14.5%	13.3%	11.1%	11.3%

Buget ● Actual

Total Membership (incl IHSS)

	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Buget	397,462	397,072	438,833	438,827	438,821	438,815	438,809	438,804	438,798	438,792	438,787	438,781	438,776
Actual	432,469	455,255	444,442	446,213	446,424	445,244	444,979	444,968	443,381	440,440	438,400	436,438	437,400
Var	35,007	58,183	5,609	7,386	7,603	6,429	6,170	6,164	4,583	1,648	(387)	(2,343)	(1,376)
Var %	8.8%	14.7%	1.3%	1.7%	1.7%	1.5%	1.4%	1.4%	1.0%	0.4%	-0.1%	-0.5%	-0.3%

Buget ■ —●— Actual

Revenue: The 2025 revenue budget was based on the Department of Health Care Services (DHCS) 2025 draft rate package (dated 10/21/24), which reflected a –0.1% rate decrease over the CY 24 Final Amended rates (dated 12/30/24), not including the Targeted Rate Increase (TRI) and Enhanced Care Management (ECM). Furthermore, the budget assumed breakeven performances for the San Benito Region and for our Unsatisfactory Immigrant Status (UIS) population. The CY 2025 Prospective rates from DHCS (dated 1/27/2025, including Maternity) represented a 5.0.% increase over CY 2024 Final Amended Rates, excluding TRI and ECM.

Nov-25 YTD Capitation Revenue Summary (In $000s)					
Region	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
CEC SIS	$1,519,463	$1,442,117	$77,347	12,697	64,649
CEC UIS	430,461	384,146	46,315	4,271	42,044
SBN SIS	85,305	63,150	22,154	1,310	20,845
SBN UIS	16,939	18,229	(1,290)	(2,253)	963
Total*	**$2,052,168**	**$1,907,642**	**$144,526**	**$16,025**	**$128,501**

*Excludes Nov-25 In-Home Supportive Services (IHSS) premiums revenue of $5.2M, State Incentive Revenue of $2.4M, and Prior Year Revenue of $18.6M.

As of November, actuals exceeded the budget by $20.2M, representing a 11.6% positive variance. This is driven by favorable rate variances totaling $20.8M resulting from increases in prospective rates compared to the budget, offsetting unfavorable enrollment of $0.6M.

Additionally, a portion of the favorable rate variance is attributable to the ECM Risk Corridor, which was already budgeted at $7.0M and contributed $1.9M in favorable impact this month, resulting in a total ECM Risk Corridor of $8.9M for November. Please note that the ECM expenses exceed the budget, and the net loss is limited to 5% of the ECM revenue.

Please note that November revenue reflects a 1% downward adjustment, lowering revenue by $1.7M, which will continue each month throughout the remainder of the year until the Centers of Medicare & Medicaid Services (CMS) finalizes the CY 2025 rates. Prior year revenue increased by $7.1M as a result of earning $1.5M from the CY 2024 Quality Withhold Incentives and $5.6M from reconciling CY 2023 rates.

As of November 2025 YTD, operating revenue stands at $2,078,3M, surpassing the budget by $166.2M or 8.7%. This favorable variance includes $16.1M from increased enrollment and $150.1M from favorable rate variances.

Medical Expenses: The 2025 budget assumed a 3.3% increase in utilization over the 2024 forecast, based on data from 2022 through September 2024, and a 4.2% increase in unit cost driven by changes in case mix and fee schedule adjustments. The 2025 incentives include a $20M for the Hospital Quality Incentive Program (HQIP), $15M the Care-Based Incentive (CBI), $12.5M for the Specialist Care Incentive (SCI), $4M Data Sharing Incentives, $3.7M Behavioral Health Value-Based Program (BH VBP), and $1M Risk Adjustment Incentives.

Nov-25 YTD Medical Expense Summary ($ In 000s)					
Category	Actual	Budget	Variance	Variance Due to Enrollment	Variance Due to Rate
Inpatient Hospital	$539,599	$531,799	($7,800)	($4,571)	($3,229)
Inpatient Services - LTC	207,553	191,644	(15,909)	(1,649)	(14,260)
Physician Services	435,366	476,946	41,580	(4,099)	45,679
Outpatient Facility	238,416	205,928	(32,488)	(1,770)	(30,718)
ECM	159,911	102,327	(57,584)	(879)	(56,704)
Community Supports	76,156	37,765	(38,391)	(324)	(38,066)
Behavioral Health	85,626	82,139	(3,487)	(705)	(2,782)
Other Medical*	292,329	241,213	(51,115)	(2,076)	(49,042)
State Incentives	2,366	-	(2,366)	-	(2,366)
TOTAL COST	$2,037,322	$1,869,761	($167,561)	($16,071)	($151,490)

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

November 2025 Medical Expenses of $196.2M are $20.6M or 11.7% unfavorable to the budget. November 2025 YTD Medical Expenses of $2,037.3M are above budget by $167.6M or 9.0%. Of this amount, $16.1M is due to higher enrollment, and $151.5M is due to rate variances. The unfavorability is primarily driven by ECM, and Community Supports (CS) from the higher-than-budget enrollment, followed by the Other Medical category, specifically from transportation and Hospice.

At a PMPM level, YTD Medical Expenses are $418.48, unfavorable by $31.12 or 8.0% compared to the budget.

Nov-25 YTD Medical Expense by Category of Service (In PMPM)				
Category	Actual	Budget	Variance	Variance %
Inpatient Services - Hospital	$110.84	$110.18	($0.66)	-0.6%
Inpatient Services - LTC	42.63	39.70	(2.93)	-7.4%
Physician Services	89.43	98.81	9.38	9.5%
Outpatient Facility	48.97	42.66	(6.31)	-14.8%
ECM	32.85	21.20	(11.65)	-54.9%
Community Supports	15.64	7.82	(7.82)	-99.9%
Behavioral Health	17.59	17.02	(0.57)	-3.4%
Other Medical	60.05	49.97	(10.07)	-20.2%
State Incentives	0.49	-	(0.49)	-100.0%
TOTAL MEDICAL COST	**$418.48**	**$387.37**	**($31.12)**	**-8.0%**

Inpatient Services: Inpatient Services remain slightly unfavorable to the budget due to the prior years' claims, including high-dollar claims. November includes a $4.5M high dollar claim in San Benito. On an incurred basis, excluding prior period, the 2025 YTD PMPM is now $105.73, which is below the budgeted amount of $110.18 through November.

Inpatient Services—Long Term Care (LTC): LTC utilization is trending slightly above budget by 2%, and unit costs are also higher than planned by 4% due to 2025 fee schedule rates coming in above budget and a higher proportion of services in higher acuity LTC levels.

Physician Services: Favorability is influenced by lower utilization of the Targeted Rate Increase (TRI) and Provider Supplemental Payment (PSP) budgets. Currently, just over half of the TRI budget is utilized for Primary Care, with a favorable variance partially offset by higher utilization. The 2025 Budget reflects $114M in TRI, of which $85M is anticipated to be utilized. The Specialty Physicians category includes a $52M supplemental payment in 2025, funded by Board-approved reserves, with an estimated $28M to be utilized as of Nov YTD. Favorability in the Specialty PSP is also partially offset by higher-than-budgeted utilization.

Outpatient Facility: The Outpatient Facility category consists of both Outpatient and Emergency Room (ER) services. ER continues to show an upward trend in both utilization per 1k and unit cost, as expected. Outpatient continues to exceed budget due to higher utilization for all of 2025, including significantly higher utilization in January. On an incurred basis, YTD PMPM actuals are $46.18 vs. budgeted $42.66, with outpatient underbudgeted so far in 2025.

ECM: The ECM budget for 2025 was based on a cautious enrollment growth projection with an anticipated 15.4k enrollments by year-end, as the program is on its path toward stabilization. However, ECM enrollments started the year at 16k and have increased to 23.5k by November. Before adjusting for the risk corridor, ECM's YTD loss through November is $100.7M. It is

projected to total approximately $118.8M for the whole year based on our revised enrollment growth assumptions. The risk corridor will mitigate $111.7M, resulting in a net loss of $7.1M.

Community Supports: Enrollments in the Community Support (CS) program were modestly budgeted, given its newness and limited history. Since the budget preparation, there has been a significant increase in CS enrollments. The YTD 2025 PMPM expense is trending at $14.96, or 100% higher than the budget and 73% higher than the revenue PMPM of $8.51. Monthly losses increased from $1.9M in January to $7.7M in November, resulting in a YTD loss of $34M. Based on current trends, full-year losses may surpass the initially projected $26M to $34.6M. We expect the unfavorable variance in ECM and CS to continue for the remainder year.

Behavioral Health: Behavioral Health is tracking closely to budget, as the Targeted Rate Increase (TRI) was appropriately incorporated starting in March and for all subsequent months. The budget also incorporates anticipated increases in utilization and unit cost in the second half of the year, in preparation for the transition to bring Behavioral Health services in-house. A slight unfavourability to budget is noted, primarily driven by a $1.5M payment to Carelon recorded in November for incorrect TRI payments prior to BH insource.

Other Medical: The Other Medical category is over budget primarily due to increased utilization and higher unit costs. Transportation is the largest contributor, which accounts for a $21.0M unfavorable variance. This is driven by higher utilization in Non-Medical Transportation from ECM/CS members and increased unit costs in both Air Transportation and Non-Emergency Medical Transportation (NEMT). The higher NEMT costs reflect add-on payments associated with bariatric transport, which require specialized equipment and support. Hospice services contributed a $6.7M variance driven by higher-than-expected utilization due to an increase in palliative care within Monterey and hospice services within San Benito, as well as under-budgeted unit costs. Additionally, Allied Health accounted for a $11.2M variance, primarily due to increased utilization of physical therapy services and increased unit costs in Home Health. These factors account for the majority of unfavorable variance in the Other Medical category.

Administrative Expenses: November YTD Administrative Expenses are favorable to the budget by $4.3M or 3.9% with 5.0% ALR. Salaries are favorable by $3.2M driven by savings from vacant positions, benefits, employment taxes, and PTO. Non-salary administrative expenses are favorable by $1.1M, or 3.1%, due to savings and the timing of actuals versus budget.

Non-Operating Revenue/Expenses: November YTD Net Non-Operating Income is $35.6M, which is favorable to the budget by $21.7M. The favorability is derived from the YTD Investment Income of $56.1M, which is $15.1M favorable to the budget due to higher interest rates. The YTD Other Revenue is $2.8M, above budget by $0.7M. The YTD Non-Operating Expense is $23.4M from the grant distribution. This is favorable to the budget by $6.0M.

Summary of Results: Overall, the Alliance generated a YTD Net Loss of $27.5M, with an MLR of 98.0% and an ALR of 5.0%.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Balance Sheet
For The Eleventh Month Ending November 30, 2025
(In $000s)

Assets

Cash	$180,985
Restricted Cash	300
Short Term Investments	804,808
Receivables	577,557
Prepaid Expenses	2,640
Other Current Assets	4,176
Total Current Assets	**$1,570,466**
Building, Land, Furniture & Equipment	
Capital Assets	$82,118
Accumulated Depreciation	(48,360)
CIP	4,038
Lease Receivable	4,133
Subscription Asset net Accum Depr	13,214
Total Non-Current Assets	**55,141**
Total Assets	**$1,625,608**

Liabilities

Accounts Payable	$272,786
IBNR/Claims Payable	356,459
Provider Incentives Payable	40,558
Other Current Liabilities	8,568
Due to State	69,051
Total Current Liabilities	**$747,422**
Subscription Liabilities	10,590
Deferred Inflow of Resources	3,899
Total Long-Term Liabilities	**$14,489**

Fund Balance

Fund Balance - Prior	$891,178
Retained Earnings - CY	(27,482)
Total Fund Balance	**863,696**
Total Liabilities & Fund Balance	**$1,625,608**

Additional Information

Total Fund Balance	**$863,696**
Board Designated Reserves Target	561,103
Strategic Reserve (DSNP)	56,700
Medi-Cal Capacity Grant Program (MCGP)*	129,334
Value Based Payments	46,100
Provider Supplemental Payments	126,466
Total Reserves	**919,702**
Total Operating Reserve	**($56,007)**

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Eleventh Month Ending November 30, 2025
(In $000s)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*437,400*	*438,776*	*(1,376)*	*-0.3%*	*4,868,329*	*4,826,842*	*41,487*	*0.9%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$186,371	$173,438	$12,933	7.5%	$2,052,168	$1,907,642	$144,526	7.6%
State Incentive Programs	(0)	-	(0)	0.0%	2,366	-	$2,366	100.0%
Prior Year Revenue*	7,113	-	7,113	100.0%	18,591	-	$18,591	100.0%
Premiums Commercial	514	393	121	30.9%	5,205	4,496	709	15.8%
Total Operating Revenue	**$193,998**	**$173,830**	**$20,167**	**11.6%**	**$2,078,330**	**$1,912,138**	**$166,192**	**8.7%**
Medical Expenses								
Inpatient Services (Hospital)	$47,936	$49,959	$2,023	4.0%	$539,599	$531,799	($7,800)	-1.5%
Inpatient Services (LTC)	20,259	17,997	(2,261)	-12.6%	207,553	191,644	(15,909)	-8.3%
Physician Services	39,450	44,724	5,275	11.8%	435,366	476,946	41,580	8.7%
Outpatient Facility	21,344	19,345	(1,999)	-10.3%	238,416	205,928	(32,488)	-15.8%
ECM	17,361	9,614	(7,747)	-80.6%	159,911	102,327	(57,584)	-56.3%
Community Supports	7,417	3,548	(3,869)	-100.0%	76,156	37,765	(38,391)	-100.0%
Behavioral Health	10,897	7,806	(3,091)	-39.6%	85,626	82,139	(3,487)	-4.2%
Other Medical**	31,540	22,653	(8,887)	-39.2%	292,329	241,213	(51,115)	-21.2%
State Incentive Programs	(0)	-	0	0.0%	2,366	-	(2,366)	-100.0%
Total Medical Expenses	**$196,204**	**$175,647**	**($20,557)**	**-11.7%**	**$2,037,322**	**$1,869,761**	**($167,561)**	**-9.0%**
Gross Margin	**($2,206)**	**($1,817)**	**($390)**	**-21.4%**	**$41,008**	**$42,377**	**($1,369)**	**-3.2%**
Administrative Expenses								
Salaries	$5,732	$6,306	$574	9.1%	$70,313	$73,505	$3,192	4.3%
Professional Fees	444	419	(25)	-6.0%	4,407	4,840	432	8.9%
Purchased Services	430	940	510	54.3%	10,480	11,981	1,502	12.5%
Supplies & Other	767	727	(39)	-5.4%	10,196	8,485	(1,711)	-20.2%
Occupancy	105	135	30	22.5%	1,307	1,444	137	9.5%
Depreciation/Amortization	715	871	156	17.9%	7,375	8,095	720	8.9%
Total Administrative Expenses	**$8,192**	**$9,398**	**$1,206**	**12.8%**	**$104,077**	**$108,349**	**$4,272**	**3.9%**
Operating Income	**($10,398)**	**($11,215)**	**$816**	**7.3%**	**($63,070)**	**($65,973)**	**$2,903**	**4.4%**
Non-Op Income/(Expense)								
Interest	$2,949	$2,587	$362	14.0%	$42,092	$37,259	$4,834	13.0%
Gain/(Loss) on Investments	1,630	-	1,630	100.0%	14,483	4,500	9,983	100.0%
Bank & Investment Fees	(28)	(62)	34	54.5%	(427)	(678)	251	37.0%
Other Revenues	355	234	120	51.3%	2,806	2,142	665	31.0%
Grants	(2,010)	(2,667)	657	24.6%	(23,367)	(29,333)	5,967	20.3%
Community Reinvestment	-	-	-	0.0%	-	-	-	0.0%
Total Non-Op Income/(Expense)	**2,895**	**93**	**2,802**	**100.0%**	**35,588**	**13,889**	**$21,699**	**100.0%**
Net Income/(Loss)	**($7,503)**	**($11,122)**	**$3,618**	**32.5%**	**($27,482)**	**($52,084)**	**$24,602**	**47.2%**
MLR	*101.1%*	*101.0%*			*98.0%*	*97.8%*		
ALR	*4.2%*	*5.4%*			*5.0%*	*5.7%*		
Operating Income	*-5.4%*	*-6.5%*			*-3.0%*	*-3.5%*		
Net Income %	*-3.9%*	*-6.4%*			*-1.3%*	*-2.7%*		

**Other Medical includes Pharmacy and IHSS.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Income Statement - Actual vs. Budget
For The Eleventh Month Ending November 30, 2025
(In PMPM)

	MTD Actual	MTD Budget	Variance	%	YTD Actual	YTD Budget	Variance	%
Member Months	*437,400*	*438,776*	*(1,376)*	*-0.3%*	*4,868,329*	*4,826,842*	*41,487*	*0.9%*
Capitation Revenue								
Capitation Revenue Medi-Cal	$426.09	$395.28	$30.81	7.8%	$421.53	$395.22	$26.32	6.7%
State Incentive Programs	(0.00)	-	(0.00)	0.0%	0.49	-	0.49	100.0%
Prior Year Revenue*	16.26	-	16.26	100.0%	3.82	-	3.82	100.0%
Premiums Commercial	1.17	0.89	0.28	31.3%	1.07	0.93	0.14	14.8%
Total Operating Revenue	**$443.52**	**$396.17**	**$47.35**	**12.0%**	**$426.91**	**$396.15**	**$30.76**	**7.8%**
Medical Expenses								
Inpatient Services (Hospital)	$109.59	$113.86	$4.27	3.7%	$110.84	$110.18	($0.66)	-0.6%
Inpatient Services (LTC)	46.32	41.02	(5.30)	-12.9%	42.63	39.70	(2.93)	-7.4%
Physician Services	90.19	101.93	11.74	11.5%	89.43	98.81	9.38	9.5%
Outpatient Facility	48.80	44.09	(4.71)	-10.7%	48.97	42.66	(6.31)	-14.8%
ECM	39.69	21.91	(17.78)	-81.1%	32.85	21.20	(11.65)	-54.9%
Community Supports	16.96	8.09	(8.87)	-100.0%	15.64	7.82	(7.82)	-99.9%
Behavioral Health	24.91	17.79	(7.12)	-40.0%	17.59	17.02	(0.57)	-3.4%
Other Medical**	72.11	51.63	(20.48)	-39.7%	60.05	49.97	(10.07)	-20.2%
State Incentive Programs	(0.00)	-	0.00	0.0%	0.49	-	(0.49)	-100.0%
Total Medical Expenses	**$448.57**	**$400.31**	**($48.26)**	**-12.1%**	**$418.48**	**$387.37**	**($31.12)**	**-8.0%**
Gross Margin	**($5.04)**	**($4.14)**	**($0.90)**	**-21.8%**	**$8.42**	**$8.78**	**($0.36)**	**-4.1%**
Administrative Expenses								
Salaries	$13.10	$14.37	$1.27	8.8%	$14.44	$15.23	$0.79	5.2%
Professional Fees	1.01	0.95	(0.06)	-6.3%	0.91	1.00	0.10	9.7%
Purchased Services	0.98	2.14	1.16	54.1%	2.15	2.48	0.33	13.3%
Supplies & Other	1.75	1.66	(0.10)	-5.8%	2.09	1.76	(0.34)	-19.1%
Occupancy	0.24	0.31	0.07	22.2%	0.27	0.30	0.03	10.3%
Depreciation/Amortization	1.64	1.98	0.35	17.6%	1.51	1.68	0.16	9.7%
Total Administrative Expenses	**$18.73**	**$21.42**	**$2.69**	**12.6%**	**$21.38**	**$22.45**	**$1.07**	**4.8%**
Operating Income	**($23.77)**	**($25.56)**	**$1.79**	**7.0%**	**($12.96)**	**($13.67)**	**$0.71**	**5.2%**
Non-Op Income/(Expense)								
Interest	$6.74	$5.90	$0.85	14.4%	$8.65	$7.72	$0.93	12.0%
Gain/(Loss) on Investments	3.73	$0.00	3.73	100.0%	2.97	0.93	2.04	100.0%
Bank & Investment Fees	(0.06)	(0.14)	0.08	54.3%	(0.09)	(0.14)	0.05	37.6%
Other Revenues	0.81	0.53	0.28	51.8%	0.58	0.44	0.13	29.9%
Grants	(4.60)	(6.08)	1.48	24.4%	(4.80)	(6.08)	1.28	21.0%
Community Reinvestment	-	$0.00	-	0.0%	-	-	-	0.0%
Total Non-Op Income/(Expense)	**$6.62**	**$0.21**	**$6.41**	**100.0%**	**$7.31**	**$2.88**	**$4.43**	**100.0%**
Net Income/(Loss)	**($17.15)**	**($25.35)**	**$8.19**	**32.3%**	**($5.64)**	**($10.79)**	**$5.15**	**47.7%**
MLR	*101.1%*	*101.0%*			*98.0%*	*97.8%*		
ALR	*4.2%*	*5.4%*			*5.0%*	*5.7%*		
Operating Income	*-5.4%*	*-6.5%*			*-3.0%*	*-3.5%*		
Net Income %	*-3.9%*	*-6.4%*			*-1.3%*	*-2.7%*		

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

**Other Medical includes Pharmacy and IHSS.

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH
Statement of Cash Flow
For The Eleventh Month Ending November 30, 2025
(In $000s)

	MTD	YTD
Net Income	($7,503)	($27,482)
Items not requiring the use of cash: Depreciation	223	868
Adjustments to reconcile Net Income to Net Cash provided by operating activities:		
Changes to Assets:		
Restricted Cash	0	4
Receivables	(142,197)	(153,314)
Prepaid Expenses	6	(1,804)
Current Assets	557	(316)
Subscription Asset net Accum Depr	0	0
Net Changes to Assets	**(141,633)**	**(155,434)**
Changes to Payables:		
Accounts Payable	129,755	(110,649)
Other Current Liabilities	(7,941)	(2,953)
Incurred But Not Reported Claims/Claims Payable	18,824	(120,733)
Provider Incentives Payable	4,126	(2,901)
Due to State	0	52,381
Subscription Liabilities	0	0
Net Changes to Payables	**144,764**	**(184,855)**
Net Cash Provided by (Used in) Operating Activities	**(4,149)**	**(366,903)**
Change in Investments	106,613	233,867
Other Equipment Acquisitions	(580)	(2,221)
Net Cash Provided by (Used in) Investing Activities	**106,033**	**231,646**
Deferred Inflow of Resources	0	0
Net Cash Provided by (Used in) Financing Activities	**0**	**0**
Net Increase (Decrease) in Cash & Cash Equivalents	**101,884**	**(135,257)**
Cash & Cash Equivalents at Beginning of Period	**79,101**	**316,238**
Cash & Cash Equivalents at November 30, 2025	**$180,985**	**$180,985**

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

Special Meeting Minutes

Wednesday, December 10, 2025
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
Ms. Anita Aguirre	At Large Health Care Provider Representative
Dr. Ralph Armstrong	At Large Health Care Provider Representative
Ms. Tracey Belton	County Health and Human Services Agency
Dr. Maximiliano Cuevas	Health Care Provider Representative
Ms. Kim De Serpa	County Board of Supervisor
Ms. Janna Espinoza	Public Representative
Dr. Donaldo Hernandez	Health Care Provider Representative
Mr. Michael Molesky	Public Representative
Ms. Connie Moreno-Peraza	County Health Department Representative

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

Supervisor Josh Pedrozo	County Board of Supervisor
Dr. James Rabago	Health Care Provider Representative
Dr. Kristynn Sullivan	County Health Department Representative
Mr. Ye Thao	Public Representative

Commissioners Absent:

Supervisor Wendy Root Askew	County Board of Supervisor
Ms. Elsa Jimenez	County Director of Health Services
Dr. Kristina Keheley	County Health Department Representative
Dr. Allen Radner	At Large Health Care Provider Representative

Staff Present:

Mr. Michael Schrader	Chief Executive Officer
Ms. Jenifer Mandella	Chief Compliance Officer
Ms. Lisa Ba	Chief Financial Officer
Mr. Cecil Newton	Chief Information Officer
Ms. Van Wong	Chief Operating Officer
Mr. Scott Fortner	Chief Administrative Officer
Ms. Anne Brereton	Deputy County Counsel, Monterey County
Ms. Jessie Dybdahl	Provider Services Director
Ms. Kay Lor	Director of Payment Strategy
Ms. Hayley Tut	Clerk of the Board

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

   Chairperson Pedrozo called the meeting to order at 3:06 p.m.

   Roll call was taken and a quorum was present.

   There were no supplements or deletions to the agenda.

   Chair Pedrozo welcomed Commissioner Ye Thao as the new Public Representative and board member from Merced.

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.

   Ms. Julissa Lozano in Merced, spoke regarding support for individuals with PTSD and similar needs, including the development of community housing..

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.

Mr. Michael Schrader. CEO, made the following announcements:

- New Chair and Vice Chair. Welcomed Supervisor Josh Pedrozo and Anita Aguirre, our incoming Chair and Vice Chair. Thanked Elsa Jimenez and Leslie Abasta Cummings for their completed service as Chair and Vice Chair.
- New Alliance Board Member. Reported that the Merced County Board of Supervisors appointed Ye Thao to the Alliance Board to the seat previously held by Dorothy Bizzini. Mr. Thao is a Coordinator for Merced Lao Family Community. Mr. Schrader will provide him with a new Board Member Orientation. We look forward to welcoming Mr. Thao at our January meeting.
- Leapfrog Hospital Safety Ratings. Informed that in November, Leapfrog released its latest hospital safety ratings. Congratulated five hospitals in our service area that earned an "A" grade, including Dominican, Salinas Valley Health, Natividad, Memorial Hospital in Los Banos, and Mercy Medical Center in Merced. Said our Alliance members are fortunate to have access to these in-network facilities, which continue to demonstrate excellence in patient safety and quality care.
- Alliance Medicare D-SNP Program TotalCare. Celebrated the launch of the Alliance's Medicare D-SNP program, named TotalCare. Enrollment began on October 15, 2026, coinciding with the beginning of the National Annual Enrollment Period (AEP) for Medicare. However, dual-eligible individuals are not restricted to the AEP and may switch to an Exclusively Aligned Medicare D-SNP program, which TotalCare is, on a monthly basis. For this reason, while the national AEP ended on Dec 7, the Alliance continues to enroll members for coverage beginning on Jan 1, 2026. As of the morning of the Board meeting, the Alliance had 409 enrollments. Further, enrollment will continue throughout the new year in 2026 as members switch from Original Medicare or other Medicare Advantage plans to our TotalCare. In addition, we will continue to market to our Medi-Cal members who age into Medicare becoming newly eligible for TotalCare.
- Medi-Cal Member Outreach and Retention (MOR). Described the Alliance's comprehensive, multi-channel campaign combining outreach and hands-on assistance to ensure Medi-Cal members enroll and renew on time, On TV, the Alliance secured more than 700 spots, each 15 seconds in length, airing from mid-October to mid-December, across six local stations that include ABC, NBC, Univision, and Estrella. On internet platforms, including TikTok and YouTube, the Alliance secured 2.7M guaranteed impressions across the five counties. On radio in Merced, the Alliance is running an advertisement through the end of December with a holiday greeting and enrollment-and-renewal message. In 150 provider offices across our 5 counties, the Alliance distributed flyers and our video, requesting they be displayed in patient reception areas. Across all five counties, the Alliance hosted a virtual convening that included 434 participants from counties, clinics, hospitals, and community organizations. In Monterey County, the Alliance hosted the County Department of Social Services and Public Health for training for Community Health Workers.
- State Budget. Reported that in November, the Legislative Analyst Office (LAO) released its annual fiscal outlook for California. The report projects a $18B shortfall for the fiscal year 2026/27 state budget, which is substantial. On top of that, the report does not factor for the potential end of revenue at the current level from the Managed Care Organization Tax (MCO Tax), likely on December 31, 2026. As such, there's concern that there could be further cuts to the Medi-Cal program in the upcoming state budget for

fiscal year 2026/27. The first step in the annual state budget process is on January 10, when the Governor releases his state budget proposal. Staff will examine the Governor's state budget proposal and keep the Board informed

Consent Agenda Items: (5.- 9. and 10C. – 10H.): 3:27 p.m.

MOTION: Commissioner Cuevas moved to approve Consent Agenda items 5-9 and 10C through 10H seconded by Commissioner De Serpa.

ACTION: The motion passed with the following vote:

Ayes: Commissioners, Abasta Cummings, Aguirre, Armstrong, Belton, Cuevas, De Serpa, Hernandez, Molesky, Moreno-Peraza, Pedrozo and Sullivan

Noes: None.

Absent: Commissioners Askew, Jimenez, Keheley, Rabago, Radner and Thao

Abstain: None.

Consent Agenda Items: (10A):

MOTION: Commissioner Pedrozo moved to approve Consent Agenda item 10A seconded by Commissioner Belton.

ACTION: The motion failed to obtain the necessary aye votes to pass with the following vote:

Ayes: Commissioners Belton, Molesky, and Pedrozo

Noes: None.

Absent: Commissioners Askew, Jimenez, Keheley, Rabago, Radner and Thao

Abstain: Commissioners Abasta-Cummings, Aguirre, Armstrong, Cuevas, De Serpa Hernandez, Moreno-Peraza and Sullivan

This item will be brought back for ratification at the next meeting due to insufficient votes.

Consent Agenda Items: (10B):

MOTION: Commissioner Sullivan moved to approve Consent Agenda item 10B seconded by Commissioner Hernandez.

ACTION: The motion passed with the following vote:

Ayes: Commissioners Abasta Cummings, Aguirre, Armstrong, Cuevas, De Serpa, Hernandez, Molesky, Pedrozo and Sullivan

Noes:	None.
Absent:	Commissioners Askew, Jimenez, Keheley, Rabago, Radner and Thao
Abstain:	Commissioners Belton and Moreno-Peraza

Regular Agenda Items: (11. – 13.): 3:30 p.m.

11. 2026 Medical and Administrative Budget. 3:32 p.m.

Ms. Lisa Ba, Chief Financial Officer, presented the proposed 2026 Medical and Administrative budgets to the board, detailing enrollment trends, revenue and expense assumptions, cost containment strategies, and the financial outlook through 2029; the board approved the budgets following discussion and questions from members.

Ms. Ba outlined the budget's focus on maintaining access to quality care, aligning provider costs with revenue, improving provider reimbursement, and sustaining operational efficiencies, with a target of 6% administrative expense.

Enrollment is projected to decline due to the end of COVID flexibility, State Budget constraints, and Federal policy changes, with revenue assumptions based on recent rate increases and a 1% withhold for quality, expecting to earn back 75% of the withhold.

Medical expenses are budgeted to increase by 4.2% year-over-year, with continued funding for provider incentives and supplemental payments; administrative expenses are capped at 6% of revenue, totaling $129.5 million.

The Alliance is implementing cost containment strategies, particularly in ECM and Community Support programs, including shifting from capitation to fee-for-service and focusing on program integrity to ensure payments align with services rendered.

The financial outlook anticipates intensified losses in 2027 with improvement in 2028, maintaining a fund balance above the targeted reserve level, and achieving DSNP breakeven no later than 2031.

A discussion ensued among Commissioners.

[Commissioner Rabago arrived at 3:33pm]

MOTION:	Commissioner Molesky moved to approve the nominations seconded by Commissioner Cuevas
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners, Abasta Cummings, Aguirre, Armstrong, Belton, Cuevas, De Serpa, Hernandez, Molesky, Moreno-Peraza, Pedrozo, Rabago, and Sullivan.

Noes:	None
Absent:	Commissioners Askew, Jimenez, Keheley, Radner and Thao.
Abstain:	None

12. Payment Methodology Changes for Housing Services. 4:13 p.m.

Ms. Kay Lor, Payment Strategy Director, presented the proposal to transition Housing Transition Navigation Services and Housing Tenancy Sustaining Services from a capitation payment model to a fee-for-service case rate. The change is intended to increase provider engagement, ensure members receive services, and better align payments with state revenue methodology.

The services support members at risk of homelessness in securing and maintaining stable housing, including needs assessment, housing search, landlord engagement, and ongoing case management.

The board was asked to approve changing the payment methodology from a monthly capitation rate to a fee-for-service case rate, requiring providers to submit at least one claim per member to receive payment. The change aims to encourage provider engagement, ensure timely encounter submissions, align payments with actual services, and better match state revenue flows, as part of a broader cost containment strategy.

Board members clarified that rates would remain negotiable within state-provided ranges and discussed the implications for cost recovery and member engagement.

A discussion ensued among Commissioners.

MOTION:	Commissioner Molesky moved to approve transition Housing Transition Navigation Services and Housing Tenancy Sustaining Services from a capitation to a fee-for-service case rate payment model, seconded by Commissioner Aguirre.
ACTION:	The motion passed with the following vote:
Ayes:	Commissioners, Abasta Cummings, Aguirre, Armstrong, Cuevas, De Serpa, Hernandez, Molesky, Pedrozo, Rabago, and Sullivan.
Noes:	None
Absent:	Commissioners Askew, Jimenez, Keheley, Radner and Thao.
Abstain:	Belton and Moreno-Peraza

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13. Alliance Investment in Property. 4:21 p.m.

Michael Daponde, outside counsel, presented statutory requirements for local government investment of surplus funds, clarifying that Alliance may acquire real estate for operational purposes but not as an investment, and addressed board questions regarding current property holdings and fiduciary duties.

Mr. Daponde explained that government code restricts investments of surplus public funds to conservative vehicles like bonds and CDs, explicitly excluding real estate as an investment. Under the Welfare and Institutions Code, the Alliance may acquire real estate for operational needs, such as office space, but not for investment purposes.

Board members have a fiduciary duty to the Alliance and must exercise prudent investor standards and avoid conflicts of interest, with recusal required if a member has a financial interest in a real estate transaction.

A discussion ensued among Commissioners.

Adjourn to Closed Session: 4:33p.m.

Chair Pedrozo moved the commission into Closed Session at 4:33p.m.

14. Conference with legal counsel – Pending litigation (Gov. Code section 54956.9(d)(1); Central California Alliance for Health v. Aggrigator, Inc.; Monterey County Superior Court case number 25CV000738.

Return to Open Session: 4;44p.m.

Chair Pedrozo reconvened the meeting to Open Session at 4:44p.m.
No was taken or reported by the Board.

The Commission adjourned its special meeting of December 10, 2025, at 4:45 p.m. to the regular meeting of January 28, 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.

Quality Improvement Health Equity Committee

Date:	September 25, 2025
Time:	12pm – 1:30pm
Location:	MS Team Meeting

MINUTES

Chair: Mike Wang, MD, CMO			Minutes by: Jacqueline Van Voerkens
	Members Present:	Dr. Caroline Kennedy, Family Medicine, Dr. Eric Sanford, Family Medicine, Dr. Madhu Raghavan, Pediatrician, and Dr. Stephanie Graziani, Pediatrics.	
	Members Absent:	Dr. Minoo Sarkarati, Internal Medicine/Pediatrics, Dr. Oguchi Nkwocha, Family Medicine, Dr. Stephanie Chang, Family Medicine, and Adriana Ceja.	
	Central California Alliance for Health staff:	Ms. Amber Schnitzius Medicare Stars Program Manager Ms. Andrea Swan QI/ Population Health Director Ms. Carissa Grepo UM Manager – Prior Authorizations Ms. Cassie Russo QI and Health Equity Supervisor Ms. Chrisy Pool Temporary Administrative Assistant Ms. DeAnna Leamon Clinical Safety Quality Manager Ms. Desirre Herrera Quality and Health Programs Manager Ms. Emily Kaufman Clinical Safety Supervisor (RN) Ms. Georgia Gordon Quality Improvement Program Advisor II Dr. Gray Clarke Behavioral Health Medical Director, Psychiatric and Psychosomatic Medicine Ms. Jessica Finney Community Grants Director Mr. Jim Lyons Provider Relations Manager Ms. Kelsey Riggs Care Management Director Ms. Kristen Rohlf Quality Improvement Manager Ms. Linda Gorman Marketing and Communications Director Ms. Maria Elena Villalobos Administrative Specialist Ms. Navneet Sachdeva Pharmacy Director Ms. Nicolette Shalita-Vega NCQA Program Manager Ms. Rebecca McMullen Behavioral Health Program Manager Ms. Sabryna Sherman UM Mgr. - Authorizations and Coordination Ms. Sarina King Quality and Performance Imp. Mgr. Mr. Scott Fortner Chief Administrative Officer Ms. Tammy Brass Utilization Management Director Ms. Vanessa Paz Health Equity Program Manager	

Quality Improvement Health Equity Committee

Date: September 25, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

		Ms. Veronica Olivarria Member Services Call Center Manager Ms. Yasuno Sato Clinical Pharmacy Manager	
Item No.	**Agenda Item**		
I.	**Call to Order**	Dr. Mike Wang called the meeting to order at 12:05 PM and welcomed the members. Dr. Wang opened the floor for any announcements. No announcements were received from the Committee. Announcement: Dr. Wang introduced new members of the committee	
Items for Approval		**Discussion**	**Action/ Recommendation**
II.	**Review & Approve Minutes**	**The Minutes of the June 26, 2025 QIHEC Meeting were reviewed.** *Dr. Eric Sanford motioned to approve the minutes from the QIHEC meeting.* *Dr. Caroline Kennedy 2nd the motion for approval.* *Committee approved June 26, 2025 QIHEC as presented.*	*The QIHEC approved the June 26, 2025 QIHEC meeting minutes.*
Action Item Follow-Up			
III.			
9/24/24 QIHEC	Q2 2024 Utilization Management Work Plan	Dr. Myers will connect with Dr. Sanford to collaborate on the outreach and health literacy training program. **Action completed**	
9/24/24 QIHEC	Discussion	Dr. Myers will reach out to Dr. Sanford regarding Street Medicine. **Action completed**	
12/18/24 QIHEC	Q3 2024 Utilization Management Work Plan	Dr. Wang and Ms. Grepo to create a one-page genetic testing criteria guide for providers for easier reference. **Action Pending**	
3/20/25 QIHEC	Q4 2024 UMWP Review	Dr. Mike Wang, Medical Director will analyze the reasons for genetic testing denials and provide education to providers if needed. **Action Pending**	

Quality Improvement Health Equity Committee

Date: September 25, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

6/26/2025	Discussion	Dr. Sarkarati expressed interest in more information regarding the CCAH video interpreter services. Dr. Myers and Desirre Herrera to connect with Dr. Kennedy, Dr. Sarkarati, and Dr. Sanford regarding video interpreter services. **Action Pending**	
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 Charter	*Approved*
		QIHET Program Evaluation	*Approved via email*
		QIHEC 2026 Meeting Schedule	*Approved*
		Delegate Oversight Report: The VSP Q3 2025 and the Carelon Q3 2025 quarterly delegate oversite summary included in consent agenda meeting packet.	*Approved*
Policies: Require QIHEC Approval			
Number/Title		**Significant Changes**	**Action/ Recommendation**
401-1201 Quality Improvement Health Equity Committee Meeting		Edits made to incorporate Medi-Cal Contract, Exhibit A, Attachment.3 Provision 2.2.5B2 and 2.2.5B3 language.	*Approved*
401-1301 Potential Quality Issue		Revised to comply with DSNP regulations and requirements.	*Approved*
401-1306 Corrective Action Plan for Quality Issues		Annual Review. No content changes. Updated formatting of policy.	*Approved*

Quality Improvement Health Equity Committee

Date: September 25, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

401-1501 Standards of Care	Revised to comply with DSNP regulations and requirements.	*Approved*
401-1607 Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight	Policy updated for AIR for APL 25-007 P&Ps CCAH APL 25-007	*Approved*
401-2001 Member Surveys	Revised to comply with DSNP regulations and requirements.	*Approved*
401-3106 Perinatal Services	Edits made to incorporate DMHC CL 20251302 RE: APL 24-023 language.	*Approved*
404-1101 Utilization Management Program	Annual plus revisions for; APL 22-003, Contract provision 2.3 l page 147, APL 22-006, AB 118 Attestation DMHC 23-025, 24-007, DMHC CL 20242579, AB 118 Attestation DMHC 23-025,	*Approved*
404-1102 Inpatient Review	DMHC Comment Letter 20242950-BHIP	*Approved*
404-1108 Monitoring of Over-Under Utilization of Services	DMHC Comment Letter 20242950-BHIP	*Approved*
404-1111-Utilization Management Assessment Process	annual review- changed Essette to Jiva	*Approved*
404-1112_Medical Necessity The Definition and Application of Medical Necessity Provision to Authorization Requests	DMHC CL re. 20242580, Compliance with Rule 1300.74.721(f), action item C15. / Updated language to more closely align with 24-007	*Approved*
404-1114_Continuity_of_Care	New IHSS COC Policy for DMHC-BHIP CL 20242950	*Approved*
404-1115_Terminal_Illness	annual review / updates for DMHC	*Approved*
404-1201_Authorization Request Process	#2 Amendment_07_DHCSAPL_PnP_ImpactedDepts_ActionItems	*Approved*

MINUTES

404-1202-After Hours Availability of Plan or Contract Physician	annual review with edits for APL 24-007 and APL 24-008	*Approved*
404-1204-Laparoscopy Cholecystectomy Authorization Process	annual review no changes	*Approved*
404-1303 Referral Consultation Request Process	Adding symptomatic cholelithiasis	*Approved*
404-1306 Extended and Standing Referral Authorizations	DMHC Comment Letter 20242950-BHIP	*Approved*
404-1307_Medical Second Opinions	DMHC Comment Letter 20251596-Finance letter	*Approved*
404-1309_Member Access to Self-Referred Services	DMHC Comment Letter 20242950-BHIP	*Approved*
404-1310_Authorization Process for Referrals to Out of Service Area and Non-Contracted Specialty Providers	DMHC Comment Letter 20242950-BHIP	*Approved*
404-1524 Long Term Care for Medi-Cal Members	annual review plus verbiage re: RCFE	*Approved*
404-1527 Palliative Care	revised for APL 25-008	*Approved*
404-1707 Acupuncture Services for Medi-Cal Members	annual review no changes	*Approved*
404-1711 Sleep Study (Polysomnography Sleep	annual review no changes	*Approved*

MINUTES

Disorder Testing) Authorizations Clean		
404-1713 Electromyography Nerve Conduction Studies	annual review no changes	*Approved*
404-1714_Technology Assessment	DMHC Comment Letter 20242950-BHIP	*Approved*
404-1741 Congregate Living Health and Alternate Residential Care Facilities	annual review no changes	*Approved*
404-1745 Community Supports Policy for Medically Tailored Meals/Medically Supportive Food	DHCS, and added clarity	*Approved*
404-1746 Housing Deposits Eligibility	updates due to DHCS	*Approved*
404-1749_Continuity of Care for IHSS Members	DMHC Comment Letter 20242950-BHIP	*Approved*
404-1749-Attachment A- Continuity of Care for IHSS Members	*NEW	*Approved*
404-1751 Housing Definition and Requirements	*NEW	*Approved*
Addendum A - Homelessness Definition	*NEW	*Approved*
Policies: Informational		
Number/Title	**Significant Changes**	**Action/ Recommendation**
401-1305 Provider Preventable Conditions	Policy changes were made to reflect the recoupment process for PPCs. Please also review the PPC workflow (attachment), which was adapted to reflect these changes.	*Approved at QIHEW*

MINUTES

		Regular Agenda	Action/ Recommendation
IV.	Q2 2025 Carelon UM Audit Results and Behavioral Health Update	Rebecca McMullen presented behavioral health utilization data for Q2, including outpatient penetration rates, Behavioral Health Treatment (BHT) service trends, and the transition of behavioral health management from Carelon to the Alliance. Ms. McMullen reported a 5.79% outpatient penetration rate for behavioral health services in Q2, with a slight increase from previous quarters. The number of unique utilizers receiving BHT services also increased, and the top diagnoses remained anxiety, depressive, and adjustment disorders. Penetration rates were higher among adults (6.73%) compared to children, and larger counties like Monterey had more unique utilizers. Ms. McMullen noted a data anomaly for Mariposa County and committed to follow up. Ms. McMullen highlighted improvements in time from assessment to first appointment, high rates of parent training, and a majority of BHT interventions delivered at home. Demographic data showed a high proportion of Spanish-speaking and Latino members, with autism as the most common diagnosis for BHT services. Ms. McMullen clarified that while Carelon previously managed behavioral health benefits, the Alliance now manages these directly, with workflows in place for bidirectional referrals with county mental health plans. Dr. Sanford asked for clarification on the definition of "penetration" in the behavioral health context. Ms. McMullen explained it refers to the percentage of total membership with a claim during the period. Dr. Sanford inquired about the direction of referrals between Carelon and county mental health. Ms. McMullen explained most referrals were from county to Carelon, with workflows for bidirectional access.	

MINUTES

		Dr. Raghavan asked if Carelon referrals for children are now overseen exclusively by Alliance behavioral health. Ms. Grepo confirmed this is correct for non-specialty mental health (up to moderate needs). Ms. McMullen committed to follow up on the Mariposa BHT data discrepancy.	
	MCAS Results	Kristen Rohlf, Sarina King, and Andrea Swan reviewed Managed Care Accountability Set (MCAS) Audit Results, highlighting performance benchmarks, county-level improvements, and ongoing interventions to address care gaps. Ms. Rohlf informed the committee of the audit reporting changes, explained that Department of Health Care Services (DHCS) now requires a single all-plan submission and separate county-level submissions, with new benchmarks for sanctions and quality withholds based on national percentiles. The committee identified areas needing improvement, such as childhood immunizations and topical fluoride in certain counties, and discussed the impact of benefit definitions and data capture issues on reported rates. Dr. Kennedy raised concerns on the impact of H1B visa restrictions on provider recruitment, especially in underserved counties, and asked if the Alliance tracks how many providers depend on H1B visas. Mr. Lyons responded that the Alliance does not currently track this in reports but can be explored through outreach. Jessica Finney noted that the Alliance Provider Recruitment grant allows immigration fees as an allowable expense. Ms. King described the Care Gap grant program, which funds after-hours clinics and locum providers to improve pediatric care measures, with successful expansion to multiple counties and notable improvements in Merced.	

MINUTES

		Ms. Rohlf and Dr. Kennedy discussed challenges with timely data for measures like chlamydia screening and A1C control, with Ms. Rohlf offering guidance on available reports and ongoing outreach to new counties to improve data submission and understanding of quality programs. Dr. Kennedy asked if the topical fluoride measure's low rate (15%) included 19-year-olds, making it difficult to meet the benchmark. Ms. Rohlf confirmed the measure spans up to age 20, which is beyond Medi-Cal's typical coverage, and explained the challenge in meeting the benchmark. Dr. Kennedy questioned how Monterey achieved a higher rate (27%) if adults are included, and Ms. Rohlf noted the state uses a dental measure that may not align with actual practice, and that feedback is provided to the state annually. Dr. Kennedy commented on the low financial incentive for topical fluoride and the difficulty in getting children to dental care, especially in Salinas, and suggested breaking out the age range to identify where the problem lies. Ms. Rohlf responded that the issue is more pronounced in the older population, and younger children are doing better. Dr. Sanford asked if the data captures fluoride varnish given at the dentist. Ms. Rohlf confirmed that Denti-Cal data is included, and next year co-located dental clinics will be incorporated into CVIS reporting. Dr. Kennedy highlighted the need for more up-to-date chlamydia data for CBI, and Ms. Rohlf committed to sending information about the MCAS portal report and continuous enrollment options.	
	Q2 2025 Quality Improvement Health Equity Transformation (QIHET)	Andrea Swan introduced the presentation of the QIHETP Workplan. Managed Care Accountability Sets (MCAS) Interventions: • Focused on closing pediatric care gaps, especially in Merced and Mariposa counties, with targeted grants for providers to run clinics for well-child visits and immunizations.	

MINUTES

| | Program Work plan | Expanded care gap grants to four counties but faced barriers with provider capacity. Data showed improvements in well-child visits, adolescent immunizations, and lead screening, with ongoing challenges in childhood immunization status (Combo 10). Collaboration with counties to collect data for follow-up visits after Emergency Department (ED) for substance use and mental illness; some counties need support with data extraction scripts. Data feeds from counties are being improved, with expectations for better rates in future quarters.
Care-Based Incentive Program:
Focused on supporting new counties (Mariposa, San Benito) to understand state measures and Alliance tools.
Released an intro video for providers and increased engagement to help clinics participate in the incentive program.
Monitored progress on measures below the minimum performance level (MPL) and tracked improvements in blood pressure control, cervical cancer screening, and diabetes management.
Dr. Kennedy asked if the high rate of uncontrolled diabetes in San Benito (89%) was accurate. Ms. Rohlf clarified it is a data capture issue, not a true reflection of control, and explained the need for better A1C data submission from new counties.

Dr. Kennedy raised concerns about the timeliness of chlamydia data for outreach. Ms. Rohlf explained that the MCAS portal report provides a monthly snapshot and can be used to identify members in the denominator for timely intervention.

Dr. Wang asked if members without an A1C value are included as poorly controlled. Ms. Rohlf confirmed that members without an A1C, or with a value over 9, are counted as poorly controlled. | |

MINUTES

		Dr. Kennedy and Ms. Rohlf discussed that poor control rates for blood pressure and A1C in new counties are also due to data capture issues, not actual clinical performance.	
		Population Health Programs:	
		• Provided 11 member workshops in various formats (phone, virtual, in-person), exceeding the quarterly goal.	
		• Used member newsletters and text campaigns to inform members about health programs, with an online sign-up form for workshops leading to high engagement.	
		• Conducted member-experience surveys showing high satisfaction and usefulness of information received.	
		• Delivered 9 presentations to internal and external partners about available services.	
		Facility Site Review:	
		• Achieved 92% completion of scheduled site reviews, with staffing challenges due to only one certified trainer.	
		• Training three new employees for California Department of Health Care Services	
		• DHCS certification: expecting two employees to be certified by year-end.	
		• Transitioned to Healthy Data Systems for better planning and reporting.	
		Potential Quality Issues:	
		• 70% increase in member grievances due to process improvements, with all regulatory cases resolved on time.	
		• Team queues are above normal ratios, and additional resources are being considered to manage growth, especially in behavioral health and Dual Eligible Special Needs Plans (DSNP).	
		Appeals and Grievances:	
		• Maintained regulatory compliance for grievance resolution, but current staffing levels are not sustainable.	

MINUTES

| | | Most grievances are related to quality of service, with discrimination grievances monitored closely. Appeals rates spiked due to changes in community supports benefits, especially for medically tailored meals and housing services. Implemented new reports for provider trends and improved monitoring/documented oversight Link to the Grievance spreadsheets were reviewed by the Committee.
Member Satisfaction Surveys:
Formed a member experience committee to address Consumer Assessment of Healthcare Providers and Systems (CAHPS) rates, focusing on doctor communication and proposing interventions.
Access, Availability, and Geo Access:
Preparing for the annual provider survey and network certification filing, with ongoing monitoring of network gaps.
Telephone Access:
Slightly missed the 80% call answer goal due to staffing issues but call abandonment rates remained low.
Implemented workforce management tools and ongoing recruitment to address high call volumes.
Cultural and Linguistic Services:
Increased provider utilization of language assistance services, collected member feedback, and provided regular informing activities and presentations.
Delegation Oversight: No recent issues have emerged; Carelon remains under continuous review. | |

Date:	September 25, 2025
Time:	12pm – 1:30pm
Location:	MS Team Meeting

MINUTES

		Approval was requested and received for the QIHETP work plan.
	Q2 2025 Utilization Management Work Plan	Ms. Grepo presented the Q2 2025 UM Work Plan, covering outcomes, trends, interventions, and future recommendations. • Pediatric Case Management saw increased number of California Children's Services (CCS) - eligible members but decreased individualized care plans due to engagement challenges. • Adult Case Management volume decreased, with expanded coverage for behavioral health and sourcing. • Enhanced Care Management (ECM) enrollment increased, with justice-involved populations added and ECM providers joining hospital rounds; readmissions dropped by 3%, except for slight increases in San Benito and Mariposa. • Academic detailing for hypertension and asthma was completed; diabetes and hypertension outreach planned for Q3. • Naloxone distribution was highest in Merced, with increased kits in Santa Cruz but overall fewer kits than Q1. • Phone system replacement led to decreased call abandonment and waiting times. • Prior authorization turnaround remained high (99.8%), with increased volume but fewer denials, appeals, and overturned appeals; medically tailored meals remain the top denial reason. • Pharmacy turnaround was 97%, with increased volume and consistent denial rates for physician-administered drugs. • Inpatient utilization: overall readmissions and average length of stay decreased, except for slight increases in Mariposa and San Benito. • Alternatives to acute inpatient care: Skilled Nursing Facility (SNF) bed days increased, short-term rehab decreased, and readmissions after rehab discharge increased; long-term care admits slightly up, but total members in long-term care decreased. • ED utilization decreased overall, with avoidable ED visits down in all counties except Santa Cruz. • Out-of-network utilization decreased after expansion highs; increased behavioral health utilization noted in late June.	

MINUTES

		• Delegate oversight: Carelon's final quarter data showed 99% turnaround, overall utilization on track, and MedImpact updated denial language and templates. Approval was requested and received for the UM work plan, member benefits, and policy updates.	
	Utilization Management Criteria	Ms. Grepo presented both UM (Utilization Management) and member benefits criteria review, highlighting that Alliance is aligning with all DHCS recommendations for additions, changes, and terminations of codes for Medi-Cal and IHSS lines of business. 1. The review included summaries of new, changed, and terminated benefits, with detailed code lists provided in the meeting packet for participant review. 2. Operational performance metrics were discussed, including high prior authorization turnaround times, reduced denials and appeals, and ongoing provider education for top denial categories such as medically tailored meals. 3. No in-depth discussion of the criteria development process occurred; the focus was on compliance with DHCS updates and making information available for review. New 2025 Codes 1. **New Benefits:** Introduction of new codes including auditory implants, genetic testing, parenteral nutrition, orthopedic seating, and SUD codes, with recommendations to activate and align with Medi-Cal and Medicare requirements 2. **Changed Benefits:** Updates to TAR criteria, code bundling, frequency limits, diagnosis code requirements, and provider allowances, with alignment recommended to Medi-Cal and D-SNP guidelines 3. **Terminated Benefits:** Termination of unused or inactive codes such as Tympanostomy G and Nasal Cannula codes, aligning with Medi-Cal and IHSS policies 4. **UM Recommendations:** Consistent emphasis on aligning benefit activations, changes, and terminations with Medi-Cal, IHSS, and D-SNP authorization requirements	*Action*: Outreach to ENT providers regarding code changes (Ms. Grepo) **Action Complete**

MINUTES

		Member Benefits: Criteria Development and Review 1. The UM Benefit Update Summary Table was attached to the packet and presented to the Committee for their review. CS policy updates (meals and housing) 1. **Medically Tailored Meals (MTM) Expansion:** MTM now includes more qualifying conditions such as prediabetes, alcoholic fatty liver disease, and mild cognitive impairment, with adjusted criteria like reduced A1c requirements and updated obesity definitions 2. **MTM Documentation:** Initial and renewal requests require specific clinical documentation from qualified providers, with renewals needing evidence of ongoing treatment adherence and outcomes 3. **Housing Services Updates:** Housing Services eligibility and documentation criteria have been expanded and clarified, including updated definitions of homelessness and increased benefit limits to $7500, with changes to covered items aligning with DHCS guidance 4. **Effective Date:** All changes for Medically Tailored Meals and Housing Services take effect on November 17, 2025 Dr. Sanford asked about the impact of code changes for Ear, Nose, and Throat (ENT) providers. Dr. Sanford proposed outreach to ENT providers regarding code changes, emphasizing the importance of clear communication to avoid payment issues. Ms. Grepo agreed to coordinate provider outreach to ensure awareness of code changes. This was accepted as an action item for the next meeting. **Action Complete:** Ms. Grepo created a sheet to inform ENT providers that DHCS Clinics and Hospitals Bulletin 610 (dated July 2025) advised that effective for dates of service on or after August 1, 2025, HCPCS code G0561 (tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral) is no longer a Medi-Cal benefit (but is still a valid code). This terminated code (G0561) is an add on code	

Quality Improvement Health Equity Committee

Date: September 25, 2025

Time: 12pm – 1:30pm

Location: MS Team Meeting

MINUTES

		to account for added resources for a special tube delivery device (especially in pediatric cases), above what the tympanostomy service code (69433) covers.	
	Emerging Issues	Dr. Sanford, Dr. Kennedy, Ms. Rohlf, and Dr. Wang discussed recent changes in immunization policy guidance, the need to update policies to reflect new state laws, and the financial impact on clinics when vaccines are removed from the VFC program.	
	Future Topics	The Committee did not request any subjects for subsequent meetings.	

Action Items

Agenda Item	What is the action item	Due date	Responsible staff
Utilization Management Criteria	Coordinate provider outreach to ensure awareness of code changes. **Action Complete:** Ms. Grepo created a sheet to inform ENT providers that DHCS Clinics and Hospitals Bulletin 610 (dated July 2025) advised that effective for dates of service on or after August 1, 2025, HCPCS code G0561 (tympanostomy with local or topical anesthesia and insertion of a ventilating tube when performed with tympanostomy tube delivery device, unilateral) is no longer a Medi-Cal benefit (but is still a valid code). This terminated code (G0561) is an add on code to account for added resources for a special tube delivery device (especially in pediatric cases), above what the tympanostomy service code (69433) covers.	12/18/2025	Ms. Carissa Grepo
Meeting adjourned at 1:25 p.m.			
Next Meeting December 18, 2025			
Approved by Committee Date: 12/18/2025	**Signature:** *Andrea Swan, RN, Quality Improvement and Population Health Director*		**Date:** 12/18/2025

Whole Child Model Clinical Advisory Committee

Meeting Minutes

Thursday, September 30, 2025
12:00 p.m. - 1:00 p.m.

Teleconference Meeting

Committee Members' Present:

Aditi Mhaskar, MD	Provider Representative
Cal Gordon, MD	Provider Representative
Hue Nguyen, MD	Provider Representative
Lena Malik, MD	Provider Representative
Michelle Perez, MD	Provider Representative

Committee Members Absent:

Camille Guzel. MD	Provider Representative
Ignacio Santana	Provider Representative
James Rabago, MD	Board Representative
Jennifer Yu, MD	Provider Representative
John Mark, MD	Provider Representative
Nicole Shelton, PA	Provider Representative

Staff Present:

Dianna Myers, MD	Chair, Interim CHEO, Medical Director
Ashley McEowen, RN	Complex Case Management Supervisor
Christy Pool	Temporary Administrative Assistant
Jana Brodock,	Lead Clinical Analyst BCBA
Jenna Stromsoe, RN	Complex Case Management Supervisor
Lisa Moody, RN	Senior Complex Case Manager
Maria Elena Villalobos	Administrative Specialist
Jacqueline Van Voerkens	Clerk of the Committee

Other Representatives Present:

Becky Shaw	CEO Merced Faculty Associates
Janna Espinoza	FAC Representative
Linda Smith RN	Director of Nursing, Merced Co. Public Health

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

2. **Oral Communications.**
   Chairperson Myers 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.

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3. **Consent Agenda Items.**
   A. <u>Approval of WCMCAC Minutes</u>
      Minutes from July 10, 2025, meeting were reviewed.
   B. <u>Grievance Update</u>
      Grievance data and update were provided to the Committee.
   C. <u>2026 Schedule</u>

   M/S/A Consent agenda items approved.

4. **Regular Business Items.**
   A. ABA/BHT
      Jana Brodock, Alliance Lead Clinical Analyst BCBA, provided a comprehensive presentation on Applied Behavior Analysis (ABA), covering its clinical indications, referral pathways, eligibility criteria, and the process for accessing services, with an active discussion and questions regarding diagnosis requirements and communication with referring providers. Ms. Brodock explained that ABA is a scientific approach to understanding and changing behavior, focusing on observable and measurable behaviors, and is typically delivered in outpatient settings such as homes, clinics, schools, and community locations, involving multidisciplinary teams. It was clarified that while ABA is most commonly used for autism spectrum disorder (ASD), it is also effective for other diagnoses such as Down syndrome, Tourette's syndrome, Attention Deficit Hyperactivity Disorder (ADHD), and oppositional defiant disorder (ODD), and can be started at any age up to 21 years old at the Alliance. Referrals for ABA do not need to be submitted directly to the Alliance but should come from a licensed referring provider to the servicing ABA provider, and that a formal diagnosis is not required to initiate ABA services; the Alliance assists families in obtaining a diagnosis by linking the member to a comprehensive diagnostic evaluation (CDE) provider if needed while starting ABA services concurrently. Prior authorization is required for ongoing ABA services after the initial assessment. Ms. Brodock provided detailed instructions for submitting referrals via the online form or provider portal, including handling cases without an established diagnosis and the importance of including caregiver information.

      Dr. Lena Malik asked if a formal diagnosis is required before referring to ABA, noting that third-party providers often require one. She questioned if the Alliance helps formalize the diagnosis if not already present. Ms. Brodock responded that the Alliance could start ABA services with a referral and will help the members get a comprehensive diagnostic evaluation if needed, running both processes in parallel.

      Dr. Aditi Mhaskar asked if a patient with maladaptive behaviors but found to have a learning disability (not autism) after assessment, could continue ABA. Ms. Brodock confirmed that ABA can be provided for other diagnoses if the provider recommends it, and goals can be tailored to the member's needs, such as attending or on-task behavior, just not academics.

      Dr. Dianna Myers asked about the process for getting information back to the referring provider after ABA evaluation, noting challenges in receiving updates. Ms. Brodock acknowledged the issue, explained current practices, and agreed to explore ways to streamline communication and ensure providers receive necessary updates.

5. **Old Business Items.**

A. <u>Transportation Update</u>
Call the Car representative was not present to provide the transportation update. Update will be provided at next meeting.

B. <u>WCM Family Advisory Committee Update</u>
Janna Espinoza provided updates from the Family Advisory Committee, highlighting new member recruitment efforts, the addition of a family from Merced, ongoing work to expand the resource guide for new counties, and recent discussions with state representatives on policy and system improvements. Ms. Espinoza reported successful recruitment of a new family from Merced, with plans for them to become voting members pending board approval and encouraged committee members to refer interested families to the advisory group. The committee is working to enhance the resource guide, particularly for San Benito and Mariposa counties, and solicited input from members to identify additional resources for these areas. Ms. Espinoza shared that a new California Children's Services (CCS) advisory group representative has been appointed to the committee, and summarized a recent presentation created by Michelle Bass from DHCS, which addressed state and federal budget impacts and efforts to automate disability verification for Medi-Cal. Ms. Espinoza shared a new family from Merced is in the process board approval to become voting members, increasing representation from Merced.
Recruiting families from Merced has been a longstanding challenge; Ms. Espinoza encouraged WCMCAC members to refer interested families to the advisory group, even for occasional participation. The WCMFAC is working to expand its resource guide, especially for San Benito and Mariposa counties, and welcomes suggestions for additional resources.

To receive a WCMFAC resource guide, committee membership referrals, or committee business please contact Kayla Zoliniak, Administrative Specialist at: kzoliniak@thealliance.health

C. <u>WCM CCS Referral Volumes</u>
Ashley McEowen, supervisor of the pediatric case management team, presented updated data on Alliance referral volumes, approval and denial rates by county, and membership changes, with discussion on the impact of pending referrals and the aging out of CCS members. Ms. McEowen reported that referral volumes have increased by about 40 since the last packet, with a significant number of referrals pending determination or documentation and provided a county-by-county breakdown. Quarter two approval rates averaged 74.7%, while quarter three rates appeared lower due to pending referrals; denial rates decreased from 20.9% to 13.2%, with expectations that approval rates will rise after retrospective review. Ms. McEowen noted that 86 young adults Alliance members turned 21 and aged out of CCS this month.

Ms. Espinoza inquired about potential increases in grievances following this transition, which Dr. Myers agreed to investigate further as an action item.

Action: Dr. Myers to investigate potential increases in grievances due to the members aging out of CCS transition.

Action Complete: The Alliance is presently unable to track grievances due to the members aging out of CCS transition based on the available member data. An evaluation was requested to identify if any logic builds could detect this.

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D. Open Discussion
Dr. Myers facilitated a roundtable for county representatives to share local updates. Feedback on referral processes, mental health access, and ongoing challenges in provider communication and resource tracking was discussed.

Santa Cruz County Update: Dr. Cal Gordon reported stable operations and effective collaboration with the Alliance, with regular meetings to address issues as they arise.

San Benito County Update: Dr. Hue Nguyen shared positive feedback from staff regarding improved mental and behavioral health referral processes since the program change, with no recent complaints from parents.

Monterey County Update: Dr. Lena Malik noted quicker mental health referrals and appreciated the ability to start ABA services before a formal diagnosis but highlighted ongoing difficulties in receiving timely updates from providers, especially for small practices.

Merced and Mariposa County Updates: Ms. Becky Shaw and Dr. Michelle Perez reported no significant updates or feedback from their respective communities, Dr. Michelle Perez report that her Mariposa families are not currently part of CCS.

Adjourn.
The meeting adjourned at 1:00 p.m.

Respectfully submitted,

Ms. Jacqueline Van Voerkens
Clerk of the Advisory Committee

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

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Physicians Advisory Group

Date:	September 4, 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 – Coulterville
	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. Casey KirkHart, Dr. Mimi Carter, Dr. Cristina Mercado, Dr. James Rabago, Dr. Caroline Kennedy, Dr. Misty Navarro, Becky Shaw, and Dr. Ralph Armstrong,	
	Members Absent:	Dr. Cheryl Scott, Dr. Devon Francis, Dr. Jason Novick, Dr. Donaldo Hernandez, Dr. Shirley Dickinson, Dr. Amy McEntee, Dr. Jennifer Hastings, Dr. Charles Harris, and Dr. Salvador Sandoval.	
	Central California Alliance for Health staff:	Dr. Mike Wang, Dr. Mai Bui-Duy, Dr. Dianna Myers, Arti Sinha, Ms. Lilia Chagolla, Ms. Tammy Brass, Ms. Jessie Dybdahl, Ms. Kelsey Riggs, Travis Moody, and Jacqueline Van Voerkens.	
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 supplements or deletions to the agenda were requested. No members of the public addressed the Group.	
Items for Approval		**Discussion**	**Action/Recommendation**
III.	Review & Approve Minutes	**The Minutes from the March 6, 2025, meeting were reviewed.** *Dr. KirkHart motioned to approve the minutes from the PAG 03/06/2025 meeting.* *Dr. Kennedy 2nd the motion for approval.* *Group approved March 6, 2025 meeting minutes as presented.*	*The **Physicians Advisory Group** approved the March 6, 2025 meeting minutes.*
Action Item Follow-Up			
	March 6, 2025 Meeting	Care Based Incentives: Investigate CPT2 coding support for practices. **Action pending**	Dr. Wang
	March 6, 2025 Meeting	Continuity & Coordination of Care, Behavioral Health & Primary Care: Investigate the data regarding lab ordering whether from the PCP or psychiatrist. **Action Pending**	Sarina King
Consent Agenda			
	Approval 2026 PAG Meeting Schedule	2026 PAG Meeting Schedule approved by Group.	
Regular Agenda			
	Agenda item		
III.	**Member Portal**	Lilia Chagolla and Arti Sinha presented on the Member Portal to the Group. Highlights included the member portal's phased rollout, noting partnership with Z Omega and the goal to empower members with self-service options. The portal launched in early 2025, initially offering features such as primary care provider (PCP) changes, demographic updates, ID card ordering, and health risk assessments. Planned enhancements for 2025–2026 include viewing care plans, authorizations, claims, filing grievances/appeals, interactive care plans, two-	

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way communication, role-based accounts, Spanish language support, and account access for minors and their guardians. The team is addressing technical and regulatory challenges, such as minor consent and privacy.

The portal is currently mobile browser-friendly but does not yet have a standalone app. Multiple participants stressed the importance of developing an app, as most members use smartphones. The team acknowledged this need and is considering it for future development.

There is no AI chat feature yet, but feedback suggested adding search and AI support similar to commercial insurance portals. The team is collecting suggestions for future improvements.

Member Engagement & Marketing soft launch is underway, with a few hundred members using the portal. Broader marketing will follow after refining features based on feedback. The portal is promoted to tech-savvy callers, and support is available via the call center.

It was noted during the meeting that currently, only adults can access the portal due to consent and privacy concerns for minors. The team is working on solutions to allow appropriate access for minors and their guardians in the future.

Spanish language support is planned for 2026. The team is working with vendors to ensure accurate translation and accessibility.

The Group emphasized using plain language (e.g., "primary doctor" instead of "PCP") and making terms like "care plan" and "grievance" more member-friendly (e.g., "my health goals," "complaint"). Suggestions included adding hyperlinks to provider clinics and ensuring the portal is accessible to those with varying technical skills.

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| | | Discussion highlighted that while many members prefer in-person or phone support, there is a growing need for digital solutions, especially app-based access. The team is balancing these needs and collecting ongoing feedback.

Next Steps:
• **Language Simplification** –revise terminology (e.g., replace "PCP" with "primary doctor" and "care plan" with "health goals") for better member understanding.
• **Complaint/Grievance Terminology** –update "file a grievance or appeal" to more accessible language like "file a complaint."
• **Hyperlinks to Clinics** – to consider adding hyperlinks to provider clinic websites in the portal.
• **App Development** – Team to explore development of a standalone mobile app for the member portal.
• **AI Chat/Search Feature** – Team to consider adding AI chat or enhanced search functionality for member support.
• **Spanish Language Support** – Team to work with vendors to implement Spanish language access by 2026.
• **Minor Consent & Access** – Team to develop solutions for minor consent and privacy to enable portal access for minors and guardians.
Marketing & Member Feedback –share portal updates with the member advisory group and incorporate ongoing feedback before broader marketing. | |
| IV. | **Criteria Development, Adoption and Review: Community Supports - Medically Tailored Meals and Housing** | Dr. Mike Wang explained that the Medially Tailored Meals (MTM) policy updates are driven by the need for reliable diagnosis verification and to address inconsistent validation by vendors. The new process requires documentation of a qualifying diet-sensitive diagnosis (e.g., diabetes, hypertension) for MTM approval, regardless of referral source (member, vendor, ECM provider). Non-clinical referrals must provide some form of clinical evidence (e.g., discharge summary, medication bottle photo). If | |

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documentation is missing, the authorization team will reach out to the member's primary care provider to obtain it.

The benefit is available to both adults and children. Pediatric-specific conditions (e.g., prediabetes, high cholesterol, fatty liver) are included, with flexibility for provider documentation. The list of qualifying conditions is not exhaustive and is based on literature review and alignment with available diets from vendors.

Initial MTM approval lasts up to 12 weeks with diagnosis documentation. Renewals require evidence that MTM is part of the care plan and that a provider is monitoring outcomes (e.g., improved A1C for diabetes). Vendors and dietitians are expected to coordinate with PCPs, and the Alliance is working on improving closed-loop communication and documentation sharing.

The MTM benefit is intended for diet-sensitive conditions, not general food insecurity. The Alliance is not reimbursed by the state for these services, so appropriate targeting is emphasized. Providers are encouraged to refer patients who would benefit most.

Providers in the Group requested clear notification when their patients start MTM and access to dietitian notes. The team acknowledged the need for better integration with provider workflows (e.g., fax, portal, HIE) and is considering bulk reporting for quality improvement.

There was a request for practical referral guides and clarity on how to select appropriate meal types (e.g., vegetable-only boxes) in the referral process. Jessie Dybdahl shared a [Meal Referral Form link](#) in the chat for provider use.

There was no substantive discussion or review of housing supports criteria or related topics in the meeting content.

		Medically Tailored Meals – Next Steps: • **Provider Notification & Documentation:** Alliance team to improve notification processes for PCPs when patients start MTM and explore ways to share dietitian notes and intervention start dates (e.g., via fax, portal, or HIE). • **Closed-Loop Referral System:** Alliance to continue developing a closed-loop referral system for community supports and ECM, targeting mid-next year for implementation. • **Criteria Review:** Alliance to consider future agenda topics for reviewing and simplifying qualifying conditions, especially for behavioral health and pediatric populations. **Vendor Coordination:** Alliance to encourage vendors to coordinate with PCPs and send relevant documentation for renewals and ongoing monitoring.	
V.	**Alliance Data Management Strategy Update/ Data Sharing Incentive**	M. Wang, MD informed the Group that the Alliance is advancing a multi-year data management strategy focused on sharing, managing, and distributing data across its network, with a strong emphasis on Health Information Exchange (HIE) integration. The strategy includes internal and external socialization, ongoing modernization of the enterprise data warehouse, and compliance with CMS interoperability requirements via a QHIO platform. Agreements are in progress with Merced and Monterey for HIE participation, and provider onboarding guidelines are being developed to streamline the process. The data sharing incentive program targets provider types in phases, starting with hospitals and SNFs, then expanding to pediatricians, PCPs, ECM providers, and behavioral health. The approach is data-driven, prioritizing providers serving the largest member populations. Hospitals and SNFs are incentivized to send ADT messages (admissions, discharges, transfers), results (labs, notes, EKGs), and medication/treatment orders to	

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the HIE, with performance measured by the percentage of encounters reported and completeness of data.

The program has increased real-time inpatient data sharing from about 20% to 80% over the past year and a half.

Payment schedules for incentives are structured around milestones, such as agreement signing, data submission initiation, and increasing data completeness over time.

The provider portal includes a redetermination date within the linked member list, supporting eligibility management.

The Group inquired on how clinics access member redetermination data? Clinics can access redetermination dates for their members via the Alliance Provider Portal, which allows organizations to download and sort by who needs redetermination.

The Group asked if there is funding for clinics to support redetermination work? Community health workers can bill the Alliance for health navigation services, which includes eligibility and documentation support for redetermination.

The Group asked what types of data are providers expected to share? Providers are expected to send ADT messages (admissions, discharges, transfers), labs, notes, EKGs, medications, and treatment orders to the HIE.

The Group inquired on what is the incentive structure for data sharing? Incentives are milestone-based, with payments tied to agreement signing, initial data submission, and increasing data completeness.

The Group asked if technical assistance or grant support available?

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| | | Technical assistance is available and ongoing, and the Alliance is evaluating cost-sharing for HIE connectivity and bandwidth. Grant support is available for infrastructure upgrades, including potential EHR enhancements, with a maximum award of $250,000

The Group inquired on which provider types are targeted and in what order?
The program started with hospitals and SNFs, then expanded to pediatricians, PCPs, ECM, and behavioral health providers, prioritizing those serving the most Alliance members.

Next steps:
Provider Onboarding – Alliance to continue onboarding new provider types in phases, prioritizing those with the largest member populations. | |
| VI. | **Open Discussion** | The group discussed Medi-Cal Redetermination.

The Group indicated that some clinics and hospitals have dedicated staff or community health workers (CHWs) to assist with Medi-Cal redetermination, while others direct members back to county eligibility offices. Some hospitals (e.g., Salinas Valley) have registration staff handling redetermination, while others rely on referrals to county offices.

 The Alliance Provider Portal contains a linked member list with redetermination dates, allowing clinics to identify and support members needing redetermination.

Questions were raised about funding and sustainability for dedicating staff to redetermination. The Group was informed that Clinics can bill the Alliance for CHW services related to health navigation, including eligibility and documentation for redetermination. | |

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		Overall, it was noted that there is no standardized process across all clinics; practices vary based on resources and internal workflows.		

Action Items

Agenda Item	What is the action item	Due date	Responsible staff
	n/a		

Meeting adjourned at 1:30 p.m.

Next Meeting:

Approved by Committee Date: December 4, 2025	**Signature:** *Mike Wang, MD, CMO*	**Date**: December 4, 2025

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

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COMPLIANCE COMMITTEE

Meeting Minutes
Wednesday, October 15, 2025
9:00 – 10:00 a.m.

Via Videoconference

Committee Members Present:

Adam Sharma	Operational Excellence Director
Andrea Swan	Quality Improvement and Population Health Director
Anne Lee	Financial Planning and Analysis Director
Arti Sinha	Application Services Director
Bob Trinh	Technology Services Director
Danita Carlson	Government Relations Director
Dianna Myers	Medical Director
Gray Clarke	Behavioral Health Medical Director
Jenifer Mandella	Chief Compliance Officer
Jessie Dybdahl	Provider Services Director
Jill Drake	Compliance Manager
Jimmy Ho	Accounting Director
Kay Lor	Payment Strategy Director
Kelsey Riggs	Care Management Director
Krishan Patel	Data Analytics Services Director
Lilia Chagolla	Member Services Director
Lisa Artana	Human Resources Director
Lisa Ba	Chief Financial Officer
Michael Schrader	Chief Executive Officer
Michael Wang	Medical Director
Navneet Sachdeva	Pharmacy Director
Nicole Krupp	Regulatory Affairs Manager
Ronita Margain	Community Engagement Director
Ryan Markley (chair)	Compliance Director
Ryan Inlow	Facilities & Administrative Services Director
Scott Crawford	Medicare Program Executive Director
Shelly Papadopoulos	Operations Management Director
Tammy Brass	Utilization Management Director
Van Wong	Chief Operating Officer

Committee Members Absent:

Lizette Podwalny	Health Services Operations Manager
Fabian Licerio	Risk Adjustment Director

Committee Members Excused:

Cecil Newton	Chief Information Officer
Jessica Finney	Community Grants Director
Linda Gorman	Communications Director
Scott Fortner	Chief Administrative Officer

Ad-Hoc Attendees:

Anita Guevin	Medicare Compliance Program Manager
Daljit Toor	Regulatory Affairs Specialist
Julie North	PMO Manager
Kat Reddell	Compliance Specialist
Nicolette Shalita Vega	NCQA Compliance Program Manager
Rachel Siwajek	Program Integrity Specialist
Rebecca Seligman	Compliance Manager
Sara Halward	Compliance Specialist
Savana Ciavatta	Associate Counsel
Stephanie Vue	Regulatory Affairs Specialist

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

   Chairperson Ryan Markley called the meeting to order at 9:03 a.m.

2. **Consent Agenda.**
   1. **Policy Hub Approvals**
   2. **Regulatory and All Plan Letter Updates**
   3. **Revised Compliance Committee Charter**

   COMMITTEE ACTION: Committee reviewed and approved Consent Agenda.

4. **Regular Agenda**

   1. **Delegation of Medicare Functions to New/Existing Delegates**

   Drake, Compliance Manager, provided an overview of the CMS-required process for pre-delegating Medicare functions of First Tier, Downstream and Related Entities (FDRs), emphasizing the need for pre-delegation assessments for FDRs and recommended committee approval for the following delegates and functions for Medicare:
   - Dignity Health (Dignity): Credentialing/Recredentialing
   - Palo Alto Medical Foundation (PAMF): Credentialing/Recredentialing
   - Santa Clara Valley Medical Center (SCVMC): Credentialing/Recredentialing

   Committee members inquired about the need for peer review and credentialing committee review and approval of the delegation was needed; compliance staff confirmed that was not necessary.

   COMMITTEE ACTION: Committee reviewed and approved delegation of credentialing and recredentialing related to the Medicare line of business for Dignity, PAMF and SCVMC.

2. CAPs Updates

Mandella provided an informational update on various Corrective Action Plans (CAPs) including internal, delegate, regulator, provider and potential CAPs emphasizing the purpose of reviewing CAPs is to proactively identify and resolve risks and ensure organizational awareness to enable cross-functional solutions.

Open CAPs:
- Employee Permissions (internal)

Ongoing CAPs:
- 2025 DHCS Medical Audit
- 2024 DMHC Medical Survey
- Process improvement related to Continuity of Care (internal)
- Process improvement related to gaps in management of assisted living
- MedImpact 2024 Part D Pre-Delegation assessment
- Resolution letters for contracted provider disputes mailed within 30 business days, non-contracted provider disputes within 45 business days
- Process improvement related to timeliness for Facility Site Reviews
- ECM Encounters and Capitation Monitoring
- 2023 DHCS Focused Audit; Transportation and Behavioral Health5 CAPs remain open in a monitoring status, with non-substantive updates since the April update.
- ECM Community Supports
- 2023 DHCS Focused Audit; Transportation and Behavioral Health5 CAPs remain open in a monitoring status, with non-substantive updates since the April update.

Closed CAPs:
- 2025 DMHC Financial Examination
- Enforcement Action related to MY 2019 Timely Access report
- Non-Pharmacy prior authorization Notice of Adverse Benefit Determinations sent to members timely
- All cases of suspected fraud and/or abuse are reported to DHCS within 10 business days
- D-SNP Pre-Delegation Assessments

3. Compliance Committee Restructure

Markley, Compliance Director, led a detailed discussion on Compliance Committee restructure, effective 01/01/2026. The new Committee structure facilitates alignment with CMS expectations and improves overall efficiency, engagement and oversight by implementing focused meetings and participation based on dashboard driven monitoring and triggers.

Sharma, Operational Excellence Director, shared feedback about the centralization of decision-making across the organization, and a desire to keep decision-making with the individuals closer to the day-to-day work. Markley clarified that the intent is to limit

attendance to promote active discussion and problem-solving, and to ensure that executive level staff have an awareness of compliance risks and planned responsive actions. Markley further clarified that the structure addresses this concern, as the discussion will focus on compliance metrics, and when metrics fall below expected performance, relevant Directors will attend to provide additional context and proposed solutions to return to compliance. Finally, there was a suggestion to ensure the Health Services Executive Director position is included in the meeting as a regular attendee, with other Committee members in agreement with the recommendation.

The meeting adjourned at 10:02 a.m.

Respectfully submitted,
Robin Sihler
Compliance Administrative and Data Reporting Assistant

DATE: January 28, 2026

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

FROM: Kay Lor, Director, Provider Payment Strategy

SUBJECT: Proposed Changes to CY 2026 Specialty Care Incentive (SCI) Program

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Recommendation. Staff recommend the Board ratify the proposed modifications to the CY 2026 Specialty Care Incentive (SCI) Program.

- Removal of Provider Completion Survey
- Removal of the Provider completion of DHCS training requirements, and
- Change the Payment Schedule for the Increase New Member Seen measure from quarterly to annually

Background:

Effective January 2026, the Department of Health Care Services (DHCS) updated the provider incentive program policy that MCPs must adhere to. The requirements include having a defined performance period, a signed contract before the performance period starts, and the contract must consist of well-defined improvement standards for the provider to receive payments, as well as a specified dollar amount linked to the successful completion of metrics. Our programs will be updated each year to incorporate lessons learned and respond to new developments.

Discussion:

Removal of Provider Completion of Survey:
The goal of the provider satisfaction survey measure was to improve survey response rates and gather valuable feedback from healthcare providers. While the survey aims to identify network access issues and collaborate with providers on solutions, the resulting improvements are often indirect and difficult to directly link to measurable quality outcomes for members. To minimize the risk of non-compliance, staff recommend removing this measure.

Removal of Provider Completion of DHCS training requirements:
The DHCS DEIB training requirement started in 2025 for all network providers and will recur every three years thereafter. The training does not directly connect to an outcome measurement. To comply with DHCS incentive requirements, staff recommend removing this measure for 2026. New providers will complete the training during the networking process and again during the recredentialing process.

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Update Payment Method for Increasing New Member Seen:
Historically, the Alliance receives complete medical cost data 90 days after the end of each quarter, which is how the current payout system is structured. However, providers may still submit additional claims at the end of the service year. These late claims may affect payouts for earlier quarters that have already been made. To ensure accurate calculations, a final reconciliation and payout are performed at the start of the following year. To reduce the risk of miscalculations, complex reconciliation processes, and confusion for providers, staff recommend switching to an annual payout system instead of a quarterly one for this measure. This change gives providers extra time to submit claims, simplifies staff calculations, and enhances payout accuracy.

Recommendation. Staff recommend the Board approve the proposed modifications to the Specialist Care Incentive (SCI) program to remove the Provider Completion of Survey and DHCS training requirements and change the payment schedule for the Increase New Member Seen measure from quarterly to annually.

Fiscal Impact.
The changes will be included in the 2026 Medical Budget for board approval in December.

Attachments. N/A

DATE: January 28, 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 Amendments: State-Only

              Secondary Contract

Recommendation. Staff recommend the Board authorize the Chairperson to sign two separate amendments to the Alliance's State-only Secondary contract (Contract # 23-30273) as described below:

1. Language adding a Risk Corridor (RC) for the Unsatisfactory Immigration Status (UIS) population.
2. Incorporating CY 2026 Prospective Rates for services covered under the Secondary Contract.

Background. The Alliance contracts with the Department of Health Care Services (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 a secondary (State-Only) Agreement 23-30273 with DHCS on January 1, 2024. The Agreement has subsequently been amended via written amendments A01 – A04.

Discussion. DHCS has stated its intention to issue two amendments to the Alliance's secondary State Medi-Cal contract including: 1. Adding RC language for the UIS population and 2. Incorporating CY 2026 Prospective Rates for Covered Services.

Staff have reviewed the UIS RC language and the CY 2026 Prospective Rates and assessed operational and financial impacts..

Fiscal Impact. There is no anticipated fiscal impact associated with this contract amendment. The 2026 budget approved by the Board in December incorporates the UIS state-only risk corridor and the CY 2026 prospective rates.

Attachments. N/A

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DATE: January 28, 2026

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

FROM: Jessica Finney, Community Grants Director

SUBJECT: Medi-Cal Capacity Grant Program 2025 End of Year Report

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Recommendation. Staff recommend that the Board accept this report on the Medi-Cal Capacity Grant Program's (MCGP) activities in 2025.

Summary. This report highlights the MCGP's strategic investments made to improve the health and wellbeing of the members we serve. A portfolio of 2025 awards is included as an attachment to this report as well as the *MCGP Performance Dashboard* with metrics through December 31, 2025.

Background. The Alliance established the MCGP in July 2015 in response to the rapid expansion of the Medi-Cal population as a result of the Affordable Care Act. Through the investment of a portion of the Alliance's reserves, the MCGP provides grants to local health care and community organizations in the Alliance service areas to increase the availability, quality and access of health care and supportive services for Medi-Cal members, and to address social drivers that influence health and wellness in our communities. Grants awarded align with the Board-approved MCGP Annual Investment Plan. The plan serves as a roadmap for defining grantmaking priorities to address Medi-Cal capacity needs in the Alliance's five counties and allocating funding to advance the goals and strategies under each of the three focus areas: 1) Access to Care; 2) Healthy Beginnings; and 3) Healthy Communities. Since 2015, the Alliance has awarded 1,121 grants totaling $235M to 278 organizations in the Alliance's service areas. Over the past ten years, the MCGP implemented 25 distinct funding opportunities designed to advance the Alliance's grantmaking goals.

Discussion. In 2025, the Alliance awarded 160 grants to 103 organizations across five counties totaling $33M. Grants were awarded across 11 funding opportunities through three competitive funding rounds and strategic direct grants to advance the Board-directed goals and funding priorities of the grant program.

To promote funding opportunities, the Grant Program staff hosted two information webinars on March 27 and April 1 with over 300 registered participants from 134 organizations. to provide an overview and updates on funding opportunities, answer questions from potential applicants, and provide technical assistance in applying for grants. In October, staff also hosted a webinar for over 317 grantee partners to spotlight Alliance resources to help them connect members to health and wellness resources and keep their Medi-Cal coverage. Collectively, these efforts equipped grantees with practical support while strengthening visibility and engagement in the Alliance's grant opportunities. Strong demand persists across program areas, with a high volume

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of applications submitted in each funding round, underscoring the program's role as a critical funding source for organizations serving Medi-Cal members.

The 2025 grant awards included:
- $10M for capital projects to expand access to primary care services
- $10M to recruit 59 health care professionals, any of whom are bilingual, into the Alliance's provider network to expand access to primary care, specialty care, behavioral health, substance use treatment and allied health services;
- $5M for targeted interventions with 20 primary care clinics to close preventative care gaps;
- $2M to support recruitment of Community Health Workers and Doulas to provide culturally competent support for Medi-Cal families;
- $5M to strengthen the capacity of trusted community organizations in delivering health education and service navigation to help Medi-Cal members effectively manage their health; and
- $1M to support healthcare technology to improve care quality and coordination.

Workforce Recruitment grants awarded in 2025 will result in a combined 72 new primary and specialty care providers, community health workers, doulas and medical assistants joining the provider network in the Alliance's service areas, many of whom are bilingual. The Alliance continued to award grants to support health care technology to improve care quality and coordination, parenting support programs to foster child development and increase access to health care services and supportive resources, and community-based programs that address social drivers of health.

In parallel with the Healthy Communities focus area to address social drivers of health, the MCGP combined $10M in the Alliance Housing Fund with the health plan's earned funds through the Department of Health Care Services (DHCS)' Housing and Homelessness Incentive Program in 2024 to award $33.2M for 20 projects in the service area. In 2025, extensive progress was made with housing partners in moving projects forward to execution that will result in over 342 units dedicated to Medi-Cal members in permanent housing, recuperative care facilities and short-term post-hospitalization housing.

The February 2026 Board packet will contain the Alliance's annual *Community Impact Report* publication which includes highlights of the MCGP's impact and will be posted on the Alliance's website and shared in the community.

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

Attachments.
1. MCGP Performance Dashboard
2. MCGP 2025 Grant Awards Portfolio
3. MCGP Focus Areas, Goals and Priorities

Medi-Cal Capacity Grant Program
PERFORMANCE DASHBOARD

About the MCGP

Since 2015, the Alliance has awarded grants to local organizations through the Medi-Cal Capacity Grant Program to improve the availability, quality and access of health care and supportive resources for Medi-Cal members in Mariposa*, Merced, Monterey, San Benito* and Santa Cruz counties.

*Joined the Alliance in 2024.

Funding opportunities are available under three new focus areas: *Access to Care, Healthy Beginnings* and *Healthy Communities.* Funding priorities are responsive to the current health care landscape, align with organizational and State priorities, and address current and emerging needs of Alliance members and the social drivers that influence health and wellness.

Total Awarded Since 2015:

$235M

Santa Cruz
29% ($68.8M)

San Benito
2% ($3.9M)

Monterey
34% ($80M)

Mariposa
2% ($5.3M)

Merced
33% ($77M)
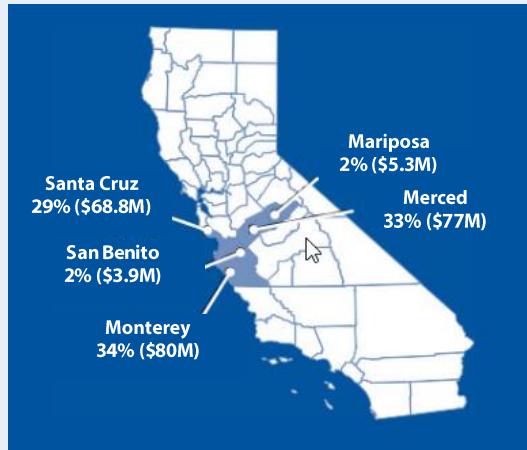
Number of Organizations Awarded:	Number of Grants Awarded:	Award Rate: Eligible Applications Received vs. Grants Awarded
278	**1,121**	**63%**

Awards by Focus Area Since 2023

Access to Care $88M

Healthy Beginnings $5.6M

Healthy Communities $9.4M
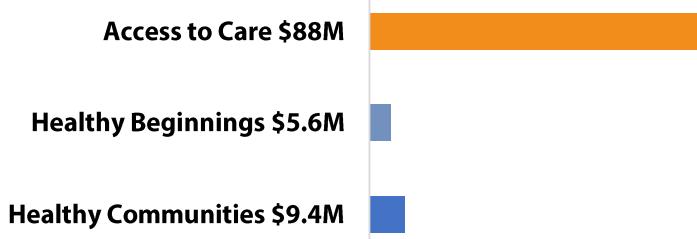
For more information about the Medi-Cal Capacity Grant Program, please visit **www.thealliance.health/grants.**

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Focus Area: Access to Care

Workforce Recruitment Programs

Workforce Recruitment Programs provide funding to support health care and community organizations in their efforts to recruit and hire community health workers, medical assistants and licensed health care professionals to provide culturally and linguistically competent care to the Medi-Cal population in Mariposa, Merced, Monterey, San Benito and Santa Cruz counties.

Provider Recruitment Program

469 grants totaling $64.8M* awarded to subsidize recruitment expenses for new health care professionals to serve the Medi-Cal population.
*Awards since 2015

341 new providers hired to date.

97% retention of all new recruits at one-year mark

63% retention of new recruits* at three-year mark
hired in 2021 or later

Community Health Worker (CHW) Recruitment

57 grants totaling $3.6M awarded to subsidize recruitment expenses for CHWs who become credentialed to provide the Medi-Cal CHW Benefit in the Alliance network.
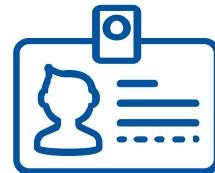
Medical Assistant (MA) Recruitment

38 grants totaling $2.2M awarded to subsidize recruitment expenses for MAs to serve the Medi-Cal population in primary care practices in the Alliance network.

Doula Recruitment

27 grants totaling $1.6M awarded to subsidize recruitment expenses for doulas to serve the Medi-Cal population in the Alliance network.

8 grants totaling $1.4M awarded to provide technical assistance to build a network of doula providers.

Workforce Support for Care Gap Closures

20 grants totaling $4.3M awarded to Merced County primary care providers to subsidize locum tenens, additional staff hours and equipment to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.

Focus Area: Access to Care

Healthcare Technology

43 grants to support the purchase and implementation of specific types of technology and infrastructure that improves Medi-Cal member access to high quality health care.

Total Awarded:

$2.6M

Healthcare Technology investments in:

Platforms for Patient Engagement and Care Coordination

Enhancements and Optimization of EHRs

Data Sharing Solutions

Telehealth and eConsult

Clinical Equipment for Quality Improvement

Capital

76 grants totaling $105M awarded for planning, expansion, construction, renovation, and/or acquisition of health care facilities that will serve the Medi-Cal population in the Alliance service area. Past capital grants were awarded for projects that expand access to Medi-Cal services through transitional or permanent supportive housing for the Alliance's most medically fragile Medi-Cal members.

50 Capital Projects

33 Complete/Operational
8 Under construction
9 In development
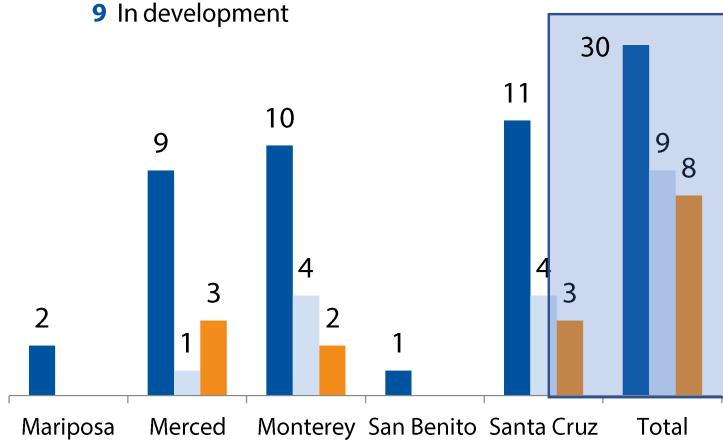
Legend:
- Primary Care or Specialty Care
- BH/SUD
- Permanent Supportive Housing

Chart data:
- Mariposa: 2 (Primary Care)
- Merced: 9 (Primary Care), 1 (BH/SUD), 3 (Permanent Supportive Housing)
- Monterey: 10 (Primary Care), 4 (BH/SUD), 2 (Permanent Supportive Housing)
- San Benito: 1 (Primary Care)
- Santa Cruz: 11 (Primary Care), 4 (BH/SUD), 3 (Permanent Supportive Housing)
- Total: 30 (Primary Care), 9 (BH/SUD), 8 (Permanent Supportive Housing)

In 2024, the Alliance Housing Fund awarded an additional $33M across 20 projects combining $10M from MCGP and $24.5M from DHCS HHIP to support temporary and permanent housing across the service area.

Equity Learning for Health Professionals

11 grants totaling $435K to support training or consulting engagements that directly support Medi-Cal members in receiving equity-oriented care. **Learning opportunities for healthcare providers in:** cultural competency and cultural humility; trauma-informed care; racism and systemic inequity in health care; and eliminating health disparities.

Focus Area: Access to Care

Transportation Infrastructure

4 totaling $3M awarded to Alliance-contracted transportation providers to expand Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services in the Alliance service area.

Project Components Include:

- ADA-compliant vehicles and equipment required for service delivery (e.g., evacuation chairs, gurneys)
- Scheduling and/or billing software
- Hardware to support administrative functions of service delivery
- Staff recruitment costs

Merced and Mariposa counties experienced:

58% increase in members served

60% increase in number of rides

Workforce Development Investments

6 grants totaling $3M awarded to support the development of new educational programs for health care professionals that will serve the Medi-Cal population.

- **77** Community Health Worker graduates to date (2023-25).
- Monterey County Workforce Development Board CHW Certificate Training Program.
- Serves Monterey, San Benito and Santa Cruz counties.

- **71** Community Health Worker graduates to date (2025).
- UC Merced Extension CHW Certificate Training Program.
- Serves primarily Merced and Mariposa counties and open to other counties.

- **10** Undergraduate students completed 10-week internships with Merced County health care providers.
- Health Career Connection Summer Internship Program.

- **109** Physician Assistant graduates to date (2020-2024).
- Program was put on hold in 2024 until further notice.
- Master of Science - Physician Assistant Program, CSU Monterey Bay.*
- Served Monterey and Santa Cruz counties.

Focus Area: Healthy Beginnings

Home Visiting

5 grants to support the implementation or expansion of home visiting programs with trained professionals that use evidence-based models and focus on health outcomes for pregnant women and parents of children up to age 5. Home visiting programs support maternal, infant and child health in the first five years of life and remove barriers to preventative health care for the Medi-Cal population.

Total Awarded:

$1.3M

Investing in early childhood development has proven benefits for children, families and society in the short and long term, and provides resources and support needed to thrive.

Parent Education and Support

29 grants to **i**ncrease access to childhood development education, parenting skills and supportive resources for parents of children up to age 5. Parent education and support programs can serve as a pathway to child development and physical/mental health care screenings, health care services and connection to supportive resources in the community.

Total Awarded:

$3.9M

Facilitated educational programs to increase knowledge in:

Parenting skills

Infant and childhood development

Children's health needs

Community resources that support health and well-being

Focus Area: Healthy Communities

Community Health Champions

28 grants totaling $3.7M to community-based organizations for organizing, training and supporting youth and adults to promote individual and community health and wellness and to advocate for equity in health care access.

San Benito, 1
Mariposa, 1
Merced, 7
Monterey, 11
Santa Cruz, 8
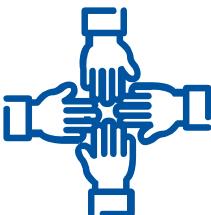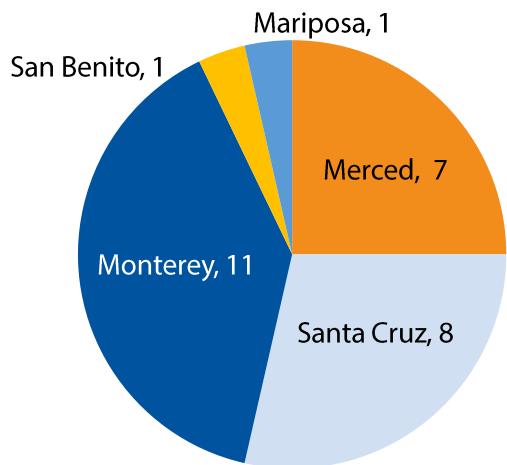
Community Health Champions projects include:

Promotion of health care services, resources and health literacy

Education on specific health topics

Empowerment of Medi-Cal members to advocate for individual and community health and access to care

Destigmatization of behavioral health and substance use disorder services.

Partners for Active Living

16 grants totaling $3.35M to support community-based projects that provide children, adults and families opportunities to engage in physical activity and recreation programs in the community. Projects engage health care providers in partnering on program coordination and referral of Medi-Cal members to these resources.

Active Living Projects Include:

Physical Activity Programming

Partnership with Health Care Provider

- Referral, coordination and promotion

Behavioral Education/Empowerment
- Component that communicates importance of physical activity for health and wellbeing

Member Engagement
- Culturally and linguistically competent programming
- Youth and other populations of focus

Mariposa 1
Merced **3**
Monterey 5
Santa Cruz **7**
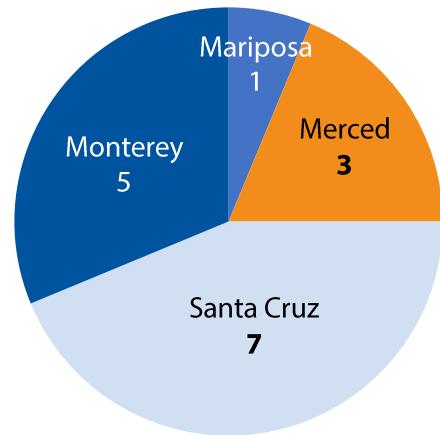
Partners for Healthy Food Access

34 grants totaling $5.2M awarded to support a variety of innovative partnerships between health care providers, community-based organizations and/or government agencies implementing community-based nutritious and medically supportive food projects to improve Medi-Cal member health and food security.

Merced
7

Monterey
13

Santa Cruz
14
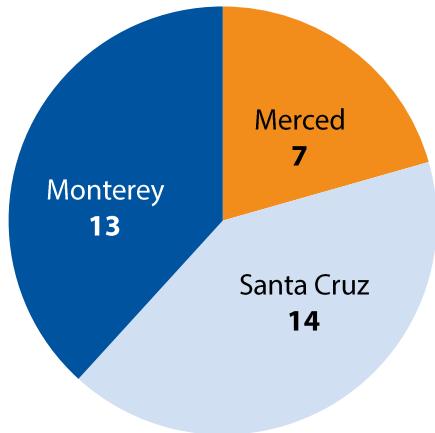
Food Access Projects Focus On:

Food Insecurity Screening

Chronic Disease Screening

Healthy Food Prescription/Distribution
- Food Bank Access Point
- Mobile Market/Farmers Market
- Produce Box Home Delivery

Referrals to Supportive Services
- Cal-Fresh Enrollment

Knowledge & Skill Building
- Nutrition/Health Classes
- Community Gardening
- Cooking Classes

For more information about the Medi-Cal Capacity Grant Program
and to view current funding opportunities, please visit
www.thealliance.health/grants

To view previous Medi-Cal Capacity Grant Program funding opportunities,
please visit **www.thealliance.health/retiredgrants**

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Medi-Cal Capacity Grant Program
2025 Grant Awards

County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Mariposa	Alliance for Community Transformations	Community Health Champions	The Bridges to Wellness project will be implemented at the Mariposa Heritage House (MHH); a drop-in center that offers peer-led wellness and recovery services for individuals experiencing mental health challenges, homelessness, and/or substance use disorders. Bridges to Wellness will (1) expand SUD services through weekly one-on-one counseling sessions and groups for relapse prevention and step study; (2) provide >1,200 meals monthly, emergency food boxes weekly, and additional food boxes to five school sites monthly; (3) host health-focused classes on topics like nutritious food preparation and budget-friendly shopping strategies; (4) in partnership with Mother Lode Job Training (MLJT), to implement a structured pathway for participants to become certified Community Health Workers.	$250,000	7/18/2025
Mariposa	Doula Jules	Doula Recruitment	Recruitment of one Doula	$65,000	7/18/2025
Mariposa	Mariposa County Health and Human Services Agency	Healthcare Technology	The Community Information Exchange project will expand and optimize the Mariposa County Information Exchange (MCIE), a community information and care coordination platform that supports cross-sector collaboration and improves outcomes for Medi-Cal members and other vulnerable residents. MCIE access will be extended to new partners, with team-specific workflows, ongoing staff and partner training, and community outreach to promote its use. Potential partners include Alliance for Community Transformations, Mariposa SAFE Families, Motherlode Job Training, Merced County 211, and the Mariposa County Unified School District.	$50,000	10/31/2025
Mariposa	Mariposa Safe Families, Inc.	Parent Education and Support	Mariposa Safe Families (MSF) will launch "Little Steps, Big Dreams" to strengthen families, prevent child abuse, and promote healthy early childhood development in Mariposa County. The project will offer parent support courses using the evidence-based Nurturing Parenting curriculum, along with family enrichment activities that build social support and emotional resilience. The program aims to connect families to preventive health care and behavioral health services, foster nurturing parenting practices, reduce caregiver isolation, and improve children's emotional and behavioral well-being.	$248,000	7/18/2025
Mariposa	Sierra Natural Birth Center	Doula Recruitment	Recruitment of one Doula	$60,000	10/31/2025
Mariposa	Star & Sky Doula	Doula Recruitment	Recruitment of one Doula	$65,000	10/31/2025
Mariposa	Yosemite Medical Clinic	Healthcare Technology	Yosemite Medical Clinic will upgrade medical equipment to enhance diagnostic capabilities, improve patient outcomes, and increase care capacity. Grant funds will be used to purchase essential equipment, including blood analyzers, ultrasound machines, EKG machines, transport ventilators, and portable otoscopes, to ensure timely and comprehensive patient care.	$50,000	4/4/2025
Merced	Advanced Radiology and Interventional Associates, Inc	Provider Recruitment	Recruitment of one Interventional Radiologist	$250,000	7/18/2025
Merced	Apex Medical Group	Provider Recruitment	Recruitment of one Pediatrician	$191,654	10/31/2025
Merced	Apex Medical Group	Provider Recruitment	Recruitment of one Primary Care Provider	$203,970	10/31/2025
Merced	Apex Medical Group	Workforce Support for Care Gap Closures	Grant awarded with the aim to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.	$107,136	3/28/2025
Merced	Best West Pharmacy	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	10/31/2025
Merced	Boys and Girls Club of Merced County	Parent Education and Support	The Boys & Girls Club of Merced County proposes Mommy & Me, a Parent Education & Support program for pregnant women and caregivers of Medi-Cal–enrolled children ages 0–5 in Merced and Los Baños. The program will offer parenting and child-development workshops, health and nutrition education, and family wellness events, supported by trained facilitators and a part-time Health Educator. Participants will have access to free childcare, a parent wellness room, healthy food options, and annual health fairs. Families will receive warm referrals to Golden Valley Health Centers, Sutter Health, and Merced County BHRS, with follow-up tracked. The program will serve about 80 caregivers annually and strengthen parenting skills, well-being, and preventive care engagement.	$250,000	10/31/2025
Merced	Bryant Orthopedic and Sports Physical Therapy	Provider Recruitment	Recruitment of one Physical Therapist	$62,500	7/18/2025
Merced	Bryant Orthopedic and Sports Physical Therapy	Provider Recruitment	Recruitment of one Physical Therapist	$62,500	7/18/2025

Medi-Cal Capacity Grant Program
2025 Grant Awards

County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Merced	California Health Collaborative	Parent Education and Support	California Health Collaborative (CHC) proposes the Circle of Care project: a 24-month, community-based initiative to improve health outcomes and family stability for Medi-Cal-enrolled pregnant women and children ages 0–5 in Merced County. The project will focus on offering comprehensive, trauma-informed, culturally relevant, and family-centered parent education, expanding access to preventive care and screenings, and facilitating high-quality referrals across medical, behavioral, and social systems. The project will serve both as a family resource group and a referral and navigation hub, anchored by trained Community Health Workers (CHWs), and will build CHC's capacity to become a contracted Medi-Cal provider for CHW services.	$250,000	7/18/2025
Merced	Castle Family Health Centers	Capital	Castle Family Health Centers (Castle) will build a new 7,000 sq. ft. medical facility at its Atwater campus to expand access for Medi-Cal members. The project will increase total clinic space to 13,800 sq. ft. and add 30–36 exam rooms, lab and imaging areas, counseling rooms, and telehealth capacity. Once complete, Castle will hire 20 new clinical staff, increasing capacity to serve 6,000–8,000 patients—70% Medi-Cal members. The expansion will improve access to preventive, women's, pediatric, and chronic care services for Atwater and nearby rural communities. Construction will be completed by December 2026, with operations starting January 2027.	$2,500,000	10/31/2025
Merced	Castle Family Health Centers	Workforce Support for Care Gap Closures	Grant awarded with the aim to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.	$220,000	3/28/2025
Merced	Castle Pharmacy	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	10/31/2025
Merced	Chenn Yow Fuh, MD, Inc.	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$92,000	7/18/2025
Merced	El Portal Cancer Center	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	10/31/2025
Merced	Family Health Medical Center	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	10/31/2025
Merced	Family Health Medical Center	Healthcare Technology	The health care technology initiative will modernize clinic infrastructure by replacing an outdated primary server, adding a dedicated backup server, and implementing a digital intake system to improve data accuracy and reduce administrative workload. The project includes purchasing two PC servers, ten Apple iPads (five as check-in kiosks across two clinic sites), Digital Hemoglobin A1C and Lead screening machines, and a medical-grade refrigerator for proper test kit storage. These upgrades will streamline operations, improve quality measure performance, and enhance the patient experience for Medi-Cal members.	$50,000	10/31/2025
Merced	Family Health Medical Center	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$80,000	7/18/2025
Merced	Gettysburg Medical Clinic	Workforce Support for Care Gap Closures	Grant awarded with the aim to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.	$50,591	3/28/2025
Merced	Golden Valley Health Centers	Capital	GVHC will demolish and rebuild the Planada Health Center at 9235 E. Broadway St. in Planada, enhancing its sustainability against climate events and ensuring continued access to high-quality care for 3,000 patients annually, 64% of whom are Medi-Cal members. The project includes raising the facility above the floodplain and expanding the number of exam rooms and dental operatories, resulting in improved service efficiency, patient care and workflow efficiency.	$2,500,000	4/4/2025
Merced	Golden Valley Health Centers	Healthcare Technology	GVHC will purchase and implement non-invasive jaundice meters (i.e., bilirubinometers) at pediatric clinics in Merced County to provide quick, accurate bilirubin readings on-site, improving convenience and reducing the need for external lab referrals. The project aims to enhance the accuracy, efficiency, and patient experience of bilirubin screening for approximately 1,100 Medi-Cal enrolled or eligible newborns annually.	$25,000	4/4/2025
Merced	Golden Valley Health Centers	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025. Grant funds may also be used for indirect costs per the approved project budget.	$170,416	5/30/2025
Merced	Gotitas De Amor Doula Services	Doula Recruitment	Recruitment of one Doula	$65,000	10/31/2025

County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Merced	Harold L Schick MD, Inc.	Healthcare Technology	Harold L Schick MD's ophthalmology practice will utilize an advanced optical biometry machine to improve cataract surgery outcomes for Medi-Cal patients. The equipment will automate key measurements, leading to more precise intraocular lens selection, reduced dependence on glasses, and fewer referrals to outside specialists.	$50,000	7/18/2025
Merced	Harold L Schick MD, Inc.	Provider Recruitment	Recruitment of one Neuro-Ophthalmologist	$250,000	4/4/2025
Merced	Kenneth R Grossman MD INC	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$225,000	4/4/2025
Merced	LifeLine CDC (Community Development Corporation)	Community Health Champions	The Wellness For All project aims to connect Medi-Cal members to the services, support, and information they need to keep themselves and their families healthy by training interns as Community Health Champions to connect residents in under-resourced neighborhoods with health and social services. Key activities include expanding LLCDC's emergency food pantries with healthier options, offering healthy cooking education (especially for seniors), providing nutritious meals and emotional support for children, completing a garden walkway for seniors, and engaging in community events to strengthen outreach and collaboration.	$240,000	7/18/2025
Merced	Livingston Community Health	Capital	Livingston Community Health (LCH) will build a new 15,734 sq. ft. comprehensive health center on the Merced College campus to expand access for Medi-Cal members and low-income residents in Merced County. The facility will include primary care, dental, behavioral health, pharmacy, lab, and imaging services, as well as space for care management and health education. In partnership with Merced College, the center will also serve students and staff while providing hands-on training for future health professionals. The project will add new medical, behavioral health, and dental providers, increasing capacity by 5,600 patients annually. Construction will be completed in 2027, with operations beginning that November.	$2,500,000	10/31/2025
Merced	Livingston Community Health	Healthcare Technology	Livingston Community Health will expand its use of Artera's digital platform to improve patient communication, streamline intake processes, and enhance community outreach across its clinics. Implementation of new platforms will increase access, efficiency, engagement and satisfaction for Medi-Cal members through automated, multilingual, and integrated workflow and communication systems.	$25,000	7/18/2025
Merced	Livingston Community Health	Workforce Support for Care Gap Closures	Grant awarded with the aim to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.	$110,000	3/28/2025
Merced	Matrescence Doula with Kristina Marguerita	Doula Recruitment	Recruitment of one Doula	$65,000	10/31/2025
Merced	Memorial Hospital Los Banos Rural Health Clinic	MA Recruitment	Recruitment of one Medical Assistant	$65,000	7/18/2025
Merced	Memorial Hospital Los Banos Rural Health Clinic	Workforce Support for Care Gap Closures	Grant awarded with the aim to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.	$110,000	3/28/2025
Merced	Memorial Hospital Los Banos Rural Health Clinic (Family Birthing Center)	Doula Recruitment	Recruitment of one Doula	$65,000	7/18/2025
Merced	Merced Doula Services	Doula Recruitment	Recruitment of one Doula	$65,000	7/18/2025
Merced	Merced Faculty Associates Medical Group	MA Recruitment	Recruitment of one Medical Assistant	$59,374	4/4/2025
Merced	Merced Faculty Associates Medical Group	MA Recruitment	Recruitment of one Medical Assistant	$59,813	10/31/2025
Merced	Merced Faculty Associates Medical Group	Provider Recruitment	Recruitment of one Primary Care Provider	$250,000	4/4/2025
Merced	Merced Faculty Associates Medical Group	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$73,475	10/31/2025
Merced	Merced Faculty Associates Medical Group	Workforce Support for Care Gap Closures	Grant awarded with the aim to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.	$110,000	3/28/2025
Merced	Merced Lung & Sleep Specialists	Healthcare Technology	MLSS will implement new technology, Somnoware and Pulm-One, to enhance patient care efficiency via purchase of equipment/software, implementation of protocols, training of staff, and education of patients. Somnoware system will improve accountability, scoring capabilities, and documentation access. Pulm-One will enhance patient access and documentation with upgraded network functions for quick test result access.	$50,000	4/4/2025

Medi-Cal Capacity Grant Program
2025 Grant Awards

County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Merced	Merced Youth Soccer Association	Community Health Champions	Merced Youth Soccer Association (MYSA) will expand its Merced United Leadership Academy (MULA) to train 70–80 Medi-Cal-eligible student-athletes as paid peer educators who deliver bilingual workshops, wellness events, and warm referrals with partners like Golden Valley Health Centers and Zócalo Health. The program will host leadership sessions and community health events focused on prevention, Medi-Cal benefits, and behavioral-health awareness, serving about 600 mostly Medi-Cal community members and building a youth pipeline into CHW and allied health careers.	$190,000	10/31/2025
Merced	Mercy Medical Center Merced	MA Recruitment	Recruitment of one Medical Assistant	$65,000	10/31/2025
Merced	Mercy Medical Center Merced (Dignity Health)	Provider Recruitment	Recruitment of one Gastroenterologist	$250,000	7/18/2025
Merced	Mercy Medical Center Merced (Dignity Health)	Workforce Support for Care Gap Closures	Grant awarded with the aim to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.	$110,000	3/28/2025
Merced	Peaks Lactation	Doula Recruitment	Recruitment of one Doula	$65,000	10/31/2025
Merced	Priyanka Jain, M.D., Inc. DBA Merced Eye Care	Provider Recruitment	Recruitment of one Cardiologist	$250,000	10/31/2025
Merced	Radio Bilingüe	Parent Education and Support	Radio Bilingüe (RB), a leading Latino and multilingual public media network, will launch a two-year educational radio campaign, Growing With Support, to improve health and well-being for Medi-Cal-eligible parents, infants, and children ages 0–5 in Monterey, San Benito, and Santa Cruz Counties. Broadcast from Radio Bilingüe's KHDC studios in Salinas, the project will deliver culturally and linguistically tailored programs in Spanish, Mixteco, and Triqui, addressing topics such as prenatal and postpartum care, childhood development, mental health, and navigating Medi-Cal services. The radio programming will feature live talk shows, PSAs, and expert interviews with local health care and social support providers to engage and inform underserved Latino and Indigenous families, while combating health misinformation and promoting access to vital community resources.	$250,000	7/18/2025
Merced	Radiologica	Provider Recruitment	Recruitment of one Radiologist.	$250,000	7/18/2025
Merced	Resources for Independence Central Valley (RICV)	Community Health Champions	Resources for Independence Central Valley (RICV) will train 8 Community Health Ambassadors per year to lead community forums, provide culturally appropriate health education, peer support, and warm referrals for Medi-Cal members in Merced County. The program will offer 10+ workshops annually on health literacy, prevention, and navigating Medi-Cal and behavioral health services, supported by a multilingual call line, online resource hub, and closed loop referral system. CHW career pathway with stipends and job coaching prepares participants for future health care roles.	$250,000	10/31/2025
Merced	Sierra Vista Child & Family Services	Community Health Champions	Sierra Vista Child & Family Services' Community Health Outreach program in Merced County aims to improve health equity for Medi-Cal members in underserved rural areas through the use Community Health Navigators to provide culturally relevant outreach, health education, and resource referrals. Program activities are designed to increase awareness of services, promote preventive care, and reduce avoidable emergency visits. Activities include community events, one-on-one engagement, and distributing outreach materials, with a goal of connecting at least 75% of participants to needed resources and developing capacity for Sierra Vista Child & Family Services to become a contracted Community Health Worker Benefit provider.	$225,670	7/18/2025
Merced	Sierra Vista Child & Family Services	Healthcare Technology	Sierra Vista Child & Family Services (SVCFS) will enhance its SmartCare electronic health record (EHR) system to improve client-centered care and streamline documentation for field-based teams in Merced County. The project includes redesigning the treatment plan template, EHR customization to meet real-time data sharing standards, and purchasing digital signature pads for use during home and community visits. These upgrades will support real-time data sharing, improve care coordination, and reduce staff documentation time.	$24,500	7/18/2025
Merced	Sport & Rehab Physical Therapy	Provider Recruitment	Recruitment of one Physical Therapist	$85,000	7/18/2025
Merced	Sport & Rehab Physical Therapy	Provider Recruitment	Recruitment of one Physical Therapist	$85,000	7/18/2025
Merced	Timothy S. Johnston, MD	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$86,167	7/18/2025

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Merced	Timothy S. Johnston, MD	Workforce Support for Care Gap Closures	Grant awarded with the aim to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.	$109,992	3/28/2025
Merced	TrueHealthCare Corp	Parent Education and Support	TrueHealthCare Corp will implement the WellStart program in collaboration with Memorial Hospital Los Banos, Rural Health Clinic to enhance parental education and support for pregnant women and children ages 0 to 5 in Merced County. The culturally and linguistically competent program aims to improve child development outcomes, strengthen family health, reduce health disparities, and promote nutritional well-being and active living via educational workshops, cooking classes, physical activity programs, lactation support, support groups, individual consultations, and resource navigation.	$100,000	4/4/2025
Merced	TrueHealthCare Corp	Provider Recruitment	Recruitment of one Pediatrician	$200,000	10/31/2025
Merced	UC Merced	Community Health Champions	UC Merced PACE's SkillRISE-CH program will engage up to 30 Medi-Cal youth in Merced County through team-based, work-based learning projects aligned with local Community Health Improvement Plan (CHIP) priorities. Youth will earn project management certification, receive mentorship from UC Merced undergraduates, and collaborate with community health organizations on real-world projects focused on mental health, preventive care, substance use, and chronic disease. The program aims to build youth career pathways in public health and health care careers, increase awareness of Medi-Cal benefits, and strengthen community organizations' capacity to serve underserved populations.	$248,851	7/18/2025
Merced	United Way of Merced County	Parent Education and Support	United Way of Merced County (UWMC) will launch the Nurturing Family Strength Program in partnership with Cultiva Greatness LLC to enhance mental wellness and strengthen parent-child relationships for Medi-Cal families. Using the evidence-based Nurtured Heart Approach® curriculum, the program offers training sessions with special adaptations for cultural/language needs, weekly support groups, and health care and social support resource navigation. The program aims to increase parental confidence and improving socio-emotional well-being of parents and children ages 0-5.	$218,845	7/18/2025
Merced	Youth Leadership Institute	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	10/31/2025
Merced	Youth Leadership Institute	Community Health Champions	Youth Leadership Institute will expand its Merced Healing Generation Center to continue serving low-income youth with mental health, housing, and support services, while launching the Youth Voices Alliance —a youth-led Community Health Worker cohort. The project will engage 10 youth as peer educators to promote Medi-Cal benefits, health education, and advocacy through trainings, webinars, health fairs, and school partnerships. Activities aim to build trust, increase access to Medi-Cal benefits and social resources, and strengthen community resilience through youth-driven outreach and wellness initiatives like a community garden and fitness workshops.	$250,000	7/18/2025
Merced/ Mariposa	Peaceful Passages Birthing Support Center	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	4/4/2025
Merced/ Mariposa	Health Career Connection	Workforce Development	To support Health Career Connection in enrolling a total of 20 undergraduate students and recent graduates through a comprehensive, 10-week, full-time paid internship program with placement at Alliance-contracted and/or Alliance-approved organizations during the summers of 2025 and 2026.	$192,000	5/1/2025
Merced/ Mariposa	Turlock Doula Services	Doula Network Technical Assistance	To support the outreach, support, and education for doulas on the Medi-Cal Doula Services Benefit and the provider enrollment process through the Department of Health Care Services and the Alliance to recruit doulas into the Alliance's network of doula providers.	$42,000	6/1/2025
Merced/ Mariposa	Wave's Embrace Doula Services	Doula Network Technical Assistance	To support the outreach, support, and education for doulas on the Medi-Cal Doula Services Benefit and the provider enrollment process through the Department of Health Care Services and the Alliance to recruit doulas into the Alliance's network of doula providers.	$42,000	6/1/2025
Monterey	Acacia Family Medical Group	Provider Recruitment	Recruitment of one Primary Care Provider	$250,000	7/18/2025
Monterey	Big Sur Health Center	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$135,100	7/18/2025
Monterey	Big Sur Health Center	Provider Recruitment	Recruitment of one Primary Care Provider	$193,000	10/31/2025

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Monterey	Center for Community Advocacy	Community Health Champions	The Promotores Comunitarios program aims to increase access to health care and mental health services for underserved populations in southern Monterey County by expanding on their model where trained Promotores (Community Peer Educators) partner with local healthcare providers to bridge gaps in access due to linguistic, cultural, and economic barriers. Organization will train and certify at least ten Promotores de Salud to serve as community health advocates for supporting low-income, agricultural workers, and Indigenous populations.	$100,000	4/4/2025
Monterey	Clinica de Salud del Valle de Salinas	Data Sharing Support	Clinica de Salud del Valle de Salinas (CSVS) will upgrade its NextGen® EHR to support secure, bi-directional, real-time health information exchange (HIE) in alignment with Medi-Cal data-sharing requirements and the CalHHS Data Exchange Framework. The project will implement technical enhancements, update workflows, and train staff to embed HIE into routine care, improving coordination and data-driven decision-making for CSVS's predominantly Medi-Cal patient population.	$250,000	10/31/2025
Monterey	Clinica de Salud del Valle de Salinas	Healthcare Technology	Clinica de Salud del Valle de Salinas (CSVS) will implement Luma Health and integrate it with the NextGen EHR to improve access, scheduling, and care coordination for Medi-Cal members. Luma will provide multilingual messaging, automated reminders, self-scheduling, waitlist automation, and telehealth/e-Consult integration to reduce missed appointments and streamline virtual care. The project will enhance patient outreach and follow-up and expand telehealth capacity, supporting faster connections to needed services and more timely preventive and specialty care.	$50,000	10/31/2025
Monterey	Clinica de Salud del Valle de Salinas	Parent Education and Support	Clinica de Salud del Valle de Salinas (CSVS) will expand parent education and integrate developmental, behavioral-health, and caregiver well-being screenings into routine pediatric visits for Medi-Cal families with children ages 0–5. The project will train staff, embed screening tools and referral prompts into the EHR, and provide bilingual, literacy-appropriate materials to strengthen parent understanding of milestones and early behavioral-health concerns. CSVS will enhance closed-loop referrals to behavioral health, Early Start/Regional Center, WIC, dental, and preventive services, with EHR-tracked follow-up. The initiative will increase screening and referral-completion rates while preparing CSVS for CalAIM's Dyadic Behavioral Health Benefit and serving more than 5,000 Medi-Cal members.	$250,000	10/31/2025
Monterey	Clinica De Salud Del Valle De Salinas	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025. Grant funds also support the purchase and implementation of medical equipment or supplies that directly relate to the quality measures targeted for improvement. Additionally, grant funds may be used for indirect costs per the approved project budget.	$330,000	5/30/2025
Monterey	Community Homeless Solutions	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	4/4/2025
Monterey	Community Human Services	Parent Education and Support	Community Human Services will expand its evidence-based Nurturing Parenting class series with bilingual facilitators to help Medi-Cal families build positive parenting skills and prevent child abuse and neglect. The program promotes healthy child development, strengthens family dynamics, and connects participants to community resources through partnerships with local health, social service, and educational organizations.	$59,000	7/18/2025
Monterey	County of Monterey Health Department - Clinic Services Bureau	Healthcare Technology	Monterey County Health Department's Clinic Services Bureau seeks funding to implement an AI Scribe, an AI transcription tool that streamlines clinical documentation in the electronic health record (EHR) during patient visits. By reducing administrative burden, the tool will enhance provider efficiency, expand telehealth capacity, and improve access and care coordination for Medi-Cal members. The project includes EHR integration, staff training, and patient education. Outcomes include more time for direct patient care, reduced provider burnout, improved documentation accuracy, and shorter wait times for patients.	$50,000	7/18/2025

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Monterey	County of Monterey Health Department - Clinic Services Bureau	Provider Recruitment	Recruitment of one Primary Care Provider	$189,908	4/4/2025
Monterey	County of Monterey Health Department - Clinic Services Bureau	Provider Recruitment	Recruitment of one Primary Care Provider	$250,000	4/4/2025
Monterey	County of Monterey Health Department - Clinic Services Bureau	Provider Recruitment	Recruitment of one Primary Care Provider	$250,000	4/4/2025
Monterey	County of Monterey Health Department - Clinic Services Bureau	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025.	$1,375,000	5/30/2025
Monterey	Doctors on Duty Medical Group, Inc.	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$136,878	7/18/2025
Monterey	Doctors on Duty Medical Group, Inc.	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025. Grant funds may also be used for indirect costs per the approved project budget.	$330,000	5/30/2025
Monterey	Eric J. Del Piero, MD, A Medical Corporation	Healthcare Technology	The project will purchase a new Zeiss CIRRUS OCT machine, along with maintenance and staff training, to expand access to advanced eye imaging for Medi-Cal members. The equipment will improve diagnostic accuracy, increase daily testing capacity, and enhance coordination with primary care and referral partners through shared OCT images. The upgraded OCT will support care for patients with diabetes, macular degeneration, and other retinal conditions.	$50,000	10/31/2025
Monterey	Gonzales Primary Care	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$208,166	4/4/2025
Monterey	Gonzales Primary Care	Provider Recruitment	Recruitment of one Primary Care Provider	$250,000	4/4/2025
Monterey	Integrated Psychological Assessment Services	Provider Recruitment	Recruitment of one Licensed Clinical Social Worker (LCSW) or Licensed Marriage and Family Therapist (LMFT)	$45,000	10/31/2025
Monterey	Integrated Psychological Assessment Services	Provider Recruitment	Recruitment of one Psychologist	$75,000	10/31/2025
Monterey	Integrated Psychological Assessment Services	Provider Recruitment	Recruitment of one Psychiatric Mental Health Nurse Practitioner	$100,000	10/31/2025
Monterey	Montage Medical Group	Provider Recruitment	Recruitment of one Cardiac Electrophysiologist	$250,000	7/18/2025
Monterey	Montage Medical Group	Provider Recruitment	Recruitment of one Neurologist	$250,000	7/18/2025
Monterey	Montage Medical Group	Provider Recruitment	Recruitment of one Neurologist	$250,000	10/31/2025
Monterey	Monterey Bay Speech Therapy	Provider Recruitment	Recruitment of one Speech Pathologist	$65,806	4/4/2025
Monterey	Monterey Bay Speech Therapy	Provider Recruitment	Recruitment of one Speech Therapist and Occupational Therapist	$59,093	4/4/2025
Monterey	Pacific Rehabilitation & Pain	Provider Recruitment	Recruitment of one Pain Medicine Provider	$250,000	7/18/2025
Monterey	Partners For Peace	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	4/4/2025
Monterey	Salinas Regional Sports Authority	Community Health Champions	The Las Reinas initiative will engage local high-school and college-age young women to deliver culturally rooted health education and navigation for Medi-Cal members in Monterey County. Trained Youth Champions and Interns will support events at the Salinas Regional Soccer Complex and other community sites, offering wellness education and warm referrals to care and community resources. The project also builds a youth-to-CHW career pathway through mentorship and experiential learning.	$250,000	10/31/2025
Monterey	Salinas Valley Foot & Ankle, Inc.	Provider Recruitment	Recruitment of one Podiatrist	$250,000	10/31/2025
Monterey	Salinas Valley Medical Clinic	Provider Recruitment	Recruitment of one Diagnostic Imaging & Mammography Physician	$250,000	4/4/2025
Monterey	Salinas Valley Medical Clinic	Provider Recruitment	Recruitment of one OB/GYN	$250,000	4/4/2025
Monterey	Salinas Valley Medical Clinic	Provider Recruitment	Recruitment of one Urgent Care Internal Medicine Physician	$232,690	7/18/2025
Monterey	Salinas Valley Medical Clinic	Provider Recruitment	Recruitment of one Diagnostic Radiologist	$250,000	10/31/2025
Monterey	Salinas Valley Medical Clinic	Provider Recruitment	Recruitment of one OB/GYN	$250,000	10/31/2025

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County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Monterey	Salinas Valley Medical Clinic	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025. Grant funds also support the purchase and implementation of medical equipment or supplies that directly relate to the quality measures targeted for improvement. Additionally, grant funds may be used for indirect costs per the approved project budget.	$55,000	5/30/2025
Monterey	Santa Lucia Medical Group, Inc.	Provider Recruitment	Recruitment of one Primary Care Provider	$144,350	10/31/2025
Monterey	Seneca Family of Agencies	Healthcare Technology	Seneca Family of Agencies (SFA) is equipping the new Children's Crisis Continuum Program (CCP) facility, in collaboration with Monterey County Behavioral Health Services Division, with technology that enhances care for youth in mental health crisis. The facility will serve children and youth experiencing acute mental health crises and includes a Children's Crisis Residential Program and Crisis Stabilization Unit. The project includes medication dispensing tools, telehealth equipment, digital communication boards, and laptops to support real-time documentation and coordination. These upgrades will improve safety, streamline treatment planning, and reduce the need for hospitalizations or out-of-county placements for Medi-Cal youth in crisis.	$50,000	7/18/2025
Monterey	Sun Street Centers	Provider Recruitment	Recruitment of one Substance Use Disorder (SUD) Licensed Vocational Nurse (LVN)	$64,262	10/31/2025
Monterey	Taylor Farms Family Health & Wellness Center	MA Recruitment	Recruitment of one Medical Assistant	$65,000	10/31/2025
Monterey	Taylor Farms Family Health & Wellness Center	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$101,886	4/4/2025
Monterey	Taylor Farms Family Health & Wellness Center	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025. Grant funds also support the purchase and implementation of medical equipment or supplies that directly relate to the quality measures targeted for improvement. Additionally, grant funds may be used for indirect costs per the approved project budget.	$110,000	5/30/2025
Monterey	Therasens Inc.	Provider Recruitment	Recruitment of one Pediatric Occupational Therapist	$90,000	7/18/2025
Monterey	United Way of Monterey County	Innovation Fund	To support United Way of Monterey County's Hope and Help Network (HHN) to drive higher impact results amongst mental health (MH) and substance use disorder (SUD) service providers in the ecosystem of prevention, intervention, treatment and recovery for Medi-Cal members in Monterey County. Through collective action, HHN members will develop collaborative strategies to optimize MH and SUD service delivery in Monterey County.	$161,390	5/30/2025
Monterey	Valley Health Associates	Provider Recruitment	Recruitment of one Substance Use Disorder Outpatient Program Director (and Counselor)	$46,958	4/4/2025
Monterey	Wonder Wood Ranch	Community Health Champions	Wonder Wood Ranch will expand its T.A.I.L.S. Program Program which provides trauma- and culturally-informed therapy through animal-assisted play and therapy, life skills development, and career preparation for underserved youth in Monterey County, with a focus on Greenfield. Youth Interns experienced in T.A.I.L.S. will lead activities with peer youth participants to promote health and wellness and take on leadership roles during community events and school trips. A Youth Coordinator will serve as a liaison between the program, community, and health providers to identify and refer Medi-Cal-eligible youth to healthcare and social supports providers.	$20,000	4/4/2025
San Benito	Hazel Hawkins Hospital	Provider Recruitment	Recruitment of one Psychiatrist	$250,000	10/31/2025
San Benito	Hazel Hawkins Hospital	Provider Recruitment	Recruitment of one General Surgeon	$250,000	10/31/2025
San Benito	Maternal Wellness	Doula Recruitment	Recruitment of one Doula	$65,000	10/31/2025

County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
San Benito	Omatochi	Community Health Champions	Omatochi aims to establish a network of local health advocates in San Benito County who can empower senior Latinx residents to improve their health literacy, access Medi-Cal services and preventive care, and destigmatize behavioral health and substance use disorder services. To achieve these goals, the organization will employ a community-based health model, where trusted individuals from within San Benito neighborhoods will be trained as Community Health Champions to provide culturally and linguistically competent outreach, education and referrals to local providers of health care and supportive services.	$100,000	4/4/2025
San Benito	San Benito Health Foundation	Workforce Support for Care Gap Closures	Grant awarded with the aim to improve quality metrics performance to reach at least the 50th percentile and potentially reach the 90th percentile.	$220,000	3/28/2025
San Benito	Youth Alliance	Parent Education and Support	Youth Alliance will relaunch FAMiLiA, a bi-weekly, bilingual parent education and peer-support program for Medi-Cal–eligible caregivers of children 0–5 in San Benito County, with a focus on teen parents.. Using culturally rooted curricula and trauma-informed engagement, the program will provide parent education, family activities, and warm navigation to preventive care and behavioral-health services, with referrals tracked in PearSuite. Families will receive childcare, transportation support, and flexible scheduling. The program will engage about 100 families through 32 sessions and events, strengthening parenting skills, increasing completed referrals, and offering pathways into Youth Alliance's Parent Alliance leadership program.	$250,000	10/31/2025
Santa Cruz	Cardiovascular Associates of Santa Cruz	Provider Recruitment	Recruitment of one Cardiologist	$250,000	10/31/2025
Santa Cruz	Coastal Health Partners	Provider Recruitment	Recruitment of one Urologist	$250,000	4/4/2025
Santa Cruz	Coastal Health Partners	Provider Recruitment	Recruitment of one General Surgeon	$250,000	10/31/2025
Santa Cruz	Coastal Kids Home Care	Provider Recruitment	Recruitment of one Occupational Therapist	$98,000	10/31/2025
Santa Cruz	Community Bridges	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	10/31/2025
Santa Cruz	Community Bridges	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	10/31/2025
Santa Cruz	Community Health Trust of Pajaro Valley	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$59,390	10/31/2025
Santa Cruz	County of Santa Cruz, Health Services Agency, Clinic Services Division	Healthcare Technology	The County of Santa Cruz Health Services Agency will use grant funds to purchase essential clinical equipment that supports quality improvement efforts and increases access to preventive care for Medi-Cal members. New equipment—such as exam tables, vaccine refrigerators, and portable diagnostic tools—will enable more cervical cancer screenings, reduce vaccine waste, and improve routine care.	$50,000	7/18/2025
Santa Cruz	County of Santa Cruz, Health Services Agency, Clinic Services Division	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025.	$220,000	5/30/2025
Santa Cruz	Crystal Lyons	Doula Recruitment	Recruitment of one Doula	$65,000	7/18/2025
Santa Cruz	Dientes	Provider Recruitment	Recruitment of one General Dentist	$119,850	7/18/2025
Santa Cruz	Dominican Hospital (Dignity Health)	Equity Learning	The Healing Connections Program will equip healthcare professionals with tools to address health disparities and create an inclusive environment. The program will train residents, doctors, and faculty to work through an equitable lens, recognize personal biases, and foster systemic change. It includes intensive training, belonging events, and leadership workshops to embed equity, cultural humility, and trauma-informed care into hospital practices. The program seeks to improve healthcare outcomes, enhance provider-patient relationships, and cultivate a culture of belonging and respect.	$40,000	4/4/2025
Santa Cruz	Mindful Transitions Doula	Doula Recruitment	Recruitment of one Doula	$65,000	4/4/2025

County	Organization Name	Funding Opportunity	Grant Description	Award Amount	Date Awarded
Santa Cruz	Palo Alto Medical Foundation	Capital	Palo Alto Medical Foundation proposes the Watsonville Primary Care Center Expansion project at 160 South Green Valley Road, Freedom, CA to enhance access to primary care for Medi-Cal members in the South Santa Cruz County area. Grant funds will support the renovation of 4,969 square feet of currently leased space at the 160 South Green Valley Road clinic to accommodate the addition of five new fully equipped patient examination rooms and offices to expand primary care, obstetric services, pediatric care and behavioral health services. The site will add five full-time primary care physicians (two new providers and three who will be relocated from Sutter Health's 550 Green Valley Road clinic) to serve patients at the clinic.	$2,100,000	7/18/2025
Santa Cruz	Pediatric Medical Group of Watsonville	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	7/18/2025
Santa Cruz	Planned Parenthood Mar Monte	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025.	$110,000	5/30/2025
Santa Cruz	Plazita Medical Clinic	Healthcare Technology	Plazita Medical Clinic (PMC) proposes the implementation of the AMBI Ambient AI Solution, an AI transcription tool that streamlines clinical documentation in the electronic health record during patient visits. By reducing administrative burden, the tool will enhance provider efficiency, expand telehealth capacity, and improve access and care coordination for Medi-Cal members. Grant funds will also be used for a SPOT Vision Screener to improve pediatric and adult vision screenings.	$35,831	7/18/2025
Santa Cruz	Plazita Medical Clinic	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025.	$110,000	5/30/2025
Santa Cruz	Positive Discipline Community Resources	Parent Education and Support	Positive Discipline Community Resources (PDCR), in partnership with Pajaro Valley Prevention and Student Assistance (PVPSA), will deliver Less Stress, More Joy, a trilingual (English/Spanish/Mixteco) parent education and support program for caregivers of children 0–5 in North Monterey and South Santa Cruz Counties. The project will offer Positive Discipline classes, playgroups, healing circles, and community pop-ups, paired with PVPSA's behavioral-health screening, triage case management, and warm handoffs to preventive and behavioral-health services. A CHW will support outreach and barrier reduction. The initiative will provide ~24 programs reaching ~100 Medi-Cal–eligible caregivers and train ~50 new Positive Discipline facilitators, strengthening parenting skills and connections to community supports.	$250,000	10/31/2025
Santa Cruz	Rheum Without Walls	Provider Recruitment	Recruitment of one Non-Physician Medical Practitioner (NPMP)	$97,006	7/18/2025
Santa Cruz	Salud Para La Gente	Equity Learning	The Patient-Provider Language Concordance Initiative aims to enhance equity learning among Salud Para La Gente's health care providers by aligning provider language skills with patient preferences, improving patient experiences, and fostering equitable care. The initiative will provide tailored medical Spanish and cultural competency training for 65 providers. The expected outcomes include enhanced communication, improved health outcomes, and reduced disparities for Spanish-speaking patients.	$40,000	4/4/2025
Santa Cruz	Salud Para La Gente	Provider Recruitment	Recruitment of one Pediatrician	$172,174	4/4/2025
Santa Cruz	Salud Para La Gente	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025. Grant funds also support the purchase and implementation of medical equipment or supplies that directly relate to the quality measures targeted for improvement. Additionally, grant funds may be used for indirect costs per the approved project budget.	$491,144	5/30/2025

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Santa Cruz	Santa Cruz Community Health	Innovation Fund	Santa Cruz Community Health (SCCH) will partner with Housing Matters to transition the Salt Air Lodge recuperative care program's limited nursing model to a comprehensive medical model of care (i.e., providing on-site primary care and other health care services). SCCH will establish regular provider hours for on-site Medi-Cal billable visits to provide clinical care services; integrate behavioral health, substance use disorder treatment, Enhanced Care Management and Community Supports into the care model; create seamless connections to SCCH's primary care network; implement evidence-based care protocols for common conditions among the unhoused population; and develop robust care coordination systems between Salt Air Lodge, hospitals, and community providers	$150,000	11/12/2025
Santa Cruz	Santa Cruz Community Health	MA Recruitment	Recruitment of one Medical Assistant	$65,000	4/4/2025
Santa Cruz	Santa Cruz Community Health	Provider Recruitment	Recruitment of one Primary Care Provider	$217,867	4/4/2025
Santa Cruz	Santa Cruz Community Health	Workforce Support for Care Gap Closures	To support the hiring of locum tenens providers and/or to allocate additional hours for existing staff to augment clinic hours and/or days to assist with closing the remaining Managed Care Accountability Sets (MCAS) care gaps through the end of 2025. Grant funds also support the purchase and implementation of medical equipment or supplies that directly relate to the quality measures targeted for improvement. Additionally, grant funds may be used for indirect costs per the approved project budget.	$493,042	5/30/2025
Santa Cruz	Second Harvest Food Bank Santa Cruz County	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	7/18/2025
Santa Cruz	Second Harvest Food Bank Santa Cruz County	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	7/18/2025
Santa Cruz	Sleep Health MD	Provider Recruitment	Recruitment of one Sleep Medicine Provider	$250,000	7/18/2025
Santa Cruz	Sobriety Works	Provider Recruitment	Recruitment of one Substance Use Disorder (SUD) Counselor	$53,747	7/18/2025
Santa Cruz	Teen Kitchen Project	Community Health Champions	The Teen Chef Community Health Champions Program will engage 200 Medi-Cal-eligible youth (ages 14–18) in Santa Cruz County to become peer health leaders through hands-on cooking, nutrition education, and community service. Teens will prepare over 300,000 medically tailored meals for people with serious illness, gain healthy cooking skills, and promote wellness in their families and communities. The project includes a Teen Chef Advisory Committee, after-school kitchen cohorts, and shared meals to build connection and health literacy, aiming to reduce food insecurity, improve nutrition, and foster youth leadership.	$173,807	7/18/2025
Santa Cruz	Watsonville Community Hospital	CHW Recruitment	Recruitment of one Community Health Worker (CHW)	$65,000	10/31/2025
Santa Cruz	Womb Tribe	Doula Recruitment	Recruitment of one Doula	$65,000	4/4/2025

Medi-Cal Capacity Grant Program (MCGP) Focus Areas, Goals and Priorities

Focus Area 1. Access to Care

The Alliance will focus on strengthening and expanding the provider workforce to address provider shortages and increase the number of providers who reflect the diversity of the Alliance's membership. The Alliance will also make investments to improve coordination across the health care system and address infrastructure and capacity gaps to ensure that Medi-Cal members are able to access high-quality care when, where and how they need it.

Funding Need
1. Health care workforce shortages in the Alliance service area impact Medi-Cal members' access to timely health care services.
2. New provider types are being integrated in the Medi-Cal health care continuum to deliver a range of new non-medical services to address social drivers of health.
3. The existing health care workforce is challenged to reflect the racial, ethnic, cultural and linguistic diversity of Alliance members.
4. Organizations that serve the Medi-Cal population need expanded capacity and infrastructure to increase access to services.

Funding Goals
1. A robust health care workforce that can deliver coordinated, person-centered care and the full array of Medi-Cal services.
2. Improved patient-provider communication and trusted relationships, resulting from an expanded network of Medi-Cal providers who are linguistically and culturally responsive.
3. Medi-Cal members are able to access high-quality care when, where and how they need it.

Funding Priorities
1. Address workforce shortages, infrastructure and capacity gaps.
2. Increase the racial, ethnic, cultural and linguistic diversity of the provider network to better reflect the Alliance's membership.
3. Improve the coordination, integration and capacity of the behavioral health system, including coordination between the physical health system and behavioral health system.

Focus Area 2. Healthy Beginnings

By investing in early childhood development, the Alliance will positively impact the health and well-being of its youngest members and their families in the short and long term, as well as ensure they have the resources and support needed to thrive.

Funding Need
1. The first five years of life are critical to health and brain development.
2. Historical and persistent trauma (including systemic racism) and adverse childhood experiences can negatively impact physical, mental, emotional and behavioral health.
3. Barriers to preventative services affect maternal, infant and child health.
4. Investing in early childhood development has proven benefits for children, families and society.

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Funding Goals
1. Families with a new child receive timely prenatal and post-natal care to ensure optimal physical and mental health for mothers and to promote healthy birth outcomes.
2. Children are healthy and thriving by age 5.
3. Children (prenatal through age 5) and their parents/caregivers have access to preventative health care services and community resources to support their families' health and well-being.
4. Parents and caregivers have the knowledge, resources and support they need to provide safe, nurturing environments for their children.

Funding Priorities
1. Increase access and use of preventative health services, early identification and intervention services, behavioral health interventions and early childhood development interventions.
2. Provide parents with social support and education about child development and parenting.
3. Assist families in navigating the health care system and connecting to health and community resources that support child development and family well-being.
4. Promote strategies for systems change that allow families to fulfill aspirations for children's long-term health and economic opportunities.

Focus Area 3. Healthy Communities

By investing in the non-medical factors that impact health, such as food and housing, the Alliance can ensure that Medi-Cal members have access to what is needed to live their healthiest lives at every stage of life. Creating communities where healthy options are easy and available to all can reduce health disparities, support healthy and active lifestyles and reduce risk of chronic disease.

Funding Need
1. Social, economic and environmental factors shape individual health and well-being. These factors influence risk for chronic conditions such as diabetes, asthma and cardiovascular disease.
2. Lack of access to healthy food, safe and stable housing, quality schools and safe places to exercise and play create barriers to health.
3. Geographic communities experience differences in environmental factors and distribution of resources, which contribute to disparities in health risks and quality-of-life outcomes.
4. Medi-Cal members experience barriers such as: limited English proficiency, transportation, childcare, and health literacy; food insecurity; overcrowded housing; insecure employment; and low wages. These barriers impede their ability to access services and manage their health.

Funding Goals
1. Medi-Cal members have access in their communities to what is needed to live their healthiest lives, support healthy options and reduce risk of chronic disease, including access to:
   - Fresh, affordable, healthy food.
   - Safe places to play and be active.
   - Permanent supportive housing for Medi-Cal members experiencing homelessness.
2. Medi-Cal members have the knowledge and resources to effectively manage their health.

3. Medi-Cal members are empowered to advocate for policy and systems changes that promote good health for themselves and their communities.

Funding Priorities

1. Focus on individuals, families and communities experiencing disparities in health.
2. Invest in drivers of individual and community health and well-being, such as nutritious food, supportive housing and safe places to be active.
3. Engage trusted community-based organizations to promote available health care services and resources to reduce disparities.
4. Support community/youth leadership development and civic engagement efforts that transform infrastructure and promote wellness and health equity for individuals and the community.

Background:

The Community Atlas is a profile of the Alliance's collaborative work in the Plan's five-county service area. This Atlas is a retrospective overview based on the work completed as of the date of this report. The collaborative work reported in this Atlas refers to the formal collaborative and partnership meetings that Alliance staff attend and/or facilitate with local stakeholders within our five-county region. The Health Care Collaboratives (HCCs) enhance the Alliance's presence in the community and advance our mission and strategic goals. HCCs present the opportunity to obtain feedback on member experience as it relates to access to care, share out initiatives and identify areas for further Alliance presence, engage in social impact efforts that aim to improve Social Drivers of Health, establish partnership opportunities such as vaccine campaigns and community investments, and understand the health access and equity landscape in our service area.

Collaborative Snapshot

In calendar year 2025, the Plan engaged with **56** collaboratives in the five-county service area.

Multi-County Collaboratives	5
Mariposa	4
Merced	17
Monterey	8
San Benito	7
Santa Cruz	15

Pie chart:
- 18% Public Health
- 14% Community Networking
- 52% Addressing Social Determinants of Health
- 16% Health Care Access
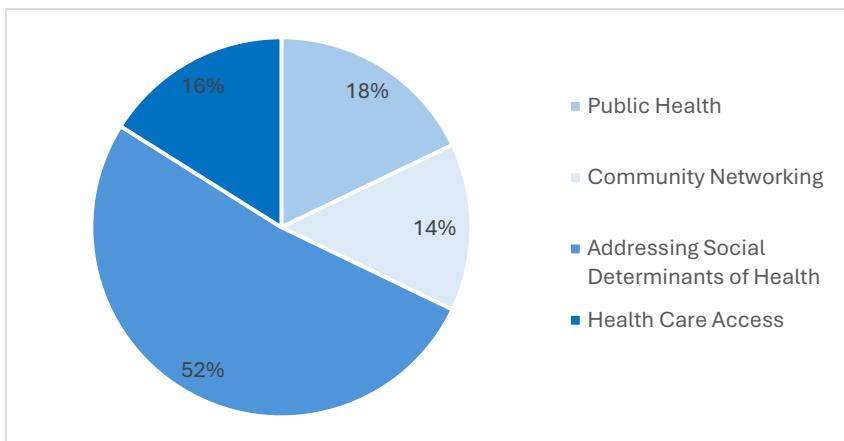
Ad-hoc and Special HCC's

In 2025, Alliance staff participated in ad-hoc and special inititiatives that supported community efforts and help advance Alliance strategic goals. Alliance staff provided presentations on Alliance benefits and on changes to Medi-Cal Eligibilty and redetermination changes (MOR Initiative) to collaboratives like the Merced Health Leadership Council and the Monterey County Office of Education Superintendents Roundtable. Further, staff attended local collaboratives on an ad-hoc basis to understand the member issues and to support partners. Finally, Alliance staff participated in special meeting initiatives, including the Local Aging and Disability Action plan for Merced County and Healthcare Reimagined in San Benito, which supported the respective counties' contribution to the Master Plan on Aging.

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2025 Community Atlas

Multi-County Collaboratives

County	Collaborative Name	Convener	Frequency	Type
All Counties	CCS Advisory Group	DHCS	Quarterly	Public Health
All Counties	LHPC Community Engagement Subgroup	LHPC	Bi-Monthly	Public Health
All Counties	WCM FAC Network Meeting	Lucile Packard Foundation for Children's Health	Quarterly	Community Networking
Monterey/San Benito	Monterey County & San Benito County ECM/CS stakeholder (CPI)	Camden	Monthly	Health Care Access
Monterey/San Benito/Santa Cruz	Uplift Central Coast Advisory Committee	Uplift Central Coast	Quarterly	Addressing Social Determinants of Health

Mariposa County

Collaborative Name	Convener	Frequency	Type
Food Insecurity in Mariposa	Mariposa HHSA	Quarterly	Addressing Social Determinants of Health
Gold Country Cal-AIM Collaborative	HC2 Strategies	Monthly	Public Health
Mariposa Abuse Prevention Collaborative (MAPC)	Mariposa Abuse Prevention Collaborative	Monthly	Addressing Social Determinants of Health
Mariposa Health and Wellness Coalition	Mariposa County HHSA	Monthly	Addressing Social Determinants of Health

Merced County

Collaborative Name	Convener	Frequency	Type
Adverse Childhood Experiences Informed Network of Care (ACEsINC)	Merced County Office of Education	Monthly	Addressing Social Determinants of Health
Behavioral Health Recovery Services Ongoing Planning Council	Merced County Department of Public Health	Monthly	Addressing Social Determinants of Health
Collaborative Planning & Implementation (CPI) Merced Collaborative	Camden Coalition	Monthly	Community Networking
Connected Care Network	Dignity Hospital and Unite Us	Quarterly	Public Health
Head Start Health and Mental Health Services Advisory Committee	Merced Head Start	Quarterly	Community Networking
HCC Coalition	Merced County Department of Public Health	Quarterly	Public Health
HFA/PAT Community Advisory Board	MCOE PAT	Quarterly	Addressing Social Determinants of Health
HLC Preventable Chronic Diseases Subgroup	Merced County Department of Public Health	Quarterly	Health Care Access
Merced ACCT (Tobacco Prevention Coalition)	Merced County Department of Public Health	Quarterly	Public Health
Maternal Wellness Coalition	California Health Collaborative	Monthly	Addressing Social Determinants of Health
Merced Breastfeeding Network	Merced Breastfeeding Network	Quarterly	Addressing Social Determinants of Health
Merced Community Public Information Officer Roundtable	Alliance	Quarterly	Community Networking
Merced County Community Advisory Board	Merced County District Attorney	Quarterly	Addressing Social Determinants of Health
Merced County LADAP	Merced County Area Agency on Aging	Monthly	Addressing Social Determinants of Health
Merced ILT	Merced Child Welfare	Monthly	Addressing Social Determinants of Health
Outreach Committee Meeting	Turning Point Community Programs	Monthly	Addressing Social Determinants of Health

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	Merced County Association of Governments	Bi-Monthly	Public Health
Regional Transportation Plan Roundtable			

Monterey County

Collaborative Name	Convener	Frequency	Type
Aging & Disability Resource Connection	County of Monterey AAA	Bi-Monthly	Addressing Social Determinants of Health
Blue Zones Project Worksite Committee Meeting	Blue Zones Project	Bi-Monthly	Community Networking
Community Alliance for Safety and Peace (CASP)	City of Salinas	Bi-Weekly	Addressing Social Determinants of Health
Medi-Cal Outreach Meeting	Community Foundation for Monterey County	Weekly	Health Care Access
Monterey County Collaborates	County of Monterey Health Department Tobacco Prevention Program	Quarterly	Addressing Social Determinants of Health
Monterey Maternal Mental Health Task Force		Monthly	Addressing Social Determinants of Health
SCORE- South County OutReach Efforts	SCORE Monterey County	Monthly	Addressing Social Determinants of Health
SUHSD Community Collaborative Convening	Salinas Union High School District	Quarterly	Community Network

San Benito County

Collaborative Name	Convener	Frequency	Type
Adult Long Term Care Committee (ALTCC)	Senior's Council (AAA San Benito)	Monthly	Addressing Social Determinants of Health
CHIP Anti-Stigma Campaign	San Benito County Behavioral Health	Monthly	Addressing Social Determinants of Health
Equity Diversity Inclusion Committee	San Benito County Behavioral Health	Bi-Monthly	Community Networking
Health Reimagined Workgroup	Seniors Council	Monthly	Addressing Social Determinants of Health
Oral Health Advisory Committee	San Benito County Public Health	Monthly	Addressing Social Determinants of Health
Safe Kids Coalition	San Benito County Public Health	Monthly	Addressing Social Determinants of Health
Wellness Coalition	County of San Benito Public Health	Monthly	Addressing Social Determinants of Health

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2025 Health Care Collaboratives Community Atlas

Santa Cruz County

Collaborative Name	Convener	Frequency	Type
Cradle to Career Community Health Leaders Collective	Cradle to Career	Quarterly	Public Health
Cal AIM Provider Learning Circles	Health Improvement Partnership of Santa Cruz County	Monthly	Health Care Access
Go for Health Collaboratives	Santa Cruz County Public Health	Bi-Monthly	Public Health
Health Improvement Partnership of Santa Cruz County (HIPSCC)	HIPSCC	Monthly	Health Care Access
Health Workforce Council	HIPSCC	Monthly	Addressing Social Determinants of Health
Monterey Bay CHW Collaborative	Cabrillo College	Monthly	Health Care Access
Oral Health Access Santa Cruz County	Santa Cruz County Public Health	Monthly	Health Care Access
Santa Cruz County PATH Collaborative	HIPSCC	Monthly	Health Care Access
ParkRX Santa Cruz County	County of Santa Cruz	Monthly	Addressing Social Determinants of Health
PVUSD Foster Youth and McKinney-Vento Taskforce	Pajaro Valley Unified School District	Monthly	Addressing Social Determinants of Health
Santa Cruz County Benefits Collaborative	County of Santa Cruz	Monthly	Health Care Access
Santa Cruz County Immigration Coalition	Santa Cruz County Immigration Coalition	Monthly	Addressing Social Determinants of Health
Santa Cruz Immunization Network	County of Santa Cruz	Monthly	Public Health
Ventures Semillitas Advisory Committee	Ventures	Semi-Annually	Addressing Social Determinants of Health
Youth Action Council	Santa Cruz Public Health	Monthly	Health Care Access

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DATE: January 28, 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 Workplan – Q3 2025

Recommendation. Staff recommend the Board accept the Q3 2025 Quality Improvement Health Equity Transformation (QIHET) Workplan report.

Summary. This report provides pertinent highlights, trends, and activities from the Q3 2025 QIHET Workplan. The workplan includes contractual required Performance Improvement Projects, operational performance metrics, health programs and cultural and linguistic services, and development of the population health management program. Refer to the QIHET Workplan attachment for additional details.

Background. The Alliance is contractually required by the Department of Healthcare Services (DHCS) to maintain a Quality Improvement Program (QIS) to monitor, evaluate, and take effective action on any needed improvements in the quality of care for Alliance members. The QIHET workplan is approved by the Quality Improvement Health Equity Committee, and ultimately, the Santa Cruz-Monterey-Merced - San Benito – Mariposa Managed Medical Care Commission (Board). The Board can direct and provide modifications to the quality improvement system on an on-going basis to ensure that actions and improvements meet the overall Alliance mission.

Discussion: Approve the Q3 2025 Quality Improvement Health Equity Transformation Workplan.

QUALITY OF CLINICAL CARE
Medi-Cal Managed Care Set (MCAS) Intervention:
Reporting purpose is to:

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.

Measurement Year (MY) 2023, Reporting Year (RY) 2024 MCAS rates for Merced County:
   • Child and Adolescent Well-Care Visits (WCV) - 50.49%
   • Childhood Immunizations - Combo 10 (CIS-10) - 19.71%
   • Immunizations for Adolescents - Combo 2 (IMA–2) - 32.02%
   • Lead Screening in Children (LSC) - 47.01%
   • Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6) - 48.69%
   • Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 61.10%

2. Improve Follow-Up After ED Visit for Mental Illness - 30 days (FUM) and Follow-Up After ED Visit for Substance Use - 30 days (FUA) measure rates by establishing monthly data file sharing from all five County Behavioral Health departments to the Alliance. These data files will capture

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services performed by the county departments for carved out services for regulatory DHCS MCAS reporting.

Goal is to exceed the MPL for MY24 or increase MY23 by 5%.
   • FUM MY 2023, RY 2024 rate was 34.55% Santa Cruz/Monterey, 20.42% for Merced County Re-porting.
   • FUA MY2023, RY 2024 rate was 39.37% for Santa Cruz/Monterey, and 39.97% for Merced.

Report Previously Identified Issues /Highlights:

For the first objective, 2024 implementation of Provider Partnerships and the Workforce Support for Care Gap Closure Grant led to greater access for members and improved performance on the majority of MCAS measures in Merced County. Targeting our DHCS sanctions for the measurement years of MY2022 and MY2023, the efforts of the program led to the improvement of all eight HEDIS measures.
Due to lack of continuous enrollment data for new counties, it was initially tough to identify measures of focus (grant activities) for San Benito and Mariposa County.
Q2 updates included the participation of 20 practices in the care gap grant, reaching 4/5 of our counties and providing nearly $5 million in funding. At three separate times, we outreached to eligible sites but due to the impact of funding cuts on practice resources there were practices that chose not to apply. As of the end of June, 5 practices were engaged in Provider Partnerships including: Castle, MFA, Apex Medical Group, Livingston, and Hazel Hawkins.

For the second objective, Q1 updates included completion of the first and second planned activity to analyze last year's ad hoc data, and outreach to all counties. Identified issues included concerns of following data protection guidelines for HIPAA privacy and 42 CFR part 2 Final Rule; completion of DHCS MOUs with all Mental Health Plans; technology and staffing capacity to abstract data and share through the requested templates; and difficulties with accommodating the data request by the end of Q1. Q2 updates included successful coordination of monthly data feeds from Merced, Santa Cruz, and Monterey County. Catch up data files covering dates of service January through June will be incorporated into the Care-Based Incentive (CBI) Q2 build. CCAH received a request form for direct access to San Benito Mental Health Plan (MHP) to create monthly BH data extracts on their behalf. Q3 updates included receipt of the Mariposa County catch-up file for January through June 2025, July 2025 to September 2025 files from Santa Cruz County, and July 2025 to August 2025 files from Merced and Monterey Counties. CCAH continued discussions on establishing SMEs for SQL access request form to gain direct access to San Benito Mental Health Plan systems for BH data extracts.

Report Changes / Updates: Although John C. Fremont and San Benito Health Foundation were engaged in Q1, they chose not to participate in Provider Partnerships.

Care Base Incentive
Reporting purpose is to: Increase CBI program resources and support to Mariposa and San Benito County participating providers. Goal is to increase county specific targeted December 2024 rates to exceed the Minimum Performance Level (MPL) or increase by 5% by December 2025.

Mariposa County CBI Measures of Focus as of December 2024:

- Child and Adolescent Well-Care Visits (37.76%)
- Controlling High Blood Pressure (20.56%)
- HbA1c Poor Control >9% (66.97%)
- Cervical Cancer Screening (25.16%)
- Chlamydia Screening in Women (48.91%)

San Benito County CBI Measures of Focus as of December 2024:
- Developmental Screening in the First Three Years of Life (21.51%)
- Controlling High Blood Pressure (11.07%)
- HbA1c Poor Control >9% (89.84%)
- Cervical Cancer Screening (43.78%)

Report Previously Identified Issues /Highlights:

For Q1, the CBI team has assigned slides, and prep work for the planned activities for the CBI into video.

For Q2, the CBI Intro video has been recorded and published to the Alliance website. The CBI team has started outreaching to Mariposa and San Benito County providers participating in CBI to see if they have interest in scheduling a CBI forensics visit or trainings on the provider portal or data submission tool with the CBI team. New barriers include some difficulty with engagement with certain providers in Mariposa and San Benito County.

For Q3, the Mariposa and San Benito County providers have been contacted by the CBI team. Seven out of the nine providers have been engaged with the CBI team scheduling meetings to gain a better understanding of the program and gain resources. For the providers who have not been engaged with the CBI team, reports of staff turnover or change in leadership have been reported.

Report Changes / Updates: No additional changes or updates to report.

Basic Population Health Management
Reporting purpose is to: Provide an update on Basic Population Health goals and activities.

Report Previously Identified Issues /Highlights: No previously identified issues or highlights.

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.
- Q3 progress: A total of 15 member workshops were completed in Q3. Virtual, telephonic and in-person workshops were completed.

Goal 2:
On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2025.

- Q3 progress: The project team included 1 article in the September 2025 Member Newsletter informing members of the Healthy Moms and Healthy Babies program available. A Q3 text campaign for members shared information on the Healthier Living Program workshops. A total of 116 members proactively signed up for programs in Q3 using the new online sign-up form.

Goal 3:
On a bi-annual basis, collect member feedback from participants in chronic disease management and wellness programs to evaluate impact.
- Q3 progress: Members are surveyed bi-annually. The next round of surveys will be completed in Q4.

Goal 4:
On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal and external partners. A minimum of 2 presentations will be conducted per quarter.
- Q3 progress: A total of 2 presentations on Health Education services and Member Health Rewards were coordinated and completed in Q3. This included internal audiences.

SAFETY OF CLINICAL CARE
Facility Site Review and Potential Quality Issues
Reporting purpose is to outline goals, activities, and target completion dates for the Safety of Clinical Care related to Facility Site Review and Potential Quality Issues.

Facility Site Review:
Report Previously Identified Issues /Highlights:

Identified Issues

1.   Staffing challenges continue to impact operational capacity, with reliance on one DHCS master-trained nurse creating a staffing risk and limiting scheduling flexibility, cross-county coordination, and CAP timeliness.
2.   Data inconsistencies between FSR and Provider Services hinder complete oversight of primary care providers both in and out of the service area. These gaps affect planning accuracy and coordination required for MOU oversight and monitoring of shared PCP sites.
3.   Ongoing workload demands and certification requirements for new FSR QI RNs have required continued prioritization of site review timeliness and CAP follow-up over process improvement activities.

Goal Results

1.   15 of 15 (100%) PCP sites with an FSR/MRR due were completed within the three-year compliance window (target: 80%).
2.   31 of 31 (100%) sites with Corrective Action Plans (CAPs) submitted responses within regulatory timeframes (target: 100%).

Report Changes / Updates:

The FSR program continues to meet all regulatory timeframes, maintaining 100% completion of required site reviews and CAP submissions. However, staffing challenges remain a key operational risk, as reliance on a single DHCS master-trained nurse limits scheduling flexibility, cross-county coordination, and the ability to absorb increases in review volume. Ongoing workload demands and certification requirements for new FSR QI RNs have required the team to prioritize timeliness of site reviews and CAP follow-up over broader process improvement initiatives. To strengthen capacity and sustain performance, the DHCS certification process for three additional FSR QI RNs is underway, with complete certification expected by Q4 2025 or Q1 2026.

Data inconsistencies between FSR and Provider Services continue to limit complete oversight of primary care providers both within and outside the service area. These gaps affect planning accuracy and coordination needed for MOU oversight with partnering MCPs where PCPs are shared across service areas. Ongoing efforts include continued use of Healthy Data Systems (HDS), active participation in the DHCS Medi-Cal Site Review Portal (MSRP) project, and development of a Tableau dashboard to align data across departments, improve planning, and strengthen collaboration with MCP partners.

Potential Quality Issues
Report Previously Identified Issues /Highlights:

Identified Issues:

1. Increasing PQI volume, primarily driven by the sharp rise in member grievance-related cases, continues to strain existing resources and affect the ability to complete cases within targeted timeframes.
2. Current staffing must balance PQI processing, CAP management, regulatory timeframes, and support for collaborative efforts and quality studies. The PQI Supervisor continues to assist with direct case processing and manages all Behavioral Health PQIs, ensuring compliance but limiting capacity for leadership, quality oversight, and quality study development.
3. Internal PQI referrals have not met timeliness goals, presenting a potential audit risk due to processing delays and the extended time needed to initiate and implement corrective actions.
4. The PQI Manager also oversees the LTSS program and LTC QAPI activities, further impacting available capacity for internal PQI investigations and proactive improvement efforts.
5. Anticipated workload growth with the inclusion of Behavioral Health and D-SNP populations in 2026 is expected to increase PQI volume and case complexity, underscoring the need for additional staffing capacity and refined workflows.

Goal Results:

1. 220/220 (100%) of member grievance-related PQIs were resolved within regulatory timeframes (target: 100%).
2. 32/45 (71%) of non-grievance-related PQIs were completed within 120 calendar days (target: 80%).

Report Changes / Updates:

The PQI program experienced substantial growth in case volume, increasing from 120 cases in Q3 2024 to 124 in Q1 2025, 211 in Q2, and 220 in Q3 2025. This represents an 83 percent year-over-year increase and a 70 percent increase since Q1. The sharp rise in grievance-related PQIs has significantly increased workload demands, stretching existing staffing resources as the team balances PQI processing, CAP management, regulatory timeframes, and collaborative quality initiatives.

To sustain performance, the PQI Supervisor continues to provide direct support in case processing and manages all Behavioral Health PQIs, ensuring regulatory compliance but limiting capacity for leadership activities, quality oversight, and quality study development. The PQI Manager also oversees the LTSS program and LTC QAPI initiatives, which further limit available capacity for program development, data analysis, and quality improvement planning.

While grievance-related PQIs have maintained full compliance, internal PQI referrals have not met the 80 percent timeliness goal, presenting a potential audit risk under regulatory standards. Delays in case processing and CAP initiation can affect the timeliness of compliance and oversight activities. To mitigate this, the team is actively triaging internal PQI referrals based on case severity, provider trends, and potential member safety impact to prioritize high-risk providers and accelerate corrective action planning.

To address ongoing capacity challenges, a QI RN backfill was approved for Q4 to help manage the increasing PQI workload, support the now-insourced Behavioral Health program, and prepare for the upcoming impacts of D-SNP implementation. Planning efforts extending into Q4 2025 and 2026 will focus on strengthening staffing resources, refining workflows, and enhancing training to ensure operational readiness, audit compliance, and effective oversight of Behavioral Health and D-SNP populations.

Appeals and Grievance Review
Reporting purpose is to: To provide an update and review of Appeals and Grievance performance, trends, and activities for the Appeals and Grievance Program during Q3 2025.

Report Previously Identified Issues /Highlights:
Identified Issues:
1. Increased AG volume continues to strain staff capacity and resources are limited across the organization.
2. Staffing deficiency continued during Q3 which impacted case timeframes.
3. Provider

Updates for AG Program

Goal 1:
Meet Regulatory Requirements 98% of the time for timely acknowledgements and resolutions. Enhanced operational monitoring occurred to support deadlines.

- Q3 Results: The AG team did not meet this requirement throughout this quarter. Missed deadlines occurred due to AG volume increases, staffing deficiency and incomplete or delayed provider information.
- Actions: New AG staff joined in September to support the increased volume. The AG Process Improvement project finalized a corrective action plan and PS escalation protocol with non-responsive providers to support timely and complete resolutions.

Goal 2:
Maintain the AG rate below 2 for QOC and QOS.
- Q3 Results: Achieved this goal. Noted grievance trends with provider availability (access), provider and plan customer service, while appeal trends with community support benefits, both medically tailored meals and housing support continue.

Goal 3:
Improve AG data quality and reporting.
- Q3 Results: Refined new report to help guide provider support and trends for substantiated issues.
- Developed new identifier and report structure for AG internal QA, non-responsive and delayed provider responses.

Goal 4:
Improve monitoring and documented oversight.
- Implemented reportable notations to improve real time transparency of AG oversight and reviews and provider non-responsive or delayed response issues.
- *Note – Identified risk with reporting indicators for non-responsive or delayed response from providers as this is a new process. PS leadership working with staff to resolve open AG activities to support monitoring and oversight activities.
- *Identified risk with delayed acknowledgments due to staffing constraints as staff maintain higher case inventory.
- Launched Grievance Resolution and Oversight Workgroup (GROW) to support monitoring and oversight activities within AG.

Report Changes / Updates: AG volume increased 4% during Quarter 3 from Quarter 2, which continued to have a significant impact on performance. This increase represents a 41% increase from the previous year during Quarter 3. To address this deficiency and prepare for D-SNP implementation, the Plan recruited 3 temporary staff and a new AG Supervisor. AG is training the new staff to support the increased inventory and expanded line of business (D-SNP). The AG Process Improvement Project will continue identifying emerging risks, developing mitigations, refining inter-departmental workflows, resources, and ongoing development.

MEMBER EXPERIENCE
Member Satisfaction Survey – CAHPS
Reporting purpose is to: Update the group on the progress of our CAHPS work and 2025 focus area.

Report Previously Identified Issues /Highlights:

Q1 updates- Previously reported in Q4 2024 and Q1 2025, there were issues getting organizational involvement and alignment on CAHPS interventions.
Q2 updates – there is greater organizational buy-in around CAHPS work with the development of Member Experience Committee (MEC) and the ongoing work with DSHP implementation and STARS, which includes a significant portion of CAHPS.
Q3 updates-Shortage in providers across the Alliance Network who speak members primary language or provide culturally competent care.

Report Changes / Updates:

Q1 updates- MY2023 (2024 results) were shared out amongst the system in Q1 at QIHEW and MCAS workgroup. To sustain organizational involvement and provide direction and support for on-going intervention work, a CAHPS workgroup was planned and executed by the end of Q1. Additionally, a focus area was chosen based on MY2023 results and additional system-wide efforts to impact Cultural and Linguistic Services as an element of our Health Equity Strategic Goal #2. Therefore, the composite of "How Well Doctor's Communicate" was chosen, focusing are efforts organizationally on member experience with communication.
Q2 Updates - Member Experience Committee (MEC) was formed and kicked off on 6/16. SMEs for CAHPS intervention work were identified and a proposal was developed for MEC on 8/11.
Q3 updates- August 11th MEC approved the following interventions:
1. Video Remote Interpreting (VRI)
2. Provider Messaging
3. Lunch & Learn Series

QUALITY OF SERVICE
Access and Availability
Reporting purpose is to: Comply with DMHC Timely Access Survey Requirements and review provider member ratios

Report Previously Identified Issues /Highlights: No previously identified issues to report.

Report Changes / Updates: Currently in progress for the PAAS survey for timely access, completed week 7, awaiting results.

Monitoring of provider ratios are in compliance, except for Internal Medicine. There was an issue w/ BH provider types w/in the report and a ticket to ITS was submitted, to be updated at the next quarterly meeting.

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:

- Service Level Performance: The service level goal was not met for Q3, achieving 35% due to increased call volume. Additionally, we experienced the loss of two temporary MSRs

during this period and a rise in staff callouts. The team is also continuing to adjust to the new phone system and the integration of BH services.

- Member Walk-Ins: Member walk-in volume continues to increase, particularly in our highly active offices in Salinas and Merced, requiring additional staff attention and resources.

- New Member Welcome Calls: We are making every effort to meet the assigned goal of 30%; however, this has become increasingly difficult as phone volume rises and member walk-ins remain a top priority.

Report Changes / Updates: Addition of FTE/ Call Center Supervisors successful, working on a workforce Management Tool and new phone system to increase efficiency.

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 previously identified issues to report.

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.

- Q3 progress – phone interpreting services: There was a total of 10,591 calls in Q3 by provider sites. This reflects an increase of 58% compared to Q3 2024.
- Q3 progress – Face-to-Face (F2F) interpreting services: There was a total of 1,973 requests in service counties for F2F. This reflects an increase of 13% compared to Q3 in 2024.
    - Santa Cruz County had 790 requests in Q3. This was a 20% increase compared to Q3 2024.
    - Merced County had 310 requests in Q3. This was a 48% decrease compared to Q3 2024.
    - Monterey County had 856 requests in Q3. This was a 73% increase compared to Q3 2024.
    - San Benito County had 17 requests in Q3. This was a 1600% increase compared to Q3 2024.
    - Mariposa County had 0 requests in Q3.

Goal 2:
Collect member feedback on their experience with language assistance services in a clinical setting.
- Q3 progress: Surveys are completed on a bi-annual basis. The project team will continue to conduct satisfaction surveys in Q4.

Goal 3:
On a quarterly basis, inform members and providers of language assistance services utilizing at least 1 member and 1 provider informing modality.

- Q3 progress:
    - Member Newsletter: The project team included 1 article in the September 2025 Member Newsletter informing members that they can select a PCP that speaks their language.
    - Provider Bulletin: The project team included 1 article in the September 2025 Provider Bulletin informing providers of interpreter services and tips for working with an interpreter.

Goal 4:
On a quarterly basis, provide at least 1 C&L services presentations to Alliance internal department staff that interact with members or providers to increase awareness of C&L services available for members.

- Q3 progress: A total of 2 presentations on C&L services were completed in Quarter 3

Delegation Oversight
Reporting purpose is to ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations, and Ensure oversight of all delegated activities by governing board.

No previously identified issues were noted.

Report Changes / Updates:

All delegate reports for the quarter were received and reviewed with no gaps identified. No issues with delegate reports. QIPH is working with Compliance to ensure all delegate reports meet NCQA requirements.

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

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

Attachments.
1. Q3 2025 Quality Improvement and Population Health Transformation Program Workplan.

SECTION 1: QUALITY PROGRAM STRUCTURE

ANNUAL EVALUATION (KRISTEN ROHLF)

Goals/Objectives for Calendar Year 2025	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 2024 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.	8/1/2025-8/30/2025 9/1/2025-12/31/2025 12/1/2025-12/31/2025	Kristen Rohlf, MPH, Quality and Population Health Manager	Update- The 2024 QI Annual evaluation is under review, set to complete by end of Q2 2025. The updates include new sections to capture the National Committee for Quality Assurance (NCQA) Health Equity (HE) Accreditation Section 5 requirements for Culturally and Linguistically Appropriate Services (CLAS) evaluation, and HE Section 6 Reducing Health Care Disparities report evaluation material. The first planned activities for the 2025 Annual QI Evaluation are set to begin in the middle of Q3.	1: No issues identified.	1. Once the 2024 annual QI evaluation is completed, assessment will begin for updated 2025 accreditation standard requirements, and any new contractual requirements from DHCS.	☐ Yes ☑ No	Planned activities are on track for completion.

PROGRAM DESCRIPTION (ANDREA SWAN)

Goals/Objectives for Calendar Year 2025	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 2025 Program Description for presentation to QI stakeholders. 2. Presentation of the Program Description to both the	1. Ensure all required sections of the workplan meet DHCS and NCQA requirements. 2. Submission of Program Description to QIHEW staff	1/31/2025-2/15/2025 3/1/2025-3/24/2025	Andrea Swan, Quality Improvement & Population Health Director Andrea Swan, Quality Improvement & Population Health Director	Update: 2025 Program Description is finalized and has been approved by QIHEC September 2025.	1: No previously identified issues	1 N/A	☑ Yes ☐ No	

QIHEW, and QIHEC for approval by 4/02/2025								
3. Develop a comprehensive 2025 Quality improvement Program Description that outlines all required DHCS and NCQA requirements.	3. Review all DHCS and NCQA requirements to ensure all sections included are relevant and share the template with business owners to begin writing.	9/30/2025-12/31/2025	Andrea Swan, Quality Improvement & Population Health Director					

ANNUAL WORKPLAN (SARINA KING)								
Goals/Objectives for Calendar Year 2025	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.	1/1/2025-2/24/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II	Qtr. 1: Q4 Workplan successfully completed and approved at Q1 QIHEW and QIHEC of 2025. Qtr. 2 Q1 updates were presented and approved at QIHEW and QIHEC. Pending Q2 updates for the August QIHEW & the September QIHEC. Qtr. 3: Q2 updates were reviewed and approved at QIHEW and QIHEC.	No previously identified issues	Continue to work with business owners on timely accurate submissions for each section.	☑ Yes ☐ No	
2. Ensure all workplan elements are properly documented and reflect appropriate follow-up by each business owner.	2. Regularly quarterly check-ins to review workplan entries with regular feedback provided to business owners when applicable.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II		No previously identified issues	Continue to work with business owners on timely accurate submissions for each section.	☑ Yes ☐ No	Cross-functional quality work across the organization is captured and tracked via the QIWP quarterly to ensure adherence to quality standards.
3. Review and approval of workplan quarterly by QIHEC.	3. Review of all workplan entries prior to each committee to ensure appropriate documentation.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Sarina King, Quality and Performance Improvement Manager Georgia Gordon, Quality Improvement Program Advisor II		No previously identified issues	Continuing the work with business owners on timely accurate submissions for each section.	☑ Yes ☐ No	

SECTION 2: QUALITY OF CLINICAL CARE

				MEDI-CAL MANAGED CARE SET (MCAS) INTERVENTION (KRISTEN ROHLF)				
Goals/Objectives for Calendar Year 2025	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. 2. Measurement Year (MY) 2023, Reporting Year (RY) 2024 MCAS rates for Merced County: 3. Child and Adolescent Well-Care Visits (WCV) - 50.49% 4. Childhood Immunizations - Combo 10 (CIS-10) - 19.71% 5. Immunizations for Adolescents - Combo 2 (IMA–2) - 32.02% 6. Lead Screening in Children (LSC) - 47.01% 7. Well-Child Visits in the First 15 Months—Six or More Well-Child Visits (W30-6) - 48.69% 8. Well-Child Visits for Age 15 Months to 30 Months—Two or More Well- Child Visits (W30-2) - 61.10% Note: Mariposa County will be reported for the first time in MY2024, RY 2025.	1. Analyze data - Q1 2. Identify providers and measures- Q2. 3. Provide workforce care gap closure grants to providers with large member populations in Merced and Mariposa Q3. 4. Continue Provider Partnership program in Merced and expand to Mariposa County to support providers in their interventions that focus on measures that are below MPL Q4.	2/1/2025-12/31/2025	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	Qtr. 3: The first grant funding round of 2025 saw 8 Merced practices and 1 San Benito practice apply and receive the Workforce Grant. Activities began in April and will run until December. Round two of 2025 saw 11 practices apply with activities beginning June and ending in December. A third round of grants was opened for Hazel Hawkins and John C. Fremont after practice inquiry, but no application was received. Overall, the care gap grant is reaching 4 out of our 5 counties and providing nearly $5 million in funding for providers to close care caps for 2025. Provider Partnerships work has continued with four Merced practices and was expanded to Hazel Hawkins. San Benito Health Foundation (San Benito County) and John C. Fremont Clinic (Mariposa County) were outreached but declined to participate due to resource limitations.	We continue to see declines to participate in the Care Gap Grant and Provider Partnerships due to competing priorities issues at the practice level such as budget cuts that are impacting their resources. Additionally, the topic of patient safety and high no-show rates are growing concern due to fears of immigrant enforcement.	Continue to track monthly data submissions from practices involved in the grant. Mid-year review of grant data. 2026 grant planning. Continue to build upon and foster new relationships within Provider Partnerships, taking referrals from the CBI team.	☑ Yes ☐ No	Pediatric care cap work in Merced County continues to be the focus of intervention work with additional focus expanding to care cap closures in our other 4 counties. Some providers are more engaged and motivated than others due to competing priorities and limited resources. The continued monetary support of practices through our care gap closure grants remains effective though with slightly less participation. We have seen providers struggle with intervention work specific to Childhood Immunization Status-10 due to

								the complexity of the measure, the need for 2 flu doses, and the rise in vaccine hesitancy. The Alliance quality team continues to work hard to get best practices out to providers and support them with appropriate resources, via coaching sessions, written resources, and cohort style learning via our Merced Quarterly Provider Meeting. We are seeing mixed results in CIS-10 rates across Merced Providers and will evaluate this data to further improve best practices.
1. Improve Follow-Up After ED Visit for Mental Illness - 30 days (FUM) and Follow-Up After ED Visit for Substance Use - 30 days (FUA) measure rates by establishing monthly data file sharing from all five County Behavioral Health departments to the Alliance. These data files will capture services performed by the county departments for carved out services for regulatory DHCS MCAS reporting. Goal is to exceed the MPL for MY24 or increase MY23 by 5%. 2. FUM MY 2023, RY 2024 rate was 34.55% Santa Cruz/Monterey, 20.42% for Merced County Reporting. 3. FUA MY2023, RY 2024 rate was 39.37% for Santa Cruz/Monterey, and 39.97% for Merced. Note: Mariposa and San Benito Counties will be reported for the first time in MY2024, RY 2025. Single plan health plan rates will be submitted to NCQA, and county specific rates submitted to DHCS.	1. Analyze last year's Merced, Monterey, and Santa Cruz County Behavioral Health Department MCAS ad hoc data files for process improvements in Q1. 2. Contact Merced, Monterey, Mariposa, Santa Cruz, and San Benito County Behavioral Health Departments for new monthly data sharing request during Q1-Q3. 3. Provide technological support and QA of received files for file layout compliance during Q1-Q4. 4. Creation of a new Alliance database to store county data in Q2-Q4. 5. Integration of new files for HEDIS vendor software extraction in Q2-Q4.	1/1/25 -3/31/25, 1/1/25-9/30/25, 1/1/25-12/31/25, 3/1/25-12/31/25, 3/1/25-12/31/25	Magdalena Kowalska, Quality Improvement Program Advisor IV Shae Redwine, Behavioral Health Program Analyst	Qtr. 3 continued to receive data from Merced County in accordance with monthly agreement to send data on or before the 15th of the month via sftp. Data feeds were established to be distributed via sftp on the 15th of each month for previous month's data for Monterey County. Continued internal discussions on establishing Alliance data-exchange SMEs for SQL access request form to gain direct access to San Benito BH systems. Addressed sftp issue with Mariposa County that delayed first file transmission. Received catch up files for January 2025 through June 2025 from Mariposa County. Addressed file layout concerns with Monterey, Santa Cruz, and Mariposa Counties. Received July 2025 to September 2025 file from Santa Cruz County. Received July 2025 to August 2025 file from Merced and Monterey Counties.	Concerns that data sharing follows all applicable data protection guidelines for HIPAA privacy and 42 CFR part 2 Final Rule. DHCS MOUs are still in process with the Santa Cruz Mental Health Plan. Technology and staffing capacity to abstract data and share through the requested templates. Mariposa and San Benito could not accommodate the data request by the end of Q1. Mariposa additionally expressed concerns about not having member level detailed information readily available.	Automation of monthly file feeds from Santa Cruz and Monterey starting in August of 2025. Continue internal discussions and push forward establishing Alliance SQL-writing SMEs for accessing San Benito BH systems via SQL query. Complete and return SQL Access Request Form Q4.	☐ Yes ☒ No	We have received county data for 4 out of 5 counties with data access to San Benito systems pending.

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

Goals/Objectives for Calendar Year 2025	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 CBI program resources and support to Mariposa and San Benito County participating providers. Goal is to increase county specific targeted December 2024 rates to exceed the MPL or increase by 5% by December 2025. Mariposa County CBI Measures of Focus as of December 2024: 2. Child and Adolescent Well-Care Visits (37.76%) 3. Controlling High Blood Pressure (20.56%) 4. HbA1c Poor Control >9% (66.97%) 5. Cervical Cancer Screening (25.16%) 6. Chlamydia Screening in Women (48.91%) San Benito County CBI Measures of Focus as of December 2024: 7. Developmental Screening in the First Three Years of Life (21.51%) 8. Controlling High Blood Pressure (11.07%)	1. Analyze CBI Forensics (CBIF) meeting requests from 2024 from Mariposa and San Benito in Q1-Q2 2. Analyze Alliance Provider Portal Data Submission Tool (DST) usage and training requests from 2024 from Mariposa and San Benito in Q1-Q2 3. Analyze CBI Q4 2024 final programmatic rates from Mariposa and San Benito CBI group providers in Q1-Q2 4. Outreach to providers in Mariposa and San Benito to schedule CBIF and additional provider portal report and DST submission training based on Q4 2024 performance, DST submission usage, and past forensics requests in Q2-Q3. 5. Create, record, and publish the CBI Intro Video to the Alliance website for the CBI 2025 program year. Add information on new portal reports like HEDIS (MCAS) Reports to training material. Complete in Q1-Q3	1/1/25-6/30/25, 1/1/25-6/30/25, 1/1/25-3/30/25, 3/1/25-8/30/25, 1/1/25-8/30/25	Cassie Russo, Quality Improvement & Health Equity Supervisor Shannon Fletcher, Quality Improvement Program Advisor II Alex Sanchez, MPH, Quality Improvement Program Advisor III Annecy Majoros, Quality Improvement Program Advisor III Britta Vigurs, Quality Improvement Program Advisor III Daryl Ford, Quality Improvement Program Advisor III Jada Edwards, Quality Improvement Program Advisor II Jo Pirie, Quality Improvement Program Advisor III Pa Moua, Quality Improvement Program Advisor II Villyginn Morris, Quality Improvement Program Advisor II	Qtr. 3. All providers in San Benito & Mariposa County were outreached. 7/9 providers have been engaged with our CBI team and scheduling meetings to learn more about the program. The team will continue to attempt to work with the remaining providers who have not been interactive.	There has been some difficulty with engagement with certain providers in Mariposa and San Benito County.	Complete follow-up visits with Mariposa and San Benito County providers participating in CBI.	☐ Yes ☒ No	The first, second, third, and fifth activities have been met, but the fourth is still in progress and on track for completion due by end of Q3. The fourth activity has been completed. However, the team will continue outreaching to the providers who have not been engaging with the team.

9. HbA1c Poor Control >9% (89.84%)								
10. Cervical Cancer Screening (43.78%)								

BASIC POPULATION HEALTH MANAGEMENT (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Party	Quarterly Update — Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Provide members with chronic disease management programs 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.	1/1/2025 -3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 3 A total of **15 member workshops** were completed in Q3. The following workshop modalities and languages were provided: • 1 in-person HLP workshop in Spanish (San Benito Health Foundation) • 8 telephonic workshops (HLP in Spanish and English, LBD in English and Spanish) 6 virtual workshops (LBD in Spanish, HWL in English and Spanish, LBD in Spanish, LBD in Spanish)	No issues to report in Q3.	The project team will continue to schedule member workshops in Q4.	☑ Yes ☐ No	Member workshops in Q3 have increased due to high numbers of member sign-ups utilizing text campaigns and a new online sign-up form for members.

2. On a quarterly basis, inform members of Health and Wellness programs and self-management tools available to them in 2024.	1. The project team will conduct outreach and education activities to inform members of services available to them via: • Member outreach calls • Member newsletter articles • MSAG presentation • Social media and/or texting campaigns	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Veronica Lozano, Quality and Health Programs Supervisor Health Educator team Desirre Herrera, Quality and Health Programs Manager	Qtr. 3 The following activities were completed in Q3 to inform members of Health and Wellness programs: • **Member Newsletter:** The project team included 1 article in the September 2025 Member Newsletter informing members of the Healthy Moms and Healthy Babies program. • **Member text campaign:** A text message was sent out to members on 8/28/25 to inform them of HLP workshops and linked to the health education programs website page. • **Member self-referrals:** The Health Educators received **116-member self-referrals** using the online sign-up form in Q3. • **PCP referrals:** The Health Educators received **96 PCP referrals** to health education services in Q3.	No issues to report in Q3.	The project team will continue to conduct member informing activities in 2025.	☑ Yes ☐ No	The text message campaigns continue to exceed expectations in member response. This method of informing members will continue to be used in Q4.
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 • The 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 of health education activities.	1/1/2025-3/31/2025 7/1/2025-9/30/2025	Kevin Lopez, C&L Program Advisor Veronica Lozano, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 3 Surveys are scheduled bi-annually. The team will report out survey results in Q4 report.	No issues to report in Q3.	The project team will continue to proactively reach out to members via outreach calls to request member feedback via satisfaction surveys.	☐ Yes ☑ No	The project team will schedule surveys to be completed in Q4.

4. On a quarterly basis, provide Health Education services and Member Health Rewards program presentations to Alliance internal and external partners. A minimum of 2 presentations will be conducted per quarter.	1. The project team will reach out to internal and external partners to schedule presentations. 2. Deliver Health Education and Member Health Rewards services presentations. 3. Request input regarding presentation content and any member needs that they have encountered regarding Health Education services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Kevin Lopez, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 3 A total of **2 presentations** on Health Education services and Member Health Rewards were coordinated and completed in Quarter 3. Presentations were delivered to the following audiences: • Alliance Quality Improvement and Population Health Orientation • Quality and Health Programs new hire	No issues to report in Q3.	The project team will continue to schedule internal and external presentations in Q4.	☑ Yes ☐ No	This goal has been successful in increasing awareness among member facing teams and ensuring Alliance staff are informed of the services available for members.

SECTION 3: SAFETY OF CLINICAL CARE

FACILITY SITE REVIEW (DEANNA LEAMON)								
Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation

| 1. 80% of existing primary care provider sites with an FSR/MRR due this quarter are completed within three years of their last FSR date. | 1. Enhance provider scheduling support by onboarding three additional QI RNs dedicated to conducting facility site reviews.

2. Implement proactive planning by reviewing all upcoming site reviews one quarter in advance.

3. Streamline scheduling by offering provider sites a selection of review dates two months before the review due date.

4. Maintain continuous communication with provider sites until a review date is confirmed. | 07/01/2025-09/30/2025 | Joana Castaneda, Quality Improvement Program Advisor; Tisha Criswell, Senior Quality Improvement Nurse, Yvette Sullivan, Quality Improvement Nurse, and Breena Siliznoff, Quality Improvement Nurse | Qtr. 3: Achieved goal with 15 out of 15 reviews completed (100%).

While the DHCS certification process for the three new FSR QI RNs remains in progress, cross-training and coverage by the DHCS master-trained nurse allowed all required site reviews to be completed on time. Certification of new staff will further sustain capacity and mitigate reliance on one certified reviewer, with completion anticipated by Q4 2025 or Q1 2026.

Proactive quarterly review planning has been fully implemented and is now standard practice. This approach improved workload forecasting and allowed the team to address scheduling conflicts or provider availability issues before deadlines.

Consistent communication and early scheduling options improved provider engagement and reduced delays. Offering date flexibility minimized cancellations and reschedules, supporting 100 percent completion.

Ongoing coordination and reminder follow-ups ensured every site had a confirmed review date in advance, maintaining compliance and provider readiness for reviews. | Staffing challenges continue to impact operational capacity, with reliance on one DHCS master-trained nurse creating a staffing risk and limiting scheduling flexibility, cross-county coordination, and CAP timeliness.

Data inconsistencies between FSR and Provider Services hinder complete oversight of primary care providers both in and out of the service area. These gaps affect planning accuracy and coordination required for MOU oversight and monitoring of shared PCP sites.

Ongoing workload demands and upcoming certification requirements for new FSR QI RNs have required continued prioritization of site review timeliness and CAP follow-up over process improvement activities. | Continue supporting the DHCS certification process for three additional FSR QI RNs, with complete certification expected by Q4 2025 or Q1 2026. This expansion will sustain performance, reduce workload concentration, and enhance cross-county scheduling flexibility.

Address internal data inconsistencies between FSR and Provider Services to ensure complete oversight of PCPs both in and out of the service area. Efforts include active participation in the DHCS Medi-Cal Site Review Portal (MSRP) project and implementation of a Tableau dashboard to align reporting and support MOU oversight with partnering MCPs for shared PCPs.

Continue quarterly monitoring to validate compliance and identify opportunities for efficiency. Once additional staff are certified, the team will resume process improvement activities, including trend analysis of CAP findings and provider education to prevent repeat deficiencies. | ☑ Yes ☐ No | While the FSR program continues to meet all regulatory timeframes, achieving 100 percent completion of required site reviews and CAP submissions, staffing challenges remain a key operational risk. Reliance on a single DHCS master-trained nurse limits scheduling flexibility, cross-county coordination, and the ability to absorb increases in review volume. Ongoing workload demands and certification requirements for new FSR QI RNs have required the team to prioritize timeliness of site reviews and CAP follow-up over broader process improvement initiatives. To strengthen capacity and sustain performance, the DHCS certification process for three additional FSR QI RNs is underway, with complete certification expected by Q4 2025 or Q1 2026 to support continued compliance with both goals.

Data inconsistencies between FSR and Provider Services continue to limit complete oversight of primary care providers, both within and outside the service area. These gaps affect planning accuracy and coordination needed for MOU oversight with partnering MCPs where PCPs are shared across service areas. Ongoing efforts include continued use of Healthy Data Systems (HDS), active |

							participation in the DHCS Medi-Cal Site Review Portal (MSRP) project, and development of a Tableau dashboard to align data across departments, improve planning, and strengthen collaboration with MCP partners.

Goals/Objectives	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
2. 100% of practices with Corrective Action Plans (CAPs) arising from FSR/MRR submit a plan to address the CAP within regulatory timeframes.	1. Enhance CAP management support by onboarding three additional QI RNs for facility site reviews. 2. Send email reminders to provider sites regarding upcoming CAP due dates. 3. Directly contact non-responsive providers via phone, involving PRRs as necessary.	07/01/2025-09/30/2025	Joana Castaneda, Quality Improvement Program Advisor; Tisha Criswell, Senior Quality Improvement Nurse, Yvette Sullivan, Quality Improvement Nurse, and Breena Siliznoff, Quality Improvement Nurse	Qtr. 2: Achieved goal with 100 percent CAP compliance. All 31 of 31 practices requiring a plan to address their CAP were submitted within regulatory timeframes. While the DHCS certification process for the three new FSR QI RNs remains in progress, workload redistribution and support from the DHCS master-trained nurse ensured consistent monitoring and timely CAP follow-up. Email reminders were implemented for provider sites with upcoming CAP due dates, improving responsiveness and reducing the need for escalation. Direct outreach to non-responsive providers by phone, with involvement from Provider Relations Representatives (PRRs), ensured all CAPs were received on time. Coordination between the FSR team and Provider Services supported tracking and validation of CAP timeliness in Healthy Data Systems (HDS), helping sustain 100 percent compliance each quarter.	Reliance on one DHCS master-trained nurse for CAP monitoring presents an operational risk as review volume increases. CAP tracking between FSR and Provider Services occasionally requires manual reconciliation to confirm closure and timeliness. While compliance remains at 100 percent, workload intensity limits time available for process improvement and CAP trend analysis.	Continue the DHCS certification process for three additional FSR QI RNs to distribute workload and maintain compliance as review volume grows. Certification is anticipated by Q4 2025 or Q1 2026. Strengthen CAP tracking integration within Healthy Data Systems (HDS) to automate due-date alerts and improve data consistency between FSR and Provider Services. Once additional staff are certified, conduct quarterly CAP trend reviews to identify recurring deficiencies, develop provider education, and implement targeted interventions to prevent repeat findings.	☑ Yes ☐ No	See above

POTENTIAL QUALITY ISSUES (DEANNA LEAMON)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation

| 1. 100% of member grievances received by QI concerning potential medical quality of care issues are resolved within the regulatory timeframes for Member Grievances. | 1. Establish due dates in SharePoint for PQIs that allow sufficient time for investigation, translation needs (if applicable), and for the Grievance Coordinator to resolve the case. 2. Promptly request medical records necessary for the PQI investigation upon case assignment to the QI RN. 3. Ensure timely coordination of discussions if the case requires MD guidance or potential P2/P3 recommendations. | 07/01/2025-09/30/2025 | Emily Kaufman, Clinical Safety Supervisor; Eleni Pappazisis, Quality Improvement Program Advisor; Naomi Kawabata, Senior Quality Improvement Nurse; Katie Lutz, Senior Quality Improvement Nurse; Sandy Clay, Senior Quality Improvement Nurse; Karen de Leon, Quality Improvement Nurse and Bethany Fung, Quality Improvement Nurse | Qtr. 3: The PQI team maintained 100% compliance with the 30-day regulatory timeframe, closing all 220-member grievance-related PQIs on time. This was achieved through proactive SharePoint tracking, timely medical record requests immediately upon case assignment, and consistent monitoring of due dates to ensure all cases met regulatory requirements.

The PQI team actively coordinated MD case discussions and P2/P3 determinations to ensure timely clinical input for accurate case resolution. This collaboration helped prevent delays, supported accurate severity scoring, and sustained full compliance despite a 70% increase in volume since Q1.

Enhanced coordination between QI and Grievance and Appeals staff, along with process improvements in SharePoint tracking, reduced administrative delays, and improved workflow efficiency.

The PQI Supervisor continued providing direct case-processing support to sustain timeliness and compliance while balancing the growing volume of grievance-related PQIs and supporting the Behavioral Health integration process. | The volume of grievance-related PQIs increased by 83% year-to-year, from Q3 2024 to Q3 2025, creating workload strain and reducing capacity for proactive quality studies and trend analysis.

Continued reliance on the Supervisor for case processing reduces available time for leadership activities, program oversight, and quality study development. | Implement the approved QI RN backfill in Q4 to help manage the increasing PQI workload and proactively prepare for Behavioral Health and D-SNP oversight activities.

Once onboarding is complete, estimated at three months, the additional staffing capacity will relieve the Supervisor from direct case-processing duties and allow renewed focus on leadership functions, quality oversight, and quality study investigations. This transition is anticipated in 2026. | ☑ Yes ☐ No | In Q3 2025, the QI team closed 220 member grievance-related PQIs, representing a 70 percent increase from Q1 and an 83 percent increase compared to Q3 2024, when 120 cases were closed. Case volume has grown steadily throughout the year, with 124 cases in Q1, 211 in Q2, and 220 in Q3. Despite this sharp rise in workload, the team maintained 100 percent compliance with the 30-day resolution timeframe.
To sustain this level of performance, the PQI Supervisor continued to provide direct support in case processing, ensuring regulatory and internal metrics were met but limiting capacity for broader leadership duties and quality improvement initiatives. This focus on regulatory PQIs and grievance resolution has temporarily delayed progress on quality study referrals and other proactive improvement activities.
For non-grievance-related PQIs, the goal is to complete 80 percent of cases within 120 calendar days. The Q3 2025 result fell short of the target at 71 percent, with 32 of 45 cases closed on time. While case volume for internal referrals has remained stable, these cases tend to be more complex—often involving P2 and P3 severity levels—and require extended coordination and follow-up. This performance gap highlights the need for additional staffing to maintain compliance |

							while advancing quality improvement activities.
							Delays in processing and implementing corrective action plans pose an audit risk, as they can affect timeliness standards and documentation expectations during regulatory review. The PQI Supervisor continues to assist with direct case processing, while the PQI Manager is overseeing the LTSS program and LTC QAPI activities, further limiting available capacity for internal PQI investigations and study development.
							To address these challenges, a QI RN backfill was approved for Q4 to help manage the increasing PQI workload and proactively plan for Behavioral Health and D-SNP oversight activities. Once onboarding is complete, estimated at three months, the additional staffing capacity is expected to relieve the Supervisor from direct case-processing duties and restore focus on leadership functions, quality oversight, and quality study investigations. This transition is anticipated in 2026.

Goals/Objectives	Planned Activities	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
2. 80% of non-grievance related PQIs are completed within 120 calendar days.	1. Triage and prioritize incoming internal referrals for the following case types: 2. Known providers for tracking and trending. 3. Providers on a CAP or involved in an open Quality Study. 4. LTSS members.	04/01/2025-06/30/2025	Emily Kaufman, Clinical Safety Supervisor; Eleni Pappazisis, Quality Improvement Program Advisor; Naomi Kawabata, Senior Quality Improvement Nurse; Katie Lutz, Senior Quality Improvement Nurse; Sandy Clay, Senior Quality Improvement Nurse; Karen de Leon, Quality Improvement Nurse and Bethany Fung, Quality Improvement Nurse	Qtr. 3: The PQI team achieved a 71% completion rate for non-grievance-related PQIs within the 120-day timeframe, with 32 of 45 cases closed on time. While below the 80% goal, this performance reflects the complexity of internal referrals, which often involve higher-severity (P2/P3) cases requiring additional clinical coordination and follow-up. The PQI team implemented triage procedures for incoming internal referrals, prioritizing known providers under CAP, those involved in open quality studies, and LTSS-related cases. This approach ensures timely attention to high-risk and repeat-trend providers, reducing potential audit exposure and strengthening provider oversight. Medical record requests and provider outreach continue to occur promptly upon case assignment, though case complexity and competing program demands have extended review timelines and delayed CAP completion. The PQI Supervisor continues to assist with direct case processing to maintain compliance amid staffing limitations, while the PQI Manager is managing the LTSS program and LTC QAPI oversight. This combined workload further impacts capacity for internal PQI processing and program development. Delays in processing and implementing CAPs present a potential audit risk due to timeliness expectations under regulatory review.	The complexity of internal referrals, particularly those assigned P2 or P3 severity levels, continues to extend investigation timelines and delay CAP completion, increasing audit risk for timeliness compliance. Current staffing resources are stretched due to the high volume of member grievance-related PQIs. The PQI Supervisor's ongoing case-processing support and the Manager's oversight of LTSS and LTC QAPI programs further limit capacity for internal PQI investigations and quality study development.	Maintain triage of internal PQIs to prioritize trending providers, high-risk cases, and those requiring CAP follow-up to reduce audit risk and improve timeliness. Implement workload redistribution once the QI RN backfill is fully onboarded to increase capacity for internal PQI processing and ensure timely closure of complex cases. Continue quarterly monitoring of timeliness and CAP completion performance to identify opportunities for improvement and ensure audit readiness and regulatory compliance.	☐ Yes ☑ No	See above.

APPEALS & GRIEVANCE REVIEW (SARAH SANDERS)

Goals/Objectives for Calendar Year 2025	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 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.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-Aug 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 3. Did not achieve goal consistently through the quarter due to severe staffing constraints in relation to the increased volume. Met regulatory timeframes with grievance correspondence 96% of the time during 25Q3.	Staffing concerns emerged in Q1, Q2 staffing request and Q3 recruitment efforts. Non-responsive or delayed responses from providers impact timely and complete resolution.	Training new staff to support the AG work. Continue exploring efficiencies through process improvement project. Track to identify patterns of provider delays or non-responsiveness with AG	☐ Yes ☑ No	

				Correspondence reports went live in Q225 to better monitor real-time activities.		concerns. Work with PS to update overdue activities to correctly identify non-responsive providers and develop QOS trending approach with Provider Services.		
2. Monitor and maintain Grievance rates below 2 per 1,000 members per month for Quality-of-Care concerns; below 2 per 1,000 members per month for Quality-of-Service concerns (NCQA standard).	1. Track and trend appeal & grievance data by both NCQA primary categories & DHCS categories for quality of care (QOC), quality of service (QOS) and access issues. 2. Track grievance and appeals for emerging quality of care and service trends. Inclusive of access trends, system issues, and actionable corrections needed.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 3: Achieved goal by restructuring reports into NCQA category structure and maintaining a rate below 2 in these areas. Trends continue around Community Support and ECM providers.	Continue requesting business owners to bring actions to SGRC (Staff Grievance Review Committee) around trends and corrections occurring.	Continue tracking and trending issues. Encourage business owners to propose corrections for actionable trends.	☑ Yes ☐ No	
3. Improve Appeal and Grievance (AG) data quality and reporting.	1. Identify reporting needs, gaps and areas for improvement. 2. Develop report for substantiated grievances to support identification of systemic issues and opportunities for improvement.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 3: Continued AG Process Improvement Project activities. Developing updated reports to track non-responsive or delayed provider responses. Working with Operational reporting team for new report prototype of AG data.	Continued need for interdepartmental engagement to refine AG process, initiate efficiencies, improve quality, and complete resolutions. Provider Services to monitor network performance, respond and share actions when needed.	Continue improving quality with data and reporting by providing timely feedback.	☑ Yes ☐ No	
4. Improve monitoring and documented oversight.	1. Initiate reportable notes within appeals and grievance (AG) system to improve transparency with oversight. 2. Develop report to quality oversight activities.	24Q4- March 31, 2025 25Q1-May 30, 2025 25Q2-August 29, 2025 25Q3-Oct 31, 2025	Sarah Sanders, Grievance and Quality Manager Lee Xiong, Grievance Supervisor	Qtr. 3: Finalized report layouts for reportable notes. Launched the new interdisciplinary workgroup (GROW) for complex grievance resolutions, monitoring and oversight.	No previously identified issues.	Continue implementing monitoring and oversight activities.	☑ Yes ☐ No	

SECTION 4: MEMBER EXPERIENCE

MEMBER SATISFACTION SURVEY – CAHPS (SARINA KING)								
Goals/Objectives for Calendar Year 2025	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 CAHPS rates for "How Well Doctors Communicate" for members 0-18 years from 91.5% to 94.4%.	1. Elicit feedback from relevant teams to develop interventions. 2. Implement interventions. 3. Study and adjust interventions.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025,	Jada Edwards, Quality Improvement Program Advisor Sarina King, Quality and Performance Improvement Manager Alex Sanchez, Quality Improvement Program Advisor Additional intervention collaboration from QIPH staff, provider relations	Qtr. 3: After the planning and execution of a system wide CAHPS workgroup with the aim of providing direction, and support for on-going strategies/interventions to target member satisfaction rates – it was decided to merge efforts and develop a "Member Experience Committee" with leadership coming from Member Services Director, Lilia Chagolla. The committee kicked off on June 16, 2025, during which the charter was approved, and SMEs were identified for CAHPS intervention planning. A workgroup took place on July 11, 2025, identifying various elements of health programs, QPI, provider services, and grants to be proposed as intervention work. August 11th MEC committee approved the following interventions: • Video Remote Interpreting (VRI) • Provider Messaging • Lunch & Learn Series	Will need to ensure there is proper awareness and organizational buy-in across the organization. Shortage in providers across the Alliance network who speak members primary language.	Continued intervention work. Planning of Lunch & Learn Series and collecting VRI and provider messaging data.	☑ Yes ☐ No	Activities for 2025 CAHPS goal off to effective start. One thing to note is the built-in lag time CAHPS surveys have. Any intervention work for 2025/2026 won't be seen in our survey results until 2026/2027 survey years.

SECTION 4: QUALITY OF SERVICE

ACCESS & AVAILABILITY (AA) (JESSIE DYBDAHL)								
Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation
1. Comply with DMHC Timely Access Survey Requirements	1. Ensure 90% of After-hours triage compliance in Timely Access Survey. (Provider Appointment Availability Survey [PAAS]). 2. Ensure 75% Urgent and routine appointment access compliance, as well as next available follow up appointment for non-physician mental health care, within required time frames. 3. PAAS work begins in the summer with vendor engagement and finalization of the project plan and contact lists. The survey is launched from August to November/December. Results are available in Q1 of the subsequent year.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Jessie Dybdahl, Provider Service Director	Q3: Currently in progress. The PAAS survey for Timely access. Completed week 7, awaiting results	No previously identified issues.	Vendor to complete the PAAS survey outreach.	☑ Yes ☐ No	On track for the MY2025 PAAS commencement.
2. Quarterly review of provider to member ratios for PCPs and High-volume/high-impact Specialties. To ensure all ratios meet regulatory requirements.	1. Ensure provider to member ratios are w/in compliance and mitigate if out of compliance on a quarterly basis. 2. The Tableau report is monitored no less than quarterly to ensure provider to member ratios are met for each required provider type.	3/30/2025 6/30/2025 9/30/2025 12/31/2025	Jessie Dybdahl, Provider Service Director	Q3: Review ratios and any outcomes. Based on the policy, standards are within compliance for provider to member ratios for all provider types, minus one. - Medi-Cal- Internal Medicine Those that we are not within compliance with, we will continue to monitor quarterly.	Not meeting ratios for the following provider types: Internal Medicine for Medi-Cal.	- Inform Grants of specialties where we aren't in compliance. - Inform Network Develop Team of necessary new specialties for recruitment. - Continue monitoring quarterly for compliance.	☐ Yes ☑ No	Current metrics are in line with requirements, except Allergy & Immunology and Internal Medicine.

GEO ACCESS (TIMELY ACCESS) (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	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 Time or Distance Standards set forth by DHCS	1. Ensure the network meets time or distance standards in compliance with DHCS requirements when a provider is available. 2. Monitor areas where no provider is available and ensure alternative access requests are in place on a quarterly basis. 3. Evaluate the non-contracted provider network to determine if recruitment might remedy access gaps. Launch recruitment efforts as applicable.	6/30/2025 12/31/2025	Jessie Dybdahl, Provider Service Director	Qtr. 2 The Alliance has submitted the Annual Network Certification (ANC) Filling to DHCS in Q1 2025, which includes the GEO Access Reports. DHCS is reviewing and will provide outcomes once available. Qtr. 4:	No previously identified issues.	Continue to monitor any gaps as they arise w/in the network and recruit as is feasible.	☑ Yes ☐ No ☐ Yes ☐ No	Completed submission of the reports. Awaiting DHCS.

PROVIDER SATISFACTION SURVEY (JESSIE DYBDAHL)

Goals/Objectives for Calendar Year 2025	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. Provider Satisfaction Survey	1. Monitor Provider Satisfaction annually. Ensure no less than 5% decrease in overall satisfaction with the plan from prior year. 2. The Provider Satisfaction Survey (PSS) is launched in the summer with vendor engagement in spring. Contact lists are sent for primary care, specialty care, and non-physician mental health care. The survey is launched from July to August. Results are available in quarter 4.	7/1/2025 - 12/31/2025	Jessie Dybdahl, Provider Service Director	1st update:			☐ Yes ☐ No	

TELEPHONE ACCESS (VERONICA OLIVARRIA)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update — Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation

1. 80% of calls to Member Services answered within 30 seconds.	1. The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard. Improvement efforts slated for 2024:
	• The adoption of a Workforce Management Tool to assist with call forecasting and representative scheduling, ensuring we have appropriate levels of staff supporting the queues at any given time/day.
	• Call Audit Optimization: We are developing formal call audit guidelines and defined audit methodology to ensure staff are adhering to Alliance updates and processes.
	• Developing additional call circles (queues) to:
	  1. Optimize resource availability.
	  2. Improve the speed of answering.
	  3. Reduce representative training time.
	  4. Increase member satisfaction.
	• Computer Telephone Enhance HSP/Finesse by adding a screen pop up of member's demographics when a member calls into the call center. This will reduce time on the phone for the MSR and will make each call more efficient. Integration: Assess staffing needs due to increase in membership
		3/31/2025
		6/30/2025
		9/30/2025
		12/31/2025
			Lilia Chagolla, Member Services Director
			
			Veronica Olivarria, Call Center Manager
				Qtr. 3: - Call Center Supervisors review Queue data throughout the day to determine if changes need to made immediately.	We were unable to meet the 80% SLA goal, achieving 35% in this period. The shortfall was primarily due to unusually high call volumes and lower staffing levels. Additionally, the transition to a new phone system and integration with BH services contributed to temporary disruptions in call handling and response times.	We have recruited and onboarded additional staff to help manage call volume, assist with member walk-ins, and support new member orientation.	☐ Yes ☑ No	Call Center Supervisors have incorporated the WM tool and are focused on real-time coaching, ensuring resources are available, and keeping HSP updates current so staff can focus on meeting the needs of callers. These efforts are expected to improve overall performance and enhance the member experience in the coming months.

2. The call abandonment rate will not exceed 5% of calls to Member Services answered before being abandoned.	The Call Center is continuously monitoring this metric as it is also included on the Operational Dashboard.	3/31/2025 6/30/2025 9/30/2025 12/31/2025	Lilia Chagolla, Member Services Director Veronica Olivarria, Call Center Manager	Qtr. 2: The call center has hired additional staff to support the calls and members walk-in volume. Coordinate lunch and break schedules to maximize the peak/busy times. Assign staff to support offices to assist with member walk-ins. Eliminate unnecessary meetings and focus meetings/trainings on business needs. Call Center Supervisors review Queue data throughout the day to determine if changes need to be made for the day - such as schedules. Training is coordinated in small teams to maximize service level.	We were unable to meet the 5% call abandonment rate target this period. The higher-than-expected call volume combined with lower staffing levels resulted in an increased call abandonment average. Additionally, our team is in the process of adjusting to a new phone system and integrating with BH services, which has temporarily impacted call handling efficiency. Due to the unusually high call volume, we made the decision to pause the New Member Welcome Calls project to prioritize timely response to incoming member calls and maintain service quality.	We have recruited and onboarded additional staff to help manage call volume, assist with member walk-ins, and support new member orientation.	☐ Yes ☑ No	Call Center Supervisors have incorporated the WM tool and are focused on real-time coaching, ensuring resources are available, and keeping HSP updates current so staff can focus on meeting the needs of callers. These efforts are expected to improve overall performance and enhance the member experience in the coming months.

CULTURE & LINGUISTICS (DESIRRE HERRERA)

Goals/Objectives for Calendar Year 2025	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 2024 baseline utilization data.	1. The project team will track utilization for the following services: • Phone interpreting services. • Face-to-Face (F2F) interpreting services. 2. Use quarterly utilization data to identify potential need to training provider network on language assistance services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 3 **Provider Utilization for Q3** was as follows: **Phone interpreting services:** There was a total of **10,591 total calls in Q3** by provider sites. This reflects an **increase of 58%** compared to Q3 in 2024. **Face-to-Face (F2F) interpreting services:** There was a total of **1,973 requests in all service counties for F2F in Q3**. This reflects an **increase of 13%** compared to Q3 in 2024. • **Santa Cruz County** had 790 requests in Q3. This was a 20% increase compared to Q3 2024. • **Merced County** had 310 requests in Q3. This was a 48% decrease compared to Q3 2024. • **Monterey County** had 856 requests in Q3. This was a 73% increase compared to Q3 2024. • **San Benito County** had 17 requests in Q3. This was a 1600% increase compared to Q3 2024. • **Mariposa County** had 0 requests in Q3. **Virtual Remote Interpreting (VRI):** This was a new service that started in Q3. A total of **57 VRI requests** were received.	No issues to report in Q3.	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.
2. 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.	1/1/2025-3/31/2025 7/1/2025-9/30/2025	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager Ivonne Munoz, Quality and Health Programs Supervisor	Qtr. 3 **Member Satisfaction Surveys:** • Surveys are scheduled bi-annually. • The team will report out survey results in Q4 report.	No issues to report in Q3.	The project team will continue to conduct satisfaction surveys in Q4.	☐ Yes ☑ No	

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update	Previously Identified Issues	Next Steps	Goal Met	Evaluation
	3. Incorporate member feedback into planning and identifying areas of improvement for the services.							
3. On a quarterly basis, inform members and providers of language assistance services utilizing at least 1 member and 1 provider informing modality.	1. The C&L team will conduct outreach and education activities to inform members and providers of services available: a. Member newsletter articles b. Provider bulletin articles c. Education materials including flyers d. MSAG presentation 2. Request input from members regarding program and services. 3. Incorporate member feedback into planning health education activities.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Ivonne Munoz, Quality and Health Programs Supervisor	Qtr. 3 The following activities were completed in **Q3** to inform members of C&L Services: • Member Newsletter: The project team included 1 article in September 2025 Member Newsletter informing members that they can select a doctor that speaks their language. • Provider Bulletin: The project team included 1 article in September 2025 Provider Bulletin informing providers of interpreting services available and tips for working with interpreters.	No issues to report in Q3.	The project team will continue to work on planning efforts to increase awareness of language assistance services to the provider network in 2025.	☑ Yes ☐ No	Utilization of language assistance services continues to increase each quarter. These increases can be partly attributed to consistent information being available regarding the availability of these services. Consistent messaging also allows new members to receive the information.
4. On a quarterly basis, provide at least 1 C&L services presentations to Alliance internal department staff that interact with members or providers to increase awareness of language assistance services available for members.	1. The C&L team will reach out to internal and external partners to schedule C&L services presentations. 2. Deliver C&L services presentation. 3. Request input regarding presentation content and any member needs that they have encountered regarding C&L services.	1/1/2025-3/31/2025, 4/1/2025-6/30/2025, 7/1/2025-9/30/2025, 10/1/2025-12/31/2025	Osiris Ramon, C&L Program Advisor Desirre Herrera, Quality and Health Programs Manager	Qtr. 3 A total of **2 presentations** on C&L services were coordinated and completed in **Quarter 3**. Presentations were delivered to the following audiences: • Member Services Advisory Group (MSAG) • Alliance Quality Improvement and Population Health Orientation	No issues to be reported in Q3.	The project team will continue to coordinate presentations for internal departments and external partners in 2025.	☑ Yes ☐ No	This goal has been successful in increasing awareness and ensuring Alliance staff are informed of the services available.

DELEGATION OVERSIGHT (ANDREA SWAN)

Goals/Objectives for Calendar Year 2025	Planned Activities to Accomplish Goals/Objectives	Target Completion (start & end date)	Responsible Staff	Quarterly Update Please include what you have done, and why you have accomplished the goal for each quarter.	Previously Identified Issues	Next Steps	Goal Met	Evaluation

1. Ensure all activities delegated on behalf CCAH and the QIPH department meet all DHCS, DMHC, and NCQA regulations.	1. Quarterly review of delegate reports to ensure compliance, and identification of any issues.	3/31/2025,6/30/2025 9/30/2025,12/31/2025	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1: Delegate reports reviewed with no issues identified.	No previously identified issues.	Continue monitoring	☑ Yes ☐ No	
				Qtr. 2 All delegate reports for the 1st quarter were received and reviewed with no gaps identified. Qtr. 3: Q2 delegate reports were reviewed and approved, and no gaps identified.			☑ Yes ☐ No	
2. Ensure oversight of all delegated activities by governing board.	2. Present quarterly updates of all reviewed activities with identification of any issues to the governing board for review, and feedback.	3/31/2025,6/30/2025 9/30/2025,12/31/2025	DeAnna Leamon, Clinical Safety Quality Manager. Kristen Rohlf, Quality Improvement & Population Health. Desirre Herrera, Quality Health Programs Manager. Andrea Swan, Quality Improvement & Population Health Director	Qtr. 1: Delegate reports reviewed with no issues identified.	No previously identified issues.	Continue monitoring	☑ Yes ☐ No	
				Qtr. 2 All delegate reports for the 1st quarter were received and reviewed with no gaps identified. Qtr. 3: Q2 delegate reports were reviewed and approved, and no gaps identified.			☑ Yes ☐ No	

DATE: January 28, 2026

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

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

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

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

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

Discussion. The Quality Improvement and Health Equity Transformation Program (QP) was modified to include language noting the Dual-eligible Special Needs Plan (DSNP) / STARS Workgroup functions under the direction and guidance of the Quality Improvement & Health Equity Workgroup (QIHEW).

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

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

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	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement & Health Equity Transformation Program (QIHETP)	
Original Date: 02/01/1996	**Date Published:** ~~07/23/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Purpose

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

Policy

The QIHETP[3] exists to assure and improve the quality of care for Alliance members, in fulfillment of California Department of Health Care Services (DHCS) requirements, Title 28, California Code of Regulations, Section 1300.70, and Title 42, Code of Federal Regulations, Section 438.330 and 438.340[4]. The QIHETP aligns efforts with DHCS' Comprehensive Quality Strategy Report and reviews actions items identified through DHCS' reports including, but not limited to, the Technical Report, Health Disparities Report, Preventive Services Report, Focused Studies, and Encounter Data Validation Report. Additionally, QIHETP oversight entities may electively incorporate best practice standards (e.g., National Committee for Quality Assurance [NCQA] standards) into the QIHETP as they deem appropriate.

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

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

QIHETP Values

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

Continuous Quality Improvement (CQI)[5]

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

Equitable and Person-Centered

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

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

2. Provide tailored, consistent, and whole-person care across all member-facing team that meet the needs and experience of our members.

3. Ensure delivery of health care services complies with all mental health parity requirements in 42 CFR section 438.900 for Alliance, Subcontractors, Downstream Subcontractors, Network Providers, and other entities.

Safe, Accessible, and Effective Quality of Care and Services

1. Ensure integration with all departments within the Alliance, current community health priorities, standards, and public health goals;

2. Continuously review, evaluate, and improve access to and availability of services, including obtaining appointments within established standards;

3. Ensure consistent patient safety processes through proactive surveillance, investigation, and appropriate actions to address quality issues related to care, service, or satisfaction; and

4. Ensure effectiveness of the quality of care and services delivered across the continuum of care by addressing preventive services for children and adults, perinatal care, primary care, specialty, emergency, inpatient, behavioral and ancillary care services, including complex health needs, emerging risk, and multiple chronic conditions for improved health outcomes.

Population Health Management Interventions[8]

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

1. Developing equity focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services; and

2. Engaging in a member and family-centric approach in the development of interventions and strategies, and in the delivery of health care services.

Comprehensive Quality Strategy Guiding Principles[9]

1. Eliminating health disparities through anti-racism and community-based partnerships

2. Data-driven improvements that address the whole person

3. Transparency, accountability, and member involvement

4. Meet disparity reduction targets for specific populations and/or measures identified by DHCS.

Scope

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

1. Quality of care services including, but not limited to: clinical quality of physical health care, behavioral health care focused on recovery, resiliency, and rehabilitation, preventive care, chronic disease, perinatal care, family planning services, and reduction in health disparities.

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

Goals and Objectives

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

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

2. Quality of services provided by the Alliance to its members, providers, the community, and internal staff:
   2.a. Align quality improvement activities with activities that promote the continuous development of a provider network that meets member needs, such as the annual Access Plan
   2.b. Implement innovative practices, such as telephonic or virtual means, to ensure that members obtain care which is timely and meets their needs
   2.c. Utilize data-driven approaches and effective analysis, implementation, and evaluation towards improved clinical outcomes, services, and experiences
   2.d. Ensure care is provided regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sex, sexual orientation, gender identity, health status, or physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, and linguistically appropriate manner[15]

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2.e.　Identify population-based strategies to identify, evaluate, and reduce healthcare disparities through analysis, equity-focused interventions, and meeting disparity reduction targets[16]

2.f.　Provide access to services and communication in alternate formats to ensure non-discrimination of members as defined in Section 1557 of the Patient Protection and Affordable Care Act[73]

2.g.　Education regarding accessing the health care system and support on obtaining care and services when needed

2.h.　Concerns resolved quickly and effectively including the right to voice complaints or concerns without fear of discrimination

2.i.　Engagement in the discussion about services, regardless of cost or benefit coverage

2.j.　Confidence that they can reach the Alliance quickly and be satisfied with the information received.

2.k.　Maintain Member confidentiality in quality Improvement discussions.

3.　Members' experience of care and service provided by the Alliance and its contracted providers:

3.a.　Monitor member satisfaction with quality of care and services received from network providers, practitioners and delegates and acting upon identified opportunities

3.b.　Obtain information on member's values, needs, preferences, and health-related goals through feedback mechanisms and touch points, such as surveys, focus groups, member outreach, care management, and other means

3.c.　Establish population health programs to empower and encourage members to actively participate in and take responsibility for their own health through the provision of health education, evidence-based tools, and shared goals for optimal health

3.d.　Create a trusted health care system to assure feelings of safety, self-efficacy, and effective communication with all their care partners

3.e.　Mechanisms to continuously monitor, review, evaluate, and improve coordination and continuity of care services to all members[17];Integrate with current community health priorities, standards, and public health goals.

Definitions

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

2.　Community Supports: Services or settings offered by a Medi-Cal health plan that are offered in place of services or settings covered under the California Medicaid State Plan, and are medically appropriate, cost-effective substitutes for services or settings under the State Plan. Services are offered at the plan's option and an enrollee cannot be required to use them.

3.　Consumer Assessment of Healthcare Providers and Systems (CAHPS): Standardized surveys of Agency for Healthcare Research and Quality (AHRQ), the CAHPS' surveys health plan members to measure their experiences with a variety of areas, including access to care and satisfaction with the health plan.

4.　Corrective Action[19]: Specific identifiable activities or undertakings of the Alliance that address program deficiencies or problems.

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5. <u>Enhance Care Management (ECM):</u> ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person centered.

6. <u>External Accountability Set (EAS)</u>[20]: Performance Measures: The EAS performance measures consist of a set of Healthcare Effectiveness Data Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). The EAS performance measures may also include other standardized performance measures and/or DHCS developed performance measures selected by DHCS for evaluation of health plan performance.

7. <u>Healthcare Effectiveness Data and Information Set (HEDIS)</u>[21]: The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.

8. <u>High Performance Level (HPL):</u> DHCS establishes an HPL for each required HEDIS performance measure and publicly acknowledges Managed Care Plans (MCPs) that meet or exceed the HPLs. DHCS's HPL for each required measure is the 90th percentile of the national Medicaid results.

9. <u>Long Term Care Service</u>s: Long-term care benefit standardization and transition of members to managed care, including managing the long-term care of members in skilled nursing facilities.

10. <u>Managed Care Accountability Set (MCAS):</u> A set of measures based on the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets, and NCQA are selected by DHCS for evaluation of health plan performance.

11. <u>Minimum Performance Level (MPL):</u> Medi-Cal managed care health plans must meet or exceed the DHCS established MPL for each required HEDIS performance measure. If MPL is not met, then an Improvement Plan must be completed. DHCS's MPL for each required measure is the 50th percentile of the national Medicaid results.

12. <u>National Committee for Quality Assurance (NCQA)</u>[22]: A non-profit organization that committed to evaluating and publicly reporting on the quality of managed care plans.

13. <u>Performance Improvement Projects (PIPs)</u>[23]: Studies selected by the Alliance, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes[24].

14. <u>Plan, Do, Study, Act (PDSA):</u> A cyclical, four-step management method used for continuous improvement and monitoring of processes. The methodology is a rapid cycle/continuous quality improvement process designed to perform small tests of change, which allows more flexibility to make adjustments throughout the improvement process[25].

Procedures

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

1. <u>Maintain Accountability of Care Systems</u>
   Accountability for the QIHETP development and performance review includes the Santa Cruz-Monterey-Merced Managed Medical Care Commission (Alliance Board), the Quality Improvement Health Equity Committee (QIHEC), Chief Health Equity Officer or designee, the Peer Review and Credentialing

Committee (PRCC), the Compliance Committee, the Chief Medical Officer (CMO), and Alliance network providers[26].

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

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

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

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

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

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

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

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

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

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

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

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

1.e.8. Whole Child Model Family Advisory Committee (WCMFAC): The WCMFAC operates under the authority of the Alliance Board and serves as a venue to discuss perspective on issues relating to diagnosis and treatment of CCS conditions as well as to review and offer advice about policies, programs and initiatives relating to care of members in the WCM program. as described in Alliance Policy 280-0003 – *Whole Child Model Family Advisory Committee.*

1.e.9. Network Development Steering Committee:
The Network Development Steering Committee's (NDSC) primary responsibility is to: 1. Monitor and evaluate member access to care through: Comprehensive, coordinated, and

regular review of access inputs, including but not limited to survey outcomes, regulatory compliance, and process-related information (e.g., grievances). 2. Support improved member access to care through oversight of the development and execution of an annual provider network Access Plan.

1.e.10. Member Support and Engagement Committee:
The Member Support and Engagement Committee (MSEC) is an interdepartmental collaborative intended to evaluate the Alliance processes that assist members in navigating the health care system. The Alliance's goal is to ensure members are supported and engaged, while being confident that they will receive appropriate care from providers and excellent service from the health plan. This committee facilitates the collaboration and integration of relevant service indicators as defined by the monitoring process, analysis, action, and measurement. Through monitoring of appropriate indicators, MSEC will identify areas of opportunity to improve processes and implement interventions. The committee also works on member outreach to provide guidance to the Your Health Matters Outreach Program as appropriate to this committee's charter and any Quality Improvement Activities within the scope of this committee.

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

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

1.e.13. 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.

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

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

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

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

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

1.g.3. Chief Health Equity Officer (CHEO)[30] or designee: Provide leadership to ensure health equity is prioritized and health inequities are addressed within the QIHETP. This role acts as part of the Regional Quality and Health Equity team.

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

1.g.5. Quality Improvement and Population Health (QIPH) Director: Under the direction of the CMO, the QIPH Director is responsible for strategic direction and management of the Alliance QIHETP. The QIPH Director manages the Alliance's preparations and response to regulatory and internal medical audits and manages implementation of selected NCQA standards. The QIPH Director is also responsible for engagement with internal and external stakeholders in the QIHETP. This role acts at the Performance Improvement Lead or may delegate this role to staff across the organization for the quality and health improvement

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efforts across the organization. This role acts as part of the Regional Quality and Health Equity team.

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

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

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

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

1.g.10.   Quality and Health Programs Supervisor(s) (QHPS): Under the direction of the QHPM, the QHPS coordinates and implements the Alliance Health Education and Disease Management programs and Cultural and Linguistic services (oversees interpretation and translation services and vendors) and processes. The QHPS also leads preparing health and disease

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management program promotional materials, including newsletter articles, and member/provider communications. The QHPS also supervises the Health Educators and Care Coordinator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1.g.29. Community Engagement Director. The Community Engagement Director and team are responsible for ensuring regional input is considered in the design and implementation of the QIHET.

1.g.30. Other staff: The Alliance encourages active involvement of all Alliance staff in the design and implementation of the QIHETP.

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

    1.h.2. Committee Minutes: QIHEC, Compliance Committee minutes, and PRCC credentialing/re-credentialing related reports, are reviewed by the Alliance Board on a routine basis[32]. QIHEC minutes are submitted to DHCS upon Alliance Board review and approval. A written summary of the QIHEC activities publicly available on the Alliance website at least on a quarterly basis.[33]

    1.h.3. QIHEP Annual Report: The QIHE Annual Report is submitted to the QIHEC for its review, approval, and submission to the Alliance Board[34], and subsequent submission to DHCS. The QIHE Annual Report includes a comprehensive assessment of QIHE activities, including an

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evaluation of areas of success and needed improvements. The report addresses clinical quality of physical, behavioral health, access and engagement or providers, continuity and coordination across setting and all levels of care, and Member experience. Effective in 2024, the evaluation includes but is not limited to: the QIHE-WP, analyses of fully delegated subcontractor's and downstream fully delegated subcontractor's performance measure results and actions to address any deficiencies, actions taken to address the annual External Quality Review (EQR) technical report and evaluation reports, planned equity-focused interventions to address identified patterns of over- or under-utilization, description of member and/or family focused care such as Community Advisory Committee (CAC) findings, Population Health management activities and findings, and outcomes/findings from Performance Improvement Projects, member satisfaction surveys, and collaborative initiatives as appropriate.

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

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

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

2.b. <u>Site Review</u>[37]: The Alliance incorporates site review requirements into the QIHETP as described in Alliance Policies 401-1508 – *Facility Site Review Process*, 401-1510 – *Medical Record Review and Requirements* and 401-1521 – *Physical Accessibility Review*. The Alliance conducts a Facility Site Review (FSR) for new primary care providers (PCPs) before initial credentialing and a minimum of every three (3) years thereafter as a requirement for participation in the California State Medi-Cal Managed Care Program. Physical Accessibility Reviews (PARs) are conducted during the initial FSR for new primary care provider sites, and at a minimum of every three (3) years upon re-credentialing[38]. Specialists and Ancillary sites that serve a high-volume of SPD members (providers whose monthly average of encounters for SPD members are above the monthly average of

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encounters) receive a PAR at a minimum of every three (3) years[39]. The Alliance ensures that member medical records are maintained by health care providers in accordance with contractual obligations[40]. The Alliance submits site review data to DHCS up to quarterly, or in a manner or timeframe specified by DHCS[41].

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

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

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

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

2.e.   Timely Access Monitoring[47]: The Alliance incorporates timely access monitoring requirements into the QIHETP as described in Alliance Policies 300-1509 – *Timely Access to Care* and 300-8030 – *Monitoring Network Compliance with Accessibility Standards*. The Alliance ensures the provision of covered services in a timely manner consistent with the DMHC Timely Access requirements and participation in the EQRO's network adequacy validation studies. The Alliance continuously reviews, evaluates, and seeks to improve access to and availability of services. This includes ensuring that members are able to obtain appointments from contracted providers according to established access standards.

2.f.   Member Satisfaction Monitoring[48]: The Alliance incorporates member satisfaction monitoring requirements into the QIHETP as described in Alliance Policies 401-2001 – *Member Surveys*, 200-9001 – *Grievance Reporting, Quality Improvement and Audits*, and 200-9004 – *Staff Grievance Review Committee*. Member satisfaction survey results are reviewed and monitored for variations. Grievance data is reviewed and analyzed regularly to identify trends as part of the Alliance's efforts

to improve and optimize the delivery and management of health care services. Grievance staff refers individual cases for clinical review to QIPH staff as appropriate and the SGRC reports trends in quality issues to the QIHEW.

2.g. Provider Satisfaction Monitoring[49]: The Alliance incorporates provider satisfaction monitoring requirements into the QIHETP as described in Alliance Policy 300-3092 – *Provider Satisfaction Survey*. The Alliance conducts annual surveys of contracted physicians to determine provider satisfaction with the Alliance's performance and to identify any provider concerns with compliance with various regulatory standards.

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

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

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

2.k. Under/Over-Utilization Monitoring[51]: The Alliance incorporates under/over-utilization monitoring requirements into the QIHETP as described in Alliance Policies 404-1101 – *Utilization Management Program* and 404-1108 – *Monitoring of Over/Under Utilization of Services*. The UM Program serves to ensure appropriate, high quality, cost-effective utilization of health care resources and that these resources are available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on evidence-based criteria, and expert clinical opinion when needed.

2.l. Population (PNA)[52]: The PNA evaluates the health education and cultural and linguistic needs of members, and the findings are used to guide the development and implementation of cultural and linguistic health education interventions. The Alliance prepares a PNA annually.[50] The Alliance will incorporate county or region-specific Population Needs Assessment, as detailed in the Population Health Management Policy Guide, to build community partnerships, improve member participation, and to fully understands the barriers preventing all populations from receiving care and preventive services as well as identify and address social drivers of health.

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2.m. <u>Community Health Assessment (CHA)/Community Health Improvement Project (CHIP):</u> Based on participating in the CHA/CHIP process The Alliance must annually review and update the following in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy:

    2.m.1. Targeted health education materials for Members, including Member-Facing outreach materials for any identified gaps in services and resources, including but not limited, to Non-Specialty Mental Health Services (NSMHS).

    2.m.2. Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and

    2.m.3. Wellness and prevention programs.

2.n. <u>Seniors and Persons with Disabilities (SPD) Activities</u>[53]: The Alliance incorporates SPD activity requirements into the QIHETP as described in Alliance Policies 404-1114 – *Continuity of Care*, 405-1112 – *Care Management of Seniors and Persons with Disabilities for Medi-Cal*, and 401-3101 – *Health Education and Disease Management Program*. The Alliance conducts studies for SPDs or persons with chronic conditions that are designed to assure the provision of case management, coordination, and continuity of care services, including ensuring availability, access to care, and clinical services.

2.o. <u>Focused Studies:</u> The Alliance participates in the external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided[54].

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

2.q. <u>Ad Hoc Data Studies:</u> The Alliance also conducts other stratified data studies to evaluate the population as needed.

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

2.s. <u>Behavioral Health Services Monitoring:</u> The Alliance incorporates behavioral health services monitoring requirements into the QIHETP as described in Alliance Policy 408-1305 – *Behavioral Health Services for Medi-Cal to ensure delivery of Medically Necessary non-specialty and specialty mental health services*. Oversight and monitoring of any delegated portions of mental health services are outlined in Policy 105-0004 – *Delegate Oversight*.

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2.t. Quality Improvement Delegate Oversight Activities[56]: The Alliance incorporates QIPH delegate oversight activities into the QIHETP as described in Alliance Policies105-0004 – *Delegate Oversight* and 401-1201 –*Quality Improvement Health Equity Committee*. The Alliance may delegate QIPH functions to subcontracting entities, as outlined in Alliance Policy 105-0004 – *Delegate Oversight*. These delegated functions are set forth in the Alliance's contracts with subcontracting entities and include specific performance and reporting standards that must be met.

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

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

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

2.x. Patient Level Data Submissions: The Alliance will utilize the DHCS' EQRO File Transfer Protocol (FTP) website when sending communications containing patient-level data.

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

3.a. Analyze and Evaluate Annual Data: Analysis is performed utilizing various current evidence-based standards as benchmarks:
3.a.1. Meet health disparity reduction targets for specific populations and measures as identified by DHCS[59];

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

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

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

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

3.a.3. <u>Preventive Care Guidelines</u>: The preventive care guidelines address periodic health and behavioral risk screening and preventive services for asymptomatic adults and children. Individuals identified as being at high risk for a given condition may require more frequent or additional screening tests specific to the condition. These guidelines establish the minimum standard of preventive care. Further details are included in Alliance Policy *401-1502- Adult Preventive Care*, and *401-1505 - Childhood Preventive Care*.

3.a.3.a. <u>Adult preventive care guidelines include</u>[63]:
1. The United States Preventive Services Task Force (USPSTF) guidelines;
2. Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (CDC ACIP); and
3. The State of California DHCS Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004.

3.a.3.b. <u>Pediatric preventive care guidelines include</u>[64]:
1. The provision of the Early and Periodic Screening, Diagnostic, and Treatment Services inclusive of education and outreach for members under the age of 21 years old in accordance with the American Academy of Pediatrics (AAP) Bright Future guidelines (All Plan Letter 23-005 and AB 2340);
2. CDC ACIP;
3. Child Health and Disability Prevention Program (CHDP); and
4. The DHCS MMCD Policy Letter 14-004.

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

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

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

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

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

3.b.3.   Publication of Board Reports;

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

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

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

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

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

3.c.   Develop Interventions
3.c.1.   Priority Setting: Use of personnel and other resources is prioritized by the QIHEC annually, taking into consideration contractual and regulatory requirements, high volume/high risk services, and quality of care issues that are relevant and meaningful to the member population. Another factor which may be considered when selecting improvement opportunities to pursue is the extent to which the issue affects care, or the likelihood of changing behavior of members or practitioners. To maximize the use of resources, QIPH activities may be selected based on their ability to satisfy multiple QIHETP requirements.

3.c.2.   Performance Improvement work including Performance Improvement Projects (PIP)[67,68]: Under consultation and with guidance from the External Quality Review Organization (EQRO) and DHCS, the Alliance conducts a minimum of two (2) DHCS-approved PIPs. One

PIP must be either an internal PIP or a small group collaborative. The second PIP must be a DHCS-facilitated state-wide collaborative.

PIPs are developed by identifying targeted areas for improvement (clinical or nonclinical) and are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and include the following elements:
- Measurement of performance using objective quality indicators;
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

In addition to Performance Improvement Projects quality improvement and health equity teams will participate in statewide and/or regional collaboratives that may improve quality and equity of care Medi-Cal members as directed by DHCS on a quarterly basis at a minimum, and these meetings may be in-person. The Alliance will leverage existing regional quality and health equity teams, where available, to support QI and health equity work for all counties across the various DHCS designated regions.

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

3.c.3.   Corrective Action Plans (CAPs):
    3.c.3.a   Provider CAPs resulting from FSR and Medical Record Review (MRR) must be addressed and documented, consistent with Alliance Policy 401-1508 – *Facility Site Review Process*. PCP sites that do not correct cited deficiencies are to be terminated from the network[70]; and
    3.c.3.b.   Provider CAPs may be an intervention for certain PQIs, as deemed appropriate by the CMO or a Medical Director[71]. Refer to Alliance Policy 401-1306 - *Corrective Action Plan for Quality Issues.*

3.c.4.   Improvement Plan[72]:
    The Alliance must submit a PDSA Cycle Worksheet to DHCS for each MCAS measure with a rate that does not meet the MPL or is given an audit result of "Not Reportable" (NR). Additionally, the Alliance will conduct Quality Improvement and health equity improvement projects in areas where performance is below DHCS' established MPLs as determined in the MCAS: Quality Improvement and Health Equity Framework Policy Guide. DHCS will notify MCPs of the due date. Submission includes analysis of barriers, targeted interventions, relevant data to support analysis, targeted interventions, and a rapid cycle /continuous quality improvement process to guide PDSA outcomes. The Alliance will conduct at least a quarterly evaluation of ongoing rapid-cycle quality improvement efforts to determine whether progress is being made.

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3.c.5.   Quality and Health Programs:

   3.c.5.a   Disease Management: Consistent with Alliance Policy 401-3101 – *Health Education and Disease Management Program*, the Alliance maintains an evidence-based disease management programs that incorporate health education interventions, target members for engagement and seek to close care gaps for members participating in these programs[73].

   3.c.5.b   Health Education and Promotion: Consistent with Alliance Policy 401-3101 – *Health Education and Disease Management Program*, the Alliance offers important health education and promotion programs for its members. These programs are intended to assist members to improve their health, properly manage illness, and avoid preventable conditions. These programs have been implemented in all Alliance service areas, and are routinely reviewed for access, quality, and outcomes and reported as part of the QIHETP[74].

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

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

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

   3.c.5.d   Chronic Care Improvement Program (DSNP): Quality Improvement and Population Health (QI/PH) Department will develop a 3-year CCIP focused on a chronic condition that is appropriate to the needs of its D-SNP member population. The condition will be selected based on a comprehensive analysis of factors such as prevalence of, and disease burden as outlined in policy 401-1801

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

References:
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105-0004 – Delegate Oversight

105-3002 – Program Integrity: Special Investigations Unit Operations

200-9001 – Grievance Reporting, Quality Improvement and Audits

200-9004 – Staff Grievance Review Committee

280-0003 – Whole Child Model Family Advisory Committee

300-1509 – Timely Access to Care

300-3092 – Provider Satisfaction Survey

300-4020 – Peer Review and Credentialing Committee – Authority, Roles, and Responsibilities

300-4030 – Credentialing Criteria and Identified Issues

300-4040 – Professional Provider Credentialing Guidelines

300-4090 – Ongoing Monitoring of Provider Credentials and Issues

300-4102 – Reporting to the Medical Board of California and the National Practitioner Data Bank

300-4103 – Fair Hearing Process for Adverse Decisions

300-4110 – Organizational Providers Credentialing Guidelines

300-8030 – Monitoring Network Compliance with Accessibility Standards

400-1109 – Physicians Advisory Group Responsibilities and Functions

400-1112 – Whole Child Model Clinical Advisory Committee Responsibilities and Functions

401-1201 – Quality Improvement Health Equity Committee

401-1301 – Potential Quality Issue Review Process

401-1306 – Corrective Action Plan for Quality Issues

401-1501 – Standards of Care

401-1502 – Adult Preventive Care

401-1505 – Childhood Preventive Care

401-1508 – Facility Site Review Process

401-1510 – Medical Record Review and Requirements

401-1519 – Infection Control Practices

401-1521 – Physical Accessibility Review

401-1523 – Non-Physician Medical Practitioner: Scope of Practice and Supervision

401-1607 – Healthcare Effectiveness Data and Information Set (HEDIS) Program Management and Oversight

401-1705 – Care-Based Incentive Program

401-1801-Chronic Care Improvement Program

401-2001 – Member Surveys

401-3101 – Health Education and Disease Management Program

401-4101 - Cultural and Linguistic Services Program

403-1104 – Mission, Composition and Functions of the Pharmacy and Therapeutics Committee

404-1101 – Utilization Management Program

404-1108 – Monitoring of Over/Under Utilization of Services

404-1112 – Medical Necessity- The Definition and Application of Medical Necessity Provision to Authorization Requests

404-1114 – Continuity of Care

405-1112 – Care Management of Seniors and Persons with Disabilities for Medi-Cal

Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement & Health Equity Transformation Program (QIHETP)	
Original Date: 02/01/1996	**Date Published:** ~~07/23/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

    408-1305 – Behavioral Health Services

    450-0002 – Population Needs Assessment and Population Health Strategy Deliverable

Impacted Departments:

    Behavioral Health

    Community Care Coordination

    Community Engagement

    Compliance

    Member Services

    Pharmacy Services

    Provider Services

    Utilization Management

Regulatory:

    California Evidence Code Section 1157

    California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2

    California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)

    California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.70

    California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.70(b)(c)

    Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 440, Subpart B, Section 440.262

    Code of Federal Regulations Title 42, Chapter 4, Subchapter C, Part 438, Subpart E, Section 438.330

    Code of Federal Regulations, Title 42, 438.330(d) incorporated via [MMC Final Rule] Medi-Cal Contract, Exhibit A, Attachment 4, Provision 1

    DHCS communication dated 8/2016 related to Title 42, Code of Federal Regulations, Section 440.262;

Legislative:

    Assembly Bills, AB-2340 Medi-Cal: EPSDT Services: informational materials

Contractual (Previous Contract):

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

Contractual (2024 Contract):

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

    Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.1

    Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.A-D

    Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6.K

    Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6.L

DHCS All Plan Letter:

    MMCD PL 14-004 Site Reviews: Facility Site Review and Medical Record Review

    DHCS APL 15-023 Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers

    DHCS APL 23-005 Requirements for Coverage of Early and Periodic Screening, Diagnostic, And Treatment Services for Medi-Cal Members Under the Age Of 21

    DHCS APL 19-017 Quality and Performance Improvement Adjustments Due to Covid-19

    DHCS APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of The California Advancing and Innovating Medi-Cal Initiative

    DHCS APL 24-004 Quality Improvements and Health Equity Transformation Requirements

	POLICIES AND PROCEDURES
Policy #: 401-1101	**Lead Department:** Quality Improvement and Population Health
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NCQA:

      HEDIS Volume 2 Technical Specifications for Health Plans

Supersedes:

Other:

      Alliance Provider Manual

Attachments:

      Attachment A: Quality Improvement Health Equity Transformation Reporting Structure

      Attachment B: Quality Improvement and Population Health Organizational Chart

Lines of Business This Policy Applies To

☒☐ DSNP

☒ Medi-Cal

☒ Alliance Care IHSS

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
01/26/2024	01/26/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
03/20/2024	03/20/2024	Sarina King, Quality and Performance Improvement Manager	QIHEW
04/25/2024	04/25/2024	Sarina King, Quality and Performance Improvement Manager	QIHEC
08/29/2024	08/29/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEW
09/24/2024	09/24/2024	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
02/14/2025	02/14/2025	Kristen Rohlf, MPH, Quality and Population Health Manager	QIHEW
04/02/2025		Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
05/08/2025	05/08/2025	Kelly Tlemcani, Business Analyst II	QIHEW
06/26/2025		Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC
12/12/2025	12/12/2025	Andrea Swan, RN, MSN, Quality Improvement and Population Health Director	QIHEC

	POLICIES AND PROCEDURES

Policy #: 401-1101 | **Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement & Health Equity Transformation Program (QIHETP)
Original Date: 02/01/1996 | **Date Published:** 07/23/2025
Approved by: Quality Improvement Health Equity Committee (QIHEC)

[1] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[2] DHCS State Medi-Cal Contract, Exhibit A, Attachment 34, Provision 2.2.6
[3] DHCS State Medi-Cal Contract, Exhibit A, Attachment 34, Provision 2.2
[4] DHCS Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2
[5] DHCS Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2B
[6] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[7] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6
[8] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.C.
[9] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[10] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6.
[11] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.A.
[12] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2
[13] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.12
[14] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6M
[15] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6F
[16] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6G
[17] DHCS Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.2.6P
[18] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[19] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[20] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[21] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[22] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[23] DHCS All Plan Letter 19-017
[24] DHCS State Medi-Cal Contract, Exhibit E, Attachment 1, Definitions
[25] DHCS All Plan Letter 19-017
[26] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.1
[27] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.2
[28] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3
[29] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[30] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 1.1.7
[31] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provisions 2.2.12
[32] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.12
[33] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3D
[34] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7
[35] [MMC Final Rule] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7.
[36] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9
[37] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.14
[38] MMCD PL 14-004; DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[39] DHCS APL 15-023; Policy 401-1521 – Physical Accessibility Review
[40] DHCS State Medi-Cal Contract, Exhibit A, Attachment , Provision 5.2.14
[41] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.14
[42] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.11
[43] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[44] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12
[45] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.12

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[46] Policy 300-4103 – Fair Hearing Process for Adverse Decisions; Policy 300-4102 – Reporting to the Medical Board of California and the National Practitioner Data Bank; 401-1306 – Corrective Action Plan for Quality Issues; 300-4090 – Ongoing Monitoring of Provider Credentials and Issues

[47] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2, DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.5

[48] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision2.2.9.C,; DHCS All Plan Letter 19-017

[49] California Code of Regulations, Title 28, Chapter 2, Article 7, Section 1300.67.2.2(d)(2)(C)

[50] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision2.2.9E

[51] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.3.3

[52] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.2

[53] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.6

[54] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9F

[55] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9G

[56] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.5

[57] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.4.16A

[58] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.5.13C

[59] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9.A4

[60] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9

[61] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9

[62] Policy 401-2001 – Member Surveys

[63] Policy 401-1502 – Adult Preventive Care

[64] Policy 401-1505 – Childhood Preventative Care

[65] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.4

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

[67] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9; DHCS All Plan Letter 19-017

[68] 42 CFR 438.330(d), Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9B

[69] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.9B5

[70] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.2.14; MMCD PL 14-004

[71] Policy 401-1301 – Potential Quality Issue Review Process; Policy 401-1306 – Corrective Action Plan for Quality Issues
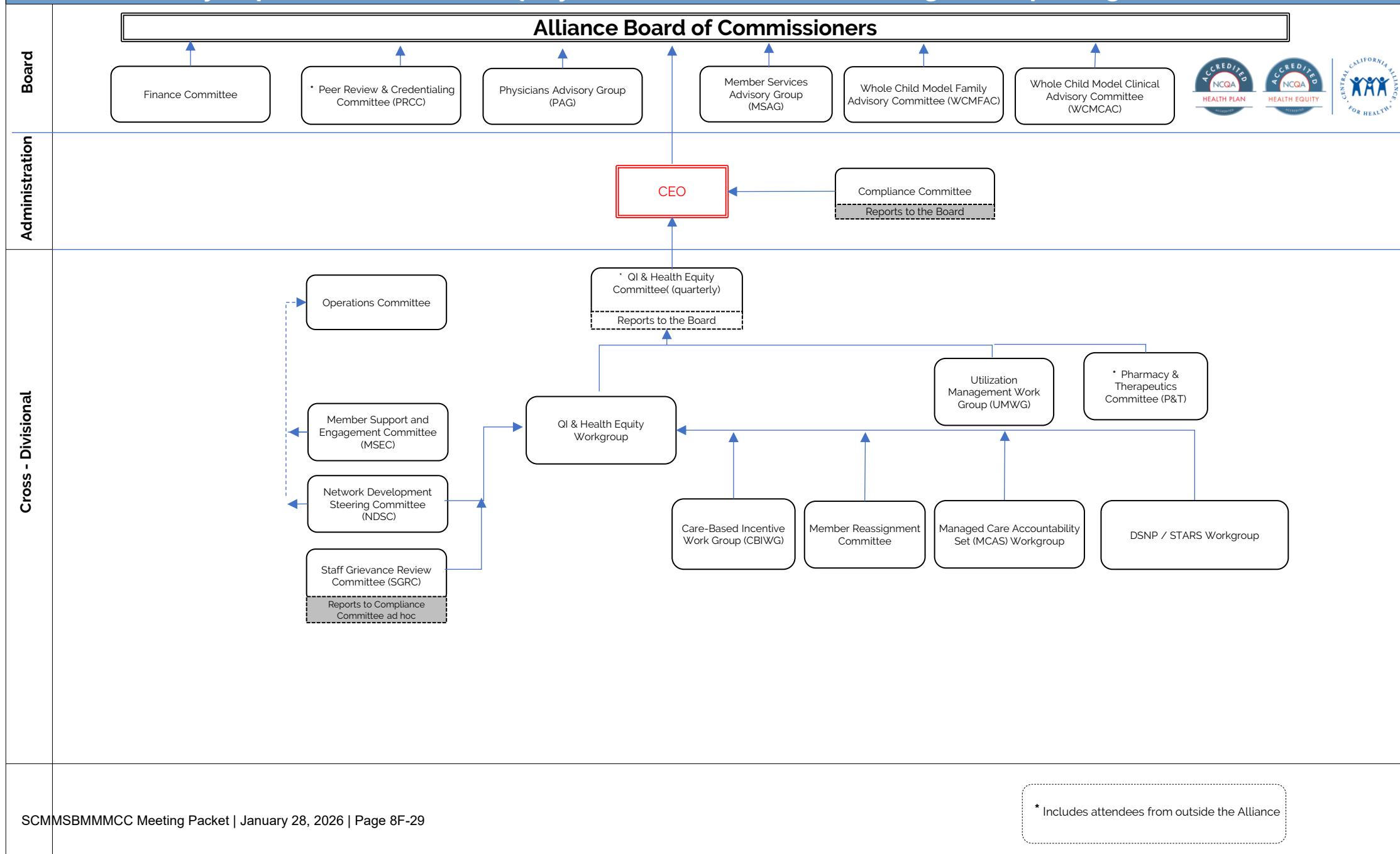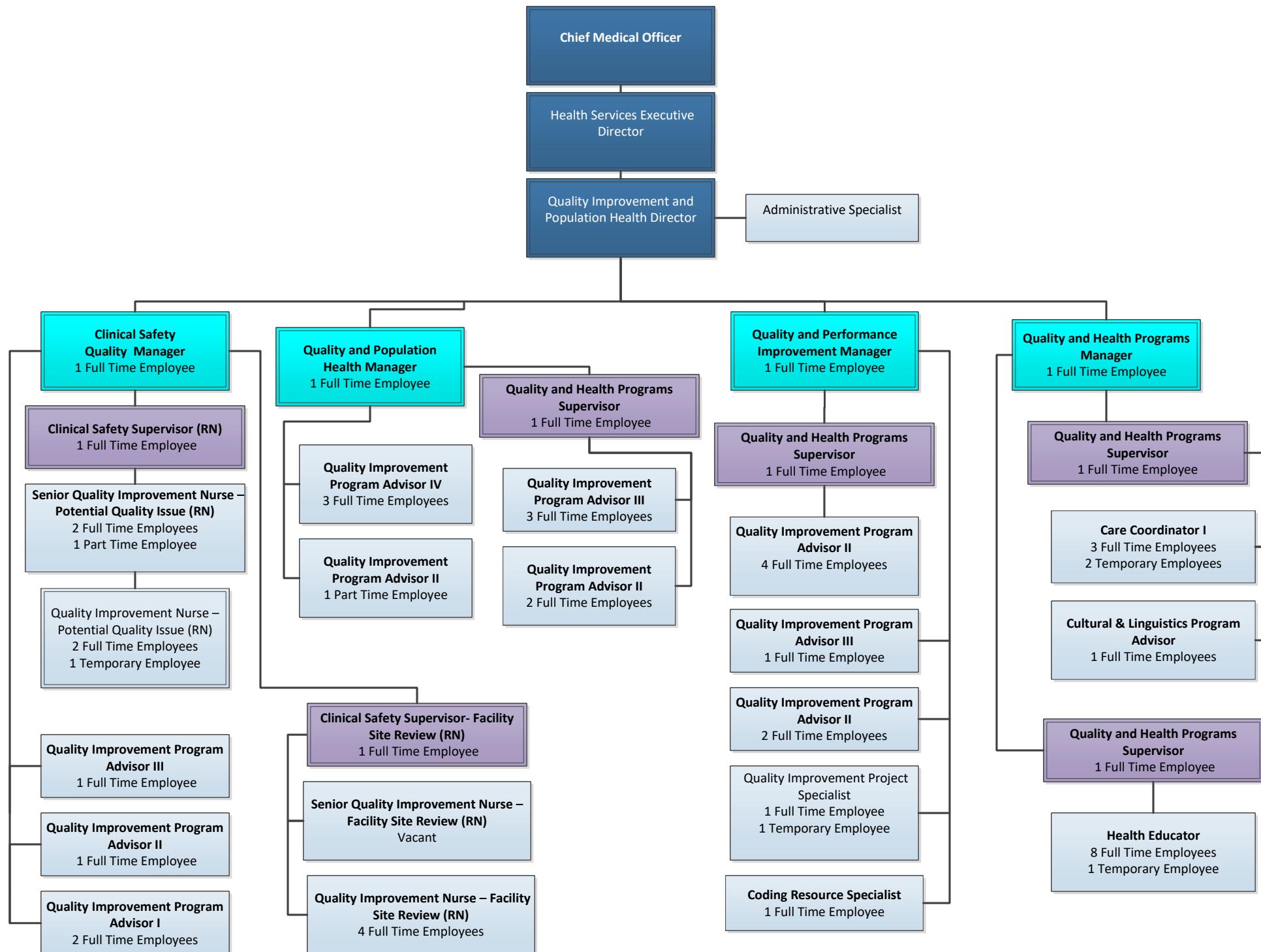
[72] DHCS All Plan Letter 19-017

[73] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.3.10

[74] DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 5.3.7

[75] DHCS APL 24-004 Quality Improvements and Health Equity Transformation Requirements

Quality Improvement Health Equity Transformation (QIHET) Program Reporting Structure

Board

Alliance Board of Commissioners

- Finance Committee
- * Peer Review & Credentialing Committee (PRCC)
- Physicians Advisory Group (PAG)
- Member Services Advisory Group (MSAG)
- Whole Child Model Family Advisory Committee (WCMFAC)
- Whole Child Model Clinical Advisory Committee (WCMCAC)

Administration

CEO

Compliance Committee
Reports to the Board

Cross - Divisional

* QI & Health Equity Committee((quarterly)
Reports to the Board

Operations Committee

Member Support and Engagement Committee (MSEC)

Network Development Steering Committee (NDSC)

Staff Grievance Review Committee (SGRC)
Reports to Compliance Committee ad hoc

QI & Health Equity Workgroup

Utilization Management Work Group (UMWG)

* Pharmacy & Therapeutics Committee (P&T)

Care-Based Incentive Work Group (CBIWG)

Member Reassignment Committee

Managed Care Accountability Set (MCAS) Workgroup

DSNP / STARS Workgroup

* Includes attendees from outside the Alliance

Updated October 23, 2025

Chief Medical Officer

Health Services Executive Director

Quality Improvement and Population Health Director

Administrative Specialist

Clinical Safety Quality Manager
1 Full Time Employee

Clinical Safety Supervisor (RN)
1 Full Time Employee

Senior Quality Improvement Nurse – Potential Quality Issue (RN)
2 Full Time Employees
1 Part Time Employee

Quality Improvement Nurse – Potential Quality Issue (RN)
2 Full Time Employees
1 Temporary Employee

Quality Improvement Program Advisor III
1 Full Time Employee

Quality Improvement Program Advisor II
1 Full Time Employee

Quality Improvement Program Advisor I
2 Full Time Employees

Quality and Population Health Manager
1 Full Time Employee

Quality Improvement Program Advisor IV
3 Full Time Employees

Quality Improvement Program Advisor II
1 Part Time Employee

Quality and Health Programs Supervisor
1 Full Time Employee

Quality Improvement Program Advisor III
3 Full Time Employees

Quality Improvement Program Advisor II
2 Full Time Employees

Clinical Safety Supervisor- Facility Site Review (RN)
1 Full Time Employee

Senior Quality Improvement Nurse – Facility Site Review (RN)
Vacant

Quality Improvement Nurse – Facility Site Review (RN)
4 Full Time Employees

Quality and Performance Improvement Manager
1 Full Time Employee

Quality and Health Programs Supervisor
1 Full Time Employee

Quality Improvement Program Advisor II
4 Full Time Employees

Quality Improvement Program Advisor III
1 Full Time Employee

Quality Improvement Program Advisor II
2 Full Time Employees

Quality Improvement Project Specialist
1 Full Time Employee
1 Temporary Employee

Coding Resource Specialist
1 Full Time Employee

Quality and Health Programs Manager
1 Full Time Employee

Quality and Health Programs Supervisor
1 Full Time Employee

Care Coordinator I
3 Full Time Employees
2 Temporary Employees

Cultural & Linguistics Program Advisor
1 Full Time Employees

Quality and Health Programs Supervisor
1 Full Time Employee

Health Educator
8 Full Time Employees
1 Temporary Employee

DATE: January 28, 2026

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

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

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

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

Background. To define the role and responsibilities of the Alliance's Quality Improvement
Health Equity Committee (QIHEC), as contractually required by the 2024 Medi-Cal Contract

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

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

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

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

HEALTHY PEOPLE. HEALTHY COMMUNITIES.

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity Committee	
Original Date: 02/01/1996	**Date Published:** ~~10/27/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Purpose

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

Policy

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

Definitions[4]

1. Corrective Action: Specific identifiable activities or undertaking of the Alliance that address program deficiencies or problems.

2. Managed Care Accountability Set (MCAS): A set of measures mostly comprised of Healthcare Effectiveness Data and Information Set (HEDIS) measures established by the National Committee for Quality Assurance (NCQA). Other measures included were developed by the Centers for Medicare & Medicaid Services (CMS) and the American Dental Association's Dental Quality Alliance. After consulting with MCPs and the External Quality Review Organization (EQRO), DHCS determines which measures are appropriate as report-only and which measures the MCPs must exceed the MPL as determined by DHCS. ~~A set of measures based on the Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets selected by DHCS for evaluation of health plan performance.~~

3. Performance Improvement Projects (PIP)[5]: Studies selected by the Alliance, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes.

Procedures

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

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	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity Committee	
Original Date: 02/01/1996	**Date Published:** ~~10/27/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

1. Structure

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

    2.b. 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 TotalCare (HMO D-SNP) (Contract H5692) line of business.

2. Responsibilities

    Primary duties of the QIHEC[8] include the following:

    2.a. Annually reviewing and approving the draft Quality Improvement and Health Equity and Utilization Management Work Plans (QIHEWP and UMWP);

    2.b. Quarterly reviewing progress against active QIHEWP and UMWP goals;

    2.c. A written summary of QIHEC activities, as well as QIHEC activities of its fully delegated subcontractors and downstream fully delegated subcontractors, findings, recommendations, and actions are prepared after each meeting, submitted to the Contractor's Governing Board, provided to DHCS upon request, and published on the Contractor's website quarterly.

    2.d. Ensures Subcontractor and Downstream Subcontractor meet QI and Health Equity standards set forth in this Contract; and

    2.e. Includes Contractor's continuous monitoring, ~~evaluation~~evaluation, and approval of its delegated functions to Subcontractor and Downstream Subcontractor. Contractor must make the findings of its continuous monitoring and evaluation of the Subcontractor and Downstream Subcontractor available to DHCS at least annually, but more frequently when directed by DHCS.

2.f. Analyze and evaluate the results of QI and Health Equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings of the activities of other committees such as the Community Advisory Committee (CAC);

2.g. Institute actions to address performance deficiencies, including policy recommendations;

2.h. Ensure appropriate follow-up of identified performance deficiencies;

2.i. Providing leadership and oversight in the implementation of quality improvement principles and activities in the daily operations of the Alliance;

2.j. Facilitating communication on the status and progress of Alliance QIHETP activities to the Alliance Board on a scheduled basis;

2.k. Participating in the development and/or adoption of specific utilization management criteria[9] and benefit parameters;

2.l. Monitoring the activities of, and providing direction to, all QIHEC subcommittees/ workgroups;

2.m. Stimulating the highest degree of commitment to quality health care and to the goal of continuous improvement;

2.n. Recommending and approving changes to select QIHETP related Alliance policies, practice guidelines, and subcommittees' proposed action plans;

2.o. Overseeing the QIHETP and UM Program policies (Alliance Policies 401-1101 and 404-1101 respectively), and the QIHEWP and UMWP for annual submission to the Alliance Board;

2.p. Reviewing, approving, and submitting the Quality Improvement and Health Equity (QIHE) Annual Report[10] to the Alliance Board;

2.q. Reviewing and advising on QIHETP related Corrective Action plans (CAP), not including credentialing/recredentialing oversight related CAPs. Individual provider issues may be referred to the PRCC and/or Program Integrity Unit depending on the nature of the issue;

2.r. Reviewing standards of care guidelines, as described in Alliance Policy 401-1501 – *Standards of Care*;

2.s. Oversight of language assistance and interpreter services as described in Alliance Policy 401-4101 – *Cultural and Linguistic Services Program*

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

Page 3 of 13

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

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

2.w. Perform all responsibilities required in 42 CFR 422.137(d)(1)-(5), including, but not limited to:

2.w.1. 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;

2.w.2. Receiving and acting upon recommendations from the UMWG.

~~2.u.1~~2.w.3. 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.

3. Requirements

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

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

3.c. Membership: Core membership consists of Alliance network providers, including, but not limited to:

3.c.1. ~~h~~Hospitals, clinics, and county partners;~~.~~

3.c.2. ~~f~~Fully delegated subcontractors ensuring representation of all required specialties as outlined below; and

3.c.3. ~~d~~Downstream subcontractors.

~~They are representative composition~~Members collectively represent ~~of~~ the provider network and provide health care services to members affected by health disparities, ~~L~~limited English ~~P~~proficiency (LEP), ~~C~~children and Youth with ~~S~~special ~~H~~health ~~C~~care ~~N~~needs (CY SHCN), ~~S~~seniors and ~~P~~person~~s~~ with ~~D~~disabilities (SPDs) and persons with

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity Committee	
Original Date: 02/01/1996	**Date Published:** ~~10/27/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

chronic conditions[14].

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 TotalCare (HMO D-SNP) line of business (Contract H5692), including

3.c.4.   A majority of members who are practicing physicians;

3.c.5.   At least one independent physician free of conflict;

3.c.6.   Clinical expertise regarding the care of elderly or disabled individuals; and

3.c.7.   Representation from various specialties.

Committee members must be in good standing with the Alliance. Good standing is defined as:

~~3.b.1.~~3.c.8.   Having an unrestricted license to practice medicine or osteopathic medicine in the state of California; and,

~~3.b.2.~~3.c.9.   Not having an open accusation or disciplinary action by any state licensing board; and,

~~3.b.3.~~3.c.10.   Not having any ongoing or unresolved program integrity corrective action plans (CAPs).

~~3.c.~~3.d. Core Alliance staff membership includes the Chief Medical Officer, Chief Executive Officer, Chief Administrative Officer, Chief Health Equity Officer, Health Services Officer, Medical Director(s), QIPH Director, QIPH Managers, Quality and Health Programs (QHP) Manager, QIPH Nurse Supervisor, Care Management Director (CM), Communications Director, Enhanced Health Services Director, Member Services (MS) Director or designees Pharmacy Director, Program Services Director, Provider Services (PS) Director, Regional Operations Directors, Utilization Management Director (UM), and Behavioral Health Manager. Ad-hoc (non-core) membership varies as topics mandate.

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

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

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

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

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

~~3.i.~~3.j. Reporting:

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

~~3.i.2.~~3.j.1.

~~3.i.3.~~3.j.2.   Annually: The QIHE Program Description is submitted to the QIHEC for review, and approval and submission to the alliance Board, and subsequent submission to DHCS and NCQA. The purpose of the QIHEW 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 received by our members and participants.

~~3.i.4.~~3.j.3.   Annually: The QIHE Annual Program Evaluation[19] is submitted to the QIHEC for review, approval and submission to the Alliance Board, and subsequent submission to DHCS and NCQA. The QIHE Annual Program Evaluation includes:

~~3.i.4.a.~~3.j.3.a.   A comprehensive assessment of the QI and Health Equity activities undertaken, including an evaluation of the effectiveness of QI interventions;

~~3.i.4.b.~~3.j.3.b.   A written analysis of required quality performance measure results, and a plan of action to address performance deficiencies, including analyses of each Fully Delegated Subcontractor's and Downstream Fully

Page 6 of 13

Delegated Subcontractor's performance measure results and actions to address any deficiencies;

~~3.i.4.c.~~3.j.3.c. An analysis of actions taken to address any recommendations in the annual External Quality Review (EQR) technical report and specific evaluation reports;

~~3.i.4.d.~~3.j.3.d. An analysis of the delivery of services and quality of care and its Fully Delegated Subcontractors and Downstream Fully Delegated Subcontractors, based on data from multiple sources, including quality performance results, Encounter Data, Grievances and Appeals, Utilization Review, and the results of consumer satisfaction surveys;

~~3.i.4.e.~~3.j.3.e. Planned equity-focused interventions to address identified patterns of over- or under-utilization of physical and behavioral health care services;

~~3.i.4.f.~~3.j.3.f. A description of Contractor's commitment to Member and/or family focused care through Member and community engagement such as review of CAC findings, Member listening sessions, focus groups or surveys, and collaboration with local community organizations; and how Alliance utilizes the information from this engagement to inform policies and decision-making;

~~3.i.4.g.~~3.j.3.g. Population Health Management (PHM) activities and findings as outlined in Exhibit A, Attachment III, Section 4.3 (Population Health Management);

~~3.i.4.h.~~3.j.3.h. Outcomes/findings from Performance Improvement Projects (PIPs), consumer satisfaction ~~surveys~~surveys, and collaborative initiatives;

~~3.i.4.i.~~3.j.3.i. An assessment of subcontracting entities performance of delegated QIHE activities;

~~3.i.4.j.~~3.j.3.j. Copies of all final reports of non-governmental accrediting (e.g., National Committee for Quality Assurance [NCQA]) if relevant, including any CAPs developed to address noted deficiencies, and an assessment of subcontractor performance of delegated quality improvement activities.

~~3.j.~~3.k. Confidentiality[20]:

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

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

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

~~3.k.~~3.l. Conflict of Interest[21]:

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

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

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

~~3.k.4.~~3.l.3.

~~3.k.5.~~3.l.4.   A QIHEC member is deemed to have a conflict of interest if there is any potential for personal, professional, or financial gain in the item being presented, or any other involvement in the matter which may impair the member's objectivity in considering the matter.

4.   Other Committees

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

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

4.c.   Quality Improvement Health Equity Workgroup (QIHE-W): The QIHE-W, under the direction and guidance of the QIHEC, is responsible for addressing high-priority and emerging quality and health equity trends requiring organization-wide and/or cross-departmental response, including, but not limited to, topics related to provider capacity, grievances, member access and satisfaction, and QIHET program activities. The QIPH Director or designee chairs the QIHE-W. Core membership includes: CMO, Medical Director(s), QIPH Director, Chief Compliance Officer, Chief Health Equity Officer, Chief Operating Officer, Health Services Officer, 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, Program Development Director, PS Director, Provider Quality and Network Development Manager, UM Director, Behavioral Health Manager, QIPH Managers, QHP Manager, and UM Managers. Ad-hoc membership varies as topics mandate. The QIHE-W is responsible for activities, including, but not limited to:

4.c.1.   Ongoing review and approval of the QIHEWP, including refining interventions to address barriers and incorporate feedback from the QIHEC, and the QIHE Annual Report[22];

4.c.2.   Annual review and approval of various QIPH policies and related processes and functions;

4.c.3.   Analysis of HEDIS/Managed Care Accountability Set (MCAS) measures and the development of strategies to improve performance;

4.c.4.   Development of QIHETP related provider and member communications;

4.c.5.   Development of disease management initiatives;

4.c.6.   Ongoing oversight of delegated QIHE activities of subcontractors;

4.c.7.   Review of language assistance and interpreter services as described in Alliance Policy 401-4101 – C*ultural and Linguistic Services Program;*

4.c.8.   Review and analysis of provider and member survey results; and

4.c.9.   Review and approval of QIHETP-related standing reports, and state mandated PIPs.

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity Committee	
Original Date: 02/01/1996	**Date Published:** ~~10/27/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

4.d. <u>Care Based Incentives Workgroup (CBIW)</u>: The Care Based Incentives Workgroup (CIWG) purpose is to provide oversight of the Care-Based Incentive program to meet timelines for incentive evaluation, contractual requirements, build schedules, and address issues that may impact the program. The CMO (or designee) chairs the CBIW. Core membership includes: QIPH Director, QIPH Program Advisors, QIPH Managers, QHP Manager, QIPH Project Specialist, QIPH Coding Resource Specialist, Medical Directors, Pharmacy Director (or designee), PS Director (or designee), Contracts Manager, and Analytics Director (or designee)

5. <u>Delegate Oversight</u>[23]

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

References:

Alliance Policies:

   105-0004 – Delegate Oversight

   401-1101 – Quality Improvement ~~and Health Equity Transformation Program~~<u>& Health Equity Transformation Program</u>

   401-1501 – Standards of Care

   401-4101 – Cultural and Linguistic Services Program

   403-1104 – Mission, Composition and Functions of the Pharmacy & Therapeutics Committee

   404-1101 – Utilization Management Program

   <u>404-1108 – Monitoring of Over-Under Utilization of Services & Attachment A</u>

Impacted Departments:

   ~~Community Care Coordination~~ <u>Care Management</u>

   Community Engagement

Compliance

Member Services

Pharmacy

Provider Services

Utilization Management

Regulatory:

Calif.~~ornia~~ Evidence Code § 1157 – Other Evidence Affected or Excluded by Extrinsic Policies

~~California Code of Regulations~~ Title 28 CCR § ~~, Chapter 2, Article 7, Section~~ 1300.70 – Health Care Service Plan Quality Assurance Program

Title 42 CFR § 422.137 – Medicare Advantage Utilization Management Committee

Legislative:

Contractual (Previous Contract):

Contractual (2024 Contract):

Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3

Medi-Cal Contract, Exhibit A, Attachment.3 Provision 2.2.5.B.2 and 2.2.5.B.3

Medi-Cal Contract, Exhibit A, Attachment.3 Provision 3.2.2-3.2.2.1

DHCS All Plan Letter:

AP~~APL 24-004~~L 19-017 – Quality Improvement and Health Equity Transformation ~~Performance Improvement~~ Requirements

NCQA:

Supersedes:

APL 19-017 – Quality and Performance Improvement Requirements is superseded by 24-004

Other References:

Consistent with *Bylaws of the Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission* (December 2023)

Alliance Provider Manual

	POLICIES AND PROCEDURES
Policy #: 401-1201	**Lead Department:** Quality Improvement and Population Health
Title: Quality Improvement Health Equity Committee	
Original Date: 02/01/1996	**Date Published:** ~~10/27/2025~~
Approved by: Quality Improvement Health Equity Committee (QIHEC)	

Attachments:

Lines of Business This Policy Applies To:

☒☐ DSNP

☒ Medi-Cal

☒ Alliance Care IHSS

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
03/11/2024	03/11/2024	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEW
04/25/2024	04/25/2024	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEC
02/19/2025	02/19/2025	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEW
04/25/2025		Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEC
07/17/2025	07/17/2025	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEC
08/29/2025	08/29/2025	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEC
12/12/2025	12/12/2025	Andrea Swan, RN, Quality Improvement & Population Health Director	QIHEC

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

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5 DHCS All Plan Letter 19-017; and DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7

6 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.2

7 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 3.1.4

8 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3

9 DHCS State Medi-Cal Contract, Exhibit A, Attachment 5, Provision 1.D

10 DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 8

11 DHCS State Medi-Cal Contract, Exhibit A, Attachment 4, Provision 6

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

13 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3

14 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3

15 Consistent with *Bylaws of the Santa Cruz-Monterey-Merced Managed Medical Care Commission (December 2023April, 2009)*

16 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3

17 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3

18 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.3

19 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7

20 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7

21 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3 Provision 2.2.3

22 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.7

23 DHCS State Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.2.5

DATE: January 28, 2026

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

FROM: Mike Wang, Chief Medical Officer, MD
              Van Wong, Chief Operating Officer

SUBJECT: Alliance Strategic Plan Annual Update

Recommendation. This report is informational only.

Summary. As the Alliance enters the final year of its five-year strategic plan (2022–2026), this report provides an overview of current performance and defines the strategic objectives that will guide successful completion of the plan in 2026.

Background. In 2021, the Board approved the Alliance's five-year plan with two strategic priorities: **Health Equity (HE)** and **Person-Centered Delivery System Transformation (PCST)**, each with two goals. In September 2022, staff introduced outcome measures to evaluate organizational performance against these goals. Building on improvement efforts from 2023, updated performance measures and refinements were shared in January 2024, reflecting a continued commitment to closing quality gaps and advancing health equity.

On an annual basis, staff provide progress updates on the strategic plan, highlighting areas of achievement as well as opportunities for course correction.

Discussion. 2025 marked a year of accomplishments and the culmination of our 2-year marathon as the Alliance attained 2 National Committee for Quality Assurance (NCQA) accreditations, insourced behavioral health from Carelon, and launched a new product, TotalCare for our dual eligible members. Alongside these initiatives, staff also prioritized advancing the 2 strategic goals of health equity and person-centered system, implementing targeted improvements to enhance outcomes for our members.

2025 Strategic Objectives Outcome
The following outlines performance trends with respect to 2025 targets which were shared with the board in January 2025. On balance, the Alliance is on track with more than half of the measures staff set forth for the year, with two measures at risk. Additional details will be provided during the board presentation outlining successes where the Alliance is on track and challenges where we are off track.

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Strategic Planning - Board Report Q425

	2025 Goal	Status
STRATEGIC OBJECTIVES - Strategic Plan Goals		
Improve Behavioral Health Services: 2.1 Improve behavioral health services and systems to be person-centered and equitable		
a. BH Insourcing Workplan Execution: % timely execution by 12/31/2025 of key milestones as established on the final BH workplan i. Network Development ii. New Hires iii. Operational Readiness	annual % attainment	On Track
b. Post Go-Live Operations (6 months post 7/1/2025) i. % BH Calls to Member Services answered within 30 seconds ii. % Clean BH claims paid timely iii. % BH referrals route to counties within 1 business day iv. % of non-expedited prior authorization requests adjudicated timely	Regulatory TAT	On Track
c. Utilization of Behavioral Health Services: Ensure same level of utilization or better for our members once BH service is in-house (6 months post 7/1/2025)	10.00%	On Track
Person Centered System Transformation: 2.2 -Ensure appropriate Enhanced Care Management program enrollment and member engagement		
a. Achieve at least 3% enrollment of total Medi-Cal population into ECM services	3.5%	On Track
b. Achieve 90% of enrolled ECM members with at least one encounter per enrolled member per month (PEPM)	90.0%	At Risk
Health Equity: 2.3 - Alliance kids in Merced and Mariposa receive the same quality care as the average Medi-Cal kid as measured through HEDIS metrics Total MCAS Pediatric Measures under P50 meeting 5 percentile improvement target	All measures meeting improvement goal	At Risk
Health Equity: 2.4 - Meet NCQA standards for culturally and linguistically appropriate care		
a. Achieve 5% increase in telephonic interpretation service utilization as measured in calls by provider offices	141 PKPY	On Track
b. Achieve 5% increase in face-to-face interpretation service utilization as measured by provider requests	35 PKPY	On Track

Some performance measures remain preliminary due to claims lag. Finalized data will be available throughout 2026, with a deadline of May 2026.

2026 Strategic Objectives & Measures

As Medi-Cal eligibility requirements evolved and the Alliance prepared to launch its D-SNP product line, strategic objectives were realigned to strengthen Medi-Cal enrollment and enhance medical management for TotalCare members with complex needs. The graphic below illustrates some key adjustments in our strategic objectives and performance measures.

Goals	Baseline
STRATEGIC OBJECTIVES	
Health Equity-1: Alliance children in Merced and Mariposa counties receive quality care as compared to the NCQA 50th percentiles for the relevant Medi-Cal HEDIS measures	Varies by County & Measures
Improve % of total MCAS Pediatric Measures by 5%ile OR meet 50th percentile if performance meets MPL Min: 5 | Meets: 6 | Stretch: 7	
Health Equity-2: Increase member retention by delivering culturally and linguistically appropriate outreach and engagement to those undergoing redetermination	
Retain eligibility for % of Medi-Cal members that undergo redetermination Min: 73% | Meets: 75% | Stretch: >80%	74%
Person Centered System Transformation-1: Improve coordination and care for members with behavioral health needs	
Convert % of BH Care Management Referrals to engagement Min: 85% | Meets: 90% | Stretch: 95%	85%
Increase Depression Screening rates Meets: 16% | Stretch: 18%	13.8%
Person Centered System Transformation-2: Ensure timely engagement of enrolled TotalCare members in case management to support their complex needs.	
% of new members receiving case management outreach within 30 days of enrollment Min: 80% | Meets: 85% | Stretch: 90%	N/A
% of members with complex needs having an individualized care plan within 90 days Meets: 90% | Stretch: 95%	N/A
Reduce % of members with avoidable ED visits for TotalCare members compared to non-TotalCare Duals Min: 2% | Meets: 3% | Stretch: 5%	N/A
ONGOING OBJECTIVES - Health Plan Operations	
Maintain Health Plan Operation: % attainment of minimum performance standards on Alliance Dashboard by meeting target for each measure	N/A
Achieve Regulatory Compliance: Annual % attainment of *new* requirements implemented within the established timeline	N/A
TOTAL POINTS	

Under the Health Equity strategic priority, the Alliance continues to focus on pediatric measures, advancing continuous improvement from our 2022 baseline year. In addition, the Alliance is shifting its focus toward linguistically appropriate outreach and member support during the Medi-Cal redetermination process. These efforts are intended to help eligible members retain Medi-Cal coverage amid the unwinding of COVID-19 flexibilities that took effect July 1, 2025, as well as other evolving regulatory requirements.

Under the Person-Centered System Transformation strategic priority, the Alliance is focused on strengthening the system of care for members with complex medical and social needs. With the launch of TotalCare, the Alliance's Dual Eligible Special Needs Plan (D-SNP), this objective emphasizes timely engagement of enrolled members in case management to ensure coordinated, person-centered support aligned with their complex needs.

Progress towards our 2026 strategic objectives will be reported to the Board quarterly.

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

Attachments. N/A

DATE: January 28, 2026

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

FROM: Jessica Finney, Community Grants Director

SUBJECT: 2026 Medi-Cal Capacity Grant Program Investment Plan

Recommendation. Staff recommend the Board approve the 2026 Medi-Cal Capacity Grant Program (MCGP) Investment Plan in this report.

Summary. This report includes the final recommendations for the 2026 MCGP Investment Plan. It provides background on MCGP governance, summarizes the key inputs on critical needs, outlines emerging grantmaking priorities and proposes how the 2026 MCGP Investment Plan could address these needs and priorities through new and existing funding opportunities. The reference document *MCGP Focus Areas, Goals and Priorities* may be found in the consent agenda of this meeting packet as an attachment to the *MCGP End of Year Impact Report*.

Background. Per MCGP governance policy, the Board-approved MCGP annual investment plan serves as a roadmap for MCGP investments, defining grantmaking priorities to address Medi-Cal capacity needs in the Alliance's service area and allocating funding to advance the goals under each grantmaking focus area. The investment plan aligns with the Board-approved MCGP framework, including focus areas, strategies, goals, Medi-Cal purpose, and sustainability requirements. The Board-approved grantmaking focus areas are: 1) Access to Care; 2) Healthy Beginnings; and 3) Healthy Communities. These focus areas, approved in 2022, categorized unmet and emerging Medi-Cal needs and opportunities, aligned with organizational and State priorities and aimed upstream investments to target root causes and prevention. The approval of an annual investment plan allows the Board to provide high-level strategic direction for the MCGP year over year and direct staff to manage program implementation and budgets based on allocated funding to meet identified community needs.

Discussion. In October 2025, staff presented the emerging priorities for MCGP investments in 2026 to the Board for consideration and input on key inputs gathered to date. Staff proposed how the MCGP budget could address identified priorities through new and existing funding opportunities in 2026.

The priorities informing the 2026 Investment Plan were identified by: 1) conducting an environmental scan of the current health care landscape, including the significant impacts of HR1 and State budget and policy priorities; 2) reviewing alignment with Alliance strategic priorities; 3) analyzing themes from each county's Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP); 4) evaluating stakeholder-identified needs obtained through interviews and surveys; 5) soliciting input from the Member and Physician Advisory Groups; and 6) assessing community uptake of existing funding opportunities.

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Based on this analysis, the following key priorities emerged that align with existing MCGP focus areas and strategies:

1. Workforce and infrastructure to improve access to high quality services, care coordination and culturally competent care.
2. Support for safety net providers to maintain or expand capacity to deliver essential services.
3. Community education and engagement to support Medi-Cal member enrollment and retention.
4. Capacity building for community-based organizations to deliver and sustain Community Health Worker benefit to deliver health care navigation and health education services.

Staff recommend a total award amount target of $20M for 2026. Based on current financial projections, it does not appear that over the next three years there will be any annual fiscal year surpluses for the Board to allocate to the MCGP. This means that the MCGP will need to operate within the existing funding for the next several years. As such, staff recommend limiting the annual award target for the MCGP to $20M in 2026.

	2025	2026	2027	2028	2029	2030
Annual Award Target	$35M	$20M	$15M	$10M	$10M	$10M
Remaining Budget	$65M	$45M	$30M	$20M	$10M	$0

Based on available funding to address identified priorities, staff recommend the 2026 MCGP Investment Plan as outlined below with the recommended $20M total award target for 2026 allocated across three strategies.

Focus Area	Strategy	Allocation
Access to Care	Healthcare Workforce *including support for care cap closure*	50% $10M
Access to Care	Health Care System Infrastructure *including support for safety net capacity*	30% $6M
Healthy Communities	Community Resources, Engagement & Empowerment	20% $4M

Conclusion. After approval of the 2026 MCGP Investment Plan, staff will refine existing programs, develop new opportunities, and make funding opportunities available for local health care providers and community partners in the Alliance's five-county service area. Funding requests that address emerging opportunities under the three strategies could be considered if funding is available.

During 2026, the MCGP annual investment planning process will be aligned with the Alliance's organizational strategic planning, providing additional input to both efforts. It will also provide the opportunity for the Board to consider recommended changes to the MCGP Focus Areas, Goals, and Priorities for 2027 and going forward.

<u>Fiscal Impact</u>. This recommendation would allocate a total of $8,500,000 from the MCGP unallocated budget to fund grant programs in each county developed under the Board-approved focus areas and strategies.
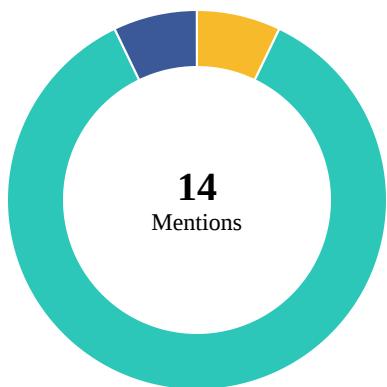
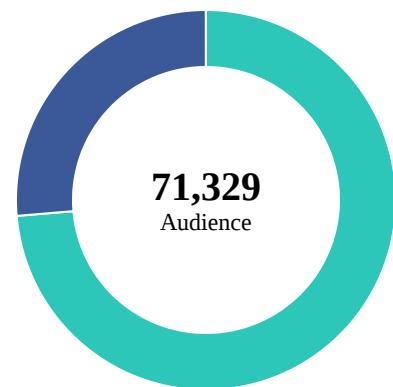<u>Attachments</u>. N/A

January 2026 Board Report

Mention Analytics

Mentions by Media Type

14
Mentions

⬤ Radio ⬤ Online News ⬤ Facebook

Audience by Media Type

71,329
Audience

⬤ Radio ⬤ Online News ⬤ Facebook

Publicity by Media Type

$907
Publicity

- Radio
- Online News
- Facebook

Impact Metrics

📻	**0** Total Radio Audience	**$0** Total Radio Publicity
🌐	**52.5k** Total Online Audience	**$907** Total Online Publicity
#	**18.8k** Total Social Audience	**$0** Total Social Publicity

14 Total Mentions

Mentions 14   **Audience** 71,329   **Publicity** USD $907

Dec 25, 2025 8:25 AM EST   ● Neu.   **1**

🔴 **Mental health care clinic for underserved opens**

| **Source** BenitoLink (CA) | **Market** Hollister, CA | **Type** Digital News | **Category** Local |

... Benito County Behavioral Health of its overflow of referrals. "Counties see more extreme cases than we do," she said. "So we get referred a lot from counties with their mild cases." Geraldine Arce with Behavioral Health agreed, adding the County "looks forward to possibly collaborating through **Central California Alliance for**

Dec 24, 2025 8:53 AM EST

● Neu. **2**

🌐 **Mental health care clinic for underserved opens**

| Source | Benito Link | Market | Hollister, CA | Type | Digital News | Category | Local |

... Benito County Behavioral Health of its overflow of referrals. "Counties see more extreme cases than we do," she said. "So we get referred a lot from counties with their mild cases." Geraldine Arce with Behavioral Health agreed, adding the County "looks forward to possibly collaborating through **Central California Alliance for**

Dec 24, 2025 8:00 AM EST

● Neu. **3**

🌐 **Mental health care clinic for underserved opens**

| Source | Benito Link | Market | United States | Type | Digital News |

... Benito County Behavioral Health of its overflow of referrals. "Counties see more extreme cases than we do," she said. "So we get referred a lot from counties with their mild cases." Geraldine Arce with Behavioral Health agreed, adding the County "looks forward to possibly collaborating through **Central California Alliance for**

Dec 11, 2025 5:00 AM

4

📻 **KAZU_FM 90.3**

| Station | KAZU_FM 90.3 |

On a sunny Friday afternoon, people line up outside Monterey County's Department of Social Services (DSS) office in Salinas. Nearby, Outreach Coordinator Brenda Nunez Rodriguez inspects a mobile outreach van as she prepares for an event happening the next day in Soledad, where she and her team will be handing out

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Dec 10, 2025 6:50 PM EST

● Pos. **5**

❶ **Monterey Herald** ✔

| Type | Post 📌 | Page Followers | 18.8k |

Medi-Cal is California's health insurance program for low-income families, seniors and adults with disabilities. It covers medical care, dental services and prescription medicine for eligible residents. After someone qualifies, the Central Coast Alliance for Health helps connect recipients with physicians and covered medical services.

Dec 10, 2025 5:30 PM EST

● Pos. **6**

🌐 **Medi-Cal benefits paperwork deadline quickly approaching**

| Source | Monterey Herald | Market | Monterey, CA | Type | Digital News | Category | Local |

... before the end of the year, citing an increase in signups. Medi-Cal is California's health insurance program for low-income families, seniors and adults with disabilities. It covers medical care, dental services and prescription medicine for eligible residents. After someone qualifies, the **Central Coast Alliance for Health**

Dec 5, 2025 4:23 PM EST

● Neu. **7**

🌀 **AT YOUR SERVICE**

| Source Monterey County Weekly | Market Seaside, CA | Type Print | Category Local |

... the pandemic, to just 488 referrals in 2024. (That decrease was due in part to the end of pandemic relief programs, and also the region's Medi-Cal provider, Central California Alliance on Health, pulling out and instead opting to develop its own system. Mad fis has tried unsuccessfully to recruit **CCAH** back into the fold.

Dec 1, 2025 1:17 PM EST

● Pos. **8**

🌐 **Public meetings for the week of Dec. 1**

| Source Benito Link | Market United States | Type Digital News |

... . Dec. 2 San Benito County Board of Supervisors at 9 a.m. The complete agenda is here. Dec. 2 San Benito County Water District at 5 p.m. The complete agenda is here. Dec. 2 San Juan Bautista Historic Resources Board and Planning Commission at 6 p.m. The complete agendas are here and here. Dec. 4 **Central California**

Nov 25, 2025 4:24 PM EST

● Neg. **9**

🌀 **Los Banos homeless housing project breaks ground, with 58 units planned**

| Source The Merced Sun-Star (California) | Market Merced, CA | Type Print | Category Local |

... to be completed and ready to accept residents in the fall 2026, according to Adam Conour of Anabasis. It will include 50 one-bedroom units, four two-bedroom unites and four three-bedroom units. The money for the project has been provided by California's Encampment Resolution Funding and the **Central California Alliance**

Nov 25, 2025 2:22 PM EST

● Neg. **10**

🌐 **Los Banos homeless housing project breaks ground, with 58 units planned**

| Source Merced Sun-Star | Market Merced, CA | Type Digital News | Category Local |

Those at risk of becoming homeless will have a temporary place to stay in Los Banos next year. A groundbreaking ceremony for a 58-unit community, called One Tree Cottages, was held in Los Banos on Friday. The $14.3 million project is a joint venture between the city of Los Banos and Anabasis LLC, a real estate investment

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Nov 24, 2025 7:51 PM EST

● Neg. **11**

🌐 **Los Banos da inicio a la construcción del proyecto de vivienda permanente One Tree**

| Source Los Baños Enterprise | Market Los Banos, CA | Type Digital News | Category Local |

... de la construcción de este desarrollo de 58 unidades. Líderes locales, organizaciones colaboradoras y miembros de la comunidad asistieron al evento, que destacó el esfuerzo conjunto detrás del proyecto. Durante la ceremonia, la ciudad reconoció a Anabasis LLC y al desarrollador Adam Conour, a **Central**

Nov 24, 2025 7:11 PM EST

● Pos. **12**

🌐 **Los Banos Breaks Ground on One Tree Permanent Supportive Housing Project**

| **Source** Los Baños Enterprise | **Market** Los Banos, CA | **Type** Digital News | **Category** Local |

... marking the official start of construction on the 58-unit development. City leaders, partner organizations, and community members attended the event, which highlighted the collaborative effort behind the project. During the ceremony, the city recognized Anabasis LLC and developer Adam Conour, the **Central California**

Nov 13, 2025 3:25 AM EST

● Neu. **13**

🌐 **United Way Monterey County develops a tool designed to make life easier for people in nee…**

| **Source** Monterey County Weekly | **Market** United States | **Type** Digital News |

... the pandemic, to just 488 referrals in 2024. (That decrease was due in part to the end of pandemic relief programs, and also the region's Medi-Cal provider, Central California Alliance on Health, pulling out and instead opting to develop its own system. Madfis has tried unsuccessfully to recruit **CCAH** back into the fold. "Building

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Nov 12, 2025 7:00 PM EST

● Neu. **14**

🌐 **United Way Monterey County develops a tool designed to make life easier for people in nee…**

| **Source** Monterey County Weekly | **Market** United States | **Type** Digital News |

ON MONDAY AFTERNOON, OCT. 13, A GROUP OF 20-SOME REPRESENTATIVES OF COUNTY AGENCIES, NONPROFITS AND POLICYMAKERS are gathered in a conference room at the Monterey County Office of Education headquarters in Salinas. They're here for the monthly meeting of the

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Visit us at

www.CriticalMention.com

Enrollment Report

County: *None* **Program:** *None* **Aid Cat Roll Up:** *None* **Data Refresh Date:** *1/6/2026 6:33:09 AM*

Enrollment Month
1/1/2025 to 1/31/2026

Membership Totals by County and Program, % Change Month-over-Month and % Change Year-over-Year
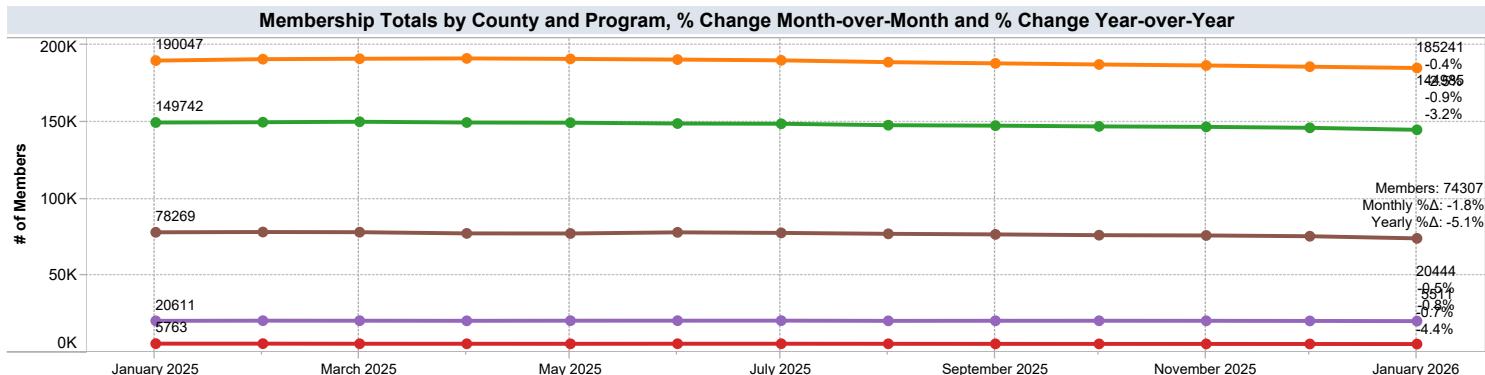
LOB	County	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
Medi-Cal	SANTA CRUZ	78,269	78,444	78,328	77,549	77,492	78,231	77,868	77,272	76,891	76,381	76,201	75,703	74,114
	MONTEREY	189,363	190,306	190,580	190,809	190,499	190,066	189,571	188,357	187,534	186,783	186,139	185,335	184,348
	MERCED	149,742	149,934	150,230	149,740	149,625	149,084	148,928	147,991	147,690	147,202	146,900	146,293	144,908
	MARIPOSA	5,763	5,766	5,698	5,681	5,657	5,704	5,709	5,657	5,617	5,599	5,587	5,551	5,496
	SAN BENITO	20,611	20,716	20,695	20,634	20,707	20,723	20,741	20,603	20,653	20,666	20,637	20,555	20,427
IHSS	MONTEREY	684	680	675	663	654	650	648	680	727	731	738	731	735
DSNP Total Care	SANTA CRUZ													193
	MONTEREY													158
	MERCED													77
	MARIPOSA													15
	SAN BENITO													17
Total Members		**444,432**	**445,846**	**446,206**	**445,076**	**444,634**	**444,458**	**443,465**	**440,560**	**439,112**	**437,362**	**436,202**	**434,168**	**430,488**

■ MONTEREY
■ MERCED
■ SANTA CRUZ
■ SAN BENITO
■ MARIPOSA

Provider Bulletin

A **quarterly** publication for providers. | **December** 2025

CENTRAL CALIFORNIA ALLIANCE · FOR HEALTH®

ACCREDITED NCQA HEALTH PLAN ACCREDITED

ACCREDITED NCQA HEALTH EQUITY ACCREDITED

MEDICAID HMO

Alliance Board Meetings

Wednesday, Jan. 28
3 p.m. to 5 p.m.

Wednesday, Feb. 25
3 p.m. to 5 p.m.

Wednesday, March 25
3 p.m. to 5 p.m.

Whole Child Model Clinical Advisory Committee Meetings

Tuesday, Dec. 16
Noon to 1 p.m.

Physicians Advisory Group Meetings

Thursday, March 5
Noon to 1:30 p.m.

Keeping our communities covered

We understand that upcoming Medi-Cal changes have created confusion and uncertainty for many families seeking to maintain access to care. The Alliance is doing all we can to retain every eligible member and help as many new people as possible gain coverage before the end of the year. Both are essential to protect continuity of care and expand access to those who need it most.

To meet the need, we are using various outreach and communication tactics to keep members enrolled and encourage new enrollees.

- **Direct outreach:** The Alliance has launched a multi-channel outreach campaign. This includes paid media campaigns, website resources and text reminders to help members stay informed and maintain their coverage.
- **Community outreach and partnerships:** Conducting member outreach and working with trusted organizations, including providers, to help people understand the redetermination process or apply for Medi-Cal for the first time.
- **Digital campaigns:** Using online messaging to spread awareness that Medi-Cal benefits and eligibility remain unchanged through the end of the year.
- **Newsletters:** Including reminders in Alliance newsletters to act quickly to obtain or maintain coverage.

We ask for your support in these efforts. Please remind members to open renewal notices and respond quickly – and inform them that Medi-Cal enrollment remains open to all through the end of the year.

Thank you for your continued partnership and for all you do for our communities.

Michael Schrader
Michael Schrader, CEO

MY2024 HEDIS award recipients

The Alliance is proud to recognize our **Healthcare Effectiveness Data and Information Set (HEDIS) award recipients for Measurement Year 2024 (MY2024)**.

These awards, grounded in the National Committee for Quality Assurance (NCQA) clinical measure guidelines, highlight the outstanding performance of our provider network in delivering high-quality care to Alliance members.

Award selection reflects a range of factors, including the number of members served, breadth of NCQA measures addressed, superior measure rate performance, and consistency of meeting or exceeding minimum performance thresholds.

We extend our congratulations to the following providers for their exceptional commitment to excellence in patient care.

AWARDEES

Acacia Family Medical Group – Prunedale

Acacia Family Medical Group – Salinas

Alisal Health Center

Clínica del Valle del Pájaro

Laurel Family Practice Clinic

MFA G Street

MFA Livingston

MFA Parkside

Pediatric Medical Group of Watsonville

Plazita Medical Clinic

Romie Lane Pediatric Group

Salinas Pediatric Medical Group, Inc.

Salud Para La Gente

Seaside Family Health Center

St. Junipero Children's Clinic

Check out all the photos of this year's HEDIS award recipients at **www.thealliance.health/HEDIS**.

Self-care during the holidays

The holiday season often brings increased stress for both patients and providers. As medical and mental health providers, self-care is essential – not only for personal health but also to maintain the capacity to care for others effectively.

Set boundaries around work and personal time
Take breaks, even short ones, to rest and recharge. Incorporate regular movement, healthy meals and snacks, and adequate sleep into your daily routine. Mindfulness practices, like deep breathing or meditation, can help reduce stress and enhance focus.

Stay connected with your support system (colleagues, friends and loved ones)
Sharing experiences helps reduce isolation and fosters resilience. At the same time, it is OK to limit over-commitment and give yourself permission to say no.

Reflect on what brings you joy during this season
Whether it's quiet time, creativity or celebration, prioritize those moments. Remember, modeling healthy self-care also encourages patients to do the same. By caring for yourself, you strengthen your ability to care for others during this demanding time of year.

2026 Care-Based Incentive (CBI) program

The Alliance's CBI program includes a set of measures encouraging preventive health services and connecting Medi-Cal members with their primary care providers (PCPs). The CBI program pays qualifying contracted provider sites, including family practice, pediatrics and internal medicine, for:

- Programmatic measures (paid annually based on rate of performance in each measure).
- Fee-for-service (FFS) measures (paid quarterly when a specific service is performed or a measure is achieved).

New programmatic measures moved from exploratory

Controlling High Blood Pressure – measures members 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mm Hg).

Measure changes

Application of Dental Fluoride Varnish – measure now requires two applications of dental fluoride by the end of 2026. Federally Qualified Health Centers with integrated dental offices can bill dental office claims via the Data Submission Tool.

Breast Cancer Screening – measure is looking at members 40-74 years of age who had a mammogram completed to screen for breast cancer. The measure is now accepting gender-affirming codes.

Chlamydia Screening – measure title changed to be non-gender-specific but is still measuring female members 16-24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia in 2026.

Immunizations: Adolescents – measure now accepts pentavalent meningococcal vaccine (MCV), and the age range for MCV has been expanded to 10-13 years of age.

Social Determinants of Health (SDOH) ICD-10 Z-Code Submission – FFS measure changed to $100 per member per tax ID per ICD-10 diagnosis code for PCPs who submit claims using any of the DHCS SDOH ICD-10 Z codes (All Plan Letter 21-009). Payment is not to exceed $7,500 per tax ID within the CBI term.

Child and Adolescent Well-Care Visits (3-21 years), Well-Child Visits in the First 15 Months, and Well-Child Visits for Age 15 Months to 30 Months of Life – removed telehealth visits from the numerator.

Coding updates

Chlamydia Screening: sex assigned at birth code exclusions.

Cervical Cancer Screening:
- Code Q0091 is no longer accepted for CBI 2026 program year.
- Self-collected hrHPV codes added.
- Sex assigned at birth code exclusion.

Leverage data to improve outcomes

What to know about Alliance Provider Portal reports

The Alliance offers patient-level reports for clinics to monitor linked members for patient outreach, establish routine preventive care and reduce adverse health outcomes.

- **Linked Member Reports** offer reports like newly linked members, members in need of an initial health appointment, or members seen in the Emergency Department or hospital.
- **Quality Reports** track information such as required screenings and well-visits. These reports are available to download to reconcile to your clinic's electronic health record for patient recall.
- **Care-Based Incentive (CBI) Reports** include your quarterly CBI performance, as well as member-level data and gap analysis.
- **HEDIS (MCAS) Reports** cover measures for which the Alliance is held to the minimum performance level (MPL) in the Medi-Cal Managed Care Accountability Set (MCAS) audit. If the Alliance doesn't exceed the MPL in these measures, the Plan may be subject to sanctions. These reports provide clinics with insight into their monthly performance in advance of quarterly CBI Reports.
- **The Data Submission Tool (DST)** is available for providers to submit data that is not captured via claims.

Email **portalhelp@thealliance.health** for more information.

TotalCare ℠
HMO D-SNP

TotalCare (HMO D-SNP) Model of Care training

Alliance TotalCare (HMO D-SNP) providers are required to complete the 2026 Model of Care (MOC) provider training. The Centers for Medicare & Medicaid Services require MOC training to be completed upon onboarding and annually thereafter.

MOC training is required to be completed by all employed, contracted and temporary staff, including providers (in or out of network) routinely participating as part of the member's interdisciplinary care team. Provider staff may include:

- Care coordination staff.
- Administrative staff.
- Other clinical or support staff.

To complete this training, you must review the training slide deck on our website and complete the attestation. You can find this training at www.thealliance.health/ totalcare-2026-moc-training.

Be on the lookout for future D-SNP trainings on our website at **www.thealliance.health/ trainings**.

If you would like to join our D-SNP provider network, email us at **joinus@thealliance.health**. Learn more at **www.thealliance. health/totalcare-recruitment**.

HEALTHY PEOPLE. **HEALTHY** COMMUNITIES.

MEDICALLY TAILORED MEALS BENEFIT

Food as medicine

As part of our Community Supports (CS) services, the Alliance covers medically tailored meals (MTMs). MTMs help meet the dietary needs of members with chronic diseases, based on a registered dietitian's assessment.

MTMs have been shown to:
- Help reduce hospital stays, emergency department readmissions and health care costs.
- Improve outcomes for members with specific diet-sensitive conditions.

We encourage you to refer eligible Alliance members!

Benefit details
The benefit covers up to two meals per day for up to 12 weeks. Providers can request extensions or renewals, but you need to indicate that MTMs are part of a treatment plan for the relevant diet-sensitive condition.

Members can get medically tailored groceries, food boxes or premade meals delivered to their home.

MTMs are meant to be part of a treatment plan, not to respond to food insecurities alone. Meals that are eligible for or reimbursed by alternate programs are not eligible.

Qualifying diagnoses
Qualifying diagnoses include:
- Diabetes and prediabetes.
- Hypertension.
- Hyperlipidemia.
- Congestive heart failure.
- Cardiovascular disease, including coronary artery disease, peripheral vascular disease or stroke.
- HIV/AIDS.
- Cancer (undergoing active treatment beyond surgery).
- Malnutrition.
- Obesity.
- Gestational diabetes or other high-risk perinatal conditions.

- Severe mental illness referred or managed by county behavioral health.
- Chronic kidney disease.
- Fatty liver disease.

For more details on eligibility criteria, please see Alliance Policy 404-1745, Community Supports Policy for Medically Tailored Meals/Medically Supportive Food, which is available on our "Provider Manual" page: **www.thealliance.health/providermanual/resources**.

How to refer
You can refer eligible members for the MTM benefit on our website at **www.thealliance.health/mtm-referral**. Members can also refer themselves for the benefit at **www.thealliance.health/membermtm**.

Questions? Contact our Provider Services team at **831-430-5504**.

Supporting patients with immunizations: Key provider talking points

Vaccines are a safe and effective way to protect ourselves from serious, often life-threatening diseases. It is essential that providers give clear, science-based information to build trust and support families in making informed, confident decisions.

Common concerns and how to respond

"There are too many vaccines given at once."
Children's immune systems handle thousands of germs daily. The vaccine schedule is safe and carefully researched.

"How do I know they're safe?"
Vaccines go through years of testing and are constantly monitored. Serious side effects are very rare and far less risky than the diseases they prevent.

"Do vaccines cause autism?"
Extensive research shows no connection. The original study has been thoroughly discredited.

"I've seen negative information online."
Gently redirect. Try this: "That's a common claim online, but large studies show otherwise. Would you like me to explain what we know from science?"

Communication tips

Listen and validate: "It's normal to have questions."

Share your personal experience: "I vaccinate my own children. I'd never recommend something I wouldn't give them."

Stay calm and nonjudgmental: Your tone builds trust.

AAP recommendations on vitamin D for infants

The American Academy of Pediatrics (AAP) recommends that all children receive vitamin D beginning shortly after birth. It's important that providers educate families on using liquid vitamin D supplements for infants and consider supplementation for older children who aren't getting the recommended intake through diet. Early intervention ensures long-term skeletal and overall health.

Why it's important

Vitamin D is essential for bone health, supporting the absorption of calcium and phosphorus.

Beyond bone strength, vitamin D also plays a role in immune system function and has been linked in research to mental health, with deficiencies associated with an increased risk of depression.

Vitamin D recommendations

- Infants under 12 months should receive 400 international units (IU) daily.
  - Breastfed infants require a supplement of 400 IU per day.
  - Formula-fed infants also need supplementation unless they consume at least 32 ounces of fortified formula daily.
  - Liquid drops are the preferred option for infants.
- Toddlers, older children and adolescents need 600 IU daily.

HEALTHY PEOPLE. **HEALTHY** COMMUNITIES.

Health resources and tools for self-management

The Alliance offers health education programs and resources to help members get healthy and stay healthy. Share our online self-management tools to help members learn about different health topics.

The tools are available in the "Health and Wellness" area of our website for the following topics:

Healthy eating, healthy weight, physical activity

Tools for children and teens: Includes personalized eating plans, a BMI calculator for children and teens, and a physical activity planner. Available at **www.thealliance.health/healthy-weight**.

Tools for adults: Includes personalized eating plans, a physical activity planner and a healthy weight assessment. Available at **www.thealliance.health/adult-weight-management**.

Depression, managing stress, avoiding at-risk drinking and quitting tobacco

Tools for adults: Includes a depression self-test, resources to manage stress and a tool to check drinking habits. Available at **www.thealliance.health/behavioral-health-care**.

Quitting tobacco tools for adults: Includes a quit plan and self-help materials to provide support with quitting tobacco and/or smoking. Available at **www.thealliance.health/quitting-tobacco**.
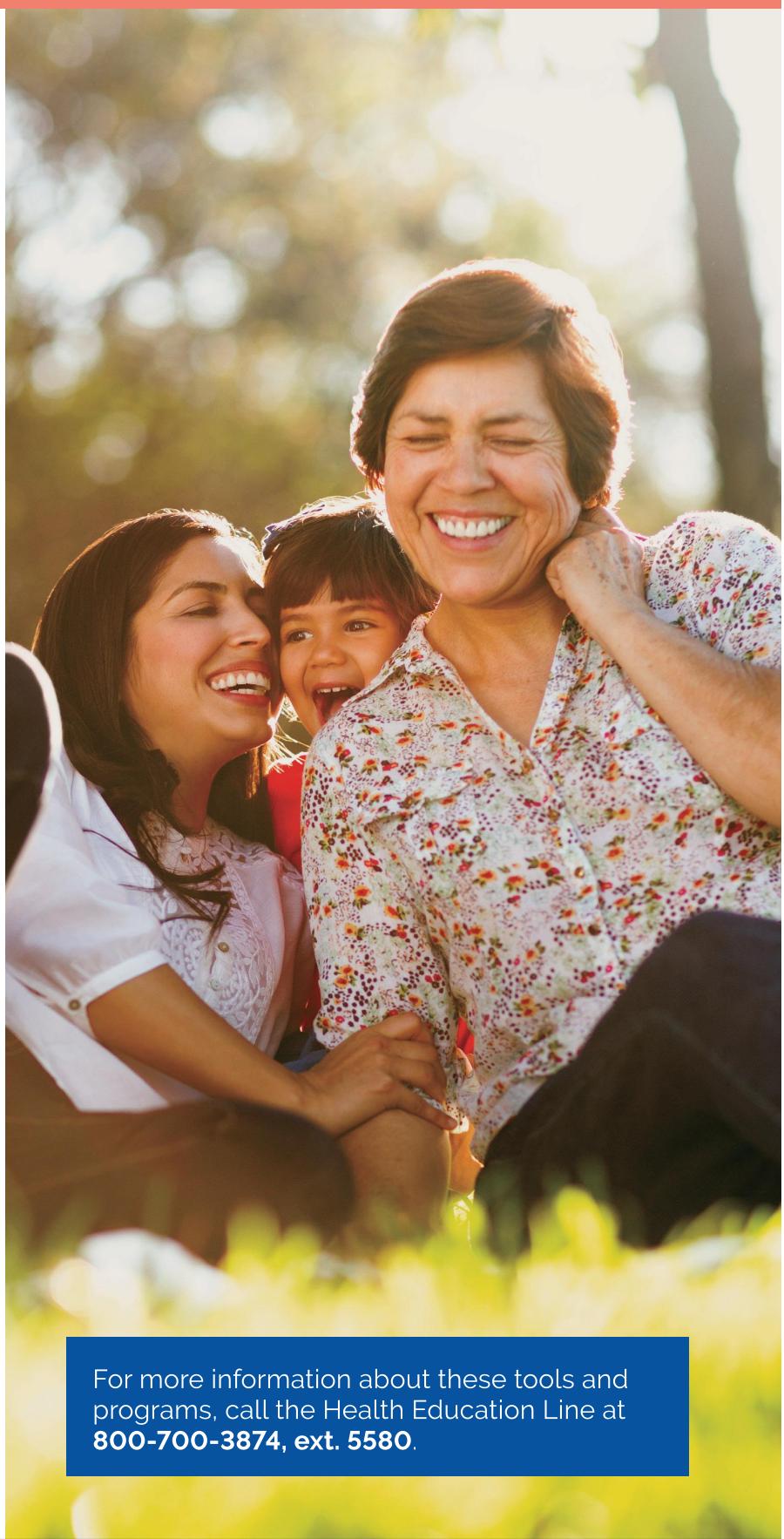
For more information about these tools and programs, call the Health Education Line at **800-700-3874, ext. 5580**.

Yearly provider fraud, waste and abuse (FWA) trends

From August 2024 to August 2025, the Alliance's Program Integrity Unit investigated approximately 72 provider-related referrals for suspected fraud, waste and abuse (FWA). The Alliance must report all suspected FWA to the California Department of Health Care Services – and for In-Home Supportive Services cases, to Monterey County. When appropriate, the Alliance's Special Investigations Unit may also notify the California Department of Justice.

The Alliance's FWA prevention program ensures compliance with federal and state standards through policies and procedures for employees, subcontractors and network providers. These include:

- Commitment to anti-FWA standards.
- Procedures for preventing and detecting FWA.
- Education on the False Claims Act and whistleblower protections.

Referrals may come from internal staff, providers, members, regulators or anonymous sources. Investigations may involve claim and medical record reviews, claim denials, payment recovery, and corrective action plans.

Key concerns identified in 2024–2025

False claims and billing. Claims submitted for services not provided, not documented or billed after a member's death.

Overutilization and impossible days. Some providers were flagged as outliers for billing for unusually high daily visit volumes. In some cases, claims lacked modifiers to show supervising and nonmedical physicians, inflating service counts.

Medical record concerns. Issues included unsupported dates of service, cloned documentation and potential record falsification.

Improper use of Enhanced Care Management and Community Supports services. Claims submitted for ineligible members with concerns such as improper linkage, vague care plans and missing outreach documentation.

Unnecessary or nonmedically necessary services. The Alliance urges providers to ensure accurate documentation and comply with federal and state laws. Proper billing helps safeguard federal funds and supports high-quality care for Alliance members. Providers should report suspected FWA to their Provider Relations Representative or through the anonymous online Report Compliance and Fraud, Waste and Abuse Concerns Form at **www.thealliance.health/potential-compliance-concern-report**.

For billing or compliance questions, providers should contact Provider Relations for guidance.

Virtual remote interpreter now available!

The Alliance now offers Virtual Remote Interpreter (VRI) services for providers to utilize. VRI services are a good option when an in-person interpreter might not be available or easy to access.

Examples where VRI services may be appropriate include:
- For telehealth appointments.
- To support members who are deaf or hearing-impaired.
- To support languages that are harder to fill in the appointment area.

Provider offices must have the required technology to utilize VRI services. You can find more information on our website at **www.thealliance.health/cultural-linguistic-services**.

To access VRI services, providers must complete the Interpreter Request Form on our website at **www.thealliance.health/interpreterrequestform** and submit it by fax to **831-430-5850**.

For assistance, call the Alliance Health Education Line at **800-700-3874, ext. 5580**. Providers can also reach out to their Alliance Provider Relations Representative for language assistance needs.

Alliance physician-administered drug list and procedures

The Alliance's physician-administered drug list, restrictions, prior authorization criteria, policies and their updates are available on the "Pharmacy Services" page at **www.thealliance.health/pharmacy-services**. If you would like to request physical copies, please contact the Pharmacy team at **831-430-5507**.

Claims submission reminder: Multiple rendering physicians

Please be advised that our claims processing system cannot accommodate claims that include multiple rendering physicians across different service lines. To ensure successful claim submissions and avoid rejections, separate claims must be submitted for each rendering physician.

For further assistance or billing-related inquiries, please contact our Claims Customer Service team at **831-430-5503**.

Thank you for partnering with us to provide accessible, quality health care guided by local innovation!

Important phone numbers

Provider Services **831-430-5504**
Claims. **831-430-5503**
Authorizations **831-430-5506**
Status (non-pharmacy) . . **831-430-5511**
Member Services. **831-430-5505**
Web and EDI **831-430-5510**
Cultural & Linguistic
Services. **831-430-5580**
Health Education Line. . . **831-430-5580**

Welcome, new providers!

New ECM/CS providers

- **Bridge Community Services of CA.** ECM/CS housing services. Monterey County.
- **Connect America LLC.** CS environmental accessibility adaptations, personal emergency response systems. All counties.
- **First 5 Monterey County.** ECM services. Monterey County.
- **Harvest Healthcare Solutions.** ECM/CS housing services. Merced County.
- **Holly Hughes & Co.** ECM services. Santa Cruz County.

- **MACT Health Board, Inc.** ECM services. Mariposa County.
- **Mercy Medical Center (Dignity Health).** ECM services. Merced County.
- **Mujeres Adelante, Inc.** ECM services. Merced County.
- **Noel Health System, Inc.** ECM/CS respite care, recuperative services, short-term post-hospitalization housing, personal care and homemaker services. Merced County.
- **Youth Alliance.** ECM/CS housing transition navigation services and housing deposits. San Benito County.
- **Youth Recovery Connections.** CS sobering center. San Benito County.

Other providers

We'd like to extend a warm welcome to over 200 new providers who joined the Alliance network! This includes ECM/CS providers, primary care providers, referral physicians, specialists and our new behavioral health network.

The Alliance now contracts with a network of behavioral health providers across our service area to directly manage nonspecialty mental health services for our members. If you are interested in joining our behavioral health network, visit **www.thealliance.health/bh**.

To see the full list of new providers, visit our website at **www.thealliance.health/new-providers-dec-2025**. To view a list of all Alliance providers, see the Provider Directory at **www.thealliance.health/providerdirectory**.

Holiday office closures

Wednesday, Dec. 24: Christmas Eve

Thursday, Dec. 25: Christmas Day

Thursday, Jan. 1, 2026: New Year's Day

Monday, Jan. 19, 2026: Martin Luther King Jr. Day

Monday, Feb. 16, 2026: Presidents Day

Living **Healthy**

A newsletter for the members of
Central California Alliance for Health

# Questions about Medi-Cal? We're here for you

If you're worried about your Medi-Cal coverage, you're not alone. The Alliance is here to help.

Medi-Cal is still open to everyone who qualifies. Nothing has changed about who can get it or what it covers. Some members may see changes to their benefits starting in January 2026, but for now, you should keep seeing your doctor and getting the care you need.

You can also get care without leaving home. Ask your doctor if they offer phone or video visits. You can call our 24/7 Nurse Advice Line at **844-971-8907** (TTY: Dial **711**), book a virtual visit through Rocket Doctor at **844-996-3763**, or connect with a doctor or promotora de salud through Zócalo Health at **213-855-3465**.

If you need more information, visit **www.thealliance.health/medi-cal-changes** or call Member Services at **800-700-3874** (TTY: Dial **711**), Monday through Friday, from 8 a.m. to 5:30 p.m.

We're here for you and your family.
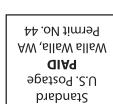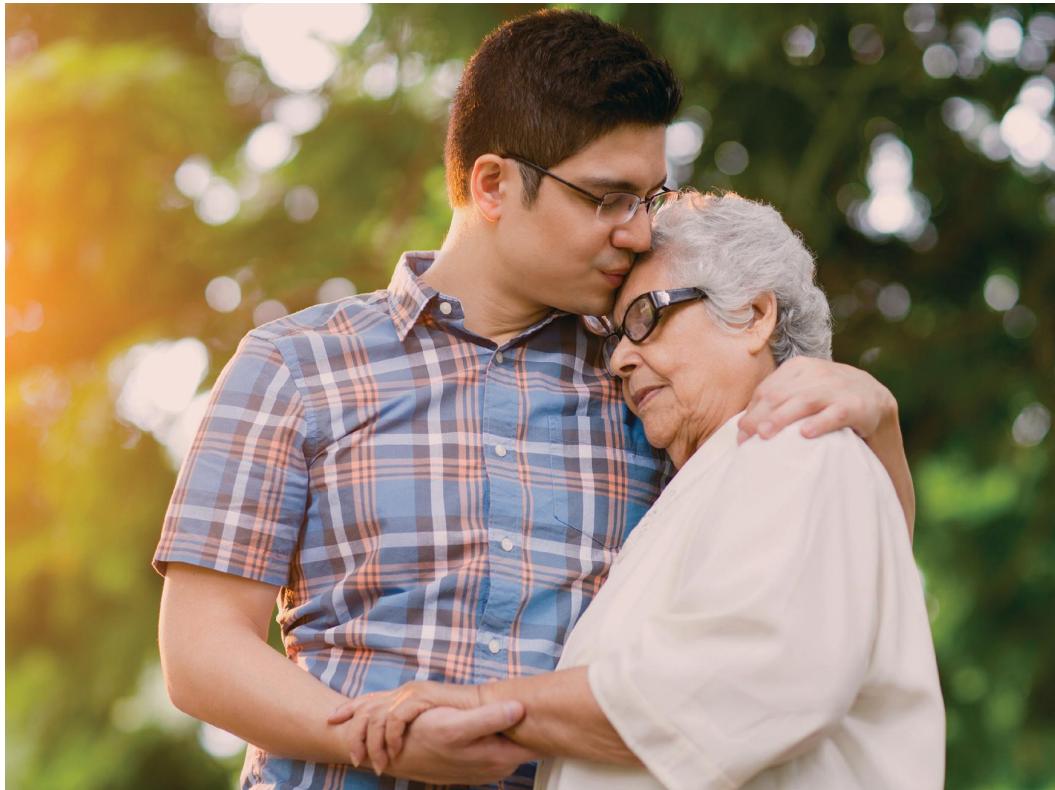
Ask the **doctor**

What should I do if I can't see my doctor right away?

Dr. Mai Bui-Duy is a Medical Director at Central California Alliance for Health. She practiced Internal Medicine primary care in Santa Cruz County for seven years and has 15 years of experience in the medical field.

Sometimes you get sick when your doctor's office is closed. Maybe you need help fast. If you can't see your doctor right away, you have other ways to get care.

Here are some ways to get care:
- Call your doctor's office advice line.
- Schedule a telehealth visit.
- Call our Nurse Advice Line.
- Visit an urgent care clinic.

What is a doctor's advice line?
Some doctor's offices have a phone line you can call when you need medical help. This line connects you to someone who can answer your questions and tell you what to do next.

What is telehealth?
Telehealth is when a doctor can see you on a video call while you stay at home. The Alliance now partners with Rocket Doctor to provide telehealth visits for flu symptoms, sore throat, allergies, digestive problems, skin conditions, urinary tract infections and more.

This service is covered by the Alliance and is available in English and Spanish. Visit **www.rocketdoctor.io/contact/california** to schedule an appointment.

What is the Nurse Advice Line?

If you are not sure where to go or what to do, the 24/7 Nurse Advice Line can help you. A nurse can help you decide if you need to go to urgent care, go to the emergency room or wait to see your doctor. Call **844-971-8907** (TTY: Dial **711**) to talk to a nurse. You can also visit **www.thealliance.health/NAL** to learn more.

What are urgent care clinics?

Urgent care is for things that are not life-threatening, like minor injuries, illnesses and infections. These clinics may offer services like x-rays and stitches. Visit **www.thealliance.health/urgent-care** to learn more.

What if I think it's serious?

If you think you are having an emergency or something that is life-threatening, call **911** or go to the emergency room right away.

These options can help you get care when you need it. If you have questions, call the Alliance Member Services Department at **800-700-3874** (TTY: Dial **711**). We're here to help!

You have prescription benefits!

If you are a Medi-Cal member, your prescription drugs that are filled at a pharmacy are covered by Medi-Cal Rx and not the Alliance. To find out if a drug is covered, call **800-977-2273** (TTY: Dial **711**) or go to **www.medi-calrx.dhcs.ca.gov**.

If you are an IHSS member, pharmacy services are managed by MedImpact. You can view the list of covered drugs at **www.thealliance.health/prescriptions**. You can also request a mailed copy by calling Member Services at **800-700-3874** (TTY: Dial **711**).

Drugs given in a doctor's office or clinic

These are considered physician-administered drugs (PAD). You can view coverage information in the Member Handbook and at **www.thealliance.health/prescriptions**. If you would like a mailed copy, please call Member Services at **800-700-3874** (TTY: Dial **711**).

Health resources and self-management tools

At the Alliance, we care about your health. That's why our health education programs give Alliance members the tools to be as healthy as possible.

The Alliance offers self-management tools to help you and your family learn about different health topics. These tools can be found on our Health and Wellness website.

Healthy eating, healthy weight, physical activity

Self-management tools for children and teens
These tools include a personalized eating plan, a BMI calculator for children and teens, and a physical activity planner. They can be used anytime to help maintain a healthy weight, eat healthy and encourage physical activity with your family.

Self-management tools for adults
These tools include a personalized eating plan, a physical activity planner and a healthy weight assessment. They can be used anytime to help maintain a healthy weight, eat healthy and fit physical activity into your week.

Depression, managing stress and avoiding at-risk drinking

Self-management tools for adults
These tools include a depression self-test, resources for how to manage stress and a tool to check drinking habits. Use each tool to search for the topics that you need. If you feel you need more help, you can talk to your doctor.

Quitting tobacco

Self-management tools for adults
These tools include a quit plan and self-help materials to help you with quitting tobacco and/or smoking.

Visit the Alliance's Health and Wellness website to find the self-management tools at **www.thealliance.health/ health-and-wellness**. For more information about self-management tools or health education programs, call the Health Education Line at **800-700-3874, ext. 5580**. For the Hearing or Speech Assistance Line, call **800-735-2929** (TTY: Dial **711**).

Alternative formats

Alliance members, did you know you can get your written information in different formats? These formats can help you if you have trouble seeing or hearing. Examples of alternative formats are:

- **Braille:** small bumps or raised dots you can feel to read if you are blind or have low vision.

- **Audio or data CD:** a CD you can listen to on a computer or a CD player if reading is hard for you.

- **Large print:** bigger letters to help you if you have trouble reading small text.

Want to try it?
The Alliance member newsletter is available on our website in large print and audio format. If you would like other written information in an alternative format, call Alliance Member Services at **800-700-3874** (TTY: Dial **711**), 8 a.m. to 5:30 p.m., Monday through Friday.

Understanding referrals and authorizations

We want to make sure you know how to get services that are covered by your health plan. Below are some important terms used in health care and what they mean.

Referral

If you are assigned to an Alliance primary care provider (PCP), you must have a **referral** to see another doctor.

- If your PCP thinks you need to see another doctor, they will fill out a Referral Consultation Form.
- If we don't have a referral, we can't pay the bill or claim from the other doctor.
- There are some exceptions. See your Evidence of Coverage or Member Handbook for a complete list. The Member Handbook is found online at **www.thealliance.health/ memberhandbook**.

Authorized referral

Our service area includes Mariposa, Merced, Monterey, San Benito and Santa Cruz counties. If your PCP refers you to a doctor out of our service area, they will need to get approval from the Alliance ahead of time. This is called an **authorized referral**.

- This means that we need to approve the referral before you can see the other doctor.
- If you are an Alliance Care In-Home Supportive Services (IHSS) member, you will need an authorized referral if your PCP refers you to a doctor who doesn't work with the Alliance—even if the doctor is in our service area.

- Alliance members who are enrolled in the California Children's Services (CCS) Program will also need an authorized referral for specialty care.

Prior authorization

The Alliance must approve some services, procedures, medications and equipment before you get them. This is called **prior authorization**.

The provider who is going to perform the service must send us a request to let us know what you need and the reason why.

- If the request is medically necessary and a covered benefit, we will approve it and you can get the service.
- If we deny a request, you can file an appeal if you disagree with our decision.

Coping with grief during the holidays

The holiday season can be hard, especially if you are missing someone who passed away, feeling sad after a breakup or facing a big life change. Instead of looking forward to the season, you might feel sadness, anger, tiredness or body aches.

It's OK to feel this way. You don't have to pretend to be happy.

Here are some things that can help

- Call Member Services at **800-700-3874** (TTY: Dial **711**) to request no-cost counseling or support.
- Join a local grief support group, or look for help online at websites like **grief.com**.
- Try to sleep at least 8 hours each night.
- Eat healthy food and drink plenty of water every day.
- Move your body daily. If you haven't exercised in a while, talk to your health care provider about exercise that's right for you.
- Connect with family, friends or neighbors you enjoy being with.
- Try activities like drawing, reading, listening to music or spending time in nature.
- If you are spiritual, connecting with your spiritual practice might also bring you comfort.

You can choose how you celebrate the holidays. It's OK to skip traditions, change them or start new ones.

Grief is different for everyone, and it takes time to heal. Be kind and patient with yourself, and remember—it's OK to ask for help.

Let your voice be heard!

We have many ways for you to let us know how we are doing and how we can improve. One of them is through our Member Services Advisory Group (MSAG).

Through MSAG, we can hear from our members and people who serve our members. We use this information to help us better understand what our members think, want and need. This group is made up of Alliance members and representatives of county and community agencies.

Meetings are held four times per year. Alliance members or parents of an Alliance member can get $50 for going to each meeting.

If you would like to know more about how to join MSAG, please email **msag@thealliance.health**, call the Alliance at **800-700-3874** (TTY: Dial **711**) or visit us online at **www.thealliance.health/msag**.

Opioids: What you need to know

Opioids are strong medicines that help people deal with pain, especially after surgery or an injury. They work by blocking pain signals in the brain. Your doctor may prescribe these medicines, but it is really important to use them the right way. Taking too much or mixing them with other medicines can be dangerous.

Examples of opioids:
- Oxycodone (like OxyContin or Percocet).
- Hydrocodone (like Vicodin).
- Morphine.
- Fentanyl.
- Codeine.

Opioids can be helpful when used correctly, but they can also be very dangerous if not taken the right way.

Medicines that can be dangerous together

Taking opioids with certain other medicines can cause serious problems. Some of these medicines include:
- **Benzodiazepines** (like Xanax, Ativan or Valium)—used for anxiety or sleep.
- **Antipsychotics** (like Abilify, Seroquel or Risperdal)— used for mental health or mood problems.
- **Sedatives** (like Ambien or Benadryl)—used to help with sleep.

All these medicines make your brain and body slow down. When you take more than one at the same time, your body can slow down too much. This can make you feel very tired, pass out (faint) or even stop breathing.

What is naloxone?

Naloxone (brand name Narcan) is a medicine that can reverse an opioid overdose. If someone takes too much of an opioid, naloxone helps them breathe again. It comes as a nasal spray or an injection and works very quickly. If someone is not waking up or is breathing slowly, call **911** and give naloxone right away.

Staying safe with opioids

- Only take medicine that your doctor prescribes for you.
- Never mix opioids with alcohol or other medicines that make you sleepy.
- Keep opioids in a safe place, away from kids.
- Ask your doctor if you should carry naloxone.
- Never share your pain medicine with others.

Opioids can help with pain, but they must be used the right way. Always talk to your doctor or pharmacist if you have questions about how to stay safe.

Care Management can help you get the care you need

It can be tricky to keep track of your health care when you are seeing different doctors or getting care from different places. If you need help with your medical care, prescriptions and behavioral health services, the Alliance can help. Here's how:

- **After the hospital.** Did you just come home from the hospital? We help with follow-up appointments and medicines.
- **Getting to appointments.** Need a ride to see the doctor? We can help set up free rides for you.
- **Special care management.** Need more help? We offer Complex Care Management services.

For more information and help in your own language, call our Care Management team at **800-700-3874** (TTY: Dial **711**). You can also call Alliance Member Services at the same number, Monday through Friday, 8 a.m. to 5:30 p.m. For the Hearing or Speech Assistance Line, call **800-735-2929** (TTY: Dial **711**).

We are texting members!
The Alliance texts members to help them keep up to date on Alliance benefits and services. Alliance texts are from the short code **59849**. To learn more, visit our website at **www.thealliance.health/member-texting**.

At every life stage.
For any health condition.

Trusted, no cost Medi-Cal health care from a local team that understands you.

The Alliance—your ally in being your healthiest self.

Nondiscrimination Notice

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 in a timely manner 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 in a timely manner to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Alliance between 8 a.m. and 5:30 p.m., Monday through Friday, by calling **800-700-3874**. If you cannot hear or speak well, please call **800-735-2929** (TTY: Dial **711**). Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066
800-700-3874
800-735-2929 (TTY: Dial **711**)

HOW TO FILE A GRIEVANCE
If you believe that the Alliance has failed to provide these services or unlawfully discriminated in another way on the basis 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, you can file a grievance with the Alliance's Civil Rights Coordinator, also known as the Senior Grievance Specialist. You can file a grievance by phone, in writing, in person, or electronically:
- **By phone:** Contact the Alliance's Senior Grievance Specialist between 8 a.m. and 5:30 p.m., Monday through Friday, by calling **800-700-3874**. Or, if you cannot hear or speak well, please call **800-735-2929** (TTY: Dial **711**).
- **In writing:** Fill out a complaint form or write a letter and send it to:
    Central California Alliance for Health
    Attn: Senior Grievance Specialist
    1600 Green Hills Road, Suite 101
    Scotts Valley, CA 95066
- **In person:** Visit your doctor's office or the Alliance and say you want to file a grievance.
- **Electronically:** Visit the Alliance's website at **www.thealliance.health**.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:
- **By phone:** Call **916-440-7370**. If you cannot speak or hear well, please call **711 (Telecommunications Relay Service)**.
- **In writing:** Fill out a complaint form or send a letter to:
    Deputy Director, Office of Civil Rights
    Department of Health Care Services
    Office of Civil Rights
    P.O. Box 997413, MS 0009
    Sacramento, CA 95899-7413

    Complaint forms are available at **www.dhcs.ca.gov/Pages/Language_Access.aspx**.
- **Electronically:** Send an email to **CivilRights@dhcs.ca.gov**.

This newsletter is also available in large print and audio formats at **www.thealliance.health/otherformats**.

Daim ntawv tshaj xo no los kuj muaj ua ntawv luam loj thiab kaw ua suab nyob ntawm **thealliance.health/hmn/tag/alternative-access**.
Este boletín también está disponible en formato de letra grande y audio en **thealliance.health/es/tag/alternative-access**.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- **By phone:** Call **800-368-1019**. If you cannot speak or hear well, please call TTY/TDD: **800-537-7697**.
- **In writing:** Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at **www.hhs.gov/civil-rights/filing-a-complaint/index.html**.

- **Electronically:** Visit the Office for Civil Rights Complaint Portal at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**.

Taglines

English
ATTENTION: If you need help in your language call 1-800-700-3874 (TTY: 1-800-735-2929). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-800-700-3874 (TTY: 1-800-735-2929). These services are free of charge.

العربية (Arabic)
يرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير اتصل بـ 1-800-700-3874 (TTY: 1-800-735-2929). هذه الخدمات مجانية.

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1-800-700-3874 (TTY: 1-800-735-2929): Այդ ծառայություններն անվճար են:

ខ្មែរ (Cambodian)
ចំណាំ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមហៅទូរសព្ទទៅលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ សម្រាប់ជំនួយ និងសេវាកម្មផ្សេងៗ សម្រាប់ជនពិការ ដូចជាឯកសារអក្សរស្ទាប និងអក្សរពុម្ពធំៗ ក៏មានដែរ។ សូមហៅទូរសព្ទទៅលេខ 1-800-700-3874 (TTY: 1-800-735-2929)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃនោះទេ។

繁體中文 (Chinese)
请注意：如果您需要以您的母语提供帮助，请致电 1-800-700-3874 (TTY: 1-800-735-2929)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1-800-700-3874 (TTY: 1-800-735-2929)。这些服务都是免费的。

فارسی (Farsi)
توجه: اگر میخواهید به زبان خود کمک دریافت کنید، با (TTY: 1-800-735-2929) 1-800-700-3874 تماس بگیرید. کمکها و خدمات مخصوص افراد دارای معلولیت، مانند نسخههای خط بریل و چاپ با حروف بزرگ، نیز موجود است. با (TTY: 1-800-735-2929) 1-800-700-3874 تماس بگیرید. این خدمات رایگان ارائه میشوند.

Taglines

हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े फ़ॉंट में भी दस्तावेज उपलब्ध हैं। 1-800-700-3874 (TTY: 1-800-735-2929) पर कॉल करें। ये सेवाएं निःशुल्क हैं।

Hmoob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau 1-800-700-3874 (TTY: 1-800-735-2929). Cov kev pab cuam no yog pab dawb xwb.

日本語 (Japanese)

注意日本語での対応が必要な場合は 1-800-700-3874 (TTY: 1-800-735-2929)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。1-800-700-3874 (TTY: 1-800-735-2929)へお電話ください。これらのサービスは無料で提供しています。

한국어 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1-800-700-3874 (TTY: 1-800-735-2929) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼື ອໃນພາສາຂອງທ່ານໃຫໂ້ທຫາເບີ 1-800-700-3874 (TTY: 1-800-735-2929). ຍັງມີຄວາມຊ່ວຍເຫຼື ອແຕ່ລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫໂ້ທຫາເບີ 1-800-700-3874 (TTY: 1-800-735-2929). ການບໍລິການເຫຼ ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊຈ້າຍໃດໆ.

Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1-800-700-3874 (TTY: 1-800-735-2929). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx 1-800-700-3874 (TTY: 1-800-735-2929). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਵੀ ਦਸਤਾਵੇਜ਼ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-800-700-3874 (TTY: 1-800-735-2929). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру 1-800-700-3874 (линия TTY: 1-800-735-2929). Такие услуги предоставляются бесплатно.

Español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1-800-700-3874 (TTY: 1-800-855-3000). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al 1-800-700-3874 (TTY: 1-800-855-3000). Estos servicios son gratuitos.

Tagalog (Filipino)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag sa 1-800-700-3874 (TTY: 1-800-735-2929). Libre ang mga serbisyong ito.

ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) น อกจากนี้ ยังพร้อมให้ค วามช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-800-700-3874 (TTY: 1-800-735-2929) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Українська (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер 1-800-700-3874 (TTY: 1-800-735-2929). Ці послуги безкоштовні.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số 1-800-700-3874 (TTY: 1-800-735-2929). Các dịch vụ này đều miễn phí.

Taglines

La Vida **Saludable**

Un boletín informativo para los miembros
de Central California Alliance for Health

¿Tiene preguntas sobre Medi-Cal? Estamos aquí para usted

Si le preocupa su cobertura de Medi-Cal, no está solo. La Alianza está aquí para ayudarle.

Medi-Cal sigue abierto para todos los que califiquen. Nada ha cambiado en quién puede obtenerlo o qué cubre. Es posible que algunos miembros vean cambios en sus beneficios a partir de enero de 2026, pero, por ahora, debe seguir acudiendo a su doctor y recibiendo el cuidado que necesita.

También puede obtener cuidado sin salir de su casa. Pregúntele a su doctor si ofrece visitas por teléfono o videollamada. Puede llamar a nuestra Línea de Consejos de Enfermeras (Nurse Advice Line; NAL, por sus siglas en inglés) las 24 horas del día, los 7 días de la semana al **844-971-8907** (TTY: Marque **711**), reservar una visita virtual a través de Rocket Doctor en **844-996-3763** o comunicarse con un doctor o promotora de salud a través de Zócalo Health en **213-855-3465**.

Si necesita más información, visite **www.thealliance.health/es/medi-cal-changes** o llame a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**), de lunes a viernes, de 8 a.m. a 5:30 p.m.

Estamos aquí para ayudarles a usted y a su familia.

Pregúntele al **doctor**

¿Qué debo hacer si no puedo ver a mi doctor de inmediato?

La Dra. Mai Bui-Duy es directora médica de Central California Alliance for Health. Practicó el cuidado primario de medicina interna en el condado de Santa Cruz durante siete años y tiene 15 años de experiencia en el campo de la medicina.

A veces se enferma cuando la oficina de su doctor está cerrada. Tal vez necesite ayuda rápidamente. Si no puede ver a su doctor de inmediato, tiene otras formas de recibir cuidado.

Estas son algunas formas de obtener cuidado:
- Llame a la línea de consejos de la oficina de su doctor.
- Programe una visita de telesalud.
- Llame a nuestra Línea de Consejos de Enfermeras.
- Visite una clínica de cuidado de urgencia.

¿Qué es una línea de consejos del doctor?

Algunas oficinas de doctores tienen una línea telefónica a la que puede llamar cuando necesite ayuda médica. Esta línea lo conecta con alguien que puede responder sus preguntas y decirle qué hacer a continuación.

¿Qué es la telesalud?

La telesalud es cuando un doctor puede verlo en una videollamada mientras usted se queda en casa. La Alianza ahora se asocia con Rocket Doctor para proporcionar visitas de telesalud para los síntomas de la gripe, el dolor de garganta, las alergias, los problemas digestivos, las afecciones de la piel, las infecciones del tracto urinario y más.

La Vida **Saludable**

Este servicio está cubierto por la Alianza y está disponible en inglés y en español. Visite **www.rocketdoctor.io/contact/california** para programar una cita.

¿Qué es la Línea de Consejos de Enfermeras?

Si no está seguro de adónde ir o qué hacer, la Línea de Consejos de Enfermeras puede ayudarle las 24 horas del día, los 7 días de la semana. Un miembro del personal de enfermería puede ayudarle a decidir si necesita acudir a cuidados de urgencia, ir a la sala de emergencias o esperar a ver a su doctor. Llame al **844-971-8907** (TTY: Marque **711**) para hablar con personal de enfermería. También puede visitar **www.thealliance.health/es/NAL** para obtener más información.

¿Qué son las clínicas de cuidado de urgencia?

El cuidado de urgencia es para cosas que no son potencialmente mortales, como lesiones menores, enfermedades e infecciones. Estas clínicas pueden ofrecer servicios como radiografías y puntos. Visite **www.thealliance.health/es/urgent-care** para obtener más información.

¿Y qué pasa si creo que es grave?

Si cree que está teniendo una emergencia o algo que pone en peligro su vida, llame al **911** o vaya a la sala de emergencias de inmediato.

📱 Estas opciones pueden ayudarle a recibir cuidado cuando lo necesite. Si tiene preguntas, llame al Departamento de Servicios para Miembros de la Alianza al **800-700-3874** (TTY: Marque **711**). ¡Estamos aquí para ayudar!

¡Tiene beneficios de medicinas recetadas!

Si usted es miembro de Medi-Cal, sus medicinas recetadas que se surten en una farmacia están cubiertas por Medi-Cal Rx y no por la Alianza. Para averiguar si una medicina está cubierta, llame al **800-977-2273** (TTY: Marque **711**) o vaya a **www.medi-calrx.dhcs.ca.gov**.

Si usted es miembro de IHSS, los servicios de farmacia son administrados por MedImpact. Puede ver la lista de medicinas cubiertas en **www.thealliance.health/es/prescriptions**. También puede solicitar una copia enviada por correo llamando a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**).

Medicinas que se administran en la oficina del doctor o en la clínica

Se consideran medicinas administradas por el doctor (PAD, por sus siglas en inglés). Puede ver la información de cobertura en el Manual para Miembros y en **www.thealliance.health/es/prescriptions**. Si desea que se le envíe una copia por correo, llame a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**).

Recursos de salud y herramientas de autocontrol

En la Alianza, nos preocupamos por su salud. Por eso nuestros programas de educación de salud proporcionan a los miembros de la Alianza las herramientas necesarias para estar lo más saludable posible.

La Alianza ofrece herramientas de autocontrol para ayudarles a usted y a su familia a aprender sobre diferentes temas de salud. Estas herramientas se pueden encontrar en nuestro sitio web de Salud y Bienestar.

Alimentación saludable, peso saludable, actividad física
Herramientas de autocontrol para niños y adolescentes
Estas herramientas incluyen un plan de alimentación personalizado, una calculadora de IMC (índice de masa corporal) para niños y adolescentes, y un planificador de la actividad física. Pueden usarse en cualquier momento para ayudarle a mantener un peso saludable, comer de forma saludable y animar a la actividad física con su familia.

Herramientas de autocontrol para adultos
Estas herramientas incluyen un plan de alimentación personalizado, un planificador de la actividad física y una evaluación de peso saludable. Pueden usarse en cualquier momento para ayudarle a mantener un peso saludable, comer de forma saludable y hacer actividad física durante la semana.

Depresión, control del estrés y evitación del consumo de alcohol riesgoso
Herramientas de autocontrol para adultos
Estas herramientas incluyen una autoprueba de depresión, recursos sobre cómo manejar el estrés y una herramienta para verificar los hábitos de consumo de alcohol. Utilice cada herramienta para buscar los temas que necesita. Si cree que necesita más ayuda, puede hablar con su doctor.

Dejar de usar tabaco
Herramientas de autocontrol para adultos
Estas herramientas incluyen un plan para dejar de fumar y materiales de autoayuda para ayudarle a dejar el tabaco o el fumar.

Visite el sitio web de Salud y Bienestar de la Alianza para encontrar las herramientas de autocontrol en **www.thealliance.health/es/ health-and-wellness**. Para obtener más información sobre las herramientas de autocontrol o los programas de educación de salud, llame a la Línea de Educación de Salud al **800-700-3874, ext. 5580**. Para la Línea de Asistencia de Audición o del Habla, llame al **800-855-3000** (TTY: Marque **711**).

Formatos alternativos
Miembros de la Alianza, ¿sabían que pueden obtener su información escrita en diferentes formatos? Estos formatos pueden ayudarle si tiene problemas para ver u oír. Algunos ejemplos de formatos alternativos son:

- **Braille:** pequeños bultos o puntos elevados que puede percibir al leer si es ciego o tiene baja visión.

- **CD de audio o datos:** un CD que puede escuchar en una computadora o en un reproductor de CD si le resulta difícil leer.

- **Letra grande:** letras más grandes para ayudarle si tiene problemas para leer texto pequeño.

¿Quiere probarlo?
El boletín informativo para miembros de la Alianza está disponible en nuestro sitio web en formato de letra grande y de audio. Si desea obtener otra información escrita en un formato alternativo, llame a Servicios para Miembros de la Alianza al **800-700-3874** (TTY: Marque **711**), de 8 a.m. a 5:30 p.m., de lunes a viernes.

Comprensión de las referencias y autorizaciones

Queremos asegurarnos de que usted sabe cómo obtener servicios que estén cubiertos por su plan de salud. A continuación hay algunos términos importantes utilizados en el cuidado de salud y lo que significan.

Referencia
Si se le asigna a un proveedor de cuidado primario (primary care provider; PCP, por sus siglas en inglés) de la Alianza, debe tener una **referencia** para ver a otro doctor.
- Si su PCP piensa que necesita ver a otro doctor, rellenará un Formulario de Consulta de Referencia.
- Si no tenemos una referencia, no podemos pagar el cobro ni la reclamación del otro doctor.
- Hay algunas excepciones. Consulte su Evidencia de Cobertura (Evidence of Coverage; EOC, por sus siglas en inglés) o el Manual para Miembros para obtener una lista completa. El Manual para Miembros se encuentra en línea en **www.thealliance.health/es/memberhandbook**.

Referencia autorizada
Nuestra área de servicio incluye los condados de Mariposa, Merced, Monterey, San Benito y Santa Cruz. Si su PCP le refiere a un doctor fuera de nuestra área de servicio, deberá obtener la aprobación de la Alianza con antelación. Esto se denomina **referencia autorizada**.
- Esto significa que necesitamos aprobar la referencia antes de que usted pueda ver a otro doctor.

- Si es miembro de Servicios de Ayuda a Domicilio (In-Home Supportive Services; IHSS, por sus siglas en inglés) de Alliance Care, necesitará una referencia autorizada si su PCP le refiere a un doctor que no trabaja con la Alianza, incluso si el doctor se encuentra en nuestra área de servicio.
- Los miembros de la Alianza que estén inscritos en el Programa de Servicios para Niños de California (California Children's Services; CCS, por sus siglas en inglés) también necesitarán una referencia autorizada para el cuidado especializado.

Autorización previa
La Alianza debe aprobar algunos servicios, procedimientos, medicinas y equipos antes de que usted los reciba. Esto se llama **autorización previa**.

El proveedor que va a prestar el servicio debe enviarnos una solicitud para informarnos de lo que necesita y el motivo por el cual lo necesita.
- Si la solicitud es médicamente necesaria y es un beneficio cubierto, la aprobaremos y usted podrá obtener el servicio.
- Puede presentar una apelación si rechazamos una solicitud y no está de acuerdo con nuestra decisión.

Hacer frente al duelo durante las fiestas

La temporada de fiestas puede ser difícil, especialmente si se extraña a alguien que falleció, si se siente triste después de una ruptura sentimental o si enfrenta a un gran cambio en su vida. En lugar de esperar con entusiasmo la temporada, puede sentir tristeza, enojo, cansancio o dolores corporales.

Está bien sentirse así. No tiene que fingir que está feliz.

Éstas son algunas cosas que pueden ayudar
- Llame a Servicios para Miembros al **800-700-3874** (TTY: Marque **711**) para solicitar consejería o apoyo sin costo alguno.
- Únase a un grupo de apoyo local para el duelo o busque ayuda en línea en sitios web como **grief.com**.
- Trate de dormir al menos 8 horas cada noche.
- Coma alimentos saludables y beba mucha agua todos los días.
- Mueva el cuerpo diariamente. Si no ha hecho ejercicio en un tiempo, hable con su proveedor de cuidado de salud sobre el ejercicio adecuado para usted.
- Conéctese con familiares, amigos o vecinos con los que disfrute estar.

- Pruebe actividades tales como dibujar, leer, escuchar música o pasar tiempo en la naturaleza.
- Si es espiritual, conectar con su práctica espiritual también puede brindarle comodidad.

Puede elegir cómo celebrar las fiestas. Está bien saltarse tradiciones, cambiarlas o empezar otras nuevas.

El duelo es diferente para todos y lleva tiempo curarse. Sea amable y paciente consigo mismo, y recuerde: está bien pedir ayuda.

¡Deje que su voz sea escuchada!

Tenemos muchas maneras para que nos haga saber cómo nos va y cómo podemos mejorar. Una de ellas es a través de nuestro Grupo Asesor de Servicios para Miembros (Member Services Advisory Group; MSAG, por sus siglas en inglés).

A través del MSAG, podemos escuchar a nuestros miembros y a las personas que atienden a nuestros miembros. Utilizamos esta información para ayudarnos a comprender mejor lo que nuestros miembros piensan, quieren y necesitan. Este grupo está formado por miembros de la Alianza y representantes de agencias del condado y de la comunidad.

Las reuniones se realizan cuatro veces al año. Los miembros de la Alianza o los padres de un miembro de la Alianza pueden obtener $50 por ir a cada reunión.

Si desea obtener más información sobre cómo unirse al MSAG, envíe un correo electrónico a **msag@thealliance.health**, llame a la Alianza al **800-700-3874** (TTY: Marque **711**) o visítenos en línea en **www.thealliance.health/es/msag**.

Opioides: Lo que tiene que saber

Los opioides son medicinas fuertes que ayudan a las personas a lidiar con el dolor, especialmente después de una cirugía o una lesión. Funcionan bloqueando las señales de dolor en el cerebro. Es posible que su doctor le recete estas medicinas, pero es muy importante que las use de la manera correcta. Tomar demasiadas o mezclarlas con otras medicinas puede ser peligroso.

Ejemplos de opioides:
- Oxicodona (como OxyContin o Percocet).
- Hidrocodona (como Vicodin).
- Morfina.
- Fentanilo.
- Codeína.

Los opioides pueden ser útiles cuando se usan correctamente, pero también pueden ser muy peligrosos si no se toman de la manera correcta.

Medicinas que pueden ser peligrosas juntas

Tomar opioides con otras medicinas puede causar problemas graves. Entre estas medicinas tenemos:
- **Benzodiazepinas** (como Xanax, Ativan o Valium): se utilizan para la ansiedad o el sueño.
- **Antipsicóticos** (como Abilify, Seroquel o Risperdal): se utilizan para problemas de salud mental o estado de ánimo.
- **Sedantes** (como Ambien o Benadryl): se usan para ayudar con el sueño.

Todas estas medicinas hacen que el cerebro y el cuerpo se ralenticen. Cuando toma más de una al mismo tiempo, su cuerpo puede ralentizarse demasiado. Esto puede hacer que se sienta muy cansado, pierda el conocimiento (se desmaye) o incluso deje de respirar.

¿Qué es la naloxona?

La naloxona (de nombre comercial Narcan) es una medicina que puede revertir una sobredosis de opioides. Si alguien toma demasiado opioide, la naloxona le ayuda a respirar nuevamente. Viene en forma de aerosol nasal o inyección y funciona muy rápidamente. Si alguien no se despierta o respira lentamente, llame al **911** y administre naloxona de inmediato.

Mantenerse seguro con los opioides

- Solo tome las medicinas que su doctor le recete.
- Nunca mezcle opioides con alcohol u otras medicinas que lo hagan dormir.
- Mantenga los opioides en un lugar seguro, apartado de los niños.
- Pregúntele a su doctor si debe llevar naloxona consigo.
- Nunca comparta sus analgésicos con otras personas.

Los opioides pueden ayudar con el dolor, pero deben usarse de la manera correcta. Hable siempre con su doctor o farmacéutico si tiene preguntas sobre cómo mantenerse seguro.
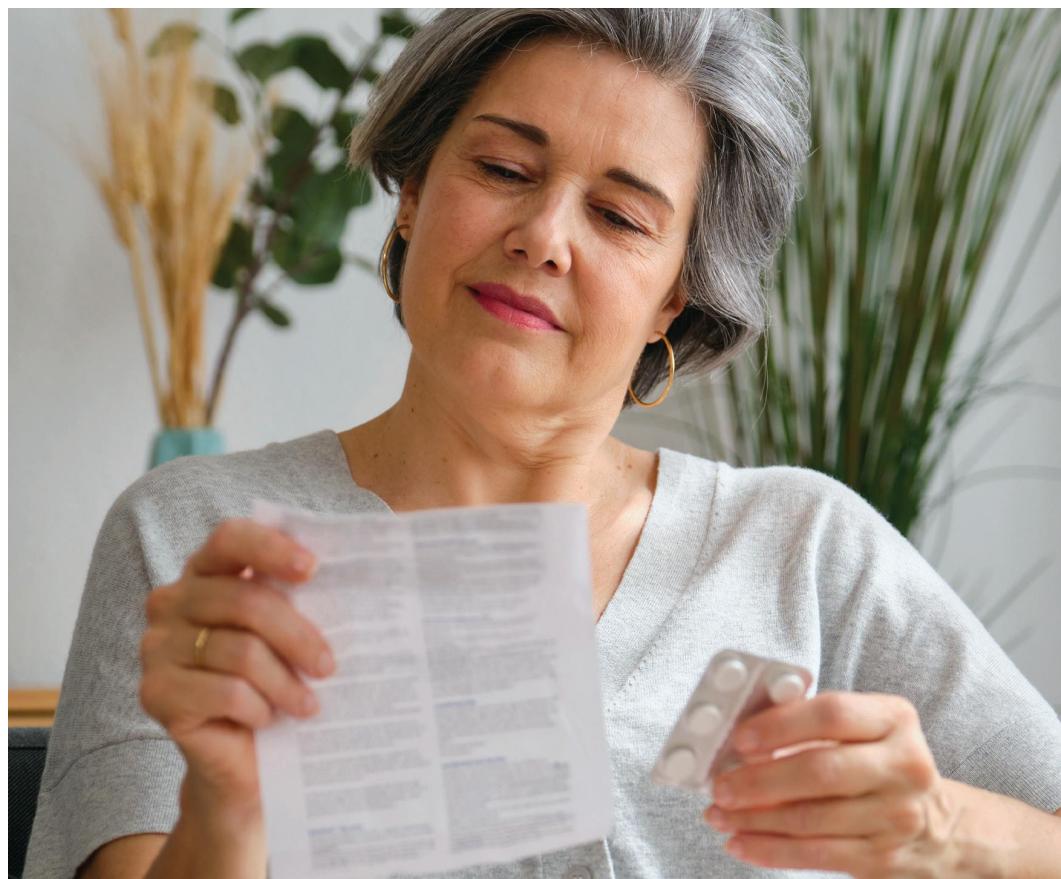
El Manejo de Cuidado puede ayudarle a obtener el cuidado que necesita

Puede ser difícil realizar un seguimiento de su cuidado de salud cuando visita a diferentes doctores o recibe cuidado de diferentes lugares. Si necesita ayuda con su cuidado médico, recetas y servicios de salud de la conducta, la Alianza puede ayudarle. Veamos cómo:

- **Después del hospital.** ¿Acaba de volver a casa del hospital? Ayudamos con las citas de seguimiento y las medicinas.
- **Llegar a las citas.** ¿Necesita transporte para ver al doctor? Podemos ayudarle a organizar transporte gratuito.
- **Manejo de cuidado especial.** ¿Necesita más ayuda? Ofrecemos servicios de Manejo de Casos Complejos.

Para obtener más información y ayuda en su propio idioma, llame a nuestro equipo de Manejo de Cuidado al **800-700-3874** (TTY: Marque **711**). También puede llamar a Servicios para Miembros de la Alianza al mismo número, de lunes a viernes, de 8 a.m. a 5:30 p.m. Para la Línea de Asistencia de Audición o del Habla, llame al **800-855-3000** (TTY: Marque **711**).

¡Enviamos mensajes de texto a los miembros!
La Alianza envía mensajes de texto a los miembros para ayudarles a mantenerse al día sobre los beneficios y servicios de la Alianza. Los textos de la Alianza son del código corto **59849**. Para obtener más información, visite nuestro sitio web en **www.thealliance.health/es/member-texting**.

En todas las etapas de la vida. Para cualquier condición médica.

De confianza; cuidado de salud de Medi-Cal sin costo ofrecido por un equipo local que le entiende.

The Alliance: su aliado en ser su versión más saludable.